The Implications of Nursing Degree Education for Future Workforce Planning in Saudi Arabia: A Case Study

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List of Abbreviations

MoH	Ministry of Health
GDP	Gross Domestic Product
MoHE	Ministry Of Higher Education
PHC	Primary Health Centre
ICN	International Council of Nurses
WHO	World Health Organisation
GCC	Gulf Cooperation Council
UK	United Kingdom
USA	United States of America
KSA	Kingdom of Saudi Arabia
KFSH&RC	King Faisal Specialised Hospital and Research Centre
SCHS	The Saudi Commission for Health Specialties
SA	Saudi Arabia
e.g.	For example
BSN	Bachelor of Science in Nursing
KSMC	King Saud Medical City
NVivo	A qualitative data analysis (QDA) computer software package produced by QSR International
UoS	University of Salford
NHS	National Health Service
PIS	Participant Information sheet
AACN	American Association of Colleges of Nursing
NCLEX	National Council Licensure Examination
TOEFL	Test Of English as a Foreign Language
IELTS	International English Language Testing System

List of Terminology

Nurse Workforce planning	The balancing of nursing workforce demand and supply against recruitment and retention.
Policy	Decisions and plans, usually developed by government/organisational policymakers, for determining present and future objectives of the health care system
Competence	*"the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare and safety"* (Model Practice Act and Rules, NCSBN. 1996: P.12).
Bachelor's Degree	Baccalaureate degree education generally comprises five years of study in SA. On completion of the programme, the graduate receives a Baccalaureate of Science Degree in Nursing (BSN).
Degree education	an academic degree for entry into the nursing profession
Diploma	Diploma education, in general, takes three years to complete in Saudi Arabia. It is hospital based and exists outside typical Higher Education Institutions.
The Saudization Plan	The plan that aims to reduce the dependency on foreign (non-Saudi) labour in order to create more jobs for Saudi nationals (Alhosis et al., 2012).
Registered Nurse	A nurse who has graduated from an accredited nursing programme and met the requirements outlined by a country's licensing body in order to obtain nursing license.
Magnet hospitals	Hospitals identified by their reputations for being good places for nurses to work- evolved from observations that hospitals that were successful in attracting and retaining qualified nurses resembled the most highly ranked U.S. corporations (Aiken et al., 2014).

Dedication

By the grace and mercy of Allah

This dissertation is dedicated to my loving family: to my mother for her kind words and wisdom, for always knowing the right thing to say and for guiding me through my life.

It is dedicated to my loving husband, Saud Albalawi, for his endless support in times of stress and for always believing in me. For his patience and understanding throughout my research, this work is dedicated to my young princes, Nawaf, Bader, Musaad, Omar and Salman, and my beautiful princess, Layan. They are the power source of my joy and happiness, without their smile, courage, and support I wouldn't have overcome challenges and stress of my PhD journey.

Most importantly, this work is dedicated to the memory of the departed soul of my father "Abdulla" who valued education and whose pride in my work has always inspired me to achieve.

I would also like to dedicate this study to my sisters, my brother and all those in my extended family for contributing their time and energy in the completion of this study and I would like to take this opportunity to thank my friends for their courage and support to continue in this work.

Finally, I dedicate this research to every nurse in the world; this thesis is very close to my heart, as are the participants and the nursing profession as a whole. I would like to dedicate this work to all of the nurses because I value, appreciate and admire the work that they do every day.

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It is my pleasure to extend my gratitude to the Ministry of Health for their kindness and willingness to provide me with an environment in which to complete my research for allowing me access to important data. Special thanks go to all the participants from the MoH, Regional Nursing Directorates, and KSMC in Saudi Arabia for their cooperation in the research.

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Abstract

Health system reconfiguration in Saudi Arabia as a response to changing demographics and related health needs is an important and timely driver for the development of nurse education, specifically, the introduction of degree education as a basic requirement for nursing practice. The Saudi government is trying to meet international standards by implementing a change to nurse education by making it an all degree profession. However, as a result, there are many challenges that still need addressing. Utilising a qualitative case study approach, documentary analysis was undertaken and semi-structured interviews were conducted with twenty-five key stakeholders in order to critically assess the actual implications of a nursing degree as the baseline criteria for and to enter nursing practice.

The formal and informal documentary analysis indicated that there was a clear lack of involvement from nurses in the consultation process prior to implementing the degree education policy. However, the interviews conducted with nursing staff (at a macro, meso and micro level) indicated general agreement that a Bachelor degree in nursing would further support the knowledge and communication requirements for improving the quality of nursing practice.

Factors affecting degree attainment included a personal commitment/passion for self-improvement, private versus government institutions, the quality of programmes of education and financial issues. Data indicated the increased knowledge base gained through degree education, supported a growth in confidence, decreased absenteeism, enhanced nursing skills and responsibilities, and gave opportunity for advancement. More importantly, such benefits increased the quality of nursing practice and patient safety outcomes.

Recommendations based on the findings of this study, highlight the importance of a process of consultation between governmental bodies and relevant nursing staff, who are affected by future policy changes. The need for a national curriculum, and a differentiation of nursing job descriptions, based on the education level attained, together with improved clinical supervision for nurses in practice.

Introduction

I have twenty years' experience in a variety of nursing roles including clinical and administrative positions within the Ministry of Health (MoH) in Saudi Arabia (SA). I qualified from a Diploma nursing programme as a Registered General Nurse in 1994. In 2000, I achieved a Bachelor's degree in nursing and worked in clinical and managerial positions. In 2003, I joined a newly established General Directorate of Nursing at the central level of the MoH as Head of Training and Nursing Programmes. In 2009, I obtained my Master's Degree in nursing education from Marymount University, United States of America (USA) and became actively involved in the development of nursing departments in twenty regions of SA, to promote nursing as a profession. I have been involved in a five-year strategic plan of nursing, promoting it as a competitive and professional choice. In 2011, I became Director of Training and Nursing programmes. This role focuses on the assessment of the educational needs for nursing across twenty regions in SA. In 2012, I joined the Nursing Technical Committee of the Gulf Cooperation Council (GCC), a political and economic alliance of six Middle Eastern countries. Working in a national leadership position in nursing helped me to select a topic that has presented a challenge within my current role. My role as a researcher and the influence that I may have exerted upon this study is discussed throughout this thesis (Section 5.2; 5.3; 5.5; 8.6).

The rapid transition and expansion of health services in SA and the current enrolment standards for hospital accreditation (Section 1:3) will change the increasing demand for allied health services in the Saudi health system because of the current shortage of healthcare providers. For example, between 2008 and 2012, both the number of MoH hospitals and the number of beds provided within them has increased by 0.9% (MoH, 2014). However, demographic, socio-economic, technological and cultural changes affect the care that is needed and also raise questions about how that care can best be delivered. Likewise, the recruitment and retention of nurses needs further exploration.

According to Lamadah and Sayed (2014), the Saudi nursing workforce is already under pressure due to nursing shortages, the comparatively poor status of nursing roles and an ageing nursing workforce that is set to retire over the next few years. Furthermore, there are not enough newly qualified nurses to replace the experienced nurses lost through retirement. Almutairi et al., (2015) estimate that the government will take more than

twenty years to train enough Saudi nurses to meet 30% of SA's nursing workforce requirements. It is therefore evident that all of these issues need to due consideration in terms of future nursing workforce planning, and this needs to be undertaken within the context of the nursing degree policy requirements for qualified nurses in SA, in both the short and long-term period.

The minimum educational requirement for entry to the nursing profession established by the MoH in 2010 is a Bachelor's degree. This was introduced in a bid to improve patient care and to elevate the status of Saudi nurses, whilst implementing the World Health Organisation's (WHO) recommendations concerning nurse education. However, the majority of the nursing workforce in SA are only educated to Diploma level (WHO, 2009). The latest statistics in the Health Statistic Annual Book (MoH, 2014) identified 67% of Saudi nurses graduated from Nursing Diploma programmes and 30% from Bachelor of Science/Nursing BSN programmes. This in effect means that there are many diploma-level nurses employed in MoH hospitals. This fact has implications for future nursing workforce planning and development in SA and in light of this, the significance of this research will be explained in the following section

Significance of this Research

Nurses are the largest staff group of the healthcare workforce in SA, and play importance role in promoting health and preventing illness (Aldossary et al., 2008). It is therefore important to understand the implications of nursing degree education as a minimum entry requirement to enter the nursing profession in order to undertake future workforce planning and to evaluate the role of nurses educated to degree level. This research therefore will have the potential to inform future nursing workforce planning and the changing role of the nurse in SA. For example, nursing education is the most important factor to enhance the professionalism of a nursing workforce (Tanaka et al. 2014). The systematic literature review of the impact of degree education upon patient care, presented in Section 3 of this thesis, has not been previously undertaken in SA. The literature review provides an evidence base to inform this thesis. Furthermore, the results of this study will enable recommendations to be made to the MoH on how to best develop a national nursing workforce planning strategy. The study is unique in that it will illuminate the experiences and views of nurses from one region of SA, drawing upon key stakeholder opinions at the

macro (strategic), meso (regional) and micro (operational) levels of nursing policy and practice. Whilst degree education and its outcomes are explored within the global literature, to date there is, comparatively little emergent evidence to inform the national policy and planning of health care and workforce within SA. This study will therefore make an original contribution to nursing knowledge, practice, and policy within SA through the key outcomes of this doctoral study.

Statement of the Research Problem

The MoH implemented the policy of degree education for the nursing profession in SA. Consequently, Diploma-entry nurse education programmes have closed, and there has been no measurement, evaluation or evidence to underpin the implications or impact of the new degree-entry policy. Because of this initiative, employment prospects for newly qualified Diploma nurses are challenging, as they may only be employed in the private health sector on a very low salary. Diploma nurses educated prior to the implementation of the MoH in 2010, policy remain in the hospitals and primary health centres of the MoH, and those working in the public sector face an uncertain future, in terms of career progression and development, as there is no current policy to address their situation, and this will be further explained in Section 1.3. Presently, in SA there are insufficient education opportunities to enable Diploma nurses to convert to a degree qualification. Therefore, it is important to know what the impact is of the degree entry requirement for future workforce planning. Reliance on degree-educated nurses is in itself potentially problematic, as there are not yet enough degree nurses to address the workforce-planning requirements, and there are nursing shortages. In essence, the implications of the MoH policy of degree education in nursing have resulted in some national tensions. For example, it is estimated that 14,000 students in SA have a health-related Diploma, spanning a range of different disciplines; their qualifications have been obtained from private health colleges (Section 2.3). Of these, 25% are nursing students (SABQ 2011). None of these students have been recruited into the nursing profession following the introduction of the Bachelor's degree nurse education policy; the entire health sector, which encompasses public hospitals run by the MoH and private hospitals, has refused to employ them because they do not meet the minimum requirements for practice. The argument is that the health system requires registered nurses who can not only practise across several health settings, both within and beyond hospitals,

but who can also work independently in clinical decision-making roles and accept responsibilities that are more diverse. This policy (2010) has therefore become a serious problem for diploma holder, appearing to be a quick fix by Royal Decree at the time of implementation, but has resulted in some unintended consequences.

Research Aim and Objectives

The aim of this research is to: Critically assess the implications of nursing degree education for future workforce planning in Saudi Arabia, in order to determine a baseline from which to develop a five-year National Nursing Strategy.

Research Objectives
To:

1. Review the MoH rationale for introducing degree level entry for nurse education and assess intended outcomes in terms of national workforce planning.
2. Determine the views of key nursing and administrative stakeholders at the strategic/macro levels of nursing policy and practice, regarding the influence of degree entry requirements on nursing workforce planning.
3. Critically appraise the experiences of a sample of practising nurses at the middle management/meso level of nursing practice, and those at the frontline/micro level of nursing practice, regarding degree education as a minimum entry requirement to the nursing profession.
4. Critically analyse the data and make recommendations that will underpin the future development of a five-year SA National Nursing Strategy for Workforce Planning.

Research Question

The research question is based on the literature review and an assessment of nursing education requirements in SA, as detailed in Chapter Three:
How will the requirements for a Bachelor Degree nurse education impact on the future nursing workforce planning in Saudi Arabia?

Structure of the Thesis

This thesis is divided into eight chapters:

Chapter One provides an overview of the Saudi context, and contains details regarding the demographic data for the country as well as economic and socio-cultural life in SA. The chapter also gives an explanation of the health system, which is divided into public healthcare sectors, other governmental sectors, and a private sector, as well as its challenges and opportunities. Finally, the chapter discusses the government bodies responsible for the legislation of national policy for the health service and education in SA.

Chapter Two provides an explanation of the nursing profession in SA, including a history of nursing in Islam, nursing education in contemporary times, nursing regulation and practice. The chapter also provides information about the history of the GCC Nursing Technical committee and its roles in the Gulf countries. Finally, the chapter concludes by providing an overview of policy perspective and an analysis of global developments in degree nurse education.

Chapter Three reviews the literature that is relevant to the research topic. The literature divided into two sections, the first section gives an overview of worldwide trends in nursing, and the current challenges related to the nursing workforce in SA. The second section involves a comprehensive systemic review of available research. Within this chapter, I critically review the available evidence related to degree education as it relates to nurse workforce planning, as well as exploring the effectual impact of professionalism, degree education and experience on the quality of patient care.

Chapter Four addresses the philosophical and methodological approaches underpinning the study design of this research. The chapter introduces the conceptual framework used in this study; provides details of the research methods, including the sampling strategy, and outlines the data synthesis approach for each aspect of the study, including documents, interviews and focus groups. Furthermore, the trustworthiness, reflexivity and ethical considerations of this research are discussed.

Chapter Five details the data collection phases for the three levels of staff, macro level (socio-political organisational and national level); meso level (policy begins to take shape

in regional level); and micro level (policy operates in local level) working within the MoH. The chapter explains the process of data collection including sampling, and analysis for each level. Finally, the outcomes of each level are presented.

Chapter Six provides the results and discussion of the documentary analysis. The chapter analyse the GCC's implementation process on the changes regarding the degree nurse education policy in SA.

Chapter Seven offers the themes emerging from the focus group and interviews. These are presented and discussed in terms of the three levels of staff participating in the study. The chapter ends with a summarised conclusion of the three levels.

Chapter Eight outlines the conclusion of the thesis. It presents the research's contribution to both new and existing knowledge and, in particular, to workforce planning for the healthcare sector within SA. The strengths and limitations of the study are also presented. Furthermore, the chapter provides recommendations for policy makers in SA. Finally, reflexivity and the researcher's role within the study are outlined.

Chapter 1 :   The Healthcare System in Saudi Arabia

1.1 Introduction

The Introduction has highlighted the structure of the thesis. In order to set the context for the study, this chapter will firstly discuss the demographic, socio-economic and cultural context of Saudi Arabia. Secondly, an analysis of the Saudi health system, which includes three sectors: the public health sector (the MoH), other governmental sectors, and the private sector, will be provided. Finally, the chapter will discuss the government bodies and their roles in legislation of national policy for the health service and education in SA.

1.2 Demographic, Socio-economic and Cultural Context of Saudi Arabia

Saudi Arabia, officially known as the Kingdom of Saudi Arabia, is the largest Arab state in Western Asia. Saudi Arabia was founded by King Abdulaziz Al Saud (Cooper & Simmons, 2005). King Abdulaziz united minor regions of the Arabian Peninsula to form the kingdom in 1932. SA covers an area of 2.25 million square kilometres and is about the size of Western Europe, occupying 80% of the Arabian Peninsula. The country location is strategically important, lying between Africa and mainland Asia, with long borders on the Red Sea, the Arab Gulf and the Suez Canal near to its north-west border (Cooper & Simmons, 2005). The Red Sea lies on the West coast and the Arab Gulf, Bahrain, Qatar and the United Arab Emirates lie to the East. SA has borders with Yemen and Oman in the South, and Jordan, Iraq and Kuwait in the North as illustrated in Figure 1-1.

Figure 1-1: The Kingdom of Saudi Arabia (Central Department of Statistics & Information, 2014

The current total population of SA is 31.2 million; 22.2 million of these have Saudi citizenship, and there are 9 million immigrants (World Population Review, 2016). The latest statistics documented that there has been a significant increase in the total Saudi population over recent decades. In 1960, the total population was only four million people; by 1980, there were 9.8 million people living within the borders of SA. By the 1990s, an increase of over six million people was documented, with the population having reached around 16.14 million people. Subsequently, the population grew by 24.2% and reached 20 million people by 2006, with approximately 22% being non-Saudi. In 2013, the population had reached 29.9 million – 67.6% of them being Saudi and 32.4% non-Saudi – which is almost eight times more than it was just half a century before (World Population Review, 2016; MoH, 2014). It is therefore evident that the Saudi population is rapidly increasing. The resulting financial benefits of this population growth have provided opportunities for the development of Saudi social organisations, including the health and education sectors.

Saudi Arabia is one of the richest and fastest growing countries in the Middle East, and the world's largest producer and exporter of oil (Cooper & Simmons, 2005; Almalki et al, 2011). In 1936, oil was discovered in SA and commercial production started during the Second World War. Oil wealth has precipitated a rapid socio-economic transition over the past years, causing a discernible impact on health status and lifestyle (Aldossary et al., 2008). The Saudi economy is sound and a well-established industry base benefits Saudi society by increasing incomes. Based on the Human Development Report (HDR 2010) SA is ranked at a high level in the human development index (0.75), giving the country a rank of 55 out of 194 countries. Oil wealth has allowed the Kingdom to build development plans and infrastructure. This improvement in the national income is expected to impact positively on healthcare services (Almalki et al., 2011).

The economic and social development of SA has taken place in the context of Islamic religious beliefs (Littlewood & Yousuf, 2000). The Holy Quran (the Holy book of Islam) and the Sunnah (prophetic practice as interpreted by the Prophet Mohammed - peace be upon him [PBUH]) are the main sources of the Islamic religion. Saudi citizens do not practise any religion other than Islam. Islam is thus the main aspect that frames Saudi culture. However, economic status, level of education and environmental factors are also responsible for the formation of culture in SA (Littlewood & Yousuf, 2000; Al-Shahri,

2002). Muslims believe that health, disease and death all come from Allah (the Arabic name for God) (Rassool 2000).

Islam promotes health by encouraging Muslims to practice the Islamic roles that promote health and wellbeing (Al-Shahri 2002), for example, through moderate eating and regular exercise, no alcohol and drug use, good personal hygiene, and breastfeeding (Rassool 2000). On the other hand, the cultural beliefs and habits strongly affect the lifestyle of the Saudi population. For example, rice with meat or chicken (Kabsa) is considered an important dish for Saudi families, and it is provided at lunch and dinner times. This kind of food is rich in fat and carbohydrates, which increases the risk of disease prevalence in SA. Non-communicable diseases account for around 70% of deaths in SA. An alarmingly increasing rate of physical inactivity among Saudis has also been documented (Mahmoud & Faramawi, 2015). Young Saudis are affected by a global epidemic of obesity. The International Diabetes Federation (IDF) reported that there were 3.6 million cases of diabetes mellitus and 22,113 deaths in 2013 related to this illness.

Therefore, the Saudi health system needs to enhance its response to such health issues through a relevant national strategy. The structure and communication between government bodies, which could help to reduce the prevalence of this disease, have been observed to be lacking for many years. For example, (Abdulhadi et al., 2013) clearly highlight the effect of diabetic education on the patients' outcomes, which helps to promote health and to prevent illness. Cardiovascular disease (CVD) is a major health issue that causes 42 % of deaths in SA, and is considered as a leading cause of mortality (WHO 2011). This is the result of the sedentary lifestyle of the Saudi culture, and includes poor diet, smoking, and physical inactivity (Mahmoud & Faramawi 2015). Moreover, asthma, breast cancer, and other non-communicable diseases can lead to death if they are not diagnosed and treated at an early stage.

Women's roles in Saudi Arabia are based on Islamic values, and include being caregivers and housewives (Rassool, 2000; Al-Shahri, 2002; Gazzaz, 2009). Men are considered as the protectors and maintainers of women and family (Rassool, 2000). The Saudi social system maintains the power of men over women and respects older people (Gazzaz, 2009).The Islamic ethical principles control the relationships among Saudi families (Aldossary et al., 2008) , for example, honesty, truth telling, respect, loyalty and sympathy.

Having considered population development and socio-economic issues, it is important to highlight the healthcare services and the challenges they face in SA. These are discussed in the next section, which also considers governmental and private sectors and their role regarding the policy of the minimum degree education requirement for entry into nursing practice, as well as the implications of this decision.

1.3 The Health System in Saudi Arabia

The health system in SA is divided into three sectors. The MoH is the key governmental provider and financer of health services in SA (Almalki et al., 2011) and it delivers around 60% of free healthcare services for the Saudi population (see Section 1.3.1). Other governmental sectors provide around 9% of care for defined population and include referral hospitals, teaching hospitals, military hospitals, and the Arabian American Oil Company (ARAMCO) hospitals – these will be explained further in Section 1.3.2. Finally, there is the private sector, which provides around 31% of healthcare services for a fee (Section 1.3.3). All governmental health services in SA are free of charge at the point of service delivery. Healthcare financing in SA is provided primarily from the government budget, which is largely based on oil and gas revenues (Al-Yousuf et al., 2002). The Saudi health system's sound economy and well-established industry base positively affects the Saudi community by increasing their income, leading to a per capita income of US$ 24,911 in 2012 (MOH, 2014). According to Al-homayan et al, (2013) the Saudi governmental budget indicates that there has been a visible increase in the total budget from 2010 to 2014, as illustrated in Table 1-1.

Table 1-1: Budget Approximate for the MoH (MoH, 2014)

Year	Governmental budget	Total budget	%
2010	540,000,000	35,063,200	6.5
2011	580,000,000	39,860,200	6.9
2012	690,000,000	47,076,447	6.8
2013	820,000,000	45,350,355	6.6
2014	855,000,000	59,985,360	7.0

Saudi healthcare services have been given high consideration by the government at all levels of care (Al-Yousuf et al., 2002), and those services have increased and improved significantly during recent decades (Al-Yousuf et al., 2002; Almalki et al., 2011). Currently, the MoH plays a significant role in the planning and implementation of

healthcare services in SA (Almalki et al., 2011). Figure 1-2 shows the current structure of the country's health system.

Saudi Healthcare System

| Govt. sector MOH (public) | Other agencies Govt. sector | Private sector |

| All levels of healthcare (Free of charge) | All levels of healthcare (Free of charge) | All level of healthcare (Paid service) |

Referral hospitals

Teaching hospitals

School health units

Security forces medical services

ARAMCO health services

National guard health affairs

Health services in the Royal Commission for Jubail & yanbua.

Employees & their families + Emergencies

Red Crescent — **Emergencies**

% of hospital services provide by various…

9.0%
59.5%
31.5%

■ MOH
■ Private
■ Others Govt

Number of hospital beds by sector in Saudi Arabia	2009	2010	2011	2012	2013
MOH	33,277	34,370	37,120	40,089	43,296
OGS	10,822	10,939	12,033	13,236	14,560
Private	11,833	12,817	14,483	16,366	18,494
Total	55,932	58,126	63,636	69,691	76,350

Figure 1-2: Saudi health system, Ministry of Health: e-Health/ICT Strategy (2014).

1.3.1 Ministry of Health/ Public Health Care System

The MoH in SA, established in 1950, is the operational body for health services (Ram, 2014). However, the greatest improvement in health services in SA began in 1970, with the expansion of the 5-year developmental plan within the MoH. This aimed to improve health status and services in SA (Al-Rabeeah, 2003). The MoH is responsible for managing,

planning and formulating health policies and supervising health programmes, as well as monitoring health services in the private sector (Al-Yousuf et al., 2002). It is also in charge of advising other government agencies and the private sector on ways to achieve the government's health objectives. The MoH supervises 20 regional General Directorates of Health Affairs (Almalki et al., 2011). Each directorate has a number of hospitals and health sectors and every health sector supervises a number of PHC centres. The role of the 20 directorates includes implementing policies, plans and programmes dictated by the MoH, managing and supporting public health services, supervising and organising private sector services, and collaborating with other government agencies and other relevant bodies.

Levels of Healthcare Services in the MoH

The MoH delivers health care services at three levels of care: primary, secondary, and tertiary (Almalki et al., 2011); with a total number of 259 hospitals (35,828 beds) and 2,259 PHC centres, which include 59.5% of health care services (MoH, 2014). However, all health sectors are undergoing rapid growth. The preventive and curative services provided by primary care centres and cases that require higher levels of care are referred to secondary care (public hospitals). Furthermore, the complex cases are transferred to tertiary care (specialised hospitals) as illustrated in Figure 1-3.

Primary
Health Care Centres

Secondry
Health care (Public Hospitals)

Terciary
Health care (Specialised Hospitals)
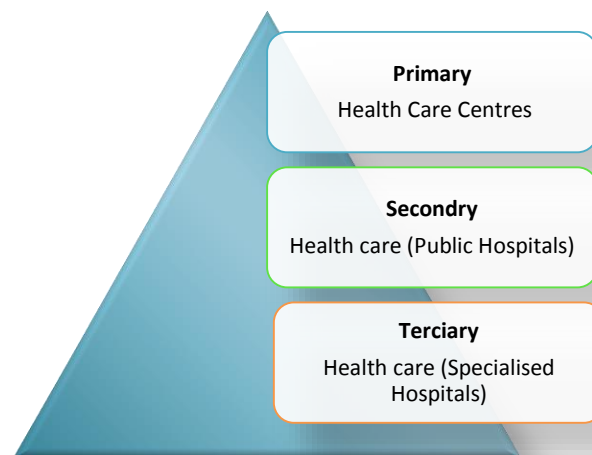
Figure 1-3: Levels of health care in MoH (Annual Statistics Book, 2014)

However, the referral system between the three levels of healthcare services is not well organised (Almalki, 2012). There are no clear communication channels or planned policies for transferring patients back to PHC from tertiary or secondary care. According to

Almalki (2012), more effort is required to address this gap and to develop strategies in order to reduce the overloading of specialist and secondary care services.

Transfer of Hospital Services to PHC Services

The health care services were mainly curative until 1980 and most of these were dependent upon the provision of treatment for all types of health problems (Almalki et al., 2011). The strategy of curative care was costly for the MoH, especially as many cases of health complications can be minimised by preventative strategies (Almalki, 2012). This strategy comes in response to a series of major challenges facing the Saudi healthcare system (Ram 2014). There is a high level of expectation of better healthcare services that can be easily accessed in accordance with a high level of care due to educational awareness of the new generation of Saudi population (Albejaidi, 2010). Applying referral systems within the public health services and focusing on PHC centres decreases overloading, improves public health care services and reduces the overall cost of care services (Albejaidi, 2010; Almalki et al., 2011; Almalki, 2012; Ram, 2014).

The Current workforce in the MoH

In keeping with the challenges that face the Saudi healthcare system, the workforce in the MoH relies on the expertise of healthcare workers recruited from different countries (Ram, 2014). In fact, the dependence on these workers reflects a serious issue with the stability of the general workforce (Al-Homayan et al., 2013). In addition, the MoH is suffering from a lack of national healthcare providers such as doctors and nurses. The latest available statistics in 2014 still indicate that non-Saudi healthcare workers make up about 54.7% of the total workforce in the MoH as illustrated in Table 1-2.

Table 1-2: Total healthcare provider workforces in the MoH (2014).

Healthcare provider	Saudi	Non-Saudi	Total	% of workforce
Physicians	7,886	19,975	27,861	9.1
Nurses	37,162	33,843	71,005	23.1
Pharmacists	1,940	266	2,206	0.72
Allied health personnel	35,659	3,574	39,233	12.8

Although there has been a large influx of foreign nurses into the country to meet the demands of the local population, SA is ranked last among Gulf countries in this field, with a current rate of 32.2 nurses to every 10,000 people (Cooper & Simmons 2005). This leaves SA behind other countries such as Qatar, where there are 54.8 nurses for every 10,000 people and, in Europe, where the typical rate is 66.3 per 10,000. Considering that the population of SA is expected to expand to 45 million by 2025 (Al-Homayan et al., 2013), this nursing deficiency could cause real problems in the future and a more robust recruitment strategy will be essential. In order to manage the situation, the Saudization plan was implemented by the SA government, with the intention of introducing more Saudi workers into the healthcare system and becoming less dependent on the expertise of nurses from other countries.

The Saudization plan

The Saudization plan is a strategy aimed at reducing the dependency on foreign employees (non-Saudi) in order to create more vacancies and opportunities for currently unemployed Saudi nationals (Gazzaz, 2009; Alhosis et al,. 2012). The implementation of the Saudization programme began with a development plan after the realisation that a heavy reliance on expatriates would create a huge gap in an unbalanced labour force, should the expatriates decide to leave the country (Alhosis et al., 2012). Due to the failure of a national workforce to meet the increased demand for labour, there was an increased dependence on foreign labour. For example, the current estimate of population growth is about 2.2% per year and the predicted population in 2020 is 31.6 million, with an increase in the "elderly" population (60 years old and above) from one million to 2.5 million by 2020 (HDR, 2010). With the fast growth of the Saudi population, the country will need an additional 15,000 to 20,000 hospital beds and roughly 15,000 more doctors (Cooper & Simmons, 2005). At the current levels of recruitment of Saudi physicians and nurses, the prospect of meeting that demand, without importing expertise, is almost zero.

However, it is very important to note that most Saudi healthcare providers are currently working in the public sectors, with the planned divestiture of publicly owned facilities; the Saudis presently employed in the public sectors will have to compete with non-Saudis in the rapidly growing private sector. In a competitive market place, it seems that non-Saudi healthcare providers, who are willing to work for lower wages, will fill many of the new

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vacant jobs in the private sectors. Despite the availability of a number of public and private programmes, self-adequacy in the supply of healthcare providers will not occur in the near future. Landry & Taylor (2012) state that given the projected reliance on foreign employees to meet the healthcare needs of Saudi citizens, the country needs to reconsider the policy of "Saudization". Moreover, in order to improve the Saudization plan within the private sector, the authorities are in the process of establishing a minimum salary, decreasing working hours to eight hours per day and providing social insurance or allowance devices similar to those in the government sector (Al-Homayan et al., 2013).

In summary, the healthcare situation has improved significantly over the past few decades and numerous strategies have been utilised to tackle tough challenges in this field. However, despite these developments, SA is still experiencing difficulty recruiting nursing staff and has a major shortage, the worst of all the gulf countries. On top of this, most of these nurses are foreign workers on which the MoH has become dependent, leaving them in a precarious situation. With the aim of having a majority Saudi workforce in the health sector, the Saudization plan was introduced and is currently being improved.

1.3.2 Other Governmental Sectors

The other government sectors in SA (See Figure 1-2), include 'referral' hospitals, such as King Faisal Specialised Hospital and Research Centre (KFSH & RC), the Ministry of Higher Education Hospitals (Teaching Hospitals), School Health Units of the Ministry of Education, Security Forces Medical Services, the Arabian American Oil Company (ARAMCO) Hospitals, National Guard Health Affairs, the Royal Commission for Jubail and Yanbu health services, and the Red Crescent Society. Each of these sectors provide free services to defined populations, usually employees and their families. Recent statistics suggest that the governmental sector operate 39 hospitals with a total capacity of 11,043 beds (MoH, 2014). The total number of nurses in employment at facilities of other governmental sectors is 28,380, of which 13.5% are Saudi; this number increased by 20.6% between 2008 and 2012 (MoH, 2014).

The other governmental sectors involved are highly efficient and function separately from the MoH, as they are structured through their direct budget. Their facilities are administered internally, and they proceed with their own levels of staffing and personnel

affairs. For instance, KFSH and RC have now become members of the best group of hospitals around the world, having achieved a Magnet rank (see list of terminology). The Executive Director of Nursing Affairs of KFSH and RC, Judy Moseley, states that nurses at KFSH & RC display ideal professional practice compared with other private and governmental sectors in SA. In approved Magnet hospitals such as KFSH and RC and King Khalid Teaching Hospital, decision-making is decentralised and the staff relationship with physicians and other care providers is more collegial. One of the requirements for achieving Magnet status, which is recognised for nursing excellence and improved patient outcomes, was that all nurse leaders and nurse managers were to hold a baccalaureate or graduate degree in nursing by 2013 (AACN, 2016), the belief being that a highly qualified nursing staff creates a more professional environment (Aiken et al., 2014).

Other governmental healthcare sectors services can be accessed through primary and secondary care facilities, with the possibility of referral to tertiary (specialist) care facilities; this proves beneficial for the employees and relatives within the healthcare sector. Moreover, the implementation of e-health and electronic information systems have been successfully applied in a number of governmental hospitals, while such services in the MoH are still moving slowly in some regions, especially those that are not directly connected to each other or to the private sectors (Altuwaijri, 2008). The facilities for health in the other governmental sectors were initially designed with a focus on providing employees of various establishments and their families with the best services. Additionally, these services are not usually accessible to outside establishments, as it is the responsibility of the MoH to develop and deliver services for them (Al-Yousuf et al., 2002). Nevertheless, some of the government sectors will react to extreme situations to provide and administer specialised healthcare services that are required by the public, for example those that are essential for certain cancer treatments.

In summary, it is evident that other governmental sectors are in a more advanced level of care than the MoH, because they provide only 9% of healthcare to a specific population (employees and their families) with an independent budget. This section gives the reader the opportunity to understand the other governmental sectors and their relation to the MoH. The following section will discuss the healthcare services in Saudi private sectors.

1.3.3 Private Sector

The private healthcare sector in SA includes different types of healthcare facilities that provide most of the outpatient treatments for a fee, through their hospitals, clinics, dispensaries, pharmacies, medical laboratories, and physiotherapy centres (Ahmad, 2012). The role of the private sector has expanded over the past two decades due to the high demand for and the restrictions placed on access to MoH facilities. The total number of private sector hospitals, beds and dispensaries increased during the period of 2008-2012 with increased inpatient treatments. For example, between 2008 and 2012, there was an 11.4% increase in the number of private hospitals, from 123 to 137 hospitals (MoH, 2014). Simultaneously, there was an addition of 2,803 beds (representing a 24.7% increase in the number of private hospital beds). The number of nurses in health facilities within the private sector stands at 28,373, and the proportion of Saudi employees increased from 5.3% in 2007 to 6.3% in 2011 (MoH, 2014).

Saudi nurses working in private healthcare can face difficulties related to various issues. These constitute pay levels, excessive working hours, restricted professional development and minimal opportunities for promotion. Hence, nurses in SA have seen that employment in the private health sector is not meeting their initial expectations, and, as a result, although the professional nursing workforce in the Saudi private sector has risen in numbers, in relation to foreign staffing levels it remains low. It has been highlighted that native nurses in SA constitute a mere 6.3% of the overall total nursing population within this sector, which demonstrates the lack of appeal of this sector to indigenous workers (MoH, 2014). While the public sector in SA has always needed to provide education to nurses, within the last decade there has been a marked increase in educational investment for nursing at diploma level throughout the private sector (Gazzaz, 2009). For instance, the western province of Jeddah has developed seven programmes for private nursing, which are separate from two other government projects. The majority of these programmes in the private sector are connected to the Saudi Commission For Health Specialties in SA (SCFHS, 2016), which promotes the development and enhancement of native workers in the country's workforce. Therefore, the Saudi government has provided private funds to encourage young Saudi people, through education and training opportunities, to secure future employment (Gazzaz, 2009).

In summary, this discussion has indicated a notable increase in the private sector health service facilities in SA, although with limited opportunities, and noted that foreign nurses constitute the majority of its workforce. This section provides valuable information that allows the reader to understand the context of the health system in SA. The following section will discuss the important governmental bodies and their role in initiating the degree education policy.

1.3.4 The governmental bodies responsible for the legislation of a national policy for health service and education

This section provides a brief overview of the governmental bodies in SA and an explanation of the ways in which they work together. The integration encompasses the role of the MoH and other government bodies such as the Ministry of Higher Education (MoHE), the Saudi Commission for Health Specialties (SCFHS), the Ministry of Civil Service (MOCS) and the GCC. These governmental bodies have an active role in the implementation and legislation of policy to make Bachelor degree education a minimum requirement for entry into nursing practice. The government bodies are illustrated in Figure 1-4.
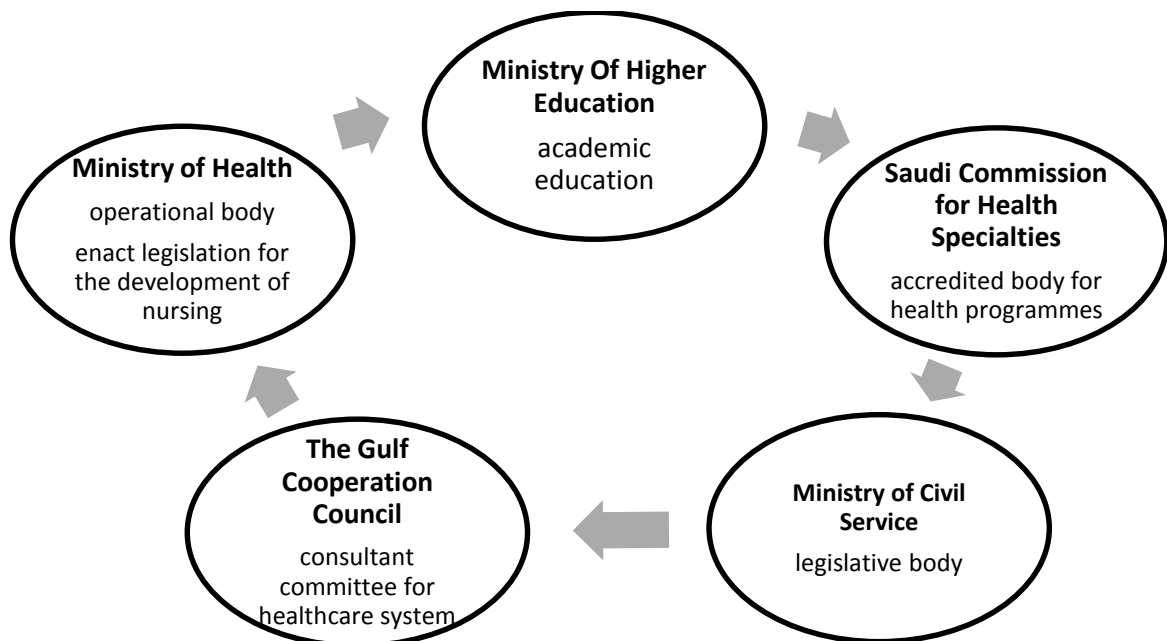
Figure 1-4: The key government bodies responsible for legislation of national policy for health service and education

Overall, the MoHE is the supervisory body for academic education, the MOCS is the legislative body, the SCHS is the accredited body for health programmes, the GCC is the

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consultant committee for healthcare system, and the MoH is the operational body. All those bodies have a close involvement with the MoH in decision-making; and they enact legislation for the development of nursing, as explained in the following section.

- **Ministry of Higher Education (MoHE)**

Through higher education programmes, every nation tries to fulfil its needs for a knowledgeable and skilled labour force, which both the labour market and its national development require (Alamri, 2011). Entering a new era of rapid development in the country's infrastructure and economy in the early 1970s, SA made a commitment to developing higher education (Alamri, 2011). In 1975 the MoHE was established in Riyadh, the capital city of SA, by Royal Decree 1/236, to regulate education policies and to implement a long-term plan for higher education. The MoHE has one of the most important roles in developing human resources, which is considered a strategic investment for any country (Alkhazim, 2003). According to Alkhazim (2003), the MoHE only supervises the universities, while other private colleges are managed directly by various governmental sectors such as Saudi commission for health specialities.

- **Ministry of Civil Service (MOCS)**

The MOCS is a supervisory body, in accordance with the terms of reference, with the responsibility of monitoring the implementation of the civil service regulations and decisions relating thereto (MOCS, 2015). In addition, it performs studies and research on the civil service, especially in the areas of job classification, allowances, bonuses, wages and compensation, and makes recommendations relating to the affairs of the civil service (MOCS, 2015). Other functions of the Ministry include proposing rules and regulations related to the affairs of the civil service, which are submitted to the Civil Service Board. The Ministry also establishes controls and record-keeping procedures for employees in order to ensure the integration of the required information for each employee, in addition to the other powers exercised by the Ministry (MOCS, 2015).

- **The Saudi Commission for Health Specialties (SCFHS)**

The SCFHS is the only accrediting body specifically for health programmes in SA. Established by Royal Decree No. M/2, dated 6/2/1413 AH (6/8/1992), it is a scientific

commission with a legal responsibility, and its headquarters are located in the Diplomatic Quarter, Riyadh, with several branches across SA (SCFHS, 2016). The SCHS is responsible for supervising and evaluating training programmes, as well as setting controls and standards for the practice of health professions. It launched its work through its competent supervisory, executive and specialist boards and committees (SCFHS, 2016).

The Scientific Nursing Board (SNB) was established in 2002 under the authority of the SCHS and aims to develop the nursing profession, nursing accreditation and registration (Almalki et al., 2011). The professional development of nursing centres on the standards of education, practice and ethics by establishing a system of accountability, and by conducting and supporting nursing research (Almalki et al., 2011). The accreditation role attempts to evaluate and approve all health programmes, educational institutions and training centres, whilst reviewing nursing qualifications from outside SA (Almalki, 2012). In addition, the SNB focuses on classifying and renewing the licences for nursing institutions, colleges and professionals (Abu-Zinadah, 2007).

The SCFHS classifies nurses with the high school equivalent of Nursing as nursing aides; nurses who hold a Diploma in Nursing are classified as Technical Nurses; nurses who hold a Bachelor's Degree in Nursing (BSN) are classified as Specialist Nurses. Furthermore, nurses with a Master's Degree in Nursing (MSN) are classified as Specialist One Nurses, and those with PhDs are classified as Nursing Consultants (SCFHS, 2016). Currently, all nurses in SA are registered with the SCFHS based on their academic qualifications, and attendance for the required number of hour's continuing education programmes is required (SCFHS, 2016). For example; 30 hours of continuing education programmes is required for technicians (Diploma) and 60 hours for specialist nurses (Degree) to renew their registration every three years.

- **The Gulf Cooperation Council (GCC) Nursing Technical Committee**

The GCC was formed in 1981 to create economic, scientific, and political cooperation among its members; Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates (Luomi, 2014). These countries have experienced rapid economic growth that influences health and illness. Increasingly chronic illnesses have promoted greater investment in health, education, and research (Lowe & Altrairi, 2014). The major initiative

that provided an incentive for the development of a strategic nursing plan in the Gulf countries was the establishment of the GCC Nursing Technical Committee (Lowe & Altrairi, 2014). The GCC Nursing Technical Committee, formed in 1993, was based on Arab Ministers decree no.4, to achieve unity among its members founded on their common objectives (Lowe & Altrairi, 2014). The GCC technical nursing members worked together in order to develop a strategic nursing plan (Luomi 2014). This was a significant achievement, aiming to improve the quality of nursing care in GCC countries. For example, the five-year strategic plan, 1993-1997, was the first stage of the plan and revolved around legislation, nursing care, and nursing education. Moreover, the technical committee of nursing in GCC countries conducted eleven symposia for nurses. Each year, the Gulf nursing symposia focus on a different significant theme, accommodated by the assigned Gulf country.

In summary, there has been a rapid development of the healthcare structure in SA. The MoH's current strategy also emphasises the shift of healthcare services from hospitals to community centres as a significant change that supports the implementation of degree education for the nursing profession. As part of that development, it is essential to highlight that a number of key government bodies play a role in the implementation of the degree education policy. This background explanation of the government bodies provides the reader with a context in which to place the documentary analysis of the GCC meetings, presented in Section 6.1.

1.4 Summary and Conclusion

This chapter has provided an overview of the healthcare system in SA. As a result of the continuing support from the government, the Saudi healthcare system has improved drastically over recent years. The Saudi population is rapidly increasing and the resulting financial benefits of this population growth have provided opportunities for the development of Saudi social organisations, including those in the health and education sectors. In addition, as part of development in the Saudi healthcare system, it is essential to note that a number of non-communicable diseases can be prevented through increased community awareness of health and disease patterns (Al-Mazrooa, 2011). Healthcare services in the three aspects of care, primary, secondary and tertiary, have enabled improvements to better deal with communicable and non-communicable diseases

compared to a decade ago. Furthermore, Saudi economic and socio-cultural development has taken place in the context of Islamic religious beliefs.

The implementation of the Saudization strategy began with a development plan after the MoH realised that there was heavy reliance on expatriate employment, created by a lack of Saudi nationals in the labour workforce. The Saudi government has faced important challenges, including the need to create a group of highly qualified Saudis able to work in complex modern economic and cultural expansion. With more than 70% of nurses being non-Saudi, public healthcare, along with other government and private sectors, have developed plans to achieve the Saudization programme in the nursing workforce. Finally, the key government bodies and administrative structures are outlined to give the reader an insight into the decision-making processes related to the nursing workforce policy and the practicalities of case study design, planning and implementation, which will be presented in detail in Sections 5.2, 5.3, 5.4, 5.5.

The following chapter will give an overview of nursing in SA, including the history of nursing in Islam and nursing education and practice in contemporary times. Finally, the chapter will provide an overview of the global development of degree nurse education from a policy perspective.

Chapter 2 : Nursing in Saudi Arabia (History, Education, Contemporary Influences and Policy)

2.1 Introduction

The previous chapter discussed the historical and current developmental structure of the healthcare system in SA, including demographic changes and the socio-economic context in relation to the different types and levels of healthcare services. This chapter presents an overview of the development of the nursing profession in SA, including its history in the era of Islam, its educational development and contemporary influences. Finally, the chapter will explore and analyse the global development of degree nurse education from a policy perspective.

2.2 History of Nursing in Islam

Florence Nightingale is recognised as the founder of modern nursing. Historically, nursing services evolved through caring for sick and wounded people in the Arabian Peninsula (Almalki et al., 2011). Although little was documented about the nursing profession during the pre-Islamic period (before 570 AD), it is believed that nursing and medicine were practised by the same healer (Almalki et al., 2011). Before the spread of Islam, the Arab community called the nurse "Al asiya" and "Al awasi". In the Arabic language, the word "Asiya" was used for a single female nurse, while the plural was "Awasi" (Miller-Rosser et al., 2006). The word "Asiya" describes holistic care that includes physical, psychological, social, emotional and spiritual care (Tumulty 2001). These terms come from the Arabic verb 'aasa', meaning, caring and emotionally supporting injury people (Tumulty, 2001). Currently, the words 'momarredhah' for a female nurse and 'momarredh' for a male nurse are used (Almalki, 2012).These two terms come from the Arabic verb 'marradha', meaning "caring for sick people".

Islamic literature has a different view of nursing. Nursing in Islam started in the era of the Prophet Mohammed (PBUH) in the 8th century (Miller-Rosser et al., 2006; Al-Hassani, 2010). This occurred when the Prophet Muhammed (PBUH) recognised nursing caregivers as a crucial part of the Muslim Army (Al-Hassani, 2010). Nursing care in the religion of

Islam is the manifestation of love for Allah and the Prophet Muhammad (PBUH). During the pre-Islamic era, nursing work was acknowledged within the faith, as well as being sponsored and actively encouraged; during the pre-Islamic period, the role of Arab women focused on reassuring and encouraging males to fight (Gazzaz, 2009). Muslim women worked as volunteers in the battlefield, providing first aid and wound care to the soldiers (Miller-Rosser et al., 2006). During that period, nursing gained strength with the participation of women as volunteers, causing an upsurge in nursing as a religious duty. This developed into organised social healthcare services (Gazzaz, 2009).

However, nursing services in Islam were not limited to the war period; it was documented in Islamic literature that Rufaidah Bint Sa'ad Al Ansareyah, sometimes called Koaiba, was recognised as the founder of nursing in the Islamic era, many centuries before Nightingale's time (Miller-Rosser et al., 2006; Gazzaz, 2009; Al-Hassani, 2010; Lovering, 2012). Rufaidah's father was a physician, and it was through him that she developed her knowledge and training in nursing skills, as she assisted regularly with caring for patients and soldiers. In addition, she was a nurse educator, and during times of war, she practised nursing by teaching and training Muslim women in her tent with the permission and support of the Prophet Muhammed (PBUH) (Lovering, 2012). She erected a small tent in Al Madinah near the prophet's mosque, which is now recognised as the first portable hospital in Islam, in order to treat injured soldiers and solve social issues (Miller-Rosser et al., 2006). In her tent, many volunteer Muslim women learnt nursing skills, enabling them to care for ill and wounded Muslims. Rufaidah is described as a model nurse, a leader and a great teacher; passing on her clinical knowledge to others she trained (Al-Hassani, 2010). She did not limit nursing practice to the clinical field, but went out into the community to address and solve the social issues that contributed to disease. According to Al-Hassani (2010), Rufaidah was both a public health nurse and a social worker.

Many different names of women who worked with Rufaidah have been recorded in the history of Islam: Om Senan Al Esla Mey (Om Ammara), Om Ayman, Safiyat, Om Sulaim, and Hind. Other well-known female Muslim nurses included: Nosaiba Bint Ka'ab Al Mazeneya, Amiinat bint Abi Qays al Ghifariyat, Om 'Atiyyah al Ansariyat, Om Matawea Al Aslameya, and Om Wareka Bint Hareth (Miller-Rosser et al., 2006; Al-Hassani, 2010). The recognition of Rufaidah Al Ansareyah as the first female Muslim in nursing is a

current phenomenon (Lovering, 2012). Until recently, nursing was not considered a respectable profession in Saudi society (Gazzaz, 2009). To improve this negative image, the national nursing organisation and GCC looked at the history of Islam to place the role of nursing within a religious framework, and this has had a positive influence on the acceptance of nursing as a good choice for women (Lovering, 2012). Moreover, the MoH in SA set aside 13 March 2008 to celebrate Gulf Nursing Day, a date parallel with the 17th day of Ramadan, the date of the battle of Badr in the second year of the exodus, the day that Muslim women's names were recorded as nurses for the first time in Islam. This day was selected by the GCC Nursing Technical Committee in its twenty-third meeting, held in Jeddah, Saudi Arabia in March 2008, and through recommendation No. 22 at meeting No. 69 of the Executive Body held in Riyadh in December 2008, it was formally adopted. The Gulf Nursing Technical Committee selected Nosaiba bint Ka'ab as the example of the best nurse in Islam; they set criteria for the Award of Nosaiba bint Ka'ab, by selecting the best nurse among those who met the criteria to receive an award.

There is little documentation of nursing history in the Arabian Peninsula in the years between the death of the Prophet Mohammed (PBUH) in 632 AD and the 1950s. However, the literature has described the practice and education of nursing in other parts of the Islamic world (Lovering, 2012). Interestingly, the story of Rufaidah can be linked to the work of Florence Nightingale at Scutari during the Crimean War. There is also the added similarity of the emergence of nursing in the face of the civil unrest and tensions of war. Again, religion and caring are entwined, similarly to nursing in the UK, where the early nurses came from religious orders and monasteries. Yet, the basis of Islam and nursing has had comparatively little representation or discussion within the global repertoire of nursing history, when compared to icons such as Florence Nightingale.

In the following section, the history of nursing education in contemporary times will presented including the curriculum outline of degree education in nursing.

2.3 Nursing Education in Contemporary Times

This section provides a brief history of the education system and nursing education in the Kingdom of Saudi Arabia. Saudi Arabia, formerly a poor, nomadic, tribal country, was catapulted into the twentieth century by the oil wealth of recent decades (Section 1. 2),

which made it a middle-income country (El-Sanabary, 1993). Major educational and economic changes occurred in the early 1960s within a traditional framework (Section 1.2), without deviating from traditional social and religious values prominent within the country (El-Sanabary, 1993). Ever since the first Saudi development plan in 1970, education has been given the highest priority in the country. Education at all levels is free to Saudi citizens and students from the age of seven years have strictly gender-segregated educational facilities. In contrast, the role of the private sector in the provision of education services has expanded over the last few decades. Currently, 29.12% of the Saudi population is under the age of 15 years (MoH, 2014), which places extra demand on educational and healthcare services. Hence, the nineteenth development plan (2010-2014) suggests the growth of the private sectors at an average annual rate of 6.6% over the period of the plan, thus increasing its percentage share of Gross Domestic Product (GDP), to around 61.5% by the end of the plan (MOEP, 2010).

An outline of the history of Saudi nursing education is explained in the following timeline:

1958-1976

The first Saudi health institute programme was initiated for young men in Riyadh by the MoH in 1958, with the collaboration of the World Health Organisation (WHO). Fifteen students who had completed six years of elementary school were enrolled for a one-year programme in nursing as Health Inspectors (Tumulty, 2001). Following the success of this initial programme, a further two Health Institute Programmes were established in the main cities, one in the capital city (Riyadh) and the other in the largest seaport and commercial centre (Jeddah). Both of the institutes opened in 1962 to enrol Saudi women (Tumulty, 2001). Students who graduated from these health institutes were appointed as nurses' aides (Miller-Rosser et al., 2006). Gradually, the MoH extended the initial one-year programme to three years and opened more institutes in different cities, recruiting students with secondary school preparation, that is, nine years of schooling (Miller-Rosser et al., 2006).

1976-1987

One of the most important steps towards professionalising nursing education was taken by the MoHE in 1976 by introducing the first programme of Bachelor of Science degree in

Nursing (BSN) in Riyadh, following in the footsteps of the US, who had introduced the first degree programme in 1965. The BSN was a 5-year course, taught in English and focusing on theory and practice (Al-Osaimi, 1994). In addition, incentives for nursing students included free textbooks and uniforms and a monthly allowance of around £150 (Gazzaz, 2009). In 1977 and 1987, BSN programmes were initiated at King Abdulaziz University (Jeddah) and at King Faisal University in the largest city in the Eastern Province (Dammam) respectively (Tumulty, 2001). With the population increase, and the subsequent increase in the number of high-school graduates, and the limited number of colleges offering Bachelor's degrees, medical and health science colleges were forced to establish strict criteria for admission, which included aptitude and admission tests (Gazzaz, 2009). More than ten years after the establishment of the university programmes, only 117 female students had graduated from the three universities with a BSN (Al-Osaimi, 1994). This small number of graduates reflects the negative image of nursing as low-level work, and the socio-cultural context that was explained in Section (1.2).

1987-1992

In this period, women's participation was low in nursing, since it remained a low-status occupation rejected by both women and men due to the negative image of the nursing profession (Almalki et al., 2011). In 1987, King Saud University in Riyadh announced a Master of Science in Nursing (MSN) to improve the image of nursing and to encourage female students to consider nursing as a career (Tumulty, 2001; Almalki et al., 2011). There were 33 health institutes by 1990; 17 institutes offering nursing education programmes for females and 16 for males in their early teens (Almalki et al. 2011). Gradually, the MoH opened more health institutes in different regions of the kingdom, offering a range of specialised facilities such as pharmacies, laboratories, anaesthesia, physiotherapy, x-ray facilities and nursing. Teaching was carried out in the Arabic language and the duration of the programmes was two years, focusing on basic nursing knowledge and skills. Students were provided with free accommodation, uniforms and a monthly allowance of £100 (Gazzaz, 2009). This was to encourage admission to nursing and other healthcare-associated programmes. However, this period shows that the MoHE and MoH were working towards different goals; the former being focused on professionalism to improve the image of nursing, whilst the aim of the MoH centred on

finding a solution to the nursing shortage in the country.

1992-2011

Junior health colleges, established in 1992, upgraded the level of training for Saudi nurses for the recruitment of high school prepared students, that is, those who had 12 years of education (Abu-Zinadah, 2007). Thus, the MoH operated two levels of nursing education through the health institutes and junior colleges. By 1993, 18 health institutes had been established for males and 26 for females (El-Sanabary, 1993). Three of these institutes were transformed into health colleges, accepting students with twelve years of education. In 1996, a PhD scholarship programme was introduced, enabling Saudi nurse leaders and educators to study overseas (Abu-Zinadah, 2007). In 2008, the governmental nursing programmes providing nursing Diplomas shifted from the MoH to the MoHE (Almalki, 2012; Jradi, Zaidan, & Shehri, 2013). In 2010, all Diploma programmes gradually began to close and the policy of requiring the BSN as the minimum educational requirement for entry into nursing practice was implemented. Recently, after the implementation of the policy, some governmental sectors and private universities have begun to deliver their own nursing education programmes to train high school prepared students for the BSN.

The previous section has provided a brief history of nursing education in SA during different historical periods. The following section will discuss the curriculum for the Bachelor's Degree programme in governmental and private colleges/universities, including the duration, content, theory and clinical hours of practice.

Governmental vs. Private College

Government universities are typically larger than private universities and comprise of many colleges. Co-educational universities operate with segregated classes such as medical college. Most research actively takes place in the large government universities. Universities operate under Royal Decree, and currently, there are 25 operating across the country including an additional three universities established this year. In contrast, private universities tend to be smaller than governmental universities and focus on the undergraduate level in specific disciplines such as medical sciences and nursing. Private universities operate under licensure from the MoHE. Currently, there are nine licensed universities in SA. However, the number of universities operating in SA has grown

significantly in recent years, with many new universities created through upgrades or mergers of colleges. However, Alamri (2011) states that the private institutions (33) outnumber government institutions (23), meaning there is stiff competition to get into nursing programmes at government universities, which forces students to go to private institutions.

In both the governmental and private universities, the BSN programme is often delivered over five years in ten semesters and consists of 50% theory and 50% practical work, including classes, clinical practice and laboratory work (Al Mutair, 2015). The five-year private nursing colleges are significantly different from governmental colleges. For example, the private colleges allow for little flexibility and do not have restrictive criteria for admission. The clinical practice conducted in private hospitals only covers a small number of patients compared to the public sector; governmental colleges provide clinical placements in public hospitals that give nursing students the opportunity to practise a variety of skills with many different patients.

The course is only available as a full-time option and it prepares nurses in general nursing practice only; it is not until after successful completion of the Bachelor's degree that a nurse will specialise. University, faculty and nursing requirements influence the curriculum design and the curriculum outline differs between governmental universities/colleges and private colleges (Al Mutair, 2015).

Al Mutair (2015) state that the mandatory classes for the BSN include the basic nursing foundations, such as medical and surgical fundamental nursing, research and ethics. Typical faculty requirements include nutrition, Pharmacology, Chemistry, Physics and Biology, and English or Islamic studies, all of which is provided in foundation classes.

According to Al Mutair (2015), the first year of the programme comprises the core subjects required by the university. It includes simulation sessions in the laboratory, preparing students for placements in clinical settings. It is recognised that nursing students require more than traditional theoretical approaches, as there is much to be learnt from experience in the field. With this in mind, students undertake clinical practice from the second year onwards and are required, in the fifth year of their degree, to complete a full internship lasting two semesters. On this placement, students rotate between each speciality to obtain

clinical practice (Al Mutair, 2015).

Clinical instructors are required to have completed the undergraduate degree, followed by at least three years' post-registration experience; these instructors work closely with the course co-ordinator and bring the students into their place of work in order to give first-hand clinical demonstrations. Those teaching the theoretical side of the course, the lecturers, hold a Master's degree or a PhD in nursing, and are also expected to have a clinical background (Al Mutair, 2015). The main goal of the curriculum and of the faculty is that nursing students should graduate with a high level of professional clinical competency.

In summary, the Saudi nursing workforce started with very few nurses; only men were able to enrol in nursing education and the course covered very basic nursing skills. It was not until 1962 that women became nurses. Women's education was perceived as a social revolution encouraging women to leave their home and go to school; a change that might challenge the prevailing tradition. Since then, nursing education has developed consistently and now there are an increasing number of educational institutions for nurses across the country. In 2008, all governmental nursing programmes that provided nursing Diplomas shifted from being under the control of the MoH to the MoHE (Jradi et al., 2013; Almalki, 2012). The latter only provides degree education, in order to improve the quality of nursing programmes. Most recently, Degree education for nurses has been implemented as a minimum requirement for nursing practice. Introduced in 2010, this policy was recommended by the World Health Organisation (WHO, 2009) with the intention of improving the quality of healthcare at a national level.

However, with this strategy, the workforce is experiencing an increase in the number of nursing students graduating from private health allied colleges with Diploma qualifications, at a time when nursing is diversifying and there are changing expectations of role development. Nursing students who have graduated with a Diploma no longer meet the minimum requirements for enrolment to be a professional nurse with the MoH and it is important to consider the consequences of this situation. For those only educated to Diploma level, it is now more difficult to find employment in the nursing profession within the MoH. Prior to this shift, it was much easier to gain employment because the nursing programme led to direct progression to jobs in the field. Despite an increasing interest in

enrolment for different nursing education programmes, (Abu-Zinadah, 2007) has estimated that it would take 25 years to train enough Saudi nurses to comprise just 30% of the Kingdom's nursing workforce. Until that time, health services in SA will potentially still rely upon a mobile expatriate workforce who will come and go, compounding the challenges not only of communication, but different levels of nursing professionalism, based upon the diverse backgrounds, experiences and different expectations of nursing roles (Abu-Zinadah, 2007)

This section has outlined the historical timeline of the nursing education up to the present day. It has described the Bachelor's degree in SA and the difference between the public and private sector courses. Finally, it has further explained the need to train new Saudi nurses. The following section will provide an overview of the policy perspective to analyse the global development of degree nurse education.

2.4 An Overview of Policy Perspectives

The idea of degree education as a minimum entry requirement for nursing practice began many years ago in developed countries and was envisaged, by global health organisations, as a strategy for future nursing (Smith, 2010). It is therefore important to give an overview of the policy, the background effort and the perspective of global organisations to improve nursing education. This section will analyse the specifics of this policy, newly implemented in SA.

Nurse education has seen important changes throughout the 20th and early 21st centuries (Klainberg & Dirschel, 2010). Prior to 2009, global standards for nursing developed in a random manner with no orientation towards standardisation of skills and training (Almadani, 2015). Since then, the development of global standards for the initial education of Nurses and Midwives has taken place in a more organised and integrated manner, led by the World Health Organisation (WHO) and Sigma Theta Tau International (WHO, 2009). The principles articulated at this stage were that nursing education should be based on developing competencies, evidence-based learning and life-long learning, interaction between client and nurse, and inter-professional collaboration (Klainberg & Dirschel, 2010).

