

**ARTICULATING THE NATURE OF
CLINICAL NURSE SPECIALIST PRACTICE**

By

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DECLARATIONS

I, Janet Deanne Bell 188051310, hereby declare that the thesis for Doctor of Philosophy is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.

A handwritten signature in black ink, appearing to read 'J Bell.', is written diagonally across the page.

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To whom it may concern

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This is to confirm that Janet Deanne Bell asked me to undertake editing and language-check responsibilities for her thesis, “*Articulating the Nature of Clinical Specialist Nurse Practice*”.

I have been in the publishing industry for 34 years as both writer and editor and taught business literacy and writing for several larger brand training organisations for over 20 years.

I have read Janet’s thesis offering language and text editing adjustments where appropriate.

Yours sincerely

Wendy K Coetzee

DEDICATION

I dedicate this work to all of you who touched my life and led me to explore beyond the edges I thought defined myself.

'If I have seen further it is only by standing on the shoulders of giants'

(Isaac Newton)

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As I end, I return to the beginning – to the people who have encouraged me, been patient with me and accommodated me; without the support of each of you none of this work would have seen the light of day.

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ABSTRACT

Critical care nursing is a clinical specialist nursing practice discipline. The critical care nurse provides a constant presence in the care of a critically ill patient. She/he creates a thread of continuity in care through the myriad of other health care professionals and activities that form part of a patient's stay in the critical care environment (World Federation of Critical Care Nurses [WFCCN], 2007).

During conversations with people who have had intimate experience of the critical care environment, they have offered anecdotes that describe their interaction with critical care nurses who they perceive to be different from and better than other critical care nurses they encountered. Despite having met common professional requirements to be registered as a clinical specialist nurse, these distinctive, unique abilities that seem to be influential in meeting the complex needs and expectations of critically ill patients, their significant others as well as nursing and medical colleagues, are not displayed by all critical care nurses. While students of accredited postgraduate nursing programmes are required to advance their nursing knowledge and skill competence, many students do not seem to develop other, perhaps more tacit, qualities that utilisers characterise in their anecdotes of 'different and better' nursing practice.

The overarching research question guiding this study was how can 'different and better' critical care nursing practice as recognised by a utiliser be explained? The purpose of this study was to develop an understanding of the qualities that those people who use critical care nursing practice recognise as 'different and better' to the norm of nursing practice they encounter in this discipline. The participant sample included patients' significant others, nursing colleagues and medical colleagues of critical care nurses, collectively identified as utilisers. The stated aim of this work was to construct a grounded theory to elucidate an understanding of the qualities that a utiliser of critical care nursing recognises as 'different and better' critical care nursing practice in order to enhance the teaching and learning encounters between nurse educators and postgraduate students in learning programmes aiming to develop clinical specialist nurses.

The method processes of grounded theory are designed to reveal and confirm concepts from within the data as well as the connections between these concepts, supporting the researcher in crafting a substantive theory that is definitively grounded in the participants' views and

stories (Streubert & Carpenter, 2011: 123, 128-129). Two data collection tools were employed in this study, namely in-depth unstructured individual interviews and naïve sketch. Constant comparative analysis, memo-writing, theoretical sampling, theoretical sensitivity and theoretical saturation as fundamental methods of data generation in grounded theory were applied.

The study unfolded through three broad parts, namely:

- Forming & shaping this grounded theory through exploration and co-creation
- Assimilating & situating this grounded theory through understanding and enfolding
- Reflecting on this grounded theory through contemplating and reconnecting

The outcome of the first part of the study was my initial proposition of a grounded theory co-created in the interactions between the participants and myself. This was then challenged, developed and assimilated through a focussed literature review through the second part of the study. Through these two parts of this study, an inductively derived explanation was formed and shaped to produce an assimilated and situated substantive grounded theory named *Being at Ease*. This grounded theory articulates how 'better and different' nursing is recognised from the point of view of those who use the nursing ability of critical care nurses through the core concern 'being at ease' and its four categories 'knowing self', 'skilled being', 'connecting with intention' and 'anchoring'.

The final part of this study unfolded in my reflections on what this grounded theory had revealed about nurses and elements of nursing practice that are important to a utiliser in recognising 'different and better' critical care nursing. I suggest that as nurses we need to develop a language that enables us to reveal with clarity these intangible and tacit elements recognised within the being and doing of 'different and better' nursing. I reflected on the pivotal space of influence a teacher has with a student, and on how the elements essential in being and doing 'different and better' nursing need to be evident in her/his own ways of being a teacher of nursing. Teaching and learning encounters may be enhanced through drawing what this theory has shown as necessary elements that shape 'different and better' nurses through the moments of influence a teacher has in each encounter with a student.

TABLE OF CONTENTS

DECLARATIONS	i
DECLARATION FROM LANGUAGE EDITOR	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT	vi

CHAPTER 1

ORIENTATION TO THIS STUDY

1.1 BACKGROUND TO THIS STUDY	1
1.2 PROBLEM STATEMENT	6
1.3 SIGNIFICANCE OF THIS WORK	7
1.4 RESEARCH QUESTIONS	8
1.5 STUDY AIM.....	8
1.6 STUDY OBJECTIVES.....	8
1.7 KEY TERMS & CONCEPTS	9
1.8 RESEARCH DESIGN & METHOD.....	11
1.8.1 Research design & underpinning philosophy.....	11
1.8.2 Research methods	13
1.8.2.1 <i>Forming & shaping this GT</i>	13
1.8.2.2 <i>Assimilating & situating this GT</i>	14
1.8.2.3 <i>Reflecting on what this GT reveals</i>	15
1.9 TRUSTWORTHINESS.....	16
1.10 ETHICAL CONSIDERATIONS.....	16
1.11 CHAPTER CONTENTS	17
1.12 CHAPTER SUMMARY.....	19

CHAPTER 2

RESEARCH DESIGN & METHOD

2.1	RESEARCH DESIGN	21
2.2	EXPLORING WITH THE GROUNDED THEORY (GT) METHOD	21
2.2.1	The development of GT as a research method	23
2.2.2	Choosing a version of GT through philosophical congruence.....	24
2.2.3	The defining processes of GT method.....	26
2.3	STUDY SETTING	29
2.4	RESEARCH METHODS	30
2.4.1	Study population & sampling processes	34
2.4.1.1	<i>Study Sample</i>	34
2.4.1.2	<i>Sample Size</i>	46
2.4.2	Data generation - collecting data	47
2.4.2.1	<i>Intensive unstructured individual interviews</i>	50
2.4.2.2	<i>Naïve sketch</i>	55
2.4.2.3	<i>Reflecting & memo-writing</i>	55
2.4.2.4	<i>Data sets</i>	56
2.4.3	Data generation - data analysis	57
2.4.3.1	<i>Forming & shaping this GT - the processes of coding</i>	59
2.4.3.2	<i>Initial coding - forming this GT</i>	60
2.4.3.3	<i>Focussed coding - forming this GT</i>	64
2.4.4	Reviewing & enfolding the literature	73
2.4.4.1	<i>The place of literature in GT</i>	73
2.4.4.2	<i>The process of sampling, reviewing & enfolding literature</i>	75
2.4.5	Reflecting.....	79
2.5	TRUSTWORTHINESS.....	80
2.5.1	Credibility.....	80

2.5.2	Transferability	83
2.5.3	Dependability	84
2.5.4	Confirmability	84
2.6	ETHICAL CONSIDERATIONS	84
2.6.1	Respect for persons	85
2.6.2	Beneficence	86
2.6.3	Justice	88
2.7	CHAPTER SUMMARY	88

CHAPTER 3

FORMING & SHAPING THIS GT

3.1	FORMING THIS GT	90
3.2	SHAPING THIS GT - <i>BEING AT EASE</i>	104
3.2.1	Category - Knowing Self	105
3.2.1.1	<i>Grounding self</i>	107
3.2.1.2	<i>Balancing self</i>	109
3.2.2	Category - Skilled Being	114
3.2.2.1	<i>Offering humanness</i>	115
3.2.2.2	<i>Handling complexity</i>	121
3.2.2.3	<i>Being influential</i>	125
3.2.2.4	<i>Knowing Self & Skilled Being</i>	131
3.2.3	Category - Connecting with Intention	132
3.2.3.1	<i>Being present</i>	134
3.2.3.2	<i>Reaching out</i>	137
3.2.3.3	<i>Feeling safe</i>	141
3.2.4	Category - Anchoring	146
3.2.4.1	<i>Always there, always everywhere</i>	147

3.2.4.2	<i>Trusting partnerships</i>	149
3.2.4.3	<i>Connecting & Anchoring</i>	155
3.2.5	Core concern – ‘Being at Ease’	155
3.3	CHAPTER SUMMARY	159

CHAPTER 4

ASSIMILATING & SITUATING THIS GT

4.1	THE LITERATURE REVIEW IN GT	160
4.2	OPENING THE DIALOGUE	162
4.3	GOOD NURSING	163
4.3.1	The notion of ‘good’ in nursing	163
4.3.2	Uncovering good nursing in ‘being at ease’	167
4.4	NURSING PRESENCE	172
4.4.1	The slowly unfolding discourse on nursing presence	172
4.4.2	Nursing presence & ‘being at ease’	175
4.4.3	The concepts of nursing presence	177
4.4.4	Comparing ‘being at ease’ with the concept of presence	181
4.4.4.1	<i>Antecedents to presence</i>	181
4.4.4.2	<i>Attributes of presence</i>	186
4.4.4.3	<i>Teasing out the attributes of presence in ‘being at ease’</i>	187
4.4.4.4	<i>Consequences of presence</i>	188
4.4.4.5	<i>How ‘being at ease’ may extend nursing presence as a concept</i>	190
4.4.5	Refining ‘being at ease’	193
4.5	SITUATING ‘BEING AT EASE’	194
4.5.1	Settling the- core concern & categories	194
4.6	CHAPTER SUMMARY	200

CHAPTER 5

REFLECTIONS ON BEING AT EASE

5.1	REFLECTION AS AN INTEGRAL ELEMENT OF GT	202
5.2	<i>BEING AT EASE</i> , EXPERTISE & PROFESSIONAL ARTISTRY	204
5.3	<i>BEING AT EASE</i> & 'DIFFERENT & BETTER' NURSING PRACTICE	207
5.4	<i>BEING AT EASE</i> & CLINICAL SPECIALIST NURSING PRACTICE	209
5.5	<i>BEING AT EASE</i> & TEACHING AND LEARNING ENCOUNTERS	211
5.6	GROUNDING THEORY - <i>BEING AT EASE</i> - ME	218

CHAPTER 6

RE-CONNECTING - CONCLUSIONS & RECOMMENDATIONS

6.1	IS THIS WORK A USEFUL GT?	221
6.1.1	Methodological & interpretive rigour	221
6.1.2	<i>Being at Ease</i> – my claim of its quality & usefulness	226
6.2	DRAWING CONCLUSIONS	226
6.3	CONTRIBUTION	230
6.4	LIMITATIONS	231
6.5	RECOMMENDATIONS FOR PRACTICE & RESEARCH	232
6.6	CONCLUSION	234
	LIST OF REFERENCES	235

APPENDICES

APPENDIX 1: Letter of study approval and ethics clearance from FRTI	248
APPENDIX 2: Request for permission to conduct research in hospitals	250
APPENDIX 3: Letter of permission to access a particular group of hospitals	251
APPENDIX 4: Letter of permission to access another group of hospitals.....	252
APPENDIX 5: Information session guide sheet	254
APPENDIX 6: Form to indicate interest in participating in this study	255
APPENDIX 7: Letter for participants	256
APPENDIX 8: Participant information & consent form	257
APPENDIX 9: Interview preparation sheet	260
APPENDIX 10: Interview guide & record sheet	261
APPENDIX 11: Naïve sketch sheet	262
APPENDIX 12: A screenshot of early initial coding in ATLAS-ti (interview 2).....	263
APPENDIX 13: A screenshot of later initial/early focussed coding in ATLAS-ti (interview 5)	264
APPENDIX 14: A screenshot of a written naïve sketch coded in ATLAS-ti (interview 3)	265
APPENDIX 15: An example of a drawn naïve sketch (interview 7)	266
APPENDIX 16: A screenshot of later focussed coding in ATLAS-ti (interview 10)	267
APPENDIX 17: Expanded mind map of ‘being able to...’	268
APPENDIX 18: Mind map of early emergent categories linked by the research question with ‘knowing’ fully expanded	269
APPENDIX 19: Fully expanded mind map of ‘being’ showing developing relationships between concepts (blue lines)	270
APPENDIX 20: Hand drawn mind map of ‘knowing self’ after 10 interview sessions	271
APPENDIX 21: Hand drawn mind map of ‘anchoring’ after 10 interview sessions	272

LIST OF TABLES

Table 2.1	The three discernible parts of this study	31
Table 2.2	Aligning the parts of the study within the research process and GT methods ...	33
Table 2.3	Final sample composition from purposive and theoretical sampling processes	47
Table 2.4	Application of GT method processes in reviewing and enfolding literature	76
Table 2.5	Examples of terms and data bases used in literature review	79
Table 3.1	Seven emergent categories: labels and descriptions	92
Table 3.2	Five categories with their concept groups and a description	95
Table 4.1	Theme groups and related personal virtues of contemporary good nursing	166
Table 4.2	Four attributes of good contemporary professional practice and enabling virtues	167
Table 4.3	Definitions of nursing presence across three decades	175
Table 4.4	Finding the fit: nursing presence and 'being at ease'	176
Table 4.5	A juxtaposition of Tavernier's and Finfgeld-Connett's work on nursing presence	180
Table 6.1	Methodological reference points of rigour within <i>Being at Ease</i>	222

LIST OF FIGURES

Figure 2.1	Purposive sampling outcome - participants and mode of access	40
Figure 2.2	Theoretical sampling outcome - summary of participants.....	44
Figure 2.3	Schematic representation of the concurrent nature of data collection & data analysis.....	49
Figure 2.4	Data items comprising a participant data set	56
Figure 2.5	Summary of initial coding process	63
Figure 2.6	Moving from initial coding to categories emerging from early focused coding .	67
Figure 2.7	Key to symbols used across mind maps.....	70
Figure 2.8	Schematic representation showing the progression from codes to core concern.....	72
Figure 3.1	A summary of the methods through which the initial 9 broad categories emerged from data sets 1-5.....	91
Figure 3.2	Being able to ... - an example of an early category mind map	93
Figure 3.3	Five emergent categories with concept groups	94
Figure 3.4	'Being' – an example of a developing category after analysis of 8 data sets. ...	96
Figure 3.5	Mind map of 'anchoring' as the preliminary core concern – initial draft.....	98
Figure 3.6	Mind map of 'anchoring' as it evolved after reflection on data	99
Figure 3.7	Emergence of the core concern through the GT coding processes.....	103
Figure 3.8	'Being at ease' – categories underpinning the core concern	104
Figure 3.9	'Knowing Self' – concept groups and relationships.....	106
Figure 3.10	'Grounding Self' - actions, processes and relationships	108
Figure 3.11	'Balancing Self' - actions, processes and relationships	110

Figure 3.12 ‘Skilled Being’ – concept groups and relationships	114
Figure 3.13 Interview 2 – clipping from naïve sketch and naïve sketch narrative	115
Figure 3.14 ‘Offering Humanness’ – actions, processes and relationships.....	116
Figure 3.15 Interview 5 - clipping from naïve sketch.....	121
Figure 3.16 ‘Handling Complexity’ – actions, processes and relationships.....	122
Figure 3.17 ‘Being Influential’ – actions, processes and relationships	126
Figure 3.18 ‘Being at ease’ – categories underpinning the core concern	132
Figure 3.19 ‘Connecting with Intention’ – concept groups and relationships	133
Figure 3.20 Interview 3 – clipping from naïve sketch	134
Figure 3.21 ‘Being Present’ – actions, processes and relationships	135
Figure 3.22 Interview 8 – clipping from naïve sketch	137
Figure 3.23 ‘Reaching out’ – actions, processes and relationships	138
Figure 3.24 ‘Feeling Safe’ – actions, processes and relationships	142
Figure 3.25 ‘Anchoring’ – concept groups and relationships	146
Figure 3.26 ‘Always There, Always Everywhere’ – actions, processes and relationships.	148
Figure 3.27 ‘Trusting Partnerships’ – actions, processes and relationships	150
Figure 3.28 Interview 8 – clipping from naïve sketch	152
Figure 3.29 Interview 9 - clipping from naïve sketch.....	153
Figure 3.30 ‘Being at ease’ – categories underpinning the core concern	155
Figure 3.31 <i>Being at Ease</i> – core concern, categories, concept groups & relationships ..	157
Figure 4.1 An assimilation of the elements of good nursing, ‘knowing self’ and ‘skilled being’	170

Figure 4.2	'Being at ease' – categories underpinning the core concern	195
Figure 4.3	<i>Being at Ease</i> – core concern, categories, concept groups & relationships ..	200

LIST OF BOXES

Box 2.1	Characteristics of participants in sample	45
Box 4.1	The core concern - 'being at ease'	197
Box 4.2	'Knowing self' – a category of the core concern	197
Box 4.3	'Skilled being' – a category of the core concern	198
Box 4.4	'Connecting with intention' – a category of the core concern.....	198
Box 4.5	'Anchoring' – a category of the core concern.....	198

CHAPTER 1

ORIENTATION TO THIS STUDY

The purpose of Chapter 1 is to offer an orientation to the research described and explained through the following chapters. In Chapter 1 I provide the reader with a foundation within which this research can be located. I achieve this through outlining my underpinning ideas and points of departure that acted as stimuli for the research question that has guided this study. I briefly introduce my approach to the study and the research method I applied during this work.

1.1 BACKGROUND TO THIS STUDY

The critical care nurse provides a constant presence in the care of a critically ill patient. She/he creates a thread of continuity in care through the myriad of other health care professionals and activities that form part of a patient's stay in the critical care environment (World Federation of Critical Care Nurses [WFCCN], 2007). A holistic approach to patient care requires that the critical care nurse must balance the readily observable bio-physiological focus of patient management with the emotional, psychological, health information and social needs of this patient as well as family. When considering the precarious health status of the critically ill patient, meeting these non-physiological needs is as complex as providing physiological care for this patient. Thus, to be able to provide care that can meet these varied needs, the critical care nurse must blend the art and science of being a specialist nurse in clinical practice. A clinical specialist nurse must be accomplished in thinking critically and creatively; taking considered, decisive actions and retaining a connection with the patient that acknowledges the patient's holistic and individual context.

A clinical specialist nurse is prepared at an educational level further than that of a generalist nurse; she/he is authorised to practice in a discipline of nursing as a specialist whose function encompasses a variety of roles including a clinical role, education role, management role, research role and consultant role (Affara, 2009:6; Forum of University Nursing Deans in South Africa [FUNDISA], 2009:8). Professional registration under regulation No R. 212 of February 1993 (as amended) recognises one as a nurse specialist in a particular discipline of clinical nursing practice in South Africa. Thus a registered critical care nurse has achieved the educational and professional requirements to be a clinical specialist nurse. Professional acknowledgement of one as a clinical specialist nurse through registration then provides a

foundation for an expectation of greater depth to and extension of nursing knowledge, skill and attitude being applied into that nurse's clinical practice. As such, when a nurse practices in this clinical specialist role; the public and colleagues can reasonably expect this nurse to understand and combine the necessary facets of a patient in a more profound and complex manner to offer a multidimensional approach to patient care. The smooth combining of multiple forms of knowledge and oneself to provide positive patient-specific nursing has been described as nursing practice expertise (Hardy, Garbett, Titchen & Manley, 2002:201). When considering this description by Hardy, *et al.* (2002:201), the natural extension of the public and colleagues' expectations is that a clinical specialist nurse should become and be an expert nursing practitioner in a particular discipline of nursing. Thus, if there is a reasonable expectation by the public and colleagues that a clinical specialist nurse is able to offer expertise in nursing practice, then there must be a way of them recognising what 'being an expert critical care nurse' means and how they experience a nurse 'being an expert critical care nurse'. That is, how the phenomenon of clinical practice expertise in South African critical care nursing may be recognised as different from the usual critical care nursing practice.

Research related to nursing expertise has focussed on developing an understanding of expert critical care nursing practice. The seminal work by Benner in the 1980's on the development of expertise and articulation of knowledge embedded in nursing practice has led to the description of practice expertise attributes and the enablers of these attributes (Benner, 2001:31-38; Benner, Tanner & Chesla, 2009:137-169; Hardy, Titchen, Manley & McCormack, 2006:261-263; Manley, Hardy, Titchen, Garbett & McCormack, 2005:23-25). These attributes and enablers of expertise were described as relating and blending with each other through professional artistry in a conceptual framework of practice expertise offered by Manley, *et al.* (2005:23). This conceptual framework culminated from a Royal College of Nursing project to explore a contemporary understanding of nursing practice expertise in the United Kingdom. Professional artistry is regarded as the hallmark or central attribute of expertise in this conceptual framework. These authors suggest that professional artistry enables an expert nurse to use professional judgement in applying science and skill through various forms of knowledge in nursing practice; and to use the self to connect therapeutically with the humanity of a patient (Manley, *et al.*, 2005:27).

While the attributes and enablers of practice expertise have been described, the flexible integration and blending of these in the clinical practice reality of becoming and being an expert nurse is not understood. There has been limited research on the role clarification in trying to define a clinical nurse specialist in South Africa (for example: work by Prins, 2010), but it appears that no study has explored or considered the concepts of practice expertise in specialist clinical nursing practice in our context in South Africa. International research has focussed on the nursing profession's understanding of expert practice with research into the process of developing expertise as well as self-recognition of expertise by critical care nurses. Whilst 'recognition by others' has emerged as an enabler of expertise in previous research (Manley, *et al.*, 2005: 25, Bonner, 2003:15-16), no published research appears to have considered this enabler from the perspective of the 'other'; that is, a person who utilises critical care nursing in some way.

Morrison and Symes (2011:163-164) comment on the necessity of exploring expert nursing practice as the consequent insights support nurses to realise the value of their practice and develops our understanding of what is necessary in the care of critically ill patients. Furthermore, she establishes that this research helps to transfer the tacit ways of being an expert in doing nursing through safeguarding this knowledge and making it available even once experienced nurses have left the workforce. It is necessary to provide a tangible expression of what this phenomenon means in nursing in South African as an opportunity exists to inform some of the significant challenges that the South African nursing profession is presently grappling with. During discussion and debate about nursing, and critical care nursing in particular, with senior nursing colleagues across the spectrum of clinical, management and educational environments, these following challenges have been highlighted with particular concern:

- Professional regulatory changes as determined by the Nursing Act (Act no 33 of 2005) require an understanding of the nature of clinical nurse specialist practice in the South African context to assist in determining at a regulatory level how a clinical nurse specialist and by extension, a clinical expert is recognised.
- It is very seldom that critical care nurses speak openly about how they perform their craft, generally limiting their narrative to task description rather than the complexity of their nursing. This custom keeps the nature and value of clinical specialist practice

hidden from public view, limiting the public and healthcare policy makers' perception of what clinical nursing expertise encompasses and contributes.

- A further evolution of the previous statement is that there is thus scant understanding of the actual value that clinical specialist nurse practice brings to healthcare. This is particularly true in understanding how the clinical nurse contributes to patient care in ways that medical practitioners, physiotherapist, dieticians and so forth cannot. Gordon (2005:14-15) notes that nursing lacks a practice narrative that describes what nurses do and how they do it; how nurses combine skills and knowledge in a unique way that enables them to rescue patients from the risks and consequences of illness.
- The diminished influence of clinical specialist nurses in the practice environment due to emigration, and possibly, a narrow focus in preparing graduates for the clinical specialist role, allow for negative clinical practice consequences to emerge. As the value of the clinical specialist nurse and nursing practice expertise is not explicit, a business case for supporting and developing practice expertise cannot be made and there is then no drive to find better solutions to the present predicament.
- Practice environments generally do not allow for clinical practice expertise to thrive. Some of the problems experienced in the critical care environments include limited and/or poor resources, limited access to supportive practice development technology, overt and covert professional bullying, and so forth; these do not encourage a clinical specialist nurse to remain in the clinical practice environment or allow practice expertise and personnel to thrive.

Possibly the greatest challenge though are concerns expressed that nursing practice in general in South Africa seems to demonstrate a lack of skill competency, accompanied by poor knowledge and detrimental attitudes (Nursing Education Stakeholder Group, 2011). These concerns were further elaborated at the 2011 National Nursing Summit where the resulting Nursing Compact documented the profession's concern regarding the decline in quality of care, and the perceived negative image of nursing amongst South African communities (Nursing Compact, 2011:1). Through practice and teaching experience, I have recognised that these documented concerns of nurses' lack of competency, deficient knowledge and undesirable attitude hold validity in critical care nursing practice. My experience in medico-legal casework has shown evidence of critical care nurses failing to apply and integrate the advanced skill competency, appropriate specialist practice knowledge

and beneficial attitude that can be reasonably expected of a critical care nurse. The vignette below describes a clinical example to illustrate these concerns:

A patient underwent emergency neurosurgery. Due to the complex nature of the operation, the patient required post-operative monitoring and management in a critical care unit. The patient had been extubated in the recovery area and an uneventful recovery, with the patient to be transferred to the general ward the following morning, was anticipated.

Soon after admission to the critical care unit the patient began to develop changes in his condition. These changes in vital signs and behaviours were assessed to be insignificant by the nurse allocated to the patient's care. The changes continued intermittently through the initial 12 hours of post-operative care with no intervention initiated by the nursing personnel in the critical care unit. By the following morning the patient had become comatose.

The patient was taken back to theatre where a large volume cerebral haematoma was drained. The patient had experienced prolonged raised intracranial pressure through the previous 12 hour. Due to the impact of prolonged raised intracranial pressure on brain structures, the patient is now severely disabled and will require full time care in an appropriate facility for the remaining years of her/his life (personal communication, 2008).

When looked at individually, the changes recorded in the patient's condition do appear minor and unrelated. However, considering that the critical care nurse should have an advanced capability in understanding, teasing out and reconnecting the threads in a complex problem; it is reasonable to expect the critical care nurses who interacted with this patient to have assessed this person's clinical condition holistically and critically. Once the individual pieces of clinical data are considered together it is readily evident that the patient was experiencing the subtle signs of increasing intracranial pressure. The patient's records also reflect an irritation on the part of the nursing personnel with the patient's apparent lack of control over some body functions. The specialist nurses responsible for the care and management of this patient should have had the necessary ability in terms of knowledge, understanding and skill to piece together the puzzle such that an early intervention could be triggered. There should also have been an underlying caring concern for the patient's comfort and need to feel safe in the hands of the nurses. This is but one example of an apparent lack of skilled insight combined with an absence of critical and caring consideration of the patient's clinical picture by clinical specialist nurses.

In contrast to the concerns discussed in the previous paragraphs, there are compelling anecdotes of critical care nurses who do meet the expectation of delivering expert nursing practice. During conversations with people who have had intimate experience of the critical care environment, they have offered anecdotes that describe their interaction with critical care nurses who they perceive to be different from and better than other critical care nurses they encountered. These 'different and better' critical care nurses are described as being 'talented', 'excellent', or 'natural' nurses, and seen as being able to connect with patients and family members, as well as colleagues and the critical care environment, in a manner that transcends the combination of knowledge and competence alone. The common thread amongst these anecdotal descriptions is that these 'different and better' critical care nurses appear able to create a unique experience of nursing for each patient or colleague in a manner that is experienced as different to and better than the nursing that is provided by other nurse colleagues in the critical care environment. These distinctive, unique abilities are not displayed by all critical care nurses yet seem to be influential in meeting the complex needs and expectations of critically ill patients, their significant others as well as nursing and medical colleagues.

As the nursing profession has tried through time to clearly communicate its place in healthcare it has moved through many forms and shapes; more often than not competing with other healthcare professions in an attempt to articulate its value and contribution. Nursing has strongly promoted a science-based approach to try to capture respect within healthcare professions. While evidence-led practice is an essential component of nursing, perhaps what sets this profession apart from other healthcare professions are the enigmatic aspects of being a nurse doing nursing? Perhaps it is these aspects that enrich the ability of expert nurses to engage with patients holistically, to flexibly combine the science and art of nursing within the individuality of each relationship.

1.2 PROBLEM STATEMENT

Critical care nurses in South Africa must graduate from SANC accredited postgraduate education programmes in order to be registered by the SANC to fulfil the role of a clinical specialist nurse. Thus one can reasonably conclude that each registered critical care nurse is equipped to combine necessary science, skill and their therapeutic self to create a unique nursing relationship with a patient and be able to accomplish the complex, holistic, integrated

practice anticipated of a clinical specialist nurse by those who utilise the services of critical care nurses.

Despite this, there are clear differences recognised in the nature of clinical specialist practice implemented by critical care nurses. People who have used and engaged with critical care nursing note that only some critical care nurses offer the 'different and better' nursing practice qualities that they anticipated from a clinical specialist nurse. While students of accredited postgraduate programmes are required to advance their nursing knowledge and skill competence, many students do not seem to develop other more tacit qualities that utilisers characterise in their anecdotes of 'different and better' nurses and nursing. Although this 'different and better' practice may be attributed to inherent abilities of some individuals, it is necessary to understand the nature of this nursing practice to elaborate its particular tacit qualities.

1.3 SIGNIFICANCE OF THIS WORK

The significance of this work lies in its contribution to developing a more whole understanding of the nature of clinical specialist nursing practice through exploring the phenomenon of a 'different and better' nurse and nursing. Greater depth of knowledge and advanced skill competence are accepted as necessary elements for a postgraduate student studying in a clinical specialist learning programme to develop, but it does seem that there are other elements or qualities that are instrumental in a nurse being able to craft a unique experience of nursing for another person. Once made explicit through exploration and explanation, these elements or qualities of 'different and better' critical care nursing can be used to enhance teaching and learning encounters in clinical specialist nursing programmes. In this way, teachers can more deliberately facilitate a student's potential to mature into a clinical practice expert equipped to achieve the breadth and depth of the 'different and better' nursing practice such that this nature of nursing practice becomes the norm of nursing care in critical care units.

Further to this, the study adds another dimension to the practice narrative of clinical specialist nursing from the perspective of an 'outsider' - the viewpoint of a person who has used and engaged with the nursing ability of a critical care nurse. The significance of this viewpoint is that it brings the voice of those people directly affected by a nurse's capabilities into sharp

relief allowing us to probe our current ways of understanding our practice and its consequences.

1.4 RESEARCH QUESTIONS

The broad research questions guiding this study were:

- How can 'different and better' critical care nursing practice as recognised by a utiliser be explained?
- How may this explanation enhance teaching and learning encounters in postgraduate programmes aiming to develop clinical specialist nurses?

The initial broad research question developed into more focussed questions during the processes of engaging with participants and, later, relevant literature, and through analysing this data. The sub-questions that developed through the study were:

- What do utilisers who engage with critical care nurses recognise as the qualities of 'different and better' critical care nursing practice?
- Why and how are these particular qualities considered to be 'different and better' by the utilisers?

1.5 STUDY AIM

The aim of this study was to construct a grounded theory to elucidate an understanding of the qualities that a utiliser of critical care nursing recognises as 'different and better' critical care nursing practice in order to enhance the teaching and learning encounters between nurse educators and postgraduate students in learning programmes aiming to develop clinical specialist nurses.

1.6 STUDY OBJECTIVES

The objectives posed for this study were:

- to explore and describe the nature of 'different and better' critical care nursing practice as this is recognised by utilisers (professional nurses, medical practitioners and patients' significant others);
- to construct a grounded theory to articulate an explanation of how the utilisers recognise 'different and better' critical care nursing practice;

- to offer my reflection on how the explanation articulated in this grounded theory may enhance teaching and learning encounters in clinical specialist nurse education programmes.

1.7 KEY TERMS AND CONCEPTS

The following key terms and concepts are clarified below for the purpose of this study.

Nature of practice

The nature of practice speaks to the intrinsic qualities of practice that together form the essence of 'different and better' nursing.

Clinical specialist nurse

The International Council of Nurses defines the nurse specialist as a nurse prepared beyond the level of a generalist nurse and authorised to practice as a specialist with advanced expertise in a branch of the nursing field; this specialist practice includes clinical, teaching, administration, research and consultant roles (Affara, 2009:6). Thus a clinical specialist nurse fulfils these requirements in the clinical arena of patient care, and specifically in this study, the registered critical care nurse within the critical care environment.

Registered critical care nurse

A registered critical care nurse is a professional nurse who has successfully completed a postgraduate or post basic programme to meet the educational and professional requirements to be registered with an additional qualification in advanced medical and surgical nursing by the South African Nursing Council as per regulation No. R. 212 of February 1993 (as amended). In the South African critical care practice environment, this person is referred to as an 'ICU nurse' or 'critical care nurse'. The registered critical care nurse is a clinical specialist nurse who is educated in advanced general nursing and is authorised to provide specialised care to critically ill patients who present with immediate or potential life-threatening illness or injury (Elliot, Aitken & Chaboyer, 2012:785).

Critically ill patients

Critically ill patients are patients who have an immediate or potential life-threatening illness or injury causing compromise to one or more organ systems. These patients are admitted

into critical care units for specialised nursing care to manage the complex effects of the initial illness or injury, manage any life supporting pharmacology, techniques and machines, identify and limit any complications, as well as care for the patient's emotional and psychological needs until the patient recovers or dies (Elliot, *et al.*, 2012:785).

Utiliser of critical care nursing

A utiliser is a person who makes use of a particular service – in this study the service is that of critical care nursing as provided by a nurse in a critical care unit. In this study, a utiliser refers to a person whose activities or interests are integrated into critical care nursing (for example: a nurse colleague or medical practitioner); or one who engages with critical care nursing either directly or indirectly (for example: patient's significant others). For the context of this study, a utiliser referred to a professional nurse or medical practitioner working in the critical care environment who has engaged with a 'different and better' nurse as a colleague, or a critically ill patient's significant other.

Patient's significant others

For the purpose of this study, a patient's significant other included her/his parents, children, siblings, spouse or life partner.

'Different and better' nurse / 'different and better' nursing

'Different and better' nurse or 'different and better' nursing refers to the collective ways that a person and/or her/his nursing practice is recognised by a utiliser as a unique and positive nursing experience that is different to and better than the norm of clinical practice provided by other nurse colleagues in the critical care environment. This 'different and better' practice seems to meet the utiliser's expectations of specialist nursing practice.

Qualities of 'different and better' nursing practice

The qualities of 'different and better' nursing practice are those essential identifying attributes or characteristics of nurses and nursing practice that are regarded by a utiliser of critical care nursing as 'different and better'.

Practice expertise

Practice expertise is nursing practice that combines and expresses the attributes of expert practice namely: holistic practice knowledge, knowing the patient, saliency, moral agency and skilled know-how (Manley, *et al.*, 2005:23-24).

Professional artistry

Professional artistry is the manner in which an expert nurse blends and relates individual self-qualities, practice skills and creative processes in applying science and technique to clinical practice (Manley, *et al.*, 2005:25-27).

Teaching and learning encounters

Teaching and learning encounters are the various and varied engagements that happen between a teacher and a student during the period they are interacting with each other for the purpose of the student learning to become a clinical specialist nurse.

1.8 RESEARCH DESIGN AND METHOD

A research design describes the researcher's broad plan to approach and then guide the study as it unfolds. The research problem and questions are the point of departure to determine the appropriate design for the study. The research design guides the researcher to apply appropriate research methods to elicit the evidence required to address the research problem and question adequately (Babbie & Mouton, 2006:74-75).

1.8.1 Research design and underpinning philosophy

The aim of this study was to elucidate an understanding of the ways (i.e. the how, what, when, where, and why), a utiliser recognises the 'different and better' clinical nursing practice revealed by some professional nurses in critical care. Through phrasing the study aim as I did, my intention to offer an explanation of the phenomenon under study was evident and, thus, within the broader qualitative paradigm, I chose to use Grounded Theory (GT) as the research method best suited to enable the development of an inductively derived explanatory theory about a phenomenon. The method processes of grounded theory are designed to reveal and confirm concepts from within the data as well as the connections between these concepts, supporting the researcher in crafting a substantive theory that is definitively grounded in the participants' views and stories (Streubert & Carpenter, 2011: 123, 128-129).

Grounded theory method has a well-established track record of use as a research method in nursing disciplines (Benoliel 2001:8, Elliot & Lazenbatt 2005:49, McCreddie & Payne 2010:782). The initial method as established and described by Strauss and Glaser in the 1960's has developed variations as different scholars have applied the method from their particular philosophical view of reality, the world and nature of knowledge. These philosophical influences tweak the foundation from which the study is approached, but do not ultimately change the method processes that characterise a grounded theory study. With an array of approaches to grounded theory to use, it is necessary for me to lay claim to the particular approach I chose to apply in this study in order to provide the reader with an orientation to the 'analytical lenses' through which I viewed this study (Mills, Bonner & Francis 2006b:9).