In 2008, the Nursing and Midwifery Council (NMC) in the UK indicated that the

minimum level for nurse training would be at Bachelor degree level (NMC, 2010). The impetus for this came from the belief that nurses' need to have a high level of knowledge and skills, commensurate with the requirements of a profession meeting the needs of complex care delivery. Additionally, the changes were intended to safeguard the interests of the public through quality nursing education, providing equal opportunities to nursing students and to create learning opportunities through practical training. (Donley & Flaherty, 2008) suggest that new and emerging issues need to be dealt with by a qualified workforce. For example, the majority of the nurses still lack essential education in certain areas such as health promotion, which is linked to the prevention and treatment of illness, a shortfall in nursing education that could easily be covered in a nursing degree programme, but unlikely to be covered properly through 'on the job' experience (Almadani, 2015).

In the post-war period, significant developments in nursing degree education were made. Across the policies reviewed in this chapter, these developments have been inspired by the relevant social and economic considerations of the time. Of these the most significant has possibly been the 1965 proposal by the American Nursing Association (ANA), which inspired similar efforts to implement a degree education policy in the UK and other countries (Reiter, 1965; Donley & Flaherty, 2008). The ANA published an early paper about degree-based entry into nursing practice in 1965, advocating that a Bachelor degree should be the minimum level for entry into nursing practice (Reiter, 1965). The reasons for this proposal included a need to strengthen a nursing education system to meet the current and future needs of healthcare (Donley & Flaherty, 2008; Smith, 2010). The Bachelor degree would provide the necessary foundation from where nurses could pursue either practitioner training or research work. According to Smith (2010), during that time only one state (North Dakota) implemented degree education as an entry requirement for nursing practice because it had the power to introduce such a change through its own nursing regulatory board.

The American Association of Colleges of Nursing (AACN), (the national voice for baccalaureate and graduate nursing programmes in the US), believed degree education has a significant impact on the knowledge and competencies of all qualified health care providers (AACN, 2016), and nurses with Bachelor degrees are well prepared to meet the demands of the current and future health care system. Smith, (2010: P3) summarised that

the rationale underlying the ANA position paper of 1965 addressing entry to practice;

> *"the changing role of government, especially its investment in nursing education and manpower training; the changing pattern of education in the US; the increasing availability of collegiate education for women; the expansion of science and technology and its impact on health and healthcare; and the new insights into human health problems"*.

Despite the limited success in North Dakota, other states in the US and other countries continued to experiment with the policy and implement it in their unique context (Smith, 2010).

Historically, in the UK two failed attempts were made to introduce the policy in the 20th century, but were met with resistance. The reluctance in adopting the policy has been due to concerns from nurses already in the profession, patients, Trade Unions, universities and the government (Brooks & Rafferty, 2010). There were concerns that making nursing a degree only profession would create a hierarchical environment, making the profession more academic, stripping the field of its compassion, kindness, common sense, communication and caring skills (Brooks & Rafferty, 2010). Furthermore, there were concerns from many that nurses would be too busy dealing with paperwork to be providing the services required from a nurse (Almadani, 2015). For example, some believed that highly educated nurses would be reluctant to meet the personal needs of patients, such as bed bathing. This was evident from the opinions voiced by some trade unions who opposed the policy, suggesting degree educated nurses will generate a segment of the workforce 'too posh to wash' though this has been refuted by the Willis Commission (Willis, 2012). The government did not want the extra financial burden of making the policy work and funding it (Brooks & Rafferty, 2010).

However, some of the arguments for the adoption of the policy from nurses already in the profession have centred on degree-educated nurses having more medical knowledge in an ever-evolving field (Donley & Flaherty, 2008). A degree will give nurses more autonomy and will enhance the characteristics of nursing as a profession (AACN, 2016). With an increase in population and a global increase in the shortage of medical staff, degree educated nurses will have the capability to develop the skills necessary to ease the burden

on healthcare systems (Smith, 2010). For example, nurses in the US can progress their degree education and skills acquired to become practitioners with prescribing powers (non-medical prescribers) which could allow better health care delivery and more readily meet the needs of the patients (Scrafton, McKinnon, & Kane, 2012; Black & Dawood, 2014; Carberry, Clements, & Headley, 2014). This shift in policy of degree nurse education supporting research in the field has already encourage nurses to have greater involvement in the development of nursing education, practice, policies, and changes in the work environment, among other calls for demonstrating how the change has already given nurses autonomy (Varjus et al., 2011).

Traynor and Rafferty (1999) proposed some of the reforms needed to make such a policy work in the UK and globally. The authors described three sets of conditions required for the transition in making degree education mandatory in nursing; context, convergence and contingency. Traynor and Rafferty (1999) describe context as the need to create positive opinions or pressurise the need for change; convergence is described as the merger of professional and government opinions; and contingency as the need to provide a plan to deal with unforeseen events following implementation, resulting in evolution of the policy. Following the uptake of the degree education policy, graduate nurses have been successful in the work force according to initial results despite fears that the quality of care would be compromised (AACN, 2016).

The duration of the pre-registration programme in developed countries may vary, likewise the Bachelor of Nursing programme is a three to four-year education programme administered at university level leading to professional entry into nursing practice (Smith, 2010). The WHO, (2009: P18) for the initial education of nurses and midwives, stated that

> *"Nursing or midwifery schools have entry requirements that meet national criteria for higher education institutions including, but not limited to, completion of secondary education."*

Conversely, university admissions in SA have entry requirements to study nursing including, but not limited to, completion of secondary education, the General Aptitude Test (GAT) and the Standardized Achievement Aptitude Test (SAAT) administered by the National Centre for Assessment in Higher Education, named QIYAS, and meeting the national criteria for MoHE (Siddiek, 2011). The five years' duration of the BSN

programme in SA is considered a long-term period comparing with the developed countries (Almadani, 2015). For example, in Canada, Australia and the US state of North Dakota, the four-year Bachelor of Nursing qualification is currently required as a standard for entry to practice (WHO, 2009). However, compared to the more common 3-year programme, the 4-year programme inducts students at a more basic level and provides the requisite foundation for formal nursing education. Since 2013, the biggest change era, only degree level pre-registration nursing programmes have been offered in the UK (Willis 2012).

Nevertheless, the Bachelor programme for nurses' contrasts with the Diploma. It includes course work taught in associated degree and diploma programmes, but at a higher level of knowledge that appraises the skills of nurses in critical thinking, research based knowledge, leadership, case management and health promotion (Hendricks et al., 2012). These skills are vital to the performance of evolving nursing roles given the dynamic context where technological development and sophisticated health care practices are creating a complex environment.

In essence, the previous discussion shows how the initial proposal by the ANA to introduce the degree policy was a starting point to bring structure to nursing education. It documents the initial resistance on the part of health care professionals, the difficulties experienced by the educational authorities and the slow progression of the policy in developed countries.

2.5 Summary and Conclusion

This chapter has provided an overview of nursing profession in Islam, history of nursing education, and the nursing workforce in the Saudi context. It has reflected on the concern that the Saudi Heath system is dependent on foreign educated nurses, recruited from different countries, even though the Gulf War in 1990 led to the country facing difficulty recruiting foreign nurses and resulted in severe shortages in the non-Saudi nursing workforce. Despite this fact, the number of Saudi nurses remains too small to meet the national workforce needs and it has been that it would take the country 25 years to build up a qualified national nursing workforce to meet 30% of healthcare services needed in Saudi Arabia (Abu-Zinadah, 2007). This is a key issue, considering that globalisation and

education are highlighted as significant indicators of the rapid socio-economic developments in Saudi context. There has been consideration of education delivery and entry requirements by nursing organisations globally and the wealth of information SA has access to from this field has been discussed in order to relate to developing its own healthcare system and manage its workforce, making it fit for the 21st century. The advantage of studying countries that have already implemented the policy to make degree level education a minimum requirement for nursing have been noted as particularly valuable, offering SA the opportunity to consider the positives and negatives of implementing such policies to shape its own policy. This initiative was driven by the need to reform nursing education as the world entered the 21st century, and to address the global impetus to reassess old policies and standardise education, that could more readily meet diverse nursing roles and the global migration of nurses from one country to another. Furthermore, other health related fields were already one-step ahead in offering and making degrees' mandatory for practice such as physiotherapy, pharmacy and social care.

The next chapter will review the current literature in two different sections. The first section will provide an overview of the global and local trends in the nursing workforce, and the second section will use a systemic review of global literature to explore the effectual impact of degree education on patient outcomes in relation to professionalism, education, and experience.

Chapter 3 :   Literature Review

3.1 Introduction

Chapter's one and two provided an overview of the context of this study including, socio-economic and cultural issues that have affected the health and disease pattern in SA, and the health care system developments that are currently influencing nursing education and practice. In order to develop a case study theory/framework, a comprehensive critical review strategy has been implemented to establish what was already known about the implications of degree education as a minimum entry requirement into the nursing profession. This allowed the identification of methodologies used, findings and any gaps in the literature.

As previously stated this chapter will present the literature review under two sections:

- The first section gives an overview of the global and local trends in the nursing workforce and explores the current shortage in nurses and the high rates of turnover. It also examines current nursing education levels and entry requirements and focuses on integrating knowledge with practical training in order to maximise the utility of the labour workforce. Finally, this section discusses the views of current nursing staff and aims to emphasise why nursing workforce planning at a national level is required in order to benefit the nursing sector in Saudi Arabia.

- The second section involves a comprehensive systematic review of current literature. A systematic review strategy informs the emerging study aim and explores empirical research literature that contains information on related studies as well as gaining insight into degree education as it relates to nurse workforce planning. It explores the effectual impact of professionalism; education; and experience on the quality of care. Finally, the accessible evidence is discussed, to explore knowledge that already exists and identify gaps in knowledge for Saudi workforce planning, and to determine the need for further research.

3.2 Section One: An Overview of Global and Local Trends in the Nursing Workforce

This section will discuss the nursing workforce trends in the global and local nursing workforce and explores the current shortage of nursing. It also examines current nursing workforce challenges which include education challenges, system challenges, and social challenges focusing on integrating theory with practical training in order to maximise the utility of nursing workforce.

3.2.1 Global trends in nursing workforce

A nursing career is one of the most demanding professions in all countries (Al-Ahmadi, 2014). It has been argued that nursing, comprises the most important healthcare provider; this being largely due to the fact that nurses spend a great deal of time with patients and are directly responsible for their quality of care and safety (Clarke & Donaldson, 2008). Furthermore, nursing forms an integral part of social, cultural, and educational improvements and the emphasis on the importance of this practice is expected to increase in the future as the global healthcare models are continuously developed with a strong focus on prevention (Clarke & Donaldson, 2008). Today, health sectors face a serious shortage of professional nursing staff worldwide (Yun et al. 2010; Oulton 2006). Nursing shortages mean that the situation in which the demand for a nursing workforce is greater than the available supply (Yun et al., 2010). According to the AACN (2016), due to this shortage, some nations are reportedly hiring unqualified nursing staff, resulting in patients not receiving the required level of care. This is particularly concerning as nursing is a profession that requires comprehensive and adequate training for standard care to be delivered (Alyasin & Douglas, 2014).

In the United Kingdom, there is a vast shortage of registered nurses in the healthcare sector. According to Aiken et al., (2014), within the National Health Service (NHS), 83% of the heath care organisations and hospitals face a shortage of nursing staff. In order to fill this gap, many nations, including England and Wales (in the UK), hire nursing staff from other countries. This affirms that it is not only Saudi Arabia that has a problem with a shortage of health care workers. Aiken et al., (2014) note that for developed countries such as England to seek nurses and other medical professionals from outside of the country

indicates a serious glitch in the nursing systems and a quick remedy for this should be a priority.

The NHS has lost 4,000 nursing staff since the year 2010 (Aiken et al., 2014). Similarly, there is a shortage of 2.4 million nurses in India according to (Nyland et al., 2015). The United States of America has the largest nursing workforce in the world, about 3 million, but it failed to produce enough nurses to meet the heath care and growing demand (Yun et al. 2010). In a similar way, it has been projected that the US will face an increasing shortage of registered nurses (RN) due to the increase in health care requirements and this shortage is believed to intensify during the period from 2009-2030 (Juraschek et al., 2012). It is estimated by the Administration of U.S Health Resources and Service that the shortages in the nursing sector will exceed 500,000 by 2020 and potentially reach one million (Rother & Lavizzo-Mourey, 2009). This is because of the low enrolment in nursing, with recruitment dropping in the past few years and available nurses retiring (Fulton et al. 2014).

Similar statistics can also be seen concerning china and, according to Yun et al. (2010), many reasons for nursing shortages in China are the same for many other countries, despite the cultural, political, historical, and economic differences. Invariably, this situation will be compounded by an ageing population and the perpetual biomedical and pharmacological developments in modern times, which ultimately enhance life. Yet, this also results in a requirement for greater levels of quality nursing for patients receiving interventions (Fulton et al., 2014). Despite the acute shortage, potential student nurses are repeatedly rejected, due to failing entry requirements or because of inadequate resources and faculty (Juraschek et al., 2012). With this in mind, this limited numbers of nurses is recognised as a global issue (Oulton, 2006; Juraschek et al., 2012; Fulton et al., 2014; Alyasin & Douglas, 2014; Aiken et al., 2014).

In the same way, it has been stated Saudi Arabia has a deficit of Saudi nurses in the country and greater levels of turnover will persist (Al-Ahmadi, 2014). However, education and training for nurses worldwide are producing qualified nurses with diplomas or degrees (Majeed, 2014). Certain scholars perceive this educational development in nursing to be the enhancement of clinical professionalism (Al-Ahmadi, 2014). Indeed, advanced educational levels in nursing, together with a specialization role, are commonly attributed

to professionalism, as the majority of western educated students deem this to be imperative to the process of nursing (Almutairi et al., 2015).

3.2.2 Saudi Nursing Workforce

This section gives an overview of the Saudi nursing workforce and explores the current shortage in nurses and the high rates of turnover. It also examines the current level of nursing education and entry requirements, focusing on integrating knowledge with clinical training in order to maximise the utility of the labour workforce. Finally, this section also discusses the views of current nursing staff in Saudi nursing workforce.

Aboul-Enein (2002), states that the Central Nursing Committee was established in 1987 at the MoH to advance the quality of nursing care. Prior to 1987, as the profession was dominated by physicians, there was no representation or formalised voice for nurses by nurses at national level. The Regional Nursing Committees were formed in 1990 to achieve delegation of decision making for nurses (Al-Osaimi, 1994). By 2003, the General Directorate of Nursing was established in the MoH under the direction of highly educated and experienced Saudi nurses, few of them holding a Master's degree (Almadani, 2015). These were the first wave of educated nurses who progressed to policy roles to subsequently inform the wider development of nursing in Saudi Arabia (MoH, 2014). This was followed by the establishment of nursing departments in twenty regions of Saudi Arabia. Such advances are expected by the public to provide evidence for the need to have nursing representation and regulation to shape nursing, recognising it as a profession that is central to the MoH and, as such to facilitate its development and presence (Almadani, 2015).

The largest group of health care professionals in Saudi Arabia are nurses; they deliver the highest percentage of health care (Lamadah & Sayed, 2014). Despite this, the nursing profession has experienced an acute shortage of qualified nurses, affecting the delivery of healthcare worldwide Almalki et al., 2011 (Fochsen et al., 2006; Almalki et al., 2011; Lamadah & Sayed, 2014). Similar to the global situation, Saudi Arabia is challenged with chronic shortages of qualified Saudi nurses, accompanied by high rates of turnover. Within the large numbers of Saudi students studying all over the world, there is a low percentage of nursing students locally and internationally (Alamri, 2011). The admission level of entry

into nursing practice to a Bachelor degree qualification, further limits the number of qualified nurses and, adds to the problem (Alamri, 2011).

Today, according to Majeed (2014), over fifty percent of the healthcare workforce is comprised of nurses. The focal point and centre of the health care system are the nurses and without them, the health care system would not be functional (Alyasin & Douglas, 2014). In Saudi Arabia, the healthcare sector workforce mostly comprises of migrant nurses; only 34% are Saudi nurses (AlYami & Watson, 2014). A major proportion of the migrant nurses use the Saudi Arabian healthcare opportunities temporarily in order to gain experience and knowledge. After gaining the required experience, they return to the healthcare sectors of the developed nations such as the USA, the UK and Australia (Black et al., 2012).

This high turnover rate among professional nurses in Saudi Arabia is adding to the concerns regarding management issues, organisational plan obstruction and bad service delivery, thus affecting the workforce and those in need of nursing care (Al-Ahmadi, 2014). The effectiveness of various healthcare systems is threatened by such problems; for example, a constant need to replace and train nursing staff. There are no reliable statistics related to this important issue in Saudi Arabia, but for the managers of the health care facilities, this emigrant movement raises concern (AlYami & Watson, 2014). High turnover of nurses creates an unstable healthcare system where the burden of the workload falls on the remaining staff (Almadani, 2015). This inevitably has the potential to compromise the care given to patients, creating an environment of discontent and affecting morale and motivation of the remaining staff (Lamadah & Sayed, 2014).

However, lower staff turnover rates, higher staff retention and increased nurse/patient ratio have been shown to be linked to higher quality of care and a reduction of in-patient stays (Collier & Harrington, 2008). High turnover of nursing staff also has a significant impact on the finances of a healthcare system (Collier & Harrington, 2008). A survey of Jordanian nurses showed job satisfaction was a significant factor in retaining nursing staff (Alsaraireh et al., 2014). As stated, Saudi nurses make up a small percentage of the total nurse workforce; this percentage is even smaller in the private health sector where native nurses make up only 4.1% of the workforce (AlMakhaita et al., 2014). This shows that the

lack of local nurses is a big problem for the countries health sector that carries a number of social, educational and individual issues.

3.2.2.1 Education Challenges

In SA, most of the nursing workforce are Diploma holders and many nursing staff do not have a Bachelor's of Science nursing degree (AlMakhaita et al., 2014). This indicates a lack of education and training among nursing staff and is seen as a hindrance in providing high quality nursing care to the patients who need an advanced level of care (Al-Ahmadi, 2014). AlYami & Watson (2014), suggest that the increasing requirements of the Saudi healthcare sector are not being met by the low number of students inducted into nursing degrees each year; this means that there are not enough graduates from Saudi Nursing schools to meet patient needs and health system demand. However, Black et al., (2012) stated the training of people, meaning the forming their personality and preparing them for accountable practice, is the responsibility of a university.

Almalki et al., (2011) stated that all nursing colleges and health institutes were transferred from the MoH to the MoHE in 2008 as the first step to improving nursing education in the KSA. Following this initiative, a Bachelor of Science in Nursing is awarded following completion of a five-year curriculum at all the universities offering the BSN programme in SA (Almadani 2015); the five-year period studied in English language was seen as adequate to impart the required skills, knowledge, and communication (Al-Homayan, 2013; Almalki et al., 2011). Nursing programmes started to improve in Saudi Arabia with the development of the curriculum and practising at graduate level. Today, applications from female Saudi nationals with the right set of abilities, skills, intelligence and motivation for the study of nursing science are encouraged in some government universities (Almutairi et al., 2015).

However, the disadvantage is that, with a five-year degree programme, the time commitment required, before being able to practice and earn a salary, could prevent people from committing to the profession (Almadani, 2015). This is particularly poignant given that professional nurses already have several complaints concerning resources and time issues. This puts SA in a dire situation because very few people have the BSN qualification, the country still ranks low in this regard, and it is accurate to state that most of the nurses in the country are Diploma graduates (Almadani, 2015). Romp et al., (2014)

explains in America, the lack of financial incentives and limitations concerning individual financial situations leads to a large number of nurses choosing not to study a Bachelors' degree. Other reasons for this choice, highlighted by Romp et al., (2014), include the individual facing restrictions in their current job or family commitments.

3.2.2.2 System Challenge

Due to the decrease in nursing staff in Saudi Arabia, the Saudi government and private healthcare sectors are becoming more and more dependent on expatriate nurses to fill the void (see Section 2.2 & 2.3). However, one of the implications of making a degree the minimum requirement for nursing practise in Saudi Arabia, which depends so heavily on foreign nurses, is that it may reduce the expatriate workforce considerably (Almadani, 2015). If a country that supplies nurses to SA does not offer nursing degrees or does not make it mandatory, SA will start reducing its recruitment from these countries.

The nursing care provided differs due to the diversity in educational and cultural backgrounds, especially among expatriates who have to adapt to and sustain the culture changes in foreign lands where they intend to practice (Almadani, 2015). Aldossary et al., (2008) suggests that the Saudi nursing department should develop Saudi national nursing staff training, in order to provide quality healthcare through familiarity with the cultural and linguistic aspects of care provision. In the absence of such measures, it would be increasingly difficult to provide high quality healthcare to the Saudi nationals. Aldossary et al., (2008) predicted that the rising requirement of health care services for the elderly was expected to increase further in the coming years and that the problem needs to be addressed immediately by the Saudi government to make the necessary improvisations to the systems to facilitate and attract more female workers (Majeed, 2014). Currently, training the nurses in specialised departments such as gerontology needs to be encouraged to cater for the growing percentage of elderly people (Al-Ahmadi, 2014).

Al-Ahmadi (2014) and Majeed (2014), asserted that with the introduction of policies attracting women to opt into the nursing profession. Although this shift is quite slow, the experts claim it will be fully achieved within the given timeframe. The cultural and religious reasons for this delay are previously detailed and evidenced by a number of researchers, notably (AlMakhaita et al., 2014). These factors are also responsible for the small proportion of female applicants when the recruitment programmes open (Al-

Ahmadi, 2014). The apropos system for recruiting and training nurses is inconsistent owing to the diversity of professionals working in Saudi hospitals (Majeed, 2014). Most often, females resort to taking administrative jobs owing to the high promotional chances (Almutairi et al., 2015).

Moreover, the number of female nursing professionals are affected by the social norm, dictating that a female will leave their job once married (Al-Makhaita et al, 2014). This means that nurses are trained, which costs them a lot of time and money, and then leave their work to start a family, this could make training to be a nurse less appealing and also decreases the possibility of retaining female staff, once trained. Overall, it has been agreed that the Saudi health system must increase the numbers of nurses in the hospitals and primary healthcare centres to meet the needs of the rising population (Aldossary et al. 2008; Al-Ahmadi, 2014; AlMakhaita et al., 2014; Majeed, 2014; Almadani, 2015; Almutairi et al., 2015).

3.2.2.3 Social Challenge

Social and cultural traditions create a number of barriers for Saudi women considering a nursing career; firstly, there is disfavour in the community towards women accepting paid work outside of the home (Gazzaz, 2009) and, secondly, the nature of the job involves working long hours in a mixed gender team. According to Gazzaz (2009), there is a lot of social pressure on Saudi nurses as the profession has a negative image. In Saudi society, nursing is widely considered akin to a house cleaner's job. With this in mind, Gazzaz (2009) explains that there are mixed opinions in Saudi communities concerning nursing as a profession for females and this can make applying to study nursing less attractive. Other factors that make nursing less appealing include low salaries and shift schedules; studies show that nurses are paid less than many other professions and, furthermore, are expected to work 48 hours a week, 30% more than the average for other professions. Amongst the negativity, however, Saudi women are increasingly entering the nursing profession; they are aware that once they gain skills and knowledge in this field they can advance and consider breaking some of the barriers in order to make improvements and further developments in this sector (Al-Homayan et al., 2013).

It is worth noting that Saudi female nurses are more likely to work in a health care centre than in a hospital (Mebrouk, 2008); due to the separation of sexes in the working

environment, set working hours and less responsibility as well as the fact that it is not necessary to work night shifts. Some families will not allow a daughter to work in a hospital setting due to the mixed gender-working environment. Another negative impact of mixed gender working environments is that it is less likely for a female working as a nurse to get married as caring for, and working with men, combined with unconventional working patterns, is deemed undesirable in a wife (Gazzaz, 2009). In addition, males tend to avoid nursing as a profession because it is considered a woman's job. The unattractive image of nursing in the Middle East and the fact that it is frowned upon for women to seek employment, helps explain why Saudi Arabia relies so heavily on foreign nurses (Al-Homayan et al., 2013).

As a result, many researchers suggest that an improvement on financial rewards for nurses is necessary, especially considering that it is one of the few jobs that requires employees to work at all hours of the day and all days of the week (Gazzaz, 2009; Al-Hassani, 2010; Al-Homayan et al., 2013). Based on the above evidence, the future of the nursing sector is bleak and calls for extensive reforms in various perspectives for high quality of service to satisfy the country's citizens and expatriates. According to Al-Homayan et al., (2013) the expectations of the citizens of the country, regarding the nursing profession, could materialise by the removal of the social elements attached to the profession. In spite of all of the concerns previously, the government hospitals have not addressed this issue and have not increased their female nursing staff by reducing working hours, neither have they improved benefits compared with other countries across the globe (AlYami & Watson, 2014). The deficiency of nurses is affecting the patients, especially the elderly groups in the community. This concern requires a profound scrutiny on the current and future nursing system, which includes training facilities. Almutairi et al., (2015), state that the hospital management in Saudi Arabia needs to address social, organisational and cultural issues in the system and maintain them periodically.

Most of the issues discussed are related to female nursing; this is because, whilst it is well known that nursing is a female dominated profession globally, it is more so in SA (Mebrouk, 2008). Although limited numbers of females are interested in the profession, due to its social image and pressures, even fewer men would consider nursing as a career (Almalki et al., 2011). There are calls for health care workers across various fields to

overhaul the policies affecting nursing in Saudi Arabia; as the current policies are seen as inadequate.

In summary, this discussion indicates that the dire shortage of nursing staff in the health care sector is compromising the quality of health care in SA. This is not only a phenomenon here, but it is a global issue. Proper professional education and training; and providing adequate job facilities to nursing staff is required in order to bring about improvements. The shortages highlighted are caused by a number of factors ranging from lack of replacement to withdrawal from the profession and the lack of resources for effective training (Yun et al., 2010; Alyasin & Douglas, 2014; Aiken et al., 2014; Fulton et al., 2014).

3.3 Section Two: A Comprehensive Systematic Review

This section presents the comprehensive search strategy, results, and key findings from the literature review. The literature review involves a systematic review of existing literature, exploring the impact of degree education entry upon care outcomes. Finally, an overview of the accessible evidence is discussed in order to explore the gaps in the global literature, and to determine the need for further research.

3.3.1 Search strategy

A systematic search strategy was used to identify gaps in the existing literature and to collect evidence about Bachelor Nursing as a minimum requirement to enter the nursing profession; this included searching a wide range of online database. The approach also analyses and summarises research findings. The first stage of a systematic literature review is a well-planned search strategy, which includes the identification of the databases to be used and the key terms to be searched (Coughlan et al., 2013).

3.3.2 Electronic database search

The Cumulative Index of Nursing and Allied Health Literature (CINAHL) is the most comprehensive resource comprising four databases and offering complete coverage of English-language nursing journals and publications from the National League for Nursing and American Nurses' Association. This database also covers nursing, biomedicine, health sciences librarianship, consumer health and 17 allied health disciplines. MEDLINE databases contain in excess of 4,800 academic and medical scientific journals and provides authoritative medical information on medicine, nursing, healthcare system, pre-medical science and much more. PubMed is the US National Institute of Health (NIH) free digital archive of biomedical and life sciences. OVID databases contain in excess of 1200 academic and medical scientific journals. These databases have been selected for this study for different reasons: the most relevant database for my topic; offering complete coverage of English Language Nursing Journals; and provides authorities medical and educational information on nursing and healthcare systems. The searches were carried out using numerous combinations of several keywords as illustrated in Table 3-1

Table 3-1: Steps for the Search Strategy

Sources Searched	Key words	Result	Related	Selected	Final result
CINAHL	Nursing Degree education	*Initial: 26,789* *Related: 412*	873	8	23
MEDLINE	Entry requirement Qualified nurse	*Initial: 16,875* *Related: 320*		1	
OVID	Workforce Minimum entry	*Initial: 583* *Related: 110*		9	
Pub Med	Baccalaureate Bachelor degree	*Initial: 80* *Related: 11*		3	
Google Scholar	Professional Quality of care	*Initial: 399* *Related: 20*		2	

3.3.3 Inclusion and exclusion criteria

Searching these databases resulted in the retrieval of a large number (873) of related articles. To reduce this number, the following inclusion criteria were applied based on the relevance to the research aim and objectives as illustrated the Table 3-2.

Table 3-2: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Published between 2005 and 2016.	Exclude all paper that published before 2005.
Only English language.	Other language.
Studies using Qualitative, Quantitative, mixed methods, and systatmatic.	Policy, report, essay, and review paper.
Studies that focusing on degree education as a minimum requirement for professional nurse to entry into practice are included.	Studies that focus in other health professional.

The preliminary search paved the way for a more focused search, based on the relevancy and period of publishing.

1. Online studies published between 2005 and 2016 were included. This decision was made based on the fact that the development of global standards for the initial

education of nurses and midwives took place over a three-year period, starting from 2005, led by the World Health Organization (WHO) and Sigma Theta Tau International (WHO, 2009). Studies published prior to this period were used in the policy perspective and analysis of global development in degree education section and in chapters one and two, to compare and contrast the development of nursing education and as background information as the world entered the 21st century. Furthermore, widening the search area too much would have led to a less focused study with meaningless outcomes as there could be dilution of information. A ten-year search period which covers the main transition phase of nursing education in Saudi Arabia should yield sufficient data for this study to ensure that only the latest evidence on the minimum requirement for a nursing degree is included.

2. Only articles published in the English language were included as English is the main professional language for health publication and medical teaching in SA (El-Sanabary, 1993).

3. Research papers were included; that is to say studies using qualitative, quantitative mixed studies, and systematic reviews.

3.3.4 Searching strategy result

Search sequences for conducting the electronic searches were generated by suitable combinations of the key words and by using the Boolean search technique. Boolean terms include the combination between terms using "AND" or "OR" in an attempt to retrieve all relevant studies (Coughlan, M., Cronin, P. & Ryan, 2013). Unrelated articles that do not meet the inclusion criteria were excluded by deliberately omitting them from the search list. Using the inclusion/exclusion criteria highlighted in Table 3-2, the search process was conducted with reference to the issues under study. The researcher carried out the review on the understanding that only the relevant articles (23) relating to the research topic were required to ensure a thorough literature review. See Figure 3-1.
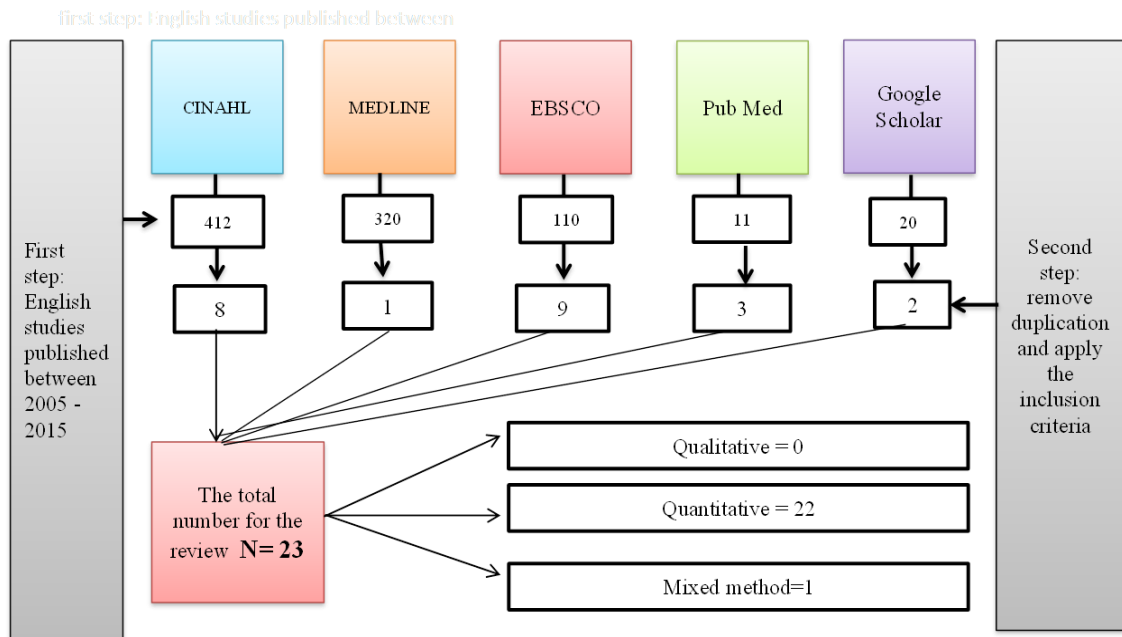
Figure 3-1: Search Strategy Steps

3.3.5 Critical appraisal process

A comprehensive systemic approach was employed to analyse the quality and rigour of the retained studies that were incorporated into the literature review. These studies were subjected to appraisal using the Critical Appraisal Skills Programme (CASP) tools (CASP, 2013). CASP tools are used to help the researcher think critically and comprehensively in order to appraise qualitative and quantitative studies (Essays UK, 2013). Goldsmith, Bankhead, and Austoker (2007), note that this tool is useful in appraising qualitative and quantitative research in health and social studies. These tools contain guideline questions that critically evaluate study aims, samples, methods and results (CASP, 2002). In the following Table 3-3, the reviewed literature in the 23 selected papers is presented according to the type of study, country of origin and methodological approaches.

Table 3-3: Summary of studies included in part 2

Author(s)/year/ country	Method	Sample	Aim	Results	Key findings
1. Aiken et al. (2009) **(USA)**	Quantitative Survey	n=10,184 nurses and 232,342 surgical patients	To analyse the net effects of nurse practice environments on nurse and patient outcomes after accounting for nurse staffing and education.	Nurses reported more positive job experiences and fewer concerns with care quality, and patients had significantly lower risks of death and failure to rescue in hospitals with better care environments.	Significance association between educational level of nurses and hospital outcome.
2. Aiken et al. (2011) **(USA)**	Quantitative Large mail survey undertaken in the four States.	n=272,783 nurses	To determine the conditions under which the impact of hospital nurse staffing, nurse education, and work environment are associated with patient outcomes.	The effect of decreasing workloads by one patient/nurse on deaths and failure-to-rescue is virtually nil in hospitals with poor work environments.	Level of education of nurses decreases the odds on death and failures.
3. Aiken et al. (2014). **(Europe)**	Quantitative Survey	n=422 730 patients and n= 26, 516 nurses.	To assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4 CAST countries with similar patient discharge data.	Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.	Increasing the number of nurses with bachelor's degree (60% of nurses) and reducing the number of patients cared for by these nurses to 6 would lower mortality rate.
4. Kendall-Gallagher et al. (2011) **(USA)**	Quantitative, Secondary analysis survey 2005-2006.	n= 28,598	To determine if hospital proportion of staff nurses with specialty certification is associated with risk-adjusted inpatient 30-day mortality and failure.	A 10% increase in hospital proportion of baccalaureate and certified baccalaureate staff nurses, respectively, decreased the odds of adjusted inpatient 30-day mortality.	Increasing the proportion of baccalaureate and certified. baccalaureate staff nurses decreased the odds of adjusted inpatient 30-day mortality

Author(s)/year/ country	Method	Sample	Aim	Results	Key findings
5. Kendall-Gallagher and Blegen (2009) **(USA)**	Quantitative, secondary data analysis of 48 intensive care units.	29 hospitals	To examine the relationships between unit certification rates, organizational nursing characteristics and rates of medication administration errors, and falls.	Unit proportion of certified staff registered nurses was inversely related to rate of falls, and total hours of nursing care were positively related to medication administration errors.	Receiving care from highly specialised/trained nurses significant reduces the odds of death
6. McHugh and Lake (2010) **(USA), Pennsylvania**	Quantitative cross-sectional design data from 8,611 registered nurses	The sample for this analysis included acute care staff nurses n = 9,445	To examine effects of hospital contextual factors and individual nurse education and experience on clinical nursing expertise.	The hospital context significantly influences clinical nursing expertise.	Nurse level of education and years of experience were related to clinical nursing expertise.
7. Bobay et al. (2009) **(USA)**	Quantitative, descriptive, correlational study	n=261 registered nurses	To determine what are the relationships of nurses' professional characteristics, including years of experience, certification, basic nursing education, continuing education, and other factors, to levels of clinical nursing expertise.	Experience as an RN was found to be highly correlated with initial level of expertise. Educational preparation and certification were not correlated with expertise.	Significant correlation between healthcare experience as a registered nurse, self-reported non-mandatory continuing education with level of expertise.
8. Sales et al. (2008) **(Canada)**	Quantitative, A retrospective observational study	n=129,579 patients from 453 nursing units.	To evaluate the association of in-hospital patient mortality with registered nurse staffing and skill mix.	An association between RN staffing and skill mix and in-hospital patient mortality depends on whether the analysis is conducted at the hospital or unit level.	No significance association between BSN education and mortality risk.

Author(s)/year/ country	Method	Sample	Aim	Results	Key findings
9. Dellon et al. (2009) **(USA)**	Quantitative. A retrospective analysis of screening colonoscopies performed..	n=3631 eligible screening colonoscopies	To determine whether the nurse experience was associated with screening colonoscopy complications, procedure length, and cecal intubation.	Nurse inexperience was associated with increased odds of screening colonoscopy immediate complications, prolonged procedure times, and decreased cecal-intubation rates.	Complications during GI endoscopy increased with nurse inexperience and education
10. Kanai-Pak et al. (2008) **(Japan)**	Quantitative, Cross-sectional survey	n= 5956 staff nurses	To describe nurse burnout, job dissatisfaction and quality of care in Japanese hospitals and to determine how these outcomes are associated with work environment factors.	Fifty-six per cent of nurses scored high on burnout, 60% were dissatisfied with their jobs and 59% ranked quality of care as only fair or poor.	Significance association between staffed hospital and quality of care
11. Kutney-Lee et al. (2013) **(USA)**	Quantitative, survey	patient discharge data from 1999 and 2006	To examine the association between bachelor degree education and mortality rate	The result found that a ten-point increase in the percentage of nurses holding a baccalaureate degree in nursing within a hospital was associated with an average reduction of 2.12 deaths for every 1,000 patients	Significance association between educational level of nurses and hospital out come e.g. decrees mortality rate
12. Estabrooks et al. (2005) **(Canada)**	Quantitative, cross-sectional analysis	18,142 patients discharged from 49 acute care hospitals in	To assess the relative effects and importance of nurse education and skill mix, continuity of care, and quality of work environment in predicting 30-day mortality	Using multilevel analysis, it was determined that the log-odds for 30-day mortality varied significantly across hospitals	Significant association between level of education and patient outcome

Author(s)/year/ country	Method	Sample	Aim	Results	Key findings
13. Friese et al. (2008) **(USA)**	Quantitative,	Nurse survey data collected in Pennsylvania for 1998–1999	To examine the effect of nursing practice environments on outcomes of hospitalized cancer patients undergoing surgery	Nurse staffing and educational preparation of registered nurses have at least a baccalaureate-level education were significantly associated with patient outcomes.	There is a significant association between the quality of the nurse practice environment and outcomes for surgical oncology patients.
14. Blegen et al. (2013) **(USA)**	Quantitative, a cross-sectional study.	data from 21 University Health System Consortium hospitals,	to examine the effects of registered nurse (RN) education by determining whether nurse-sensitive patient outcomes were better in hospitals with a higher proportion of RNs with baccalaureate degrees.	Hospitals with a higher percentage of RNs with baccalaureate or higher degrees had lower congestive heart failure mortality, decubitus ulcers, failure to rescue, and postoperative deep vein thrombosis or pulmonary embolism and shorter length of stay.	Significant association between level of education and patient outcome
15. PARK et al. (2007) **(UK)**	Quantitative, Self-completion questionnaires employing open and closed questions were sent to graduates 9 months after graduation and at intervals over the next 6 years.	n = 180 graduating between 1994 and 2000	This paper reports the views of nurses graduating from the University of Nottingham School of Nursing, UK, 1994–2000, Bachelor of Nursing (Hons) course, concerning career aspirations, progress and reflections on their qualification.	Most respondents were confident and motivated in their nursing careers. Promotion, increased responsibility, further study, specialization and qualifications were career priorities. Recent qualifiers also focused on changing jobs, travel and working overseas	Nurse motivation is increased with promotion, responsibility, specialization and career priorities.
16. Spetz et al. (2013) **(USA)**	National Sample Survey	Registered Nurses n=120,000	To examine the return to baccalaureate education from the perspective of the nurse.	Lifetime earnings for nurses whose initial education is the BSN are higher than those of AD nurses only if the AD program requires 3 years and the discount rate is 2 percent.	Higher nursing education translated to higher earnings and of being an advanced practice registered nurse

Author(s)/year/ country	Method	Sample	Aim	Results	Key findings
17. Yakusheva et al. (2014) **(USA)**	Retrospective observational patient-level analysis of electronic data. Linear and logistic regression modeling with patient controls and diagnosis and unit fixed effects.	n=1477 direct care nurses	To conduct the economic analysis of meeting the 80% BSN threshold on patient outcomes and costs, using linked patient-nurse data.	Continuous BSN proportion was associated with lower mortality. Compared with patients with <80% BSN care, patients receiving ≥80% of care from BSN nurses had lower odds of readmission and 1.9% shorter length-of-stay. Economic simulations support a strong business case for increasing the proportion of BSN-educated nurses to 80%.	There was an inverse association between the continuous BSN proportion and the odds of in-hospital mortality (Association Between Patient Outcomes and Nurse Education)`
18. Hwang et al. (2009) **(Seoul, Korea)**	A cross-sectional survey was conducted.	The participants were comprised of 693 nurses at three general hospitals in Jinan, People's Republic of China and 593 nurses at two general hospitals in Seoul, Korea	To compare the factors influencing job satisfaction among Korean and Chinese nurses.	Professionalism was the common factor influencing job satisfaction in Korean and Chinese nurses.	Professionalism was positively related to job satisfaction
19. Kubsch et al. (2008) **(USA)**	Online survey developed by the researchers tested perceived professional values	n=198	Compared perceptions of professional values of 198 RNs according to their level of nursing education and other potentially influential factors.	A significant difference was found in perceived professional values according to level of nursing education, position or title, and professional organization membership.	Significant association between the level of education and professionalism.

Author(s)/year/ country	Method	Sample	Aim	Results	Key findings
20. Tanaka et al. (2014) **(Japan)**	A descriptive design	n=1501 registered nurses	To examine the levels of and differences in nursing professionalism. Comparisons of the total level of professionalism in educational preparation, current position, years of experience, and current practice	The results revealed that Japanese nurses had low levels of professionalism, and professionalism was related significantly to higher educational preparation, years of experience as a nurse, and current position as a nursing administrator or faculty.	Higher educational preparation and years of experience as a nurse were associated with high levels of professionalism
21. Solomon et al. (2015) **(Ethiopia)**	Mixed method Data were collected from the study participants using pre-tested Likert scale type self-administered & In-depth interview were held with 6 key informants	n=332 registered nurses (survey) n= 6 (in-depth interviews	To identify the relationship between organizational culture and nursing professionalism in addition to socio demographic, personal and societal factor.	Self-image was a significant predictor of professionalism score The overall result indicated that slightly over 6% of the variance in nursing professionalism could be explained by self-image. Those nurse who have positive self-image scores 0.207 times more on professionalism score than those with negative self-image.	Organizational culture, societal factors, personal (education) factors were associated with professionalism
22. Ross et al. (2009) **(USA)**	A survey design. Critical care nurses from 10 Critical Access Hospitals.		To determine the influence of registered nurses' certifications and years of experience on comfort level in emergencies	Number and type(s) of certifications and years of experience as an RN were associated with higher comfort levels.	Number and type(s) of certifications and years of experience as an RN were associated with higher comfort levels.
23. Friese et al. (2008) **(USA)**	Quantitative survey of nurses and aggregated to the hospital level.	n= 25,957	To examine the effect of nursing practice environments on outcomes of hospitalized cancer patients undergoing surgery	Receipt of care in National Cancer Institute-designated cancer centers significantly decreased the odds of death, which can be explained partly by better nurse practice environments	The practice environment of registered nurses was significantly associated with surgical outcomes for cancer patients.

A total of 23 primary research papers were selected for the present review. The majority of the studies were found to explore the impact of degree education on patient outcome from a quantitative perspective. Most of the studies utilised the quantitative methodology (n=22), only one paper (Solomon et al., 2015) used a mixed-methods approach. In addition, the country of origin is included to highlight the fact that few studies emerge from Europe, by comparison with those from the USA. The table summarises the methods used in the selected papers, sample size and how data were analysed. These articles will be further discussed within four key areas:

- Study aims;
- Sample;
- Method; and
- Results.

3.3.5.1 Study aims

The aims of 19 studies focused on the relationship between degree nurse education, hospital nurse staffing and health outcomes of the patients. Four of the studies examined the relationship between nursing education and professionalism (Kubsch, Hansen, & Huyser-Eatwell, 2008; Hwang et al., 2009; Tanaka et al., 2014; Solomon et al., 2015). These four studies also investigated if professionalism was related to health outcomes of the patients and nursing job satisfaction. Further, factors that were related to professionalism were explored in these studies. Only one study (Solomon et al., 2015) used a mixed methods approach when investigating the relationship between organisational culture and nursing professionalism. Solomon et al., (2015), also explored whether personal factors, which included level of education, was associated with professionalism.

Five of the studies (Estabrooks, Midodzi, & Cummings, 2005; Friese, Lake, Aiken, Silber, & Sochalski, 2008; Kanai-Pak, Aiken, Sloane, & Poghosyan, 2008; Aiken et al., 2011, 2014) also investigated the impact of the work environment and patient outcomes. For instance, Aiken et al. (2011) specifically examined if decreasing the workloads of the nurse or decreasing the ratio of nurse to patient could help reduce mortality risk within hospital settings. In addition, the study investigated if the nurse to patient ratio was related to the level of nursing education of the nursing staff. In Aiken et al. (2014), a further

assessment was undertaken on nurse to patient ratio and educational qualification of nurses from nine European countries. Friese et al.'s (2008) study examined the practice environments of the nurses and how these influenced health outcomes of cancer patients who underwent surgery. Similar to the study of Friese et al., (2008), Kanai-Pak et al. (2008), investigated how nurse inexperience and work environments influence the quality of care received by patients in the hospital setting. The quality of work environment and patient outcomes was also examined in Estabrooks et al., (2005).

All of the studies included in the present review presented clear aims. This is crucial when appraising the quality of the studies. Polit and Beck (2013) explain that clearly presented aims would inform the readers and other healthcare practitioners whether the study is worth reading and if results could be applied to their local practice. All articles included in this review were relevant to the present study since all focused on the impact of degree nursing education. It is noteworthy that all retrieved studies were not conducted in Middle Eastern countries and more specifically SA abroad. The main aim of the present review is to examine the influence of nursing degree education on nursing workforce planning in Saudi Arabia. However, there is still a paucity of qualitative studies on degree nurse education in Saudi Arabia's healthcare system and/or how this may correlate with patient care, health outcomes and patient safety. As part of evidence-based care, using results from published studies undertaken in other countries could help inform current nursing practice and workforce planning in Saudi Arabia. Greenhalgh (2014) explains that findings from quality published studies could be used to inform practice, policies and healthcare planning. It should also be noted that there is also a paucity of literature on how nursing degree education could influence nursing workforce planning in a particular country. However, using available evidence from the studies retrieved for the present review could increase the knowledge of policymakers regarding the impact of raising education levels of nursing staff.

3.3.5.2   Sample

Study samples were drawn from registered nurses in different fields of nursing practice. Fifteen of the studies recruited participants or examined nursing records from the US (Dunton, Gajewski, Klaus, & Pierson, 2007; Friese et al., 2008; Kubsch et al., 2008; Bobay, Gentile, & Hagle, 2009; Dellon, Lippmann, Galanko, Sandler, & Shaheen, 2009; Ross & Bell, 2009; McHugh & Lake, 2010; Aiken, Clarke, Sloane, Lake, & Cheney, 2008;

Aiken et al., 2011; Kendall-Gallagher & Blegen, 2009; Kendall-Gallagher et al., 2011; Kutney-Lee, Sloane, & Aiken, 2013; Blegen, Goode, Park, Vaughn, & Spetz, 2013; Spetz & Bates, 2013; Yakusheva, Lindrooth, & Weiss, 2014). One study was conducted in Ethiopia (Solomon et al. 2015), one in the UK (Park et al. 2007) and another study was undertaken in Korea (Hwang et al., 2009). Two studies from Japan (Kanai-Pak et al., 2008; Tanaka et al., 2014) and another two studies from Canada (Estabrooks et al., 2005; Sales et al., 2008) were included in this review. Meanwhile, the study of Aiken et al., (2014) used in-patient records and observations of nurses from nine countries in Europe.

The majority of the studies included in this review recruited a relatively large sample of nurses or used a large number of nursing records and observations from different countries. For example, the retrospective observational study of Aiken et al., (2014) used 26,516 nursing records from nine European countries and 442,730 In-patient records. These very large sample sizes could reduce sampling and reporting biases (Polit & Beck, 2013). This also suggests that findings from other healthcare settings could be used to inform practice. Since the samples were taken from observations of nurses and patient records in nine countries, this would enhance the generalisability and transferability of the findings to a more heterogeneous group of patients and nurses (Parahoo, 2014). Secondary data analysis was also evident in Kendall-Gallagher, Aiken, Sloane, and Cimiotti (2011), which used 28,598 patient data to examine if the proportion of staff nurses with specialty certification was associated with 30-day mortality risk of patients undergoing surgery. In another study led by Aiken et al., (2009) data from 232,342 surgical patients and 10,184 nurses from 168 hospitals in Pennsylvania, USA were used to analyse if nursing staffing and education were associated with patient outcomes. In Aiken et al., (2011) 272,783 nurses from four states in the US were recruited to the study to examine the impact of nurse education on patient outcomes. Overall, the sample sizes of the studies included in this review ranged from 29 to 272,783 registered nurses. Only the study of Solomon et al. (2015) used a mixed methods design and recruited six key informants for the qualitative part of their study. The very small sample size is appropriate for in-depth interviews since a qualitative study does not aim to generalise findings to a larger and more heterogeneous group of people (Bowling, 2014). Instead, smaller sample sizes would allow healthcare practitioners to explore a research phenomenon in more depth and detail (Coughlan et al., 2013).

While the studies reviewed provide important information for this study unfortunately none involved participants from Saudi Arabia or countries from the Middle East. It is argued that the socio-cultural context of the nurses in Saudi Arabia could differ from those in the US, Japan, Korea, UK, Ethiopia, Canada and Europe. Although this could be identified as an a limitation, it is noteworthy that the relatively large sample sizes of these studies would reduce sampling bias. This suggests that healthcare practitioners and policymakers in Saudi Arabia could use information from these studies in understanding how nursing education could influence health outcomes of the patients and professionalism. Results of these studies could also be used in nursing workforce planning in SA.

3.3.5.3 Method

A majority of the studies used cross-sectional surveys. Cutcliffe and Ward (2007) emphasise that a cross-sectional survey would allow researchers to randomly or purposively select a representative sample from the target population of a study. While generalisability of the findings of a survey may be considered a limitation, this concern is addressed when there is random sampling and recruitment of a relatively large sample size (Bowling, 2014). Most of the studies reviewed, which were conducted in several large hospitals, recruited a relatively large sample size. It is also important to examine if the survey has a high response rate, as this would indicate that the study is important to the respondents or is easy to administer amongst the participants (Ellis, 2013). The majority of the studies reviewed had a response rate of more than 30%, considered appropriate for surveys (Polit & Beck, 2013). However, one of the limitations of a survey is the risk of reporting bias (Creswell, 2013). Participants may choose not to disclose their actual practice in healthcare settings (Greenhalgh, 2014). In the studies reviewed, the risk of reporting bias was reduced, as responses of the participants were correlated with other data such as, patient records and incidence of hospital infection or 30-days mortality.

In some studies, (Kubsch et al., 2008; Hwang et al., 2009; Tanaka et al., 2014; Solomon et al., 2015), the level of education of the nurses was correlated with their degree of professionalism. Most of the questionnaires used to measure professionalism were developed from previous studies. For example, in Hwang et al., (2009) the study authors developed the questionnaire on professionalism and nursing job satisfaction from results of previous studies. The questionnaire was piloted amongst selected participants for

reliability and internal consistency. Following the pre-testing of the questionnaire, it was revised using expert opinion and re-tested. This is crucial since validity of each scale used in the questionnaire would ensure that questions used would measure professionalism (Parahoo, 2014). Using Cronbach's alpha Hwang et al.'s (2009) questionnaire scored 0.93, which indicated high reliability (Polit & Beck, 2013).

Meanwhile, seven studies, (Dunton et al., 2007; Friese et al., 2008; Sales et al., 2008; Dellon et al., 2009 ; Kendall-Gallagher & Blegen, 2009; Kendall-Gallagher et al., 2011; Yakusheva et al., 2014) carried out secondary data analysis using retrospective study design. One of the benefits of a retrospective study design is the ease in gathering data. Most studies using secondary data analysis retrieved data from electronic health records, cancer registry or hospital records. A retrospective study is less expensive and faster to carry out compared to a cross-sectional study (Creswell, 2013). Further, characteristics of the respondents, which included level of nursing education, can be correlated with health outcomes of patients (Creswell, 2013). However, it would be difficult to examine confounding factors that might have influenced the outcomes of the patients in the studies since the outcomes have long occurred before the gathering of data (Ellis, 2013). Despite this limitation, secondary data analysis enabled investigators to examine the relationship between the level of education of the nursing workforce and general health outcomes of the patients. The latter included 30-day mortality and incidence of hospital infections. Only one study (Solomon et al., 2015) utilised a mixed methods study design. This type of study design would help validate the findings of a survey with results of in-depth interviews (Bowling, 2014).

Overall, the methods used in the studies included in this review were appropriate in answering the studies' respective aims and objectives. For instance, a survey is not only economical but could record several characteristics, attitudes and knowledge of respondents in a single setting (Coughlan, M., Cronin, P. & Ryan 2013). However, an in-depth interview could help explore nurses' perspectives on professionalism and how their level of education influenced their professionalism. Further, an in-depth interview could provide rich data that can be analysed into themes and used to answer research aims and objectives (Ellis, 2013).

3.3.5.4 Results

Importantly, almost all of the studies investigating the relationship between knowledge and patient outcomes, reported an inverse relationship between levels of education and preventable hospital deaths or rates of complications, such as hospital infections (Estabrooks et al., 2005; Dunton et al., 2007; Friese et al., 2008; Kanai-Pak et al., 2008; Aiken et al., 2009, 2011, 2014; Dellon et al., 2009; Kendall-Gallagher & Blegen, 2009; Kendall-Gallagher et al., 2011; Kutney-Lee et al., 2013; Blegen et al., 2013; and Yakusheva et al., 2014). Only Sales et al., (2008) reported conflicting findings with the majority of the studies included in this review. Sales et al., (2008) did not find a significant association between registered nurse education and the mortality of the patients in ICU settings. It could argued that the study of Sales et al., (2008) done in small setting, with specialised and experienced nurses rather than level of education. However, results suggested that there was significant association between increased registered nurse (RN) staffing in non-ICU units and mortality risk. Increased RN staffing was statistically significantly associated with a decrease in mortality risk of the patients in a non-ICU setting. It would appear that nurses assigned to ICU settings have higher levels of education and expertise. Hence, when an analysis was conducted on the levels of education of ICU nurses and health outcomes of patients, it would appear the level of education would not influence mortality risk of the patients. In contrast, RN staffing in non-ICU settings would have a greater impact on mortality risk since some nursing staff might only have an associate degree. Results of this study would suggest that levels of education of the nurses could influence mortality risk of patients especially in non-ICU settings.

The level of education of the nurses also influenced their level of professionalism in four studies (Kubsch et al., 2008; Hwang et al., 2009; Tanaka et al., 2014; Solomon et al., 2015) clinical expertise in two (McHugh & Lake, 2010; Bobay et al., 2009) in two, and comfort level in one (Ross & Bell, 2009). Increasing the proportion of registered nurses was also associated with improvements in health outcomes (Yakusheva et al., 2014). When an economic evaluation was performed, nurses who acquired higher levels of education were more likely to enjoy higher compensation compared to nurses with associate degrees (Yakusheva et al., 2014). Higher nursing education also translated to career promotion and becoming an advanced nurse practitioner (Yakusheva et al., 2014).

3.3.6 Key Themes in the Literature

The review of the literature revealed the importance of nursing education and how it translates to improving patient outcomes and mortality risk, and reduces complications in hospital settings. Since the main aim of healthcare is to improve the quality of care through reducing mortality risk and complications, investing in the education of nurses could help improve the overall health outcomes of patients. When applied to Saudi Arabia's healthcare settings, introducing policies that would improve nurse education and allow for continuing professional education for registered nurses could help progress positive health outcomes for patients. Nurse workforce planning could include provisions that would support registered nurses when taking graduate studies or allowing nurses with a Diploma to pursue a BSN. Most of the literature reviewed in the present study also recommends continuing health education for nurses in order to improve the nursing environment, and promote professionalism and expertise amongst nurses. The key themes identified from the literature are illustrated in Table 3-4.

Table 3-4: Key themes identified from literature

Country of origin	Authors	Key themes
United State (USA) ; Canada; Europe; Japan;	Estabrooks et al., 2005; Dunton et al., 2007; Friese et al., 2008; Kanai-Pak et al., 2008; Aiken et al., 2009, 2011, 2014; Dellon et al., 2009; Kendall-Gallagher et al., 2009, 2011; Kutney-Lee et al., 2013 Blegen et al., 2013; Yakusheva et al., 2014.	Nursing education is associated with improved patient outcomes.
	Sales et al. 2008.	No association between BSN education and mortality rate.
Japan; Seoul, Korea; USA.	Kubsch et al., 2008 ; Hwang et al. 2009; Tanaka et al., 2014; and Solomon et al., 2015; Bobay et al., 2009; McHugh & Lake, 2010	Nursing education as correlated with professionalism and clinical expertise.
Ethiopia; UK; USA.	Ross and Bell (2009); Park et al. (2007); Spetz and Bates (2013).	Nursing education promotes career and economic development of nurses.

The following section will discuss three key themes shared by the studies identified in Table 3-4; (1) nursing education is associated with improved patient outcomes; (2) nursing

education is correlated with professionalism and clinical expertise; and (3) nursing education promotes career and economic development.

1- Nursing education is associated with improved patient outcomes

Specific patient outcomes highlighted in the reviewed studies included reducing the 30-day mortality risk and complications. For example, Blegen et al., (2013) demonstrated that hospitals with higher proportions of nurses with BSN degrees had lower rates of mortality, deep vein thrombosis and/or pulmonary embolism, hospital-acquired pressure ulcers and infection due to medical care. Blegen et al., (2013) is one of the first studies to suggest that apart from reducing mortality risks, increased BSN education has other beneficial effects. While Blegen et al.'s (2013) study focused only on patients with congestive heart failure, the rest of the studies reviewed indicated higher education levels were associated with better health outcomes for different groups of patients The rest of the studies included in the present review suggested that higher education levels were associated with better health outcomes for different groups of patients (Estabrooks et al., 2005; Dunton et al., 2007; Friese et al., 2008; Kanai-Pak et al., 2008; Aiken et al., 2009, 2011, 2014; Dellon et al., 2009; Kendall-Gallagher & Blegen, 2009; Kendall-Gallagher et al., 2011; Kutney-Lee et al., 2013; Blegen et al., 2013; Yakusheva et al., 2014).

It should be noted that these studies were conducted in multiple hospital settings across different countries in Europe, the US, Japan, Canada, Ethiopia and Korea. Results were consistent in demonstrating increased nursing education could lower mortality rates of patients and improve health outcomes. Only study Sales et al., (2008) suggested that improving nursing certification could have more impact in non-ICU healthcare settings compared to ICU settings (Sales et al., 2008). When applied to Saudi Arabia's healthcare setting, increasing the education level of practicing nurses could promote positive patient outcomes.

The majority of the studies also suggest a higher ratio of registered nurses could lead to positive health outcomes of the patients. For instance, hospitals employing a higher proportion of registered nurses with BSN degrees had lower failure to rescue, 30-day mortality and cardiac deaths (Blegen et al., 2013). Similarly, Aiken et al., (2011) demonstrated that regardless of work environment or type of patients admitted to hospital settings, increasing the BS nursing workforce by 10% would reduce mortality risk by 30-

days mortality risk. Aiken et al., (2014) also indicated that preventable hospital deaths would be reduced by 7% if 60% of the nursing workforce had BS degrees. It should be noted that the studies carried out by Aiken et al. (2011, 2014) were conducted in the US where nurses could practice with associate or BS degrees. When applied to Saudi Arabia's healthcare setting, the findings of Aiken et al., (2011; 2014) would suggest the hiring of nurses with BSN would be more beneficial compared to hiring nurses with only associate degrees.

2- Nursing education as correlated with professionalism and clinical expertise

Four studies (Kubsch et al., 2008; Hwang et al., 2009; Tanaka et al., 2014; and Solomon et al., 2015) investigated the association between nursing education and professionalism and clinical expertise. These studies also correlated clinical expertise and professionalism with health outcomes of the patients. Tanaka et al. (2014) reported higher educational preparation and years of experience as a nurse were associated with high levels of professionalism. Importantly, higher levels of professionalism were associated with increased job satisfaction (Hwang et al., 2009). While the study of Hwang et al. (2009) recruited Korean and Chinese nurses, the findings of this study have important implications in Saudi Arabia's nursing environment. The results of Hwang et al.'s (2009) study indicate that raising the level of professionalism could help retain nurses due to higher job satisfaction. It has been noted previously that job dissatisfaction amongst nurses could result to high nursing turnover (Hwang et al., 2009). Hence, when conducting nursing workforce planning, policymakers should also consider how to retain nurses. High turnover of nurses could result to poor patient care and poor health outcomes (Hwang et al., 2009). Hence, increasing the levels of education of the nurses could be one way of reducing nursing turnover (Collier & Harrington, 2008).

This review also shows that clinical expertise is crucial in promoting positive health outcomes for patients (Bobay et al., 2009; McHugh & Lake, 2010). Interestingly, Bobay et al., (2009) found that non-mandatory continuing education was significantly associated with higher perceived levels of clinical expertise. Bobay et al., (2009) also acknowledged that apart from educational preparation, years of experience as a registered nurse, is associated with clinical expertise. In SA, institutionalising continuing professional education, which would include pursuing higher education, could help raise the clinical expertise of the nurses. In turn, this could improve patient outcomes.