Mills, Bonner & Francis (2006a:26) note that the chosen research paradigm must be congruent with the researcher's belief about the nature of reality. I believe that my understanding of reality at a moment in time results from my interactions with different people, values, contexts and so forth. My understanding of a concept develops between myself and the other (be it another person, an experience, a context) at that moment in time. Any understanding co-created between myself and the other is open to being changed through any further interaction. A co-created understanding that is then influenced through further interaction may confirm my existing understanding of a concept, expand it or disrupt my existing understanding completely. Through reflecting on my beliefs as an individual, as well as my identity in critical care nursing as this had developed through living out various roles in nursing as a clinical nurse, a unit manager, a teacher and a researcher in the discipline; I chose to apply constructivist approach to grounded theory as developed mostly through Kathy Charmaz's work from 2000.

Constructivist grounded theory recognises that meaning is co-created by the researcher and participants during the processes of data generation. The researcher (and her/his values) is viewed as an active participant in the study, contributing also to its outcome through authoring the reconstruction of meaning grounded in the data. This rendering of grounded theory method is aligned with my beliefs about the nature of reality, and is inclusive of my well established identity in critical care nursing. The philosophical underpinning of constructivist grounded theory, my affinity with this philosophy and its fit with the substance of study is further elaborated in Chapter 2.

1.8.2 Research methods

The following explanation provides a brief introduction to grounded theory as methodology for this study as well as the relevant methods applied. Chapter 2 and Chapter 3 provide an extensive reflection on and explanation of the research methodology and methods used.

The broad context of this study encompassed the acute care environments of the healthcare sector in the Cape Metropole and Winelands districts in the Western Cape Province. More specifically the context was defined by those persons who utilise the services of critical care nursing within the state and private sector hospitals in these districts.

The study unfolded through the following parts, each briefly described in the following subsections:

- Forming and shaping the grounded theory through exploration and co-creation
- Assimilating and situating the grounded theory through understanding and enfolding
- Reflecting through contemplating and reconnecting

1.8.2.1 *Forming and shaping this grounded theory*

The first part of this study comprised the processes of population sampling and data generation. In keeping with the method processes of grounded theory, data collection and data analysis processes occurred concurrently with each participant's data set informing and focussing subsequent collection and analysis interactions.

I engaged with people who had utilised the capabilities of critical care nurses and elicited their stories of 'different and better' nurses and nursing through individual interviews. Initial study participants were accessed through hospitals that offer critical care services in the Cape Metropole and Winelands districts as well as through word-of-mouth about the study.

Two data collection tools were employed in this study, namely in-depth unstructured individual interviews and a written or drawn naïve sketch. Constant comparative analysis, memo-writing, theoretical sampling, theoretical sensitivity and theoretical saturation as fundamental methods of data generation in grounded theory were applied (see Chapter 2). These processes were implemented in the following manner:

- each set of informant data, namely the interview narrative, naïve sketch, naïve sketch narrative and interview notes, were analysed as soon as possible after that data collection session;
- the data were fractured through the initial coding process through applying the process of constant comparative analysis;
- common threads were developed through subsequent interview sessions whilst being open to new ideas and interpretations;
- theoretical sampling and focussed coding were applied once a core category seemed to be emerging from the coding process;
- memos, reflective notes, and questions to consider were written or drawn in mind maps consistently throughout the data collection and analysis period to capture the researcher's ideas and insights into the gradually coalescing theory;
- theoretical saturation determined the end point of data collection.

On completing this part of data generation, i.e. data collection and analysis processes, the core concern and its related categories had been formed. The grounded theory took on a definite shape as the actions, processes and relationships within each category as well as across categories, and how these integrated to explain the core concern were developed. The consequence of this part of data generation was my first proposition of a grounded theory that had been co-created in the interactions between the participants and myself in the interview sessions and then between their data and myself during the process of analysis. This first proposition of a grounded theory was then compared with relevant nursing scholarship to challenge and reconcile this explanation of this social process.

1.8.2.2 *Assimilating and situating this grounded theory*

The second part of this study explains how I challenged the emergent theory with nursing scholarship to reach a deeper grasp of how the phenomenon of 'different and better' connects with current ideas.

My first proposition of a grounded theory was further challenged, developed and assimilated through a focussed literature review. grounded theory method places the in-depth literature review after analysis of the participants' data and establishes literature to be used as a source of additional data that is subjected to the same processes of that guided the collection and analysis of participant data (Charmaz, 2006: 165). Particular concepts that featured robustly

during data analysis were used to focus theoretical sampling of the published scholarship such that relevant and current knowledge was used to develop the emerging grounded theory. The principles of theoretical sampling and saturation as well as the process of constant comparative analysis were applied in analysing and integrating literature to develop the concepts, categories and core concern of the initial theory. I provide my argument to situate the place of this grounded theory in advancing and challenging our current understanding of practice.

Through these two parts of this study, the unique grounded theory method processes supported an inductively derived explanation to be formed and shaped in terms of the core concern, related categories as well as the relationships between and within these. An assimilated and situated substantive grounded theory articulating the core concern and categories of recognising 'better and different' nursing from the point of view of those who use the nursing ability of critical care nurses was produced.

1.8.2.3 Reflecting on what this grounded theory reveals

The final part of this study unfolded in my reflections on what this grounded theory had revealed about nurses and nursing practice in a clinical specialist discipline. I grappled with the insights and meanings that had emerged from my conversations with participants and my immersion in specific scholarship that were articulated in the detail of this grounded theory.

I used the articulated theory to confront my own assumptions about expertise in clinical practice and explore how my ways of thinking about this topic had morphed to a more complex understanding of practice expertise. This grounded theory illuminates elements of nursing that are important in a utiliser recognising 'different and better' nurses but which remain hidden in our practice. These elements of nursing are not unknown to nurses or others but we seem unable (or perhaps unwilling) to verify these tacit abilities as essential in nurses and nursing. I reflected on how this grounded theory challenges us to develop a language that enables nurses to reveal these intangible and tacit elements within the being and doing of nursing in a complex healthcare system.

Finally, I thought about and argued what I see this grounded theory revealing about how we should be influencing postgraduate students in learning programmes intended to develop clinical specialist nurses. I deliberated on how the philosophy and stated purpose of a postgraduate programme may need to be explored and refined to align the intention of the

programme with the reality of eliciting the potential of a student in moving to becoming and being a 'different and better' nurse. I reflected on the pivotal space of influence the teacher has with a student, and deliberated on how the elements essential in being and doing 'different and better' nursing need to be evident in her/his own ways of being a teacher of nursing. I offered my opinion as to how I see teaching and learning encounters may be enhanced through drawing what this theory has shown as necessary elements that shape 'different and better' nurses through the moments of influence a teacher has in each encounter with a student.

1.9 TRUSTWORTHINESS

'Without rigor research is worthless, becomes fiction, and loses its utility' (Morse, Barrett, Mayan, Olson & Spiers, 2002:14). Rigor in this qualitative study was expressed in the concepts of trustworthiness as described by Guba & Lincoln (1985, as cited in Babbie & Mouton, 2006: 276-278).

My considered reflection on the meaning of the concepts of credibility, transferability, dependability, and confirmability supported my intentions and actions in authentically enacting these concepts consistently through the processes of the study. I worked from a foundation of respect for my participants, my study promoters, my profession, knowledge creation and myself. I ensured that my actions within the research methods and thought processes related to my chosen methodology were transparent and verifiable.

A detailed discussion of the particular ways and means that trustworthiness was assured through the study is offered in Chapter 2 as well as in Chapter 6. This is further reinforced by the detailed discussions and explanations offered through the remaining chapters and in the study data included in this document showing how trustworthiness played out through in this study.

1.10 ETHICAL CONSIDERATIONS

Ethical research requires consideration of the scientific integrity of the research process and fundamental ethical principles - how these apply to and 'live' within a study.

Three fundamental ethical principles were used to guide each interaction and consideration of this study, namely respect for persons, beneficence and justice. The consideration and

application of each of these fundamental principles, as well as the procedures of ethical approval for the study, is discussed in detail in Chapter 2 and reflects through the content of the subsequent chapters.

A primary consideration for conducting a study that can assert to respecting the principles of ethical research is to be certain that the work does actually contribute to and develop the body of knowledge it claims to be part of. The study conducted contributes to the profession of Nursing by providing a grounded theory that offers an explanation of how better and different critical care nursing practice is recognised by those engaging with critical care nurses and nursing. It offers a reflection on how teaching and learning encounters in clinical specialist nurse education programmes may be enhanced through using the insights offered in this emerged grounded theory.

1.11 CHAPTER CONTENTS

Chapter 1 – Orientation to this Study

Through Chapter 1 I have provided a frame to the research described and explained through the following five chapters. I have outlined my underpinning ideas and points of departure as well as my approach to the study and the research method I applied during this work.

Chapter 2 – Research Design and Method

Chapter 2 provides a detailed exposition of the design and method applied in the study. I present my rationale for using grounded theory as my method of choice to gain insight into how the research question posed to guide the study may be answered. Further to this, I offer a discourse on the congruence of this methodology, and in particular constructivist grounded theory method, with my world view and what I believe about the nature of reality and how knowledge comes to be known.

My particular application of the methods of grounded theory within the study is explicated. The specific methods of identifying and selecting participants, the symbiotic and congruent processes of data collection and analysis, and how each of these was employed is described and explained in detail. The considerations of trustworthiness and ethical research practice, and how these were woven through the study is discussed.

Chapter 3 – Forming and Shaping this grounded theory

This chapter describes the progression of data generation from the first interview to an emerged first explanation of how ‘different and better’ nurses/nursing is recognised. I show how the data collection and analysis moved through the initial coding process to focussed coding and on to the development of categories to identifying the core concern of utilisers in recognising better and different nursing. I explain how the particular methods of grounded theory were continually applied in enabling the core concern and its related categories to emerge from the participants’ data. I provide a detailed explanation and discussion of the actions, processes and relationships that characterise each category; and demonstrate how the categories interact to create the core concern for a person in recognising ‘different and better’ in a nurse or nursing.

Chapter 4 – Assimilating and Situating this grounded theory

The value of the literature review in the grounded theory methods lies in it being a further source of data to continue the constant comparative method of data analysis. This chapter clarifies and develops the grounded theory developed from the participant data by weighing the emerged explanation against the published relevant nursing scholarship. I explain how I decided what constituted ‘relevant scholarship’ using the processes of grounded theory method. I offer my argument as to how the reviewed scholarship deepened this explanation articulated in the emerged grounded theory and how this explanation deepens current perspectives in literature. I end the chapter in offering an explanation of how ‘different and better’ nursing is recognised by utilisers in a grounded theory situated in my current understanding of the participant data and the enfolded literature.

Chapter 5 – Reflections on *Being at Ease*

A certainty in applying grounded theory method is that you as researcher constantly question and compare what you are hearing, seeing, reading, thinking, and feeling in relation to the question that triggered the study. Engaging in deep reflection in this way, through thinking about concepts and relationships, and then thinking about those thoughts, was an essential facet in making sense of the data, its emerging meaning and eventual form.

In this chapter I share my reflections as to how the emerged grounded theory challenged and deepened my understanding of nursing expertise. I offer my thoughts about what I see this

grounded theory as revealing about nursing. I consider the ways and means that the knowledge generated through this work may influence teachers and students during their encounters in becoming and being specialist clinical nurses who meet the expectations of those people they engage with in practice. For the final section of the chapter I explore how my experience of conducting this study has helped me to question my own ways of being and doing as a person, a nurse and a researcher.

Chapter 6 – Reconnecting - Conclusions and Recommendations

This final chapter of this thesis reconnects the outcome of the study with its beginning stimulus to show how the research aim and objectives were met. In addition to establishing the congruence of the end with the beginning of this work, I provide a brief analysis of how this study outcome meets the requirements of being a grounded theory that has quality and usefulness. Finally, I offer my recommendations as drawn from the insights revealed through this grounded theory for nursing practice (education and clinical) as well as for further research.

1.12 CHAPTER SUMMARY

South Africa needs registered critical care nurses who think, behave and practice in congruence with being publicly and professionally acknowledged as clinical specialist nurses. This acknowledgement as a clinical specialist nurse carries particular expectations of skill and engagement. As such, when practicing in this clinical specialist role, the expectation from the public, colleagues and peers of a more complex type of nursing requiring one to apply multifaceted abilities to combine all patient related facets at a deeper knowledge and skill level must be met.

This study explored how those who engage with critical care nursing recognise the person and practice of some nurses in South African critical care environments as different from and better than the usual nursing practice provided by most other nurses. An inductive design applying grounded theory method supported the emergence of a grounded theory to explain the core concern of study participants.

Chapter two introduces and explains the research design and method as applied in this study. In particular, I explore my decision to use constructivist grounded theory based in the congruence of its philosophical underpinning and view of the researcher with my beliefs about

reality and knowledge creation. The way in which I understood and applied the distinctive processes of grounded theory method is meticulously described and explained to provide a solid foundation for discussions in Chapter 3 and Chapter 4.

CHAPTER 2

RESEARCH DESIGN AND METHOD

My purpose in Chapter 2 is to provide a substantial research process foundation to the discourse that follows in the next chapters of this work. I offer a detailed explanation and discussion of the research design and method applied during this project. I reflect on and explain the reason underlying my choice of research method, the adaptations I made to the method as influenced by my context and how each stage of the scientific process was respected through the study.

2.1 RESEARCH DESIGN

The research design describes the researcher's broad plan to guide the study. The research problem and questions provide the point of departure in determining an appropriate design for the study. The research design guides a researcher to apply appropriate research methods to elicit the relevant data required to address the research problem adequately (Babbie & Mouton, 2006:74-75).

The aim of this study was to elucidate an understanding how, what, when, where, and why a utiliser recognised the 'different and better' clinical nursing practice as revealed by some professional nurses in critical care. The intention of the study was to collect, organise, analyse and interpret data that explored and explained the meaning of this social phenomenon as experienced by people in their world, as such a qualitative research design was an appropriate choice for this study (Malterud, 2001:483; Babbie & Mouton; 2006:646; Creswell 2007:37). A qualitative design encompassing an exploratory approach framed within the methods of grounded theory was applied to achieve the stated study aim.

2.2 EXPLORING WITH THE GROUNDED THEORY METHOD

An exploratory approach is relevant when little is known about the particular phenomenon under study (Maree, Creswell, Ebersöhn, Ferreira, Ivankova, Jansen, Nieuwenhuis, Pietersen, Plano Clark & Van der Westhuisen, 2007:265). The phenomenon is engaged with from a perspective of curiosity and discovery to gain

insight into this phenomenon. Burns and Grove (2009:359) note that the intention of this approach is to deepen the knowledge of a specific field rather than offer generalisations to larger populations as is the intention of other type of approaches to research.

Grounded theory method embraces an exploratory approach to engage with a research question. grounded theory is concerned with discovering facets of social processes in people's lives to generate an abstract analytical representation of the processes at play. The method's primary purpose is to explore concepts and the connections between these concepts that emerge from the participants' data. In this way an inductively derived theory about a phenomenon emerges that is patently grounded in the participants' experiences of a particular social process – the product of the study then being called a grounded theory (Charmaz 2014:1; Creswell 2007:63; Streubert & Carpenter, 2011:123,128-129). Grounded theory method is seen to allow a researcher freedom to explore the research topic in a way that enables issues to emerge through rigorous, detailed and systematic processes (Jones & Alony, 2011:96). Grounded theory differs from other qualitative research methods in that the expressed intention of the method is to build an abstract theoretical understanding to explain a social process (or experience) rather than provide a deep description of an experience (Charmaz 2014:4; Gibson & Hartman 2014:63).

International research has focussed on the nursing profession's understanding of expert practice with research into the process of developing expertise as well as self-recognition of expertise by critical care nurses. Whilst 'recognition by others' has emerged as an enabler of expertise in previous research (Manley, *et al.*, 2005: 25; Bonner, 2003:15-16), no published research appeared to have considered this enabler of expertise from the perspective of the 'other'; that is, a person who utilises critical care nursing in some way. While there seems to be limited research available on the role clarification of the South African clinical nurse specialist (for example: Prins, 2010), no study had explored or considered the enigmatic aspects of how a 'different and better' nurse is recognised in clinical specialist nursing practice and what this perspective may mean in the context of specialist nursing practice.

Approaching the study from a mind-set of exploration and discovery of meaning was important to gain a multifaceted, profound explanation of the phenomenon of 'different

and better' nurses and nursing in the eyes of a utiliser. grounded theory was there for a reasonable and appropriate method to apply in this study.

2.2.1 The development of grounded theory as a research method

Grounded theory as a research methodology was developed in the mid-1960s by Anselm Strauss & Barney Glaser whilst working at the School of Nursing, University of California San Francisco (UCSF). Strauss secured a grant towards a study on patients dying in hospitals; this grant was part of initiating and developing the doctoral programme in nursing at UCSF. Towards the end of the study, he and Glaser realised that they had applied a method to the data that was ordered, systematic and rigorous but that departed from the hypothetico-deductive testing methods of theories prevalent in the social sciences at the time (Morse, Stern, Corbin, Bowers, Charmaz & Clarke, 2009:13). Strauss & Glaser explained their principles and concepts of grounded theory in a book entitled *The Discovery of Grounded Theory* published in 1967; offering that the purpose of the grounded theory as research method was to develop theory from data rather than using data to confirm or reject a hypothesised theory. grounded theory method was described as an inductive process focussed on explaining important issues in people's lives, to offer theory that could then be tested using more traditional methodologies (Glaser & Strauss, 1967:2-5). Grounded theory established a more systematic method of working with qualitative data in response (Dunne uses the word 'revolt') to the dominance of quantitative ideology in social science research at the time and the subordination of qualitative work through criticisms of this work as having little scientific substance (Dunne, 2011:112).

From its beginnings in the disciplines of Nursing and Sociology, grounded theory as method of research has been applied to and has influenced many other disciplines, a few examples being those of education, cultural studies, business and communication technology (Morse, *et al.*, 2009:13). These same authors contend that the widespread uptake of the method lies in the researcher being able to elucidate an understanding, - an explanation of the social processes under study as experienced within a group of people. Through applying grounded theory method processes, the phenomena, its actions and processes, are explained in terms of the attributes, core process/es, and relationships elicited within the participants' data. Further, this data then provides the base, or grounding, to the theory that emerges through analysis, synthesis and

conceptualisation; a theory clearly linked to the data whilst being generalisable to other occurrences (Morse, *et al.*, 2009:14).