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The results of this systematic review also demonstrate that nursing education is not only associated with clinical expertise, professionalism and improvements in patient outcomes but also with personal outcomes for the nurses. Nurses would appear to be more confident and comfortable in providing care to their patients if they have earned more certifications on nursing care (Ross & Bell, 2009). The benefits extend beyond feelings of comfort, to career development. In a UK study, (Park et al., 2007), satisfaction in nursing careers was associated with specialisation of careers and obtaining advanced nursing degrees. Nurse motivation also increased with promotion and career advancement (Park et al., 2007). The impact of nursing education also results to higher earnings. Spetz and Bates (2013) explain that higher nursing education translated to higher earning potential and actual lifetime earnings, especially if nurses completed a BS nursing degree compared to an associate degree. However, this review did not investigate factors that might facilitate or hinder nurses from pursuing higher degrees. Family obligations or personal circumstances might deter or promote nurses from pursuing higher degrees (Spetz & Bates, 2013). Employers of nurses could also have an important role in influencing the educational decisions of the nurses. Spetz and Bates (2013) suggest that some nurses might not pursue higher education if they feel that there is a lack of support from their own employers.

3.3.7 Effectual impact upon patient care through degree education and experience

An increasing amount of evidence has begun to emerge that demonstrates the level of beneficial abilities BSN graduates bring to the profession of nursing, which is thought to enhance the care and safety of patients (Tourangeau et al., 2006; Tourangeau, 2006; Kendall-Gallagher et al., 2011; Blegen et al., 2013; Fossen, 2014). Nevertheless, a perpetual global challenge arises from the lack of qualified nurses, as a multitude of entry levels persist in nursing practice, resulting in disparate educational levels for nurses. Through the modern era, it has been suggested nurses should attain a minimum education level of a Bachelor's degree that enables the expansion of knowledge, as educated nurses within interdisciplinary healthcare teams irrefutably improve patient outcomes (Tourangeau et al., 2006; Tourangeau, 2006; Kendall-Gallagher et al., 2011). Very few studies exist that compare dynamics (influencing factors) within nursing, although there is a growing body of research providing evidence of improved patient outcomes being

derived from better educated nurses (Fossen, 2014). For instance, lower mortality rates within hospitals are linked to nurses who provide care possessing a minimum education level of a BSN (Estabrooks et al., 2005; Tourangeau et al., 2006; Tourangeau, 2006; Van den Heede et al., 2009; Yakusheva et al., 2014). Restricted evidence exists that demonstrates patient outcomes being positively affected by nurses who are certified in separate specialisations, even though more nurses have started to acquire these qualifications. According to Fossen (2014) since nursing touches and addresses issues that relate to the health of individuals, advancing to at least a BSN level gives sufficient insight into the human physiological, psychological and social functioning that makes it easy to address health matters that may affect them.

Kendall-Gallagher & Blegen (2009), in conducting a review of 279 adult patient charts in 29 different hospitals, found that a significant decrease in skin breakdown correlated with higher proportion of nurses certified with a BSN. Another recent cross-sectional study conducted by Blegen et al., (2013), aimed to examine the effect of registered nurse education on patient outcomes. Data were collected from 21 University Health System Consortium (UHSC) hospitals in the US, four quarter from each hospital. The results concluded that there is a significant association between nursing education and patient outcomes and that this goes further than considering mortality rates. Hospitals with high proportions of nurses with a baccalaureate or higher level of education had lower rates of mortality from CHF, Hospital Acquired Pressure Ulcers (HAPUs), postoperative Deep Vein Thrombosis (DVT/PE), and reduced length of stay (Mary et al., 2013). However, the study may be limited to generalisability due to the small sample size. In addition, the data collected for their study were from 2005, and may not replicate the current level of patients' outcomes.

A separate cross-sectional analysis was conducted by Estabrooks et al., (2005) evaluating the outcome for over 18,000 discharged patients from a total of 49 acute care hospitals in Alberta, Canada between 1998 and 1999. The aim of the study was to assess the effects and relevance of nursing education and abilities, together with the continuity of care and the quality of the workplace environment. Hence, it was feasible to predict the 30-day mortality possibilities following the adjustment of institutional factors and characteristics of these individual patients, who were diagnosed with acute myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, pneumonia, or stroke.

Overall, 44.2% of the month-mortality variance was explained by patients of a certain age who suffered from multiple diseases. Subsequently, post-adjustment following the comprehension of patient co-morbidities and demographics, as well as the defined format of study and teaching for a fixed-effects model within hospitals, it became possible to understand the significance of hospital nursing characteristics that assist in predicting 30-day mortality rates, and how people rate their relevance. On average, higher nursing education stood at 0.81, a full mix of nursing skills was at 1.26, and improved nurse-physician relationships was relevant at 0.74. Therefore, in an effort to reduce 30-day mortality risks for patients, nursing characteristic developments are seen as imperative within hospitals.

However, certain studies cited in the previous discussion have incorporated factors that indicate conflicting findings in regards to baccalaureate preparation. Two individual studies reported positive evidence in the mortality rate, relationship and baccalaureate attainment levels of nursing staff. It was determined that mortality rates were decidedly lower when care was delivered by baccalaureate-educated nurses (Estabrooks et al., 2005; Blegen et al., 2013). Overall, throughout the previous two decades, there has been increasing attention on how patient mortality and survival rates are impacted by the nursing care provided within the hospital setting. Nevertheless, inconsistent knowledge into hospital structures impacts on the quality of patient care and this topic is perhaps worthy of further investigation.

One specific longitudinal, retrospective, two-stage panel study was designed to incorporate a cross sectional sample of three sources of data collected between 1999 and 2006 (Kutney-Lee et al., 2013). These data sources were administrative patient discharge information, a nurse survey and the Annual Survey from the American Hospital Association. The study examined a possible correlation between patient outcomes and nursing education within 134 clinical hospitals. It was ascertained that for every 1,000 patients an average 2.12 deaths were reduced as a direct connection to the 10% advancement in hospitals that employed baccalaureate educated nurses, as well as a reduction average of 7.47 deaths for a sub-group of patients who had experienced complications. Consequently, Kutney-Lee et al.'s (2013) research highlighted a progressive marked decline in fatal surgical outcomes directly correlated to hospitals employing baccalaureate-qualified nurses. Unfortunately, due to the limitations of the study, namely

being carried out in only one state, the research findings are not generalizable to national or global situations.

Aiken (2010) examined the connection between registered nurses who possessed specialty certification and their effect on the risk adjustment outcomes of about 1 million discharged adults, who received orthopaedic and vascular surgery in non-federal hospitals in California, Florida, New Jersey, and Pennsylvania. Findings indicated that those who have speciality certifications were more likely to neutralise risks and enhance adjustments following this type of surgery. This implies that attaining speciality education can positively impact on risk adjustment outcomes (Aiken, 2010). Historically, through expert and collaborative nursing practice, the specialty certification for a registered nurse is believed to actively advance patient outcomes, as it constitutes a demonstration of defined clinical knowledge that is acquired through both formal education and experience (Kendall-Gallagher & Blegen, 2009).

It is eminent that within the modern, complex and rapidly changing healthcare environment it is imperative to adequately inform nursing officials, educators and policymakers of the available evidence in order to provide efficient and beneficial educational strategies. As a consequence of taking such action, a competent nursing workforce can be instilled, who will have the necessary knowledge and skills to deliver excellent patient care.

The evidential correlation between nurse educational levels, particularly BSN and above, and patient health outcomes has been demonstrated by nursing research literature. Reduced hospital mortality rates, reduction in length of stay, less medication errors and procedural violations have been shown to be associated with better educated nurses, especially when they had studied to baccalaureate level (Estabrooks et al., 2005; Tourangeau et al., 2006; Tourangeau, 2006; Kendall-Gallagher & Blegen, 2009; Kendall-Gallagher et al., 2011; Aiken et al., 2011; Blegen et al., 2013; Kutney-Lee et al., 2013; Blegen et al., 2013). Furthermore, these findings were not limited to the USA, but have been found in various countries and nursing specialties (Estabrooks et al., 2005; Tourangeau, 2006; Friese et al., 2008; Aiken et al., 2009 ; Van den Heede et al., 2009; Aiken et al., 2014).

Nursing and professionalism

Nursing professionalism is defined as the knowledge, skills, behaviours, and values required for nurses to be registered (Veenema et al. 2016). According to Tanaka et al. (2014), professional practice in nursing includes commitment to compassion, caring, accountability, individual responsibility, collaboration and ethical values and believes. Nurses have established educational and practical standards and nursing professionalism in is a great demand within the healthcare system (Tanaka et al., 2014).

However, professionals within healthcare have considered various approaches to rectify the shortage of nurses educated to deliver a high standard of care. The challenges facing contemporary nursing are to improve education levels, with the potential for determining the baccalaureate degree as a prerequisite to practice entry. For instance, the National Council of State Boards for Nursing in the U.S. has reported that around 66% of associated degree courses are attended by new nurses, while in Canada it is a requirement for all nurses to hold a baccalaureate degree. Likewise, advanced collaboration from funding bodies to university boards has been stated as imperative in the dynamic process of addressing the issue of educational capacity. This is evident in New Zealand as Committee on Inter-Institutional Cooperation, as it collaborates to enable the institutions to share faculties, curriculum, simulation technology, sites for clinical placement, and application portals (Cleary et al., 2009). Furthermore, scholarships for hospitals and faculty loans have been procured, together with successful foundation funding partnerships between organisations and government bodies within the private sector (Cleary et al., 2009). It is an impetus for policy makerss, nursing boards and HE institutions to come together to collaborate to ensure nurse education is delivered at degree level.

In western countries, the nursing students are seeking to be professionals by attending higher education, for example, obtaining a degree and specialisation in their chosen aspect of nursing; these elements have been reported a priority within research on BSN graduates' aspirations, career progression and job satisfaction. A study by Park et al. (2007) that involved a sample of bachelor nursing students graduating between 1994 and 2000, found a strong focus on getting promotion, gaining experience and further specialisation. Rambur, McIntosh, Palumbo, and Reinier (2005) claim that BSN nurses have a higher degree of professionalism than others with a lower level of education; their 'RN Job Analysis and Retention Study' indicated their findings were lined to social return on

educational investment. A large cross-sectional survey was conducted by (Hwang et al., 2009). The study aimed to compare different factors influencing job satisfaction among nurses. The study included a sample of 693 Chinese nurses and 593 Korean nurses. The results indicated a significant correlation between levels of education and levels of professionalism. Furthermore, Kubsch et al. (2008) compared perceptions of professional values of 198 registered nurses, according to their level of education and other influential factors. The study found RN-BSN nursing student demonstrated a higher rate of professionalism than other students.

Nursing and experience

A number of studies looked at the concept of 'years of experience' being a factor in delivering better health outcomes. For example, this notion could be considered akin to research on the number of accidents involving inexperienced drivers, compared with those with a lot of experience. Obviously, experience allows a driver to develop key skills. However, when it comes to nursing, and nursing experience, the research does not show such clear results. While studies do concur that inexperienced nurses are less likely to detect complications (Dellon et al., 2009), it is a common theory that nursing expertise develops best with continued exposure to experiential learning (Dunton et al., 2007; Bobay et al., 2009).

Bobay et al. (2009) in a cross sectional analysis of data from 8,611 registered nurses (RN) that aimed to determine the relationship between nurse experience and education with other hospital contextual factors with the level of clinical expertise found a significant correlation between experience as an RN nurse with an initial level of expertise. Another study conducted by Dunton et al. (2007) aimed to review eight of the total 25 quality indicators from the National Database of Nursing Quality Indicators (NDNQI). They identified a decrease in the fall rate by one percent for every increase in year of nurse experience. Furthermore, the same study highlighted a decrease of hospital acquired pressure ulcers of 1.9% for each year of nurses' experience (Dunton et al. 2007).

Research on the impact of experience on nursing practice and medical error generally considers a nurse to be 'expert' after having completed five years of clinical experience (Orsolini-Hain & Malone, 2007; Dellon et al., 2009). McHugh & Lake (2010) identify these nurses as those that will stand out among others by being able to make critical

decisions and, at the same time, grasp the nature of a situation as a whole; they are also able to recognise potential problems and alert the necessary people to them before they occur. These characteristics mean that less time is wasted and, essentially, the level of patient care is improved (McHugh & Lake, 2010). Expert nurses also act as educators for less experienced nurses and are often consulted and relied upon for help.

However, it is important to consider the difference between experience and expertise; these are two related but entirely different concepts. Experience is necessary to become an expert, however it is not enough alone to class a nurse as an expert; therefore, not all experienced nurses will be experts (Christensen & Hewitt-Taylor, 2006; Ericsson, Whyte, & Ward, 2007). Although, it is clear that the repetition and continuous exposure to practice that comes with experience is essential for establishing critical thinking and developing an idea of judgment, we cannot tell exactly how much of an impact this actually has on patient outcomes. In attempting to define a number of years of practice, related to the outcomes for patients, a number of factors obscure the results; these include technological changes, which have resulted in a number of errors. These changes, along with information updates and organisational demands mean that health care professionals need to be continuously seeking further education and expanding their knowledge in order to adapt. For example, research conducted by Kanai-Pak et al. (2008), highlights hospitals where 50% of the nursing workforce were inexperienced (less than 4 years of practice) reported the probability of job dissatisfaction, poor-to-fair quality of care and staff burn-out to be twice as high when compared to those with considerably less experience and lower educational attainment. Most evidence indicates that nurses and midwives with more years of experience are more skilful and knowledgeable than others.

Nursing and Education

McHugh & Lake, (2010) state that it is theory and principles that give nurses the tools to know which questions to ask, to easily identify patients' problems and to provide quality care by making the right decisions. Although there is little research that looks specifically at the educational composition of staff in relation to individual clinical nursing expertise, it is suggested that the level of education of a group of staff would contribute to the development of expertise in a clinical setting (McHugh & Lake, 2010; Blegen et al., 2013).

Following research results showing the positive effect of higher educational levels on patient care, the recommendations of the Institute of Medicine (2011) are concerned with increasing the percentage of staff with a BSN qualification to 80% by 2020. This research, as discussed earlier, has been highlighted in the literature and can be associated with a decrease in failure to rescue and mortality rate (Estabrooks et al., 2005; Tourangeau, 2006; Friese et al., 2008; Van den Heede et al., 2009; Aiken, 2010; Kendall-Gallagher et al., 2011; Aiken et al., 2014).

This was confirmed in a more recent, cross-sectional study conducted across 21 universities from 84 quarters of quality data that analysed the association between RN education and patient outcome (Blegen et al., 2013). Further to this, significantly lower rates of congestive heart failure mortality, deep vein thrombosis, and length of hospital stay were noted.

Furthermore, a cross-sectional analysis of data collected from 6,611 nurses conducted by McHugh & Lake (2010). The study revealed that the composition of hospital staff, concerning the proportion of nurses with a minimum BSN level of education, had a direct correlation with the number of nurses at a more advanced level of expertise. The results of this study suggests working in a hospital context can significantly influence clinical nursing expertise. The generalisability of the results of McHugh & Lake's (2010) study is subjected to certain limitations. For instance, the data sourced is dated 1999 and only represents nurses in Pennsylvania; these factors mean that the findings cannot be easily generalised and it must be considered that the information sourced could be a little outdated, due to variances over time.

The results of research into the relationship between nursing experience and patient outcomes were inconsistent. When it comes to studies that considered the effects a nurse's level of education had on patient care, there are few identified with the majority of the research exploring 30-day mortality and failure to resuscitate (Estabrooks et al., 2005; Tourangeau, 2006; Van den Heede et al., 2009; Aiken, 2010; Aiken et al., 2014). The research in this area is not only minimal, but also quite specific. For instance, there is only two study that looks into multiple nurse characteristics to determine their effect on patient sensitive outcomes (Kendall-Gallagher et al., 2011). This research provides valuable information on how individual nurse characteristics might influence each other and how these influences are then transferred to patient care.

In both types of research, concerning the relationship between nurse education or nurse experience and patient outcomes, studies were conducted in speciality units, such as oncology or intensive care, and could have been more generalizable had they covered a broader range of illnesses (Kendall-Gallagher & Blegen, 2009; McHugh & Lake, 2010; Kendall-Gallagher et al., 2011).

Overall, a significant association between the education of nurses and patient outcomes was found (Tourangeau, 2006; Tourangeau et al., 2006; Van den Heede et al., 2009; Aiken et al., 2011; Kendall-Gallagher et al., 2011; Blegen et al., 2013; Aiken et al., 2014). However, there were two studies contradicting this that concluded that there was no correlation between BSN education and improved patient care (Sales et al., 2008; Bobay et al., 2009).

3.4 Summary and Conclusion

In summary, the nursing profession, on a global level, is experiencing a number of difficulties, most notably being short staffed and this resulting in the employment of under qualified nurses. In addition, a large number of potential students are not accepted onto programmes due to strict entry requirements. These concerns present a particular challenge for SA where the situation is severe and many potential nurses are discouraged by the social stigma surrounding the profession. The introduction of the BSN as a minimum requirement has shown positive results but also presents problems considering the time it will take to ensure that all nurses are educated to this standard.

This chapter has considered the challenges for the nursing profession on an international level and, more specifically, in SA. The literature review has highlighted a number of key themes discussed in two sections:

First section; most notably there appears to be some issues related to the nursing workforce in SA: these have been categorised under educational, system, and social headings.

- Educational issues include the fact that many nursing personnel do not hold a Bachelor of Science Nursing degree and this lack of education for nursing staff is a hindrance in providing high quality nursing care to the patients who need an advanced level of nursing.

- System problems involve reassessing policies and regulations related to nursing along with the turnover and retention rate of nurses.
- Social issues include the working environment involving the gender ratio, long working hours, job dissatisfaction and low wages, as these factors are a cause of the high turnover rate, as well as reinforcing the social image of nursing practice.

The second section of this chapter demonstrated a correlation between the number of BSN trained nurses and an improved level of patient care. These have been categorised under the following key themes:

- Nursing education is associated with improved patient outcomes.
- Nursing education is correlated with professionalism and clinical expertise.
- Nursing education promotes career and economic development of nurses.

This literature review has revealed the importance of nursing education and how this translates into improvements in patient outcomes, for example reducing mortality risk and complications in hospital settings. Most of the literature reviewed in the present study also recommends degree education for nurses in order to improve nursing care, promote professionalism and enhance expertise amongst nurses.

The following chapter will detail the philosophical rationale and methodological approach for the study, including the sampling criteria, data synthesis, trustworthiness, and ethical considerations.

Chapter 4 :   Methodology

4.1 Introduction

The previous chapter critically reviewed the available evidence related to degree education as it relates to nurse workforce planning and explored the effectual impact of degree nurse education on quality of care, presenting the reader with the key themes. This chapter will introduce the case study method which was used to examine the implications of a degree as the minimum requirement for nurse practice in Saudi Arabia. First and foremost, an overview of the philosophical rationale is offered, considering methodological approaches including a discussion on qualitative and quantitative methods. A justification for the use of case study methodology as an appropriate choice for this research is provided. The chapter also includes a description of macro, meso, and micro theory/framework which were used in this research together with an explanation of the data collection process, analysis, and ethical considerations; with a particular focus on what the research considers the implications at all levels, from the MoH to selected members of staff employed in public hospitals.

4.2 Philosophical Rationale

This section aims to explore the researcher's perspective of the ontology, epistemology, and methodology that underpins this study. It is important to consider such philosophical positions to help answer the research questions of 'why' and 'how' in order to develop a strong understanding of the nature of reality and how that reality can be known (Creswell, 2003).

Ontology is the sum of beliefs that reflect an individual's interpretation about what constitutes a fact (Phillimore & Goodson, 2004). It is associated with the central question of whether social entities need to be perceived as objective or subjective. However, my Islamic cultural background has shaped my personality. The values, beliefs, and education that I carried inspire me to see reality from a different perspective. This, combined with my experience as a practising nurse, has underpinned my ontological position and given me the power to choose the appropriate situation and method. Ontology is explained as the study of the existence of reality (Hudson & Ozanne, 1988).

Epistemology, on the other hand, explores the interconnection between the researcher and the existence of facts (Phillimore & Goodson, 2004), or the way in which it is acquired or established. Epistemology is the study of the fact and scope of existing knowledge (Reimer-Kirkham et al., 2009). Phillimore and Goodson, (2004) state that the epistemological stance an individual adopts indicates their beliefs on world knowledge and how this is acquired. The epistemology of this case study approach is formed in the context of the argument that "*there are multiple realities integrated into the form of multiple constructs*" (Guba & Lincoln, 1994: P. 110).

However, these two key philosophies have different assumptions. Firstly, a reality exists that is detached from our awareness and on which the basis of our existence is created or developed, resulting in the term of foundationalism. Secondly, that reality does not exist, but rather an existence is both indirectly and socially constructed, which is consequently determined by a specific culture, event, or period in time (Guba & Lincoln, 1994).

Thus, to determine the meaning of individual events, the constructivist approach is used, which also helps in understanding the events in relation to their reality. According to Denzin and Lincoln (2011) the constructivist approach provides the researcher with an opportunity to attain knowledge regarding the reality of the event, and it also provides the researcher with insight into the possible solutions for the issues (Baxter & Jack, 2008). This paradigm supports the use of the qualitative method to explore the different views of participants at three levels of an organisation (macro, meso, and micro). Furthermore, this approach does not look at the meaning of the event from an outside perspective; instead, it requires the researcher to gain in-depth knowledge, as understood by the participants (Rodwell, 1998). Therefore, it is very important for me as a researcher to understand the multiple realities, relating to the issue under exploration, from the perspective of the participants. The reality, in context, is degree education as a minimum entry requirement for nursing practice in SA, which will be analysed by taking a contextualised view of the existing policy and putting into practice this important decision for the future nursing workforce.

However, having an appropriate research question is an essential element in selecting the research methods and methodology (Creswell, 2003). The path the research takes is prejudiced by the position of the researcher in relation to their philosophy about scientific knowledge and truth. Therefore, to select an appropriate research method for this study, it

was first necessary to contemplate my own philosophical position in relation to research, evidence and knowledge. Smith (2001); Polit and Beck (2013) claim that this is imperative for three reasons. Firstly, it permits the researcher to select the most appropriate methodology to conduct the investigation; secondly, it permits the evaluation of other methodologies helping to avoid any incongruous selection and superfluous work; and finally, it may inspire the researcher to go beyond their aforementioned level of experience to try new tactics within their research. Procto (1998) supports this opinion by stating that uniformity between the objectives of the research, the research questions and methods selected and the philosophy of the researcher is essential to any research project.

The previous discussion provides the philosophical rationale from 'my view', on the ontology and epistemology stance that underpins this study. It is important to consider such a philosophical perspective to help answer the research question in order to develop a strong understanding of the situation under study. The following section discusses the methodological approach in general and the case study in particular.

4.3 Methodological Approach

Research methods are professional techniques that are used to structure, collect and analyse the data relating to the research question (Polit & Beck, 2013). There are two different paradigms that have a significant implication for the research method: the positivist and the relativist paradigms or quantitative and qualitative approaches (Polit & Beck, 2013). These two paradigms have contrasting worldviews and assumptions about reality (Creswell, 2013). They are, essentially, the two primary methodological approaches that are actively seeking researcher recognition (Ellis, 2013). In seeking to identify causal factors or indeed generate scientific rules, they do not solely allude to the concept of natural science in their ontological and epistemological theories but utilise an identical approach a suggested by Phillimore and Goodson (2004).

Ultimately, positivist methodology aims to compile and analyse numerical data, to prove a single truth. The objective of this methodology is to provide explicit and precise casual factors, which are indisputable, rather than trying to interpret the data (Polit & Beck, 2013). The main benefits of using this technique are (1) the study can be reproduced without difficulty and (2) the findings are generalisable (Creswell, 2013). These qualities

are results of the purely statistical nature of the structured method of data collection (Polit & Beck, 2013). Nevertheless, one of the typical objections cited against positivism is the lack of clarity in interpreting the findings of, for example, surveys– the main one is positivism does not take account of human experience and how human beings arbitrate between their experiences (Creswell, 2013). The question arises as to whether this criticism is justified, as the key elements of this method are concerned with the patterns of cause and effect, rather than the significance of these behaviours (Creswell, 2003). While it is obvious that the methods used when undertaking positivist research are indeed scientific, the concept of "objectivity" herein is not strictly maintained in this study.

Conversely, qualitative methods are typically used by relativists, interpretivists or constructivists, in line with the ontological and epistemological stance of the researcher (Procto 1998). Qualitative methodologies seek to establish the significance of social conduct, which allows for a wealth of knowledge to be gathered (Ellis, 2013). Based on the idea that all information requires analysis in order to provide contextual sense, relativists employ various techniques including interviews, focus groups, case studies and other methodologies to gain a more comprehensive understanding of the research area (Yin, 2013). While, according to positivists the findings of qualitative research are not reliable, valid and/or generaliseable, they do proved a deeper understanding from a human perspective, as is the case with this study (Park, 1991).

The advantages and disadvantages of qualitative methods and the reason for accepting case study as an appropriate method for this research are identified in Table 4-1.

Table 4-1: Advantages and Disadvantages of Qualitative Data Collection Methods

Methodological Approach (Qualitative)	Advantages of Method	Disadvantages of Method	Reason for Accepting/Rejection Method
Ethnography	This approach is based on the observation of an occurrence. The researchers study the phenomenon and interpret it according to the participants' perspectives (Nurani, 2008). It does not depend on on people willingness to provide information.	Vulnerable to observe bias. Hawthorne effect-participant usually perform better when they know they are being observed. Does not provide information to understand why people behave the way they do.	I rejected this approach because it focused on the observation of cultural and social interaction in daily lives. In addition, I have a limited time for data collection for my research and this method tends to take a longer time to generate and analyse data than other methods.
Phenomenology	It studies structures of conscious experience as experienced from a subjective or first person point of view, along with its intentionality.	It is challenging to describe or interpret phenomenon according to its context without bias (Shi, 2013).	It is a more descriptive approach. This approach focuses on describing the meaning of phenomenon that all participants have experienced by using in-depth interviews.
Grounded Theory	Rigorous method that facilitates theory development. The researchers do not make use of available theories to make sense of the data, instead, interpretations come from the data itself (Hussein et al., 2014).	It is difficult for inexperienced researchers to collect data based on the budding theory.	High potential for error. Researchers may end up documenting people's experiences without understanding the social process.
Case Study	Explains, describes or explore phenomena in everyday contexts (Yin, 2009). Observation of phenomena occurs in its natural context (Zainal, 2007).	Difficult to generalise results due to sample limitations. Represent depth of evidence rather than breadth.	A case study allows me to use multiple sources of evidence that helps to address a range of behavioural and historical issues (Stake, 2003; Baxter & Jack, 2008; Yin, 2013).

This used qualitative case study (constructivist approach) to investigate people's personal realities in order to gain insight into the effectiveness of degree nursing being a

requirement in SA and its implications in the reality of contemporary practice (Guba & Lincoln, 1994; Yin, 2013; Polit & Beck, 2013). This approach is helpful when there is little information about the research focus, or if it is not possible to distinguish the issues under consideration from the participants' context, or where it is important to determine how issues are dealt with in the context of their surroundings (Park, 1991). Furthermore, this approach is helpful in circumstances where interaction between the researcher and the research participant is essential in order to better understand and draw conclusions about the research focus (Rodwell, 1998).

4.3.1 Research Design

Research design assists in directing or pointing researchers towards the focus of their studies. According to Joubish et al. (2011), a research design is the paste that glues all of the components in a research project together. Yin (2009) identifies three conditions to be considered when determining the appropriate research method:

1. The type of research question posed
2. The extent of control the investigator has over actual behavioural events; and
3. The degree of focus on contemporary as opposed to historical events.

The relationship between the three conditions and the related research methods (as outlined in Table 4-2 determine the most suitable approach to use.

Table 4-2: Relevant Situations for Different Research Methods (Yin, 2009: P.8).

Method	The type of research question posed	The extent of control the investigator has over actual behavioural events	The degree of focus on contemporary as opposed to historical events
Experiment	How, why?	Yes	Yes
Survey	Who, what, where, how many, how much?	No	Yes
Archival Analysis	Who, what, where, how many, how much?	No	Yes/no
History	How, why?	No	No
Case Study	How, why?	No	Yes

As Table 4-1 indicates, the relationship between the three conditions and the related research methods determined the most suitable approach to use. In this instance a case study was the most appropriate method to use with "how" and "why" questions that

require no control of behavioural events and a focus on contemporary events, which made it a good fit for this study. Yin (2009) pointed out that "how" and "why" are more explanatory in nature and are more likely to lead to the use of case studies. Furthermore, Yin (2009) explains that case study survey entails planning, determining the study design, resource gathering and allocation, data collection, analysis, and reporting. Although each stage is distinct, it is linked to other stages as the processes are dependent on each other and all affect or are affected by the research findings.

Yin (2009) makes a comparison between case study and other research methods. He elaborates that the case study approach provides results showing how and explaining why certain events happen the way they do. It is also the most applicable research method in cases where the researcher has no power over the events. Yin (2009) advises the readers to select data collection and analysis methods before embarking on the project.

Yin (2009) guides the researcher in choosing the most appropriate case study type depending on the research goals, data gathering, and evaluation methods. After theory development, the researcher also makes a catalogue of other hypotheses that may explain the phenomenon. According to Yin (2009), this strengthens the research plan and validity. The scholar may select holistic, single case, embedded or multiple case designs. Single-case studies are chosen because they are critical, acute, and representative. During the determination of the survey design, the author emphasises on the creation of a study pool protocol as it affects the research findings.

Unlike other literature that only outlines information sources, Yin (2009) explains data gathering principles such as the use of several sources, database development for future use, and preserving a series of proof. The ideologies are necessary for research, as they are associated with quality control. Scholars can increase the reliability of a study through triangulation of results obtained from different data sources. Regarding reporting, the author explains that an understanding of the audience determines the report's language and tone.

However, the implication of a degree nurse education policy required an in-depth and extensive description within the context of the social-cultural phenomenon in SA. The case study methodology, justification, and how it is processed for this thesis will be discussed further in Section 4.4.

4.4 Case Study Methodology

A case study is a research methodology focused on gaining an in-depth understanding of a particular phenomenon within a specific time. It is a popular approach among qualitative researchers Case studies are commonly used in organisational studies, nursing and clinical sites, across the social sciences and in other fields (Yin, 2013); and there is some suggestion that the case study method is increasingly being used, with growing confidence, as a rigorous research strategy in its own right (Stake, 2003). Robson (2002: P.146) defined a case study as:

> *"A strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real-life context using multiple source of evidence".*

Case studies can also be used to explain, describe or explore phenomena in everyday contexts (Yin, 2009). According to Yin (2013) a case study is comprised of five components, and these are followed to structure this research: a study question; its proposition (if any); its unit of analysis; the logic linking the data to the propositions; and the criteria for interpreting the findings. In designing the inquiry, these components are organised and consistent with each other. Extra attention has been given to the fourth and fifth components focusing on the planning of the data collection and analysis, as recommended by (Yin, 2009). In relation to these components, the relevant literature regarding the case under study was reviewed before conducting any data collection (Section 3.2, 3.3).

Case studies may utilise multiple methods of data collection and do not rely on a single technique (Ary et al., 2014). Interviewing, observation, reviewing documents, and other methods may be applied (Ary et al., 2014). Whatever techniques are applied, all are focused on a single phenomenon or entity and attempt to collect data that can help comprehend or understand the focus of the study.

Table 4-3 indicates the strengths and weaknesses of the different data collection techniques for case study research, as identified by Stake (1995) and Yin (2009).

Table 4-3: Type of evidence Yin (2009, P80).

Source of Evidence	Strengths	Weaknesses
Documentation	Stable - repeated review Unobtrusive - exist prior to case study Exact - names, etc. Broad coverage - extended time span	Retrievability – difficult Biased selectivity Reporting bias - reflects author bias Access - may be blocked
Archival Records	Same as above Precise and quantitative	Same as above Privacy might inhibit access
Interviews	Targeted - focuses on case study topic Insightful - provides perceived causal inferences	Bias due to poor questions Response bias Incomplete recollection Reflexivity - interviewee expresses what interviewer wants to hear
Direct Observation	Reality - covers events in real time Contextual - covers event context	Time-consuming Selectivity - might miss facts Reflexivity - observer's presence might cause change Cost - observers need time
Participant Observation	Same as above Insightful into interpersonal behaviour	Same as above Bias due to investigator's actions
Physical Artefacts	Insightful into cultural features Insightful into technical operations	Selectivity Availability

Documents are physical materials in which facts or ideas have been recorded and can reveal a great deal about the people or organisation that produced them and the social context in which they emerged (Prior, 1974). They can take on different forms Yin (2009); such as agendas, letters, minutes of meetings, memoranda, or any relevant document that could add to the database of the case study (Stake, 1995). All are useful and rich sources of information for a qualitative researcher (Stake, 1995; Creswell, 2003; Yin, 2009). The documents should be reviewed carefully to ensure validity and to avoid unnecessary data

being included in the database. Documentary review can be used to verify evidence that is gathered from other sources. Over-reliance on documents can contribute to exploration of the wrong leads by inexperienced investigators (Yin, 2009). Documentary analysis is a social research method and an important research tool in its own right; it is an invaluable part of most schemes of triangulation (Prior, 1974). It refers to the various procedures involved in analysing and interpreting data generated from the examination of documents and records relevant to a particular study (Prior, 1974). Archival documents include service records, charts, maps, lists of names, survey data and others such as personal records and diaries. The accuracy of the records should be evaluated carefully before using them (Yin, 2013).

The interview is one of the most vital sources of case study information. Yin (2009, P.90) states that:

> "*Most commonly, case study interviews are of an open-ended nature, in which you can ask key respondents about the facts of a matter as well as their opinions about events."*

Focus groups are another type of interview. Comprising a small group of participants purposively chosen to fit key criteria and who have similar characteristics, these discussions aim to provide qualitative data in a focused dialogue (Morgan, 1997). This dialogue is the 'interaction element' that is the key point in understanding how focus groups can be used to generate a different type of collected data than is possible from a face-to-face interview (Billson, 2005). Direct observation is a useful technique for providing additional information about the case being studied (Yin, 2013). Direct observation occurs when the researcher conducts a field visit to gather data. The observation could be as simple as casual activities or as formal as measuring and recording behaviours. In this study, it was not deemed necessary to observe the participants, considering that the focus was predominantly on their perspectives and, therefore, it was what they had to say that was important. Participant observation is a special technique of observation in which the researcher is an active observer in the study. This technique provides opportunities to perceive reality from the perspective of the observer "inside" the case rather than externally (Stake, 1995). The last source of evidence is a physical artefact that includes tools, instruments, artworks, notebooks, computer output and other physical evidence that can be used during a field visit (Yin, 2013).

Case studies allow researchers to use multiple source of evidence that help to address a range of behavioural and historical issues (Stake, 2003; Baxter & Jack, 2008; Yin, 2013). The purpose is to use several sources of data as a triangulation of evidence. Triangulation increases the reliability of the data collection and is considered a strength within case study research (Baxter & Jack, 2008). A case study attempts to illustrate the subject's entire range of behaviours and the relationship of these behaviours to the subject's history and context (Brown, 2008). The researcher goal was to ascertain the influence of degree education as a minimum entry requirement into nursing practice on the planning and development of the nursing workforce, based on evidence from multiple resources. In this study, the researcher did not consider it sufficient to use a single data collection method. It is important to understand why there are minimum educational requirements and what factors contribute to this phenomenon by employing a holistic systems-based approach (macro, meso and micro).

The case methodology approach in this study is a single-case design that required one unit of analysis, where events are limited to a single phenomenon (Yin, 2013). This allows the researcher to build theory where little data or theory exists in the current literature (Yin, 2009). In this case, the researcher is able to respond flexibly to the emergent discoveries made during the data collection process due to the nature of the case study design that allows for the creation of innovative theory by combining paradoxical evidence from different levels (macro, meso, and micro) into a unified theory.

In this research, the "case" or the "unit of analysis" is the policy relating to the entry requirements for nursing and their implementation. At a deeper level, implications of the way in which this research is conducted are explored and this will entail the consideration of all aspects that could affect the results, ensuring that the data is analysed precisely and systematically (Yin, 2013). In order to provide a more inclusive view of which factors influence the minimum educational requirements for entry-level practice as a registered nurse in SA, multiple methods of data collection were considered and selected. These include; document analysis, in-depth interviews with stakeholders and focus groups of a sample of practising nurses at the meso and micro levels. Each of these data collection methods was selected to help understand or interpret the focus of the study. Thus, they required different skills from the researcher.

As previously mentioned the existing research on the case topic is extremely limited; to my knowledge, there is no existing study that forms a baseline for research on this topic and it is therefore important that the study is exploratory. The case study needs to be exploratory because no one has yet explored the implication of degree entry requirements for professional nurses in Saudi Arabia. For example, this study is about a relatively unknown issue. Therefore, it is important to determine what is going on, from the perspectives of people working within the health system and functioning at all three levels, as a basis for future planning. A case study approach was appropriate for this study since it allowed the researcher to build evidence where little data or theory existed in the current literature (Stake, 2003; Baxter & Jack, 2008; Yin, 2013). This approach was also suitable since it allowed the researcher to respond flexibly to the emerging discoveries made during the data collection process. For all the reasons given, a qualitative case study design was deemed appropriate for this research.

4.5 Macro, Meso, and Micro Theory/Framework

Frame analysis is a way to explore occurrences in organised steps and determine what is exceptional in a given case or experience (Goffman, 1974). A "frame" or framework defined by Goffman (1974) as a "schemata of interpretation" to explore, perceive, identify and label events, experience, and their implications. This definition has been expanded by other researchers to include factors such as utilisation of resources politics, character, causation and the course of change (Caldwell & Mays, 2012). Based on this initial "schematic of interpretation", this study will use Caldwell & Mays' (2012) adaption of Goffman (1974) theory includes three levels; macro, meso, and micro framework/theory. macro, meso, and micro framework/theory, as it considers the mechanism of decision translation from policy idea to a programme in action, and looks at the mechanism of decision translation from policy development to policy implementation. This is how the policy idea was presented, when recommended to the MoH by WHO (2009).

This usually includes the organisation and structuring of experiences by an individual's perception of background events (Caldwell & Mays, 2012). This will be achieved by analysis of how the participants, at each level within the organisation (macro, meso and micro levels), shape their understanding of degree nurse education.

The idea behind selecting the macro, meso and micro levels within the MoH and the wider health service setting for framework analysis was influenced by the need to understand the process, direction and influence of degree education policy on multi levels and to study the interconnection between evidence across different organisational levels (Pope et al., 2006). In this particular case study, the different organisational levels are evident within the MoH in Saudi Arabia. Goffman (1974) argued that researchers use their background or experience to organise their understanding of something and to guide future action. I am interested in the macro, meso and micro levels of healthcare, and wish to explore the possible implications of introducing degree education at these levels in order to gain new knowledge to inform further workforce planning as a whole. According to Caldwell & Mays' (2012), macro-meso-micro framework/theory is a useful way of exploring the transition of a policy from a high level of notion to plans in action, as illustrated in Figure 4-1.
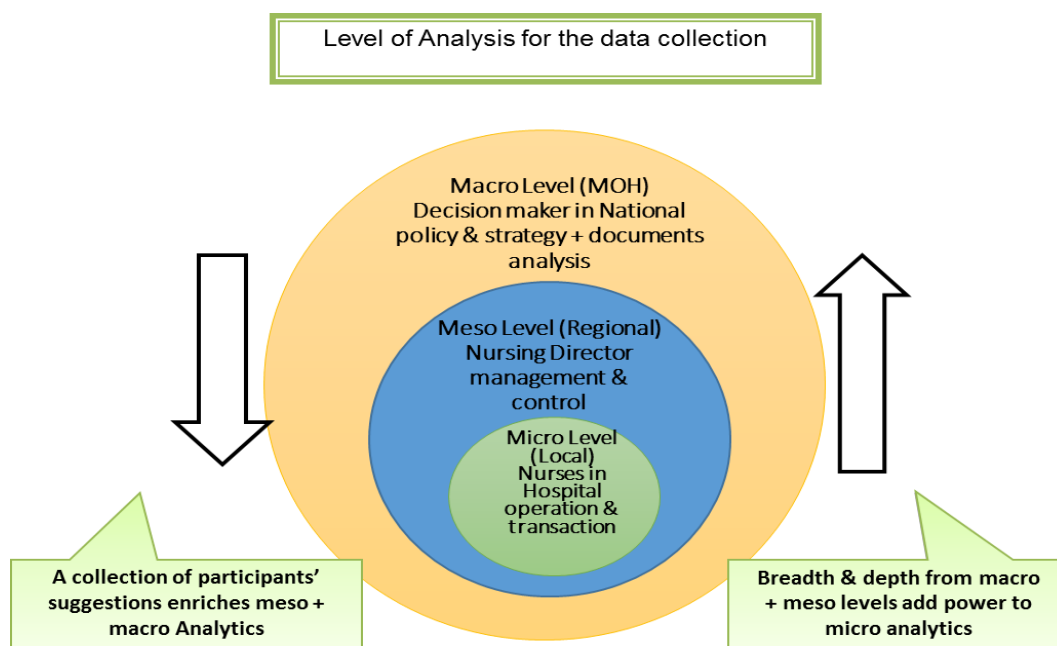
Figure 4-1: Macro, Meso and Micro levels of Analysis

Figure 4-1 illustrates the macro, meso, and micro levels of practice in relation to their influences on graduate entry nursing. Data collection is concerned with the influence of degree entry nursing from strategy through to operation, capturing the influences at all levels of practice within the healthcare context. To guide the collection and analysis of data, it is useful to define each level of organisation in this study.

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Macro Level

The macro level is concerned with policy idea development and implementation of degree education as a minimum requirement for those wishing to qualify as a nurse; this is treated as an issue requiring "government action" (Caldwell & Mays, 2012: P.3). The employees working at this level are the decision makers, such as the General Director of Nursing, the General Director of Personal Affairs and the General Director of Education and Scholarship. These decision makers are concerned with policy conceptualisation and planning prior to the implementation phase achieved through in the MoH; this is the largest governmental sector in the Saudi health system, where the policies explained in Section 1.3.1 are established.

Meso Level

The meso level concerned a sample of Regional Nursing Directors, from all five parts of the country (north, east, south, west and centre). This level is where the "policy begins to take shape" (Caldwell & Mays, 2012: P.3). At this level, the policy translates to a programme in action, where there is a chance its aims may be misunderstood (Caldwell & Mays, 2012).

Micro Level

The micro level in this study is the local settings, for example: nurses in clinical areas, including nurses, managers, and educators. This level is where the "policy operates" (Caldwell & Mays, 2012: P.3). It is important that the macro level within the MoH supervises and monitors the practical implications of the policy, in order to confirm its correct application at this level. The policy is implemented and its impact is followed up through evaluation within hospitals and primary health settings.

Analysis of the different views of participants at each of the three levels of this framework, complemented by documentary analysis, will enable the exploration of the impact of degree entry requirements on nursing workforce planning, and a subsequent interpretation in terms of its effectiveness. This will also inform future nursing workforce planning and development in the MoH.

4.6 Methods

Data was collected from participants working at all the three levels (macro, meso, micro) within the organisational structure of the MoH in SA, explained in Section 4.5. Face-to-face interviews and focus groups were the chosen methods of data collection for this research, complemented by documentary analysis.

This approach involved semi-structured interviews/focus groups with a variety of associated Ministry stakeholders and nurses at the three levels of administration and practice, as illustrated in Figure 4-2.

Macro Level: (Central), Documentray Analysis + face-to-face, semi structure interview/ Decision maker (MoH), Riyadh./ work office of the decision maker during working hours

Meso Level: (Regional), focus group semistructure discussion/ Regional Nursing Directors / central auditorium of MoH during working hours.

Micro Level: (Local) focus group semistructure discussion nursing manager, nurse directors and staff nurses (Diploma & Bachelor)/ conference room, King Saud Medical City

Figure 4-2: Data collection elements.

Multi-sectorial input must be gathered in order to best understand the full span of implications across the board. The primary source of data collection in this research is as follows:

- **Documents**

  MoH documents that include the meeting documents of the GCC Nursing Technical Committee related to the decision to have a degree entry requirement for nursing, and the process for implementation of this policy. Printed documents were reviewed.

- **Semi-structured Interviews**

  Open semi-structured, face-to-face interviews were implemented to collect in-depth information from the first level of administration (Macro level). This enabled the

researcher to explore the participants' views and experiences related to degree education and its effects. Merriam (2009) suggests semi-structured interviews are valuable if the researcher needs to gain more information from key informants, as semi-structured interviews are guided by the situation being explored.

- **Focus group interviews**

  Focus groups are used to obtain multiple perspectives on the same issue at the same time (Morgan, 1997). In this research, focus groups were used to collect evidence from participants working at the meso and micro levels. Each group had eight to twelve participants as recommended by Barbour (2007).

4.6.1 Sampling Criteria

For each data collection strategy within this research, at each level of the framework (Section 4.5), purposive sampling was used to recruit people who have a background in the phenomena under study. This qualitative strategy enables the researcher to select specific subjects from the target population to meet the criteria being studied (Merriam, 2009). A purposive sample simplifies the selection of participants who show a specific feature or characteristic necessary for the research outcomes (Baxter & Jack, 2008). It is a non-randomised approach that is not concerned with generalizable or reproducible outcomes; instead it aims to yield a sample that is information-rich (Barbour, 2007). Moreover, purposive sampling is described by (Morgan, 1997) as the deliberate or conscious choice of research participants on the basis of their knowledge or expertise. In this way, this form of sampling enables the provision of information that is relevant to the study's focus and research questions (Creswell, 2013).

In addition, Yin (2013) suggests that purposive sampling is suited to case study design. It contrasts with random sampling where participants are allocated to data collection on a random basis. Since a qualitative case study is concerned with the in-depth exploration of a specific phenomenon and there is no desire to determine incidence, prevalence or statistical significance in the finding (Yin, 2013), a small sample size is considered acceptable. Miles et al., (2014) discuss that a small sample size is desirable in qualitative enquiry in order to explore phenomena in adequate depth and detail, provided that the sample is representative of the population under study and is able to deliver adequately rich data (Teddlie & Tashakkori, 2010). This type of sample shows different perspectives of the participants from three levels (macro, meso, and micro) on the situation, processes,

or events that will help the researcher to understand the problem and the research questions (Creswell, 2013). The inclusion and exclusion criteria for each level of sampling within this study are illustrated in Table 4-4.

Table 4- 4: The inclusion and exclusion criteria for each level of sampling.

The levels of sampling		Inclusion criteria	Exclusion criteria
1-Macro level	***Phase one:* Documentary Analysis**	The minutes of meetings of the GCC Nursing Technical Committee. Arabic documents (Arabic is the native and formal language used in formal meeting for all ministries in SA). Paper and electronic	Unrelated documents such as attached reports, tables and lists.
	***Phase two:* Face –to-face interview n=4**	Stakeholder who is involved in the decision to establish the Bachelor of Science in Nursing (BSN) as a minimum entry requirement for nursing practice. Working as a General Director in the MoH. Male and female.	Stakeholder who is not working in the MoH and not involved in nursing decision.
2- Meso level: *phase three:* one focus group n=6		Regional Nursing Directors. Saudi nationality. Male and female.	Staff nurses and Nursing Directors in hospitals and primary health care centres.
3- Micro level: *phase four:* **Three focus groups** **Group one**: n=7 **Group two:** n =4 **Group three**: n=4 **Total: n=15**		**Focus group 1** Nurse Manager and Educator in KSMC. Saudi and non-Saudi Male and female	Staff nurses, nursing directors and nursing educators from other hospitals.
		Focus group 2 Staff nurses in KSMC Diploma holder Male and female Saudi nationality English speaking 5 years' experience	Non-Saudi staff nurses. (All will be Saudi staff throughout, not expatriates – important to establish Saudi views of MoH 'Saudization' plan include plans to have all Saudi nurses' administrative levels).
		Focus group 3 Staff nurses in KSMC Bachelor qualified degree nurses Male and female Saudi nationality English speaking Two years' experience	
Total sample size		**25 participants**	

4.6.2 Study Location

This study took place in Riyadh, the capital and largest city of SA, as well as its financial and administrative centre. For example, it houses embassies, the government, and the head offices of international companies, bringing many more expats into the community.

4.6.2.1 Setting

The study was conducted in the MoH setting, located in the capital city, Riyadh, and its selected hospitals. This setting was selected for the study because the city is linked to other regions through a modern international airport that makes it accessible for all participants from different regions (meso level) to participate. The interviews at the macro level were conducted in the participants' work office, at the MoH headquarters, during working hours and the focus group for the selected regional directors was organised in the main conference room at this location. The focus groups at the micro level were arranged in the fieldwork setting of King Saud Medical City (KSMC). KSMC has a 1,400-bed capacity, distributed among the different departments of the City. It is composed of three hospitals: a General Hospital, Maternity Hospital, and Children's Hospital.

4.7 Data Synthesis

Having sampled suitable participants and collected data from multiple sources and methods: documentary analysis, interviews, and focus groups; it was necessary to synthesise the results in order to discuss the implications of the study. Content analysis is a systemic approach that can be used to analyse data using either a deductive or inductive approach (Elo & Kyngäs, 2008). Kohlbacher (2006) seeks to encourage the integration of qualitative content analysis into case study research and considers it an important element of the process. This involved qualitative content analysis and the use of NVivo software to organise the data collected within this study. In addition, a reflective field notes were used to assist in the interpretation of data. This process is commonly used in nursing research such as mental health, gerontological, and public health studies (Elo & Kyngäs, 2008).

This study used two different approaches to analyse the data:

- First; Prior's (2003) framework (an inductive approach to qualitative content analysis) was used to analyse the documents as a first phase in order to construct an

understanding of the influence degree education requirements have had on the nursing workforce. The framework will be discussed further in Section 5.2.3.

- Second; Zhang and Wildemuth (2009) framework involving eight steps, as illustrated in Figure 4-3, was used to analyse the data collected from the interviews and focus groups.

1. Preparing the Data
2. Define the Unit of Analysis
3. Develop Categories and a Coding Scheme
4. Test Your Coding Scheme on a Sample of Text
5. Code All the Text
6. Assess Your Coding Consistency
7. Draw Conclusions from the Coded Data
8. Report Your Methods and Findings
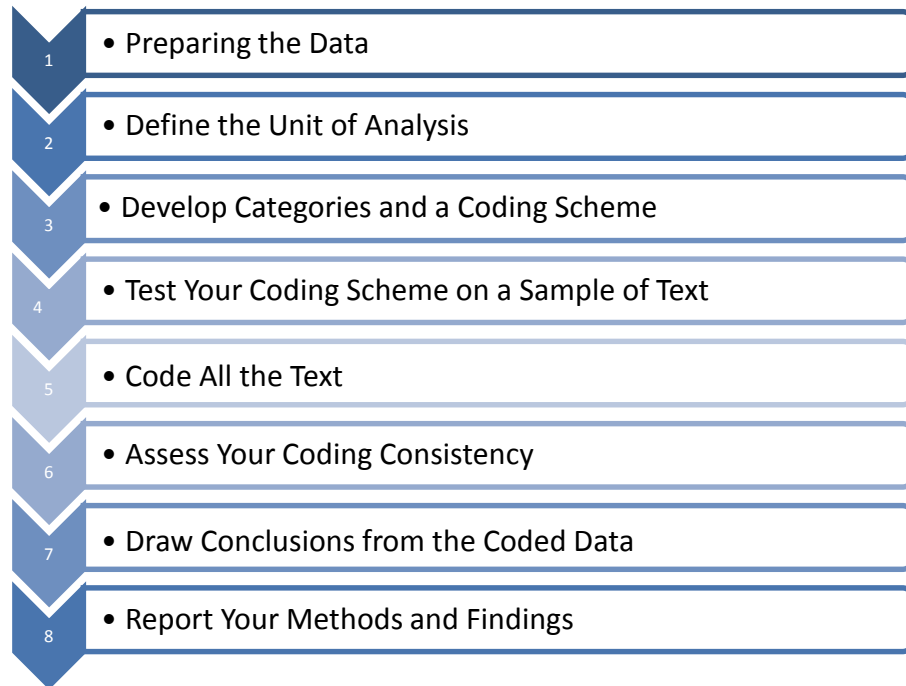
Figure 4-3: Phases of Content Analysis (Zhang & Wildemuth 2009)**.**

The following are the general steps of qualitative content analysis suggested by Zhang and Wildemuth (2009) was used in analysing the interviews:

1. **Preparing the Data**: The interviews/focus groups were audio recorded, transcribed verbatim for review and uploaded to NVivo, qualitative analysis software for undertaking content analysis.

2. **Defining the Unit of Analysis:** The interview transcripts were read and re-read to familiarise myself with the text and gain a first impression of the content.

3. **Developing Categories and a Coding Scheme**: During the initial phase of the content analysis, the researcher developed several categories of response type, based on the initial read and re-read of the transcripts as well as the literature reviewed for the study.

4. **Testing Your Coding Scheme on a Sample of Text**: Using the categories developed, the coding scheme was tested by coding a section of the micro-level focus group transcript. The coding scheme served to enable the researcher to

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effectively categorise the data offered by the participants and was therefore used in the coding of all the textual data obtained for the study.

5. **Coding All the Text:** Text was then coded into categories (coding scheme). Relevant statements/responses offered by participants were coded (highlighted and labelled) into the various thematic categories, and were assigned a node (code label) that described the response type. This was done by carefully analysing each participant's response/statement within the context of the discussion and coding and categorising the responses into nodes (descriptive labels), to reveal commonality of responses. If no category existed in the coding scheme for the response type, a new category was added to ensure the capture of all relevant data. NVivo was used to track the type and location of responses (Hilal & Alabri, 2013).

6. **Assessing Your Coding Consistency:** The coding categories with response nodes coded were re-read and evaluated to ensure coding was appropriate to each category. In addition, the researcher explored the coding for redundancy and similarities of codes, combining and/or separating coded content as necessary.

7. **Drawing Conclusions from the Coded Data**: From the final coded content in each thematic category, key common themes were identified and discussed, citing textual examples from the transcripts to support theme development and in-depth understanding for the reader.

8. **Reporting Your Methods and Findings**: Data were presented according to thematic categories using frequency of mention to highlight the key common themes, tables and textual examples to support conclusions. Conclusions at each data source level (micro, meso, and macro) were then synthesised and combined to reveal the overall conclusions of the analysis.

4.8 Trustworthiness of the Study

Any research design embodies a logical set of statements; its quality can be arbitrated according to certain logical tests. In qualitative research, scientific 'rigour' is less quantifiable, mainly because it merely consists of anecdotal evidence, is biased by the researcher, and lacks generalisability (Baxter & Jack, 2008). For this reason, the term 'rigour' that relates to the quality of a research process is replaced by the term

'trustworthiness' for judging 'naturalistic inquiry' (Guba & Lincoln, 1994). The trustworthiness of qualitative research can be assessed by several frameworks/models (Guba, 1981; Guba & Lincoln, 1994). Guba (1981) developed a significance model of trustworthiness or "rigour" that offered four strategies, illustrated in Table 4-5, to establish credibility, transferability, dependability and confirmability (Sandelowski, 1986).

Table 4-5: Four strategies to establish credibility, transferability, dependability and confirmability

Credibility	Confidence in the 'truth' of the findings
Transferability	Showing that the findings have applicability in other contexts
Dependability	Showing that the findings are consistent and could be repeated
Confirmability	The extent to which the findings of a study are shaped by the respondents and not the researcher's motivation or interest

4.8.1 Truth-value/Credibility

Truth-value is an important concept for the qualitative researcher as it enables them to tell the truth and reflect on the credibility of the study analysis and results. Phases and constancy were considered throughout the data collection and analysis to ensure that the findings and interpretations were accurate, which Creswell (2013) refers to as validation. The accuracy or credibility of the findings of this research were determined through certain strategies such as member checking or triangulation as suggested by Creswell (2013). The establishment of operational measures for the concepts of the study ensure construct validity; for this research multiple sources of evidence were used during the data collection phase, including: interviews, focus groups, and document review. The validation of this study was ensured according to the credibility criteria, as described by Merriam (2009).

1. Rigorous fieldwork methods were used to generate and analyse data that was relevant to the aim of the study.
2. I had appropriate experience and training to undertake this research study. The presentation of 'self' is acknowledged and discussed through the process of reflexivity.
3. This study underpinned by the philosophical values of qualitative inquiry: methods that embrace social interaction and interpretation of meaning, purposive sampling, inductive analysis and holistic thinking.

Other strategies used to enhance the truth-value were peer review, cross-case analysis, triangulation, member checks and reflexivity. A detailed explanation of these strategies follows:

Peer review

Yin (2013) suggests that the truth-value of a data collection process can be assessed through peer review. Also known as peer de-briefing, according to Guba and Lincoln, (1994: P. 308) peer review includes:

> "*A process of exposing oneself to a disinterested peer in a manner paralleling an analytical sessions and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind*"

The above quote suggests the researcher can gain useful feedback from an outsider, with an unbiased viewpoint, in order to uncover any issues or perspectives, which may have been overlooked. This process challenges the researchers' assumptions; it also assists the researcher in establishing their interpretation of the data with the opportunity to share and defend the results of the study to ensure that they are reasonable and plausible. To this end a draft report was comprehensively reviewed by peers (Section 5.3, 5.4, 5.5).

Cross-level analysis

Within this study, any outlying results or themes were carefully identified and reported on Section 7.5. Analysis of negative or contrary themes and embedded cases enabled the researcher to consider and confirm patterns in the data and enhanced the credibility of the data analysis.

Triangulation

Yin (2013) suggests that triangulation is the hallmark of a case study. Triangulation is the process of confirming evidence from different individuals, types of data, or methods of data collection (Creswell, 2013; Yin, 2013; Merriam, 2009; Stake, 1995; Merriam, 2009; Creswell, 2013; Yin, 2013), similar to peer review. This use of multiple data sources allows for an in-depth understanding and the uncovering of alternative perspectives regarding the study findings generated by other data collection methods (Denzin & Lincoln, 2011). In qualitative research, this is a way of assessing the credibility of a study

by ensuring it is comprehensive and well-developed (Merriam, 2002). For this reason, this study considered more than a sample of nurses, but chose a variety of participants in different positions within the hospital setting; nurses, managers, regional directors and decision makers. In this research, the data collected was triangulated, that is the analysis resulting from the interviews and focus groups and document review were explored in relation to each other. Furthermore, the analysis process involved triangulation in that a sample of cases was selected to be analysed independently by supervisors. This allowed the researcher's interpretation of the results to be compared to other viewpoints.

Member checking

Member checking involves sending the transcribed interviews back to the participants for review and confirmation (Section 5.3, 5.4, 5.5). Despite the criticism that this technique has received from some researchers, such as Sandelowski (1986), namely because it relies on the assumption that there is a fixed truth of reality that can be recorded by a researcher and authenticated by a participant, others believe it to be one of the most important strategies in establishing credibility (Guba & Lincoln, 1994). The value of member-checks is in the ability to ensure that the researcher has not misinterpreted what the participant has said or the participant's viewpoint. With this in mind, member-checks were involved in this research process to enhance the credibility of the study. The verbatim transcripts of the interviews were returned to participants and these, along with the researcher's study notes, were used to summarise the key points of each interview.

Reflexivity

Reflexivity is defined by Guba and Lincoln (1994:P. 183) as *"the process of reflecting critically on the self as researcher".* Reflexivity also includes taking action based on my reflections and it takes account of my involvement in the research process (Section 5.6). A reflexive researcher is aware that his or her own thoughts and/or attitudes can influence the research process, such as interpersonal interactions during the data collection process (Freshwater, 2005); hence, the case study obviously acknowledges the direct position of the researcher in the study process (Bryar, 2000). This process necessitates the researcher to inspect and record the impact of self on the research in order to recognise where areas of bias could be evident, many authors believing this to be unavoidable within any research, regardless of the paradigm (Freshwater, 2005). In order to address these concerns, a

reflective journal was kept with the aim of limiting bias and an in-depth report on reflexivity is included within this thesis (Section 5.6 & 8.6). Reflectivity is used in this study to enrich the quality of the research findings in relation to trustworthiness and transferability (Guba & Lincoln, 1994).

4.8.2 Applicability/Transferability

The concept of applicability, as suggested by Guba and Lincoln (1994), considers to what degree research conclusions are relevant to a wider field than simply that specifically addressed in a piece of research (Anney, 2014). However, the specifics of situating case studies in real-life settings, and thus making them qualitative, arguably makes them unsuited to being assessed for their applicability (Sandelowski, 1986). This is supported by Anney (2014), who suggest the conclusions of case studies are fundamentally unsuited to being considered relevant on a larger scale. Baxter and Jack (2008) highlight the insularity of case studies.

Concurrently, it is not always the case that a case study is considered in isolation, but as part of a larger body of research. Baxter and Jack (2008) suggest that in this eventuality, the manner in which the research is carried out and later presented is important. An alternative is proposed by Guba and Lincoln (1994), who discusses the terms 'fittingness' or 'transferability' as a means of evaluating applicability. However, Yin (2013) states that the conclusions of case studies are problematic when used to explain phenomena occurring in a larger setting. However, it can be highly useful in contributing to the creation of theories. Yin (2013) explains that case studies present opportunities for broadening the scope of existing theories. In doing so, their findings become relevant on a larger scale.

Sample size is another feature of case studies that can affect their applicability and validity. For instance, by focusing on a minimal number of participants, the specifics of a situation potentially take precedence over identifying factual data (Creswell, 2013). Baxter and Jack (2008) suggested that accepted sampling procedures are often omitted in case studies, thus making their findings even less applicable or representative. Yin (2009) disputes this, presenting the idea of 'deep data', which comes into existence specifically because of the concentration on a specific group or individual. Yin (2009) has produced a model for case studies to address concerns relating to sampling procedures, which is designed to make case studies more valid and thus, potentially, more applicable. Rather than considering

random sampling, qualitative researchers must provide a detailed description of the study process and setting in order for any reader to be able to assess the applicability of the research results and judge them against studies in other settings (Guba & Lincoln, 1994).

While the more traditional idea of generalisation may not be suitable for a case study, it is still important to consider how the findings of this research could be transferable to other contexts and valuable for other studies. This can be achieved by allowing the reader to fully understand the research process so that they may be able to consider it in relation to their own work. With this in mind, the following steps were taken in order to make the study appropriately transferable or 'fitting':

1. A detailed account of each level is provided so that the reader can develop their own understanding of the findings (Merriam, 1997).
2. Participants were selected using purposive sampling to ensure that the study covered a wide range of contexts and was able to compare and contrast between different topics concerning the study aims.
3. Three levels (macro, meso, and micro) have participated considered in this research in order to provide data for within-case and cross-case analysis. This will facilitate information relating to the specifics of each level and ensure the identification of interesting and possibly contrasting relationships between levels (Stake, 1995).