Glaser & Strauss's later differences regarding the method of grounded theory resulted in a lengthy (and to some extent continuing) debate between themselves and their followers as to what constitutes 'true' grounded theory. This debate is further fuelled by the progression of the methodology by other grounded theory researchers. Two recent examples of this methodological progression are constructivist grounded theory (Kathy Charmaz, 2000) and situational analysis (Adele Clarke, 2003); with each permutation of the methodology adding new fuel to the debate begun so long ago. Mills, *et al* (2006a:26) view these various forms of grounded theory to be "... points on the methodological spiral reflecting their epistemological underpinnings". These authors note though that each permutation of grounded theory still requires a researcher to attend to methodological features that are shared by all versions. Thus, each form of grounded theory differs in terms of claiming how knowledge is created and how we know our reality; yet have a common, recognisable connection to the roots of the grounded theory method through the application of its particular processes (for example: theoretical sampling, constant comparison and treatment of literature).

2.2.2 Choosing a version of grounded theory through philosophical congruence

The diversity offered by the versions of grounded theory and the determined views presented by the various authors created a complex array from which to decide on the most appropriate version of grounded theory to apply in my study. A particular comment by Mills, *et al.* (2006b:26) and again by Jones & Alony (2011:97) highlighted that a researcher must consider the 'fit' of a research paradigm with her/his beliefs about the nature of reality and knowledge. In these comments I found a valid point of departure from which I was able to make a choice as to which version of grounded theory was most appropriate for this study in relation to my view of reality and knowledge creation.

It is necessary for me to make a clear statement of which variation of grounded theory I made use of as this provides the reader with a 'sense of the analytical lenses' (Mills, *et al.*, 2006b:9) through which the unfolding research process and emerging theory is

explained. In brief, I believe that reality is created within the interactions of people and their worlds. In holding this belief, I accept that different realities are able to co-exist. My understanding or knowledge of any idea or concept results from my interactions with different people, values, context and so forth, that may engage with each other at that particular time. Any understanding or meaning that is created is open to being changed through any further interaction; this change may be to develop and grow my current understanding or to disrupt it completely. Fundamentally, my ontological and epistemological points of departure in how I view reality and knowledge creation are congruent with the underpinnings of constructivist grounded theory.

The constructivist perspective has underpinning assumptions that are relativist, and interpretivist. These assumptions proffer that there is no objective reality rather that multiple realities exist simultaneously. Reality is constructed between the people participating within a situation relative to and through their interpretation of social context and concepts; truth is negotiated through dialogue. Thus within a constructivist perspective, reality is socially constructed and ever-changing (Mills, *et.al.*, 2006a: 26).

Constructivist grounded theory is situated within this perspective, being ontologically relativist and epistemologically subjective and transactional. In being ontologically relativist this variation of grounded theory views reality as relative to the context within which this happens. Research acts conducted within a situation are influenced by both the interaction of participant and researcher, as well as what each brings into this encounter from their individual history, culture, experience and so forth. The research encounter and outcome is constructed between the researcher and participant, influenced by the conditions within which the encounter happens as well as other conditions of which those involved may not be aware of or have chosen. Furthermore, constructivist grounded theory is epistemologically subjective, this being the notion that valid knowledge lies within the person's/people's interpretation of a moment (Bryant & Charmaz, 2007:607; Charmaz, 2014:12-13; Mills, Chapman, Bonner & Francis, 2007:74, Mills, *et al.*, 2006a:26; Mills, *et al.*, 2006b:9). The parallels between Charmaz's constructivist grounded theory, my personal philosophy and how I make sense of reality became evident, and thus I chose to apply this form of grounded theory in my study.

Constructivist grounded theory teases out the meaning of a social process as this understanding is co-created by the researcher and participant, departing from the traditional grounded theory perspective of the researcher being an objective observer. The researcher and participant interact in relationship – Mills, *et al.* (2006b:9) speak of a partnership, through which a common understanding is constructed of the everyday meaning a process holds within the context under discussion. The researcher-participant relationship is reshaped in constructivist grounded theory, locating the researcher and her/his values as integral elements of the research process and an inevitable part of the study outcome. The researcher-participant relationship is interactive and both individuals' experiences influence the co-constructing of meaning in the interaction (Mills, *et al.*, 2007:74). A focus on creating reciprocity in this relationship supports the co-construction of meaning and is nurtured through the researcher reflecting on her/his own assumptions as influenced by her/his position, privileges, perspective and interactions; as well as a heightened awareness for the participant's story. The researcher plays an active role as the author of a reconstructed meaning as this emerges from each participant-researcher encounter and coalesces into an explanation of common meaning of the social process under study. The situating of the researcher as a co-constructor highlights a particular feature of constructivist grounded theory – the centrality of the researcher within the study reality. Charmaz (2014:14) notes that this subjectivity and role of the researcher in constructing and interpreting data was her *raison d'être* for labelling this form of grounded theory as 'constructivist'.

I applied the inductive, interpretive, comparative, iterative, emergent processes of grounded theory (see section 2.2.1.3 below) through the 'analytic lens' of Charmaz's constructivist perspective, to offer an co-created understanding of the meaning held in the way 'different and better' nurses and nursing are recognised by people who engaged with critical care nurses (Charmaz, 2014:13, Mills, *et al.*, 2006b:9).

2.2.3 The defining processes of grounded theory method

As noted in my earlier discussion, whilst the epistemological and ontological underpinnings of constructivist grounded theory differ from what is termed 'classical' grounded theory in literature (i.e. the grounded theory of Glaser), the interactive, comparative, and iterative processes that are specific to grounded theory method

remain common across versions. Charmaz (2012:2-4) notes that grounded theory broadly offers a systematic method of collecting and analysing data to develop a substantive theory in the study of social processes. A substantive theory offers a theoretical explanation of a delimited problem in a particular area (Bryant & Charmaz, 2007:610; Charmaz, 2014:344).

Grounded theory requires an iterative cycle of data collection and analysis with the following particular grounded theory method processes evident through this cycle:

- concurrent data collection and analysis

Concurrent data collection and analysis means that data analysis, or coding the data, must begin from the first instance of data collection. Through the researcher engaging in these activities in a cyclical, concurrent way, each participant's data set informs and focusses the subsequent collection and analysis of data; grounded theory method scholars establish this as a central principle of any grounded theory work (Corbin & Strauss, 1990:59). The interwoven relationship of data collection and analysis supports openness to variation as a researcher engages, responds and adjusts in the exchange between data and codes whilst, in the words of Egan (2002:284) still providing "... an informed course".

Coding is the term used in grounded theory for attaching a label to a piece of data; these labels provide the tentative groundwork for the concepts and categories that characterise a grounded theory. The purpose of coding is to conceptualise the data through analysis and pattern finding. Coding is the fundamental tool of analysis in grounded theory studies. In coding the data from the first instance of collection, early connections and common concepts for exploration and development in following data collection sessions are revealed. to firmly ground the emerging theory in the actions, processes and meanings ascribed by participants to a social process (Charmaz, 2012:5, Birks & Mills, 2011:9-10).

- constant comparative analysis

Constant comparative analysis is an inductive process of comparing data with data, data with codes, code with code, code with category, and category with category, looking for similarities and differences. This process of comparison is applied within a participant's data, across participants' data, through the group's data set, and then

with relevant published literature. Constant comparative analysis (also referred to as 'constant comparison' or 'comparative analysis') is used to elicit the properties of categories and range of categories in a grounded theory and raise the level of abstraction of concepts. This method of analysis facilitates identifying significance and meaning through immersing the researcher into the world of the participants. Through invoking analytical questions of the data, constant comparative analysis provides the researcher with the opportunity to expand and clarify data, for example: in reflecting on a code, the researcher may ask "What is going on here, and how does this participant see it in a similar or different way to a previous participant?". This approach to analysis provides the groundwork from which explanation is able to form (Charmaz, 2014:342; Reed, 2004:403-404).

- memo-writing

Memo-writing is the grounded theory way of the researcher recording thoughts, feelings, ideas, questions, or hypotheses about the codes and emerging categories in whatever way these arise and however this makes sense to the researcher – in Urquhart's (2013:194) words memos are 'a tool for theorising'. Memos are used by the researcher from the earliest engagement in data collection and analysis. There is no defined way of memo-writing, no requirement of number, length or appearance; rather the requirement is that the researcher use this technique to consider, question and clarify her/his sense of the data (Charmaz, 2014:162; Charmaz, 2012:9; Urquhart, 2013:110).

- theoretical sampling

Theoretical sampling is the purposeful sampling of data sources specifically for their ability to reveal rich and relevant data, to fill out an understanding of a concept. It is predicated on data analysis and not through population dimensions. Theoretical sampling is sequential to initial sampling of participants and is driven by the emerging outcomes of the initial coding process with the purpose to refine, develop and flesh out significant codes or categories. Thus, sample size is established as a function of theoretical completeness rather than population representativeness. Theoretical sampling strengthens data quality through focussing questions in constant comparative analysis, building systematic checking into this analysis. Sampling for data development deepens the researcher's insight into the meaning of a social

process (Charmaz, 2014:345; Charmaz, 2012:3,10; Cutcliffe, 2000:1477; Drauker, Martsolf, Ross & Rusk, 2007:1137; McCallin, 2003:204; Thomson, 2011:48)

- theoretical saturation

Theoretical saturation speaks to the requirement in grounded theory that data are collected until no new properties of a category emerge as contrasted to data saturation which is achieved in the repetition of concepts by data sources. Theoretical saturation ensures that categories of the grounded theory are fully developed and complete. Theoretical sampling and theoretical sensitivity guide the researcher to knowing when this place of theoretical saturation is reached (Charmaz, 2014:214-216; Urquhart, 2013:194).

- theoretical sensitivity

Theoretical sensitivity is the researcher's awareness that underpins her/his ability to recognise and extract from data those elements that have relevance to the emerging theory. This ability extends further to the researcher being able to understand, clarify and refine extracted elements and their relationships in abstract terms. Theoretical sensitivity begins in the researcher's personal and professional experiences and heightens through the processes of doing a grounded theory study (Bryant & Charmaz, 2007:611; Corbin & Strauss, 1990:42).

These six processes provide the fundamental method framework for any grounded theory study and stipulate the ways that grounded theory differs from other qualitative research methods. Morse *et al.* (2009:14) comment that in each instance that grounded theory is applied, the method 'requires adaptation in particular ways as demanded by the research question, situation, and participants for whom the research is being conducted.' Therefore, through the remaining discussion and explanation of this chapter as well as through Chapters 3, 4 and 5 I will demonstrate and explain how I have interpreted and applied each of these processes through my study.

2.3 STUDY SETTING

The broad borders of the setting for this study are provided by the critical care environments in state and private sector hospitals of the Cape Metropole and Winelands districts in the Western Cape Province. These environments provide services to those people who are in need of specialised nursing and medical care to

manage any life-threatening consequences of an illness or injury. While these services do extend to include care for paediatric critically ill patients, this study is contextualised by those environments that provide adult critical care services.

These environments provide the space for people who need care (including patients and their significant others) to interact with those people who provide care (such as nurse and doctors). The interactions of these two groups of people delineate the more precise setting of this study. It is through their experiences of interacting with nurses doing nursing in the critical care environments that the specific setting of this study is located – the interaction between a nurse and another person that is formed by the other person's need to engage with that nurse's capabilities in nursing.

2.4 RESEARCH METHODS

This section provides a full, detailed description of the grounded theory method as I applied it to generate an explanation of the phenomenon under study – the process of generating data through collecting data and then data analysis. I show how the particular method processes of grounded theory were utilised in generating data that slowly led to an inductive explanation of how utilisers recognise a 'different and better' nurse.

The nature of grounded theory does not easily lend itself to the traditional, structured explanation of research method possible with most other research approaches. Many of the grounded theory method processes are dynamically intertwined and occur concurrently which defied my attempts to neatly fit my account of implementing these into defined and recognisable sections and subsections. While I have shown how each requirement of the research process was implemented during this study, my explanation of how I applied the grounded theory methods has influenced the way I have separated or integrated particular components of the information in this chapter and those that follow. This may perhaps create a feeling of discomfort for the reader expecting the story of this study to be presented in an traditionally recognisable pattern, however the content of each chapter within the whole of the thesis provides evidence that the requirements of the qualitative research process along with the principles of the grounded theory method are provided for in my discussions.

I felt that finding a reasoned, practicable manner of progressing through this discussion and following chapters was necessary; to offer a type of broad itinerary to orientate a reader and show my ways of applying the method that eventually revealed an emerged grounded theory. To this end I have situated my discussion within three discernible parts of this work that are shown in Table 2.1. That I can relate three discernible parts to this study seems to create an impression that the completion of one part led to the beginning of the next, but this would be a naïve interpretation as this study was never particularly linear in its manner of unfolding. Rather the processes of the grounded theory method required that I move with the data, back and forth along the ideas and experiences of the participants and similarly back and forth in the data when enfolding nursing scholarship and later as I reflected - creating an almost Mobius-like shape to the study as it evolved to its current incarnation.

Table 2.1 The three discernible parts of this study

PART #1	PART #2	Part #3
Forming and shaping	Assimilating and situating	Reflecting

Part #1 I have called ‘forming and shaping’ as this refers to the part of the study where I explored the phenomenon of ‘different and better’ in nurses/nursing with participants. Through engaging and co-creation my first proposition of a grounded theory emerged through the interactive, iterative and comparative processes described in section 2.2.1.3.

Part #2 is labelled ‘assimilating and situating’ in reference to the part of the study where my first proposition of a grounded theory was compared to relevant nursing scholarship. The consequence of this part being a more fully developed grounded theory assimilated with and situated in reference to the scholarship base of relevant nursing knowledge.

Part #3, is called ‘reflecting’ as this part encompasses my thoughts on the conclusions and recommendations I believe this work supports, and on reconnecting the emerged grounded theory with the stimuli for this study, .

Table 2.2 extends the orientation to the discussion by offering a summary of how the process recognisable as the scientific method of research was respected across the

three discernible parts of this study. In Table 2.2 I identify the process of the grounded theory method that was applied within each part as well as the product of that part and its contribution to the final whole outcome of the study.

Table 2.2 Aligning the parts of the study within the research process and grounded theory methods

STUDY PART	RESEARCH PROCESS	APPLIED GT PROCESS	PRODUCT OF PART	OUTCOME FOR STUDY
# 1 Forming & shaping through exploration and co-creation	• Population sampling	<ul style="list-style-type: none"> • purposive sampling • theoretical sampling • theoretical sensitivity 	<ul style="list-style-type: none"> • initial proposition of a GT to offer an explanation of the social process under study 	a developed GT offering an explanation of how utilisers recognise 'different and better' nurses and nursing
	• Data collection	<ul style="list-style-type: none"> • constant comparative analysis • memo writing • theoretical sensitivity • theoretical saturation 		
	• Data analysis	<ul style="list-style-type: none"> • initial coding • focused coding • constant comparative analysis • memo writing • theoretical sensitivity • theoretical saturation 		
# 2 Assimilating & situating through understanding and enfolding	• Literature review	<ul style="list-style-type: none"> • theoretical sensitivity • theoretical sampling • constant comparative analysis • memo writing • theoretical saturation 	<ul style="list-style-type: none"> • scholarship assimilated with initial GT proposition • a grounded & situated explanation of the social process under study 	
# 3 Reflecting through contemplating and reconnecting	• Returning to the research question, study aim & objectives	<ul style="list-style-type: none"> • theoretical sensitivity • constant comparative analysis 	<ul style="list-style-type: none"> • my thoughts on this GT in terms of nursing, expertise and teaching & learning 	a submission of my reflection on how this GT contributes to nursing broadly and developing clinical specialist nurses specifically

Through the following discussion I intend to fulfil two of my responsibilities as a researcher – to acknowledge the foundation and structure accorded to my study by the grounded theory method and then contribute to scholarly debate by providing an explanation as to how and why I adapted and applied the various processes of grounded theory method within the research process of this study (Urquhart, 2013:178). The discussion is divided into the following subsections:

- study population and sampling processes
- data generation – collecting data
- data generation – analysing the data
- reviewing and enfolding the literature
- reflecting.

2.4.1 Study population and sampling processes

The accessible population for this study comprised those individuals who worked within or accessed the adult critical care services of the health care sectors in Cape Metropole and Winelands districts. The study sample participants were drawn from the accessible population of persons who in some way utilised the services of critical care nurses in clinical practice. These individuals included professional nurses and medical practitioners working in the critical care environment; as well as the significant others of patients' who had accessed the adult critical care services in any acute care hospital environment in the Cape Metropole and Winelands districts of the Western Cape Province.

2.4.1.1 Study Sample

An essential point of departure in sampling processes for a grounded theory study is that the researcher samples participants for the purpose of theory construction rather than population representativeness or data generalisation (Charmaz, 2006:96,101). The initial sampling of participants is conducted through a purposive process, a "...calculated decision to sample at a specific locale to a predetermined yet reasonable set of dimensions" (Cutcliffe, 2000:1477). Once common ideas emerge from the data, grounded theory method requires that the sampling process is led by the theoretical

categories that emerge from the data in order to develop a theory that is truly grounded in the participants' data. Integrated collection and analysis of data means that as specific ideas or concepts emerge from the participants' conversations; these concepts are the basis of informing further selection of study participants - the purposive sampling then changes to a theoretical sampling process. Charmaz (2014:197) offers a succinct and simple differentiation – 'initial sampling in grounded theory gets you started, theoretical sampling guides where you go.'

At the outset of this study sites were purposively identified in order to access potential participants. This sampling technique was used in order to access a site where those individuals who would be most likely to offer specific data regarding the unit of analysis would be available to invite to participate in the study (Burns & Grove, 2009:355). The unit of analysis in this study was, broadly: how a person recognised 'different and better' nursing. Therefore the people who were most likely to provide real life data about the unit of analysis were those people who worked alongside or closely with the critical nurse, as well as those who closely observed nursing care in action at the patient's bedside. That is, those people who participated in or engaged with critical care nursing and those people whose activities or interests were integrated into nursing care – nursing and medical colleagues, and patient's significant others. The most appropriate sites where these people could be found were hospitals offering intensive care services.

Access to Hospitals

The purposively identified sites where the researcher would have been able to access appropriate study participants included three hospitals where critical care services are available in the state healthcare sector and seventeen hospitals offering critical care services across three private sector healthcare companies.

I chose to access into the private sector hospitals as the point of departure for the individual participant sampling process. This choice was mostly influenced by the prompt approval by particular hospitals to allow me to access their intensive care units as study sites. The complex and protracted nature of applying to access state sector services was further complicated by my study being approved and registered at a university outside of the province where I intended to generate data. The initial

sampling processes allowed me to access potential participants in the private hospital sector, however as the data generation processes unfolded, I engaged with people who had experienced nursing services in both private and state sector critical care units.