4.8.3 Consistency/Dependability

Anney (2014) states that the validity of a study should take into account how consistent the data gathered is; that is to say whether similar conclusions would be reached if it was repeated. As Anney (2014) explains, the idea of consistency is closely connected to dependability. However, it is worth noting that the real-life quality of case studies and other qualitative research engenders variableness to a strong degree (Guba & Lincoln, 1994). With this in mind, Guba (1981) proposes the idea of 'dependability' within which variability is applied only to certain parts of the study. Guba (1981) describes the use of audit trails, clear and detailed records of the study, to assess the dependability of data used in research by means of providing documentary evidence of the exact research process. This study considered the following audit trail; at each stage of data collection and the processes documented, as shown in Table 4-6.

Table 4-6: Audit trail

Category	Audit trail
Raw data	Tapes, audio files, transcripts, documents, field notes and copies of electronic records, stored securely. All interview data were anonymised before storage.
Data reduction and analysis products	The process of coding individual transcripts and the collated findings, stored as hard copies and electronically as Word documents
Data reconstruction and synthesis products	The development of themes and their inter-related connections with each other and existing literature, within-case findings and across-case findings, all stored as Word documents, electronically.
Notes relating to methods and procedures	Researcher's decisions concerning the study, recorded as field notes.
Materials relating to intentions	The research proposal, available upon request; a copy is held by the MoH & UoS Ethics Committee that approved this study. Copies of written confirmation of access to the MoH and its hospitals are included in the appendices.
Instrument development information	An exhaustive list of all forms and guides is provided in the appendices.

4.8.4 Neutrality/Confirmability

Following dependability, Guba (1981) also states the importance of neutrality in assessing the validity of a study. As Guba (1981) Kreftling (1991) explains, neutrality considers the possibly impact of, for example, researcher bias and pre-held viewpoints on the conclusions of a study, in opposition to the direct influence of the participants and the research environment. To this end, neutrality interlinks with confirmability (Anney, 2014). Triangulation and reflexivity are considered when assessing the neutrality of qualitative research, as they also are in the instance of truth-value and previous scholarship. Similarly, Miles, Huberman, and Saldana (2014) states that cost-effectiveness should be evaluated with regard to case studies. The concept of deep data, as proposed by Yin (2009) is also relevant here, as case studies offer the opportunity to observe and analyse participants to a substantial degree.

As Miles et al. (2014) notes, case studies can be both costly and time consuming, considering that a very limited number of participants are being researched for a given duration, where other types of study may potentially include a far greater number. Yin (2009) challenges this with the assertion that this is exactly the method through which intense observation and research can result in the production of deep data that comparative

studies with larger sample sizes may potentially miss. This relates to the concept of conflicting interests (Miles et al., 2014). In order to find a compromise of sorts, steps such as including participants from a wider variety of educational backgrounds and experiences would be necessary.

In summary, an audit trail was established in order to document every aspect of this study. Research is continuously affected to some degree by abundant variables over which there can be no complete control. Within a quantitative study, researchers attempt to distance themselves from the research in order to reserve objectivity and provide validity (Creswell, 2003). Within a qualitative study, the influence of the researcher is far more apparent than in quantitative methods, since there are no attempts on the part of the researcher to be independent of the findings, mainly when employing 'close up' data collection methods such as fieldwork. Quite the opposite, subjectivity and engagement are incorporated within qualitative enquiry and are accounted for through the process of reflexivity (Freshwater, 2005).

4.9 Ethical Considerations

A number of ethical considerations are associated with the case study process. According to Stake (1995) the confidentiality and anonymity of participants are the main points for ethical consideration within a case study. Firstly, there is the issue of confidentiality agreements surrounding information given by Ministry officials, because if the case study is not appropriately designed, it may be possible to identify research participants, especially those in high positions and in focus groups. The research was conducted in accordance with the ethical principles published by the Royal College of Nursing (RCN, 2011). One of the most important among these principles is that for data collection and analysis: all confidential documents should be placed inside a locked cabinet and access should be allowed only to authorised persons (RCN, 2011). This ensures that documents are secured and the personal opinions of participants are not exposed or compromised.

The UK Data Protection Act (1998) was applied as the framework to protect the data of this research. All participant information was coded and anonymised; only the researcher and supervision team at the UoS had access to anonymised data. However, no names or personal details were used that could identify places, individuals, or professional roles, and such data was removed from transcriptions and audio recordings. The study displays two

forms of data; a hard copy and an electronic copy. Hard copy data was kept in a locked cabinet accessible only to the researcher. Electronic data was secured on a password protected external hard disk and connected only to the researcher's private laptop, the only person who had access to the saved study data. Furthermore, during the study period, all data were considered highly confidential and carefully handled with respect to participants' anonymity and dignity to avoid breach of confidentiality. Besides that, all anonymised hard and electronic data will be kept for three years following the study, whilst publication and dissemination take place. The data will then be discarded through confidential shredding and secure deletion methods.

For the face-to-face interviews, the Code of Ethics (RCN, 2011) recommends that interviews should be performed after informed consent is given and should ensure the confidentiality of information disclosed by the participant. Furthermore, the interviewee should have the right to withdraw at any time without fear of adverse consequences (RCN, 2011). For the focus group stage, there will be special consideration of confidentiality. For example, all interview participants were assured total anonymity and ensured that they would not be mentioned by name or position in the final written report. There will be no disclosures to a third party; only anonymised discussion in my thesis and subsequent publications and presentations. To address this, coding was used to protect the anonymity of place, person and role.

For participants in this study the protection of their human rights was assured throughout the study. Participation in the research was voluntary; and this was reinforced by sending the consent form, the information sheet, and the interview questions before the interview. Data collection started after approval was obtained from the Research Ethics Panel of Salford University and the MoH in Saudi Arabia (Appendix 4.2; 4.3), thereby ensuring the protection of human subjects involved in this study. The process of obtaining permission to access the facilities of the MoH is illustrated in Appendix 4.1. Data collection included adult respondents over the age of 18 years and did not involve any vulnerable populations.

It was a long process to obtain permission from the MoH to gain access to its hospitals, and make practical arrangements with the three levels of participant. Fortunately, this process was helped by the Saudi cultural attaché, who provided me with an introductory letter to the MoH to facilitate access, recruitment of participants and preparation for the data collection phase. Concurrently, there was a need to visit the MoH in Riyadh to obtain

ethical approval. This took around four to six weeks. In February 2015, while I was waiting for the research approval, I contacted my place of work and met the General Director of Nursing in order to explain the purpose of the study and the research process so that I would be able to gain access to valuable resources and ultimately data for the study. The General Director was supportive and provided all the facilities that I needed such as an office, computer, printer, internet access and telephone.

The research proposal was submitted to both the General Director of Nursing and the General Director of Research for review and approval at the MoH in SA. Within the MoH, such ethical approval is equivalent to that granted by any ethical committee in a UK academic setting. The policy of the University of Salford (UoS) is to obtain ethical approval from the university in the first instance, followed by approval from the area where the research is to be conducted; in this case Saudi Arabia. Evidence of the latter then needs to be passed to the former. The ethical approval was obtained from Rachel Suttleworth (University of Salford) in February, 2015 (Appendix 4.2). The Saudi ethical approval from the MoH and its hospitals was obtained in March, 2015 (Appendix 4.3).

4.10 Summary and Conclusion

This chapter has discussed the research methodology for this study, considering the philosophical perspectives of the research and discussing the most appropriate research paradigms, with a primary focus on the justification for using a qualitative case study. The macro, meso, and micro level theory/framework of Caldwell and Mays (2012) was highlighted, followed by the consideration of the study design, data collection and analysis. The three levels identified by Caldwell and Mays (2012) macro, meso and micro, within the MoH context were detailed, along with the four phases of the study design. In addition, the choice of sampling method was explained, accompanied by the sampling criteria.

Furthermore, the importance of the trustworthiness of the study has been considered; an in-depth discussion has been provided on this matter with a particular focus on reflexivity and the potential of the researcher's influence on the research. Finally, the ethical considerations that apply to the conduct of this study were discussed, including the necessary documents obtained by both the UoS and the MoH that made the study possible.

The following chapter will highlight the research process and provide an in-depth analysis of the reality concerning the implications of the study, looking at the effects of the policy requiring a Bachelor's degree education as a minimum for entry into the practice of nursing in SA. This analysis will consider the perspectives of the participants from all three levels, macro-meso-micro, within the context of the MoH.

Chapter 5 : Data Collection Phases

5.1 Introduction

The previous chapter explored the methodology of the study, detailing the researcher's philosophical position, the research paradigm and its theory/framework. The three levels of analysis for data collection were explained and data synthesis was considered. Finally, the importance of the study's trustworthiness and the ethical considerations were discussed. This chapter describes the protocol for the data collection in more detail. At the Macro level (phase one) a documentary analysis was utilised to gain more information about the rationale and processes followed by the decision makers at the MoH concerning the policy to introduce degree education as a requirement for qualified nurses. At the Macro level (phase two) face-to-face interviews took place to understand the perspectives of a sample of decision makers at the MoH regarding the influence of the degree education policy on nursing workforce planning and development. In addition, at the Meso level (phase three), data was also collected through the use of one focus group. Finally, at the Micro level (phase four) data collection was undertaken within four focus groups and a meticulous explanation of the data transcription and analysis is given The flow chart in figure 5.1 illustrates progression of how each thesis stage inform the next.

Phase 1 : Documents review
Documentary analysis was utilised to gain more information about the rationale and processes followed by the decision makers at the MoH concerning the policy to introduce degree education, this helped me to identified the gap in knowledge and ask the decision makers more questions at the macro level phase.

Phase 2: Macro level
This level provided more information about the missing parts of orgnisation between the macro, meso, and micro level. The policy for degree education in nursing has been endorsed in a top-down process.

Phase 3: Meso level
This level showed that there is a lack of involvement of Regional Nursing Directors in the descision process and provided rich evedence for asking more questions at the micro level.

Phase 3: Micro level
This level provided significant information from the nurses who worked directly with patients in hospitals, and those who had been directly affected by the introduction of the policy.

Figure 5-1: The progression of thesis stages

In the following section, the data collection process is explained for each level focusing on: sampling, data collection procedures and data analysis.

5.2 Macro Level (Phase one): Documentary Analysis

The first phase of this study is the analysis of MoH documents with the purpose of understanding the influence of degree entry policy and assessing the intended outcomes for national nursing workforce planning in SA. This process of documentary analysis included mapping the thematic content analysis and allowed scoping the envisaged requirements of degree-educated nurses in practice.

5.2.1 Sampling

The documents used for this study were the minutes of the last six meetings conducted by the GCC Nursing Technical Committee, who introduced the recommendation of degree education as the minimum entry for nursing practice. The introduction of this new policy within the Saudi MoH was a suggestion of the WHO, who supported its implementation. This form of documentation was located in the organisational committee's files of the MoH. Since these files are the property of the MoH and are used as data for research purposes, I came to an agreement with the MoH about how the contents could and could not be used and how confidentiality would be preserved; these ethical considerations for the study were discussed in Section 4.9. Specific inclusion criteria for documents were implemented (Section 4.6.1), which included primary source documents relating only to policy implementations that were written in the Arabic language, which is the formal language used in communication for all ministries in SA. Other, unrelated attached reports and lists were excluded. Documents that included the decision process for degree entry requirement for nursing practice in Saudi Arabia were subjected to review. The summary of the sample documents is identified and illustrated in Table 5-1.

Table 5-1: The summary of the GCC documents

	Documents selected	No. of Pages	Date of meeting	Key findings theme
D1	Meetings of the GCC Nursing Technical Committee in Jeddah, Kingdom of Saudi Arabia (KSA), no. 30	16	18-19 March, 2015	Rationale for change A Good Decision
D2	Meetings of the GCC Nursing Technical Committee in Dubai, United Arab Emirates (UAE) no. 29	14	13-14 April, 2014	Rationale for change A Good Decision
D3	Meetings of the GCC Nursing Technical Committee in Bahrain, no. 28	14	5-6 March, 2013	Rationale for change A Good Decision
D4	Meetings of the GCC Nursing Technical Committee in Oman, no. 27	20	5-4 March, 2012	Rationale for change A Good Decision
D5	Meetings of the GCC Nursing Technical committee in Kuwait, no. 26	14	24-25 April, 2011	Steps toward change
D 6	Meetings of the GCC Nursing Technical Committee, Abu Dhabi, UAE, no. 25	14	30-31 March, 2010	Steps toward change Global direction
D7	Booklet GCC (Challenge and achievement of nursing in Gulf countries for the period 1993-2013).	79	Published in 2014	Steps toward change Challenge and achievement of nursing in Gulf countries for the period 1993-2013.
Total number of pages		171		

5.2.2 Data Collection Procedure

In the first instance, the central office of the MoH in Riyadh was contacted to gain permission to collect the overall data for this study (Section 4.9). This included the documents that met the inclusion criteria of the study (Section 4.6.1) that served to build the evidence about the decision process for the degree entry requirement for qualified nurses in SA, and to fill the gap in knowledge related to workforce planning and development. This prepared me, as a researcher, to become more oriented and familiar with all the processes that had been applied when implementing the decision before conducting the interview (Prior, 1974).

I accessed the files that contained these documents, which were kept in printed form in a special folder, and placed in the office of the General Director of Nursing. I conducted a brief overview of the documents to exclude any unrelated papers. The documents

comprised 629 pages, with 171 pages containing the exact meeting records being included and 458 pages including attached reports, tables and lists related to other Gulf countries that were excluded as illustrated in Figure 5-2.
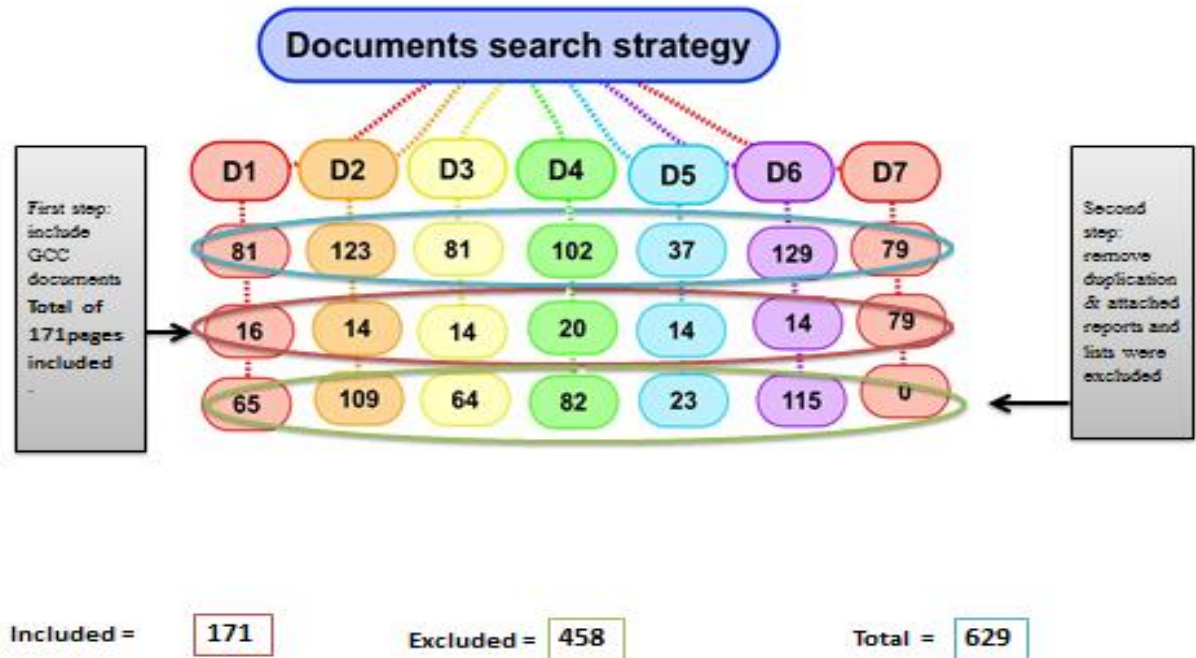
Figure 5-2: Document searching strategy

All of the included meeting records have the pages numbered consecutively as separate documents, and the excluded pages were attached in an unorganised manner without page numbers. I scanned the documents and saved the electronic copies onto my encrypted computer. I also developed a database on my personal computer that contained secure files for each phase of the study (documents, macro, meso and, micro level interviews and focus groups transcripts), to organise and save the large amounts of data that I had collected, as suggested by Stake (2003) and Yin (2013). Each file contained electronic records of multiple sources of data that I made, along with my reflective notes.

However, most of the documents are not easily accessible and contain evidence that would take a researcher a long time and much effort to gather alone. The most important advantage of using documents in social research is their stability. Unlike other sources of data, such as interviews or observations, the presence of the researcher does not alter what is being investigated. According to Merriam (2002) documents in qualitative research are

objective sources of data unlike other forms, indicating that documents are a good source for my case study research because they ground my exploration in the context of the phenomenon being studied and they validated and triangulated evidence from interviews and field notes (Guba & Lincoln, 1994). Indeed, these documents work as valuable social facts to confirm the information obtained from other sources (Prior, 1974), and it is very important to check whether these documents can assure objectivity, consistency and accuracy. The collected documents for this study are primary sources, which increases their trustworthiness and credibility. They were used for the purpose of this study only.

5.2.3 Data Analysis

Documentary analysis is mainly applicable to rigorous, qualitative case studies, constructing rich descriptions of a single phenomenon, event, organisation, or programme (Stake, 1995; Yin, 2009). The documents for this study were analysed using Prior's (2003) framework and included careful reading and re-reading as well as annotated commentary about any important information relevant to the purpose of the study. The initial coding of the documentary analysis was based on the questions of (Prior, 2003) who has conducted inclusive work on using documents in social research, which I used as a guideline to understand and analyse the documents.

Prior's (2003:P.26) provides valuable information about the nature of documents in organisations as illustrated:

- Documents form a field of research in their own right, and should not be considered as mere props for action.
- Documents need to be considered as situated products, rather than as fixed and stable things in the world.

Documents are produced in social settings and are always to be regarded as collective (social) products.

Determining how documents are consumed and used in organised settings – that is, how they function – should form an important part of any social scientific research project.

In approaching documents as a field for research, we should always keep in mind the dynamic involved in the relationships between production, consumption, and content.

When I entered the fieldwork to collect documents related to degree education policy, I was challenged with decisions as to which documents were the most relevant to the situation. I found that (Caulley, 1983: P.23) provided four important rules for choosing documents that guided me to decide the appropriate documents for my research as illustrated:

1. Incomplete observation and faulty memory are reasons for the inadequacy of testimony.
2. The longer the time interval between the incident described and the writing of the document, the less reliable the document. Therefore, choose the document that is closer to the event described.
3. Some documents are intended as aids to one's memory, some are reports to others, some as apologia, some as propaganda, and so on. Therefore, documents differ as to their purpose.

The more serious the writer's intention to make a mere record, the more dependable the document is. The more confidential the document (for example, the fewer eyes that are allowed to see it), the more 'naked" the truth revealed by the document.

The documents comprise seven documents, six meeting records including policy related to degree nurse education and practice, various Gulf countries' reports include strategic planning, action plans, curriculum outlines for different level of nursing programme; the booklet summarising the overall meeting achievements and challenges. The seven documents comprising 171 pages meeting the inclusion criteria and were subsequently analysed, while the unrelated documents were excluded.

Each meeting record commenced with minutes of the meeting, which included the date and time of the meeting, a list of the meeting members and those unable to attend, acceptance or corrections/amendments to previous meeting minutes, decisions made about each agenda item – for example: action agreed, next steps, outcomes, items to be held over to another meeting, recommendations, and date and time of the next meeting. This meeting was conducted once or twice per year and the GCC members included two representatives from each of the six countries of the Council: Saudi Arabia, Kuwait, Bahrain, Oman, Qatar, and the United Arab Emirates, and 2 from Yemen, whose accession to various GCC authorities has been approved by the GCC.

Prior (2003) analysis procedures for analysis began with a complete reading of the meeting records. I then re-read the documents, making notes in the side margins. A third reading entailed the actual coding of the sentences/phrases/words of the minutes of the meetings. To code the document data, I highlighted each relevant statement (irrelevant material was not coded; this process of determining what data is relevant to the topic under investigation is termed "data reduction") (Merriam, 2002). I could not use NVivo to arrange and organise the data because the documents were written in Arabic, so data was organised manually to include using notes and memos to document initial thoughts. Memos helped me to move from an empirical to a conceptual level and to identify the issues that required further exploration in the data analysis (Caulley, 1983).

However, Mogalakwe (2009) provides quality control criteria to assess documents, these are authenticity, credibility, comprehensiveness and meaning. As a researcher, I was aware of the potential risks of being misinformed by evidence when collecting documents and a number of protective steps were taken. These included: identifying the authenticity of the document to ensure the source used for analysis was correct, ensuring that the texts within the document were consistent with the context and that the information was clear, accurate and consequently from the original version. Some documents are partly in the public domain because they are published and freely accessible, such as the booklet of the Gulf Cooperation Council's (GCC) achievements, whereas other documents may be classified, confidential or otherwise unavailable to the public, such as the actual minutes of the GCC meetings, which are not published or accessible even for nurses.

5.3 Macro Level (Phase Two): Face-to-Face Interview

The first phase was documentary analysis and this phase was the second stage of data collection which involved face-to-face interview analysis. I collected data from administrative stakeholders to determine the different views at the strategic/macro level of nursing policy and practice, regarding the influence of degree entry requirements on nursing workforce planning.

5.3.1 Sample and Recruitment

A purposive sampling technique was used to recruit a sample of decision makers working at the MoH to participate in face-to-face interviews. These participants were invited by

email and provided with a Participant Information Sheet (Appendix 5.1) which included information, an explanation of the study and consent form (Appendix 5.2). To ensure an adequate sample, the four key informant stakeholders who met the inclusion criteria (Section 4.6.1) were engaged in the interview. This provided the most meaningful information in relation to the case study to help the researcher to understand the problem and the research questions (Creswell, 2013). Semi-structured, in-depth interviews were used to explore different views of stakeholders regarding degree education and its influence on nursing workforce planning. Each individual interview was conducted at a scheduled time set with each participant.

5.3.2 Procedure of Data Collection

Semi-structured face-to-face interviews were utilised for each participant at a scheduled time they had booked previously. Interviews are the most common source of data collection (Yin, 2009 ; Stake, 1995).

At the beginning of each interview, I welcomed and thanked the interviewee for their involvement and introduced myself to them, after which I explained the purpose of the research study to orientate the interviewees with the research topic.

Each interview was digitally recorded to enable it to be saved on to a computer, with the consent of the participant, to aid accurate transcription. This allowed me to concentrate on the conversation of each interviewee. This generated a data trail to which I could refer, as recommended by Polit and Beck (2013).

I used five combination types of questions as guidelines (Appendix 5.9) in the interviews as suggested by Krueger and Casey (2015). This combination of questions allowed the participants to focus on the important points of the research questions as suggested by Polit and Beck (2013).

The questions moved from general to more specific and from relative to important issues in the research literature (Krueger & Casey, 2015). During the interviews I took notes to help me concentrate on the participants' response, develop probing questions and to explain the issues in depth or to clarify certain words. I continued to interview and probe until it was felt no more useful data could be gained (Merriam, 2009).

At the end of the interview, I debriefed participants by allowing sufficient time for each participant to raise concerns and to make sure they felt they could contact me if necessary. All interviews took place within the interviewees' organisation or workplace and lasted between 30 to 60 minutes. Each interviewee was assured of anonymity and confidentiality regarding the information given.

Finally, each of the interviewees was thanked for their contribution and informed that they would receive a copy of their transcript by email. Following each interview, I immediately started reflecting on my notes and added any ideas or interpretations for any words related to the gathered data. Further, I reflected on the process of each interview to note anything that might have had an effect on the trustworthiness of the collected data or the rigour of the study to add in the final report. Each interview was conducted separately on different days.

5.3.3 Data Analysis

I started my transcription of the data by first listening to the recorded interview that was uploaded to the computer to ensure the accuracy of the recorded sound. The second time I listened to the whole interview without interruption whilst reading my review notes as annotated during the interview. This enabled me to remember the details and other nuances of the participants. For the second step of analysis, I opened a new Microsoft Word page in the database for the macro level data that included the electronic records of interviews. I developed one template page for each interview, including date, time, level and given code, within a table that included questions, answers, and researcher's comments (Appendix 5.3). I believed that organising the work from the beginning would help me to work systematically and smoothly. I was very careful when I did the transcription, and for this reason I developed certain rules that I would follow, including: selecting a quiet place that contained an office or table and chair, and turning off my phone and annotating a hardcopy of the interview with a marker pen.

In addition, I used headphones to listen actively to the recorded interview to capture the conversation accurately, listening to full sentences before stopping the recorder to write. Sometimes I listened to sentences many times to capture the exact words by using the forward and back buttons to repeat the conversation, noting down the exact words and

including repetition, silence and pauses. All names were removed from the transcript and indicated by their given code as in Table 5-2.

Table 5-2: Macro-level (Decision-makers)

Position	No	Nationality	Given code
General Director 1	1	Saudi	GD1
General Director 2	1	Saudi	GD2
General Director 3	1	Saudi	GD3
General Director 4	1	Saudi	GD4

All the audio-recorded data obtained from the four face-to-face interviews was saved on the macro level database as an audio file. Each transcript was organised and given space to add any further notes during analysis. The transcription method was very time consuming; in order to fully engage in the data collection process, I personally transcribed all the data. The transcripts had many grammar mistakes because most of the participants didn't speak English fluently and English is the second language in SA. However, despite the mistakes contained, the transcripts were not corrected to avoid changing the meaning of the interviewees responses. In order to back up the outline themes, quotations from interview transcripts are provided in original format (Section 7.2, 7.3, 7.4). Furthermore, to avoid changing the meaning, irrelevant parts of the transcripts have been removed as indicated by the ellipsis points [….]. An example of one-to-one interview transcript was attached in Appendix 5.4.

I reviewed the transcriptions with the original records to check the words and spellings and to correct some work to ensure the accuracy of data as suggested by Zhang and Wildemuth (2009) and explained in Section 4.7. A one-hour interview could take up to six hours to transcribe as the data was reviewed several times both by myself and a peer reviewer. In addition, the transcription report for each interview was sent to the interviewee to validate the information given. The majority of the participants (3 of 4) replied and agreed that the transcript reflected what was said in the final interview and one participant did not respond. A final check was conducted before all data was saved securely on my personal computer, flash memory, and email drop box.

I started coding any data related to the thematic framework (Section 4.7) by selecting the statement/words and copying it into another document, under an initial constructed

heading. For example, a title heading was made for this comment that provides an overall description of the sentiments described within the illustrated Figure 5-3:
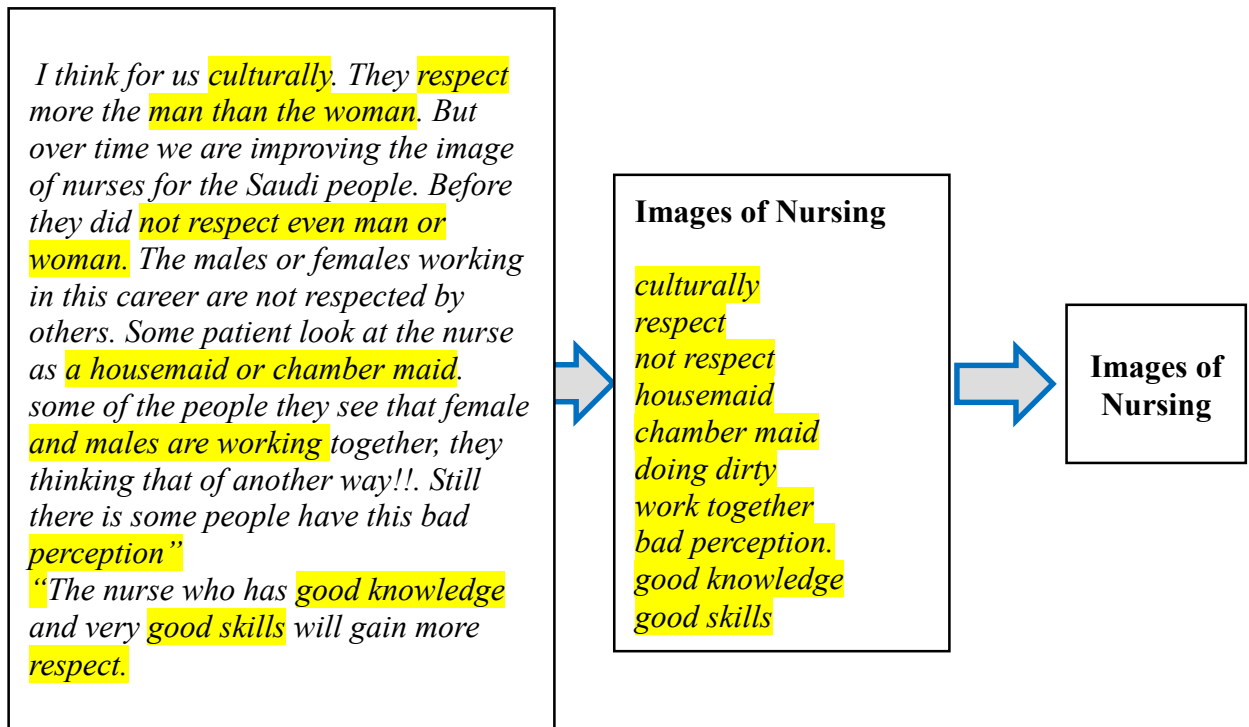
Figure 5-3: Example 1 of analysis process

NVivo software was used in a similar process to categorise the data and "drag and drop" the highlighted statement into a heading within the programme rather than in a separate document (Hilal & Alabri, 2013). According to Zhang and Wildemuth (2009), the basic functions are supported by the NVivo programme include text editing, note and memo taking, coding, text retrieval, and node/category manipulation. It has been suggested that using the software in data analysis adds rigour to qualitative studies (Greenhalgh, 2014). For example, I would select the entire section of a quote/statement and paste this comment under a heading that summarised the idea of that statement (Appendix 5.5). In some cases, the quote could be put under more than one heading, depending on whether more than one idea had been noted in the statement. If the quote did not fit into an existing heading, a new heading was created for it.

A log of the headings and the four participants was kept in either the NVivo programme, if used, or in an Excel file where qualitative software was not used. This was undertaken during the coding so that I could easily see the categories and trends, and the frequencies at the end of the analysis. Each statement was coded using this process, throughout the

transcription. More and more headings were built, and termed "categories," and for example, coded sections were added to existing headings as illustrated in Figure 5-4.
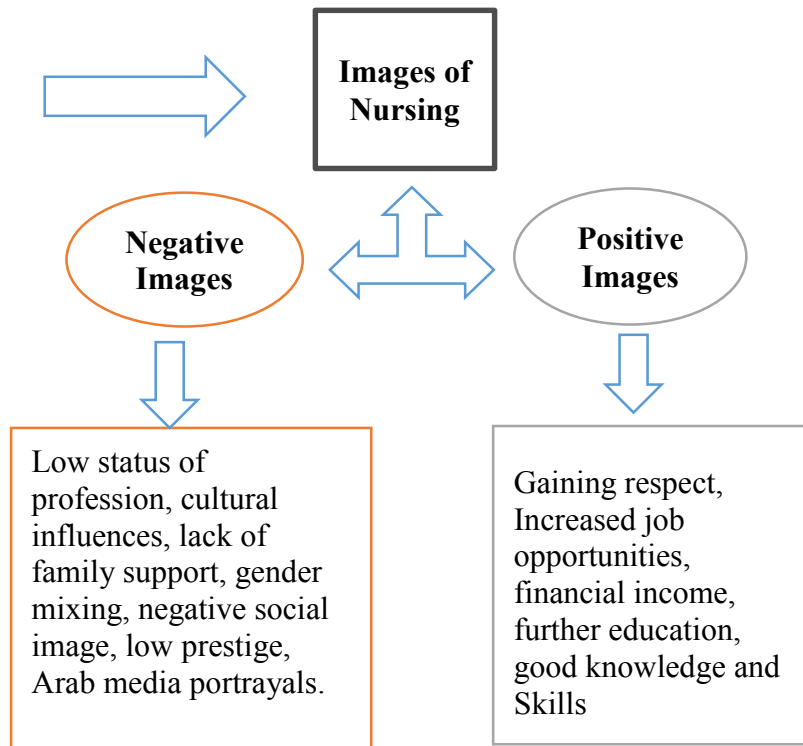
Figure 5-4: Example 2 of analysis process

Once the coding had been completed, headings were revisited to determine whether they were repetitive and could be combined. After this, headings and their similarity were reviewed to ascertain which could be grouped or "clustered" together by topic. This allowed organisation of the headings under several different "themes" of sorts, which generated the "thematic categories" presented in the write up.

A midmap for each thematic category title was generated, which included the headings – called constituents – that were grouped under this thematic category, and the number of participants that mentioned that particular element or constituent. To write up the section in the analysis report, all the comments made under that thematic category were reviewed along with the frequency of mentions, how the category was formed and the most frequent responses related to this category.

Addition of verbatim examples allows the reader to gain a "picture" of the participants' experiences or thoughts on the topic and more specifically, the thematic category being presented. Once all the thematic categories had been described and presented, all the

thematic category results were re-analysed, and high frequency data and extremely relevant data were noted, taking into consideration the narratives and individual textual descriptions of each participant. In places, the narratives gave a strong sense of certain elements that needed to be included in the final analysis. These high frequency and extremely pertinent data are grouped into overarching themes or composite structural descriptions that describe the findings representative of the sentiments of the group as a whole. These results are then analysed in relation to the research question in a discussion considering the implementation of the new policy requiring nurses to have a minimum of a Bachelor's degree education.

5.4 Meso Level (Phase Three): Focus group

This is the third phase of data collection (Section 4.6.1). I collected data from middle management (meso level), looking at information from the Regional Nursing Directors to critically assess their experiences regarding degree education as a minimum entry requirement for the nursing profession.

5.4.1 Sampling and Recruitment

The target sample for this level was selected from the Regional Nursing Directors in order to assess their views about the influence of nursing degree entry requirements upon career pathways and nursing roles. There were twenty Regional Nursing Directors working under the umbrella of the General Nursing Directorate in the MoH. The regions are located under five geographical zones (north, south, east, west and the central area) and a purposive strategy was used to recruit six Regional Nursing Directors for the focus group, from across all of the zones, to reflect the geographic spread and population distribution of the country. This number is in keeping with good practice for focus groups as recommended by Barbour (2007). Purposive sampling shows different perspectives on the situation, process or event that will help the researcher to understand the problem and the research questions (Creswell, 2013).

A focus group discussion was used to collect in-depth information from different perspectives. A focus group discussion is a more active and dynamic social discussion, unlike face-to-face interviews, and thus a cumulative understanding of the identified situation can be achieved (Billson, 2005). Focus groups are small groups of participants

with particular characteristics and criteria that provide qualitative data in a focused dialogue (Krueger & Casey, 2015). It is the 'interaction element' that is the key point to understanding how focus groups can be used to generate a different type of collected data than what is possible from a face-to-face interview (Yin, 2013). The six participants who met the inclusion criteria (Section 4.6.1) were invited to attend the focus group discussion and provided with a PIS and consent form (Appendix 5.6 and Appendix 5.7). The practical arrangements for the focus group, including the place and time, were prepared earlier and participants were informed of the details in good time.

5.4.2 Data Collection Procedure

At the beginning of the data collection for this level, focus group discussions were arranged with the Regional Nursing Directors in the main auditorium at the MoH. The appointment, setting and arrangements were made specifically to coincide with their mid-year meeting to more easily facilitate their involvement in the focus group. The groups were directed by two facilitators as suggested by Billson (2005); one as a note taker (assistant moderator) and my self, the researcher, as a moderator for the group. The moderator was responsible for planning and facilitating the discussion, building relationships of trust with the participants and being a good listener, non-judgmental and flexible (Billson, 2005). The roles of moderator and assistant moderator are summarised in Table 5-3.

Table 5-3: The roles of moderator (researcher) and assistant moderator (note taker) in focus groups.

Moderator	Assistant Moderator (MA)
Set up equipment, arranged refreshments and organised the interview room. Welcomed the participants as they arrived and distributed honorariums.	Supported the Moderator in setting up equipment and organised the interview room.
Oversaw data gathering, negotiated with the AM regarding the level of detail of note-taking (to supplement and not replace mechanically-recorded data). Facilitated the discussion.	During the interview monitored equipment, welcomed latecomers and resolved interruptions. Took notes throughout the discussion for the purpose of debriefing (as negotiated with the Moderator). Did not take part in the discussion unless exceptionally requested.
Thanked participants.	Looked through notes and summarised key points/issues.
Debriefed the session with the AM immediately after the interview. Transcribed and analysed interview data.	Contributed to debriefing immediately after the interview. Supported the ongoing data analysis process.

The assistant moderator and I were oriented to the skills and the task for each discussion. For classification purposes, the participants registered and were provided with a name tag with a code consisting of the capitalised first letter of their job title to ensure anonymity.

All the consent forms were signed by the participants, the environment was checked to ensure that the atmosphere was comfortable and coffee was provided. The moderator adapted seating positioned around a circular table for the focus group as suggested by Morgan (1997). This arrangement put the moderator in an equal position to the participants. The digital recorder was placed in the middle of the table to record the sound clearly. The researcher welcomed and thanked the focus group for their involvement and introduced herself to them. A PowerPoint presentation was initially given, which included the purpose of the research study, the participants' rights and the structure and guidelines for the focus group to introduce the interviewees to the research process (Appendix 5.8).

The tape recorder was checked before conducting the discussion, and the guidelines for asking questions were followed (Appendix 5.9). In line with the necessary ethical precautions, the moderator explained the confidential nature of the data to be recorded and reassured participants of their anonymity in the final report and other research outputs. Since anonymity is impossible during focus group discussion, trustworthiness is an essential element and participants were reminded that what is said inside the meeting room is shared in a non-judgemental environment, and nothing discussed during the focus group should be talked about outside the room (Guba & Lincoln, 1994). This is extremely important, as nothing discussed during the focus group should be talked about outside the room. Icebreakers/explanations were used to introduce the session. The semi-structured interview was guided by five prepared combination types of questions (Appendix 5.10), as suggested by Krueger and Casey (2015). Additionally, the themes that identified in the literature were used to direct the initial conversation of the focus group.

The group discussion was audio-recorded with the prior consent of the participants. Polit and Beck (2013) recommended that this would generate a data trail to which the researchers could refer back. The assistant moderator wrote the contextual interview notes and entered them into the database for this study. The moderator debriefed participants at the end of the focus group discussion. It is important to allow sufficient time for participants to raise concerns and make sure they have the contact details of the researcher. I concluded the group discussion and summarised the important themes with the

participants by delivering closing remarks. I respected the rights and dignity of all those who were involved in the research and thanked them for their participation by distributing an appreciation certificate.

5.4.3 Data Analysis

All the recorded audio data obtained from the focus groups group working at the meso level were saved on the computer as audio files. The recorded interviews were transcribed into printed text using Microsoft Word documents. The oral conversation was transcribed verbatim to written conversation and included repetition, silence and pauses. For classification purposes, I gave a code for each participant in the group to ensure anonymity as illustrated in Table 5-4.

Table 5-4: Meso-level (Regional Nursing Directors)

Position	No	Nationality	Given code
Regional Nursing Director 1	1	Saudi	RND1
Regional Nursing Director 2	1	Saudi	RND2
Regional Nursing Director 3	1	Saudi	RND3
Regional Nursing Director 4	1	Saudi	RND4
Regional Nursing Director 5	1	Saudi	RND5
Regional Nursing Director 6	1	Saudi	RND6

Transcribing the data for focus groups is time consuming; more so than one-to-one interviews. It took around 6 to 8 hours to transcribe one focus group. The assistant moderator and me, reviewed the transcribed data many times and sent the transcription report for each participant in the focus group by email to validate the information given. The majority of the participants (4 of 6) responded and agreed that the transcript was fine and reflected what was said. Two group members did not respond. For transcribing and analysis, I used the same technique as adopted previously with the data gathered from macro level participants (Section 5.3.3). Finally, I checked all the data for accuracy and saved it securely on my personal computer, flash stick memory, and email drop box.

5.5 Micro Level (Phase Four): Focus Groups

This was the last phase of data collection (Section 4.6.1). I collected data at the micro level, looking at information from the nurses who worked directly with patients in hospitals and PHCs, and those who had been most affected by the introduction of the

policy (Caldwell & Mays, 2012).

5.5.1 Sampling and Recruitment

Focus group discussions were used to identify constructs of the issue under investigation. Focus groups reflect the epistemological commitment to a people-centred design that focuses on the importance of understanding how people think about the world and their subsequent actions (Morgan, 1997). This epistemology is of relevance to the degree education policy that requires a bachelor's degree as a minimum requirement for entry into practice in relation to the health organisational system. At level, three focus group discussions were conducted at King Saud Medical City (KSMC) to allow sufficient exploration of the phenomena. Focus group studies frequently depend on purposive sampling wherein participants are chosen based on the objectives of the study. By using purposive sampling, I was able to place them in specific focus groups according to their professional roles and allied with their individual perspectives to link the points made in the groups' discussion as suggested by Krueger & Casey (2015). The use of explicit placements in specific groups for the purposes of this study enabled a more consistent group discussion, thus endorsing meaningful deliberations as opposed to heated discussions (Teddlie & Tashakkori, 2010). Focus groups may comprise eight to twelve members for each group as recommended by (Billson, 2005). nurses autonomy (Varjus et al., 2011).

In this phase, three focus group discussions were conducted to allow sufficient exploration of the research topic. Conducting more than one focus group discussion has the potential to enhance the reliability of data by detecting a consensus across the different groups (Morgan, 1997). The first focus group included a purposive sample of three nurse managers of the three hospitals and one nurse educator. All were invited by email, and received the PIS and consent form (Appendix 5.11 & Appendix 5.12 respectively). The second and third focus groups included purposive random sampling of four staff nurses with bachelor's degrees and four staff nurses with a Diploma, who were invited to participate by use of a poster covering the inclusion criteria for the study (Appendix 5.13). The sample was achieved on a first-come, first-served basis, with a reserve list established in case anyone withdrew at a later date. The total sample size for this level was twelve participants divided into three focus groups. Finally, the place, date and time for the three

focus groups were arranged and the information was given to participants in good time to enable them to attend.

A purposive strategy was used for all groups. Six nurse managers from three hospitals and one nurse educator attended the focus group discussion. The second and third groups included eight participants in total. The purposive random sampling strategy was used because the staff nurses working in the clinical area of KSMC represented a large number of healthcare providers with different levels of nursing education and experience. It was difficult to invite them by their name or job title because they were all staff nurses; the poster inviting them was placed in each nursing department. This helped the researcher to focus on a sample of the nursing population, both Diploma and degree educated nurses, with the inclusion criteria (Section 4.6.1). According to Patton (1990), purposive random sampling is small in size, which adds credibility to the sample when the potential purposive sample is large. The eight participants were divided into two focus groups; four of them were Bachelor's degree nurses and four were Diploma holders, and involving them in discussion enabled the participants to talk freely about the topic. Furthermore, focus group experts commend the use of several different groupings based on characteristics such as the level of education (Morgan, 1997; Krueger & Casey, 2015). This number was still in keeping with good practice for focus groups that can work effectively, with as few as 3 or as many as 14 participants being recommended by Gill et al. (2008).

5.5.2 Data Collection Procedure

After permission was obtained from the MoH, I contacted the hospital Director of KSMC to gain their permission to access the hospitals. The Director referred me to the Nursing Director Office in KSMC with a letter of permission to conduct the interviews and facilitate the necessary arrangements. The Nursing Director assigned one nurse as Assistant Moderator (AM) for the researcher and this nurse made the practical arrangements for conducting the focus group discussions..

The three focus group discussions took place within the interviewees' working day and lasted between 90 and 120 minutes. At the beginning of each focus group discussion, the researcher welcomed and thanked the interviewees for their involvement and introduced herself to them. The aim of the research study was explained. Each focus group discussion

was audio-recorded with the consent of the participants to aid accurate transcription. The audio recorder was placed in the centre of the round table to enable the sound to be recorded clearly. The confidential nature of data recording was explained in Section 5.4.

Two moderators (See Table 5.3) facilitated the groups. The skills of the moderators are vital to the effectiveness of focus groups (Billson, 2005). The semi-structured technique was guided by five prepared combination types of questions (Appendix 5.9) as suggested by Krueger and Casey (2015). Opening questions were used to enable participants to feel comfortable and talk freely. For example, at the beginning of the discussion, the participants were asked to introduce themselves and their background experience. Then, introductory questions were used to get participants to focus on the topic and to start thinking. For example, I asked them about their educational pathway as registered nurses.

Transition questions were used to provide links between the previous questions and the key questions. For example, I asked them about their opinions regarding the minimum requirement of a degree for entry to practise as a registered nurse. These questions guided me to the key questions that focused on the major areas of the research study. At the end, I asked them about any recommendations they would like to add in order to bring the session to a close. During the data collection process, I was able to explore the rich description in order to capture strength, direction and the inter-relationships of the influential elements relating to the research questions. This process provided context to the participants' perceptions of how sustainability initiatives impact their engagement (Creswell 2013). The moderator debriefed participants at the end of the focus group discussion. It was important to allow sufficient time for participants to raise concerns and to make sure they had the contact details of the researcher. Again, the session was concluded and summarised and I thanked them for their participation by distributing an appreciation letter.

5.5.3 Data Analysis

All the recorded audio data obtained from the three focus groups were saved on my computer as audio files. The recorded interviews were transcribed into printed text using Microsoft Word documents. The oral conversation was transcribed verbatim and included repetition, silence and pauses. For classification purposes, I gave codes for each participant

within the micro level which matched the inclusion criteria (Section 4.6.1) for each group as follows:

Group One include Seven participants including senior nurse managers and educators were given different codes to ensure anonymity as illustrated in Table 5-5.

Table 5-5: Group one (nurse managers and nurse educators).

Position	No	Nationality	Given code
Senior Nurse	1	Saudi	SN1
Senior Nurse	1	Saudi	SN2
Senior Nurse	1	Non-Saudi	SN3
Senior Nurse	1	Saudi	SN4
Senior Nurse	1	Non-Saudi	SN5
Senior Nurse	1	Non- Saudi	SN6
Senior Nurse	1	Saudi	SN7

Group Two include four staff nurses with a Bachelor's degree were given different codes as illustrated in Table 5-6.

Table 5-6: Group two (staff nurses with Bachelor degrees).

Position	No	Qualification	Given code
Junior Nurse	1	Bachelor's degree	JNB1
Junior Nurse	1	Bachelor's degree	JNB2
Junior Nurse	1	Bachelor's degree	JNB3
Junior Nurse	1	Bachelor's degree	JNB4

Group Three included four staff nurses with Diploma education, and they were given different codes as illustrated in Table 5-7.

Table 5-7: Group three (staff nurses with Diploma).

Position	No	Qualification	Given code
Junior Nurse	1	Nursing Diploma	JND5
Junior Nurse	1	Nursing Diploma	JND6
Junior Nurse	1	Nursing Diploma	JND7
Junior Nurse	1	Diploma	JND8

Each group included classifications that matched the inclusion criteria for that group. Moreover, transcriptions for the three focus groups were saved in a micro level database in an organised manner and uploaded to NVivo qualitative analysis software for content analysis, which followed the open-coding process (Hilal & Alabri, 2013; Zhang & Wildemuth, 2009), explained previously in the macro level analysis (Section 5.3.3). The results and discussion of the interviews and focus groups are presented in Chapter 7.

5.6 Reflexivity

This section presents my experience, beliefs, values, position and perspectives during the data collection process that may shape or effect the research method. Indeed, these factors are considered important issues in all research types, but particularly in qualitative research. To ensure that I am aware of my own influence on the research process I developed a reflexive journal (Appendix 5.13), a type of personal diary where I made regular entries during the research process, specifically highlighting those whereby I can take any necessary action (Guba & Lincoln, 1994). For example, in the documentary analysis phase, I faced a lot of difficulty in analysing the documents, as the documents were in the original professional Arabic language that contained certain words with a broader meaning. I could not use the NVivo programme in this phase because of the language. Therefore, I tried to search for a framework to analyse the documents. I found that the documentary analysis guidelines were the best to guide me to reach, select, and analyse these documents (Prior, 1974). Analysing documents was time consuming, and for me was the worst stage of this study. I read the documents many times, and every time I discovered something significant to the research aim. On the other hand, this stage made me more confident, knowledgeable and oriented to the whole system and process of policy implementation.

Throughout the data collection process, a number of elements were kept consistent in the three levels (macro, meso and micro), such as the importance of confidentiality (Section 4.9), achieved through coding, and ensuring that all participants in the interviews and focus groups for each level were comfortable within the discussion environment. Creswell (2013) described an insider researcher as one who is part of the social group they are studying. Being an insider researcher can have several advantages, such as: a greater understanding of the culture being studied; not altering the flow of social interaction

unnaturally; promoting a rapport with interviewees, access and ethics; knowing how to ask for and where to gather data; having empathy for the interviewees' perspective as suggested by researchers (Stake, 2003; Merriam, 2009a; Yin, 2009; Creswell, 2013).

However, there are also some disadvantages of the insider role that have the potential to impact on the trustworthiness of the findings. For example, as an 'insider researcher' in the macro and meso levels, I was aware that decision makers and regional directors may respond to me in my other roles; as a 'colleague' of those participants who were decision makers at the macro level and as a 'director' to the meso level participants. During the interviews, some participants asked for encouragement that they were saying the right things and I had to offer them reassurance that I was not looking for a particular answer, only their opinions on the subject matter. Meso level participants looked uncomfortable during pauses and expressed their desire to help me as much as possible to obtain the adequate data.

Participants at the meso level frequently said 'as you know' as they knew I was aware of their issues, which shows the problem of assuming understanding in this situation of familiarity in the research field. The frequency of this phrase was especially apparent when I reviewed the verbatim transcripts. (Miles et al., 2014) points out the problem associated with taken-for-granted perspective and difficulties with critically examining something that can appear self-evident. I was aware of the need to counteract any assumption made on my behalf, so I responded to this comment by asking the participant to explain what they meant. I was very conscious to view the participants' responses as objectively as possible by not assuming understanding, questioning phrases and comments, interpreting the comments correctly and thinking about all the possible interpretations.

In the micro level focus group, I was partly an insider researcher by virtue of my role as a director, and an outsider researcher as I was not employed in the hospital and did not know any of the participants (staff nurses with Diplomas and Bachelor's degrees). This insider/outsider role was helpful as it allowed the benefits of insider status but the limitations of the researcher/participant relationship were easier to retain. In this situation, participants would possibly not have perceived any internal risk to revealing detailed information about the organisation, even if this was negative. I was able to focus on being predominantly a researcher in this environment, as I did not have the responsibility of a director.

As a confident and organised interviewer, I was able to quickly build a trusting relationship with the participants and put them at ease, giving them the time and opportunity to express their views. This is consistent with the interpretivist perspective, based on the interaction between myself as a researcher and the participant (Polit & Beck, 2013). I was conscious of my influence on this interaction, especially in terms of influencing the flow of the interview by being interested in some of their comments more than others, thus leading the interview in a certain direction.

In order to ensure that the participants had the freedom to respond without adverse influence, the interview schedule began with some introductory questions about their views on degree education as a minimum requirement to enter practice before asking key questions.   The semi-structured interview allowed the participants to identify and discuss their response freely while I continued to be aware of the potential for me to direct the conversation. In addition, I sought confirmation of my interpretations of interview data throughout the interview, and at the end of the interview, I summarised key points and asked the interviewees to add any related information. I was open-minded about issues raised and probed for further information in order to fully understand the significant information each interviewee possessed.

The interpretation of the data was affected by the connections made between the data within each level and across levels and involved comparing and contrasting data for similarities and differences. The differences were delicate and sometimes difficult to extract, but important information is explained in the findings. For example, the participants at the micro and meso levels expressed mixed opinions about the importance of degree education as a minimum requirement to enter practice as a professional nurse. These could have been negatively influenced considering that some of them were Diploma-educated nurses and could not take a degree due to many factors such as age, limited places on the programme, and requirements for high scores in English test (IELTS). On the other hand, macro level participants, like governors, opposed the views of micro and meso level participants, claiming that there were no obstacles to join the programmes. As a researcher, I am aware of the importance of being highly alert to subtle aspects of data, to make these clear and to adapt to collecting data from different people functioning at different levels and from different areas of the country in order to portray a holistic view in the study.

5.7 Summary and Conclusion

This chapter has discussed the data collection protocol for three levels of the framework (four phases), detailing the sampling, data collection procedure, and data analysis of each group within the MoH (macro, meso and micro levels). The documentary analysis (phase one) has been used to gain more information from the documents of the GCC nursing committee about the policy to introducing degree education as a requirement for qualified nurse's in SA, to critically assess the implications of this policy and to determine a baseline from which to develop a national nursing strategy for future workforce planning. The face-to-face interviews with macro level (phase two) participants has been undertaken with a sample of decision makers at the MoH to understand their perspectives of the influence of the degree education policy on nursing workforce planning and development. The meso level data collection (phase three) has been conducted with one focus group to determine the views of a sample of practising nurses at the middle management/meso levels of nursing practice, regarding the influence of degree entry requirements on nursing workforce planning. The micro level data collection (phase four) has been undertaken within the frontline/micro level people engaged in nursing practice, regarding degree education as a minimum requirement for entry to the nursing profession and a meticulous explanation of the data transcription and analysis is given.

Using documentary analysis in combination with interview techniques allowed me, as a researcher, to gain in-depth and rich information about the situation under study (Creswell, 2013; Merriam, 2009a; Yin, 2009; Stake, 2003). Finally, the chapter concluded with my personal reflections throughout the data collection process.

The next chapter presents the results of documentary analysis summarised in three important thematic categories evident across all documents analysed, from which common sub-themes were revealed in the data related to each category.

Chapter 6 : Documentary analysis: Results and Discussion

6.1 Introduction

Chapter 5 offered the analytical processes for documentary analysis and analysis of participant responses to the interview questions and focus group discussions at three levels (macro, meso, and micro). This chapter is divided into two sections.

The first section presents the results of the documentary analysis, while the second section offers a discussion of those results. The results of the interviews and focus groups at the macro, meso, and micro levels will be presented in Chapter 7. The initial coding from the documentary analysis was based on the research aim, which was to critically assess the implications of Bachelor's degree nurse education as a minimum entry requirement for nursing practice, to determine a baseline from which to develop a national nursing strategy for workforce planning and development. The objective, pertinent to this section of the research, was to:

- Review the MoH rationale for nurse education degree entry and assess the intended outcomes in terms of national workforce planning.

Relevant documents as described in Section 5.2 were analysed comprehensively and systematically using Prior (2003) framework analysis and these were explained in section 5.2.3. Analysing documents prior to the interviews helped me to gain a rich understanding of the policy process. The analysis attempted to understand the process and outcomes that occurred across the case study, to develop a comprehensive description and explanation (Polit & Beck, 2013). The two sections within the chapter will detail each of the three identified thematic categories emerging from the reviewed documents (D1, D2, D3, D4, D5, D6, and D7). Cognitive/mind mapping (Miles et al., 2014) will be used within three sub-headings to illuminate the analytical and thought processes related to each thematic category and the documentary analysis as a whole.

Documentary analysis resulted in the generation of three thematic categories evident across all documents analysed, from which common sub-themes were revealed in the data related to each category. The interrelated thematic categories emerging from in the documentary analysis are illustrated in Figure: 6-1.

- Theme 1: Rationale for change
- Theme 2: Nursing as an agent for change
- Theme 3: Making the change
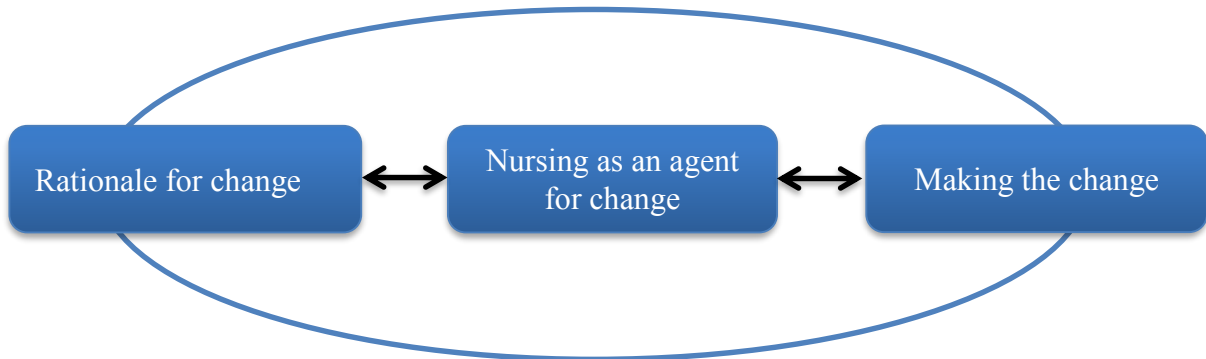
Figure 6-1: The three thematic categories from the documentary analysis

6.2 Rationale for Change

This was a significant thematic category identified from the documentary analysis, which underlined the rationale for change and the need for global standards for the future nursing workforce in the Gulf countries. This theme included two important subcategory themes, illustrated in Figure 6-2.
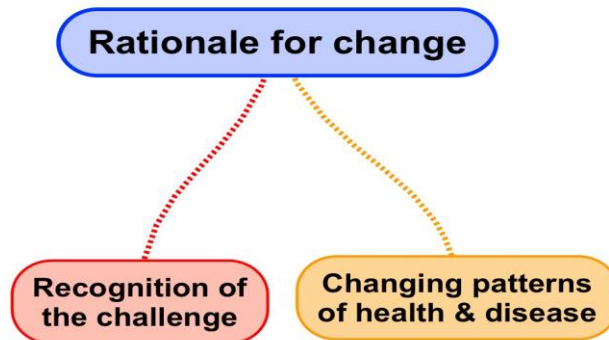
Figure 6-2: The first category in documentary analysis

6.2.1 Recognition of the challenge

The GCC Nursing Technical Committee recognised the importance of change in nursing education and practice to meet patients' expectations by focusing on the quality of healthcare services. The committee was aware of, and knowledgeable about, the health challenges facing the Gulf population and the reasons for the change in nursing education

as stated in D7:

"the initial education of professional nurses has arisen for several reasons such as an increasingly ageing population, onset of diabetes, obesity, hypertension, etc." (D7, p.8).

‏‏"وقد تم تنفيذ الحد الأدنى للدخول إلى مهنة التمريض لعدة أسباب مثل زيادة السكان المسنين، ظهور مرض السكري، والسمنة، وارتفاع ضغط الدم، وغيرها"

The document also shows the GCC's recognition of increasing demands for healthcare services at different levels of service provision, the increase in the number of other health professionals, besides nurses, and the need to assure the right access to healthcare services. In addition, there is recognition of the shortages of professional nurses, especially in the rural and border areas in SA, which includes the north, south, east, and west areas. The shortage of nurses is an important issue within Gulf countries and it is expected to increase as health demand grows. This issue was highlighted in D7, p.19 as:

"Shortage of national nursing staff and lack of national nursing leaders is the first issue that affects the nursing workforce in the Gulf countries"

‏‏"نقص الكادر التمريضي الوطني نقص في القيادات التمريضية الوطنية هي القضية الأولى التي تؤثر على القوى العاملة التمريضية في دول مجلس التعاون الخليجي"

The health challenges and issues listed in the documents are examples of the rationale for change in the initial education for nurses. Expanding health services and increasing health complexities require high-level skills within the nursing workforce. Analysis of the GCC document (D7) shows the GCC nursing committee's awareness of this current situation, and the need for professional nurses who are capable of dealing with a diverse population and providing high quality care. In summary, the challenges are presented as a strong rationale for change to match the future direction of healthcare highlighted by (WHO 2009) and global healthcare organisations.

6.2.2 Changing patterns of health and disease

It was acknowledged from the documents' analysis that the changing patterns of health and illness/or disease in the Gulf countries were related to demographic changes. For example, the GCC technical members in D1 listed some examples of global health challenges that might influence the quality of healthcare services and nursing workforce planning in Gulf

countries, as illustrated:

"Population growth rate, equality of healthcare demands and needs, and
emerging health threats" (p.26).

"معدل النمو السكاني، والمساواة بين مطالب الرعاية الصحية والاحتياجات، والتهديدات الصحية الناشئة"

The population of SA increased from 4.0 million in 1960 to 31.5 million people in 2015 (World Population Review, 2016). Recent statistics show that there is a substantial change in the Saudi age structure related to an increase in life expectancy and decrease in fertility rate (MoH, 2014). Non-communicable disease accounted for 71% of all deaths in SA, with cardiovascular disease the leading cause of death due to a high rate of physical inactivity and unhealthy lifestyle (Mahmoud & Faramawi, 2015). The incidence of diabetes mellitus has increased globally and locally over the past decade. In SA, 20% of the population over the age of 20 complained of type 2 diabetes, which is considered the highest rate in the world (Section 1.2). Many of these issues reinforce and underline not only the need to promote health and prevent illness, but also highlight the important role of a degree nurse who can administer unique care in all three stages of healthcare; primary, secondary, and tertiary (D 6.4).