Permission to access participants in the hospitals belonging to three private sector healthcare companies was requested according to the research application protocol of each environment (see Ethical Considerations). Although I submitted application to all three private sector hospital groups to be able to access the various hospitals belonging to each group, permission was granted by only two of the hospital groups. Once the hospital group had granted access permission, I was required to approach the management structures of each hospital individually to request permission to access their critical care environments. I was granted permission to access the critical care environments of three hospitals. These three sites were used for the initial purposive sampling of individual participants.

The Purposive Sampling Process

Purposive sampling of individual participants was applied as a point of departure to begin the data collection and analysis processes. Sampling criteria (see bulleted list below) directed the invitation of appropriate individuals to contribute to the study. Once particular concepts began to emerge from the data, and later as categories developed, the purposive sampling technique was replaced by theoretical sampling. My thinking and manner of applying theoretical sampling is offered in the subsection following this one.

Study participants were accessed through the hospitals that offer critical care services in the Cape Metropole and Winelands districts in the Western Cape Province. After ethical approval for the study was received from the Faculty Research, Technology & Innovation (FRTI) committee of the Faculty of Health Sciences at Nelson Mandela Metropolitan University, and permission to access the appropriate hospitals was granted (see Ethical Considerations), a purposive sampling process was applied to invite possible participants from the first hospitals that allowed me to access the critical care environments. The sampling criteria guiding the initial purposive sampling were as follows; a prospective participant must be:

- a professional nurse or medical practitioner who worked in the adult critical care environments;

OR

- a significant other (specifically a: parent, child, sibling, spouse or life partner) of a patient who had spent a period of at least five (5) days in an adult critical care unit.

I decided not to include patients in this study sample. My initial reasoning was that the physiological and emotional effects of their illness (for example: haemodynamic instability, organ system failure), drug treatment regimens (for example: analgesics and sedatives), organ support interventions (for example: mechanical ventilation) and so forth, would hamper their participation due to either a decreased level of consciousness or a significant limit to their ability to communicate easily and effectively.

Purposive sampling - participants 1 and 2

Two pilot sessions were conducted to assess the clarity and fit of the springboard statements of the two data collection tools to ensure these would elicit relevant data during the individual interviews. Both data collection tools were assessed by conducting a full intensive unstructured individual interview with the participant as well as her/him producing a naïve sketch. Two participants who met the inclusion criteria were purposely identified and asked to participate in the pilot sessions. The first pilot session was conducted with a significant other of a patient who had been admitted to and subsequently died in an intensive care unit; this interview occurred telephonically due to unforeseen circumstances on the part of the participant. The second pilot session was conducted with a registered critical care nurse and was held face to face. In both instances, the participants chose the venue or modality of interview. Informed consent was obtained from both participants.

After each interview was completed, I explained the idea behind the naïve sketch tool to each of the participants. The second participant completed the task without needing any additional assistance; the first participant described what she would have done had she been physically present with me. On completion of each session the pilot participant indicated that both the interview and naïve sketch springboard statements

were clearly formulated and easily understood. No adaptations were required to the content of the interview springboard statement, probing questions or guiding sentence in the naïve sketch; or the format of the interview, thus the data from each pilot session were included in the study as data set one and data set two.

Purposive sampling - participants 3, 4 and 5

Once I had access granted into the hospitals, I began the process of purposive sampling of prospective participants. I contacted the Nursing Manager at the hospitals who had permitted me to access their critical care environments. We agreed to arrangements such that I could work directly with the unit manager of the critical care units. I met with the unit manager of the critical care units to determine the best time to hold informal information sessions with possible participants regarding this study. These appointment times were designed to have the least impact on clinical nursing and patient care.

The purpose of the information sessions was to invite individuals, who met the inclusion criteria, to participate in the study. The information session lasted for an average of 15 minutes. The informal information process was kept short and focussed in order to offer the most relevant information to the attendees within a short period of time. The short, focussed session was necessary to ensure that there was the least impact on the clinical environment and patient care as significant personnel shortages cannot allow the absence of any person from the environment for an extended period of time, this approach ensured an ethical underpinning to the sampling process (Morse, 2007:1004). I returned to each hospital to repeat the information session over successive days to allow for the maximum number of possible participants to be reached.

The information sessions were held in the nursing station. I presented a brief overview of the study to those professional nurses who were interested in listening to me (see Appendix 5). The attendees were handed a form on which to indicate their interest in contributing to the study (see Appendix 6). The participation form included a brief written description of the study and implications of their participation to assist them in making their decision whether to participate in the study or not. Each attendee was asked to indicate 'yes' or 'no' on the participation form. Any attendee who indicated

'yes' was prompted on the form to provide their name and contact details (telephone number or e-mail address). These participation forms were folded closed by the attendee, and were placed in a sealed box such that only I was able to determine who was interested in participating in the study. The participation box was available in the unit for 3 days after the last information session was conducted. The use of the participation form respected the attendees' right to privacy as only I had access to knowing who may eventually consent to participate in an interview.

I opened the box away from each hospital site. I developed a data base of the attendees who had indicated their willingness to participate and who had provided contact details. The data base included the following columns for information: pseudonym, date of interview, place of interview, any repeat contacts for further data. Later in the study, the same database was used to track the process of participation to ensure that all participants were treated similarly and fairly, as well as to provide an audit trail for the study promoter and co-promoter to fulfil their role in confirming dependability of the study data generation processes. No other person was allowed access to this database. A separate list identifying the person and contact details behind the pseudonym was developed and was only accessible to the researcher. Of all the people who attended the information sessions, six people indicated their interest in participating in the study. I contacted each positive responder according to their preferred contact method to re-establish their willingness to participate and confirm their participation. Two registered nurses out of the initial six agreed to participate in interview sessions.

Medical practitioners who met the inclusion criteria were purposively identified and invited to participate in the study. Information sessions were held on an individual basis and followed the same format as those sessions presented in the critical care units. In the purposive sampling phase, no medical practitioners indicated an interest in participating in an interview session. However, later during the theoretical sampling process, two medical practitioners did indicate an interest in participating.

Those significant others whose family member was in the critical care unit were approached to participate in the study based on advice from the critical care unit's personnel. On advice from the gatekeepers, I approached a patient's significant other and requested their permission to explain the study briefly. One family member initially

indicated an interest in participating, but later withdrew on the day of the interview. Another patient's significant other heard about the study via 'word of mouth'. This person had experience of the family member being admitted to an adult critical care unit for more than two weeks and contacted me to indicate interest in participating in the study.

Thus, during the initial data generation processes, the described purposive sampling process elicited five participants who agreed to contribute to the study through an interview and naïve sketch. The first five participants comprised three registered nurses, and two significant others, see figure 2.1 for a graphic depiction of this process.

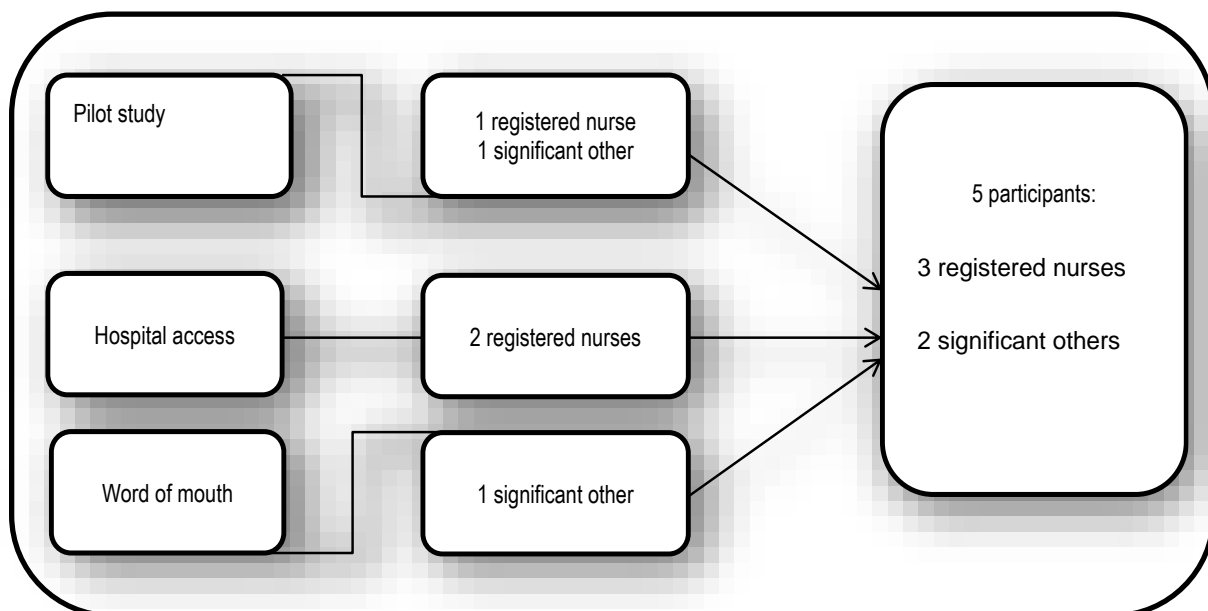


Figure 2.1 Purposive sampling outcome - participants and mode of access

On completion of each interview, the recording of the conversation and the interview notes were reviewed to conduct a preliminary analysis such that the common emerging ideas could be explored in the following interview (Urquhart, 2013:64; Birks & Mills, 2011:71). The comparative analysis processes revealed specific ideas clearly running through both of the first two interviews. As well as being open to new thoughts and opinions from the participants, I used these common points to elicit further insight into these notions during the following three interviews (see section of data analysis for full explanation of this process). Based on the common emerging ideas across all five interviews, I moved from a purposive sampling process which had provided the point of departure for data generation to a theoretical sampling process to identify and

include further participants such that the construction of theory was supported (Charmaz, 2006: 100).

The Theoretical Sampling Process

As I have already emphasised though this chapter, an important aspect of grounded theory method is that collecting and analysing data are integrated; and that data collection is driven by the analysis once common concepts or categories begin to emerge from the participant's' data sets. This integrated cycle supports the generation of theory from the data and requires that purposive sampling be replaced with theoretical sampling as concepts began to emerge from the data analysis process. The focus of theoretical sampling is to pursue and hone concepts emerging from the data, ground the emerging categories and properties in the data; and ensure that the grounded theory is comprehensive (Charmaz 2014:193; Charmaz, 2006:96,101; Urquhart, 2013:134,186).

Theoretical sampling specifically seeks to refine concepts in terms of relationships, context, consequences and so forth (de Vos, Strydom, Fouché & Delport, 2009:329). Charmaz (2006:107,110) and then Birks & Mills (2011:69) establish that theoretical sampling is the iterative strategy that underpins the emergent nature of a grounded theory rather than it merely being a way of going about sampling participants. Theoretical sampling assists in developing an explanation of concepts in the theory through iterative conceptualisation, enabling a researcher to follow the emerging story line suggested by the data again underpinning the theory as this is emerging from the data (Urquhart, 2013:8,18,184). Constant comparative data analysis directs theoretical sampling of participants to elucidate meanings and variations in the data, to refine key categories and identify where gaps in the data occur. The researcher makes strategic sampling decisions as to who may be an information rich data source to develop the analytically directed emerging concepts and categories (Urquhart, 2013:194; Charmaz, 2006:100,106,110; Birks & Mills, 2011:10-11).

I initiated theoretical sampling after conducting an analysis of the first five participant data sets. A data set contained the interview recording and transcription, naïve sketch, naïve sketch dialogue, and interview notes generated in the conversation with each participant. Through reflecting on the common ideas and concepts that were evident

across the data sets, I considered who would most likely be able and willing to engage with the topic under study to provide specific data that would further develop the concepts emerging about the unit of analysis. I applied my understanding of the purpose and process of theoretical sampling in intentionally identifying prospective participants based on their potential to confirm or challenge insights, deepen understanding of concepts and explicate relationships between ideas that had emerged through data analysis. In this way data analysis drove further sampling and assisted in explicating the ideas emerging from the data.. The discussion on data analysis provides additional information on the common ideas and emerging categories.

There was no intention in my study planning or implementation to separate the data into the different 'types' of participants, to assign identifying 'type' labels onto a data set or to manipulate the numbers of participants according to 'type'. Rather I considered them all as utilisers of critical care nursing within my assumption that while their stories may be different, the underlying qualities of the nurse within the stories that enabled the utiliser to recognise the 'different and better' nurse would be in essence the same across utilisers. While sampling criteria guided me in identifying relevant possible contributors, the participants who became contributors to the study did so because of their interaction with critical care nurse and not particularly because of the role they fulfilled in the critical care environment or in relation to a patient. Participants were invited into the study because they were willing to talk about the topic under study, to guide and inform my developing understanding and eventual explanation of their ways of recognising a 'different and better' nurse.

Through constant comparative analysis within each individual data set as well as between data sets, I had come to see that the common ideas and concepts showed congruency in the qualities and way a 'different and better' nurse was recognised across the nurse participants and significant other participants. A grouping of congruent ideas and tentative categories became established early on in data analysis. While there was some variation in the way an idea was explained, this seemed more related to the individual's ways of seeing the world rather than down to the specific role they filled in critical care. Egan (2003:283) offers that in theoretical sampling, participants are considered based on their potential capacity to offer

intriguing variation for comparison. With consideration of the unfolding ideas and the similarity of insight across the participants, I decided that the development of the data concepts and categories would be best served through specifically inviting experienced critical care medical professionals, professionally mature nurses and at least one more significant other who had had a longer exposure to critical care nurses. I thought they would be able to delve deeper into the emerging concepts to reveal their grasp of the relationships and complex actions or processes underlying these concepts.

Theoretical sampling - participant 6

I had not been successful in including medical practitioners during the initial purposive sampling process, but felt that an experienced critical care medical colleague would provide a useful contribution in generating a thorough picture of the social process under study. In particular, a recurrent idea that developed across the first five interview session was that 'different and better' nurses seem to have sound relationships with medical staff; they appear to be relied on and trusted by doctors in ways that other nurses are not. I felt that medical colleagues would provide additional insight into this idea. I identified two medical practitioners who had many years of experience in the critical care environments and approached them directly with an invitation to participate in this study. While both agreed to participate initially, only one medical practitioner did engage in an interview session.

Theoretical sampling - participants 7, 8 and 9

During the data collection period guided by theoretical sampling there were three professionally mature registered nurses who I identified as being able to further elaborate on the emerging concepts around recognising a 'different and better' nurse in critical care units. Some of these concepts included: further distilling of the idea that nurses recognised 'different and better' nurses in ways other than only competence or displayed skill, and to explore the notion that the relationships generated between nursing colleagues seemed to be characterised by almost the same aspects that significant others recognised.

When considering the nature of the research topic and the purpose of their contribution being to refine meaning and deepen understanding of the concepts from previous

interview sessions, it was essential that these participants were able to express their insights clearly, provide examples and clarify their conversation to ensure I had correctly grasped their points of view; these participants were selected in part because of their ability to interact in this way. Their invitation was though mostly influenced through their being experienced critical care nurses who had worked in a variety of critical care environments in both private and state sector hospitals, as well as in a range of positions for example: as permanently employed nurses, as agency nurses, as shift leaders and as unit managers. This meant that they had all engaged with a diverse critical care nurse practice base and were able to offer insights informed through and by their varied experience.

Theoretical sampling - participant 10

A third significant other was approached and invited to participate based on this person's conversation with me about her/his experiences in critical care. This person had experienced multiple critical care admissions of a family member to different critical care units over a period of six months as well as previous admissions in the less recent past. This family member was admitted to critical care units in a private hospital, public-private partnership hospital and a state sector hospital. The person indicated interest in speaking to me on the topic of the study and we arranged a meeting at the person's convenience. I invited this person to participate as I wanted to explore further some of the aspects that the previous two significant others had shared, mostly around the connection that seemed to develop between the person and nurse as well as the outcome of that connection being developed and sustained.

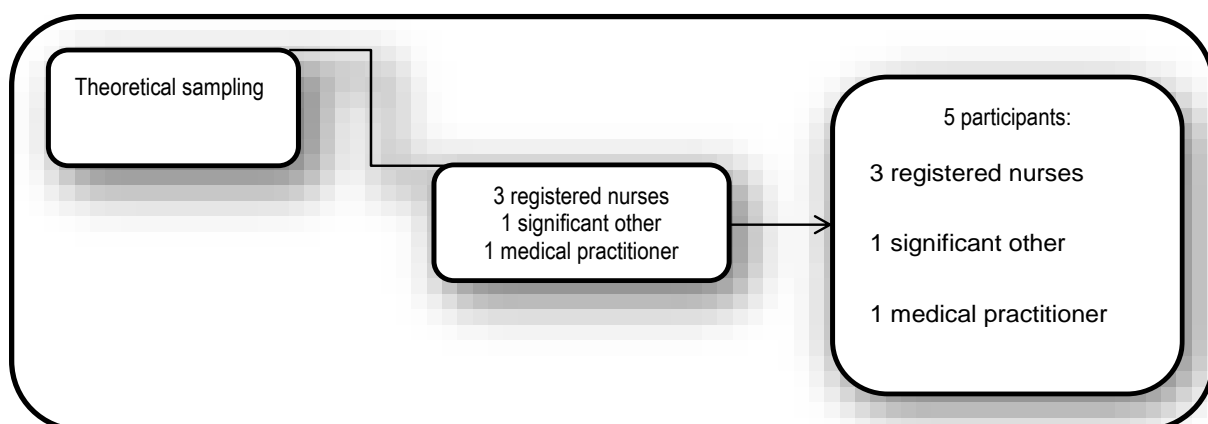


Figure 2.2 Theoretical sampling outcome - summary of participants

These prospective participants were contacted personally, telephonically, or by e-mail to determine whether they would be interested in participating in an interview session. Once they had expressed interest, the study information was e-mailed to the participants. An appointment was made to conduct the interview session once the person had confirmed reading the study information and had made a commitment to participate. Figure 2.2 provides a summary of the theoretical sampling process in terms of participants. See section 2.4.7 to understand how the interview sessions were conducted and the data collection tools that were used.

Interviews continued until the concepts become saturated and I had determined their fit in the emerging theory, respecting the notion of theoretical saturation. Once theoretical saturation had been reached, the final number of theoretically sampled participants was five of who three were registered nurses, one a significant other and one a medical practitioner. These participants were able to provide rich, clear and specific data about their engagements with critical care nursing, their perspective contributed to the depth and credibility of the data.

In box 2.1 below I have summarised the salient characteristics of the people who were included in the participant sample. The summary depicts the varied levels and types of experience or exposure to critical care environments that the participants had had that were relevant to their contribution to exploring the social process under study.

Box 2.1 Characteristics of participants in sample

Participant 1 - Registered critical care nurse with approximately 10 years' experience in critical care in private sector hospitals with experience as significant other of critically ill patient

Participant 2- Significant other of critically ill patient

Participant 3 - Registered nurse with approximately 1 year experience in private sector hospital, recent experience as final year student nurse in critical care units in state sector hospital

Participant 4 Significant other of critically ill patient – experience of two different critical care environments

Participant 5 - Registered nurse with approximately 8 years' experience in critical care in private sector hospitals, manager of unit.

Participant 6 - Specialist medical practitioner with more than 20 years' experience in critical care environments in state and private sector hospitals

Participant 7 - Registered nurse with approximately five years' experience in critical care in state sector hospitals, agency nurse in private sector hospitals.

Participant 8 - Registered critical care nurse of about two years, experience as a registered nurse in critical care of about three years mostly in private sector hospitals with some experience in state sector hospitals. Experience as significant other of critically ill patient. Fulfilled roles as shift leader, educator.

Participant 9 - Registered critical care nurse with more than 20 years' experience in critical care environments in private and state sector hospitals. Fulfilled roles as bedside critical care nurse, unit manager, educator, agency nurse

Participant 10 - Significant other of critically ill patient – experience of three different critical care environments across state, private and public-private partnership hospitals

2.4.1.2 Sample Size

Sample size in grounded theory is guided by sufficiency of data rather than representativeness of a population. Sufficiency of data is determined by theoretical saturation and influenced by theoretical sensitivity to ensure a complete as possible explanation of a social process has emerged - as such sample size is ultimately determined by theoretical saturation (Bruce, 2007:8-10; Dey 1999 in Charmaz, 2014:215; Thomson, 2011:47).

I continued to identify and include participants through theoretical sampling until no new data emerged to clarify or expand the properties of the core concern or categories. Theoretical saturation was achieved when I was satisfied that all categories were as well developed as was possible at the time, with all elements described and accounted for as well as that the properties, variants and the relationships between categories were well established. Once theoretical saturation was determined, ten (10) participants had contributed 38 separate items of data into the sample.

The second contributor to sample size in this study is the specific literature or scholarship that is used as a further source of data. Within the principles of the method, literature is not preferenced over the participants' contributions, rather through the application of the same processes of theoretical sampling, constant comparative

analysis and theoretical saturation, sampled literature is used to challenge, consolidate, extend and situate the emergent theory.

I engaged with nursing scholarship after I had analysed all of the participants' contributions and the grounded theory had taken on a form and shape. I initially identified 49 published articles as being relevant to the emergent grounded theory. Through the process of theoretical sampling and constant comparative analysis between the literature sources, I consequently used the content of 36 of the 49 articles as data. I applied the process of constant comparative analysis between the ideas, concepts, explanations, actions, processes and relationships elicited from the literature sources and the actions, processes and relationships that comprised the emerging theory. I continued to review and compare scholarship until I felt that the grounded theory was as fully developed as I could achieve in the context of my current understanding of the grounded theory method, the participant's data and relevant scholarship; as well as my capacity to implement these processes – all contributors to determining theoretical saturation.

Thus the final sample used for this study comprised 38 data items from participants and 36 literature articles, a final sample size 74 items. Table 2.3 provides a summary of the contribution of each sampling process to the final sample size.

Table 2.3 Final sample composition from purposive and theoretical sampling processes

PURPOSIVE SAMPLING	THEORETICAL SAMPLING		FINAL SAMPLE COMPOSITION	
PARTICIPANT DATA ITEMS	PARTICIPANT DATA ITEMS	ARTICLES	PARTICIPANT DATA ITEMS	ARTICLES
18	20	49	38	36

2.4.2 Data generation - collecting data

I have used the term 'data generation' to identify this section and section 2.6 in respect for the nature of co-creating and reconstructing a common understanding about a social process in constructivist grounded theory. Birks & Mills (2011:73-74) differentiate between data collection in other research methods and data generation

in grounded theory method with respect to the relationship of the researcher with the data. These authors consider the figurative distance that exists between the researcher and the source of data in this distinction. They argue that in the norm of data collection practice, the researcher has limited influence on the data source, while in the processes of data generation the researcher is actively engaged with a participant as the data source.

The interview sessions I held with the participants in this study were active in nature. I experienced the sessions as dynamic, complex conversations where the participant offered ideas and engaged with these, they allowed me to gently probe until we came to a common understanding of that idea. These intensive individual interviews provided the beginnings of co-creation and a resonant influence throughout reconstructing an explanation from the data sets. The concept of data generation felt more congruent to me when reflecting on the nature of the interview sessions, and how the participants' voices continued through analysis and into following interview sessions along with the intertwined nature of collecting and analysing data in grounded theory method.

In keeping with the processes of grounded theory methods, data generation processes occurred concurrently as far as was realistically possible. In figure 2.3 I offer a schematic representation of how the concurrency of data collection and analysis may be viewed. As each data collection session is analysed the patterns and codes revealed through that analysis guided the following interview session.

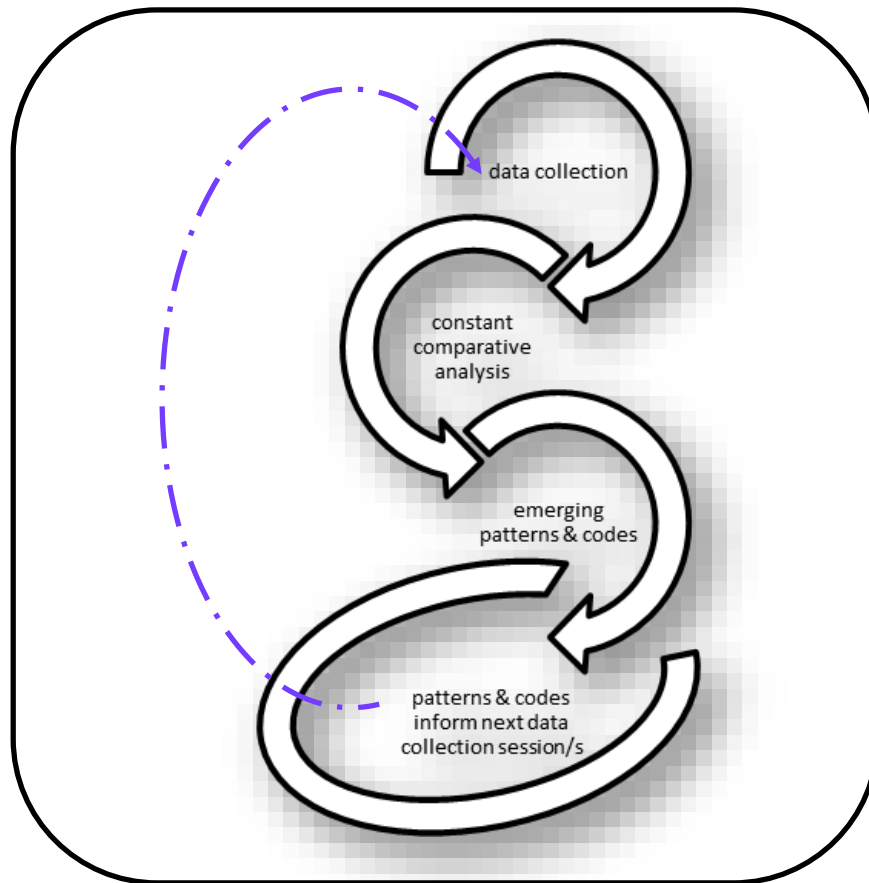


Figure 2.3 Schematic representation of the concurrent nature of data collection and data analysis

An in-depth discussion of the data generation phase is offered in this subsection supplemented with how data analysis guided theoretical sampling and theoretical saturation in the following section. Chapter 3 offers an explanation as to how the data generation and analysis processes enabled the grounded theory to emerge from the participants' data.

Egan (2002:284) noted that data collection in grounded theory requires not only creativity and responsiveness from the researcher, but also determination to achieve a sufficiently thorough understanding in interpreting and comparing the data. It was with this in mind that I chose to employ two data generation tools in this study, namely intensive unstructured individual interviews and a naïve sketch. These two methods were applied with all participants. A pilot session of both data collection tools confirmed that the interview and naïve sketch springboard sentences were clear and succinct. During the pilot interview sessions I asked both participants for feedback about the springboard statements as well as the interview session and naïve sketch; and their

experience of the interview session. Both participants expressed that they had found the springboard statement for the interview as well as the naïve sketch easy to understand and stimulating. The second participant suggested sharing the interview springboard statement with a participant prior to the interview as this would allow a person time to reflect more deeply on their ideas and the data would benefit from this deeper thought and time to reflect. I realised that during the naïve sketch, participants needed to be able to express themselves in ways that make sense to them; study participants were later encouraged to write a story, compile a list, create a diagram or to draw a picture depending on their preferred way of expressing themselves.

2.4.2.1 *Intensive unstructured individual interviews*

Intensive unstructured individual interviews were used to generate data for this study. Interpretive enquiry is supported through intensive interviewing as this method permits the in-depth exploration of the participants' experiences and their interpretation of that experience (Charmaz, 2006:25). Chenitz & Swanson (1986, as cited by Wimpenny & Gass, 2000:1487) noted that the unstructured interview is commonly used in grounded theory studies, particularly in the initial stages of data generation. An unstructured interview explores the participants' particular experiences of and insights into the topic of the interview, offering interpretation and construction of their realities (Charmaz, 2006: 25-26). Charmaz (2014:85) further offers that grounded theory and intensive interviewing are well matched in that both are open ended yet structured, emergent whilst being shaped, unrestricted but paced and flexible.

Intensive interviewing encompasses particular characteristics that support it being a flexible and emergent tool. The following list by Charmaz (2014:56) identifies these characteristics:

- participants have first-hand experience that fits the research topics
- in-depth exploration of participants' experiences and situations
- reliance on open-ended questions
- objective is to obtain detailed responses
- emphasis is on understanding the participants perspectives, meanings and experiences
- probing into unanticipated areas such as implicit views

These characteristics of intensive interviewing confirmed this to be a fitting tool of data collection as it aligns well with the nature of the topic under study and the study aim in this project. Intensive unstructured interviews were appropriate to use in this study as this approach allowed the participants to speak for themselves rather than respond to and restrict their contribution to a set of specific questions. The participants directed the conversation and, in this way, the concepts that emerged from the data are grounded in the participant's stories and thus, their reality (Charmaz 2014:58). An unstructured intensive interview is deliberately loose and flowing to encourage the participant to do the talking, but a general plan is developed to guide the interview around the theme of the study (Babbie & Mouton, 2006:289). An additional benefit of developing an interview guide is found in a comment by Karp (2009 in Charmaz, 2014:63) that the work of developing an interview guide is a "...yet another point in the research process when I try to clarify the analytic motifs and ambitions of my work." As I worked to develop the springboard statement for the interviews I spent time reflecting carefully on the content and form of the springboard statement. Thinking about the manner and content of how I wanted to engage with each participant led to me becoming more aware of what I may bring into the conversations and provided a beginning to my developing deeper sensitivity to ideas and concepts I hold from my personal history and professional experiences. In this way I was better able to recognise and challenge these ideas in our conversations and during analysis to ensure that each concept had grasp for the participants as well as for myself, and that I did not force the data to fit my preconceptions. The statement below was used as a springboard to initiate the interview conversation (see Appendix 10):

- Think about your experiences in this/any critical care environment – think of a professional nurse (or nursing sister) that, for you, has stood out from other professional nurses in a positive way. Tell me what you think makes her/his nursing stand out from the nursing provided by other nurses.

Charmaz (2006:26, 2006:30) comments that the preamble of the interview is necessarily open-ended and broad to encourage detailed discussion about the topic, fostering unanticipated answers and stories to emerge during the discussion. The intention of the springboard statement was to focus the participant's attention to nursing practice by a professional nurse in the critical care environment that had

caught her/his attention in a positive way, but without prescribing what that nursing practice may have looked like, how it was experienced by the participant or under which circumstances the 'stand out' nursing practice occurred and so forth. The springboard statement was deliberately kept broad to allow the participant to take the conversation in the direction that made most sense to her/him whilst still providing some context and frame to the interviews (Charmaz, 2014:64-68).

Charmaz (2006:27) reflects on the importance of recognising that interviews mirror what the interviewer and interviewee bring with them to the session; that the data generated is a reconstruction of a reality between these two people. Aspects such as professional position, perceived hierarchical position, experience and personal history all contribute to what a participant offers, grasps, hides or emphasises in the co-construction of an understanding of a phenomenon that occurs during the interactions between the people in an interview setting. It is necessary to be aware of these influences within and on the data as a reminder that each data collection session provides a glimpse into a particular reality that exists for that moment between those people. As such, in her reflection, Charmaz seems to emphasise that constructivist grounded theory is not a static entity, but almost a dynamic complex system that adapts as that reconstruction of reality within the interview is altered for each contributor as she/he changed by every moment of their life.

Knowing that my personal and professional history held sway in influencing the conversation that unfolded during the interview session required that I spend time reflecting on the springboard statement to know where my preconceived ideas, trigger points and possible blind spots lay. I did this to try to ensure that I participated as a partner in the conversations rather than as a director of the conversation. I reflected prior to beginning the first session and then after each session again such that I became aware of how I responded to a participant in an interview. In doing this I became more sensitive to challenging my influence during an interview (and during data analysis) by determinedly comparing my preconceptions and prejudices with the participant data such that my interaction with a participant was respectful of our relationship as co-constructors of a common understanding of the social process under study.

While it is important that the participant does the majority of the talking during the interview, the researcher takes on an active role to co-ordinate the interview process to elicit relevant and appropriate data (Charmaz, 2006:26; Birks & Mills, 2011:75). I was guided by the responses of the participant, and where pertinent supported their conversation through use of phrases such as 'tell me more', or repeating what they had said in an inquisitive tone to encourage further elaboration, rephrasing their comments to clarify my understanding; or to develop their meaning and intention further. I focussed on remaining flexible during the interview sessions to follow the story each participant wanted to tell, facilitating the conversation but still working to keep the core of our exchange on their recognition of 'better and different' nursing practice. This flexibility required that different prompts or probes were used within and across the interviews to support the emergent nature of this form of data generation. When needed, I did use probing sentences to gain insight into the participant's answers or refocus the conversation. Examples of probing sentences that were used:

- Explain how you felt when this nurse was around in the unit.
- Give me an example of how this nurse behaved differently
- Tell me about an interaction where you decided that this nurse was/is providing care that is in some way that stood out positively for you.
- Tell me what qualities you saw in this nurse while she/he was working
- Tell me what it was about these qualities that made this nurse's interactions a good experience for you.

A suitable time, venue and method convenient to the participant was established to conduct the interview. Two interviews were conducted in the participants' offices, one was conducted telephonically due to unexpected complications that arose during the day of the interview for the participant and seven participants chose to meet in a public space, usually a coffee shop or outside venue. Within the circumstances of each venue, we chose the optimal space to support the participants' comfort and privacy as well as voice recording logistics for the interview. I engaged in informal conversation with each participant to create a comfortable, gentle and relaxed space within which the interview could occur.

Prior to commencing any of the interviews, I outlined the purpose and nature of the study for each participant and requested their consent for participation. Each

participant was provided with an information letter (see Appendix 7) and an informed consent document (see Appendix 8). The participants read through the documentation with the assurance that I would answer any questions that may have arisen. Once satisfied with the content of the documents, all participants signed the informed consent form. The section of the consent documentation detailing the contact details of the researcher was detached and handed to the participant. My method of recording the interview and note taking was explained as well as the how the interview and then naïve sketch would be conducted (see Appendix 9). I assured each participant of my authentic interest in their stories and the value of their perspective to this study.

The interview was recorded using the digital recording applications on a smart phone as well as an iPad. The devices were placed on the table next to the participant. These devices were left on to record any conversation during the time of the interview as well as when the participant completed the naïve sketch. During the interview, I made short notes to capture what I heard the participant emphasising either through change in tone of voice, repetition of a similar words or phrases or through self-defining their meaning (see Appendix 10). I used these notes during the interview to revisit the concepts that emerged later during the interview and explore them further. The same notes were useful during the following interviews to see if similar concepts were discussed or to introduce these into the conversation. I made a note of the common emerging concepts on the margin of my notes page to use as prompts as necessary. As data generation becomes more focussed through theoretical sampling, so does the focus of the interview sharpen and become more specific through focussing on the concepts emerging from data analysis (Charmaz, 2006:29).

Each interview lasted between 40 - 45 minutes. I drew the interview to a close at this point by asking if there was any aspect in particular the participant wished to revisit. Once the participant confirmed that they had completed their contribution, I asked her/him to compile a naïve sketch. Each session was completed within one hour. I thanked the participant for their time and contribution and requested their permission to contact them later during the study for further elaboration should I feel this to be needed.

2.4.2.2 *Naïve sketch*

The second tool used to generate data for this study was a naïve sketch. On conclusion of the interview, the participant was asked to create a naïve sketch (a short description or drawing) of the three main qualities they would recognise as making a critical care nurse 'better and different' to their colleagues (see Appendix 11). The narrative provided in the naïve sketch provided additional data to reinforce inform and deepen the participant interview data. I provided the participant with a pen and sheet of paper on which the guiding sentence was written, and requested that the participant complete the naïve sketch at that time. The naïve sketch was guided by the following sentence:

- Picture the person you have just spoken about – write down or draw the top three qualities of that person that you would recognise as making them better and different to their colleagues

Of the ten participants, four chose to draw a picture and the remaining six participants used words either in a diagram or a descriptive list (see appendices 14 and 15). The recording devices remained switched on during this period to ensure that any verbal explanations by the participant were also captured.

2.4.2.3 *Reflecting and memo-writing*

Immediately after each interview I spent time reflecting on the conversation, noting down any additional aspects that came to mind in terms of the participants' attitude, gestures, engagement and expression. I also noted my own feelings towards the session as well as my experiences during the session. I wrote down what I felt I needed to consider prior to and during the following interview. In the following chapters I do indicate where and how I used memo-ing as a tool during data analysis and particularly in connecting concepts and developing ideas as these became apparent from the data.

As I noted earlier in this chapter, memo-writing is a defining process of grounded theory. Initially I struggled with this activity as I felt that I should be writing a formal type of essay in order to be doing memo-writing correctly. Despite applying myself to the idea of memo-writing, my attempts were stilted and rubbish as my concerns of doing this wrong essentially shut down my ability to express any ideas trying to take

root. Fortunately my frustrations led me back to reading about memo-writing where the cogent advice across authors was to just free yourself to write in whichever way makes sense to you. From this point, many of my memos took the form of mind maps, or as notes on my data analysis mind maps (see Appendices 20 and 21 as examples), as this is my preferred way of transferring my thoughts to paper and then back into my thoughts for more musing.