Health and disease patterns in SA have changed over recent years due to demographic, socio-economic, and cultural factors as discussed in section 1.2. In addition, D1, D2 and D6 present some examples of health challenges that illustrate the complexity of health needs and demands in the Gulf countries. However, from analysing the GCC documents, the results show that the GCC nursing committee recognised the key factors affecting the health of individuals, families and populations, which are stated in D1 and reviewed again in D2 (p.31) as follows:

- *Demographic change (ageing population, birth rate)*
- التغير الديمغرافي- الشيخوخة السكانية، ومعدل المواليد

The GCC committee recognised demographic change as a major factor affecting health and disease patterns in Gulf countries. Saudi life expectancy has increased to 74.5 years, which exceeds the regional average by 6 years and the global average by 4 years (WHO, 2006). This phenomenon can be attributed to other issues, such as variation in birth and mortality rates. The ageing population in SA is growing at a faster rate than the Middle

East average (Almalki et al., 2011), which is considered as an important health indicator for policy makers:

- *Changing pattern of health and disease*
- تغيير نمط الصحة والمرض

The social life pattern is the second factor identified, and a major control factor impacting on health and disease in the Gulf countries. Lifestyle-related diseases occurring in Gulf countries are associated with eating patterns and decreased physical activities (Section 1.2). The risk factors for chronic (non-communicable) diseases such as coronary heart disease, stroke, obesity and diabetes mellitus are increasingly prevalent in SA. According to Mahmoud and Faramawi (2015), the most important risk factors for non-communicable diseases include high blood pressure, high cholesterol, inadequate fruit and vegetable intake, overweight and obesity, physical inactivity and tobacco use; all of which are major factors influencing mortality in developing countries. The WHO (2011) report shows that 26.6/1,000 female and 46/1,000 male deaths in SA were associated with non-communicable diseases. These statistics illustrate health indicators that may predispose the direction of future health policy (Mahmoud & Faramawi, 2015; WHO (2011). Symposia have actually taken place in SA for specific health action planning purposes. Moreover, the health system in SA and the pervading socio-cultural context of life were explained in Section 1.2 and 1.3: for example, increasingly sedentary lifestyles, and this led to increase the expectation of the Saudi population as listed in D1:

- *Increased expectations of public and health services users*
- زيادة التوقعات من مستخدمي الخدمات العامة والصحة

Increased expectations of health services users is the third factor affecting the healthcare system. The expectations of the Saudi population for quality healthcare services are expanding (Al-Yousuf et al., 2002). These expectations reflect the transformation in the quality of healthcare services, such as the use of technology and social media to engage with their patients (Section 1.3). The Saudi population are becoming more aware and knowledgeable regarding healthcare services and they expect more services from the government sectors. Within the interviews and focus group discussions (presented in Section 7), there was anecdotal evidence of this concern, with some questioning health policy and planning to match improved public knowledge of health matters, and a related

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desire for higher levels of service. This finding is in keeping with wider consumerism and expectations regarding healthcare provision in other contexts. For example, in the UK, the Patients Association, (2013) is an active body that represents the public regarding health provision. 'INVOLVE' was previously developed in 1996 and aims to support active involvement of the community in NHS, public health and social care research (Ham et al., 2015). However, with regard to increasing expectations amongst new generations in SA, the Saudi health system has undertaken some initial steps aimed at:

- *Increased access to and choice in health services*
- زيادة الوصول والاختيار على الخدمات الصحية

This aims to increase communities' direct control over their care. This in itself has potentially led the community to select and compare between the different levels of healthcare services (Section 1.3). Most private health sectors provide unique online services to their patients. They concern themselves with high quality management, placing emphasis on patients and their families as customers and consumers of health, and have an attendant focus upon patient satisfaction. For example, the mission of Al Mishari Hospital states that:

> *"Dr. Abdul Rahman Al Mishari Hospital is committed to superior quality and*
> *safety in meeting the health care needs of the clients we serve by fostering*
> *advanced and compassionate health care services"*

Furthermore, the private sectors also follow the same direction of the MoH, which aims to:

- *Shift the delivery of healthcare services to a community setting.*
- التحول في تقديم خدمات الرعاية الصحية إلى بيئة مجتمعية.

Moving healthcare services out of hospitals to the community has been a global direction for many developed countries such as the USA, Canada, and the UK. This is in keeping with the WHO (2009) recommendations to enhance community services. Some countries, such as Australia, Norway, and Sweden, are further on in the process of shifting care out of the hospital to the community (RCN, 2013). This includes delivering care closer to home, reducing hospital readmission and length of stay, increasing patient choice and

satisfaction, addressing health needs for elderly people, and early intervention and disease prevention.

However, despite the GCC nursing committee's commitment to encourage community service development, there is limited evidence to show real investment in the community. The MoH is supportive of moving care closer to patients (Section 1.3.1). For example, there is a MoH strategy to expand primary healthcare services (Almalki et al., 2011). Yet, more community investment is needed by the MoH to achieve this shift. That said, promotion of community health services and increased uptake by the population does require some public education, as there is a preference for hospital care. For example, patients present at emergency departments for non-urgent cases rather than attending the community services provided and this is in keeping with trends in the UK (Brooks & Rafferty, 2010). Accordingly, the GCC Nursing Technical Committee's knowledge regarding the nature of technology playing a pivitol role in delivering health promotion programmes in the community (D1) is the overall result of shifting healthcare services to the community, and indicates the importance of using:

- *Advanced technology and innovations in the healthcare system.*
- التكنولوجيا المتقدمة والابتكارات في نظام الرعاية الصحية.

The GCC Nursing Technical Committee, policymakers and stakeholders all acknowledge that technology continues to change at lightning speed, and impacts the way healthcare is planned and organised. Technology is growing and playing an important role in almost all healthcare services, from patient registration to discharge and follow up (Black et al., 2012). New technology provides cost effective services to organisations, patients, families, and the community. Devices such as iPads, smart phones and tablets are starting to replace healthcare processes such as recording, reporting, monitoring, transferring, and so on. Advanced technology contributes to knowledge, practice, services, and consultations that are now being taken beyond the boundaries of the hospital and integrated with user-friendly and accessible devices (Black et al., 2012). The MoH has embarked on e-health strategies with some success, and this service is being extended to rural areas and smaller hospitals in more remote Saudi regions. Saudi nursing scholarships and study leave applications are already processed online in the MoH.

All the identified challenges illustrate the need for change in the traditional models of care and require advanced professional skills in transforming nursing education and practice to

manage complex healthcare, meet service demand and address patients' needs. These challenges have been identified by the GCC nursing technical committee as a rationale for change within nursing education, namely progression to degree education.

6.3 Nursing as an Agent for Change

While the previous section has illuminated the GCC committee's rationale for change, this thematic category presents the role of the nursing profession as an agent for change. It was identified from the documentary analysis that a key message of the GCC Technical Committee of Nursing was the emphasis of the role of nursing as an agent for change in education, practice, and management. The role of the GCC Nursing Technical Committee was explained in section 2.5. Reviewing the documents shows there is agreement on the part of GCC members regarding the importance of nurses as agents for change in transforming healthcare services locally and globally. The GCC committee also emphasised the importance of preparing the national nursing workforce for a broader role (D1, D2, D3 & D7). The key theme/question that emerged from the documents is what the transformed nursing education and practice in Gulf Countries could and should be like, and what knowledge, skills and attitudes nurses with degree education will need. In summary, there was consensus within the GCC documents that nursing has the potential to act as an agent for change, yet there was little accompanying detail as to how to take the change forward and implement it within nursing education and the wider profession.

Three important subcategories resulted from the thematic category "Nursing as an agent for change", and these are summarised in the illustrated mind map in figure 6-3.
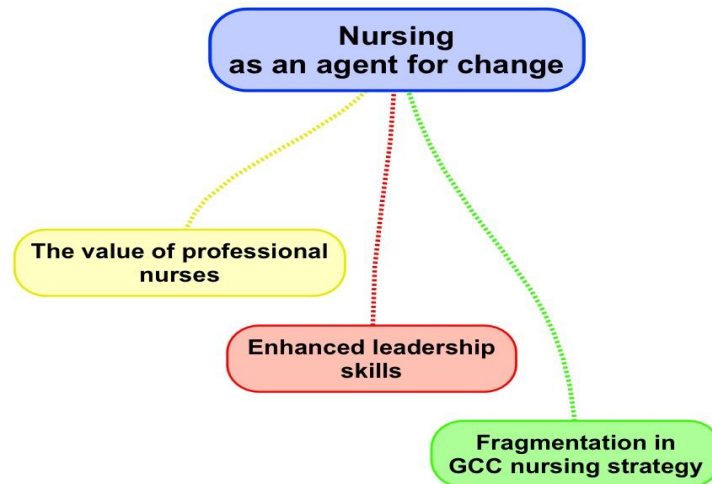
Figure 6-3: The second category in documentary analysis

6.3.1 The Value of Professional Nurses

The value of professional nurses is a subcategory theme identified from the meeting minutes of GCC. For example, the nursing committee of the GCC provided recommendations in their meeting in Kuwait (D 5), and highlighted the important role of professional nurses in transforming nursing education and practice. According to their discussion documented in the meeting records (D7), nurses in the GCC countries represent the largest group of healthcare providers, compared with other healthcare team members, and this adds to their significant contribution to healthcare systems in primary health care, critical care, and community services.

"Nurses and midwives make up the greater part of the Gulf healthcare workforce"

D7, (p.10)

نسبة الممرضات والقابلات تشكل الجزء الأكبر من القوى العاملة الرعاية الصحية الخليجية

It is argued that the nursing committee also recognised the unique contribution of the nursing profession to health services, social services and the community as a whole. The GCC committee in D5 state that the professional nurse is able to:

"Provide a holistic nursing care that is socially and morally acceptable and based on evidence and scientific research, using critical thinking in decision-making in the provision of care and upgrading them to reduce risks and control of diseases and assist in the rehabilitation and respect for the dignity of the patient at death" (D5)

"تقديم الرعاية التمريضية الشاملة بحيث تكون مقبولة اجتماعيا واخلاقيا مبنية على البراهين والبحثي العلمي مستخدما التفكير الابداعي في اتخاذ القرارات في تقديم الرعاية والارتقاء بها للتقليل من المخاطر والسيطرة على الامراض والمساعدة في اعادة التأهيل واحترام كرامة المريض عند الوفاة"

The fast socio-economic transition period of SA and its implications for high standards of professional nursing skills to extend programmes of health promotion and prevention, in response to changing health needs was discussed in sections 2.1 and 2.2. This type of care can be provided only by highly educated nurses who can readily adapt to global changes and manage the complexity of healthcare services as recommended by WHO (2009).

By virtue of nurses' numbers as the largest group of healthcare providers (D7), and their advanced knowledge, skills and attitude, professional nurses must help to lead the change in future workforce planning to meet the population's needs.

According to the Gulf nursing committee (D5, p6);

"Preparing nurses for professional roles is the future direction for all countries; the curriculum of nursing programmes must focus on professionalism; reflect the patients' needs and be immediately applicable to the central role of nurses to meet the strategic goal of the MoH: patient first"

إعداد الممرضات لدور المهني هو الاتجاه في المستقبل لجميع البلدان، والمناهج الدراسية لبرامج التمريض يجب أن تركز على المهنية. تعكس احتياجات المرضى وتكون قابلة للتطبيق فورا إلى الدور المركزي للممرضات لتحقيق الهدف الاستراتيجي من وزارة الصحة: المريض أولا

In keeping with professional identity and the development of professional skills for nurses as advocated by the GCC, there is a need to reflect professional themes within the nursing curriculum. This is a key point within the MoH policy discussed in section 3.4. This theme is also revisited within the recommendations resulting from this case study, which will be discussed in section 8.3. It is interesting to note in the last quote that most of the reviewed documents in this study have highlighted the unique role of nurses and their contribution to healthcare services (D1, D2, D3, and D7).

The GCC actually wishes to harness this role for nurses in the Gulf countries. Unfortunately, it is argued that while nurses have much influence and professional potential, they do not use it; they are holding themselves back due to socialisation, and the societal context of SA has the potential to hold them back (Gazzaz, 2009). For example, some families feel there is a certain stigma around the nursing profession. It has been reported that the mother of a male nurse refused to recognise her son as a nurse; instead, she referred to him as a doctor within the community (Miller-Rosser et al., 2006).

However, by focusing on knowledge as the key to nursing professionalism, and the role and actions of the individual nurse, it is suggested that one is missing the point (Section 3.3.7). There should also be focus on the superstructures that are the substance of professional standing and autonomy (Meerabeau et al., 2004). It is therefore essential that nursing education and services be restructured from the foundations upward, in addition to supporting the individual nurse to become confident and autonomous. According to Meerabeau et al. (2004) this gives the opportunity for the community to view power relations differently; organisation/community, male/female, professional/unprofessional.

This would challenge the current social concepts within the nursing community in SA and give space to develop a global model to improve the nursing profession's organisation and education and build a more positive future career for Saudi nurses (Section 2.4). Within this framework, it is important to consider the role of nurses at each level of education and the impact that this has on patient care, with a particular focus on providing a flexible nursing workforce. Therefore, it is argued that the intellectual expansion of nursing influence, autonomy and freedom hinges politically on its power relations with other healthcare providers, such as doctors and social workers. Moreover, it hinges on the relationship of nursing within the MoH structures (Section 2.2).

6.3.2 Enhanced Leadership Skills

This is another subcategory theme developed from reviewing the GCC documents. The document D 5 shows that there is a recognised need for nursing leadership skills within the Gulf countries. The GCC emphasises the role of Saudi nurses as future leaders and the need to involve them in the national strategic plan for Middle Eastern countries' crisis and related national disaster planning,

"Enable nursing leaders in each of the GCC countries to participate in the national strategic and operational policies and plans for dealing with disasters and crises" D5.2

"تمكين القيادات التمريضية في كل دولة من دول المجلس من المشاركة في وضع السياسات والخطط الاستراتيجية والتنفيذية للتعامل مع الكوارث والازمات"

Nurses are at the frontline of care in responding to any situation that might influence the health and illness status of the population, such as natural disasters or human induced disaster. For example, during the Hajj season, the population in Makkah (Mecca) increases from 200,000 to over three million people. The masses of people that arrive in Makkah for the Hajj pilgrimage, coming from all over the world, create a critical situation and overt pressure on healthcare services, in which a number of emergencies are reported (Alamri, 2010). This happens for several reasons, such as the heat, overcrowding and breathing difficulties. SA has recorded an increase in natural disasters; for example, flash floods and torrents in Jeddah (*Sale*) and dust storms in central Riyadh and northern cities (*Aa'jj*). These, in turn, are causing an increase in the number of accident and emergency cases that are transferred to hospitals and emergency centres (Alamri, 2010; Almalki, 2012). These types of sudden crisis require a high level of nursing leadership skill and management in order to deliver good care in good time.

In keeping with professional practice, the GCC nursing committee in D2 also views leadership and management as key components of the BSN curriculum. Leadership theory is currently taught in year 4 of pre-registration nursing programmes. For example, the BSN programme outline that was developed by the GCC committee sets as one of its objectives that,

"the bachelor's degree nursing students will apply leadership and decision making concepts and skills in the provision of nursing care in different healthcare settings including hospitals and primary healthcare centres" D2.4.

"طلاب التمريض من درجة البكالوريوس سيطبقون مفاهيم ومهارات القيادة وصنع القرار في تقديم الرعاية التمريضية في مجال الرعاية الصحية المختلفة بما في ذلك المستشفيات ومراكز الرعاية الصحية الأولية"

This supports the evidence presented in the Saudi context of nursing education in section 2.3 to involve nurses as leaders within 'Saudization' strategies (Section 1.3.1). The scope of leadership set out in the GCC documents (D2) suggests that leadership skills and

management are more appropriately taught through practice via continuing education programmes, in order to prepare nurses to present leadership skills as part of nursing practice. Strengthening the visibility and the value of the nurse leadership voice is the major priority that needs investment to shape governance.

In summary, the above analysis indicates that there is GCC recognition of the nursing leaders' role at the national level of strategy and planning, and there is commitment to developing educational programmes to increase the number of national nursing leaders in order to meet community needs and healthcare demands. In recognition of this, the Saudi MoH realised the unique value of degree prepared nurses within practice to improve the quality of care and patient safety. However, other health agencies such as military hospitals, teaching hospitals, and Magnet hospitals have already implemented this policy to enhance leadership skills for all nurses, as explained earlier in section 1.3.2. Other governmental health sectors in SA have already applied the degree requirement for nursing practice in their system to enhance nursing leadership and raise the standards of the quality of care. However, the MoH is still progressing slowly and a key finding is that there is little detail on how to implement the required change.

6.3.3 Fragmentation in GCC Nursing Strategy

The previous subcategory theme illustrated the GCC Nursing Technical Committee's views regarding nursing leadership skills and effectiveness in the Gulf countries. This subcategory theme reveals explains the fragmentation found in nursing education and practice within the Gulf countries.

Analysis of the documents suggested that there is some variation in the levels of initial nursing education and the minimum entry level for professional nurses within the Gulf countries. For example, some Gulf countries such as Kuwait considered initial nurse education programmes at secondary school level to be sufficient (D7.3), while other countries such as SA recently specified university-level education as the minimum point of entry to the health professions for nurses (D7.3).

 In addition, nursing education takes place in a number of governmental and private college/universities (Section 2.3). These settings create considerable fragmentation within content of nursing education and the resulting practice abilities of nurses. For example, the governmental nursing colleges provide free education to a limited number of national

students through a 5-year degree programme, which includes a one-year internship in the governmental hospitals (Section 2.3).

However, the GCC Nursing Technical Committee proposed national general curriculum guidelines for nursing education in recognition of the fragmentation across Bachelor Degree, Diploma, and bridging programmes in order to standardise the curriculum outlines for nursing education in the Gulf countries. These curriculum guidelines were written in Arabic in D1, D2, and D3.

The curriculum outlines the three educational pathways to becoming a registered nurse in the Gulf Countries as follows:

The first pathway is Diploma-nursing education, and the duration of the programme is,

> *"not less than two and half years and aims to provide direct patient care in hospitals and primary healthcare centres"* (D2, p.3-4)

لا تقل عن سنتين ونصف وأهدافها توفير الرعاية المباشرة للمريض في المستشفى ومراكز الرعاية الصحية الأولية

The second pathway is Bachelor's degree nursing education,

> *"offered in five years, which includes all the content in the Diploma but an in-depth study of the pathophysiology, nursing research, pharmacology, leadership and management, community and public health, ethical and educational principles, and nursing informatics"* (D2, p2).

عرضت في خمس سنوات والذي يتضمن كافة المحتوى في الدبلوم ولكن دراسة متعمقة من الفيزيولوجيا المرضية، والبحوث والتمريض، والصيدلة، والقيادة والإدارة، والمجتمع والصحة العامة، والمبادئ الأخلاقية والتربوية، والمعلوماتية التمريض

The third pathway is a bridging programme, which

> *"provides additional education for Diploma holders who want to expand their knowledge and advance their skills to get the bachelor's degree"* (D2, p.5,6).

" توفر التعليم الإضافي لحامل الدبلوم الذين يرغبون في توسيع معارفهم وتطوير مهاراتهم للحصول على درجة

البكالوريوس

The three levels of nursing education outlined in the GCC Nursing Technical Committee documents (D1, D2, D3) are summarised in Table 6-1 to identify the similarities and differences.

Table 6-1: Nursing education pathways in the GCC countries

Nursing programme	BSN	Diploma	Bridging
The aim of the programme	Prepare nursing students that are able to provide holistic nursing care to individuals, communities and society at all three levels (primary, secondary, tertiary) in accordance with the approved standards in order to promote health and improve quality of life.	Provide the basic level of nursing care to individuals & society, and work within healthcare team in order to promote health and improve quality of life.	Prepare qualified staff who are able to provide a holistic nursing care to individuals, communities and society at all three levels (primary, secondary, tertiary) in accordance with the approved standards in order to promote health and improve quality of life.
The duration	4 years, the programme starts instruction after completion of high school.	2 ½ years, the programme starts instruction after completion of high school.	The duration of the programme depends on the total number of hours of the previous programme.
The internship period	12 months of clinical practice.	6 months of consolidated practice.	6 months of consolidated practice.
The theory part	50%	50%	_____
The practical	50%	50%	_____
Total credit hours needed for graduation	125 credit hours 1 credit hour theory= 1 hour/week 1 credit hour lab= 2-3 hours/week 1 credit hour clinical= 4-5 hours/week.	70 credit hours 1 credit hour theory= 1 hour/week 1 credit hour lab= 2-3 hours/week 1 credit hour clinical= 4-5 hours/week.	_____
The nursing licensure	Licence provided after passing the national exam.	Licence provided after passing the national exam.	------
Classification	Specialist.	Technician (generalist).	Specialist.
Continuing education and renewal license	20 hours/year.	10 hours/year.	20 hours/year.

It appears that there are both similarities and differences across the nursing programmes as noted in Table 6-1. For example, the aims of the BSN and bridging programmes are

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typically the same, whilst the duration of the internship in the bridging programme is different from the BSN and similar to Diploma nursing education. However, Table 6-1 demonstrates that the GCC still provides the outline curriculum for the three levels of nursing education, which means there are some Gulf countries that have still not implemented the degree education policy. Also, the results indicate some fragmentation in nursing education and practice in the GCC countries and this may relate to demographic and socio-economic factors (Section 1.2). For example, Kuwait does not implement the policy of degree nurse education as a minimum requirement for nurses to enter practice, whereas it is well established in other countries.

Together these results provide important insights into fragmentation of initial education as a minimum requirement for nursing practice and the value of the professional nurse in the Gulf countries. The following section, 'Making the Changes', will discuss the last theme of documentary analysis that includes the purpose of the GCC itself and all the outcomes of introducing degree nurse education in SA.

6.4 Making the Changes

Making the changes is the final thematic category identified from the documentary analysis. All the reviewed documents suggested that the GCC nursing technical committee were proposing, developing, and presenting a strategy to make changes within nursing education and practice, as a result of the changing health context (Section 3.2.2).

This thematic category 'Making the changes' comprised two sub-themes: the process of the GCC itself, and the outcomes of introducing degree education as illustrated in Figure 6-4.
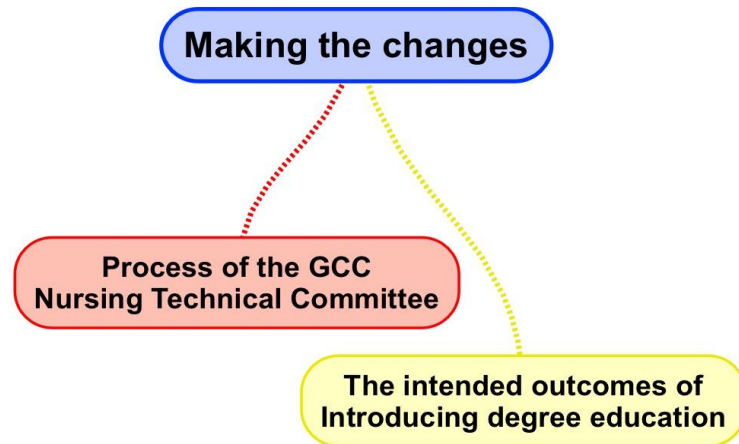
Figure 6-4: The third category in documentary analysis

6.4.1 Process of the GCC Nursing Technical Committee

The process of GCC working is itself worthy of discussion in relation to nursing workforce planning and degree education. For example, it could be argued that the GCC committee worked in comparative isolation, in that nursing, at all levels of strategy and practice in SA, nurses did not appear to have been involved in GCC working processes. The GCC technical members of nursing have grappled with issues, limitations and beliefs as they have considered the need for significant change in nursing education and practice in the Gulf countries (D7). The GCC Nursing Technical Committee reviewed the outline of the action plan for each country (D7). For example, an action plan was presented at the GCC meeting as a checklist (D7), which includes an action plan for nursing strategy for each country, as illustrated in Table 6-2.

Table 6-2: Action plan for nursing strategy, the GCC booklet 1993-2013, (2014).

As can be seen, Table 6-2 does not present the process or the measures to implement degree nurse education; it does not include a timetable to detail how or when actions should be taken. The Table does not indicate plans for piloting, or programme evaluation processes. For example, the action plan for 2006-2010 includes different objectives; one of them is highlighted in Table 6-2, as

"Take the necessary measures to implement the recommendation of the World Health Organization that required one level only (university degree/ bachelor's) as a minimum requirement for entry into practice". (P.68).

اتخاذ الإجراءات اللازمة لتنفيذ توصية منظمة الصحة العالمية التي تتطلب مستوى واحد فقط (شهادة جامعية / البكالوريوس) كحد أدنى دخول إلى واقع عملي

Therefore, the action plan on Table 6.2 is open to interpretation, and there is a clear lack of specific guidelines for implementation. The analysed documents do not show who should take action during the SA implementation process for Bachelor's degree nursing education. For example, there is no evidence in the documents that the MoH General Directorate of Nursing should form a working group and develop an action plan, first regionally, to pilot and then roll out the education programme. In addition, there is no consultation period suggested in document D7 to discuss the implementation of degree level nurse education within SA, within the macro, meso or micro levels of nursing, or

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with other interested stakeholders such as medical services, patients and others. The documents added the recommendations of the WHO as one objective of the nursing strategy in Gulf countries, but the details of how WHO (2009) would implement the policy were lacking or not included within the documents analysed.

Further to the process of change, and the lack of detail and clarity, it was identified that the committee members from SA only included two nursing leaders from the macro level. The nurses from the meso and micro levels (who would implement the degree nurse education policy) were not involved or informed about the details that were discussed in the meeting. In contrast, the other Gulf countries have two different members on the committee; one from the MoH, and the second from higher education at the macro level; so at least there was some consideration of education and training issues. The third point concerns the language of the documents analysed and their accessibility. For example, the documents were not available on the internet, or internal health service web sites. Had the documents been made available via the MoH website, nurses would have had the opportunity to look at and consider the new policy.

Furthermore, the documents were written in the Arabic language, whilst English is the standard professional language for health communication and publication in SA (El-Sanabary, 1993). As the documents are written in Arabic, expatriate nurse managers, who would know the content of degree nurse education, and who would have prior experience of it, would not be able to help or advise with the process of implementing degree nurse education. For example, in the large hospitals, the Directors of Nursing are British, or American, and they would have some experience of degree education, and would have views to offer in support of implementation and rolling out the policy within SA. As it is, they were not in a position to comment.

In summary, the processes within the GCC Nursing Technical Committee contributed to working in isolation, without the involvement of nurses from the meso and micro levels. Additionally, piloting and consultation periods were missing from the process of implementing degree level nurse education, as evident in the documents analysed. It is argued that such involvement of nurses at the macro, meso and micro levels of nursing in SA was crucial in order to successfully take forward the implementation process for degree nurse education, including preliminary piloting and evaluation, prior to the national introduction of such programmes of study.

6.4.2 The intended outcomes of degree education

Whilst the previous sub-category relates to the process of the implementation of degree nurse education in SA, this category identified the intended outcomes of degree nurse education. For example, the analysis outlined the outcomes of current issues of the Gulf health system that were mainly related to nursing shortages and patient outcomes. In this thematic category, the GCC committee wanted experienced nurses, national independent leaders, with knowledge and skills to achieve the Saudization plans and to decrease the dependence on foreign workers (Section 1.3). However, there are factors hindering this outcome, with issues such as changing health and disease patterns, changing expectations, shortage of nurses, and nurses with insufficient experience. In addition, there are increases in patient complaints noted by the GCC.

According to the GCC nursing technical committee in their discussion about nursing care and patient satisfaction (D5), the total number of patients' complaints increased with the current nurse shortage in SA, as regards independent working with different situations. They state that:

> *"The nursing care that is provided by nurses is not meeting the patients' needs due to the lack of professional nurses with experience"* (D5, p:10).

العناية التمريضية التي قدمت من قبل الممرضات لم تلبي حاجة المرضى بسبب نقص الممرضين ذوي الخبرة

Secondly, the necessary knowledge and skills base for nursing practice has changed and become more advanced with degree education level, but the curriculum of the nursing programme has remained the same (D6).

> *"The expansion of knowledge in the medical field requires a qualified nurse who is able to work independently and deal with different health situations"* D6.4

توسيع المعرفة في المجال الطبي تتطلب ممرض مؤهل قادر على العمل بشكل مستقل والتعامل الفوري مع الحالة الصحية المختلفة

Lastly, there has been slow progress in developing different job descriptions for nurses based on their educational level (D 6). This indicates that there is a lack of job description details for nurses from Bachelor's or Diploma levels and all nurses are implementing the same role. There is a need to improve and update the curriculum of nursing programmes to meet the current and future needs of service users. However, there remain two fundamental

problems: one being nurses with a diploma, and the other about the disparity among the curriculum and the variance in quality.

In summary, these sections have presented the findings from an analysis of GCC documents, detailing three key thematic categories that support the need to change nursing education, to address the gap between current nursing education, which has remained relatively static despite societal changes, and current health practice, which has also changed. The three themes illustrate that the GCC were aware of these issues, but how to change nursing in the real world was not explored, in terms of action planning, consultation periods with nurses and others, piloting and evaluation projects prior to the roll out of degree nurse education in SA. The three major themes identified from analysing the GCC documents are:

- The rationale for change includes the recognition of the challenges and changes in health and disease patterns that required advanced professional skills to meet service demand and patient needs.
- Nursing as an agent for change includes the GCC's recognition of the value of professional nurses and enhanced leadership skills necessary for national nursing leaders to work at a strategic level in order to raise the standards and subsequently the quality of care. Furthermore, the fragmentation in nursing education and practice is highlighted within this theme.
- Making the changes includes the process of degree implementation and an evaluation of the intended outcomes of degree education.

The overall results of the documentary analysis suggest that the GCC Nursing Technical Committee worked in isolation. To date, the GCC Nursing Technical Committee's documented meetings have not been published, and this means nurses do not have access to the proposed strategy or to the implementation process. Also, piloting and consultation periods were missing from the implementation process of the degree nurse education policy. These points are further discussed and critiqued in Section 6.5.

6.5 Discussion and Critique of Documentary Analysis

Having presented the three thematic categories, this section of the chapter will provide a discussion and critique of the categories, drawing upon the data from the GCC Nursing Technical Committee and information within the previous chapters, including the global literature. As stated at the outset of this chapter, the analysis of documents enabled me to gain in-depth information and a rich understanding of the policy process intended to support the implementation of nursing degree education. The key understanding to emerge from the analytical process relates to the lack of nursing and community involvement within such plans to introduce nurse degree education as a requirement SA. The critical implication from this lack of involvement is that potentially nurses at all levels in SA did not understand why there was a need to introduce degree level education, how it would be introduced, or what their role would be within the future nursing workforce.

The first of the three thematic categories from the documentary analysis, 'rationale for change', reflects a wider global debate regarding the structure and process of health services and the role of nurses within them (Section 2.4). Most of the global health system is facing many health challenges, including workforce development, ageing populations, nursing shortages, and the quality of healthcare (WHO, 2011; Ham, Baird, Gregory, Jabbal, & Alderwick, 2015; AACN, 2016). Nursing leaders have highlighted many of the issues raised by the GCC internationally through global forums such as the ICN and the WHO. The WHO Nursing and Midwifery progress report (2008-2012) highlights the changing nature of the global population with a rise in non-communicable diseases and the need for high quality care from nurses, which can be achieved through better education, leadership and autonomous roles (WHO, 2013). Similar views were echoed by more local groups such as the Royal Australian College of Nursing (RACN, 2004), The King's Fund (Ham et al., 2015) and the American Association of College of Nurses (AACN, 2016). It would appear that the GCC Nursing Technical Committee were very aware of the global health challenges in developed countries, and the need to adapt nursing education and develop the nursing workforce to respond to changing health needs. However, it would appear the rationale for change was not discussed anywhere outside the GCC Nursing Technical Committee.

Given the global context of nursing and related societal challenges identified by the GCC Nursing Technical Committee and others, it may be worthwhile for one institute such as the WHO to initiate and regulate initiatives to harmonise degree nurse education. The process would have a collaborative input from individual countries such as SA, overseeing its implementation at the local level to enable the provision of a regional, specific and appropriate programme.

The WHO World Health Assembly (WHA) already provides a similar mandate, which develops and strengthens strategies for nursing and midwifery (WHO, 2016); these include nursing and midwifery workforce capacity by providing support to Member States on setting targets, action plans and developing interdisciplinary health teams. It is suggested that such mandates could be further developed to encompass the standardisation of nurse education within countries so that eventually the education level and training of nurses will be comparable globally. This is particularly important for SA where a vast number of nurses are from overseas, owing to the social and cultural stigma associated with the nursing role (Gazzaz, 2009; AlMakhaita et al., 2014), and as a result the lack of uptake of the profession by locals.

Making degree education mandatory only in a selected country such as SA may affect the recruitment of vital staff, therefore affecting service level. The WHO aims to standardise nursing standards globally and have already highlighted themes, which act as foci to develop and deliver the mandates. Themes include: education and competency; management and leadership; and governance. To cover these areas, these could be developed further to cover the findings of the GCC. Whilst a the positive point of the WHO driving and overseeing such an initiative is that it has a global oversight and can therefore see the bigger picture (WHO, 2009), the worry is that, with such a large organisation with a general outlook, the actions and policies can be diluted, lacking focus and drive at the implementation level. Unlike the WHO, where policymakers consist of a wide range of healthcare professionals with different stakeholders, the International Council of Nursing (ICN) is a network of nurses and it is suggested that it may be better placed to oversee the implementation of the education programme for nurses globally (ICN, 2015). The ICN already has an Education Network dealing with policies devoted to the educational needs of nurses (ICN, 2015), however, this is recent and still under development. This would be an ideal opportunity to incorporate the issue of degree level

education as a global requirement for nursing (AACN, 2016), and would cover the Gulf region. The specialised nature of the organisation would mean that the issue is more likely to be dealt with. If the WHO and ICN worked together to develop this strategy, there would be a point of contact globally and locally for nurses to gain help and support, with the WHO driving and overseeing the global development and ICN taking responsibility for monitoring local progress through the local nursing network/representatives.

The pattern of health and disease presentation is changing (Section 1.2). There is an increase in non-communicable diseases such as diabetes and CHD due to urbanisation affecting the global population (Jadelhack, 2012; Mahmoud & Faramawi, 2015; WHO, 2016), all of which pose different types of nursing problems. As the trend in changing disease patterns is a global issue, this should make it easier to standardise education and training due to the common nature of the problem and allow a competent workforce to shift globally with ease (WHO, 2016). Better healthcare would surely result in a decline in non-communicable diseases, not only due to sedentary lifestyle and urbanisation, but also due to the ageing population (Fulton et al., 2014). Whilst an increase in longevity and an ageing population is a sign of good healthcare, it will become a major challenge for policymakers in the future (Almalki et al., 2011).

Saudi Arabia will need to consider whether the policies it develops meet the needs of this future population. In SA, acute coronary disease is one of the biggest killers in the adult population, accounting for 23% of the total deaths in SA (MoH, 2014). Training and resources to deal with such issues need to be addressed by the GCC nursing technical committee to equip nursing staff to appropriately respond at the primary, secondary and tertiary levels of care (Section 1.3). Preparedness will reduce financial and staff burdens. The cost to the MoH in treating patients with heart conditions is on average US $10,710, with an average stay in hospital ranging from eight days, if patients do not have co-morbidities, to 11 days if they have co-morbidities (Osman et al., 2011).

The rising rate of obesity is likely to add to this problem in the future (Mahmoud & Faramawi, 2015). The financial impact presented here further strengthens the rationale for change. Other trends that highlight the need for change include the high expat workforce and high turnover of nurses in SA (Almalki et al., 2011); the GCC needs to take this into account to increase local recruits and also improve staff retention, especially as the latter has been shown to be correlate with quality of care (Collier & Harrington, 2008;

Schwendimann, 2015). Furthermore, one study shows that primary healthcare staff in SA were more dissatisfied with their role and the work-life balance due to staff shortages (Almalki et al., 2011); therefore, this is an area that would need to be addressed in an agenda of change. Almalki et al. (2011), recommend a revision of nursing education in SA to bring it in-line with other developed countries in order to tackle some of these issues highlighted. In particular, the highly multinational workforce also affects the quality of care due to language and cultural barriers, and therefore an increase in a locally educated competent workforce is likely to increase standards (Almutairi & McCarthy, 2012).

Saudi Arabia is the largest country in the GCC (Lowe & Altrairi 2014), and plays a special role in the religion of Islam (Aldossary et al., 2008; Gazzaz, 2009; Lowe & Altrairi, 2014). SA houses the holy pilgrimage sites of Mecca and Medinah which see millions of visitors from around the world every year, particularly in the month of Ramadan and during Hajj (Alamri, 2010). This increases the risk of disasters and the need for medical care (Veenema et al., 2016). Hajj season sees an increase in the number of visitors to Mecca by millions and as a result has seen outbreaks of several types of diseases, fires, and stampedes, posing unique problems for nursing staff (Alamri, 2010). This type of local problem needs specialist training which must be incorporated into education programmes; therefore, staff with this specific knowledge are vital on any ICN or WHO education development committee. As the recruitment of foreign nursing staff in SA is high (AlYami & Watson, 2014), movement of staff within SA needs continuous improvement programmes that train nurses on local issues (Almalki et al., 2011). In addition to these unique issues, SA has seen many sandstorms, floods and earthquakes in recent years and studies show nurses in government hospitals are not prepared for such disasters or emergency management care (Jradi et al., 2013; Alamri, 2010). In light of this education needs to include better training on disaster management and emergency medicine as a way of responding to contemporary needs and providing better healthcare services (Veenema et al., 2016).

In relation to the second thematic category, 'nursing as an agent for change', it could be argued that the GCC Nursing Technical Committee endorsed nursing as an agent for change and advocated the professionalisation of nurses and enhanced nursing leadership skills. Regardless of what nation or region is analysed, policy and standards for professionals invariably exist to protect the public and maintain a high level of care and the

case of the nursing profession and healthcare in general, is no exception to this rule. Tanaka et al., (2014) proposed that nursing professionals needed two pillars to gain power and deliver a professional service, autonomy and self-regulation.

Autonomy and empowerment are key factors for nurses to deliver a high standard of care (Meerabeau et al., 2004), especially in SA, which is currently lagging behind compared with other areas such as North America. In light of this, there needs to be a drive to change the current nursing situation in SA. The GCC recommends a change in the education and training of nurses to deal with the evolving health needs of SA and the Gulf countries and this includes nursing professionalization and enhanced leadership. The role of degree education within nursing has been identified and recommended by the WHO, (2009) and ICN, (2015). One of the drivers for such change is the movement of care from the hospital to the community; this being a necessary transition to deal with the rise in the ageing population. Adapting the healthcare system requires well-qualified, skilled nurses who can take on leadership roles; a degree education being likely to equip Saudi nurses with these skills (Miller-Rosser et al., 2006). Conversely, it can be argued that delivering care in the community, especially to the elderly, requires compassion, understanding and experience; the backbone of nursing, rather than a degree education (RCN, 2013), and the drastic change in the educational system may not be necessary.

With regard to nursing professionalisation and nursing leadership in SA, it needs to be acknowledged that these norms are partially born out of domestic factors of culture, healthcare approach, and ethnicity that are SA and the approach that has developed therein. For example, whilst the GCC Nursing Technical Committee endorses nursing development, within nursing education and practice, the nursing profession is still seen by some individuals as a lowly career option due to poor work-life balance, poor pay, high workload and lack of autonomy (AlMakhaita et al., 2014). The nursing degree policy mainly affected females as they were the target group, and males were not offered equal opportunity for nursing degrees (Gazzaz, 2009). However, as part of the recognition of nurses as agents of change, master's degrees in nursing have recently been offered in a few universities for male nurses in order to widen the field (Almalki et al., 2011). There may be several reasons why there has been fewer uptakes by men. This could include issues related to gender perceptions of nursing, and the cultural practice of gender separation for education (Gazzaz, 2009; AlMakhaita et al., 2014). However, the equity of nursing

education between males and females remains problematic, and there are still no master's courses for men in many cities in SA, limiting the profession to a predominately female-only profession and reducing the potential for an increase in the local workforce and increasing gender-specific inequality and imbalance (Alamri, 2011).

The GCC Nursing Technical Committee lean towards professionalising nursing in Gulf countries in part, by making a degree a minimum requirement for entry into the nursing profession. In doing this, the belief is that it is more likely to empower graduates and raise the profile of the nursing profession within the country. Degree educated nurses' show an increased set of professional skills and development applicable to primary and tertiary health care settings, as well as a better level of care delivery (AACN, 2016; Aiken et al., 2014; Tanaka et al., 2014).

Making degree-level entry a minimum requirement can also pose risks to the nursing profession. For example, due to the expense associated with obtaining a degree, which is longer than a Diploma, there is the potential to exacerbate the current shortage of nurses in SA (Lamadah & Sayed, 2014; Almadani, 2015), where the majority are Diploma educated (AlMakhaita et al. 2014). Also, there are concerns from some Patient Associations that the policy may cause a shift from patient-centred care which involves compassion and dignity, vital to nursing, to a role that is concerned with personal achievement (The Patients Association, 2013). Graduates are more likely to exhibit problem-solving skills and take on leadership roles (AACN, 2016). Graduate nurses are more likely to be promoted over Diploma-educated nurses, and more likely to apply critical thinking and problem-solving skills in the patient healthcare pathway (AACN, 2016), which is vital in an environment with evolving health needs. Integral to professionalism, leadership and management, are considered by the GCC Nursing Technical Committee, as a vital part of effective nursing care. For this reason, nurses must be involved in the implementation of education and practice policy in order to improve patient care (Varjus et al., 2011).

At the three levels of organisation in the MoH, there is a lack of recognition of the importance of nursing leadership in driving future change. In contrast, before the UK made a nursing degree mandatory, it carried out an extensive consultation with all UK nursing bodies including the NMC, incorporating the feedback into their recommendations. Such consultation with frontline staff ensures that a programme that is fit for purpose is developed. The GCC proposals did not appear to involve frontline nursing staff with local

experience in the decision making process, which is a major issue as it undermines the value of professional nurses. Saudi nursing leaders who are confident on the global level would ensure that the Gulf region is able to learn from international experiences, share Gulf nursing expertise and be involved in planning, developing, implementing and coordinating solutions to global nursing challenges (Abualrub & Alghamdi, 2012; Alghamdi & Urden, 2016).

The GCC report does recognise the challenges facing SA nursing and how leadership from nurses could help with some of these challenges. However, whilst the report states that degree education and continuous improvement programmes will help alleviate some of the issues highlighted above, there is a lack of commitment to engage the community in health service delivery. This is an area where nursing and consumer leadership could have a positive impact in care delivery such as those seen in the UK with the Patient Association and 'INVOLVE' (Ham et al., 2015). Furthermore, the report does not cover how and who will fund these programmes, or how this will affect new nursing recruits. The GCC document recognises that nurses could be agents of change, but fails to address how or identify areas of investment to make this happen. Nursing leaders should be prepared for all levels of health administration and autonomy should be promoted among nurses to ensure that they have the freedom to work effectively (Donley, S.R. & Flaherty, 2008; Abualrub & Alghamdi, 2012; Alghamdi & Urden, 2016; Veenema et al., 2016). For example, frontline nursing staff would have first-hand knowledge of expectations of patients, any issues with service delivery, and enable a bottom-up process to increase the chance of developing relevant policies within the context of clinical practice. The document overlooks the fact that many of the recommendations mentioned with regard to challenges and leadership do not mention a timescale for implementation to improve these important issues. There should have been a clear strategy with timelines, as they all affect quality of care and patient safety, and are therefore important areas of discussion. Nursing leaders could help with effective implementation of strategies (Alghamdi & Urden, 2016 ; Veenema et al., 2016). There is little published literature on the role of nursing leaders in SA, suggesting empowerment of nurses is lagging behind other countries. One recent study by Bdeir et al. (2014) shows that a nurse-led heart clinic was extremely successful in demonstrating that nurses, as clinical leaders in the SA, could work just as well as in other global scenarios.

In relation to the second category, the fragmentation in the education of nurses in the GCC was clearly identified. SA offers both Degree and Diploma level education in nursing and the Saudi MoHE has a policy to deliver high quality education to international standards in nursing. This has been addressed by significantly increasing the funding of student nurses, scholarships and encouraging study abroad (Alamri, 2011; Al-Homayan et al., 2013). The political and social pressure to conform to standards of other developed nations in making degree education in nursing mandatory has driven the change in SA (Alamri 2011). The introduction of such is considered a step towards reducing the fragmentation in nursing education previously seen in SA. Al-Turki (2010) note that up until the latter half of the 20th century, no graduate or postgraduate experience was required in order to become a nurse. Although educational standards still existed, the fragmented nature of these standards created a situation by which individual states and regions, not to mention different universities and colleges/technical schools, all had different standards in North America and Europe (AACN, 2016).

Having different standards has caused great difficulty within the nursing community. In Europe, over the last 30 years, there has been a two-phase drive to reform nursing education (Spitzer & Perrenoud, 2007). Stage one was to unify nursing education, and stage two involved taking diplomas and on the job training into universities as part of the standardisation programme. However, due to lack of clarity within the policy, this caused great diversity in the levels of nursing education, duration of clinical practice, and the offering of higher qualifications (Spitzer & Perrenoud, 2007). As a result of fragmentation, Europe has many different levels of nursing qualifications, varying from country to country, with some still offering diplomas whilst others offer a myriad of Bachelor's, Master's and PhD programmes (Lahtinen et al., 2014). The level and extent to which growth and further understanding within the nursing profession could be exhibited was hampered because of multiple standards creating an uneven labour force (Lahtinen et al., 2014). The inequitable distribution within the labour force and the non-standardised programmes of education across Europe influenced the nursing profession, giving impetus for the drive to standardise nursing education and encourage other nations to follow suit (Aiken et al., 2014).

These findings are indicative of the value of professional nursing and leadership skills has been highlighted as significant indicators of the rapid socio-economic developments in the

Saudi context (Abualrub & Alghamdi, 2012; Alghamdi & Urden, 2016). Failure to make effective use of nursing leaders across three levels of the organisation will limit its potential. It seems therefore that the GCC nursing technical committee are exclusively focusing on developing nursing education and practice in the Gulf countries, targeting government organisations, human resources, nursing education, nursing care, and nursing research. Within the GCC there is a clear fragmentation in nursing education, with nurses being exposed to a variety of educational pathways. Only SA has implemented the policy to make a degree in nursing mandatory, closing all Diploma programmes as a quick response to the WHO (2009) recommendations. There is no indication that nurses were involved in the decision making process, which could effectively have an impact on care delivery. Having made the decision to implement the policy, it needs to be executed with the aid of the media to reach a wide target audience and ensure its success (Ventola, 2014).

The change from Diploma to degree level entry in nursing may see a shift in the public's perception of the profession due to the prestige and accolade that comes with a degree. If this is the case, it may allow the profession to gain more respect and recognition in a country where nursing is seen as a low status job (Section 3.2.2). If successfully managed, there is scope for the policy to shape the future of the country through changes in culture, education and social perceptions of nursing as a profession.

In relation to the third thematic category, 'making the changes', it could be argued that nurses are an important factor in the change process due to their power and professionalism in frontline healthcare delivery. As previously suggested, SA recently made the degree in nursing mandatory without consultation, piloting or sharing the decision making process with the three organisational levels, including community feedback. This is in contrast to Lewin's change theory (1951), which stresses the importance of giving attention to the right variables to ensure successful change (Kritsonis, 2005). The lack of attention to change management theory, such as Lewin's theory (1951), may influence how successful a policy is implemented, and subsequently those it affects; in this case the nursing workforce. The Saudi Arabian MOH and MOHE did not look at examples of practice for degree education in other countries, and yet evaluation and benchmarks exist. For example, the NMC (2010) was slow to recommend Bachelor education as a standard entry requirement in the UK. The Willis Commission Report found that despite the concerns of the NMC and patient groups mentioned earlier, degree

educated nurses have had a positive impact on the quality of care delivered, which is the primary goal of the nursing profession (Willis, 2012).

Steps towards the change in nursing education in SA, were evidenced by Almalki et al. (2011), who discussed the standardisation of policy surrounding nursing degree requirements when it was established in the West. Prior to this, nursing education was already being reformed following a haphazard start to the profession; the US federal Nurse Training Act of 1964 recommended the introduction of nursing baccalaureates, advanced practice and PhD programmes by injecting funds to mobilise the initiative. Following this, nursing education entered universities in the 1980s in the US (Scheckel, 2009).

The initiation of changing nursing education, was further discussed by Al-Mazrooa (2011) who showed that the development of standards and policy evidenced in North America, was a direct result of the private marketplace encouraging stakeholders to seek out common denominators and core standards that would lead to a more effective workforce and was specifically useful for the nursing sector. Therefore, the steps towards changes were more about the private sector being able to give a guarantee concerning minimum levels of care and standards, through an enhanced higher level of education and training. The changes in education taking place in SA is a process that has already happened in many developed countries, or is currently happening in other countries, and therefore the ad hoc changes taking place in SA are not unique, but typical of many other nations (Al-Mazrooa, 2011).

Finally, while these documents show in North America it was the private sector who determined the shift in nursing education, the lessons learned were translated to the Saudi context and other developing nations. Governments sought to gain rapid parity with developed nations by implementing these changes within only a few short years, in comparison to the countries of North America and the UK who had rolled out the changes over decades (Smith, 2010; Donley, S.R. & Flaherty, 2008). Following in the footsteps of the UK, USA and Canada, SA and other developing nations, chose to initiate rapid changes within their own countries using evidence from the countries they were following in order to be part of a global workforce and culture (Mebrouk, 2008). Although this might encourage one to believe that the Saudi model of nursing policy and educational standards focuses its core goal upon matching/copying the West, the MoH, as well as other

responsible entities, are uniquely interested in specifying and defining the approach, which SA will take to healthcare within the coming years.

As such, GCC stakeholders within the system seek to implement standards that will be beneficial to the issues and interpretation of healthcare provision that are currently deemed to be the most representative of future expectations within Gulf populations. In the steps towards making the change, the GCC recognises that there are differences between the West and the Gulf states. The synthesis between Western standards and a unique GCC model is ultimately, what is helping to construct policy that is exhibited throughout the entire healthcare sphere, specifically nursing education (Al-Ahmadi, 2014). Even though globalisation has a powerful impact with regard to improving cultural understanding and effecting standards in a way that might not be encouraged within another paradigm (Almutairi et al., 2015), the unique differentials that exist within cultures are not always something that should be minimised (Suliman et al., 2009). For instance, a specifically designed system of education can provide the GCC stakeholders with a unique inference with respect to Gulf healthcare issues. Within such an understanding, the GCC nursing committee is encouraged to realise that as standards and globalisation encourage unique policy shifts within institutions and government structures, the need and requirement to consider the dynamics of a particular region and the unique physical, emotional, spiritual, and cultural needs that a specific population might require are still relevant (Suliman et al., 2009).

The GCC healthcare provision is state-funded and requires little if any monetary contributions from individuals. The overall involvement that the government has in designing policies and requirements that help to define the nursing profession within Gulf countries is profound. Whereas this level of control has allowed for the development of the MoH and other aspects of the GCC in a beneficial way, the net drawback that it exhibits is that it constricts the overall number of individuals that are willing to pursue an education and obtain degrees within the nursing profession (Miller-Rosser et al., 2006). Ultimately, the rapid and sustained changes with respect to the qualifications and requirements have been illustrated within documentary analysis and have been discussed in this chapter. It is argued that as career options have extended over the past few years, individuals are no longer as interested in pursuing nursing as a career path as they might have been previously. What this has created is a situation in which government control has actually

reduced the overall incentive for individuals to engage in nursing and pursue a career within the healthcare industry. This is especially troubling; particularly as the nursing profession needs to expand significantly over the next few decades. As the current population continues to age, analysts expect that the overall number of elderly people within society, and thus individuals most likely to use the healthcare system, will increase greatly (Al-Ahmadi, 2014).

When applying these changes, policymakers within the government should be mindful of the fact that remuneration for the nursing profession should match the increase in standards and policies that are being implemented. SA would need to encourage people to continue to consider nursing as a viable career path (Gazzaz, 2009). Further, government involvement in the policy to develop standards should reflect the market and improve upon the degree (Aboul-Enein, 2002). This is not to say that the Saudi model of economics or healthcare provision is in any way government controlled. It merely denotes the fact that as the market continues to grow and expand, the policymaking structures and standards need to grow commensurately. Change always takes time and effort, which requires a theoretical frame or well-studied plan for its implementation and evaluation. According to Lowe and Altrairi, (2014: P.254),

> *"Nursing in the GCC is undergoing the growing pains Western countries experienced in the past. The focus on the changing image of nursing, university education, technology, and increased participation in the business world has all contributed to nurses remaining in-country to develop the profession."*

The point is not just to change practice, but rather to take heed of past experiences of others and to initiate examples of good practice such as consultation processes. If the vision of degree education in the Gulf countries is not a shared collaborative process involving all stakeholders, no change will occur, and the status quo may continue. In light of this, another approach is now needed to improve the planning and development of the future nursing workforce. One weakness of the GCC report is that it does not discuss any piloting projects, but focuses on the implementation and impact of such a programme in SA. The West and SA have very different demographics and culture, which could potentially affect the success of the policy. For example, SA does not have professional nursing bodies such as those in the UK or US. In these countries, policy development is supported by such bodies and they are able to steer issues raised towards a more

favourable outcome for nurses. The lack of professional bodies could hinder the effort to reach the 'gold standard' in nursing in SA (Abualrub & Alghamdi, 2012; Alghamdi & Urden, 2016). In addition, whilst many of the countries adopting the mandatory degree programme operate on evidence-based practice (EBP), SA appears to lag behind in the use of EBP in policy development, which could be a hindrance in trying to develop a healthcare system similar to that of the UK, USA and Canada.

The key points from the discussion of documentary analysis are:

- The GCC supports the nursing profession and recognises the need for change; that said, the documents analysed did not provide details about change strategy and implementation programmes. Without those details, the policy for degree education in nursing has been endorsed in a top-down manner, using the formal communication channels between national managers, regional directors, local nursing managers and nursing staff.

- The need to reform nursing education as the world entered the 21st century drove the global impetus to reassess old policies and standardise education, address the diversity of nursing roles and accommodate the global migration of nurses from one country to another (Almutairi et al., 2015). Furthermore, other health-related fields were already one-step ahead in offering and making degrees' mandatory for practice, for example; physiotherapy, pharmacy and social care, demonstrating that the nursing field was slow in transforming policies, which could compromise the quality of patient care (McHugh & Lake, 2010).

- Transforming care from a focus on hospitals to a focus on the community is a global priority (Al-Mazrooa, 2011). Many countries recognise the need to develop and expand productivity at the same time as reducing healthcare costs (Aiken et al. 2014). Transferring care from hospitals to the community has created tensions within the MoH due to nursing shortages and an ageing workforce that is set to retire over the coming years, especially during the transition phase (Lamadah & Sayed, 2014). The GCC documents present an argument at the national level to invest in the workforce (D7), however, the reality is very different. If the MoH are

to meet the rising challenges and demands of an ageing population with complex health and social care needs, there needs to be investment in nursing education and practice. This would strengthen the workforce, especially as there are not enough newly qualified nurses to replace the experienced nurses, who will retire in the coming years (Kattuah, 2013).

- Gulf countries and other nations, seek to standardise educational expectations and requirements, as a means of creating a broader and more differentiated workforce that is able to integrate the needs of a dynamic and shifting labour market/economy (Lowe & Altrairi, 2014). Although this dynamic has proven to be untrue in many different organisations and labour markets, the level of national standardisation that exists within healthcare systems throughout the globe is more developed than many other sectors (WHO, 2009; RCN, 2013). The underlying reason for this has to do with the ongoing research and best practices that developed nations have put forward. As a means of implementing the policy and standards, it is a necessity for the educational system to set similar and universal standards for degree implementation. While standards relating to other sectors of education are important, the GCC highlights the importance of building a body of knowledge. Such evidence will provide for the diverse and global workforce of tomorrow, which will create an inherent demand for nursing students to meet basic proficiency levels that are exhibited elsewhere throughout the globe (WHO, 2009; RCN, 2013; AACN, 2016).

- The future process of changing the current healthcare system in SA needs to follow Lewin's (1951) change theory, which stresses that change must happen with attention given to the right variables to conceptualise and observe the current change (Kritsonis, 2005). In this case, the major variable would be the change from Diploma to degree as a minimum requirement for entry into nursing. Monitoring this variable would need input from nurses, as they are the frontline staff with first-hand experience and the main service providers. The change theory model proposes unfreezing-changing-refreezing as a three-part process in changing human systems (Weick & Quinn, 1999). The first step in Lewin's (1951) process of the change model is to unfreeze the existing situation. Unfreezing involves the

removal of forces that resist change – usually initiated by dissatisfaction – to allow step two of the model to take place (Weick & Quinn, 1999). In this case, the dissatisfaction would be the level of care and the inability to meet the requirements of the current and future nursing demands in SA due to changes in the demographics and evolving health needs of the population. The second step in the process of change is movement of the target system to a new level of equilibrium (Kritsonis, 2005). This step required three actions to assist the movement, namely, encouraging employees to agree that the status quo is not beneficial to them and persuading them to view the problem from a fresh perspective; working together on a mission for change; and connecting the views of the group to well-respected, powerful leaders that also support the change (Kritsonis, 2005). The third step of the change model is refreezing. This step needs to take place after the change has been implemented and sustained over time. It is the integration of the new policy into the community values and traditions as suggested by Kritsonis (2005). This step aims to stabilise the new equilibrium resulting from the change by balancing the force of driving and restraining. The GCC showed weakness by not following Lewin's change theory model, as the process of change was not clearly identified or planned appropriately.

- Finally, the mandatory requirement for nursing being an all degree profession is recent in the GCC countries, with long-term evaluation still ongoing. Therefore, pilot studies in SA would have been ideal to give a flavour of the likely success and impact of the policy. Pilot studies are small trials of an 'intervention' which can help identify strengths and weaknesses, providing an opportunity for the latter to be eliminated when the programme is rolled out (Leon et al., 2012). Pilot studies are an essential step in implementing policies, interventions or innovative approaches, and their lack can increase the chance of failure (Leon et al., 2012).

6.6 Summary and Conclusion

This chapter analysed the GCC implementation process on the changes in nursing degree education policy in SA and how this might impact on service users and the community. Having critically analysed the GCC policy for the implementation of changes in nursing education, the above sections reveal that the GCC implementation process appropriately

identified the need for change, the issues affecting the current and future needs of the SA healthcare system and also the desire to raise the quality of care standards. However, within the GCC implementation process, the analysis of the relevant documents has indicated that there was a clear lack of involvement from Saudi nurses in the process and it appeared to be a top-down decision-making process. This is a clear failure of what should have been a more collaborative process, and could impact on the successful implementation of the policy to introduce the minimum degree requirement for entry into nursing practice. Furthermore, there was a clear lack of a planning and implementation strategy and/or pilot studies, as it was a rushed process in order to make immediate changes based on other nations' experience. The drive to make changes was based on what was happening in the UK, the US and Canada, which have significantly different healthcare demands, demographics and needs. A direct application of another country's policy may not work in SA due to the high number of foreign nurses from different countries, where a nursing degree may not be an option or mandatory, therefore affecting recruitment further. There were, in part, efforts to tackle issues with the shortage of local staff with increased funding, scholarships and support, but no details as to actual figures were given on how many scholarships would be available, for whom and how much funding was being allocated. The GCC did not discuss what would be done locally to raise the profile of nurses socially; currently nursing is seen as a 'low-level' career option, explaining the shortage of local nurses. The GCC does mention that the introduction of the nursing degree should help raise the profile of nursing due to the higher educational award and the subsequent professionalisation of the role. In conclusion, the results of this discussion indicate that there was significant effort by the GCC nursing technical committee to improve the nursing workforce in Gulf countries. The outcomes of degree education, and the consequences for practice and patient experience, are not clearly explained in the GCC documents. These were difficult to identify when undertaking the documentary analysis, and hence it became a significant sub-theme, which will be explored in more detail within the analysis of participant discussion in chapter 7.

The following chapter will present the findings of the interviews from the participants in this case study with relevant discussion of these results.

Chapter 7 : Participant Perception and Experiences: Findings and Discussion

7.1 Introduction

Chapter 6 offered the results of the documentary analysis together with an integrated critique and discussion within each of the three themes. This chapter presents and discusses the results of the data that reveal the participants' perceptions and experiences relating to the following research objectives:

- Determine the views of key nursing and administrative stakeholders at the strategic/macro level of nursing policy and practice, regarding the influence of degree entry requirements on nursing workforce planning.

- Critically appraise the experiences of a sample of practising nurses at the middle management/meso levels of nursing practice, and those at the frontline/micro levels of nursing practice, regarding degree education as a minimum requirement for entry to the nursing profession.

Analysis was undertaken within the macro, meso and micro levels of the nursing within the organisation of organisation, and results across all three levels are presented in this case study. The macro level was comprised of one-to-one interviews with four decision makers (Section 5.3). The meso level comprised one focus group, including six regional nursing directors (Section 5.4), and the micro level involved three focus groups: group one included seven nursing managers and educators, group two involved four nurses with BSN education, and the third group comprised four nurses with Diploma level education (Section 5.5). This is further explained in section 5.6.1.

In this chapter, the themes identified within each of the three levels are presented, followed by a synthesis of the results to provide a cross-level analysis. The thematic findings reveal the perceptions and experiences of all those in the groups as a whole (Baxter & Jack 2008). The recorded interview and focus group data were analysed using a content analysis framework (Zhang & Wildemuth 2009), as described further in Section 4.7.

- The analysis of data was assisted by the use of NVivo, qualitative analysis software, which provided an organised workspace for the categorisation and tracking of the coded content (Hilal & Alabri 2013). The process involved the classification, sorting and arrangement of the data in order to examine relationships in the data, both within levels and across levels, through analysis of the three participant levels.

The participants offered a unique insight into the problems and difficulties experienced in Saudi nursing practice with regard to the nursing workforce and its planning. A cognitive/mind map was utilised to summarise the result of themes and their relationships across all three levels. The themes were visually organised using a mind map diagram of the data analysis (Elo & Kyngäs 2008).