I used mind maps to develop an idea or concept or connection from the data, as well as to reflect on the ways I responded to what the data revealed. I used these mind maps as the grounding framework of my discussions and explanations of chapters 3, 4 and 5. Within the fairly chaotic looking circles, lines, squiggles, words, and colours, concepts became connected into categories and categories into a core concern.

2.4.2.4 Data sets

The taped interviews were transcribed verbatim by myself. The transcripts were reviewed for completeness and correctness by simultaneously listening to the recording and reading the transcript. The recorded interview, transcription and naïve sketch were identified with the participant's pseudonym and date of session for retrieval and audit purposes.

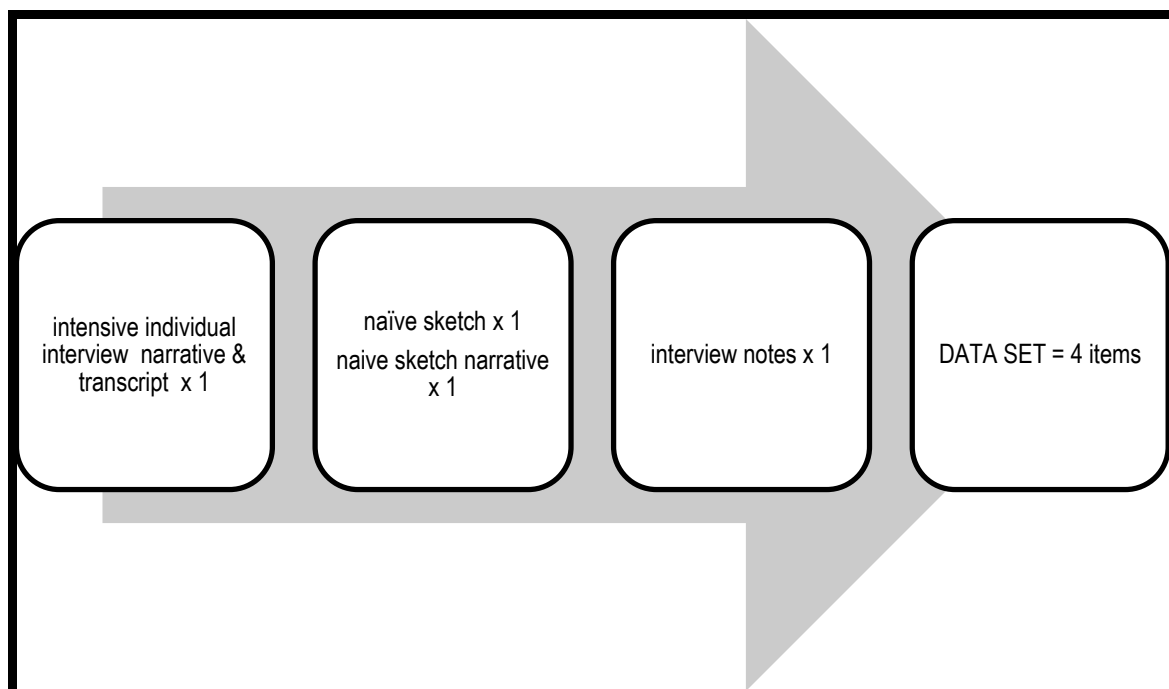


Figure 2.4 Data items comprising a participant data set

Figure 2.4 shows the elements of each data set compiled with a participant. These elements in each data set were used during the constant comparative processes of data analysis.

2.4.3 Data generation - data analysis

Data analysis in grounded theory is an iterative, interpretive, analytic cycle of decontextualisation and recontextualisation of the collected data. Data is decontextualized through coding and then recontextualised through the recognition of patterns and relationships amongst these coded data to establish a core category and sub-categories, as well as the relationships of and between these categories (Glaser & Strauss, 1967:105-109; Bryant & Charmaz, 2007:194-196; Starks & Trinidad, 2007:1375). This particular method of data analysis is known as constant comparative analysis and is also referred to as constant comparison in the discussions that follow. The purpose of constant comparative analysis is to enable the emergence of categories from the data to explain the actions integral in a social process; the social process in question for this study being the participant's recognition of 'different and better' nursing (Glaser & Strauss, 1967:105-113; Corbin, *et al.*, 1990:3, Creswell, 2007:160).

Constant comparative analysis begins with coding the collected data. Coding provides the first step towards conceptual abstraction (Bryant & Charmaz, 2007:272) and emergence of theoretical links from the data. Through attaching a conceptual label (called a code in grounded theory method) to incidents in the data the researcher begins to move beyond description of ascribed meaning in the data to discover and interpret the dimensions of the research problem. Coding provides the bones of the analytic framework from which defining relationships, processes, actions, and interactions of the core concern begin to emerge and eventually take shape as a grounded theory. Coding underpins the explanation of what is happening in the data, as well as the researcher's grappling with meaning in the data and guides decisions about further data gathering (Charmaz, 2006:46). The approach of coding data in terms of 'actions' rather than 'themes' moved the data analysis from being descriptive in nature to explanatory in nature, that which allows for the generation of theory (Charmaz, 2014:116; Charmaz, 2006:137).

I transcribed the interviews verbatim with the assistance of F4 transcription software (available at <https://www.audiotranskription.de/english/f4.htm>). The F4 transcription software enabled me to upload a digitally recorded interview and manage the audio playback to ease the process of transcribing the spoken words to written text. The features of this programme, for example in slowing the playback speed, a short period of repeat on restarting audio as well as time stamping the text transcription relevant to the audio recording, were helpful to me in efficiently transcribing the interview recordings and rechecking the accuracy of the transcription. I chose to do the transcription myself as I felt this was an important step in immersing myself in the data through being required to pay complete attention to each spoken word during the initial transcription, and then combining reading and listening during the reviewing the accuracy of the written text with respect to the recorded interview.. Once satisfied that the transcription was a full and true reflection of the interview, I was able to begin the coding process.

The interview transcript, scanned naïve sketch and interview notes were saved into a qualitative data analysis software package, ATLAS-ti (2012, version 7.1.8). ATLAS-ti is a computer software programme used mostly in qualitative research to manage the often vast amounts of data generated and support the coding processes of data analysis (available at <https://atlasti.cleverbridge.com>). I primarily used this software package to manage the data sets, code the data sets and save the coding outcome for each participant's data set. The software was also useful in viewing any of the data sets side by side to facilitate constant comparative analysis. Furthermore, I used the software to retrieve codes and quotations during the process of writing about the grounded theory as this emerged from the participant data.

In remaining congruent with the constructivist paradigm within which this work is situated, Charmaz's adaptation of grounded theory data analysis processes was applied to the data in this study. Charmaz identifies at least two main phases within grounded theory coding – an initial phase where each line of data is coded, essentially 'fracturing the data' (Birks & Mills, 2011:95) to elicit early analytic ideas in terms of incident comparison, emerging phenomena and beginning patterns to pursue in data collection and further analysis.

The second phase, called focussed coding in constructivist grounded theory, attends to the sorting, synthesising, integration and organising of larger chunks of data. Codes that appear most salient and significant develop into categories which begin to show the explanatory, conceptual patterns in the data. Integration of relationships between categories is conceptualised from focussed coding through subsequent analytic steps providing coherence and moving the ‘... analytic story in a theoretical direction’ (Charmaz, 2006:46,63; Birks & Mills, 2011:97). Where indicated by the data analysis, a third phase of theoretical coding may be appropriate. Charmaz however cautions against imposing a framework of theoretical codes onto the analysis (Charmaz, 2006:66).

Throughout the various levels of coding, I compared incidents in the data and wrote or drew memos. Constant comparison is an essential core process of grounded theory methodology through which the data is interrogated by comparing incidents within the data to elicit and develop codes, categories and eventually the core concern of the emerging theory.

2.4.3.1 Forming and shaping this grounded theory - the processes of coding

A key feature of grounded theory method is the concurrent nature of data collection and analysis with analysis of interview data in this study driving the focus of following participant interviews. As described previously, in meeting the participants at their convenience this had the effect of limiting the time available between interviews to do a full analysis of the data. To be able to accommodate my participants’ schedules but still respect the essence of this feature it was necessary that I tweaked my manner of applying the data collection-analysis cycle.

I reflected on my experience of the interview immediately after its completion and made notes about aspects that had resonated during the interview; for example where a participant emphasised an aspect under discussion or perhaps used unusual words to describe an incident or where they became physically animated while telling their stories. I listened to the recording of the interview, considered the naïve sketch and reviewed notes I had made during the interview. This process enabled me to identify some broad concepts that were common across the first two interviews and seemed significant to the participants. Each interview and note set was compared with those of the previous participants. While this process was ‘quick and dirty’, impressions of

some emerging conceptual threads developed from comparing the first two interviews' recordings and notes, tentatively offering that better and different nurses are recognised through their:

- Ways of handling death and dying
- Being sure of self without arrogance
- Being everywhere at the same time
- Connecting with the family
- 'Having knowledge and skill as a given'

During the subsequent three interview sessions I deliberately listened to identify whether the participant highlighted ideas similar to these conceptual threads through the conversation. Where similar concepts were introduced by the participant, I asked probing questions to encourage the participant to elaborate on the nature of that conceptual thread without limiting the conversation. New ideas were explored through the participant telling stories of experiences, explaining how they felt during an experience and offering comparisons with incidents where they experienced nurses who they felt did not stand out in a positive way during an interaction.

2.4.3.2 Initial coding - forming this grounded theory

The purpose of coding, according to Charmaz (2006:47), is to learn what the concern is of the participants about a particular social process and begin to treat this analytically. In the context of grounded theory methodology, the word *concern* is used within its meaning of being of interest or importance to somebody; thus to rephrase the word use and clarify the intended meaning of the word *concern*; the purpose of coding is to learn what is of particular interest or importance to the participants. In this study I wanted to understand the concerns of my participants (that which is significant to them or having effect on them) in recognising nurses who stood out in a positive way. Initial coding became the door through which I began understand and to develop my understanding of their concern.

Initial coding applies preliminary conceptual labels to the data and in this way begins to open up the data from participants. One of the most important and necessary conditions of the initial coding phase is that the researcher must remain open to the data and the theoretical possibilities held within the data. Coding should be done

rapidly and in a reflexive manner that remains close to the data. The viewpoint of 'remaining close to the data' is shared by all proponents of grounded theory methods; this means that the data remains visible within the conceptual codes, the categories and all the way through to theoretical explanation. Keeping the data visible and the theory grounded in the data is assisted by using codes that reflect action. Researchers are advised to see the action in data segments and code accordingly using gerunds (a verb that functions as a noun) as far as possible. Initial coding results in a set of codes that must be seen as provisional, the researcher remaining open to other possibilities, ready to review or rename codes to find the best fit to the data. The code set is comparative in that the codes have been compared with other similar and different codes in determining fit to the data. The codes are grounded in the data, meaning that the code is reasonably and reliably based within the participants' data – evidence to support that code is readily found in the data (Charmaz, 2006:45-50; Birks & Mills, 2011:95-97; Urquhart, 2013:23-24; Bryant & Charmaz, 2007:196, 275-277).

I chose to conduct 'line by line' coding of the interview transcripts during this initial coding process. Charmaz (2006:50) indicates that 'line by line' coding is appropriate when data provides detailed consideration of contexts and actions that is revealing and significant. The data in this study comprised stories and observations made by the participants. These offered detailed descriptions, complex explanations and rich examples to illuminate how they recognised nursing and nurses who stood out positively to them.

The ATLAS-Ti software breaks the transcript into lines of data when an interview is uploaded into the programme rather than following the sentence structure and breaking the data at particular punctuation marks such as full stops. I analysed the data using the lines of narrative as these were displayed in the software. Line by line coding requires close reading of, and intimate engagement with the data as you code only a line of data at a time and not the full sentence of the narrative. Due to the way a transcript narrative is broken up into lines by a software package, you do not become embroiled in the participant's story which helps to reduce the possibility of making assumptive leaps about the data, rather you are enabled to look at the data critically, questioning the processes, meanings, consequences and so forth within the data to generate new ideas to pursue or build within the data sets or during following

interviews (see appendices 12 and 14 for screen shots of the Atlas-Ti work space showing my early initial coding of part of an interview and a naïve sketch).

In order to 'fracture' the data, I was guided by the following questions developed from advice offered by Charmaz (2006:50-51) in order to see actions and identify significant processes within the data:

- what is going on? (process or action)
- what process is at issue here? What might be happening here?
- how can the process be defined?
- how did the person feel/think/act when process was in play?
- what are the consequences of the process?
- what language is used?
- what do they mean behind the language?

After my first 'quick and dirty' encounter with the data sets, I went back to each data set for a more thorough immersion in the participants' contributions. I worked quickly but thoroughly through the interview transcript first. I read through line-by-line carefully, applying the questions offered in the bulleted list above to the data in each line. In answering the questions that did apply to a particular segment, I attempted to code using gerunds as far as possible. A gerund is a verb that functions as a noun in a sentence and ends in '-ing'. Charmaz (2006:49, 136) notes that coding with gerunds helps to elicit the actions and sequences within the data limiting the likelihood of summarising the data to topics. Using gerunds is also seen as a way for the researcher to remain close to the participant's experience by beginning analysis from their perspective. If I was unable to find a suitable gerund type code, I used a descriptive label and later returned to that quote from the data to reconsider how the segment could be coded in action. Each interview transcript was initially coded separately from the remaining interviews. Constant comparison was applied within coding of each transcript, comparing code with code to enter the data and grasp the participants' meaning within their explanations.

The naïve sketch for each interview was then subjected to the coding process. Some participants created naïve sketches with words and diagrams whilst others were simple line drawings with labels for clarity or identification. I analysed the written or

diagrammed sketches in terms of the words used in locating the top three qualities of the nurse who stood out, in how these words were layered and elaborated on. Where line drawings were offered, I looked at the whole picture in terms of its composition and then the particular aspects that were emphasised or connected. Emphasised aspects were those parts of the picture that were darkened or bolded, underlined, drawn disproportionately larger or smaller than other aspects, as well as how these aspects were seen to interplay with the labels provided by the participant. Relationships that participants indicated between words or between parts of diagrams and sketches were coded. I then listened to the narrative that I had recorded while the participant completed the naïve sketch. I listened to how the participant emphasised particular qualities and what the participant spoke of whilst they were writing or drawing to compare this narrative to the naïve sketch in order to understand their emphasis of stand-out qualities and the relationships between the components of these qualities as recognised by the participants. This constant comparison between the naïve sketch and the narrative embedded this initial coding within the participant's data.

Finally I reread the interview notes I had made during each interview and compared these to the data of the interview transcript and the naïve sketch. Figure 2.5 provides a diagram that summarises the initial coding process to its outcome.

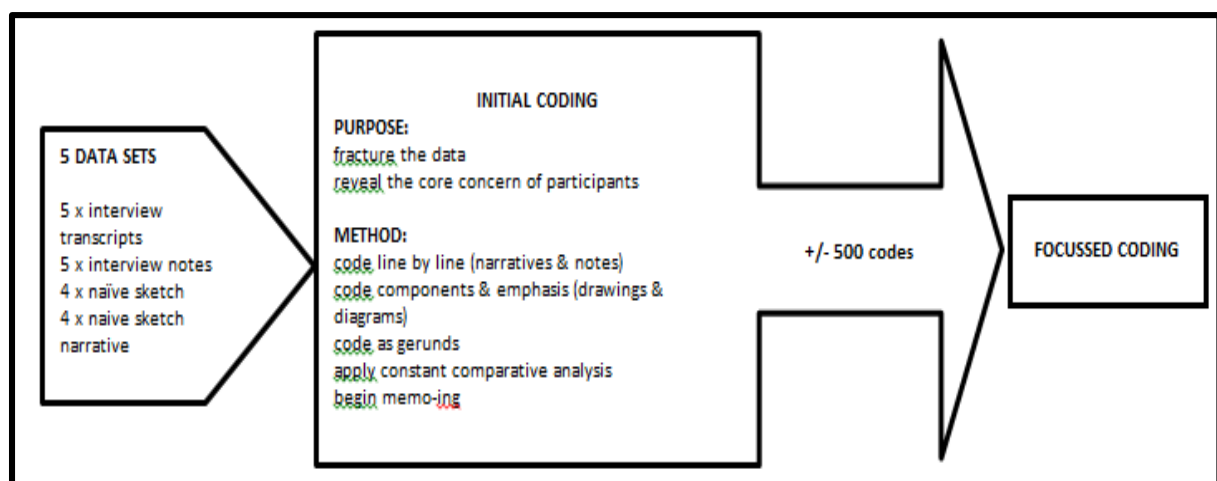


Figure 2.5 Summary of initial coding process

Thus for each participant, the interview transcript, naïve sketch and narrative and interview notes were separately coded, then compared with each other. Once each participant's data set had been through this process, the codes across the data sets

were compared with each other. During this comparison process, my purpose was to identify codes where I had used similar wording but that had the same meaning in the data and then to condense these into one code with a more refined yet still tentative meaning. This process of comparison remained embedded in the participant's data as for each similar code I asked the following questions based on Charmaz (2006:51) to ensure that codes meaning the same within the data were coalesced:

- What is actually happening here – what action or process, and how does it develop?
- How is the participant expressing their concern – what language, emphasis, feelings, thoughts, actions are shared?
- How are these incidents similar or different to each other?

My initial coding of the first five interviews generated almost 500 codes that had been assigned during the coding process. After using the questions in the above bullet list to 'clean' the codes, I began to group them according to the comparability of their purpose or action. In this way the second stage of coding – focused coding, was initiated. During the process of focussed coding, the initial codes are sorted and synthesised to pinpoint and develop salient categories. These categories then become the next layer of the foundation from which the core category of the grounded theory eventually emerges; appendix 13 is a screen shot of the Atlas-Ti work space showing my coding of part of an interview as I began to move between initial and focussed coding. A focussed code 'label' when applied to a grouping of initial codes offers a more conceptual view of the processes or actions revealed by the participants' data (Charmaz, 2006:57; Birks & Mills, 2011:11-12, 97-99).

2.4.3.3 *Focussed coding - forming this grounded theory*

It is during this phase of focussed coding that connections between codes develop and the relationships, influences, and so forth of these connections become explicated. Conceptual explanatory patterns begin to emerge and theoretical integration may begin. It is relevant to note that the change from initial coding to focussed coding is not necessarily a linear process. I returned to the data constantly to recheck my interpretation and understanding of the participant's stories of processes and actions related to recognising nursing or nurses that stood out for them.

I began to apply focussed coding within the data from the first five data sets. Returning to the data to compare my developing understanding with the words of the participants kept me open to the possibilities of different relationships or new codes becoming apparent even after moving into the focussed coding phase.