7.2 Macro level

The macro-level analysis consisted of face-to-face, one-to-one interviews with four administrators functioning at the macro level. The arrangements for these interviews and coding have been previously described in detail in section 5.3. The main goal of interviewing the key stakeholders at the macro level was to determine their views regarding the influence of degree entry requirements on nursing workforce planning. Using a content analysis framework (Section 4.7) resulted in the generation of three main thematic categories:

- Theme 1: 'A Good Decision'
- Theme 2: 'Use of bridging programmes 'I don't see that there is any obstacle…'
- Theme 3: 'Education and experience are important in giving quality care'

Common sub-themes relating to each category were also generated from the data. All these interrelated thematic categories are illustrated in Figure 7-1.
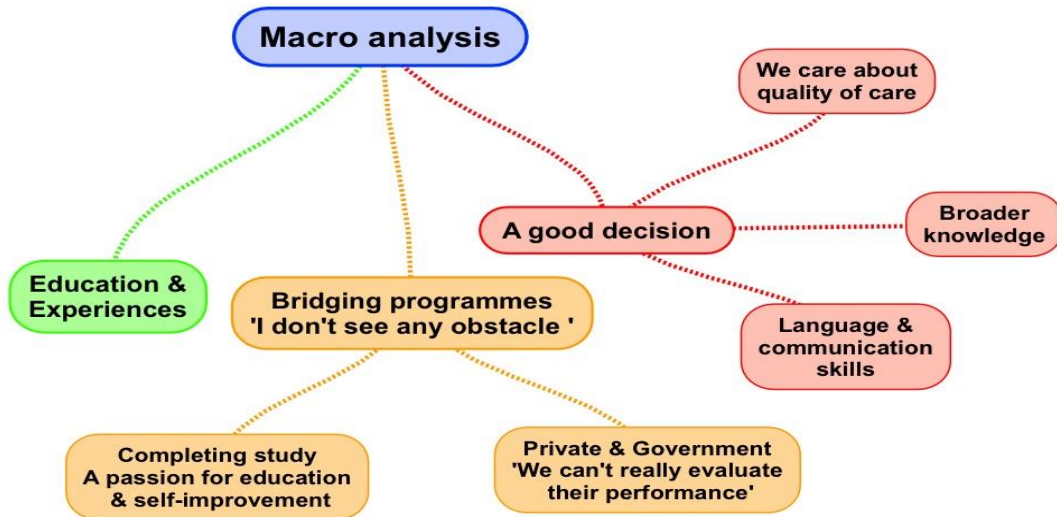
Figure 7-1: The thematic categories and subcategories for the macro level

7.2.1 'A Good Decision'

This is a significant theme identified from the interviews with participants functioning at the macro level. Participants shared their perceptions of introducing degree education as a minimum entry requirement to nursing. This theme generated three important subthemes, as illustrated in Figure 7-2.
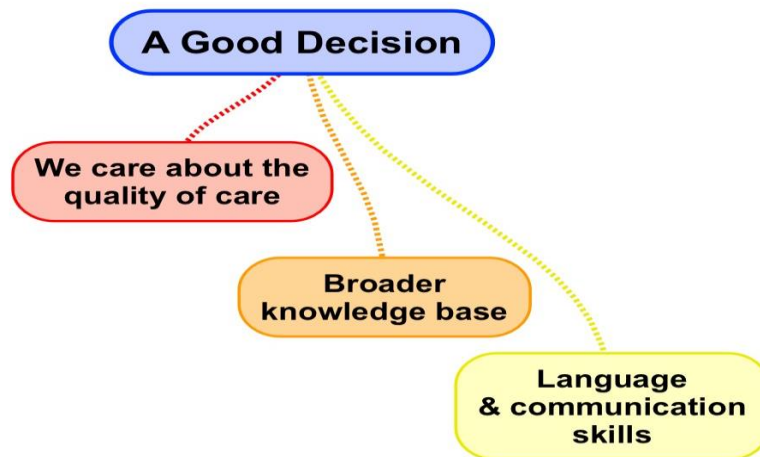
Figure 7-2: The first theme in the macro level analysis

All four of the macro-level interviewees expressed agreement with the requirement for Bachelor degree education for entry-level nursing practice. One of the Directors (GD2)

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participating in the interviews discussed the requirement as it being a "good decision" in terms of preparing well-qualified nurses:

> *"The knowledge and language [of a Diploma graduate] is not as the Bachelor's. The Bachelor's has more knowledge rather than the Diploma. ... I think this is a good decision to prepare well-qualified staff nurses".*

Similarly, another Director (GD1) described the degree requirement as a means of improving the quality of patient care and supporting the nursing profession by providing advanced education through bridging programmes, enabling nurses with a Diploma education to convert their award to degree level:

> *"A Bachelor's degree is not a precondition to enter the service, as the nursing service already exists in the form of technicians and specialists, but following MOH's evaluation of the training level throughout the Kingdom, in accordance with the instructions and regulations issued by WHO to improve health institution programmes, it was proposed that the minimum should be the Bachelor's degree, which was adopted during Dr. Alrabeeah's time as Minister of Health (1431-1432/2010); recruitment in the technician category was then stopped, where Bachelor's degree was then adopted for the specialist category. The objective thereof is to promote a nursing profession which the health sector relies on throughout the hospitals and primary health centres, representing more than 50% of the total health services within the MoH ...".*

Director (GD4) also expressed similar views, suggesting that Bachelor degree education was best for those starting a nursing career and especially when lacking practice experience. This director also felt that it was an educational requirement for specialised nurses, describing the effect on quality of care related to communication, knowledge, and language skills necessary to provide high quality nursing and fewer medical errors. The director stated;

> *"Bachelor's level is the best for nurses to start work either in a hospital or at community level or anywhere in the hospitals or community. We found by evidence that a Bachelor's degree should be the minimum requirement. If they have a BSN*

degree, they have fewer medical errors, fewer nursing errors and as we know, our hospitals and the medical services in Saudi Arabia are getting better and better. And we have new technologies coming for which we need nurses well-equipped with knowledge and skills....".

The Director (GD3) also strongly supported degree education for nurses and for other health care professionals:

"I strongly agree to go with the bachelor's degree for an entry level to practice either for nurses or any healthcare professional. There is enough experience, practice, knowledge, enough time for training".

In light of the requirement for Bachelor degree education as a minimum entry requirement for nursing practice, interviewees functioning at the Macro level noted that the decision to close Diploma level nursing education was influenced by the GCC Nursing Technical Committee and WHO recommendations. One participant suggested:

"Okay, the level of entry as Bachelor's degree, it was agreed by the GCC countries, it is the recommendation of the WHO, which we take into consideration. Yes, it was the nursing leaders who took the decision in the GCC countries and it was agreed by all ministries of health in GCC countries. To close all Diploma nursing schools is different in every GCC country because each country has their own situation and they have different numbers of nationals going from country to country. For Saudi Arabia we decided to close the Diploma level because we have many governmental universities started with the nursing school, we have 28 governmental universities. So we have a good space to occupy nurses. This is only governmental and if you go to private now we have more than 42 and some more are going to start around the kingdom. So when we close the Diploma this will not affect how many nurses will graduate. We just made it better from Diploma level to bachelor's level" (GD4).

Analysis of the interviews conducted with those functioning at the macro level identified sub-category themes highlighting the benefit of degree education as a minimum

requirement for nurses to enter professional practice, believing this was "a good decision". The directors agreed that it would lead to improved care, a broader knowledge base for practising nurses, and enhanced language and communication skills – all vital components of quality nursing practice.

7.2.1.1   'We Care about the Quality of Care'

The first sub-theme within the theme 'A Good Decision' was 'we care about the quality of care'. The Director (GD4) expressed the view that quality of care was necessary and that the Diploma nurse was not adequately educated to provide the level of care that would meet public expectation at the required standards. For example,

> *"We have new technologies coming that require nurses well-equipped with knowledge and skills, so with the Diploma level it is difficult to meet this. The community also needs well-experienced nurses. People now are changing with all these technologies around us. People can easily search for their disease; what kind of care you are giving them and what care they need. Patients are very smart now and the nurse needs to be smarter. And more skill is needed to give the right care to the patients. We care about the quality of care".*

The primary benefit related to degree education as a minimum entry requirement for nursing noted by the macro-level participants was the improved quality of nursing practice, through offering improved nursing skills and ultimately, quality of nursing care. The Director (GD2) stated that:

> *"The first benefit is improved quality of care, and improved staff skills. This will create a good chance to form staff, that can lead the nurse and build a good background where the nursing management, or nursing administrator, depends on these staff to lead the development process, as they have a basic and good clinical background that can help them improve the quality of care and the quality of the environment in the hospital".*

Director (GD4) concluded that the benefits of a Bachelor education in nursing would sustain better patient outcomes, stating:

> *"we are going to have a better outcome, better care. People feel satisfied when they have the necessary care".*

All four directors agreed that the Bachelor degree is a good base for improving the quality of care within the practice environment. This was evident in the next sub-theme, a 'broader knowledge base'.

7.2.1.2 'Broader Knowledge Base'

One of the ways to achieve quality nursing care described in the previous section is through obtaining a broader knowledge base, with participants functioning at the macro level describing Bachelor degree nurses as being able to demonstrate a broader knowledge base due to more intensive study:

> *"The knowledge and language [among Diploma nurses] is not as the Bachelor's nurses. The subjects being studied are more in the Bachelor's rather than the Diploma, as the Bachelor's has a broader knowledge base than the Diploma"* (GD2).

Another interviewer explained that Bachelor degree nursing education programmes included a wider knowledge base than Diploma nursing education programmes, for example:

> *"In our educational system we have a problem with the curriculum design. The Diploma graduates from two and ½ years know nothing, not even the basics. If we go with the Bachelor 's degree, we can add more to their curriculum about research, ethics, practice. If it is a Diploma graduate of two years, there is not enough time to teach them the basics and go to the advanced level"* (GD3).

The above quotes suggest two of the decision makers at the macro level (GD2 & GD3) recognised knowledge as being an important factor in deciding to introduce Bachelordegree nursing education rather than continuing with nursing education at Diploma level. As highlighted in the above quote (GD3), Diploma programmes are of two years' duration, compared to five years for Bachelor's degree. Perhaps more importantly, the directors were able to articulate an important aspect of providing quality nursing care –

that of language and communication skills – which was identified as a third sub-category within this theme.

7.2.1.3   'Language and communication skills'

Another way to ensure the quality of nursing practice is to enable nurses to develop enhanced language and communication skills. Participants at the macro level specified the benefits of degree nurse education in relation to the ability to speak and write in English, and to be familiar with the language of healthcare practice in SA, both of which would contribute to enhanced communication skills in practice. The directors believed educating nurses to degree level would facilitate better communication with patients and doctors alike. As well as the ability to communicate with other care providers (doctors and technicians), the directors believed Bachelor degree nursing education contributed to the nurses' confidence and professional esteem. One participant stated:

> *"Our Diploma [nurses] have fewer years of studying their language, not up to the extent allowing them to read and search for references. They are not at the level to communicate with the doctors. And they do not have the full confidence in language and communication skills" (GD4).*

In summary, there appeared to be consensus from the participants functioning at the macro level that the themes and the sub-themes identified above, enhanced quality of care, nursing knowledge, and language and communication, were the cornerstones of good nursing practice. These elements of nursing were identified as valuable reasons for degree education as a minimum entry requirement for nursing practice. There was also a view that Diploma-educated nurses were no longer adequately prepared to provide the necessary quality of care or to meet the public's expectations regarding standards of nursing care.

7.2.2   Bridging programmes, 'I don't see any obstacle…'

Using the bridging programme as a national strategy to enable nurses with Diploma level education to access Bachelor degree nursing education, opportunities, was the second theme that emerged when the data from participants working at the macro level was analysed. This theme comprised two sub-themes as illustrated in Figure 7-3.

Figure 7-3: The second theme in Macro level analysis

Given that the majority of nurses in SA are Diploma graduates, participants functioning at the macro level believed the introduction of bridging programmes would be the best way to meet the requirements of the new political agenda for nurses. They believed the introduction of a bridging programme would help to support the continued education of Diploma nurses to Bachelor degree level and beyond:

> *"In MoH, we started from three years ago a national programme known as IFAD [local scholarship], which allows the nurses to take a bridging course in governmental college to upgrade them to bachelor's degree level"* (GD3).

The Director (GD4) offered a thorough understanding of the national programme for bridging these nurses to Bachelor's level:

> *"Right now we have a national programme. We have 13 nursing bridging programmes for males and 17 for females. So we have quite a good number of bridging programmes. We have a plan to send our staff to get their BSN degree. It is going quite well. But we need quite a lot of time to cover all those ...we have quite a number of Diploma nurses, we are not in a hurry. This is happening through the world. We are on the right track. Inshallah, hopefully we can finalise all those"* (GD4).

The standardisation of education was also noted as being critical to supporting GCC standardisation and the ability to recruit nurses from GCC countries. One Director stated

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the following:

> *"It is really good. It is the big step we are taking forward. Because all people in Arab countries will just move freely. It is good for the citizens. You finish the same programme and curriculum. When you move from one country to another people are familiar with what you study and you will not face many problems. You will not face problems like your certificate not being valid. So this is the main idea to allow the people in Gulf countries move freely and that will make their life easier"* (GD4).

The statement above was supported by another participant, adding that there are no obstacles for diploma nurses in accessing the bridging programme and nurses also have opportunities to continue with postgraduate programmes, including Master's and Doctoral level education:

> *"I don't see that there is any obstacle, as the Ministry efforts are currently directed towards the bridging programme, with the evidence that increasing numbers have been sent to universities within the Kingdom and abroad with the ability to continue in postgraduate programmes such as Master's & PhD"* (GD1).

There appears to be consensus regarding degree education being a good decision for nursing in SA, and there is agreement that plans to convert Diploma nurses to degree level are in place. These opportunities for advanced education will help to support raising the quality of nursing practice throughout SA and Gulf countries. Moreover, most of the macro participants (GD3, GD4, & GD1) agree that there are no obstacles or difficulties facing Diploma nurses wishing to convert their education to bachelor degree level. However, the macro level participants did note educational differences in programmes of study based on whether these programmes were within private educational institutions or governmental institutions. This division is explored further in the following sub-themes.

7.2.2.1   Private and Government Conflict? 'We can't really evaluate their performance'

The macro level interviewees recognised the differences in nursing programmes/outcomes between the governmental and private colleges/universities. For example, within SA,

nursing education is offered in private and public organisations (Section 2.2). Part of the problem with the private institutions is that they are too new to evaluate. Despite similar standards, every institution uses a unique curriculum. One Director explained:

"For the private colleges because they are still new, we can't really evaluate their performance. For the governmental colleges we have three old colleges, their graduates are really good graduates, good outcomes. For the rest of the colleges they are still new, they just started. Of course they do not have the same curriculum but of the same standard. Like certain hours for the theory and for the practical but then every college is different as anywhere in the world. The basics are the same, this is what we care about" (GD4).

This participant perceives old (traditional) colleges to be good and yet realises that new developments in healthcare lead to changes in education. This point will be discussed further in Section 7.6. All the institutions have to meet the standards set by the MoHE. Although these are difficult to assess, they were described by participants as having differences in the curriculum, such as elective level coursework. However, one Director (GD3) noted there is a perceived lack of experience and skills among nurses who graduated from the private institutions in Saudi Arabia:

"I cannot compare but what I know is that the accredited body in private or government institutions is the Ministry of Education. What I know is that the curriculum should be the same, and if there is a difference, it is in the elective courses. That's all. ... but what I faced in my experience in their hospitals, we have a lack of experience and skills of nurses who graduated from the private institutions here in Saudi Arabia" (GD3).

When asked why these perceived educational differences between private and government institutions may exist, one Director suggested:

"The students who graduate from private colleges mainly they did not get the chance to study in the government university because they have low grades, especially in their secondary school. First it is in the level of education; second

money because the private colleges are looking for the money not students; third, the locations of the clinical because the private college does not have access to good teaching hospitals for their students and mainly they practice in a low standard private hospital which has a contract with them to train their students" (GD2).

In summary, macro level interviewees agree that there are differences between private and government-nursing colleges/universities, including curriculum design, level of teaching, and clinical areas for gaining practical experience. In light of this, the macro level interviewees recognised the need to standardise nursing education for all nursing in SA. This standardisation would have a number of important implications in terms of nursing workforce planning, and differences in education and experience. The following sub-theme discusses the factors affecting completion of study for nurses.

7.2.2.2   Completing study: a 'passion for education and self-improvement'

The macro-level participants described two primary factors contributing to or hindering completion of study. One factor was the nurses' passion for education and self-improvement, which served to support continued educational progress and degree completion:

> *"My passion for education and self-improvement guided me to complete the study. I believe that to improve myself I need to improve my knowledge. It is good to lead the development of the career in my country and I think by getting a high education we can improve our plan for nursing, nursing is a first line, and we can improve the care to our patients. By widening my knowledge, it is not just helping me, it is helping the other nurses because I am working as a decision maker in MoH"* (GD1).

The second factor was an inhibitory factor, financial obstacles, which limited nurses' abilities to fulfil educational goals and needs. One participant discussed bureaucracy in scholarship and difficulties obtaining funding for educational advancement. In addition, difficult admission criteria can be limiting for nurses who desire to complete their studies. Lastly, this participant also noted that acceptance was difficult for nurses who graduate

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from private colleges, as the government universities favour government university graduates:

> *"Yes in the beginning I found it was difficult applying for scholarship. It was not easy. It takes a long time. You know bureaucracy in scholarship. I always depend on others' opinions if they allow me or not. It does not depend on you unless you want to pay for yourself the fees of the scholarship. So I think these days are better than before. The scholarship process needs to improve to arrive at the point we want it to be at, and I think ten years ago it was not possible to take a Bachelor's degree for men in Saudi Arabia and these days there is a chance. There is a high number of people who want to complete their studies and they face difficult criteria for acceptance in universities, and these are the obstacles... for the people who graduated from private universities who are not the priority to be accepted to complete their studies in governmental institutions, all the governmental universities target those who graduated from governmental universities and colleges"* (GD2).

In summary, the above indicates that it seems some informal agreement that plans to convert Diploma nurses to degree is in hand, but it is a slow process and will take time to implement effectively. Also there appear to be educational differences in programmes of study, based on whether these programmes were delivered within private educational institutions or governmental institutions, and these differences were noted by the macro level participants. However, three of the macro participants (GD3, GD4, & GD1) agreed that there were no obstacles to converting Diploma educated nurses to bachelor degree educated nurses. One director (GD2) stated that certain obstacles did exist for a number of nurses who wished to complete their studies; such as difficult criteria for university admission. The following sub-category identified the importance of both experience and education within nursing practice.

7.2.3   'Education and experience are important in giving quality care'

This was the final theme within the analysis of views from participants at the macro, or strategic level of nursing organisation and delivery within SA. Specific to providing

quality nursing care, participants also discussed the importance of both education and experience. Although the requirement for Bachelor degree nursing education was supported, as illustrated within the previous themes, the participants did not minimise the importance of experience and the ideal combination of both experience and education in the provision of quality nursing care. However, it was noted that without education, experience could still lead to continued levels of quality care, but without career advancement. The nurse would simply provide care based on what had worked in the past, as opposed to understanding why decisions were made and/or improving care decisions based on evidence and informed problem solving. One participant highlighted the importance of both education and experience to ensure quality practice:

> *"It makes a difference if a person has a degree with experience rather than a degree only without experience. If you have a degree and education that means you know the rationale of the things you do; but if it is only experience you do things because you see other people doing it or you did it before and it worked; you just carry on and do it. But if you have the education you know why you do it and can even do it better. Education and experience are both important in giving quality care"* (GD4).

Although noting the ability of experienced degree nurses to provide a high level of quality care, this participant also recognised the limitations of a recent graduate lacking experience, and in the case of Diploma nurses, lacking appropriate education as well:

> *"Diploma nurses with accumulated experience of 10 to 15 years know how to deal with cases more than the doctor. But these days it is difficult to recruit Diploma nurses; if we employ them or recruit them we need at least a minimum of 6 months of theoretical foundation to build their knowledge and clinical skills to keep in touch with the patient"* (GD2).

7.2.4   Conclusions from Macro-level data analysis

The following conclusions are derived from the common themes revealed from the macro-level participants:

- Benefits of nurses having Bachelor degrees included improved quality of nursing and better patient outcomes, which may be supported by the other noted benefits of nurses having a broader knowledge base and enhanced language and communication skills. The macro-level participants described and generally agreed with the need for the BSN, believing this to be a good decision.

- Noting the use of bridging programmes to support Diploma level nurses to acquire Bachelor degree status, whilst recognising the differences between private and government colleges/universities and the quality of education in the private versus government institutions also saw agreement in the need for national standards for the nursing curriculum.
- Both education and experiences are seen as important factors in increasing the level of quality care, but without the latter alone leading to career advancement.

Despite the noted importance of education (having a Bachelor degree), participant responses contributed to an understanding of factors that affect completion of study. These were commonly noted to be (a) passion/self-improvement (supporting educational attainment) and (b) financial obstacles (limiting factor) comprising the second theme (Theme 2). The final theme (Theme 3) developed from the data was related to the importance of both education and experience in providing quality nursing care.

7.3 Meso level

The meso-level content analysis consisted of a single focus group interview with six meso-level regional nursing directors, each of whom had different levels of qualifications and experiences. The detailed organisation of these interviews has been explained in Section 5.4. These meso-level participants offered their personal insight into the problems and difficulties experienced in Saudi nursing practice in different regions. General themes identified from focus group data at the Meso level were quite similar to those identified from the micro-level data, which will be explored in Section 7.4.

- Theme 1: 'Nursing should be BSN'
- Theme 2: Quality of care and educational levels
- Theme 3: Both [experience & education are important]

The themes and sub-themes identified from analysis of the meso level data are illustrated in Figure 7-4.
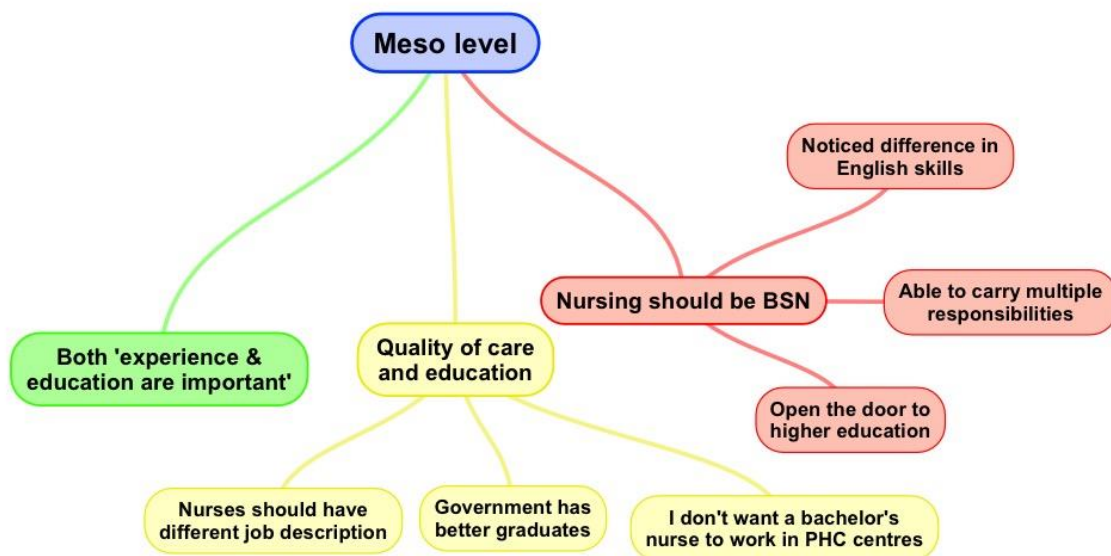

Figure 7-4: The three themes and subthemes within analysis of meso level data

Each of these themes are discussed individually with textual examples from the focus group transcript to support understanding and theme development.

7.3.1 Nursing should be BSN

This is the most significant theme identified from the meso level participants and includes three subcategories, illustrated in Figure 7-5.
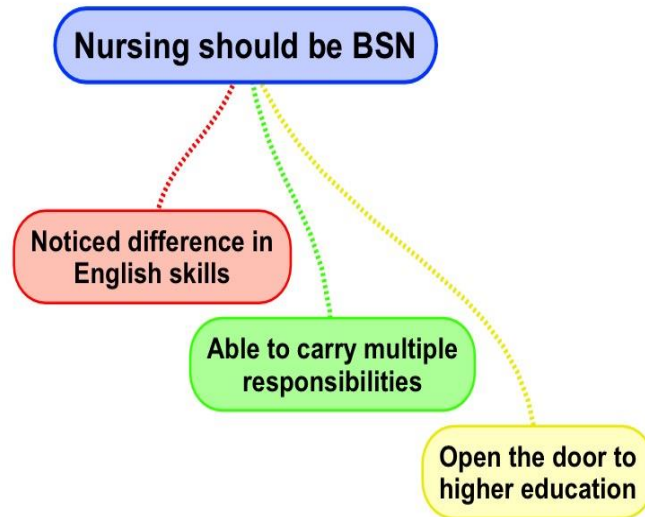

Figure 7-5: The first theme in Meso level analysis

The meso-level data revealed general agreement with the minimum requirement for a Bachelor degree for nursing practice. Five regional nursing directors (RND2; RND2; RND4; RND5; and RND6) acknowledged the decision to create a Bachelor's degree as the minimum requirement; for example, the director (RND5) stated that:

> "*This decision was promulgated during the term of Dr. Rabea, which stipulated that nursing should be BSN.*"

Participants' considered it vital that nurses remain able and responsible for keeping up with the complicated and continuously changing nature of nursing practice and that a BSN was the way to ensure this could happen:

> "*Personally, I appreciate the decision and personally I like this decision. The health process in general witnesses remarkable development in this complicated time. Health work is getting more complicated and in turn we should ensure an efficient nursing profession to meet and keep abreast of the development and complexity of the health sector. Indeed, those enrolled in nursing should have*

> *BSN as a minimum entry which means that they should be bachelor's degree*
> *holders" (RND5).*

The regional director RND3 also noted that increased quality of care and safety of patients is a basic requirement, suggesting patients require this level of care, and this level of care requires degree level education:

> *"Currently, the basic requirements for nursing services are quality and patient*
> *safety. Even patients are requesting better healthcare services, which means that*
> *they know the quality of service and they ask for enhancement. ... ... Saudi female*
> *nurses should have a Bachelor's degree as the minimum education requirement".*

Ultimately, participants within the focus group believed the benefits of attaining a Bachelor's degree over a Diploma in Nursing supported improved quality of nursing care, greater patient safety and more positive outcomes. This was noted by (RND1) as follows:

> *"Based on my experience in the Ministry of Health, with due regard to the fact*
> *that I graduated from a secondary health institute and thereafter studied in a*
> *health sciences college, and was promoted to study the bachelor's in college, I*
> *noticed the difference in the quality of care between nurses who were studying in*
> *college and those in university. There are remarkable differences in terms of*
> *information, training and dealing with patients" (RND1).*

In contrast, one regional director presented a different opinion regarding the decision to introduce BSN as a minimum requirement to practise nursing. The director stated that:

> *"I disagree, we need different levels and we still need the Diploma nurses. The*
> *Diploma has a level of skills not just the Diploma title. They have a level of*
> *knowledge, experience, behaviour, and technical skills. The Diploma should have*
> *clear educational pathway within a specific frame such as the bachelor degree. I*
> *need a Diploma to do specific roles. I believe that the Diploma can deliver a good*
> *care if they graduate from government institutions. We must not forget that we*
> *have been trained by Diploma holders"* (RND1).

In summary, these results indicate that most of the participants working at the meso level support the decision that nurses should be educated to degree level. Only one participant (RND1) voiced the need for different levels of nursing to provide different levels of care. The following section presents the sub-categories identified within the overarching theme 'Nursing should be BSN'. Within the sub-themes, greater proficiency in English language skills, the acceptance of responsibility and improved opportunity for accessing higher education are all recognised.

7.3.1.1 'Noticed difference in English skills'

One commonly noted benefit of Bachelor versus Diploma level nursing education was in English language skills:

> "*English language, we have noticed the difference of education, noticed a difference in English skills*" (RND3).
>
> "*English and communication skills is better in Bachelor's programmes than Diploma education*" (RND5).

The regional nursing director continued to elaborate on the benefits in terms of communication with non-Arabic speaking doctors:

> "*I studied in university and all the subjects were teaching in the English language and when we worked in our hospitals they deal in English, even the documentation in patient files was in English. We have doctors who are of non-Arabic origin who only understand English, which is a medicine and nursing language. In general, I consider the English language is a professional language and proficiency in it is improved with degree education*" (RND5).

7.3.1.2 'Able to carry multiple responsibilities'

An additional benefit noted by the meso level participants, was the BSN degree supporting greater knowledge and the ability to use this knowledge in clinical practice, leading to nurses being able to carry more responsibility. One participant described the Bachelordegree nurse as:

> *"[an] Accountable person who is able to carry multiple responsibilities and care for different cultures" (RND3).*

Another participant explained this concept in more detail, articulating how advanced education and knowledge can support skill development and facilitate nurses taking on more responsibilities:

> *"For instance, the bachelor's nurse has a huge academic volume of information. The academic education prepares the nurse for better understanding and awareness. For example, we study pharmacology, physiology, psychology, autonomy, family, growth and development of humans, and how we deal with patients of different ages. The nurse will graduate having higher cultural skills in general and in their profession in particular, which special emphasis on the nursing degree". (RND5).*

7.3.1.3 'Opens the door to higher education'

In addition to being able to take on and handle advanced workplace pressure and responsibilities, the benefit of Bachelor level education can be increased opportunities for additional advanced education, and ultimately career development. For example, one participant in the meso level focus group described that:

> *"This makes her accommodate the work and then start to develop her capabilities through courses. Thereafter, the bachelor's degree opens the door to higher education, which is considered an excellent idea" (RND5).*

Some of the participants at the meso level indicated that there were some obstacles to completing degree education. Not all Diploma nurses can access bridging programmes, because they are not able to meet the admission criteria. For example, one director lists the obstacles and states that:

> *"First is the age. For instance, 40-year-old nurses do not have the right to enrol in the supplementary programmes. Second, English language is required, such as*

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TOEFL. They should open the domain for enrolment without complicated standards. They should open the field to encourage people to join" (RND4).

Another director shares their own experience regarding joining bridging programmes:

"before two years, I decided to complete the bachelor's, but it was conditional on being below 40 years of age. The certificate should not be more than 10 years old and the TOEFL grade should be 4.75, as well as full dedication to work" (RND6).

With regard to the above about the benefit of a Bachelor degree, and the obstacles that face Diploma holders when trying to complete their degree education, the meso level participants emphasised that these obstacles need to be considered for future nursing workforce planning. However, the benefit of nursing degree education depends on the quality of the BSN programme in private vs. government colleges/universities, which may affect the quality of nurses it produces. This is explained in the following theme.

7.3.2 Quality of care and educational levels

This is the second overarching theme identified from the meso focus group and includes three unique sub-themes, 'Government has better graduates'; 'Nurses should have different job descriptions' and 'I don't want a bachelor's nurse to work in PHC centres'. as illustrated in Figure 7-6.
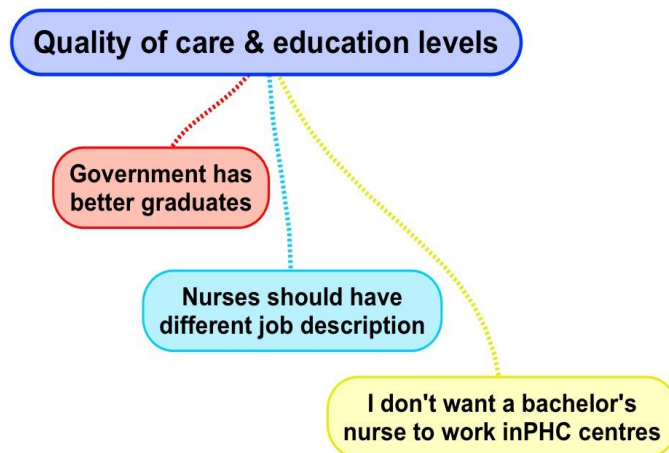
Figure 7-6: The second theme in Meso level analysis

7.3.2.1 'Government has better graduates'

Participants at the meso level list certain issues that could influence the quality of care and those that might be associated with educational levels. In addition, the participants described the differences between education attained at private institutions of higher education and that attained in government institutions. The perception that government education maintained quality as compared to private nurse education was in keeping with views offered within the macro level discussion (Section 7.2).   The private institutions were described, by meso level participants, as not having the same level of education as that demonstrated at the government institutions. For example, five meso level participants explained their perceptions of the Bachelor degree at government versus private colleges:

*"It should be governmental college. ... I say that government has hundred times better graduates than private" (*RND3).

"Currently bachelor's is granted from private institutions which do not have the same level. Nevertheless, the level is worse. Private academies provide Bachelor's at the same quality of Diploma and the same study" (RND2).

"The regulations should be enforced in the private sector; the government graduates they do not have problems. Because private colleges are not under control, it focuses on business" (RND5).

"but it is unfair that you have a Bachelor's and they do not understand anything" (RND4).

"Currently the nursing profession witness desertion by Diploma holders. For instance, male nurses who have a Diploma intend to complete their study in other careers and now they are health information specialists, working in social services, hospital management due to the barriers and obstacles that prevent completion of the Bachelor's degree in nursing" (RND4).

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These participants highlight that due to a lack of regulation and control over private institutions, these organisations are able to award Bachelor degrees to nurses even if they do not have a high level of skill; these decisions being made based on business development rather than quality of patient care. Many participants at the meso level concur that graduates from governmental institutions have a better level of education.

7.3.2.2   Nurses should have different job descriptions

As well as recognising a need for regulation across government and private institutions, the meso level participants also noted the need for a more structured distinction between job descriptions for nurses based on education levels. Such distinction could be based around nurse technician, nurse specialist, and senior specialist. These different specialties in nursing provide the continuum of care. One of the regional nursing directors, who argued against the decision for nursing education to be all at degree level, and strongly advocated for other levels of nursing to perform different levels of skill, stated that:

> *"Nurses should have different job descriptions and nursing practice varies in terms of nursing care. I need health assistants, I need nursing technicians and I need specialists and senior specialists, which means that I need each level to perform different care"* (RND2).

> *"Nursing, technician, bachelor's, specialist or senior specialist all of them working together"* (RND3).

> *"There is not any difference in the job description of the nurse with a bachelor's or the nurse with a Diploma"*, *"They are working the same* (RND3, RND6)

The participant RND1 calls for the demarcation of nursing roles according to qualification.

> *"Currently there is a job description for all except health assistant, but in fact each technician and specialist has the same work, even the master's holders working as nurses, they do the same work which means there is no demarcation".*

Most of the participants in the meso level focus group (RND2; RND3; RND6D, RND1) agreed that there was a need for job descriptions in order to differentiate between the nursing roles appropriate to their level of education and the care they can deliver. One participant believes that these descriptions are already in place, to some extent, but that they are not implemented and this means that all the nurses with different levels of education provide the same care because there is a shortage of nurses. This is an important issue requiring further discussion and concerns many areas of the healthcare sector, including Primary Healthcare Centres (PHC).

7.3.2.3 "I don't want a bachelor's nurse to work in PHC centres

This is an interesting subcategory. Analysing the focus group data for the meso level, nurses identified that there is a misunderstanding of the role for nurses who work in primary healthcare or in community centres. For example, it is notable from the focus group interview that some nursing directors have not recognised the important role of the PHC nurse and the reason behind the implementation of degree education as a minimum requirement for entry into practice. They thought that nurses who were working in the PHC did not need degree education, because the work was perceived as only needing basic skills. This is a significant finding; given that the future direction of global health organisations emphasises Bachelor degree education as an important step to meet the community needs. This was an unexpected finding:

> *"I don't want a bachelor's nurse to work in PHC centres; I need them to work in hospitals. The Diploma nurse can work there ….it is basic skills"* (RND4).

> *"So, why is there no replacement plan in the hospital? For example, we cover the shortage with a Diploma holder, then gradually replaced the Diploma with the bachelor's degree and shift the Diploma holder to a primary health centre in the border area. The duties of primary health centres are easy, only basic nursing skills and there is no workload"* (RND1).

Other participants build on this by noting the placement of degree-educated nurses in PHC centres to be a waste of their skills.

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"This is not a requirement, we discuss here the nursing specialist, once she starts the work after graduation they recruit or direct her to the health centre. It is useless. Such health centres are few. I was head nurse in a hospital, it was impossible for any specialist nurse to work in a primary health centre and we returned her back to work in the hospital. This is right" (RND4).

"This point drives us to the basic point which is that the requirements in nursing practice or nursing services is a bachelor's, either in hospitals or in primary health centres, but the system does not support us on this point, when you say you need a bachelor's now, and the aim is to develop all employees to be bachelor's graduate for the services! The hospital is not less important than the health centre, and the regulation does not support us on this point by saying that the credentials of a health centre is a bachelor's, even if we consider that services will be better due to the bachelor's holder's presence. I do not foresee that they should be directed to basic care as basic care does not require a bachelor's" (RND1).

In summary, the above quotations indicate that participants at the meso level have trouble understanding the decision to send degree educated nurses to work in PHCs while hospitals are still reliant on Diploma educated nurses. Many directors believe this to be a waste of resources as they consider that nurses working in PHCs only need a basic skill set compared to those in hospitals. This is in opposition to the future direction of global health organisations and the GCC, both of whom emphasise Bachelor degree education as an important step to meet community needs. As the participants at the meso level were not included in the consultation process for the implementation of the degree education requirement policy, regional directors may find it difficult to see the reasoning behind these decisions. It is therefore important to consider the inclusion of those working at the meso level in the consultation process, as previously discussed in the findings from the documentary analysis. While the importance of educational level is emphasised, participants also expressed the importance of experience and the need for a balance between experience and education, which is discussed in the following theme.

7.3.3   Both [experience and education are important]

Another theme emerging from the meso level data, as was found in the previous macro level group (Section 7.2), was the distinction between experience and education, both being recognised as important in terms of supporting nursing knowledge, skills, and quality practice. This issue was described and acknowledged by the participants in the focus group as follows:

> *"Both [experience and education are important], because the nursing leader needs a good background experience in nursing practice"* (RND3).

> *"Both supplement each other, which means I graduated from a bachelor's but was trained by a Diploma holder" (*RND1).

> *"I can summarise it, based on my age and experience, experience has a major role in terms of guidance, performance, personality, punctuality, communication and skills. Experience is considered as a source of evidence"* (RND2).

> *"Experience is not only a source of evidence; it is considered as a base of information. The education supports the experience and experience depends on trials"* (RND6).

One of the participants noted that experience supports decision making in practice, as a nurse will use their background experiences to manage a given situation. This participant stated:

> *"Experience supports your decision. For example, you deal with a certain situation based on your background experiences*" (RND5).

Five participants (RND3; RND2; RND1; RND6; RND5) agreed that both experience and education are important in nursing practice. However, the implementation of the degree requirement policy means that many very experienced nurses with Diploma education are not able to obtain higher positions in the healthcare sector, which could impact on the quality of patient care.

7.3.4   Conclusions of meso level analysis

The qualitative content analysis of the meso level data obtained for the study resulted in the identification of several key common themes related to the research questions, including:

- Meso level participants agreed with the minimum requirement of the Bachelor Degree in Nursing, considering that 'nursing should be a BSN' (Theme 1). Within this theme, participants discussed the benefits gained by the attainment of a Bachelor's degree, including difference in the level of English language and communication, increased responsibility and the ability to carry out multiple tasks, and the opportunity for education and career advancement.

- These participants also identified the quality of care and education level (Theme 2) as a key point; they discussed differences between private and government institutions in terms of education offered, noting insufficiencies among the private institutions. This brings into question the need for standardising the curriculum of degree nurse education in order to avoid discrepancies between private and governmental institutions, which have arisen due to a lack of regulation.

- The participants also discussed a need for job descriptions to reflect the different levels of education, as well as the controversy surrounding distribution of degree-educated nurses. There was a strong belief that bachelor degree nurses should not work in PHCs, as participants deemed these nurses 'overqualified' for the position and the hospital setting are in more need of their expertise.

- Finally, participants emphasised the importance of experience in addition to education (Theme 3).

7.4 Micro frame (phase four)

Micro level participant data was obtained from focus groups with nurses with a Bachelor's degree, staff nurses who obtained certification through a Diploma nurse education programme, and interviews with nurse managers and educators in hospitals. The qualitative content analysis of the micro level data (previously described in Section 5.4) resulted in the generation of several themes, from which common themes were revealed in the data related to each category. The themes were:

- Theme 1: Pathways to nursing.
- Theme 2: General agreement towards the Bachelor Degree.
- Theme 3: 'We do not have any difference between the BSN and the Diploma holders'.
- Theme 4: 'The curriculum in the private colleges is very different from the government institutions'.
- Theme 5: Images of Nursing.
- Theme 6: Professional scope of responsibility.
- Theme 7: Nurse education versus experience.

The thematic categories identified from analysis of the micro level data are illustrated in Figure 7-7.

Figure 7-7: The thematic categories and subcategories within analysis of micro level data

7.4.1 Pathways to Nursing

The micro-level participants described a variety of pathways into their own nursing careers in different countries, which included the national board licensure exam, gaining a Diploma, and sometimes moving on to Bachelor's or Master's degree education or beyond. These educational gains were obtained from both governmental and private colleges. The following examples demonstrate different paths to nursing:

> *"I graduated from a high Diploma college (3 years and a half), I work 4 years as staff nurse…. then complete my study in BSN and graduate from governmental University" (*JN3*).*

> *"I was a staff member with a Diploma, after that I went overseas to continue my studies for a Bachelor's degree… four years of Bachelor's degree"* (JN1).

Some described continuing education over many years of nursing:

> *"I am actually going to complete 22 years in my nursing career. I graduated from university as a general nurse then I got a master's in nursing" (*SN2*).*

> *"I graduated from university four years ago and joined up to work as an RN for 3½ years in Cardiothoracic ICU"* (SN3).

Different preparation standards were evident in nurses' training in different countries:

> *"I am … Korean. I've been working in nursing for about 7 years now. We have different preparation. ..It is made of two categories, one is the Diploma and the other is the Bachelor's degree…after they completed their curriculum they both proceed to the National board licensure exam. Only those who pass the exam may be a registered nurse. That is the educational pathway in Korea".* (SN7).

> *"I am a previous dean in the Philippines. What we currently have in our country*

as a minimum requirement is a Bachelor of Science in Nursing. Although we had like twenty years back a graduate nurse, this is similar to the Diploma graduates, that we are having here; but this is already being phased out in the Philippines" (SN5).

A director level nurse described the process of registration and the benefits of different aspects of nursing education. This shed light on the focus of the quality of the Saudi national licensure exam provided by SCHS compared with the exam of developed countries such as the National Council Licensure Examination (NCLEX) in the USA.

"I think in the USA there is an exam called NCLEX. I wish we had the same exam here because it would be a tough exam that would assess background and give a good impact; the important thing is the patient. Every person, even without a certificate, should go through this exam, to be an RN to work with patients. Our priority is patient safety" (SN1).

All levels of nursing Diploma education have a different type of exam (required to be a registered nurse) with the same title and the same roles. These statements demonstrate the variety of participant pathways in nursing education from different countries, cultures and levels of education, considering the different views and classifications of national licences that they undertook for entry into nursing practice. This allows for a broad evaluation of perspectives when considering the implementation of the policy for a Bachelor degree as a requirement for entry into nursing. Although each participant's pathway was different, as in the macro and meso level analysis, there was a general agreement on the topic of the BSN being an appropriate minimum requirement, and this is discussed in the next section.

7.4.2 General agreement towards Bachelor's degree

The Bachelor degree as a minimum entry requirement for nursing practice was considered by macro level participants as an important decision that will have a considerable impact on future workforce planning and development. At the micro level, participants who were staff nurses with a Diploma or Bachelor's degree were asked if they felt a minimum degree should be acquired and if they did, what that would be. Four participants (JN2, JN4, JN6 and SN7) described that this would be dependent on the individual and their level of

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general knowledge, languages, ethics and commitment, interest and passion, practice, and specific skill sets:

"Depends on the personality, passion and the background of the person." (JN2)

"It is related to the personality not the level of degree" (JN4).

"I think this depends on herself, not on the degree, because I saw some nurses in my practice work well even with Diploma, high Diploma, or a Bachelor's. If she has language, ethics, and interest in nursing she will work" (JN6).

"We have other factors that can affect, as I mentioned, could be like commitment, might be the language, might be the interest or some people may select nursing because they thought it was an easy job" (SN7).

Three participants from the focus group of Bachelordegree holders (JN1, JN2, and JN4) also asserted that a Bachelor degree should be required, making the following statements:

"The minimum should be a Bachelor's degree to improve the quality of nursing care" (JN1).

"A Bachelor's should be an ideal candidate for an entry level nursing job" (JN2).

"We prefer the Bachelor's degree for nursing practice because nurses with a degree provide holistic care for patients, families, communities and the population across all ages and genders" (JN4).

In contrast, two participants from the Diploma holders felt that a Diploma was adequate (JN6 and JN5):

"For me I think it's okay for a high Diploma. But we need strong subjects and in-depth knowledge" (JN6).

"For me a Diploma is okay, if she can understand everything she can do her work" (JN5).

The majority of the participants that were nursing managers and educators (SN2, SN3, SN5, SN7, and SN1) acknowledged that a nurse should have Bachelor degree education and above. For example:

"Yes it should be a Bachelor's and above" (SN2).

"Yes actually, if we want to improve health services, it must be from Bachelor's and above" (SN3).

"I have seen that it is very much needed that nurses who come in as initial practitioners should have a BSN degree." (SN5).

"We can clearly see the understanding because they learned English from the University so they know how to speak, understand and write. This will all have a huge impact on our nursing care" (SN7).

"The ideal is to have a Bachelor's degree and I will not accept any nurses to come to work in this hospital without a BSN degree because of patient safety" (SN1).

This section provided the largest set of significant themes regarding the importance of degree nurse education in practice and its influences on healthcare services. This section highlights the BSN degree being considered of higher quality, because it increases the level of care and patient safety, whilst reducing mistakes and improving the quality of care and overall health services. Moreover, with five years of education (four years in college containing theory and clinical practice, and one full year internship in hospitals) delivered in English, a nursing degree gives them a greater command of the English language, which improves verbal and written communication. All these factors may have an impact on the professionalization of nursing. Overall, the participants at the micro level seemed to put a lot of responsibility on the shoulders of degree nurses, having high expectations, and they thought that they could do anything when they had a degree education.

7.4.3 'We do not have any difference between the BSN and the Diploma holders'

The majority of micro level participants agreed that the Bachelor degree holder is better than a Diploma holder in terms of knowledge, skills and attitude, all of which are considered basic competencies for nurses to provide safe and competent care to patients, individuals, families, communities and populations. However, there are more specific competencies that should be obtained from Bachelor degree education, for example: leadership skills, teaching skills, and assessment skills. Regardless of the development of specific competencies, some participants stated that all nurses with different qualifications are undertaking the same type of work and they did not see any differences in the practice of diploma holders and degree nurses, as illustrated in Figure 7-8.
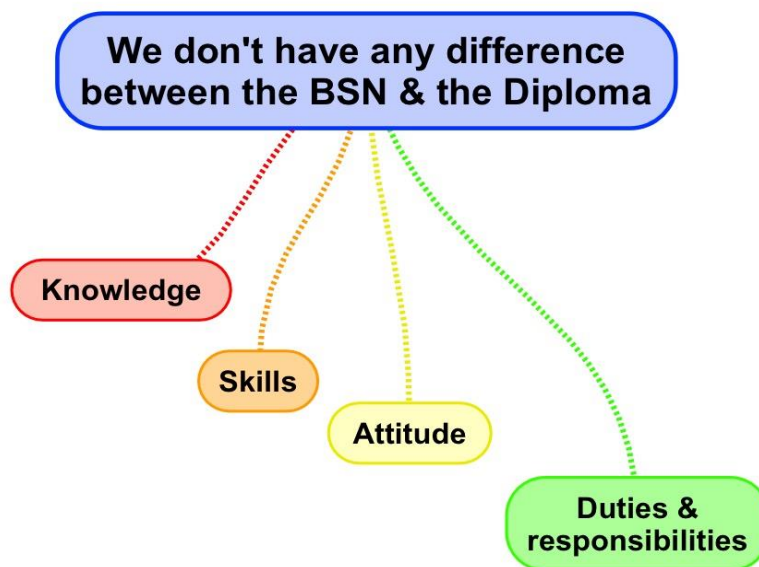

Figure 7-8: Third theme in micro level

Four participants (SN4, SN1, SN6 and SN5) noted that certain factors are relevant to degree education and can influence nursing workforce development in Saudi Arabia. For example, participants believed having a Bachelor degree equated to having greater knowledge, skills, attitude and communication, with the ability to speak and write in English and/or Arabic being incredibly valuable. Many of these skills were organised under the basic competencies, with participants stating as follows:

Knowledge

"I think one of the important issues with our nurses here is the knowledge…BSN degree nurses have a general understanding of the theory concept …should have knowledge, should have a good background about physiology, anatomy, pathology. Good background about psychology too to deal with patients and pharmacology to know the side effects and contra indications for each medication." (SN1).

Skills

"They have advanced clinical skills such as medication calculation, IV cannulation, catheterisation…. almost all of them have abilities to provide patient care proficiency" (SN4).

"If we are talking about competency in the nursing assessment, medication management, calculation and administration, knowing the complications, side effects of the medication, total patient care, evaluation, therapeutic nursing actions or interventions: it is really I think that the nurses with a Bachelor's degree level will have better competency in these" (SN5).

Attitude

".. They are more mature, more committed, accountable, confident and... more prepared" (SN6)

"We are evaluating our nurses based on three things: knowledge, attitude, and skills. Knowledge is important and I think it is impacting people's attitudes" (SN1).

Duties and Responsibilities

*"Compared to my place we do not have any difference between the BSN and the Diploma holders" (*SN5).

*"We have both of them the Bachelor's degree and Diploma nurses, they are providing the same duties and responsibilities to the patient" (*SN6).

"What is different about these nurses is that they have different classifications, technicians and specialised nurses. Then they come to work as staff nurses providing the same total patient care" (SN1).

These findings illustrate that participants believe Bachelor Degree nurses are expected to be accountable and competent professionals, in terms of knowledge, skills and attitude. Another important finding relates to there being no differences in the job description of nurses in the real world, as they often function in the same role. At this stage, these results initially support the idea of developing a national competency framework to meet patient and current health system needs and to solve the inconsistencies in nursing standards, roles, and responsibilities. More specific and diverse competencies are needed for nurses with a Bachelor degree. Furthermore, job descriptions should be determined for each level of nursing practice in order to improve the quality of care delivered by the nursing workforce.

7.4.4   'The curriculum in the private colleges is very different from the government'

This is one of the important themes identified from the analysis of the different views of practising nurses at the micro level. The participants noted that there is a remarkable difference between the outcomes of nursing in government and private colleges, as illustrated in Figure 7-9
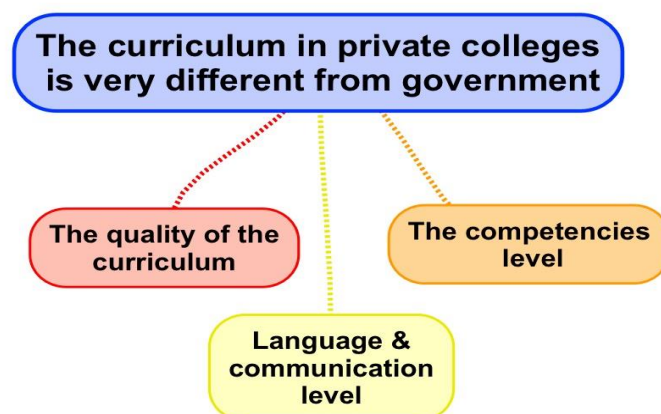

Figure 7-9: The fourth theme in the micro level

One of the managers discussed other factors related to the quality of the curriculum of

nursing programmes in private institutions. This included issues such as Bachelor Degree educated nurses coming in with no experience to replace experienced nurses with diplomas. Having new nurses with a Bachelor degree, without experience, and Diploma nurses with experience, might affect nursing practice due to certain factors such as commitment. Furthermore, the participants in the micro level noted that the quality of the curriculum offered during attainment of the Bachelor degree plays an important role in achieving the desired level of competency and to improve the nursing workforce. For example:

"We have a lot of new staff who have graduated with a Bachelor's degree from private colleges but still they cannot really handle the patient and they cannot even pass the competency; which means there is something different or a problem either in their curriculum or in their commitment" (SN1).

Similarly, in the focus group with nurses with Bachelor degrees, one participant noted that:
"The curriculum in the private college is very different from the government… Yes, very, very weak." (JN3).

Likewise, the level of competence (knowledge, skills and behaviours) could also be affected by the quality of education and where they obtained their education, such as from government or private institutions. Participants commented on the distinct differences in educational quality and curriculum. One participant stated:

"The majority we have are Diploma educated and also we are talking about two or three categories. The Diploma is three and a half years and they were from governmental institutions like the Health Science College… under MoH and we have the other one from the private institutions. ...we saw the difference, with experience, background information, abilities, performance in practice and outcomes" (SN2).

Language and communication skills were also identified as key factors for a degree nurse:

"The new Diploma which we have is common now, it's the private institution

*Diploma…they don't speak or communicate in English. They do not have the basic things (skills)… they are weak and we have to train them first to study English…, the Bachelor's, sure… with English, with the good background of theory and practice   Also with the respect of the institution where he or she comes from, we are having some Saudi Bachelor's nurses who do not even pass with us" (*SN2*).*

Problems regarding the quality of education in private universities was another factor raised by one manager, as noted in the following statement:

*"we have private and government colleges. Actually we are facing problems - most of the students or staff who graduated from the private colleges are facing problems with the competencies. Actually some of them we asked 'where did you do your competencies'? One answered me in an honest way, the Institute told her just stay at home, 6 months, then you come and I will give you the certificate!!!! … the private sector is focused on the money more than the quality, which is really affecting our staff. But some of them wanted to learn and try their best to learn. They do not have the basic skills, especially from the private sector" (*SN3*).*

Different educational levels can be a factor that influences quality of patient care. One participant commented:

*"The staff educational level is an important factor that has an effect on the quality of care. We have different levels of nurses …the ones who graduates from a Diploma lasting 2 and a half years needs to be focused on bedside nursing rather than making decisions because they …don't have any knowledge. Nobody came with them for the practice (no clinical instructor or preceptor)" (*SN4*).*

However, some participants noted that commitment of the individual was a critical factor in the quality of care delivered and that performance depended on the individual's personality, regardless of whether they held a Bachelor degree or Diploma qualification. For example:

"Yes, Bachelor's degree holders are better than Diploma holders. When it comes to skills, or some other commitment, however, it completely and purely depends on

*individual commitment. It is not a guarantee if they are a Bachelor's holder that they are better in every aspect. ..We have Diploma holders in our Paediatric Hospital, and their commitment is much better .. They are very dedicated people…. and their performance is better than Bachelor's nurses. They want to learn, they have the initiative, they have the interest to learn" (*SN3).

"Commitment is something important. Lack of commitment actually affects the staffing plan and also the working hours. Rather than interfering with nursing administration once they enter the hospital. .... we really have to look again at the curriculum and the teaching methods in the schools" (SN1).

In a similar way, participants also felt the quality of nursing practice was related to the personality and background of the person rather than the level of education.

*"It is in the personality not in the level of the degree. It depends on spirituality, values, beliefs and the cultural background of the person" (*JN2).

Together these results support the macro and meso level comments and provide important insights into the quality of the curriculum framework that was implemented in both private and governmental colleges. These curricula lacked standardisation, eliciting a need for evaluation and national standardisation to cope with the current and future complex healthcare needs of the Saudi population. Few participants thought that having a Bachelor's degree would help to advance their career. There were subtle and overt differences in private and government curricula, as well as the quality of education each provided. The government colleges provided higher levels of education, whereas at private colleges this was considered inferior in quality, primarily because private colleges were financially oriented. However, there was debate regarding what constituted a 'good nurse', some participants believing it was improved knowledge, skills and behaviours attained through their level of education, while others thought that it was the personality, commitment and background of the individual that mattered more than the level of education.

7.4.5 Images of Nursing

Participants at the micro level described several cultural and social factors influencing the degree level attained by the nursing staff; and shared their views on focus group discussion, as reflected by healthcare providers and patients. Notably, social and cultural influences were discussed in relation to degree level nurses, including family pressures and professional respect, some of which were associated with perceptions of gender roles. Some of the positive perceptions included better opportunities for nursing careers and increased pay, greater knowledge, opportunities for nursing specialisation and further education. All of these were commonly cited factors thought to influence degree level education among the micro-level participants. The negative influential factors were related to cultural and social influences, family pressure, disrespect and the controversy surrounding gender mixing in the workplace; the latter affecting opportunities for female nurses in terms of their education as illustrated in Figure 7-10
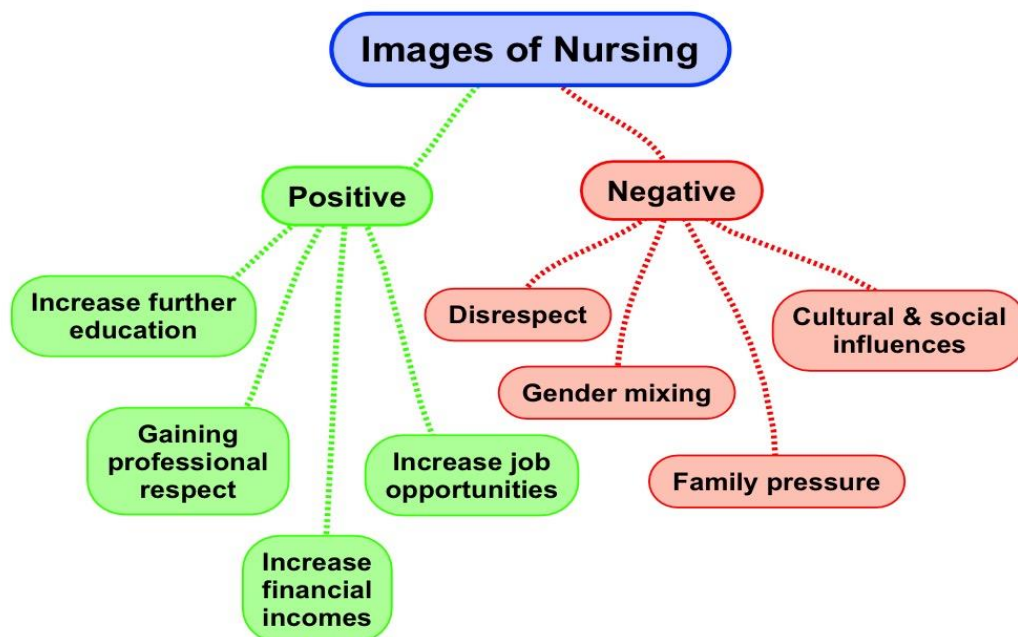

Figure 7-10: The fifth theme in the micro level

The following subthemes demonstrate how these positive and negative images of nursing were evident across all groups, nurse mangers and educators, degree and Diploma level nursing staff, functioning at the micro level.

7.3.5.1 Positive image

The career and economic advantages of attaining a degree education were associated with positive images of nursing, such as increased job opportunities, improved financial income, gaining professional respect, and opportunity for further education. Participants in the micro level focus groups reported these opportunities as follows:

Increased job opportunities

*"I am thinking of my future career for myself, for financial outcome and a good position. I am thinking, what is the easiest way to get a salary and to have some respect… I discovered that nursing is the best way to get it, that's why I became a nurse" (*SN1).

"If you have a Bachelor's degree you can have good position like a head nurse" (JN7).

Gaining Professional respect

*"The one who has good knowledge and very good skills will gain more respect and will gain more knowledge and can also work in administration" (*JN1).

"Now, I discovered that the senior and consultant physicians, they respect nurses just now because their education and experiences are improved" (SN1).

Increased financial income

"Yes because of many factors. If you are thinking financially, with a Bachelor's degree you will have a good salary instead of the Diploma. ..Gain more knowledge... it will give you a variety of ways to continue your study" (JN2).

*"With a Bachelor's degree you will have a good salary... Second thing...when you graduate with a Bachelor's degree you will have more knowledge. Third thing, the Bachelor's degree will give you a variety of ways to continue your study. ...it will give you a link to many different opportunities - unlike a Diploma" (*JN4).

Increased further education opportunity

"[With a] Bachelor's degree we can gain more knowledge, when compared to a Diploma. As a Bachelor's graduate, we can further our studies to a master's degree and PhD; we can continue. We can have the chance to go abroad because nowadays if you see the outside offers are only for the Bachelor's degree, not the Diploma. .... You can go to further your studies, and increase your salary" (JN1).

While it is clear from the quotes above that there are numerous positive perceptions of degree level nursing, participants also noted that, as a whole, nursing is still viewed in a negative light. Participant's thoughts regarding this topic are shared in the following section.

7.3.5.2 Negative image of nursing

According to participants, the negative image of nursing can be linked to certain cultural, social and family beliefs in SA.

Cultural and social influences

"I can see our culture is important here; as Saudi people we are not expecting a male person to be a nurse. We think in Saudi Arabia, nursing is a job for females only and that's why we don't have a lot of male nurses who graduate from a Bachelor's degree to work with us" (SN1).

"I think for us, socially, they respect more the man than the woman. But at this time the image of nurses is improving for the Saudi people." (JN2).

Family pressure

"Some families push their daughters or sons to study nursing only because of the need for financial gain". (SN5).

"Some families do not allow their daughters to work in the night shift or in the male ward" (SN4).
"One female nurse left nursing after marriage because her husband did not allow

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*her to work for different reasons" (*JN1).

Disrespect

"I am seeing that there is a respect for physicians - why don't they have respect as a nurse? There is no respect for nurses" (SN1).

"The male or female working in this career, they are not respected by others. ...some patients are coming to us ...acting like we are housemaids or chamber maids" (JN2).

Gender mixing

"They see that we are doing dirty work, some of the people they see that females and males are working together, they are thinking about that in another way! Still there are some people that have this bad perception" (JN1).

These comments are valuable because they offer an insight into why degree education is not easily achievable for all nurses, some are pressured to take the quickest route into employment and some are demoralised and are likely to drop out of their course. It is clear that some participants see the introduction of the minimum requirement as a way to combat these negative views, making nursing a more valued profession with better financial opportunities, especially considering that the Bachelor degree is required in order to begin a Master's degree when a nurse wishes to specialise.

7.4.6 Escape from Professional Responsibility

Participants at the micro level discussed some of the professional issues they associated with diploma educated nurses. These included language barriers, medication errors and absenteeism as illustrated in Figure 7.11.

Figure 7-11: The sixth theme in the micro level

Participants felt that obtaining a Bachelor degree offered professional benefits in terms of gaining a greater knowledge base, improving their general nursing skill set, particularly communication skills, gaining opportunities for further advancement, being better prepared and more competent for the work environment, and supporting an increase in patient safety.

One participant felt that:

> *"It is very much needed that nurses who come in as initial practitioners should have a BSN degree... because this would complete the requirement of professionalism"* (SN6).

Many participants from nursing mangers and educators believed that this level of professionalism was not being met by nurses with a lower level of education. Participants' believed this is due to a number of different factors which will be illustrated within the following subthemes. The key issues addressed are absenteeism in hospitals and frequency of medication errors affecting the quality of patient care. Both of these concerns were perceived by the participants to be a result of language barriers.

Overcoming absenteeism

One of the significant benefits of employing nurses with a Bachelor degree was the

increased level of knowledge, which was felt to support nurse confidence, language skills (and communication), and combat absenteeism. It could argued that the stress of nurses from the language barrier and medication error might also affect the hospital organisation in terms of absenteeism and quality of care as suggested by Alsaraireh et al.(2014). Nurses lacking this level of education were noted to have difficulties understanding the patient's situation, as well as using English, which caused confidence issues and absenteeism. This was described by one manger (SN1) as follows:

> *"When I talk with most senior nurses, we discuss the biggest issues; we faced chronic cases of absenteeism and we found that most of them were nurses with a low level of education. When I investigated them, to understand their situation and why they were absent regularly, I discovered that they were absent because they wanted to avoid responsibility".*

One of the managers added some examples from personal experience to support the reasons for absenteeism, such as:

> *"one of my staff told me that 'I did not come on duty because I am afraid to talk in front of the physician and he might ask me about the patients and I can't answer because I don't understand their situations.' Also because they don't speak English, so they can't endorse the case to non-Saudi nurses" (*SN5).

Likewise, another nursing manger gave an example of an evidence-based study:

> *"We did a study about absenteeism here in KSMC, the most significant factor is workload and the second is endorsement. Because they don't have good English and they don't have good knowledge, they are absent from the duty"* (SN1).

Medication errors

Micro level participants considered that nurses with a Bachelor degree education were more professional in communication and medication administration than Diploma nurses. For example, two participants noted that:

"Patients were safe when handled by nurses with Bachelor's degrees - even their English is good. Because you couldn't imagine that some of the Diploma nurses can't read English, how they interpret physician's orders and medical orders! We discovered that some of our patients did not receive medication because the nurse technician (NT) couldn't read English" (SN2).

""We discovered that nurses who make a lot of mistakes have a low level of education. So, if we need safe practice you have to have at least a Bachelor's degree" (SN3).

The evidence presented demonstrates that both absenteeism and medical errors are perceived to be linked to low levels of education and in turn impact patient care. The participants explained their perceptions regarding an association between nursing qualifications and quality of nursing practice and a high level of education. For example a Bachelor degree, was seen as critical to providing excellence in nursing care. This was discussed by one of the manger:

"I need our patients to be safe and I need safe nursing practice ... I think there is a good relationship between nursing qualifications and professional nursing practice. ...I am a member of the committee of central events of mortality and morbidity and I can say there is a strong relation or correlation between nurses' qualification and central events. ... because usually when we are reviewing the cases of central events, we discover that people who have a high level of mistakes have a low level of education. So, if we need safe practice you have to have at least a Bachelor's degree" (SN1).

In conclusion, it was felt a Bachelor degree helped to develop professionalism, which in turn helped to nurture nurse confidence, accountability and language skills (and communication), and overcome absenteeism. There was a perceived association between nursing qualifications and quality of nursing practice and professionalism.

7.4.7 Education versus Experience

The perception of the importance of experience and education was identified during the

focus groups discussion. When asked about the importance of experience versus education, in terms of professional benefit, participant responses at the micro level were varied, with some noting education as being critical over experience, some vice versa, and some suggesting that both were important. For the majority, both were considered important. For example:

> *"It's the same - both Diploma and Bachelors are the same. How they are performing. For example, if they are doing any procedure. We do it step by step. We start from…hand washing then explain the theoretical, go to the patient side. We go for the procedure in the correct manner step by step. Okay. … This is called staff performance… it is no different between Diploma and Bachelor's. It's the same"* (SN2).

> *"For me both of them are important because without experience you cannot note how to solve your problems. So if we mix between the new graduates and the experienced ones, both of them will teach each other, the new have knowledge…have new research, have more evidence they would teach the experienced ones. They have the experience how to deal with and solve the problem. Both of them [experienced nurses and new graduates] are important; they complement each other"* (JN4).

The importance of education was highlighted, specifically in terms of new research or knowledge that might advance the field or better patient care; with some participants suggesting if nurses only have practice experience they may not be providing the best care.

> *"The Diploma nurse will say, for example, (I already have more knowledge than you from experience). Nurses they know by their practice or their way. These ways might affect the patient as they will stick to that experience. That's where there is a problem. They need first to update their knowledge and to be ready for change. Because nurses stay a long time in practice. They are not ready to change their practice. They want to stick with that"* (JN3).

Two members of the Diploma nurses focus group, when asked if they needed more experience than knowledge, stressed the importance of knowledge as well as experience.

These two nurses (JN6 and JN8) simply stated, "*I need knowledge*" and "*more knowledge.*"

In contrast, another participant, this time in the focus group of nurses with a Bachelordegree, stressed the importance of skill development (with experience) over education:

> *"We begin with theoretical and practical right? Actually…the main important thing is skills. So how are we performing? For example, if you are... administering an injection or something. First, we have to be aware of the knowledge about the actions and everything. We have knowledge but how we perform that is very important…So skills are more important than knowledge. Knowledge is also needed; it's like the first and foremost thing but more than knowledge we have skills. So what we apply to the patient to prevent error. To improve"* (JN1).

What is significant from these comments is that education and experience are complementary to each other and are perhaps co-dependent in terms of providing quality nursing care. Two nurses, however, did think that skills were more important than education, but the majority believed that education and experience went hand in hand.

7.4.8 Conclusions from the micro level analysis

The following conclusions are derived from the common keys themes with sub-themes revealed from the data presented in the micro-level sections:

- The variety of pathways available for entry into the nursing profession (Theme 1); the agreement that BSN education is better than a Diploma (Theme 2); the importance of developing job descriptions for each level of nurse, Diploma and Bachelor's degree (Theme 3); the difference in quality of curriculum between private and government institutions (Theme 4); the positive and negative images of nursing (Theme 5); the professional scope for the implementation of degree education as a minimum requirement was highlighted, specifically concerning absenteeism and medical errors (Theme 6); and the argument of education versus experience was addressed (Theme 7).

- It was highlighted that a BSN degree is considered to have more quality because it increases competency, patient safety, reduces mistakes and improves quality of care and thereby improves health services. Also, it was noted by the participants that the curriculum and competency levels lacked standardisation, eliciting a need for evaluation and national standardisation to cope with the current and future complex healthcare needs of the Saudi population.

- Consideration was given to the greater proficiency of the English language with Bachelor nurse education and how this impacted on the professionalisation of nursing. Along with socio-cultural aspects, the economic advantage of holding a Bachelor degree was seen in terms of advancing career pathways and more job opportunities, thereby enhancing the standard of living.

- In short, it was felt that the Bachelor degree helped to develop professionalism and improve the image of nursing, which in turn helped to support nurse confidence, accountability and language skills (and communication), and overcome absenteeism. Furthermore, it was felt that education and experience complemented each other and shared equity in the provision of quality nursing. The following section will present the synthesis of findings across macro, meso, and micro data sources.

7.5 Synthesis of Findings across Micro, Meso, and Macro Data Sources

Combining and analysing the conclusions of each of the three levels (micro, meso, and macro participant groups) is important, as the data revealed commonality across these groups, demonstrating significant findings that support cross-case themes. These themes support the following conclusions drawn from across all three levels of data.

- Theme 1: General acceptance and agreement with the minimum requirement of BSN for nursing staff to support adequate knowledge and communication requirements for quality nursing practice. In addition, the importance of individual qualities and skills was noted. Discrepancies in education offered through private versus government institutions were

raised, and the feasibility of using bridge programmes to support continuing education of Diploma nurses were discussed.

- Theme 2: Factors affecting degree attainment included personal commitment/passion for self-improvement, private versus government institution education quality and financial factors (incentives or promotional opportunities or obstacles) were highlighted.

- Theme 3: Benefits of BSN include knowledge supporting confidence and decreased absenteeism, broader knowledge base, greater communication and language skills, enhanced nursing skills and responsibilities, opportunities for advancement and increased pay, and increased quality of nursing practice, patient safety and improved outcomes, and quality of care.

- Theme 4: Perceived importance of both education and experience, with a focus on education, supporting knowledge and patient care through advancement and in-depth understanding.

- Theme 5: Need for differentiation of distinct nursing job descriptions based on the education level attained and a focus on the quality of patient care through education, validation and regulation of standardisation for the BSN, and adequate supervision.

Only two themes were not discussed across all three levels:

- The impact of social, cultural and family influences on degree attainment (nursing image), which was only discussed at micro level.

- The belief that degree educated nurses are too qualified to work in PHCs and that this impacts on patient care in hospitals, which was only identified at the meso level.

The following section will present an overall discussion of the result of three levels (macro, meso, and micro) of data identifying several areas where workforce planning and mobilisation could be affected by the mandatory degree nurse education policy.

7.6 Discussion of macro, meso and micro levels

Analysis of macro, meso, and micro level data revealed interesting themes and a dilemma for workforce planning following the implementation of the mandatory degree level nursing education in SA. In the early part of this chapter, the results of interviews with macro, meso and micro level participants are presented. Analysis of across all three levels allowed the identification of several themes, which would otherwise have been missed if a cross-group analysis had not been undertaken. The following discussion brings these themes together and identifies several areas where workforce planning and mobilisation could be affected by the mandatory degree policy.

7.6.1 The degree and its role in healthcare quality

Macro level participants agree that the decision to make a nursing degree mandatory was good and likely to play a key role in improving the quality of patient care. Participants also believed that the gap in degree level education among existing staff could be readily addressed by offering bridging programmes. At the meso level, the majority of participants agreed that the decision to make a degree mandatory for nurse education was a good idea, as recommended by global organisations (WHO, 2009; Willis, 2012; RCN, 2013; AACN, 2016). The meso level participants based their opinion on the fact that they noticed degree educated nurses had better English language skills and were contributing to enhanced communication skills. They acknowledged that the official language of medicine was English (El-Sanabary, 1993), therefore making this an essential skill. Micro level nurses also agreed that English language skills were important in care delivery, but overall their concerns were slightly different to the meso and macro level participants.

Micro level participants agreed that nurses have various pathways for obtaining their qualifications and that courses are different. However, they were all ultimately driven by their desire to care for patients, by delivering good quality care. However, there was less emphasis on undertaking degree level education and more on a commitment to providing quality nursing care (Section 7.4.2). There were mixed opinions on whether all nurses should be required to be educated to degree level. Participants felt that the decision to study for a degree over a diploma should be based on individual choice, which is likely to be reliant on their personality, drive and academic ability. They also recognised that within

society there are differing levels of willingness and ability to study and perform jobs. Nursing education should not be so specific, but reflect these differences in healthcare settings by offering people a wider range of opportunities and not limiting them to one group of people (Almalki et al., 2011). According to Micro level nurses with degrees it was necessary to obtain degrees whilst diploma holders thought nursing was more to do with their personal ability commitment and level of skill.

Micro level nursing managers preferred degree educated nurses working in in-patient wards because they felt this had a positive impact on patient safety. This was not followed up in a discussion around experience which, for some, is an important aspect of patient car. However, micro level nursing managers did recognise that commitment is also very important, and expert diploma educated experienced nurses have shown better commitment to ensure the delivery of quality care, in some instances more than certain degree-educated nurses as suggested by other researchers (Orsolini-Hain & Malone, 2007; Dellon et al., 2009). This important recognition may help with the recruitment of diploma educated experienced nurses over degree educated nurses, thereby utilising available resources in the workforce to maximise output (McHugh & Lake, 2010). Furthermore, micro level staff thought that the commitment of expert nurses was more important for workforce planning at local level, particularly with regard to delivering quality care. If nurses are not committed to their work, then planning rotas and offering quality care becomes difficult (Dunton et al., 2007).

The view at the micro level was that such commitment is not just associated with education, but is reliant on personality. However, one micro level nursing manger pointed out that following investigation into absences, a high number of absentees were diploma educated nurses. One of the reasons for their absences was identified as fear of tackling difficult clinical situations due to a lack of English language skills and understanding of the patient's problem, which caused nurses to avoid such situation. Nurses with a lower level of education were more likely to make clinical errors (Tourangeau et al., 2006; Tourangeau, 2006; Kendall-Gallagher et al., 2011; Blegen et al., 2013; Fossen, 2014), this would of course affect self-confidence and could lead to absence from work, affecting the team and the care they can provide to patients. In such cases, on-the-job specific training for staff nurses may help overcome such issues in a quicker and cheaper way, rather than having to re-educate nurses in universities (Al-Ahmadi, 2014).

All of this highlights the multifactorial aspect of workforce planning and healthcare quality that is not just dependent on nurses being degree educated and having the necessary academic skills, but also recognises the importance of being able to apply such knowledge and skills. Too much emphasis on degree level education and career progression, as seen in the macro and meso levels, could negatively impact on the patient-nurse relationship, thus affecting the safety and quality of care by using a top-down process (Meerabeau et al., 2004). There have been fears from patient groups that the mandatory degree policy may make nursing a less compassionate profession (The Patients Association, 2013).

Indeed, interviews at all three levels (especially macro and meso) revealed that those in favour of the degree placed a lot of emphasis on career development, academic ability and management of healthcare systems rather than the patient-nurse relationship and compassion (The Patients Association, 2013). Some micro level participants felt that nurses were entering the profession to study for a degree and the accolade that comes with it for financial reasons. For example; a high salary and career development rather than to look after patients; may actually compromise the quality of care. Whilst this is a valid concern, in the UK the Willis Commission Report (2012) found that such issues did not affect the quality of care and therefore the reason for initially entering nursing should not affect the quality of care. The Willis Commission Report also suggested that the quality was improving as a result of the uptake of degree education (Willis 2012) .

If more Saudi nationals were to take up nursing due to the professionalization of the career, the majority of the workforce would not be English speaking; there would be an increase in Arabic-speaking nurses and less reliance on foreign staff. A high multi-cultural/national workforce has been linked with reduced quality of care (Al-Ahmadi, 2014). However, as degree education develops and enhances English language skills and communication, this would not be an issue in workforce planning as there would be less reliance on foreign staff (Al-Homayan et al., 2013). This should alleviate some of the issues seen with lack of communication. However, the enhancement of communication skills should help mobilise the workforce, enable local staff to take up advanced degrees and qualifications abroad and help develop the healthcare service by providing local staff with clinical training to international levels (Al Mutair, 2015). To realise this potential, nursing opportunities need to be publicised through the media to raise their profile (Ventola, 2014).

Meso and macro level participants felt that degree educated nurses were more likely to multi-task and therefore would be more resourceful than diploma educated nurses. The multi-tasking ability comes from acquisition of broad in-depth knowledge that they are able to apply more readily in their roles. Furthermore, a degree can open doors for further specialised education and personal development such as the uptake of master's and PhD programmes. The enhanced communication skills of degree educated nurses were also noted by the macro level participants, who believed this would increase knowledge and skills. The skills referred to here are medication calculation, IV cannulation, catheterisation, knowing side effects of medication and signs of illness in patients, among others.

Macro level participants believed that degree education could make up for the lack of experience in graduates compared with diploma educated experienced nurses. It was suggested degree level education would be good for those beginning a career in nursing as well as for those wanting to specialise, as it offered nurses the opportunity to gain skills and specialised knowledge that reduced nursing errors and increased quality of care (Aiken et al., 2014). Macro level participants appreciated experience as an important part of delivering quality care, but believed the diploma-educated nurses were more likely to deliver continuous quality care based on processes that have worked in the past, rather than apply critical thinking and leadership to improve services and innovate. They argued that these were skills graduates were likely to possess, concurring with the findings of Veenema et al. (2016).

Nurse-led clinics in SA have already been shown to be successful in demonstrating leadership skills (Bdeir et al., 2015). As consumers, it would be interesting to to gain the patients' view of graduate nurses versus diploma-educated nurses and the quality of care they receive. Currently, studies in this area are lacking in Saudi literature and need to be explored in order to gain an overview of the impact of degree education on the nursing workforce and quality of care in SA.

Macro level participants stated that enhanced communication skills and knowledge were partly due to nurses being better at using technology, and thus better able to support those who are in need of care. At the meso level, participants agreed that healthcare delivery was becoming sophisticated and complicated, and nurses need to keep up with this trend; a degree education better prepares nurses for this. Advancement in technology and the

availability of information means patients are knowledgeable about healthcare (Black et al., 2012). Interestingly, participants at the micro level, whether degree educated or diploma educated, did not raise this as an issue, suggesting perhaps this was not an area of concern as the meso and macro level participants were suggesting.

Macro level participants believed that there was a gap in the level of knowledge taught on diploma and degree courses, but the latter offered a better knowledge-based programme. This was the main reason for being in favour of the mandatory degree policy. There was a failure to recognise that degree programmes can be demanding, as shown in many countries where the policy has been implemented (Brown, Anderson-Johnson, & McPherson, 2016; Craft, Hudson, Plenderleith, & Gordon, 2016). This may have a negative impact on successful completion rates compared with diploma programmes, and thus negatively impact the workforce (Rother & Lavizzo-Mourey, 2009). The MoH and MoHE would need to look into this when developing standardisation policies (Section, 6.5).

Meso level participants also pointed out an interesting fact that would help develop the workforce. The nursing profession in SA needs to have more devolved roles with better job descriptions. Nursing roles need to be specialised into specific roles such as administrative, technical, or senior nursing (Considine et al., 2007). Definition and clarity in job roles would allow nurses to home in on their strengths and develop these further by being able to refer to their job description to improve their career prospects (Almutairi et al., 2015). It would enable line managers to arrange appropriate training to improve the quality of service (Hendricks et al., 2012). Different people have different abilities, different ambitions, and different rates of learning, therefore offering specific roles based on their level of education that enable nurses to focus on their strengths should help with job retention, job satisfaction and career progression (Almutairi et al., 2015).

Under a diploma education system, there is no demarcation of roles, resulting in Master's level nurses doing the same job as diploma educated nurses. This devalues and undermines advanced degrees and reduces the attraction of the job due to lack of opportunities in career progression (Al-Ahmadi, 2014). Jobs where an individual is unlikely to advance, despite having good academic qualifications, are likely to deter people from taking up more specialised courses. Meso level nurses highlighted that such job descriptions already exist, but are not applied in practice due to the shortage of staff. This means the nurses are

not able to fulfil their specific roles and instead all staff have to help with all roles to fill the gap created by the staff shortage. Such issues should be reduced by professionalising the course, which would help increase uptake of the profession, as identified by Rosseter (2013) which in turn should increase the workforce, as understaffing can lead to excess pressure which compromises quality of care (Rother & Lavizzo-Mourey, 2009; Almalki, 2012).

Macro and meso level participants concurred that whilst a degree is important in quality healthcare, experience is also important. Participants in both groups agreed that as the degree course is a recent addition to the education system in SA, it is obvious that they had been taught by experienced diploma educated nurses in order to qualify; illustrating experience is also important and goes hand in hand with education. Experience was recognised as a strong factor in making decisions and using judgement in clinical situations, and it also supports education (McHugh & Lake, 2010). This indicates that experienced diploma educated nurses should be encouraged to stay on in practice in order to enable the workforce to take advantage of their experience.

7.6.1 Career and healthcare development

Macro and meso level participants believed that degree qualified nurses were more likely to become nurse managers and progress in roles quicker. Enhanced communication skills allowing nurses to communicate better in English with patients, doctors and allied healthcare professionals were thought to contribute to their career advancement (Almalki et al., 2011; Al-Homayan, 2013). Both levels of participants believed that degree education opened further gates of opportunity, such as allowing nurses to study for Master's degrees and PhDs, further increasing specialised skills, knowledge and career development. At the macro and meso levels, there is a lot of emphasis on academic ability and career progression; but at the micro level, there was more discussion on delivering quality care to patients being the primary role of nurses. There was a mixed response on the value of degree education over diploma and experience. Micro level participants understood that both experience and education went hand in hand and that the nursing profession is constantly changing. It could be argue that to be flexible and acquire new skills for nursing workforce as and when required, and be open to change in order to provide high quality care rather than simply focusing on further education and existing experience (Kattuah 2013).

The macro level interviewees understood that those with a diploma should be given an opportunity to gain the knowledge degree educated nurses acquire through bridging programmes. This should allow better workforce planning as a valuable proportion of experienced nurses would not be excluded from the workforce. This may help increase the number of nurses in the workforce by encouraging diploma educated nurses and those already on diploma courses to stay on in the profession despite the sudden change. It should entice new recruits to take up a professional career.

Micro level diploma educated staff appeared to be unconcerned about rushing to enrol on bridging programmes to alleviate the apparent gap in their knowledge, and instead spoke of their commitment and experience as being more important. Those wishing to complete degrees felt that being degree qualified and more academic earned them respect from doctors and consultants that would help with promoting the image of nursing in SA (Al-Malki et al., 2011). This may contribute to increased uptake, as it has been shown that with increased professionalization comes respect that has previously been lacking (Miller-Rosser et al., 2006). The stigma comes from the public and patients who view nurses as maids, as identified by Gazzaz (2009). Professionalization of the profession may help patients change their view of nurses, which can help nurses to deliver better quality care (Willis, 2012). In families, there can be a lack of support, for example parents refusing to acknowledge their children are nurses due to the stigma associated with the profession, as highlighted by (Meerabeau et al., 2004), which has affected the uptake of nursing as a career. Professionalisation of nursing may make parents proud and more supportive, thus encouraging their children towards this career pathway (Al-Malki et al., 2011), which in turn would have a positive impact on the workforce.

At the micro level, the discussion on career progression was mixed. Micro level participants were more concerned with the status of the nurses and how this may be affected. For example, nursing was seen as a low-level job in SA, with much social stigma attached to it (Miller-Rosser et al., 2006; Gazzaz, 2009). Nurse participants thought the stigma was a result of nursing being a female-only profession, but opening doors for men to study nursing will help the profession gain more respect, as culturally in SA, men earn more respect than women (Al-Malki et al., 2011). Changes in such negative images can only help open the doors of nursing to a wider number of applicants, which would help with recruiting and educating an appropriately skilled workforce (Al-Malki et al., 2011).

Micro level participants thought that the mandatory degree policy and professionalization would be likely to have a positive impact on the image of nursing, so is therefore more likely to attract more applicants which would in turn help counteract some of the staff shortages identified by Alyasin & Douglas (2014), It would also provide more local nurses who can communicate with native patients, and therefore help mitigate the issue seen with lack of communication due to poor English language skills. Local nurses would better understand the cultural needs of patients and thus be able to increase service delivery (Suliman et al., 2009). Poor language and communication skills can affect the quality of care provided (Al-Ahmadi, 2014). Other positive impacts of professionalization identified by the micro level participants that would again help mobilise the workforce were better pay and the ability to progress professionally more quickly than diploma educated nurses. This echoes the opinions of macro and meso level participants. The opportunity for promotion, greater responsibility and salary may confirm the fears of some patient groups that have said that making nursing a degree-only profession may turn it into something that becomes an accolade rather than a patient-centric role (INVOLVE, 2012). Indeed, one participant said the reason they entered nursing was because the individual desired a role in which they obtained respect, a good salary, and was able to progress up the career ladder. Going for a career that earned an individual respect and appropriate remuneration should not be a negative thing; it could motivate staff to do well due to appropriate reward. The Willis Commission Report (2012) already stated that quality of care has improved due to the introduction of nursing degrees, even if this is due to individuals wishing to pursue a career in nursing due to its professionalisation.

7.6.2 Nursing education and bridging programmes

Interviews at the micro level revealed many pathways to nursing education; this was partly due to the multinational workforce arriving from different countries offering different nursing pathways. However, it was evident that despite the recent decision to make degree education mandatory, many of the interviewees already had diplomas, as well as a degree and higher level certificates such as a Master's degree. This shows that the drive to excel and progress in a career was already there and is not something that would be driven by degree education. Therefore, the desire to excel in nursing was not dependent on being degree educated. Diploma educated nurses already had the drive to continue to pursue education that would help develop their knowledge and career.

The meso level participants explained the reason for favouring the degree programme. The degree curriculum taught in subject areas such as pharmacology, physiology, psychology, autonomy, and human development was producing more academic nurses than diploma educated nurses (Almadani, 2015; Al Mutair, 2015). However, this finding from the micro level nursing participants suggests diploma educated nurses can be just as academic. The data revealed there are a number of bridging programmes to help male and female students to convert their diploma to a Bachelor degree (Almadani, 2015). Meso level staff pointed out that in the past males could not study for a degree in nursing, but this had now changed and should help with managing the nursing workforce and mobilisation of skills. These programmes are already offered at private and government colleges (Al Mutair, 2015).

There is also a perception at the macro level that there would be no problems or issues with the uptake of bridging programmes. The only issue that the macro level interviewees did recognise was that the private colleges offering nursing degrees are new, and there is therefore little information regarding the quality of such courses. In contrast, the meso level nursing professionals agreed that the degrees taught in government institutions are of excellent quality, which should help develop a well-taught, knowledgeable nursing workforce. The meso level participants also felt that private institutions did not offer the quality of teaching seen in government institutions. This means that simply studying for a degree does not guarantee a higher quality academic education as implied by macro level participants. Studying for a degree over a diploma has shown that nurses experience higher burnout, stress and drop-out rates Brown et al. (2016); Craft et al. (2016), which can have a negative impact on the availability of nursing staff following implementation of the mandatory degree policy. The interviews highlighted that graduate nurses from private institutions have been found to lack the competence seen in graduate nurses from government institutions, which would affect their recruitment/career prospects. This would affect the workforce through the lack of appropriate candidates despite the availability of degree 'qualified' nurses.

Degree courses need standardisation, monitoring and evaluation in private and government institutions, especially because of the new policy. Lahtinen et al. (2014) state that the lack of standardisation can affect the labour market, workforce planning, quality of care and staff mobilisation. In fact, one meso level participant stated that in private institutions, the standard and content of the degree programme were akin to those of the diploma

programme. This would mean that there would be no point in a diploma-educated nurse with experience going to the extra trouble of acquiring funding, enrolling and going through the degree programme in private institutions. Furthermore, the interviews revealed that government hospitals, which are the biggest recruiters of nurses, preferred students who had graduated from government universities due to the disparity in teaching between government and private institutions. This means that nurses who graduate from private institutions would have a harder time getting a job over their government institution educated counterparts, and this may deter students if they do not get into government universities (Al Mutair, 2015). This highlights that simply offering a course with the title 'degree' does not guarantee quality education and supports the need for tight monitoring and evaluating as mentioned above. The lack of regulation and oversight of courses in private institutions means that they are more focused on increasing business rather than teaching to improve quality of care and develop the future workforce. Such gaps and inequality in education can undo the good that has been predicted and on the professionalization of nursing (Omer, 2012) and could be tackled by introducing professional bodies and gold standards (Abualrub & Alghamdi, 2012; Alghamdi & Urden, 2016).

Although macro level participants stated that there should be no issues with the uptake of bridging programmes, they admitted that the expenses and bureaucracy associated with getting on to a course and obtaining scholarships could affect uptake and therefore affect the workforce negatively (Lamadah & Sayed, 2014; Miller-Rosser et al., 2006). Conversely, meso level participants thought diploma qualified nurses would face problems trying to enrol on bridging programmes. Many diploma-educated nurses would be older; nurses over 40 years old would be unable to enrol on bridging programmes, which would affect a large number of experienced nurses. To tackle this problem, the MoHE would need to lift this restriction in order to help increase the number of experienced staff taking up degrees and bringing their experience back into the healthcare environment, rather than being excluded by the new regulation. Another issue highlighted was the minimum score of Test of English as a Foreign Language (TOEFL) or International English Language Testing System (IELTS) requirement. Some of the diploma-educated nurses may not meet the minimum requirement and would be excluded from enrolling on bridging programmes, thus excluding them and removing their experience from the workforce. Experience plays a vital role in quality of care, with experienced nurses making fewer clinical errors,

without baccalaureate status having significance in the outcome (Dellon et al., 2009). Therefore, to attain maximum benefit in workforce planning and skill utilisation, attention must be paid not only to recruiting graduate nurses but also retaining nurses with experience in the workforce. Furthermore, access to grants and scholarships should be made easier for diploma educated nurses and first time students to study for a degree in nursing.

There is a belief at the macro and meso levels that although the MoHE sets the standard, the way the courses are taught in the newer private colleges and the older traditional government colleges is different. At the macro and meso level there appears to be a consensus that graduates from private institutions are not as well-trained and skilled as nurses who graduate from government institutions. Such issues can affect the quality of care. The difference in education is blamed on the lack of focus on the curriculum and too much focus on finances. Macro level participants anticipate that standardisation would help diminish some of these issues and alleviate some of the worries that students have about graduates from private colleges, who are seen as candidates with a lower quality of education. Indeed, it was the global drive to standardise nursing education that led to the mandatory degree policy in the first place, as nurses were moving internationally with varied levels of education, making it difficult for the workforce to maintain quality (WHO, 2009). Standardisation was aimed at reducing issues with recruitment and qualification and increasing quality (Almutairi et al., 2015). This level of standardisation should be applied at the local level in SA to make the policy successful; especially as the GCC document revealed the drive to change the nursing profession was driven by patients' desire for quality healthcare (Albejaidi, 2010). Government institutions mostly offer free courses, whereas attending private institution requires finance; this can affect the number of students taking up nursing degrees and graduating, especially as more students would have to arrange finances to fund their studies, which has been highlighted as a problem.

7.6.3 Workforce organisation and mobilisation

Macro level participants believed that the standardisation of nursing education programmes allowed for better staff movement and workforce mobilisation with the GCC. Standardisation would reduce the worry of potential employers checking the level of education and whether it is significant. Standardisation of education and skills would allow nurses to be more easily recruited internationally and would help alleviate shortages in the

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workforce due to lack of appropriate qualifications as well as perhaps increasing staff retention (WHO, 2009; Rother & Lavizzo-Mourey, 2009). Whilst this may work well in the long term, the mandatory degree policy is a recent initiative and there is still a vast number of diploma-educated experienced nurses in the workforce. The strong opinion at both the macro and meso level participants for supporting degree education, and from nursing managers at the micro level, where strong statements such as 'I will not accept any nurses to come to work in this hospital without a BSN degree because of patient safety' (SN1) may actually hinder workforce planning in the short term. This attitude may alienate experienced diploma-educated nurses in favour of recent graduates with academic abilities, but who also lack the nursing experience which ultimately may impact on patient care and safety, thus defeating the object of the degree programme. Furthermore, if professionalization of nursing as a career increases the number of people wishing to take up the degree and increases competition for courses in government universities, a higher number of students may opt to go to private institutions (Ahmad, 2012). As previously discussed, there is a concern that graduates from private institutions are not sufficiently competent. This may affect the workforce, as there may be a high number of unemployed graduates because their degrees are not valued due to the belief that undertaking a degree at a private institution is similar to a diploma, with new students not having the experience.

One very important theme to emerge which is likely to have a significant impact on nursing workforce mobilisation and organisation was the belief at the meso level that diploma- educated nurses had fewer skills and could be placed to work in the community or Primary Health Centres. Degree-educated nurses were considered overeducated for this environment and more suited to work in hospitals. In contrast, participants working at the micro level did not raise this issue, perhaps indicating there was less hierarchical thinking within this group of participants. This type of thinking at the meso level is indicative of a top-down process and can affect policies, which ultimately affect the (Meerabeau et al., 2004). This may be a step backwards as the healthcare needs are changing in the Middle East (Shuriquie et al., 2008), with healthcare moving from hospitals to the community. It is envisaged that this move will allow the delivery of a service that is geared towards preventative medicine, early treatment, healthcare education and lifestyle changes, especially as longevity in the overall population increases (WHO, 2009; Almalki et al., 2011; MoH, 2014) . There are plans in SA to implement more PHC policies, which should help make healthcare more cost-effective (Jadelhack 2012). The change is also in response

to the increase in non-communicable diseases which account for around 71% of deaths in SA (Mahmoud & Faramawi, 2015), and thus the face of PHC is changing and needs appropriate action (Almalki, 2012). If people working at the meso and macro levels continue to believe the more educated and better skilled nurses should work in the hospitals, the success of delivering contemporary healthcare within the community will be compromised.

The idea that degree-educated nurses would be a waste of resources if placed in the community undermines the value of community nursing and its importance in quality healthcare delivery. Furthermore, moving diploma educated nurses from the hospital and confining them to the community, because it is seen as a role of lower responsibility, undermines all their previous contribution and hard work and will create resentment, which has been shown to affect staff retention (Schwendimann, 2015).

At the micro level, many participants believed that there was not much difference in the jobs that diploma and degree educated nurses perform. Creating job descriptions that limit the practice of degree-educated nurses may actually affect the workforce negatively, especially as there is a belief at the micro level that the care they provide is the same despite the difference in education. This emphasises support the importance of job roles, job description, and role demarcation.

7.7 Summary and Conclusion

In summary, this chapter has been derived from the common themes revealed from the data presented in the macro, meso and micro levels and has identified several areas where workforce planning and mobilisation could be affected by the mandatory degree policy. The following conclusions are derived from the common themes revealed from the cross-group analysis of the three levels of data collection: The degree and its role in healthcare quality; career and healthcare development; nursing education and bridging programmes; and workforce organisation and mobilisation.

A degree education should help propel the Saudi nursing workforce on to a global platform, enabling mobilisation in the GCC and globally. However, in the process of training the new generation of degree-educated nurses, it is important to take full advantage of the availability of diploma-educated experienced nurses. These diploma-

educated nurses have helped develop the healthcare system gain its current status and should continue to play an important role in the future of healthcare delivery rather than being excluded out of the workforce. This is recognised at the micro level, but also needs recognition at the macro and meso levels of nursing.

The following chapter will present the conclusion of this thesis. The research strengths and limitations of the study will be acknowledged. Following on from this I will identify the original contribution this thesis makes to existing nursing knowledge and its potential influence on workforce planning. The chapter will provide recommendations that will underpin the future development of a five-year SA National Nursing Strategy for Future Workforce Planning. Finally, the researcher reflects upon the research process to provide key lessons for future research.

Chapter 8 :   Conclusion and Recommendations to underpin Future Workforce Planning Initiatives in SA

8.1 Introduction

The previous chapter presented the result of data collected and analysed from participants working at the macro, meso, and micro levels. The chapter included an integrated critique across three levels of analysis and this was followed by a discussion based on the findings of this study and those of the studies critiqued within chapter 3, the literature review. This concluding chapter is the final chapter of this thesis and is related to the objective:

- To critically analyse the data and make recommendations that will underpin the future development of a five-year SA National Nursing Strategy for Future Workforce Planning.

The chapter begins by presenting the strengths and limitations of the study, followed by its unique contribution to existing knowledge. The major recommendations derived from the findings of this study for future nursing workforce planning and development in SA are then highlighted. Finally, the researcher reflects upon the research process and provides key lessons for future researchers.

8.2 Strengths and Limitations of the Study

This study has many strengths: the nature of the study and its uniqueness in taking account of the three levels of the MoH (macro/national, meso/regional, and micro/local); the period of the study aligning with current changes in SA; and the triangulation of data against the backdrop of an extensive literature review of the history of nursing education and contemporary trends. All of these aspects have facilitated putting this into context.

This unique study provides a national vision for Saudi workforce planning and development that reflects the vision of different decision makers and practice nurses in the field; from the macro, meso and micro levelsl. Furthermore, the perceptions at all three levels are explored through the current policy of degree education. This study also investigated the research question within the context of the political, social, and cultural

background of SA. It also illustrates how the Saudi healthcare system addresses the international and the GCC requirements and standards. The study coincided with an important period of time that witnessed many challenges and changes in both the MoH and the education system in SA, such as the closing of all diploma programmes for nursing. The findings of this study have contributed new knowledge to the understanding of degree education and its influence on workforce planning and development.

However, limitations within the study design may restrict the findings to the Saudi contexts. Case study methodology has been criticised for a lack of transferability, as, by definition, the uniqueness of the case is often bound by location and time, but also because a small sample cannot represent a whole population (Merriam, 2009). The utility and transferability of findings from qualitative case studies should therefore be judged by criteria congruent with the philosophical values of research. By its very nature, a case study is an in-depth examination of small samples of events, programmes, people, or circumstances, with the sample being selected for originality or uniqueness and not for its representativeness of the target population. As such, the research aim is to study the sample intensely and thoroughly, to gain better understanding of the phenomenon within a given context. Yin (2009) argues that a unique case can also be a single example of a broader class of things. This study did not intend to generate findings that would be statistically generalizable, but rather sought to provide naturalistic generalisation as described by (Stake, 2003). However, in-depth description of each level of people working within the MoH has been provided, together with pertinent documentary analysis, to enable the readers to draw their own conclusions regarding this case study.

8.3 The research contribution

This thesis has explored and assessed the implications of introducing a nursing degree as a minimum requirement for qualified nurses in SA. The current study was undertaken because there is not an established evidence base to consider the implications of degree-educated nurses in terms of future workforce planning, quality of nursing care and patient experience. Whilst other developed countries have recommended degree education for all nurses, in SA, this policy was implemented by the MoH in 2010, with arguably insufficient planning and no body of evidence regarding the implications of this policy. In light of this, the findings presented in this thesis provides an unique original contribution by providing

valuable evidence regarding the implications of Bachelor degree nursing education in SA, as a baseline from which to develop a national nursing strategy for future workforce planning and development. This study will contribute to nursing knowledge and workforce planning in several ways:

- The papers reviewed explored education attainment and its relationship to Saudi health outcomes (Al-Ahmadi, 2014; Alyasin & Douglas, 2014; Aiken et al., 2014; Majeed, 2014; Almutairi et al., 2015). There is currently little consideration of Saudi workforce policy and planning, and implications following the introduction of degree education as a minimum requirement for nurses.

- Whilst the papers reviewed give a local or regional prospective on the nursing workforce (Aldossary et al., 2008; Gazzaz, 2009; Almalki et al., 2011; Almalki, 2012; Al-Homayan et al. 2013; AlYami & Watson, 2014; Alyasin & Douglas, 2014; AlMakhaita et al., 2014; Lamadah & Sayed, 2014), they are small scale studies. While such research is required to describe and understand the nursing situation.

- This study is the first within the MoH to adopt a consultative approach that involves key nursing and policy stakeholders at the macro, meso and micro levels of nursing. In addition, this case study methodology will contribute to the development of knowledge and understanding about the process of policy implementation; and stakeholder involvement in developing strategic policies. It is anticipated that the case study design could be used in other areas of policy development. The involvement of different stakeholders across the sectors, Government bodies who are responsible for economic and social policy through to those delivering care, would facilitate ownership of the plan. This comprehensive integration of stakeholders will ensure every aspect of the planning is covered and arranged for nursing future workforce planning and development of a national strategy in SA.

- The majority of studies conducted in different countries regarding similar or related topics used the quantitative method. Only one study used mixed methods. This study will be the first study exploring the implication of degree nurse education by using the qualitative approach that is giving voice to those that are actively

involved in the new policy of degree level education being a requirement for all nurses in SA. This study builds on this evidence and in doing so is in a position to proposev national strategies and recommendations for workforce planning. The outcome will be a series of action plans that underpin future evidence-based workforce requirements.

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8.4 Recommendations

This section provides the recommendations from the data identified within this study. It will start first by presenting the participants' recommendations at each level of the organisation, followed by the overall recommendations from all levels together with three key messages.

The macro level participants' main recommendations for improvement of nursing care were:

- Implementation of differentiated nursing job descriptions, based on educational level.
- The need for adequate supervision, follow-up and accountability for the nursing workforce.

Participants working at the meso level provided recommendations for improvement of nursing care:

- Validate the requirement for Bachelor's level education for all nurses to ensure training and education that is appropriate and necessary for nursing staff.
- Nurses who are educated to degree level are thought more likely to be able to promote public awareness about the use of primary healthcare centres, thus taking the pressure off hospitals.
- It was specifically noted that the regulations are not enforced in the private sector, implying the need for more standardisation of national regulations.
- To bridge the gender gap through expansion and/or addition of nursing colleges offering Bachelor degrees for males to increase the education level among this group of nurses.

Finally, participants working at the micro level offered their recommendations with regard

to the issue of standards for nursing education. Three major recommendations emerged from this data supported:

- The creation of job descriptions for nurses that better reflect their level of education. This is necessary to address the nursing shortage, which was felt to necessitate a tolerance for lesser qualifications.

- Recommendation for a focus on the quality of education to produce quality nurses, rather than increasing the number of nursing colleges or increasing the number of nursing graduates with poor levels of knowledge and/or skills.

- Support for the creation of education opportunities for Diploma holders to join bridging programmes for conversion to degrees without any obstacles, which will expand the supply of degree nurses.

Overall, the recommendations suggest two levels of job description, one focusing on the Bachelor degree nurses and the other on Diploma nurses. The quality of education was also seen as important for the future nursing workforce development. Furthermore, the Diploma nurses called for the provision of opportunities for bridging programmes and the removal of the obstacles hindering their access to and completion of their studies. The recommendation is to enhance the status of nursing in SA to make it a worthwhile career and this has to be tackled by first dealing with some of the existing social stigma evident in SA (Gazzaz, 2009). The Saudi government needs to use the media to help engage with people and promote a positive image of the nursing profession to help with the shortfall in the local workforce (Almalki et al., 2011).

Universities need to improve their curricula in order to cope with the changing and evolving needs of the nursing profession and the people for whom they provide care. This needs to be reinforced at the macro level by standardisation of a national curriculum, as the current disparity for the preparation of professional nurses is also a factor affecting the outcomes of providing quality care. The major nursing strategists need to focus on combining knowledge with skills training to benefit the nursing profession and to improve its conditions.

The studies of Park et al. (2007); Ross & Bell (2009); and Spetz and Bates (2013) could be used when supporting nurses with Diploma in Saudi Arabia who are planning to achieve advanced degrees. Offering tuition reimbursement for BSN and graduate-level education

without any obstacles might help increase the nursing education level in Saudi Arabia. Since baccalaureate education and Master's degrees are likely to confer benefits to both patients and nurses, policies that encourage nurses in Saudi Arabia to pursue further education should be supported. Saudi Arabia's healthcare system should also consider the accessibility of colleges offering baccalaureate degrees or Master's degree programmes. Proximity to these educational institutions might increase the total number of nurses with BSN or advanced degrees.

The Cross-level Recommendations: Three Major Key Messages:

Key Message 1

The Gulf countries have a wealth of information from the global nursing field to refer to in order to develop their own healthcare system and manage their workforce to make it fit for the 21st century (WHO, 2009). In future, the GCC nursing committee needs to assess the opportunity for looking at countries that have already implemented the policy of making degree level education a minimum requirement for nursing and working with the outcomes of this to shape their policy. To date, the policy has been implemented directly in a top-down manner, with people at the meso and micro levels not being involved. In future policy decisions need to take account of this and involvement from the bottom up should be standard practice. Additionally, when introducing a new way of working, there should be an inbuilt pilot study and/or evaluation capturing the challenges and strengths of the project, thus enabling appropriate action to be taken.

Key Message 2

Diploma nurses and funding for healthcare fall under the authority of the MoH and nurse education comes under the MOHE. In order to bridge the gap, there needs to be better communication and links between the two organisations (MoH and the MoHE); or the policy needs to be transferred to one of the two for coherence, for example the MoHE. In Switzerland, due to the two main different linguistic communities, the nursing education model has taken two separate pathways with high variability and inconsistency between them (Spitzer & Perrenoud, 2007), defeating the goals of organisations such as the WHO

and the International Council of Nurses (ICN) in trying to standardise nursing education globally. SA could learn from the Swiss example in bettering its own nursing education system by merger or even the creation of a new department to help drive the initiative. In fact, there is acknowledgement of nursing power in theory, yet even with a degree education, nurses might lack the means to change and adapt and use their skill set – possibly, but not exclusively, to the context of the current Saudi health system outlined in Chapter one, and possibly to do with the theories of managing change in any setting. Achieving this is dependent on having a robust, standardised curriculum, a faculty that can deliver education at the right level, and clinical settings that facilitate nurses putting their learning into practice. The nursing workforce in SA needs strong strategy and national planning

> *"to ensure the presence of the right nurse with the right qualification in the right role, at the right time, in the right place with the proper authority and appropriate recognition"* (Affara & Styles, 1992:P .18).

Key Message 3

Professional development within nursing should be reinforced by evidence, within the context of a national nursing strategy. The debate about the comparative value of generalist and specialist nurses is a distraction from the need to support professional nursing development and effective leadership programmes. This needs to be taken seriously by the key government bodies in the context of implementation for change and to address the recommendation for future workforce planning and development. Nurses must be positive and active in negotiating the limitations of the health services they provide, recognising the potential contribution of themselves and other healthcare professionals.

All of these recommendation and keys messages will inform the development of a five-year national nursing workforce plan in Saudi Arabia. The findings of this thesis will disseminated through the following dissemination plan.

8.5 Dissemination Plan

This thesis has critically analysed the degree education policy as a minimum requirement for professional nurses to enter practice in SA. The findings will be disseminated through

the following steps:

- The recommendations from this study will be submitted to the policy makers in the governmental bodies in order to implement the national nursing workforce plan, including improving nursing competencies and considering the future role of nursing at different levels. The researcher will request a meeting with the deputy minister and other decision makers, including the general director of nursing in the MoH in order to discuss the results of this study and to consider how they can be translated into monthly action plans for the nursing workforce.

- A copy of the results and recommendations will be sent to the key Saudi government departments such as the MoH, MoHE, SCHS in order to raise awareness of nurses and other healthcare providers about the value of degree nurses in the Saudi community.

- An oral presentation with a brief description of the study and its results will be given to the regional nursing directors during their annual meeting.

- A publication about workforce planning and developments for nursing in SA in professional peer-reviewed national and global journals, such as the Journal of Nursing Education (global level) and Journal of Health Specialties (national level); the latter being the official publication of the Saudi Commission for Health Specialties (SCFHS).

- Publications: "Using case studies to explore the influences of nursing degree education on the nursing workforce in SA"; "Degree education as an entry requirement for qualified nurses in SA: a policy analysis"; and "The perception of micro level nurses about Bachelor degree as a minimum requirement for professional nursing practice in SA" will be submitted to the PubMed Journal, which is a peer-reviewed international journal and has literature from MEDLINE, life science journals, and online books.

- The findings of this study will be available on the PhD resource website of University of Salford Library in the UK.

- Participation in international conferences to present the findings of this study; for example, conferences organised by WHO, ICN, ANA, and NHS.

- Participation in national and local conferences in different cities within SA and future working groups for regional impact.

- An official nursing committee will be established by the General Directorate of Nursing with seminars being delivered on a quarterly basis in order to provide up-to-date information regarding job descriptions and nursing roles and to follow up the degree nurses' performance in hospitals and PHCs.
- Adding a couple of post doctoral studies – patients' perspective of the degree level nurse in SA.

8.6 Personal Reflection on the research process

Being a decision maker at the MoH and a member of the GCC Nursing technical committee, and now a PhD candidate, has supported my role on my PhD journey. I became president of the Saudi Society at the University of Salford and I worked as a volunteer at different social and educational activities such as the Saudi national day, which helped me to build a good academic communication network. However, studying abroad in a western country with a different language was inspirational, as I completed my Master's degree in the US. Adaption to the weather and environment in the UK was a significant change in my life. Living with my family in Manchester was a motivating factor as it provided me with support for my future during the process of my PhD. On the other hand, it was stressful as my sons are teenagers and I struggled to combine study with family commitments. I have undertaken this research independently, and have regularly engaged with my supervisors, colleagues and post-graduate research students to discuss the research process and to receive their feedback and comments about all phases of the study, including my role and position. In order to make a clear audit trail of decisions made throughout this study, I have maintained a reflective diary throughout the research process, recording a range of activities, such as field notes and schedules, areas of concern and interest, tutorials, and the rationale for any decisions (Appendix 5. 14) as suggested by Alvesson & Skoldberg (2009). My multiple roles in this research process have included researcher, interviewer, interpreter, moderator and facilitator, and my previous roles as a senior nurse, decision maker, policy maker and successful student nurse must also be acknowledged. Accordingly, my own characteristics, experience, skills, understandings, values and motivation have influenced this study. In particular, I was aware of my 'insider' researcher role as moderator within the macro, meso and micro levels of data collection and analysis. I am an experienced interviewer, having been involved in nursing recruitment throughout my career as a nurse director in the MoH for the past 20 years. My experience

as an interviewer facilitated many aspects of the data collection process, such as familiarity with building interpersonal relationships, confidence in organising the fieldwork needed for this study, accessing the documents and discerning which were pertinent, and contacting the participants from different levels.

Researcher motivation is a vital part of the research process (Alvesson & Skoldberg 2009). Although a relatively inexperienced researcher, I have been highly motivated to undertake this research and have brought specific skills, knowledge, and experience to my role as a researcher. As stated in the introduction, the initial idea for this research originated from my background experience with responsibility for workforce planning and development. I also had responsibility for contributing to the nursing strategic plan by ensuring that potential nurses were successful in undertaking bridging programmes. Although originally driven by issues relating to the minimum requirement criteria for Diploma nurses and the shortage of staff, it became apparent early in the research process that the findings would not be limited to aspects of nursing education and practice, but would offer new insights into other aspects of workforce planning and development, such as the quality of care. Additionally, I am a highly organised person who completes tasks thoroughly with a high degree of honesty. This ability to manage complex responsibilities, manage large volumes of data, and act with honesty and integrity has stood me in good stead to complete this study to a high standard.

8.7 Summary and Conclusion

The need to reform nursing education as the world entered the 21st century drove the global impetus to reassess old policies and standardise education powered by the diversity of nursing roles and the migration of nurses from one country to another. The trends followed so that as one country made it mandatory to make a degree in nursing the minimum requirement, soon after others followed. One of the main reasons for this shift can be attributed to many researchers demonstrating that education of nurses was directly linked to quality of patient care (Section 2.4). In the Middle East, including GCC Countries, there is a great shortage of nurses, with the majority of the workforce being foreigners. In light of this, Middle East countries need to participate in the global nursing arena, by being seen to provide the same level of care. Gulf countries such as Saudi Arabia

have also recently implemented the policy of degree education as a minimum requirement to entry into nursing practice following trends in developed countries.

The future of access to PHC and nursing education will depend on increasing the number of the BSN nurses. Achieving this goal will help the Saudi health system to meet patients' future needs and demands; and improve the future nursing workforce. There is clearly a need for an improvement in future workforce planning and development in nursing practice in SA. Major changes in the Saudi healthcare system will require profound changes in education and practice for nurses before and after they receive their licences. Appropriate professional education and providing adequate job facilities to nursing staff is required in order to bring improvements. The universities need to improve their curriculums in order to cope with the changing and evolving needs of the nursing profession. The nursing staff promotional hierarchy should be revisited and improved as that is also a factor affecting the lack of professional nurses. The major nursing strategists have put their focus into combining knowledge with training to benefit the nursing profession and to improve its conditions. The issues of nursing staff, like lack of promotion, need to be carefully considered and resolved. On the job training and education should be provided in order to keep them up to date with the latest in health technology and develop their skills as part of their continuing professional development. These form the backbone of the healthcare sector, and their betterment is an imperative. Degree nurses will be able to provide the required level of health care and a level of professionalism that is necessary in providing quality health care

In conclusion, this chapter has highlighted the contribution of this study to existing knowledge regarding nursing practice, education and policy. It provides recommendations for policy makers in the key governments bodies (MoH, MoHE, SCHS and MCS). The recommendations based on the findings of this research highlight the importance of the differentiation of distinct nursing job descriptions based on the education level attained together with a focus on improving the quality of patient care through education, validation and regulation of the standardization of BSN curriculum, together with adequate supervision. In addition, the dissemination plan for the results is explicated, as well as some of my own reflections on the research process.

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Appendix 4.1
The process of obtaining permission to access the facilities of MOH
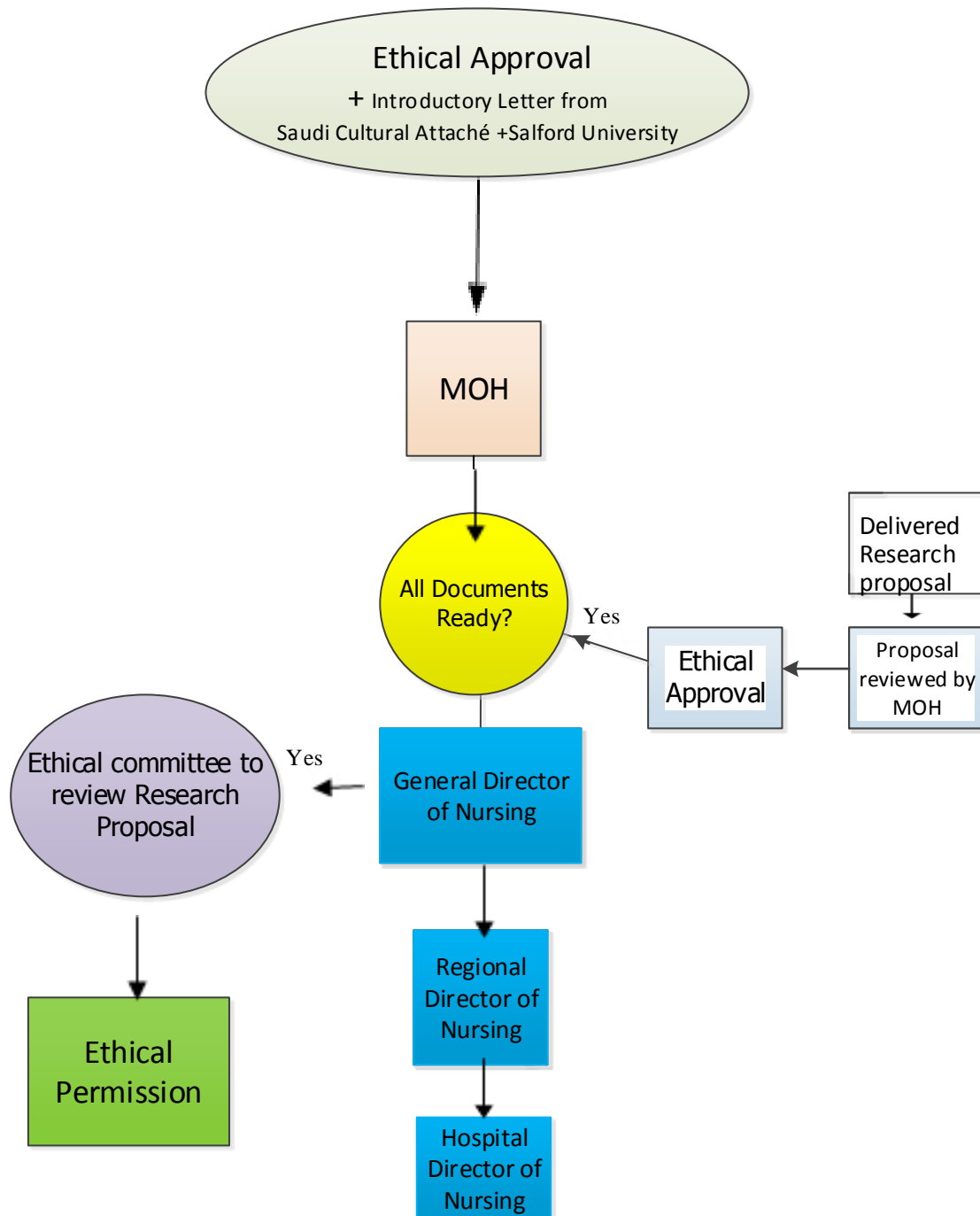
Ethical Approval
+ Introductory Letter from
Saudi Cultural Attaché +Salford University

MOH

All Documents Ready?

Delivered Research proposal

Proposal reviewed by MOH

Ethical Approval

Yes

Ethical committee to review Research Proposal

Yes

General Director of Nursing

Regional Director of Nursing

Hospital Director of Nursing

Ethical Permission

University of Salford
MANCHESTER

16 February 2015

Dear Noura,

RE: ETHICS APPLICATION HSCR14/119 – Degree education as an entry requirement for qualified nurses: A case study to inform nursing workforce planning in Saudi Arabia

Based on the information you provided, I am pleased to inform you that application HSCR14/119 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

Kingdom of Saudi Arabia
Ministry of Health
King Fahad Medical City
(162)

مدينه الملك فهد الطبية
King Fahad Medical City

المملكة العربية السعودية
وزارة الصحة
مدينه الملك فهد الطبية
(١٦٢)

IRB Registration Number with KACST, KSA: H-01-R-012
IRB Registration Number with OHRP/NIH, USA: IRB00008644
Approval Number Federal Wide Assurance NIH, USA: FWA00018774

March 4, 2015
IRB Log Number: 15-087E
Department: External
Category of Approval: EXEMPT

Dear Noura Almadani,

I am pleased to inform you that your submission dated March 4, 2015 for the study titled '**Degree education as an entry requirement for qualified nurses: A case study to inform nursing workforce planning in Saudi Arabia**' was reviewed and was approved. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of department or unit in KFMC or an external institution to commence data collection.

We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown above.

If you have any further questions feel free to contact me.

Sincerely yours,

Prof. Omar H. Kasule
Chairman Institutional Review Board--IRB.
King Fahd Medical City, Riyadh, KSA.
Tel: + 966 1 288 9999 Ext. 26913
E-mail: okasule@kfmc.med.sa

Approved
0 4 MAR 2015
K F M I R B

القيد: 1327775
التاريخ: 17-05-1436هـ-08-03-2015م
مرفقات: 10

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الموضوع: بحث الطالبة /نورة المدني.

سعادة/ مديرعام الشؤون الصحية بمنطقة الرياض   المحترم
ص. لسعادة/مدير مركز الأبحاث بمدينة الملك سعود الطبية   المحترم
ص. لسعادة/رئيس لجنة الأخلاقيات بمدينة الملك سعود الطبية   المحترم

السلام عليكم ورحمة اللّه وبركاته، ، ، ،

إشارة إلى موضوع الطالبة / نورة عبداللّه رضا المدني، المبتعثة من وزارة الصحة لدراسة درجة الدكتوراة في تخصص "التمريض" بكلية التمريض والقبالة والخدمة الإجتماعية، بجامعة سالفورد بالمملكة المتحدة، رقم الهوية الوطنية (١٠٢٧٩٥٨٩٥٦) والرقم الأكاديمي (A1039) وعنوان الرسالة:

" الدرجة العلمية كشرط لدخول مهنة التمريض :دراسة حالة لإعلام تخطيط القوى العاملة التمريضية في المملكة العربية السعودية "

نحيطكم علماً بأن الطالبة قد إستوفت كافة المستندات المطلوبة من الإدارة العامة للبحوث والدراسات بوزارة الصحة ولجنة الأخلاقيات بمدينة الملك فهد الطبية (مرفق صورة)، وتمت الموافقة على تسهيل مهمة إجراء هذا البحث، وحيث أن المذكورة عاليه ستنفذ دراستها في مدينة الملك سعود الطبية.

وعليه ، نأمل من سعادتكم التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمتها لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين خلال قيامها بمهام بحثها، مع العلم بأن وزارة الصحة تضمن حقوقها في نتائج هذا البحث من خلال إتفاقية المشاركة في البيانات والتي تم توقيعها بين الباحثة والإدارة العامة للبحوث والدراسات.

وتفضلوا بقبول أطيب التحيات ، ، ،

مرفق ملخص المقترح البحثي، ، ، ، ،

مساعد مدير عام الإدارة العامة للبحوث والدراسات

ص. عذاري فيصل العتيبي

To whom it may concern

Royal Embassy of Saudi Arabia   *7/12/2014*
Cultural Attaché Office   *15/2/1436*
London-United Kingdom

Dear Sir,

This is to inform you that, this is a preliminary approval letter to *Ms. Noura Abdulla Almadani,* Student ID: (1027958956), who submitted an application to *The General Directorate for Researches and Studies, Ministry of Health, at Kingdom of Saudi Arabia (GDRS-MoH)* to conduct her research project titled "*Degree education as an entry requirement for qualified nurses: A case study to inform nursing workforce planning in Saudi Arabia*" as a part of her Ph.D Degree thesis at College of Health and Social Care School of Nursing, Midwifery, Social Work and Social Sciences, Salford University, Manchester, UK.

Please note that the proposal needs to be accepted by MoH scientific and ethical reviewing committees prior conducting the study at MoH hospitals, Al Riyadh Region according to our rules and regulations.

For any questions or inquiries, please contact: *Dr.Hisham Aziz* (+966536887602).

e-mail: research@moh.gov.sa

Yours Sincerely

Director General
General Directorate for Research and Studies

7 Dec 2014

Appendix 5.1
Participant's Information Sheet (PIS): For macro level of administration

Study title: (The Implications of Nursing Degree Education for Future Workforce Planning in Saudi Arabia: A Case Study).

I am currently completing a research study for my PhD in Nursing at the University of Salford. I would like to invite you to be part of this research study. Ethical approval has been obtained from the University of Salford and it is important that you understand both the purpose of the research and your role as a participant. Please ask any questions if any part of the information is unclear to you. Finally, it is your decision whether or not to be part of the study and you may withdraw at any time.

What is the purpose of the study?

This research seeks to investigate the extent of your knowledge regarding workforce planning and development as a consequence of the introduction of degree entry pre-registration nurse education.

Why have I been invited?

The main reason for including you in this research is because you have a high level of knowledge and experience about nursing workforce and entry requirement for qualified nurses in Saudi Arabia.

Do I have to take part?

It is your choice as to whether you want to participate in this study. This information sheet will provide details to help you make this decision and you can contact me if you have any question about the research. If you agree to be part of the study, you will be asked to sign a consent form. You are free to withdraw at any point while taking part in the study.

What will happen to me if I take part?

• You will be asked for consent to attend a face to face tape recorded interview.

• The face to face interview is intended to explore your knowledge and experience about the nursing workforce and entry requirement for qualified nurses in Saudi Arabia. You may also be asked to explain your answers in detail.

- The length of the interview will differ depending on the details you would like to offer in response to the questions asked. However, the interview will take approximately 30-60 minutes.

- The interview will be held in a quiet and private place in the Ministry of Health during working hours.

- The interview will be a confidential and stored safely. The study will have two forms of data, a hard copy, and soft copy. Hard copy data will be kept in a locked locker and no one will be authorized to use it except the researcher. The soft copy data will be secured in a password protected external hard disk and will be connected only to researcher private laptop, only the researcher can access the saved study data. Your identity will be kept secure by the researcher.

Expenses and payments?

The Ministry of Health will cover any expenses for this research.

What are the possible disadvantages and risks of taking part?

There are no personal risks associated with participation in the study

What are the possible benefits of taking part?

I cannot promise the study will help you but the information I obtain from the study is intended to help determine future workforce planning and development needs as a consequence of the introduction of degree entry pre-registration nurse education in Saudi Arabia.

What if there is a problem?

If you would like to complain about any aspect of the interview, please contact the first supervisor Dr. Nancy Smith or Dr Karen Staniland in the first instance, or the University of Salford College of Health and Social Care Research and Innovation Manager –

| Dr Nancy Smith | n.j.smith@salford.ac.uk | School of Nursing, Midwifery, Social |
| Dr Karen Staniland | k.staniland@salford.ac.uk | Work & Social Sciences |

Will my taking part in the study be kept confidential?

The information that you provide will be confidential. No names will appear in the study. Your identity and personal contact details will be known only to the researcher, the research assistants, and the research supervisors at the University of Salford. The

researcher will not use your name or any information that could reveal their identity in this or any future research study, publication, conference presentation or teaching session. Storage and destruction of data will conform to the Data Protection Act (1998). Any information about you which leaves the Ministry of Health will have your name and address removed so that you cannot be recognised.

What will happen if I don't carry on with the study?

You have the right to withdraw from the study at any point without prejudice and this will not affect your care in any way. If you withdraw from the study all the information and data collected from you will be destroyed and your name removed from all the study files.

What will happen to the results of the research study?

The results will be published in a PhD thesis and parts of the study may be published in health care journals and/or presented at conferences. You have the right to ask for the results if needed and the choice of seeing the completed transcript following interview.

Who is organising or sponsoring the research?

The University of Salford and Ministry of Health

If there are any further questions regarding this study, you can contact me (by phone or email) or my supervisors (by email) as follows. If you prefer, we can arrange to discuss this invitation, face to face, at a mutually convenient place and time.

Thank you for giving your valuable time in reading this letter

Contact Details

 Researcher

- Noura Almadani, PhD candidate, School of Nursing, Midwifery, Social Work & Social Sciences, University of Salford, Salford, Greater Manchester, United Kingdom, M6 6PU. Tel: +447462662646 or at n.almadani@edu.salford.ac.uk,

 Supervisors

- Dr Nancy Smith at n.j.smith@salford.ac.uk
- Dr Karen Staniland k.staniland@salford.ac.uk

Research Participant Consent Form for macro level of administration in the MoH

Title of Project: The Implications of Nursing Degree Education for Future Workforce
Planning in Saudi Arabia: A Case Study.
Ethics Ref No: HSCR14/119
Name of Researcher: Noura Almadani

➢ I confirm that I have read and understood the information sheet for the above study and what my contribution will be.	**Yes**	**No**
➢ I have been given the opportunity to ask questions through the use of an interview guide	**Yes**	**No**
➢ I agree to take part in the interview	**Yes**	**No**
➢ I agree to the interview being tape recorded	**Yes**	**No**
➢ I understand that my participation is voluntary and that I can withdraw from the research at any time **without giving any reason**	**Yes**	**No**
➢ I understand how the researcher will use my responses, who will see them and how the data will be stored.	**Yes**	**No**
➢ **I agree to take part in the above study**	**Yes**	**No**

Name of participant (print) …………………………………………………………
Signature   …………………………………………………………

Date   ……………………………….

Name of researcher taking consent   **Noura Almadani**
Researcher's e-mail address   **n.almadani @ edu.salford.ac.uk**

The template page for transcript data

Level name:

Date:

Time:

Number of participants:

Given code for interviewee (participant):

Given code for interviewer (researcher):

Questions	Answer	Researcher note
Q1:		
Q2		
G3		

Appendix 5.4 Example of categorisation of the data by NVivo at the micro level.

MICRO LEVEL	0	0	8/28/2015 3:39 PM
Demographic information	0	15	8/28/2015 3:40 PM
Methods or educational pathway to nursing	0	0	8/28/2015 3:41 PM
national board licence exam	2	2	8/28/2015 5:36 PM
diploma or Bachelor's	0	0	8/28/2015 5:36 PM
Bachelor's degree	2	5	8/28/2015 5:37 PM
governmental college	1	1	8/28/2015 3:42 PM
health institute	1	1	8/28/2015 3:43 PM
private college	1	2	8/28/2015 3:44 PM
college diploma	1	1	8/28/2015 5:40 PM
Difference between diploma and high diploma	0	0	8/28/2015 3:51 PM
Duration	1	1	8/28/2015 3:51 PM
Salary	1	1	8/28/2015 3:51 PM
Same or different license exam	0	0	8/28/2015 3:55 PM
Curriculum	1	6	8/28/2015 3:55 PM
Minimum degree that should be acquired	0	0	8/28/2015 3:56 PM
Dependent on individual qualities	3	9	8/28/2015 3:57 PM
general knowledge	3	3	8/28/2015 4:02 PM
Languages	3	6	8/28/2015 4:02 PM
ethics and commitment	2	3	8/28/2015 4:02 PM
interest or passion	2	4	8/28/2015 4:03 PM
Practice	1	1	8/28/2015 4:02 PM
specific skill sets	1	1	8/28/2015 4:02 PM
Bachelor's	3	7	8/28/2015 5:40 PM
HS diploma	2	0	8/28/2015 3:56 PM
Factors that influence degree levels	0	0	8/28/2015 4:05 PM
social influences and pressures	3	4	8/28/2015 6:24 PM
family pressures	1	2	8/28/2015 6:24 PM
Respect	1	1	8/28/2015 9:10 PM
individual commitment and focus	2	5	8/28/2015 6:00 PM
related to social culture	1	1	8/28/2015 6:01 PM
problems with quality of private universities	2	4	8/28/2015 6:26 PM
attaining financial security or getting promotions	2	5	8/28/2015 7:46 PM
completing the study	1	5	8/28/2015 4:05 PM
governments need stricter rules	1	1	8/28/2015 6:25 PM
Bachelor's degree	1	1	8/28/2015 6:27 PM
differences in licensure	1	1	8/28/2015 6:30 PM
responsibility to patients	1	1	8/28/2015 7:44 PM
ability to advance education	1	2	8/28/2015 9:03 PM
Benefit gained from Bachelor's degree	0	0	8/28/2015 4:12 PM
Greater knowledge base	4	11	8/28/2015 4:17 PM
Improved communication	2	2	8/28/2015 4:18 PM
Improved skillsets	2	2	8/28/2015 4:21 PM
More advancement opportunities	2	4	8/28/2015 4:28 PM

Some problems with absenteeism	2	5	8/28/2015 6:50 PM
Better prepared for work environment	1	2	8/28/2015 6:52 PM
Increased patient safety	1	2	8/28/2015 7:40 PM
Importance of experience versus education	0	0	8/28/2015 4:35 PM
Both	2	3	8/28/2015 4:45 PM
Education	2	4	8/28/2015 4:45 PM
Experience	2	3	8/28/2015 4:45 PM
Minimum requirement for entry level to be elevated to BSN level	0	0	8/28/2015 4:48 PM
Mistakes from diploma	2	6	8/28/2015 4:48 PM
Constant self-improvement	2	4	8/28/2015 4:51 PM
More comprehensive information	1	1	8/28/2015 4:49 PM
Ability to deal with emergencies and critical cases	1	2	8/28/2015 4:50 PM
More benefit from lectures	1	1	8/28/2015 4:50 PM
Quicker registration	1	2	8/28/2015 9:07 PM
Both can benefit from the others	1	1	8/28/2015 9:11 PM
Need for educational advancement	1	3	8/28/2015 9:12 PM
Qualities of ideal nursing candidate	0	0	8/28/2015 5:10 PM

Sample of transcripts for one-to-one interview and focus group

Level name: Macro level /Face-to-face interview number 4

Date: Time: 10:00am -10:45am

Total number of participants: 4

Given code for interviewee (participant): GD4

Given code for interviewer (researcher): N

The highlighted areas are the exact quotation used in the main thesis.

Questions	Answer	Researcher note
Q1 Hi Good Morning. Is the information that I sent to you about my study is clear, and do you have any questions before we start? Can you introduce yourself e and your background experience in nursing?	**GD4** Good morning. Everything was clear thank you to send me the information prior the interview. This is GD4. aaa I have a master's degree in Nursing. ummm I have a long experience in working, almost about thirty years working. I work under the MOH this time……[Data removed for anonymity]	This question used to get people talking and feeling comfortable.
Q2 In your opinion, what is the minimum degree that should be required for entry-level practice as a registered nurse?	**GD4** Bachelor degree is should the minimum requirement. You will end with better quality of patient care, giving care, another many benefits that we found as the reference said. And this is what we found from our work. And we know that our hospital and the medical services in Saudi Arabia is getting better and better. And We have new technologies coming that require nurses well-equipped with knowledge and skills, so with the Diploma level it is difficult to meet this. The community also needs well-experienced nurses. People now are changing with all these technologies around us. People can easily search for their disease; what kind of care you are giving them and what care they need. Patients are very smart now and the nurse needs to be smarter. And more skill is needed to give the right care to the patients. We care about the quality of care. Quality care needs to be given to patients. The diploma cannot give this quality care. Our Diploma [nurses] have fewer years of studying their language, not up to the extent allowing them to read and search for references. They are not at the level to communicate with the doctors. And they do not have the full confidence in language and communication skills. We feel that the bachelor's degree should be the minimum requirement	This question used to get the participant to start thinking about the topic at hand.
Q3 With this new policy of the	**GD4** Ok, the level of entry to be bachelor's degree it was agreed by the GCC countries, it is the recommendation of the	These questions provide a link

minimum requirement of BSN as the level of entry…Do you think it is necessary to close the diploma nursing, and are the nursing mangers are involved in the decision making of this policy?	WHO, which we take into consideration. Yes it was the nursing leaders who take the decision in the GCC countries and agreed by all ministry of health in GCC countries. To close all diploma nursing school is different in every GCC country because each country have their own situation and they have different number of nationals going from country to country. For Saudi Arabia we decide to close the diploma level because we have many governmental university started with the nursing school, we have 28 governmental universities and they have nursing all. So we have a good space to occupy nurses. This is only governmental and if you go to private now we have more than 42 and some are going to start around the kingdom and you can have nursing program each. So when we close the diploma this will not affect how many nurses will be graduated. We just made it better from diploma level to bachelor level	between the introductory questions and the key
	Can you explain to me the outcomes of Nursing colleges in SA? and What is the differences between the governmental and private colleges?	
	GD4 Bachelor level, I cannot say up to now…I have met some of these graduates and they are really doing good. They are doing quite well. The one who graduated from the governmental and private colleges in BSN level. For the private colleges because they are still new, we can't really evaluate their performance. For the governmental colleges we have three old colleges, their graduates are really good graduates, good outcomes. For the rest of the colleges they are still new, they just started. Of course they do not have the same curriculum but of the same standard. Like certain hours for the theory and for the practical but then every college is different as anywhere in the world. The basics are the same, this is what we care about it.	
	Do they have the same curriculum?	
	GD4 No of course they do not have the same curriculum but of the same standard. Like certain hours for the theory and for the practical they do not have to take less than that. But then every college is different as anywhere in the world. They have something extra here and something extra there. The basic are the same this is what we care about.	
	Is there any direct supervision from the General Directorate of Nursing?	
	GD4 No, we are not dealing with education because we deal with the services. For education it with the Ministry of higher education so they are the ones dealing with them supervising all colleges and universities, all the nursing program and other different programs. We only share with them. Most of the, mot most, I can say some of our directorate in different region. Because we have this regional directorate in Riyadh Region We have 20 other offices in the kingdom, some of the heads of these offices are members of the committee in the university, consulting committee in the university so they are giving their opinion and consulting with them in whatever is needed for the nursing education	
Q5 What the benefits	**GD4** This is what I said previously, that we are going to have a	These questions

| that can be gained by requiring BSN as the entry level practice for qualified nurse? | <mark>better outcome, better care. People feel satisfied when they have the necessary care</mark>.
After you close the diploma programme. Do you think the Job description will remains the same or what?
Of course there should be a difference in job description of diploma level and bachelor level and there is a competency for each level. There is a job description for each level. But believe me this is not what is happening in the real situation right now. Why, because we do not have enough number of bachelor's degree graduates. It is not applicable at this time. Yes in some other hospital not in MOH it is applicable and they are working on that because they have enough bachelors degree. For us it is a bit early now but it's ready to be applied whenever we get the right number. At the moment we stop taking recruiting nurses from outside unless they are BSN graduates with a certain experience depending on the country where they graduate from as a requirement of the Saudi Commission here. For the meantime we carry on the same until further application for that when it is suitable.
Since the current work force is mostly diploma holder. What do you think is the good solution to elevate their degree level?
GD4 We have a plan for all those diploma holder. Before we are sending them for bridging program all universities in the world. But <mark>right now we have a national programme. We have 13 nursing bridging programmes for males and 17 for females. So we have quite a good number of bridging programmes. We have a plan to send our staff to get their BSN degree. It is going quite well. But we need quite a lot of time to cover all those …we have quite a number of Diploma nurses, we are not in a hurry. This is happening through the world. We are on the right track. Inshallah, hopefully we can finalise all those</mark>.
What is the actual number of those diploma who are in bridging programme?
GD4 It is not a fix number there is variation every year. Almost like we are sending around 100 – less than 100 each year but we have more numbers in the national university.
Do you think there are any obstacles for diploma nurses to going for bridging programme? Kindly explain to me this point?
GD4 Yes the university does not take the old graduates here. Some university ask less than 10 years or some five years. Some universities require less than 40 age. If more than 40 they will not allow. We try our best to work on this policies and law with the MOH to allow them to proceed with their bachelor's degree or at least to allow them to be in private colleges on their own to allow them to have the degree. This is the solution we can say as of now. You know it is all over world when you get certain age you cannot go and that the ministry will not pay for that. But it should be allow for them to take the degree they want on their own. Just give chance from their work to go for exam and their own time even.
Do you think there is a difference in experience and level of education between nurses? Explaine please? | focus on the major areas of concern. The majority of the time is devoted to discussions of these questions. |

	GD4 Of course there is a difference experience is very go and it is really needed. <mark>It makes a difference if a person has a degree with experience rather than a degree only without experience. If you have a degree and education that means you know the rationale of the things you do; but if it is only experience you do things because you see other people doing it or you did it before and it worked; you just carry on and do it. But if you have the education you know why you do it and can even do it better. Education and experience are both important in giving quality care.</mark> **Since you are a member of GCC, What do you think is the standardization of the education program of nursing in the GCC?** **GD4** <mark>It is really good. It is the big step we are taking forward. Because all people in Arab countries will just move freely. It is good for the citizens. You finish the same programme and curriculum. When you move from one country to another people are familiar with what you study and you will not face many problems. You will not face problems like your certificate not being valid. So this is the main idea to allow the people in Gulf countries move freely and that will make their life easier.</mark> **Could you explain to me more when the GCC will start to standardize the nursing education?** **GD4** What happen its just been working; It has long time also it has been worked. We have two levels. We have the technical and the bachelor level. Technical level now in Saudi Arabia is no more and has been stopped. For the bachelor level is agreed by all MOH but now it is under the Ministry of higher education. They all know the agreement but then again it is still a recommendation also. But we are in the right track. All our program is approved. It is not less than the requirements. It is going okey right now.	
Q6 Over all can you describe what is your ideal candidate of the entry level to nursing practice.	**GD4** As we said before I agree about the bachelors level. I think it is the level of entry to a job. Of course even if you have the bachelors you need an experience. So <mark>Bachelor's level is the best for nurses to start work either in a hospital or at community level or anywhere in the hospitals or community. We found by evidence that a Bachelor's degree should be the minimum requirement. This is what all the reference says. If they have a BSN degree, they have fewer medical errors, fewer nursing errors and as we know, our hospitals and the medical services in Saudi Arabia are getting better and better. And we have new technologies coming for which we need nurses well-equipped with knowledge and skill</mark>. Of course if you work in administrative level this is different completely you need specialize experience and certificate. **Do you have anything to add?** **GD4** Thank you very much I wish you all the luck in your study.	Ending questions bring the interview to closure.

Level name: Micro level /Focus group

Date: Time: 10:00am -12:00am

Total number of participants: 7

Given code for interviewer (researcher): N

Given code for interviewees (participants):

Position	No	Nationality	Given code
Senior Nurse	1	Saudi	SN1
Senior Nurse	1	Saudi	SN2
Senior Nurse	1	Non-Saudi	SN3
Senior Nurse	1	Saudi	SN4
Senior Nurse	1	Non-Saudi	SN5
Senior Nurse	1	Non- Saudi	SN6
Senior Nurse	1	Saudi	SN7

	Nursing mangers
N – Okey. Good morning Everybody! Before we start do you have any question? Did you sign the consent? Is the information that I sent to you about my study is clear, and do you have any questions before we start? How did you become a registered nurse or what was the educational pathway that led you to your initial licensure as a nurse?	Respondents – Good morning! Respondents – No Respondents – Yes Good morning. Everything was clear thank you……..… **SN1-** I am executive nursing director of one of a big medical city in KSA, and I have many years of experiences in nursing practice and management. **SN2**- Assalamu Alaikum WW. I am SN5 I am actually going to complete 22 years in my nursing career. I graduated from university as a general nurse then I got a master's in nursing. **SN3-** I graduated from university four years ago and joined up to work as an RN for 3½ years in Cardiothoracic ICU. **SN4-** Assalamu Alaikum aaah my name is SN4 . Graduate from the College Nursing Health aaah diploma. I am working until now 26 years. My background of the work I am now the Nursing Director in Maternity Hospital King Saud Medical City. Actually the degree for the staff to be a registered nurse. I think from my experience is diploma because we have a different diploma. We have Health Care Assistant 1 ½ year and we have also Diploma 2 ½ year and we have also Diploma from College. I think from College will be the best now to start the degree because I have a good quality of training and work. They have full responsibility with work. For the other Diploma they need more concentrated training to be more …yani… registered as a nurse. And also of course in the future we need to be Bachelor's Degree. **SN5**- I am a previous dean in the Philippines. What we currently have in our country as a minimum requirement is a Bachelor of Science in Nursing. Although we had like twenty years back a graduate nurse, this is similar to the Diploma graduates, that we are having here; but this is

Those graduate nurses way back were upgraded to BSN through a bridging program. I think we shall be discussing more on this issue of BSN and diploma later. That will be all for now in the meantime.

SN6- My name is SN6. I have Master's degree in education and communication. Aaaah My actual experience is 9 years. Amm actually aaah we observe now we have different pathway. Before we observe like aaah we are accepting from the secondary school and even from the elementary school. Now a days they have there are changes in the pathway. Now they are requesting that they have to pass the Bachelors and they have the reason to use this different pathway.. aaaah base on the different incident and recommendation that's why the change the pathway from previous years to now.

SN7- I am … Korean. I've been working in nursing for about 7 years now. We have different preparation. ..It is made of two categories, one is the Diploma and the other is the Bachelor's degree…after they completed their curriculum they both proceed to the National board licensure exam. Only those who pass the exam may be a registered nurse. That is the educational pathway in Korea.

…[Data removed for anonymity]

N- In your opinion, what is the minimum degree that should be required for entry-level practice as a registered nurse?

SN2- The minimum requirement…based on our experience, based on the situations we are confronted with. What I have seen that it is very much needed that nurses who come in as an initial practitioner should be a BSN degree. Because this would complete the so called requirement of professionalizing them and make them ready over the role that they have to play. Because, If we are going to compare to the situation we are facing here, we have nurses of different types of nurses, those with two years or three diploma nurses as oppose to those with bachelors degree. Really those with diploma comes with less prepared, less mature as compared to those BSN holders; who are more mature and who comes to us more prepared and who have these complete preparation of having the general education given them and as well as the nursing education, as a complete package. Yes it should be a Bachelor's and above.

SN3- *Yes actually, if we want to improve health services, it must be from Bachelor's and above.*

Aaah actually we also have to face that is the reality. We cannot also escape. We have a lot of staff now who is bachelor but still they cannot really handle the patient and they cannot even pass the competency; which mean there is something like different or problem in their curriculum or either in their commitment. Yes I agree to be Bachelor and above but still I think because before we were working as a diploma. We were working very well so not really with excuse that the….Yes the certificate is important updating with the new information, but the commitment is something important and what still like a …I think I will talk in my country, in Saudi Arabia, as my

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concern. Yeah, we really have to look again for the curriculum. The teaching in the schools.

SN7- Yes this is one of the factors, but We have other factors that can affect, as I mentioned, could be like commitment, might be the language, might be the interest or some people may select nursing because they thought it was an easy job.

SN5- I have seen that it is very much needed that nurses who come in as initial practitioners should have a BSN degree
.

SN7- We can clearly see the understanding because they learned English from the University so they know how to speak, understand and write. This will all have a huge impact on our nursing care.

SN1- The ideal is to have a Bachelor's degree and I will not accept any nurses to come to work in this hospital without a BSN degree because of patient safety. I need our patients to be safe and I need safe nursing practice ... I think there is a good relationship between nursing qualifications and professional nursing practice. ...I am a member of the committee of central events of mortality and morbidity and I can say there is a strong relation or correlation between nurses' qualification and central events. … because usually when we are reviewing the cases of central events, we discover that people who have a high level of mistakes have a low level of education. So, if we need safe practice you have to have at least a Bachelor's degree.

SN4- For us here in MOH a staff they graduated they take to pass the Saudi Commission in order to take a license and they will apply for recruitment. After that they enter the hospital. We have our General Orientation Program and there is Hospital Wide Program after that we go to the Specific Orientation. *aaaah* According to the seniority of the staff and also the competency of the staff; They will be going to the level after charge nurse *aaaah* head nurse to go to that pathway. Right now we will have inn sha Allah a Career Pathway…We are going to rank the staff according to qualification, experience and how to go all the way. Either the staff go as a head nurse, for administrative, quality or education. *aaaah* Initial education we have diploma and we have baccalaureate, masters or phd. For diploma we should have also according to their years in school. 3 and a half years, which is high diploma and we have 2 and a half; either she be a health care assistant or a nurse technician with this degree. While BSN is categorize as specialist *aaaah*. This is the variation here even between diploma to diploma. 3 years and a half diploma should be more qualified we can say and competent rather than the one who come two years.

SN3- I think the pathway that we have is something from one year diploma up to PhD and we can touch the *aaaah* the relation between variation. Even as mentioned by Ms. Dareen we have 2.5 diploma, 3.5 yrs diploma. For every director of nursing I think they will prefer the 3.5 years Diploma in nursing because they received a more maybe education and their…. This education is actually covering some item, some topics that are no covered in 2.5 years. And of the again as we discuss before is the medication management. The *aaah* if you want to

	ummmm make a test for those two levels for certain medication calculation you will see that aaaa 3.5 is really better. They are aware of the side effects of the medication. How to admit to them safely for the patients. We also have bachelor's degree, masters degree, PhD *aaaah* but the issue here we have all of them from different sections, from different sectors, from different institutions, we have variations not only in the qualifications. We have a variation in the level of the outcome of the providers, of the education institutions. **N – Ok so what do you think is the factor that influence over the degree preference?** **SN2**– I have a lot of things to add I agree with her. Actually first of all I believe in the commitment. Because we have some people who are HCA and their performance is better than with the Bachelor. They want to learn, they have the initiative, they have the interest to learn. Really they would love to continue their study but I think we have like some limitation. Like a HCA they cannot continue like a bachelor or something like that. So I think the first and the last thing is the commitment, and this is depend. I don't know sometimes may be. We can observe now most of the nurses are still young and they don't have the, they feel that they are already responsible. They feel like they are not feeling they are working with the life of patient. Anytime they can be absent, anytime they don't care. Even they answer us like, "even if you deduct that from our salary it's okey!." Like that they don't have that interest to deal with the life of the patient. And it is really the main problem. If they don't have this sense hoe they will be working as a nurse. **SN4** –We have some diploma and HCA is better than the bachelor. It means it depends on the person himself, their commitment. How they not how the certificate perform them. Because now we have some Bachelor nurses will say, "*We will not touch patient.*" They are looking only for the certificate while they don't have any skills in nursing. So the commitment is number one. Still I think the culture of education is absent from them. If we will some education or activities. Always they are absent or they will escape from the activities. "*As if like they are eating our head this information,* " they are thinking like that. They are not thinking this information will push me to be more competent and I can deal in good way. Also there are lots of factors also in order to be more honest. Like the wasta. And I don't know, I don't have translation on this one, but wasta mean we have like some student who came, who are not competent and while they will go to there… Like we have internship, I mean…Even if they are not competent from our side they will go to their college and they will release for them that they are competent and they will go. Then we will face problem with this staff. That's why even if you will evaluate them not competent during their period still in their college they will let them go and work. So I will face like problem. We have not only in our hospital, this is I think become more global problem for us. And they have really to focus on something before the disaster will happen. We have really a lot of factors but this are the important things and really we are suffering.
So what do you think the influence of degree	**SN1-** I think one of the important issues with our nurses here is the knowledge…BSN degree nurses have a general understanding of the

education has on the nursing workforce?	theory concept …should have knowledge, should have a good background about physiology, anatomy, pathology. Good background about psychology too to deal with patients and pharmacology to know the side effects and contra indications for each medication. We are evaluating our nurses based on three things: knowledge, attitude, and skills. Knowledge is important and I think it is impacting people's attitudes .aaaaa What is different about these nurses is that they have different classifications, technicians and specialised nurses. Then they come to work as staff nurses providing the same total patient care.
	SN4- They have advanced clinical skills such as medication calculation, IV cannulation, catheterisation…. almost all of them have abilities to provide patient care proficiency.
	SN5- If we are talking about competency in the nursing assessment, medication management, calculation and administration, knowing the complications, side effects of the medication, total patient care, evaluation, therapeutic nursing actions or interventions: it is really I think that the nurses with a Bachelor's degree level will have better competency in these. Compared to my place we do not have any difference between the BSN and the Diploma holders.
	SN6- They are more mature, more committed, accountable, confident and... more prepared. We have both of them the Bachelor's degree and Diploma nurses, they are providing the same duties and responsibilities to the patient.
	SN2: Patients were safe when handled by nurses with Bachelor's degrees - even their English is good.
	N: Why? Could you explain more?
	SN7- Because you couldn't imagine that some of the Diploma nurses can't read English, how they interpret physician's orders and medical orders! We discovered that some of our patients did not receive medication because the nurse technician [NT] couldn't read English
	SN3- We discovered that nurses who make a lot of mistakes have a low level of education. So, if we need safe practice you have to have at least a Bachelor's degree SN1: We have a lot of new staff who have graduated with a Bachelor's degree from private colleges but still they cannot really handle the patient and they cannot even pass the competency; which means there is something different or a problem either in their curriculum or in their commitment.
Why do you think the minimum educational requirements for entry-level practice as a registered nurse have been elevated to the baccalaureate level?	**SN2**- Because the majority we have are Diploma educated and also we are talking about two or three categories. The Diploma is three and a half years and they were from governmental institutions like the Health Science College… under MoH and we have the other one from the private institutions….. …we saw the difference, with experience, background information, abilities, performance in practice and outcomes. The new Diploma which we have is common now, it's the private institution Diploma…they don't speak or communicate in

	English. They do not have the basic things (skills)… they are weak and we have to train them first to study English…, the Bachelor's, sure… with English, with the good background of theory and practice Also with the respect of the institution where he or she comes from, we are having some Saudi Bachelor's nurses who do not even pass with us.
What benefits could be gained by requiring a Bachelor's degree for entry-level practice as a registered nurse?	**SN1**- I am thinking of my future career for myself, for financial outcome and a good position. I am thinking, what is the easiest way to get a salary and to have some respect… I discovered that nursing is the best way to get it, that's why I became a nurse. Now, I discovered that the senior and consultant physicians, they respect nurses just now because their education and experiences are improved. Also, I am seeing that there is a respect for physicians - why don't they have respect as a nurse? There is no respect for nurses I can see our culture is important here; as Saudi people we are not expecting a male person to be a nurse. We think in Saudi Arabia, nursing is a job for females only and that's why we don't have a lot of male nurses who graduate from a Bachelor's degree to work with us.

SN4- Some families push their daughters or sons to study nursing only because of the need for financial gain only.

SN2- Given for example here in the kingdom those who come in an entry level for their education enter with an option. BSN is being provided, Diploma is being provided. However, the factors that influence them is more on the *idea of quick fix*. You know, I can have it, I can have my job and I can be earning. And there are also social influences and pressures. Like some family pushes them because of the need for financial gain. So they push them hard and push them to finish early and let them earn their living early also. However, we can also look at how the offerings of this education in the country. Many unfortunate stories we heard. We have talked to this diploma nurses who say to us that it is too easy to earn the diploma certificate because they make them pass when they don't deserve to pass. And these institutes who are providing these certificates to them even they don't pass, which I think the government should have stricter rules. The government has to really make sure that they are doing their job. Actually according to them that they do not really sweat over their studies. So it was not clearly emphasize to them what is exactly the role that they have to face when they come to the hospital. That's why when they come to us after this two years and one and a half year. They come too surprise over their responsibilities because when they were at their school it was not really shown to them what is the real world in nursing. It might have been what is emphasize to them how much they will earn. How much they can buy out of my salary. The value was not in place. Unlike, if I can raise this point on the Philippines, the curriculum is really emphasizing on the value. That is why up until this time, with all due respect to other nationalities, they would speak highly of a Filipino Nurse. Known to be very compassionate, because in the curriculum itself it is emphasize there that no nurses should graduate if they are not compassionate, no nurses should even graduate if they are not God fearing. Because nursing is not a simple job. Imagine that you are going to be taking care of people that you do not even know, you have not seen them before so if you do not have all |

	these values within you how can you be that effective.
	SN1 – Bachelor's degree should be required for a staff nurse for the reason that was mentioned before of having shortage for nurses. Aaaa also, the classification is different so once we have different classification from the Saudi Commission so what the implementation of this in our institution. *aaaah* Logically *aaaah* if the bachelor's degree nurses they are classifies as specialized nurse and nurses of diploma degree are classified as technician so the critical question is we cannot easily answer. Will we have the same duties and and responsibilities when in the health care settings is better? This is the question. How can we answer only we have our own competency. Because they have different licensure exams. Well for my point of view what is different from these nurses they have different classifications, technicians and specialized nurses. Then what they want to come to work as staff nurses providing total patient care for a patient. So we should have the same competencies for them. So the competencies that we have would be the indicator if they will provide total patient care or not. But again because of the shortage we are doing this completely, because of the shortage and also the large numbers. We have large numbers of *aaaah* diploma holders. Year by year they graduate as compared with BSN. I think this should also be a vision here in KSA to decrease …*yani* to –form institutions and to support people to go to universities for BSN. Once this is not really implemented it's a challenge. Once the Minister of Health let's say he has 35, 000 of Diploma nurses what he will do . He will let them sitting at home not doing anything. No! they also need to work. It is a challenge even to the Minister of Health. So it's a complicated formula but we can but if we know the root causes we can solve. If we can decrease the number of diploma holders. The graduates of Diploma holders we can easily *aaaah yani aaah* we have a better people joining the hospital, the KSMC.
	N- Is there a difference with the competency of the bachelor's degree to a diploma graduate? What about the job description? Or both of them take the certification work with the same job description? Clarify for me… **SN3-** *aaaah* Compared to my place ==we do not have any difference between the BSN and the diploma holders. But here, I depend on degrees. When I am informed that we have a new employee who is bachelor's degree, I am feeling much, kind of trust, even without seeing or knowing about this nurses' competency.== When I simply see diploma or transferred from different institution, we started to sigh because those nurses who graduated from government school were some other official accredited institution, they now know exactly what to do. What nursing, what kind of responsibility they should perform here. So even if they are not very much excellent in their performance. We can clearly see the understanding because they learned English from the university so they know how to speak, understand and write. ==This will be all of a huge impact on our nursing care==. And the other one *aaah* because they also go for internship in governmental institution; they know what is this routine work of the nurses so. I cannot say that they are always excellent but at least they are clearly aware of their duties and also their routine works what to do. But diploma holders especially

from this institute graduates they do not have any single understanding of the English word so they cannot actually do it in the competency check off because they cannot understand any of the English instruction and when it comes to the documentation sample of what they do make a copy and paste from the previous shift nurse. And assessment literally have no idea and at the same time they have consider nursing as very easy thing.

SN 4 - As Sister SN 3 mentioned many of them consider this job just as a job without a sense of responsibility or a sense of dignity. Either, they work hard or not, either they are competent or not since ministry is not going to terminate them so they were simply ignorant of every single thing. They do not have initiative, no motivation. They do their duties simply they just stay there and they really present so much of misbehavior and even affect relatively to those who work so hard. So as kind of a byproduct or something even those nurses who work so hard and are present every single day. They are not even coming very often.

N – Is this competency used for both of the diploma and Bachelor's holder?

SN7– *aaaaaah* yeah. And No, but for diploma and bachelor degree yeas but for HCA they have different scope of service totally. *aaaah* this no. 1, before we only have one job description for a nurse. But now a days I think Nursing Total Quality Management work to have different job description per specialty. I work in Surgical I have a surgical nurse job description, orthopedic nurse, ER, OR, ICU nurse job description. This specified. But we will talked again as they mentioned the English language. We don't have. That is why they never read prescription. They do not know what is actually inside. Whatever you will give them is for them so their scope of service they will like follow and even the competency as she mentioned they are not passing because they do not know what is inside. *Aaaah* this one from one side. Then we have like mentioned that not like necessary that bachelor are good and diploma are bad. Like from the experience we discover students who correct our staff actually. Like the student are correcting the staff. You can just imagine how the level of staff sometimes we have. This one is based on the commitment. If they want to learn they will learn . If they don't they will not and many problems for us here. If as they mentioned administrative action from the ministry it would be okey. Now we can see for example most of the hospital are divided into HOP, which they called Hospital Operation Program and Ministry. People in HOP are more going to the rule and they will not have many absent because they know there is a labor law. Like if she will not pass they will like terminate her. Warning letter. But for us as a Ministry even of we careless it is like she guarantee that nobody can move me. Nobody can sometimes in one week we have two hundred absenteeism. In one day you can imagine how they are suffering. Trying to pull out even not competent nurse from different area to cover only this area. So this is also from the factor.

N – what the differences between diploma holder and degree holder in terms of skills, knowledge, and attitude ? Do you face any challenge with these two categories?

SN2- It's the same - both Diploma and Bachelors are the same. How they are performing. For example, if they are doing any procedure. We do it step by step. We start from…hand washing then explain the theoretical, go to the patient side. We go for the procedure in the correct manner step by step. Okay. … This is called staff performance… it is no different between Diploma and Bachelor's. It's the same.

SN2: The new Diploma which we have is common now, it's the private institution Diploma…they don't speak or communicate in English. They do not have the basic things (skills)… they are weak and we have to train them first to study English…, the Bachelor's, sure… with English, with the good background of theory and practice   Also with the respect of the institution where he or she comes from, we are having some Saudi Bachelor's nurses who do not even pass with us.

SN3- we have private and government colleges. Actually we are facing problems - most of the students or staff who graduated from the private colleges are facing problems with the competencies. Actually some of them we asked 'where did you do your competencies'? One answered me in an honest way, the Institute told her just stay at home, 6 months, then you come and I will give you the certificate!!!! … the private sector is focused on the money more than the quality, which is really affecting our staff. But some of them wanted to learn and try their best to learn. They do not have the basic skills, especially from the private sector.

 SN4- The staff educational level is an important factor that has an effect on the quality of care. We have different levels of nurses …the ones who graduates from a Diploma lasting 2 and a half years needs to be focused on bedside nursing rather than making decisions because they ...don't have any knowledge. Nobody came with them for the practice (no clinical instructor or preceptor.

SN1- Yeah, thank you for this question, actually from the weakness point that you asked *aaaaa* I am sure 100% sure that the ultimate goal here at KSMC in Nursing Department is to have a nurses with Bachelor's Degree as a minimum requirement to be a staff nurse, bedside nurse taking care of patients, providing total patient care. One of the barriers not to achieve this objective, before setting this objective or hitting this objective. We have the huge number of diploma nurses. The challenge here if you just choose to make the Bachelor's Degree nurses so what you will do with the number of diploma nurses. So we created actually, there was a full proposal to improve the level if those nurses and was request by our nurse leaders to the CEO to have bridging courses for them. We have as you know, like any other institutions, we have been meeting challenges for implementation. *Aaa ummmm* so we are, we have both them the Bachelor's degree and

of the patient but in the unit that I am working NTQM unit we are checking the compliance of the nurses in providing the standards of care so we are monitoring them., we are asking them their perceptions, their awareness and we really, we have a difference especially for those new nurses. The Bachelor nurses, they have really a better *ummm* better information, better skill. But you know once those diploma nurses, they have experience in KSMC like 3 years, 4 years experience. They mostly, they became really skillful and knowledgeable by time. But as mentioned by Miss Sun there is a better chance for the Bachelor's degree for may be for promotion. For example *aaaah* but again our goal here is to have Bachelor degree nurses providing total quality care. Again we have previously objective for this, even for the job description we could not for that time put this because of the huge number of the diploma nurses in KSMC. I think Ms Dareen she can describe more of the nurses that we have on the percentage of those so that the idea can be clear.

SN3- *aaah* majority we have its diploma and also we are talking about two or three categories. The Diploma which is three and a half and they were from governmental institutions like Health Science College. Nursing under MOH. And we have the other one from the private institutions. Actually as a benefit from the bridging from the previous years we saw. We can say one of our product is Ms Amna now that she has her Master's Degree. Yes, we saw the difference, with her experience, there is, what we can say good outcomes from that one. If we will go to the new diploma which we have, which is common now, it's the private institution diploma. Which is they don't have English. They do not have the basic things which you have from that point start teaching them. Actually when we found that they are weak and that their basic we have to train them. To train them as a language we are using is English. So we cannot have them unless we have to teach them by letting them first to study English. So this is our point. So when BSN will come, the Baccalaureate, sure… You know with English, *aaah* with the good background, also with the respect of the institution where he would come. Because even with Baccalaureate we are having some Saudi which they did not pass with us even.

SN4 – Regarding the competency for the diploma and the bachelor's degree…as a hope that this will be the answer to your question. There is a diploma or bachelor's degree… Their key role in nursing, actually is saying the outcome of those who studied in the university, there is a difference in the diploma and bachelors degree. Basic principle in nursing actually saying and also the requirement skills for nurses, in fact is saying so for those become a difference between bachelor's degree and diploma. The competence check off and the second point those patient so far that we are taking care of they do not depend on our degree. They are all saying either you have master's degree or PhD degree, diploma or simply the BSN. The patient population sees us helping people they do not negotiate with our degree, and the third we are tertiary hospital; that means we are suppose to provide great care to the community. It means again people in our community and also in our hospital we don't deal about our degree. We do care about our

	patients based on nurses actual ----, education and train, and knowledge of what they gained. From the beginning we have curtained expectations from the staff and they are actually considered, and supposedly actually capable and competent. When the NSDD launch this competence check off. We have actually have expectations from the staff. What they are suppose to know, what they possess within themselves. Because of this I don't think there is a need to have difference between diploma and BSN in competence check off. SN3- Yes, Bachelor's degree holders are better than Diploma holders. When it comes to skills, or some other commitment, however, it completely and purely depends on individual commitment. It is not a guarantee if they are a Bachelor's holder that they are better in every aspect. .. SN1- Commitment is something important. Lack of commitment actually affects the staffing plan and also the working hours. Rather than interfering with nursing administration once they enter the hospital. …. we really have to look again at the curriculum and the teaching methods in the schools.
Overall, describe your ideal candidate for an entry-level nursing job?	SN3- For me it should be Bachelor's degree. Especially here at least those graduate from university, nursing medical university who have BSN and they have general understanding in the theory concept and almost all of them they have English proficiency. At least when we speak to them in English we can communicate with them without any specific issues and at the same time they are much excellent rather than diploma workers. We have Diploma holders in our Paediatric Hospital, and their commitment is much better .. They are very dedicated people…. and their performance is better than Bachelor's nurses. They want to learn, they have the initiative, they have the interest to learn. That is one thing I can say since they have studied the appropriate curriculums. They in fact have better understanding in nursing for that. For that I prefer BSN degree for the competencies so and commitment purely because of this issue. **N – Do you agree with that?** SN2- You know I strongly agree with that because you know the issue of language in KSMC in aaaa communication, aaaa documentation, so the English language. The proficiency on this language is really better of those graduate from universities having bachelor degree. Finally comparing between the two programs, the nuniversities and the colleges. I think that we still have enough opportunity if we are talking about aaaa competency in the nursing assessment, medication management, and collation of medications. Medication administration, knowing the complications, side effects of the medication aaaa total patient car, evaluation, therapeutic nursing actions or interventions. It is really I think that the nurses with aaaa having Bachelor degree level have better competency in this. SN4– If you just allow me I will add something. If you will ask me for example of the ideal and if I really had to make thing. Actually I would

like first any new staff will not join to the hospital to work they have to come with a certificate of English. To prove really that they have entered English course. Because now we are facing some people are writing in Arabic that sometimes just I know that they are studying in their language and everything in their language. For us we are different we are using English we have to be an Englis. This number 1. Number 2, I know in some country even of the student pass they will make final exam. They will take fundamental in Nursing, Ethics, Pharmacology aaaa some like the important topics. Okey. If they will pass I would like them to provide for any internship. The copy of their exam, the final exam with the English course. They have to make their internship on the same place that they are going to work. Like in our allow me to mention. Like King Faisal, King Fahd City. They will live them to the internship of their hospital so. If they will do the internship in our hospital and they will follow our evaluation for one year. If she is pass I can accept her in our hospital. If not she can go to the other area or other hospital and perform another internship. I am sure if they will conduct like this the staff they will be more competent. They will know the nursing group and the culture of nursing will be changed.

N – Do you have anything to add.

SN3- Agree to improve the educational level of our staff. <mark>We are agreeing about them to have Bachelor's degree as their entry level</mark>. The degree to enter in the health care team. *aaaah* But which we have right now is the percentage more than 50%, I can say that the Bachelor's degree and the High Diploma is only 10% of our total staff of the Saudi National. But if you are talking of the Diploma with higher we need to improve them.

SN4- I think the government *aaah* should have stricter rules over the schools licensed to operate as Nursing Schools. Because after all, I go back to what SN3 was saying the students that you have now would be your future nurses and this will be the ones who is going to take care of you.

SN7- The nursing who graduate from the college, from diploma, and they are having good experience in the ward they need to improve their self and they have to take the chance for the government to give them…*yani*….more and more excellent to continue.

SN1- If I suggest I really think this study is going to be affecting some kind of yourself and also for the MOH.

SN2- I just want to complete my ideas in two points. Yes I agree like we have to have the Bachelor's degree with passing competency including English before let them really *aaah* work as a staff in our institute. 2nd thing disciplinary service must be implemented system base on the labor law in their work otherwise

SN6- <mark>It is very much needed that nurses who come in as initial practitioners should have a BSN degree... because this would complete the requirement of professionalism</mark>. We see that trend itself is to have a

bachelor degree nurse as a minimum requirement. This is the trend here now in this hospital. And I know it is also outside KSA. *ummm* the other issue that I think is my personal belief here. My personal belief its really difficult based on the challenges we have and the DON they know better than me of the current statistics of the diploma nurses that we have. Its really the challenge will become bigger if we will receive another huge amount of diploma nurses in KSMC. It is against the goal of this department in KSMC. So this can be accomplished if there is better coordination between MOH, the hospitals and the civil services. This is my point.

SN1- We did a study about absenteeism here in KSMC, the most significant factor is workload and the second is endorsement. Because they don't have good English and they don't have good knowledge, they are absent from the duty. When I talk with most senior nurses, we discuss the biggest issues; we faced chronic cases of absenteeism and we found that most of them were nurses with a low level of education. When I investigated them, to understand their situation and why they were absent regularly, I discovered that they were absent because they wanted to avoid responsibility".

SN5- one of my staff told me that 'I did not come on duty because I am afraid to talk in front of the physician and he might ask me about the patients and I can't answer because I don't understand their situations.' Also because they don't speak English, so they can't endorse the case to non-Saudi nurses. Likewise, another nursing manger gave an example of an evidence-based study:

SN4: aaa I have some suggestion. Actual suggestion. I heard about the Saudization started year 2003 or 4. For the Saudization I have no objection at all. This is what I say to myself staff, I mean my supervisors, I have no objection to Saudization. This is your country where you should be the one who really keep and protect and treasure for the coming years. It means rather than depending on foreign expatriates providing and educating Saudi nations in a better way, organize in systemic way it will be more beneficial for Saudi citizens to have qualified and also very standardize nursing care so I really hope your research will inform, some kind of future plan or better kind of blueprint for Saudization to give Saudi people better workers out to care.

Study title: The Implications of Nursing Degree Education for Future Workforce Planning in Saudi Arabia: A Case Study.

I am currently completing a research study for my PhD in Nursing at the University of Salford. I would like to invite you to be part of this research study. Ethical approval has been obtained from the University of Salford and it is important that you understand both the purpose of the research and your role as a participant. Please ask any questions if any part of the information is unclear to you. Finally, it is your decision whether or not to be part of the study and you may withdraw at any time.

What is the purpose of the study?
This research seeks to investigate the extent of your knowledge regarding workforce planning and development as a consequence of the introduction of degree entry pre-registration nurse education.

Why have I been invited?
The main reason for including you in this research is because you have a high level of knowledge and experience about nursing workforce and entry requirement for qualified nurses in Saudi Arabia.

Do I have to take part?
It is your choice as to whether you want to participate in this study. This information sheet will provide details to help you make this decision and you can contact me if you have any question about the research. If you agree to be part of the study, you will be asked to sign a consent form. You are free to withdraw at any point while taking part in the study.

What will happen to me if I take part?
You will be asked for consent to attend the focus group which will be tape recorded. The agenda will include all the activities you may need from the registration time to the debrief session. As illustrated in the following table

Table 1: Time line Agenda for meso level focus group.

Process overview from 12:00pm to 14:00pm
➢ Registration & welcome participants and thank them for attending,
➢ Review the purpose of the focus group & introduce facilitators.
➢ Ask participants to briefly introduce themselves
➢ Highlight key points for discussion & moderator will begins focus group questions
➢ Session debrief (to ensure all points have been captured effectively and comprehensively)
➢ Close the session and thank participants for their participation & distribute of appreciation certificate.

- A focus group aims to explore your knowledge and experience about nursing workforce and entry requirement for qualified nurses in Saudi Arabia. You may also be asked to explain your answers in detail.

- The actual length of the focus group will range from a one to two hours.

- The focus group will be held in the main auditorium hall in the Ministry of Health.

- The focus group will be a confidential and audio tape recorded. The interview will be a confidential and stored safely. The study will have two forms of data, a hard copy, and soft copy. Hard copy data will be kept in a locked locker and no one will be authorized to use it except the researcher. The soft copy data will be secured in a password protected external hard disk and will be connected only to researcher private laptop, only the researcher can access the saved study data. Your identity will be kept secure by the researcher.

Expenses and payments?

The Ministry of Health will cover any expenses for this research

What are the possible disadvantages and risks of taking part?

There are no personal risks associated with participation in the study

What are the possible benefits of taking part?

I cannot promise the study will help you but the information I obtain from the study is intended to help determine future workforce planning and development needs as a consequence of the introduction of degree entry pre-registration nurse education in Saudi Arabia.

What if there is a problem?

If you would like to complain about any aspect, please contact the supervisor Dr. Nancy Smith or Dr Karen Staniland in the first instance, or the University of Salford, School of Nursing, Midwifery, Social Work & Social Sciences and Social Care Research and Innovation Manager -

Dr Nancy Smith	n.j.smith@salford.ac.uk	School of Nursing, Midwifery, Social Work & Social Sciences
Dr Karen Staniland	k.staniland@salford.ac.uk	

Will my taking part in the study be kept confidential?

The information that you provide will be confidential. No names will appear in the study. Your identity and personal contact details will be known only to the researcher, the research assistants, and the research supervisors at the University of Salford. The researcher will not use your name or any information that could reveal their identity in this or any future research study, publication, conference presentation or teaching session. Storage and destruction of data will conform to the Data Protection Act (1998). Any information about you which leaves the Ministry of Health will have your name and address removed so that you cannot be recognised.

What will happen if I don't carry on with the study?

You have the right to withdraw from the study at any point without prejudice and this will not affect your care in any way. If you withdraw from the study all the information and data collected from you will be destroyed and your name removed from all the study files.

What will happen to the results of the research study?

The results will be published in a PhD thesis and parts of the study may be published in health care journals and/or presented at conferences. You have the right to ask for the results if needed and the choice of seeing the completed transcript following interview.

Who is organising or sponsoring the research?

The University of Salford and Ministry of Health.

If there are any further questions regarding this study, you can contact me (by phone or email) or my supervisors (by email) as follows. If you prefer, we can arrange to discuss this invitation, face to face, at a mutually convenient place and time.

Contact Details

Researcher

- Noura Almadani, PhD candidate. School of Nursing, Midwifery, Social Work & Social Sciences, University of Salford, Salford, Greater Manchester, United Kingdom, M6 6PU

Tel: +447462662646 or at n.almadani@edu.salford.ac.uk,

Supervisors

- Dr Nancy Smith n.j.smith@salford.ac.uk
- Dr Karen Staniland k.staniland@salford.ac.uk

<div align="center">**Appendix 5.7**</div>

Research Participant Consent Form for the (Meso level) Nursing Regional Director

Title of Project: The Implications of Nursing Degree Education for Future Workforce Planning in Saudi Arabia: A Case Study.
Ethics Ref No: HSCR14/119
Name of Researcher: Noura Almadani

	Yes	No
➢ I confirm that I have read and understood the information sheet for the above study and what my contribution will be.	**Yes**	**No**
➢ I have been given the opportunity to ask questions through the use of the participation information sheet.	**Yes**	**No**
➢ I agree to take part in the focus group	**Yes**	**No**
➢ I agree to the focus group activities being tape recorded	**Yes**	**No**
➢ I understand that my participation is voluntary and that I can withdraw from the research at any time **without giving any reason**	**Yes**	**No**
➢ I understand how the researcher will use my responses, who will see them and how the data will be stored.	**Yes**	**No**
➢ I understand the confidential nature of the focus group and I will not repeat what has been discussed in the group with anyone outside of the group**.**	**Yes**	**No**
➢ **I agree to take part in the above study**	**Yes**	**No**

Name of participant (print)   ……………………………………………………………………

Signature   ……………………………………………………………………

Date   ………………………………………………………………

Appendix 5.8

Structure and guidelines for focus group interviews

Introduction:

Focus groups explore topics that may not be easy to explore in one-to-one interviews, and data are generated and collected in a group setting as a meeting at which a group of people engage in intensive discussion and activity on a particular subject or project.

Objectives:

The main objective of using focus groups is to use the interaction data generated during discussion between the participants to gather information from members of a clearly defined target audience that will increase the depth of the enquiry and reveal aspects of the phenomenon assumed to be otherwise less accessible.

The expected outcomes from the focus group:

1. The participants will be able to communicate and interact with each other effectively.
2. The participants will be able to summarise each topic and organise them into different themes.
3. The moderator will be able to control the group discussion by emphasising free discussion, and then move toward a more structured discussion of specific questions.
4. The note taker will be able to capture all the data effectively and comprehensively.

General Guiding information:

1. The focus group will run from 12:00 p.m. to 14:10 p.m.
2. Your contribution in the focus group is vital to achieve the purpose of the study.
3. It is important to accept other opinions and viewpoints among the group.
4. It is a discussion session and everyone who has an opinion will be heard and all points will be discussed.
5. There will be an assistant who will be responsible for writing the minutes of the focus group.
6. Your travel to and from the focus group will be paid.

7. There will be a lunch provided for the participants.

8. A tape recorder will be used after gaining written permission from the participants. However, there will be a note-taker who will be responsible for writing down the details of the focus group.

9. The study has been approved by the College of Health and Social Care Research Ethics at University of Salford and the Ethics Committee at the Ministry of Health (General Directorate of Nursing in Saudi Arabia).

Guiding Roles for Focus Group:

It is very important to establish some ground rules prior to the focus group.

Participants will therefore be asked to:

- ➢ Turn off their phones.

- ➢ Let one person talk at a time.

- ➢ Assure maintenance of confidentiality. "What is shared in the room stays in the room."

- ➢ Hear everyone's ideas and opinions, as they are all valuable.

- ➢ Hear all sides of an issue – both the positive and the negative.

These guidelines will be presented to the group, and displayed throughout the discussion, on a flip chart page in a clearly visible location. Participants will establish their own guiding principles for the discussion, which the note-taker will add to the flip chart page.

QUALITATIVE INTERVIEW QUESTIONS GUIDE

Questions (Guiding)	Response	Follow-up (Probing Questions)
1. How did you become a registered nurse or what was the educational pathway that led you to your initial licensure as a nurse?		
2. In your opinion, what is the minimum degree that should be required for entry-level practice as a registered nurse?		
3. What influence do you think degree education has on the nursing workforce?		Rationale?
4. What benefits could be gained by requiring a Bachelor's degree for entry-level practice as a registered nurse?		
5. Why do you think the minimum educational requirements for entry-level practice as a registered nurse have been elevated to the baccalaureate level?		Rationale?
6. Overall, describe your ideal candidate for an entry-level nursing job.		

Appendix 5.10
Interview questions guidelines

There are five general types of questions that will be used as a guideline in the interviews as suggested by Krueger and Casey (2000).

• ***Opening questions*** are used to get people talking and feeling comfortable.

• ***Introductory questions*** are used to get the group to start thinking about the topic at hand. They help focus the conversation.

• ***Transition questions*** provide a link between the introductory questions and the key questions.

• ***Key questions*** focus on the major areas of concern. The majority of the time is devoted to discussions of these questions.

• ***Ending questions*** bring the session to closure.

The following themes from the Literature Review of this study will be used to guide the interview:

Education challenge

- Different approaches of nursing education
- Impact of degree education on nursing workforce
    - Skills
    - Knowledge
    - Attitude

System challenge

- Nursing policy & regulation
- Saudization Plan
- Nursing turnover & retention
- Working condition

Social challenge

- Ageing
- Women and society
- Cultural diversity

Appendix 5.11
Participants' information sheet (PIS)
For nurses from King Saud Medical City (Micro level)

Study title: The Implications of Nursing Degree Education for Future Workforce Planning in Saudi Arabia: A Case Study.

I am currently completing a research study for my PhD in Nursing at the University of Salford. I would like to invite you to be part of this research study. Ethical approval has been obtained from the University of Salford and it is important that you understand both the purpose of the research and your role as a participant. Please ask any questions if any part of the information is unclear to you. Finally, it is your decision whether or not to be part of the study and you may withdraw at any time.

What is the purpose of the study?
This research seeks to investigate the extent of your knowledge regarding workforce planning and development as a consequence of the introduction of degree entry pre-registration nurse education.

Why have I been invited?
The main reason for including you in this research is because you have a high level of knowledge and experience about nursing workforce and entry requirement for qualified nurses in Saudi Arabia.

Do I have to take part?
It is your choice as to whether you want to participate in this study. This information sheet will provide details to help you make this decision and you can contact me if you have any question about the research. If you agree to be part of the study, you will be asked to sign a consent form. You are free to withdraw at any point while taking part in the study.

What will happen to me if I take part?
You will be asked for consent to attend the focus group which will be tape recorded. The agenda will include all the activities you may need from the registration time to the debrief session. The following is the time-line agenda:

Process overview from 9am to 12pm
➢   Registration & welcome participants and thank them for attending,
➢   Review the purpose of the focus group & introduce facilitators.
➢   Ask participants to briefly introduce themselves
➢   Highlight key points for discussion & moderator will begins focus group questions
➢   Session debrief (to ensure all points have been captured effectively and comprehensively)
➢   Close the session and thank participants for their participation & distribute of appreciation certificate.

- A focus group aims to explore your knowledge and experience about nursing workforce and entry requirement for qualified nurses in Saudi Arabia. You may also be asked to explain your answers in detail.

- The actual length of the focus group and transcriptions will range about one to two and half hours, this the time where the data will be recorded.

- The focus group will be held in the main auditorium hall in King Saud Medical City, which is easily accessible for all and it is well prepared with all educational supplies and audio-visual equipment's to allow more sound quality that will help in transcription of audio-taped interviews (Asbury, 1995).

- The focus group will be a confidential and audio tape recorded. The researcher will explain the confidential nature of data recorded and inform subjects of the maintained anonymity of their identities. The researcher will request that everyone states their agreement to the confidentiality and non-judgmental response to whatever is said in this room. This is extremely important as nothing that is discussed here should be talked about outside the room. The interview will be a confidential and stored safely. The study will have two forms of data, a hard copy, and soft copy. Hard copy data will be kept in a locked locker and no one will be authorized to use it except the researcher. The soft copy data will be secured in a password protected external hard disk and will

be connected only to researcher private laptop, only the researcher can access the saved study data. Your identity will be kept secure by the researcher.

Expenses and payments?

The Ministry of Health will be covered any expenses or payments for this research

What are the possible disadvantages and risks of taking part?

There are no personal risks associated with participation in the study

What are the possible benefits of taking part?

I cannot promise the study will help you but the information I obtain from the study is intended to help determine future workforce planning and development needs as a consequence of the introduction of degree entry pre-registration nurse education in Saudi Arabia.

What if there is a problem?

If you would like to complain about any aspect, please contact the supervisor Dr. Nancy Smith or Dr Karen Staniland in the first instance, or the University of Salford, School of Nursing, Midwifery, Social Work & Social Sciences and Social Care Research and Innovation Manager –

| Dr Nancy Smith | n.j.smith@salford.ac.uk | School of Nursing, Midwifery, Social |
| Dr Karen Staniland | k.staniland@salford.ac.uk | Work & Social Sciences |

Will my taking part in the study be kept confidential?

The information that you provide will be confidential. No names will appear in the study. Your identity and personal contact details will be known only to the researcher, the research assistants, and the research supervisors at the University of Salford.   The researcher will not use your name or any information that could reveal their identity in this or any future research study, publication, conference presentation or teaching session. Storage and destruction of data will conform to the Data Protection Act (1998). Any information about you which leaves the Ministry of Health will have your name and address removed so that you cannot be recognised.

What will happen if I don't carry on with the study?

You have the right to withdraw from the study at any point without prejudice and this will not affect your care in any way. If you withdraw from the study all the information and data collected from you will be destroyed and your name removed from all the study files.

What will happen to the results of the research study?

The results will be published in a PhD thesis and parts of the study may be published in health care journals and/or presented at conferences. You have the right to ask for the results if needed and the choice of seeing the completed transcript following interview.

Who is organising or sponsoring the research?
The University of Salford and Ministry of Health.

If there are any further questions regarding this study, you can contact me (by phone or email) or my supervisors (by email) as follows. If you prefer, we can arrange to discuss this invitation, face to face, at a mutually convenient place and time.

Thank you for giving your valuable time in reading this letter.
Regards.
Noura Almadani
PhD candidate, School of Nursing, Midwifery, Social Work & Social Sciences
University of Salford, Salford, Greater Manchester, United Kingdom, M6 6PU.
Contact Details
- **Researcher**

    Noura Almadani
    Tel: +447462662646 or at n.almadani@edu.salford.ac.uk,
- **Supervisors**
    Dr Nancy Smith at n.j.smith@salford.ac.uk ,
    Dr Karen Staniland k.staniland@salford.ac.uk ,

Research Participant Consent Form for the nurses from King Saud Medical City
(Micro level)

Title of Project: The Implications of Nursing Degree Education for Future Workforce

Planning in Saudi Arabia: A Case Study.

Ethics Ref No: HSCR14/119
Name of Researcher: Noura Almadani

➢ I confirm that I have read and understood the information sheet for the above study and what my contribution will be.	**Yes**	**No**

➢ I have been given the opportunity to ask questions through the use of the participation information sheet.	**Yes**	**No**

➢ I agree to take part in the focus group	**Yes**	**No**

➢ I agree to the focus group activities being tape recorded	**Yes**	**No**

➢ I understand that my participation is voluntary and that I can withdraw from the research at any time **without giving any reason**	**Yes**	**No**

➢ I understand how the researcher will use my responses, who will see them and how the data will be stored.	**Yes**	**No**

➢ I understand the confidential nature of the focus group and I will not repeat what has been discussed in the group with anyone outside of the group**.**	**Yes**	**No**

➢ **I agree to take part in the above study**	**Yes**	**No**

Name of participant (print)   …………………………………………………………………

Signature   …………………………………………………………………

Date   ………………………………………………………………

Appendix 5.14
Sample of Reflexive Journal

Date: 7th March, 2015

Phase 1: documentary analysis

I accessed the files that contained these documents, which were kept in printed form in a special folder, and placed in the office of the General Director of Nursing. I conducted a brief overview of the documents to exclude any unrelated papers. However, most of the documents are not easily accessible and contain evidence that would take a researcher a long time and much effort to gather alone. The documents were in the original professional Arabic language that contained certain words with a broader meaning. I could not use the NVivo programme in this phase because of the language. I set myself 2-3 hours/day during works hours to review documents. However, it took far longer and I had to spend this time for 4weeks+ due to the mass of information and the language was written in Arabic.

I scanned the documents and saved the electronic copies onto my encrypted computer; I also developed a database on my personal computer that contained secure files for each phase of the study to organise and save the large amounts of data that I had collected.

Analysing documents was time consuming, and for me was the worst stage of this study. I read the documents many times, and every time I discovered some information significant to the research aim and objectives. On the other hand, this stage made me more confident, knowledgeable and oriented to the whole system and process of policy implementation.

Throughout the data collection process, a number of elements were kept consistent in the three levels (macro, meso and micro), such as the importance of confidentiality, achieved through coding. When I entered the fieldwork to collect documents related to nursing degree education, I was challenged with decisions as to which documents were the most relevant to this situation.

I could not use NVivo to arrange and organise the data because the documents were written in Arabic, so data was organised manually to include using notes and memos to document initial thoughts. Memos helped me to move from an empirical to a conceptual level and to identify the issues that required further exploration in the data analysis.