While I continued to use the Atlas-Ti software package for applying codes to the data, I moved to using a mind mapping software programme (XMind 2013) for the process of beginning to link and recontextualise the emergent codes. This choice is founded in my own learning style where I prefer to create and use pictures or diagrams to understand phenomena and the varied relationships within these. I developed a mind map of the groupings of codes into broader categories. I did this by printing a list of the codes that I had compared and refined as described earlier. Using this list I then identified codes where I had used the similar wording and grouped these together using different coloured highlighting; again referring to the participant's quotes attached to a code to clarify and confirm that these codes did in fact belong together in some way. I used these highlighted lists to develop a mind map. I began with the research question as the core of the mind map to avoid imposing a core category on the data in any way. The research question also served to remind me constantly of the trigger to determining the core concern of my participants; this continued to centre my focussed coding process.

The focussed coding analysis process that I followed with each data set was as follows:

- The transcription was reread and confirmed as accurate to the recorded interview
- The transcription was coded to categories as described in the previous paragraph
- The naïve sketch was coded to categories
- The naïve sketch narrative was listened to for additional data that explained or elaborated the naïve sketch and was coded
- The naïve sketch and narrative coding were compared
- The interview transcript and naïve sketch coding were compared
- The interview notes were reread and compared to the outcome of the transcript and naïve sketch comparison to confirm or expand the coding and categories

- Codes that emerged from this focussed coding phase were compared against the existing codes and memos to firmly establish how these may or may not be different, and how they may relate to the seven categories.

Nine initial categories emerge

Constant comparison remained the method of how I engaged with the data. I considered the initial codes attached to the first five data sets and compared these with each other using similar questions to those listed on pages 42 and 44, but expanded their breadth and depth by applying Kipling's 'Six Honest Men' – what, where, when, why, how and who. Kipling refers to this group of questioning words in a story titled Elephant Child that was published as part of the Just So Stories (Kipling, 1902), where they are used as a point of departure in discovering and understanding the world. I used this group of interrogative words in a similar fashion to develop Charmaz's questions I had already used and to create additional questions to probe the data more deeply and trigger new ideas. Examples of the questions follow below:

- What action or process is happening or may be happening here?
- Who is involved and how are they involved?
- Where is this action or process happening?
- When does this action or process happen and what changes things?
- Why does this action or process happen?
- Is this action or process part of a broader interaction/event? If yes – how, when, where, why, who?
- If not the above, then where does it fit?
- What are the consequences of the action or process?
- What may be hidden or assumed here?
- How else could this action or process be seen or understood?

Through constant comparison, by questioning the intention and focus of each code, more significant codes began to emerge from the data to develop into the initial tentative categories of the focussed coding phase. Each of these initial focussed coding categories encapsulated a group of codes that seemed to offer insight into the actions and processes the participant's engaged in when recognising nurses that

stood out for them in a positive way. Nine broad initial categories initially surfaced from the sea of codes. Figure 2.6 provides a diagrammatic representation of this process.

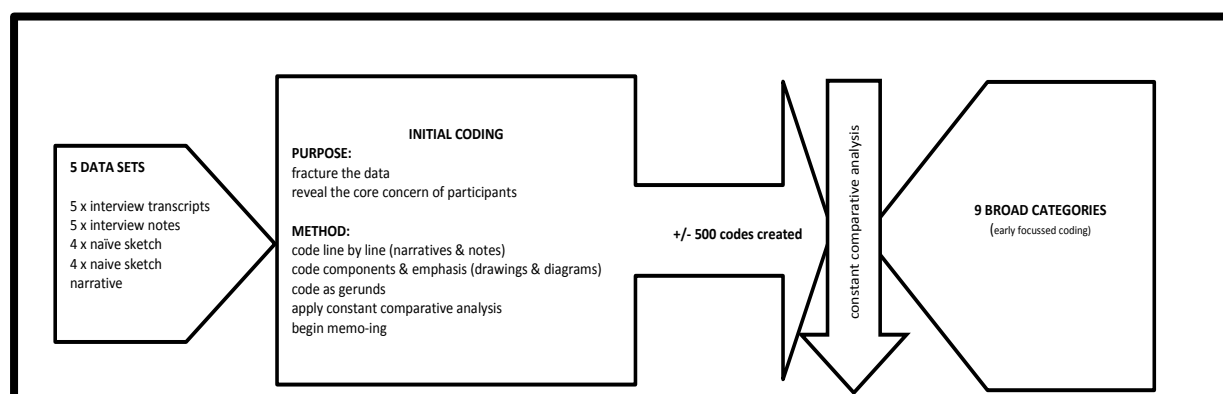


Figure 2.6 Moving from initial coding to categories emerging from early focused coding

From nine categories to seven categories

Within these nine initial categories I again went through a process of refining the codes. I determined whether codes with similar labels may mean the same within the data and condensed these into a single code, I attached a memo to explain my thoughts such that I would later be able to justify my choice or review my choice. I moved codes around within the category to expose relationships that participants had identified in their stories and placed similar codes together to begin to show possible relationships between codes. I subjected the codes within the category to the same set of questions previously described in trying to gain deeper insight into the participant's concern, this helped to refine and begin to define the relationships between the codes within a category. Codes were also compared across categories to ensure that their fit within a category was appropriate and evident in the data. Codes were moved around to refine relationships or, where codes may have had a better fit, into a different category. Thus, a second mind map developed through comparison across codes within a category and then across categories.

I created memos in the form of written pieces and mind maps whenever a question arose in my mind about what was happening in the data and how I thought the data related to each other or to another emerging category. I explained in memos why I chose to group a particular code within one category and not a different category. I memo-ed any ideas that came to mind whilst engaged in conversation with a

participant and when considering the codes that I felt I should explore within the data again or which I needed to check across the data sets to determine whether the concept fitted across the participants.

I turned my attention to the categories and wrote memos for each category to elaborate what that category meant broadly to me and how it was grounded in the data. I then considered each category and reflected on any connections between categories that would make one become part of another. This process was informed through applying the same set of coding questions previously referred to and in this instance, constant comparison between these first tentative categories led to refining of the number of categories from nine to seven.

From seven to five categories

The seven categories provided the foundation from which I applied focussed coding to the remaining five data sets as these were collected (data sets 6-10). In each instance, a participant's data set was analysed with consideration to the seven categories and the constituent codes as these built through each consecutive interview session.

Instead of applying a code to each line of data as I did in the initial coding process, I considered the incidents within the lines of data and compared whether that incident was already reflected within a category, how it may confirm or elaborate the codes within that category in terms of relationship, action or process, or whether it was a completely new code emerging from the data. In order to better manage the complexity of the mind map as it grew to illustrate the categories and codes, I separated each category from the large mind map (referred to as the 'summary mind map' from this point onwards) and created a unique mind map for each category with its constituent codes and developing actions, relationships and processes, the mind maps are included in the explanation of how this theory emerged in Chapter 3.

Each data set (of data sets 6 – 10) was analysed as described above, applying constant comparison of data with codes, codes with codes, codes with categories and categories with categories. Once a data set had been analysed, I applied the outcome of the analysis to the mind map of each category prior to engaging with the next data set. The mind maps for each category were updated in terms of additional codes,

relationships between codes and eventually relationships between categories. By engaging with the data analysis in this way, I was able to see which particular interactions were emphasised by the participant. I then used this emphasis in terms of the allocated code as a pointer in analysing the following data set to develop and elaborate the particular interaction. In this way, both during data collection and data analysis the concerns of the participants in recognising nurses that stood out in a positive way remained the core of the study with the emerging categories, constituent processes and actions grounded in the participant's data. Once again memo writing provided an important tool in explicating the relationships evident between the codes, keeping track of questions that arose for myself whilst analysing data and to consider how the categories were beginning to coalesce.

Through applying the described process to the analysis of data set 6 it became apparent that the number of categories could be refined from seven to five categories. Thereafter focussed coding of data sets 7 and 8 confirmed my interpretation and grouping of the codes within the above categories. Relationships between codes that had been tentatively established during analysis of data set 6 became founded and developed further. Each category matured with its particular actions and processes becoming more explicit. Interactions within and between the five categories became more obvious and formed.

As I continued with data analysis, I noted that there were particular words or phrases that all the participants used. As I moved through the data in the coding process I used symbols to note where particular words, phrases or ideas were emphasised through repetition during an interview and across interviews, or where the participant emphasised a particular concept verbally or in the naïve sketches, some of these symbols are present in figure. I found these emphasised, common words useful in refining my data analysis and keeping the reconstruction of meaning focussed into the participants' explicated meanings. A key to these symbols is offered as part of Figure 2.7.

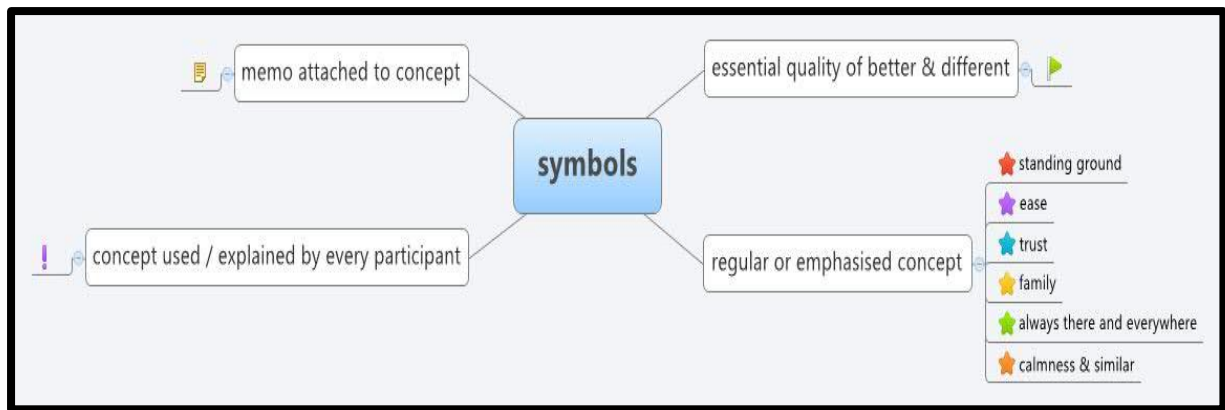


Figure 2.7 Key to symbols used across mind maps

Five categories to four plus an emerging core concern

A particular process (or interaction) between the categories emerged and became more distinct as data analysis continued. When eight data sets had been analysed, the focussed coding process led to the categories becoming more refined and specific in terms of internal processes of, as well as relationships between, categories. After analysing eight data sets, two of the categories were combined as they each seemed to be rather more part of the other as opposed to separate from each other. This left four categories that had each become more definite in shape in terms of the actions, processes and relationships between concepts of each category. As is the nature of data analysis and category development in grounded theory method; categories were subsumed into other categories and some were relabelled as the actions and processes within categories were developed and explicated. Nine emergent initial categories were refined to four separate yet interrelated categories that together shaped a first tentative and preliminary explanation of the participants' core concern. In Chapter 3 I explain my thinking in terms of the concepts and categories as these moved and developed in relation to each other to reveal the core concern of the participants in recognising 'different and better' nurses who create a 'different and better' experience of nursing.

I continued to apply constant comparative analysis to the data sets of interview nine and ten, using focussed questions to revisit the transcripts and the audio record as I felt necessary to be able to fully tease out the complexity of this social process to uncover, reconstruct and explain the nature of the emerging core concern and related categories. I had become sensitive to particular concepts through the emphasis and

repetition of these in interviews as well as during coding, but remained open to the possibility of different priorities coming to the fore during interview nine and ten. To this end I continued to apply the process of working through and with the data as has been described using constant comparative analysis and memo writing.

Through reflection on these two data sets and deliberation on the meanings of the words I had used, I found that I needed to reconsider and refine some labels to better reflect the concepts and relationships between these within a category. The effect of these two interviews on the emergent theory was to realign the relationship between two of the categories to enable the actual core concern of the participants to be revealed and explicated. This again led me back into the previous data sets to compare and confirm that this specific concern was reflected within the earlier data and to fully develop its connections with the four categories already fashioned through the coding process.

Figure 2.8 shows a schematic depiction of how the grounded theory emerged from the participants' data sets. On the left side of the figure the beginning point of over 500 codes that were revealed during the initial coding process is shown. As further data sets were analysed the codes became grouped and refined into categories through the initial and focussed coding activities. Data analysis processes led to categories becoming more formed and refined in shape, depth and completeness (as symbolised by the deepening colours across each row). The codes condensed to 9 broad initial categories and then eventually to the core concern and with its related four categories when theoretical saturation was determined to have been achieved from the data at hand (see Appendix 16 for a screen shots of the Atlas-Ti work space showing my focussed coding of part of an interview).

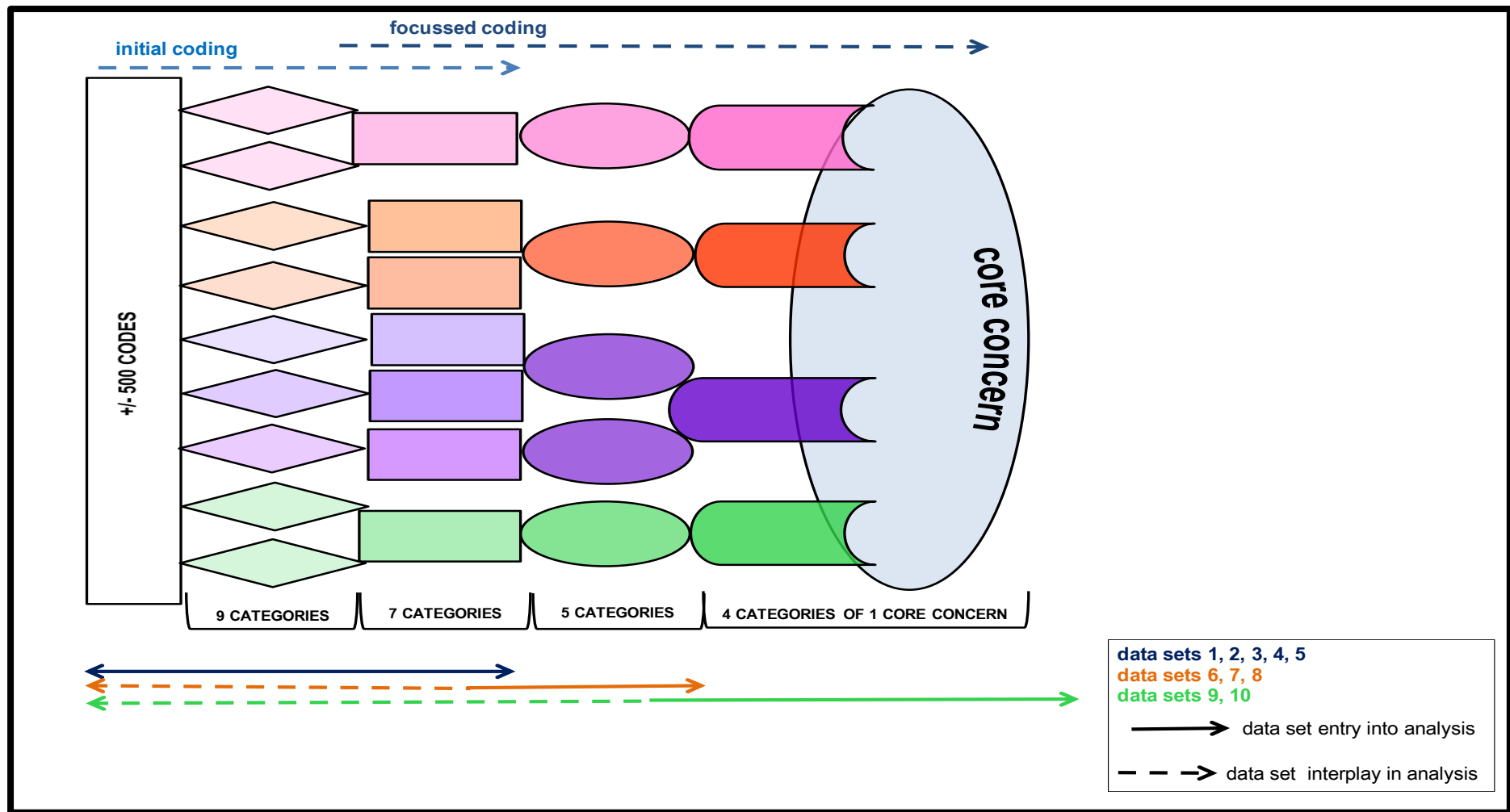


Figure 2.8 Schematic representation showing the progression from codes to core concern

My explanation of this evolution of the core concern and its related categories is offered in Chapter 3. I show how these became formed and shaped from the participants' data sets to an emergent first proposition of a grounded theory through the processes explained in the chapter - initial coding, focussed coding, constant comparative analysis, memo writing, theoretical sensitivity, theoretical sampling and theoretical saturation.

2.4.4 Reviewing and enfolding the literature

The purpose of the following discussion is to elaborate how I engaged with relevant literature. The discussion firstly focusses on the place of literature in a study using grounded theory, and secondly on the way I applied grounded theory methods to identify, review and enfold existing knowledge into the emerging explanation.

2.4.4.1 *The place of literature in grounded theory*

Dunne (2011:111) confirms an important precept of grounded theory when he emphasises that the method focusses on developing new theory that is grounded in empirical data collected in the field and not on testing hypotheses taken from existing theoretical frameworks. This precept that underpins the research process of grounded theory work was claimed by the originators of the method, Glaser and Strauss, in the opening pages of their 1967 book, *Discovery of grounded theory*, where they assert that grounded theory constitutes a pioneering methodology that facilitates discovering theory from data (Glaser & Strauss, 1967:2-5). In respecting this precept, empirical data is privileged over existing theoretical concepts which changes the way literature is placed, used and integrated into the study.

The typical place and use of literature is so well established in the research process that a deviation from the norm, such as that in the grounded theory process, allows for misunderstanding to cloud discussions and lends to misinterpretation of the value placed on extant theory in this method. As an example in my own experiences during this PhD journey, I was engaged by concerned mentors throughout my time of proposal development regarding the absence of a firm theoretical perspective which would inform my study from its outset and an apparent paucity of scientific literature underpinning my argument leading to the research question. While these are

perceived to be deficits in the view of researchers with extensive experience in applying other qualitative and quantitative research designs, this is a reasonable application of the principles of grounded theory method.

These common misconceptions about the method are further clouded by the debates within the community of grounded theory scholars as to the timing and use of extant theory in the area under study. Dunne (2011:113) advises any researcher using grounded theory to be sufficiently well-versed in the debates around the method such that you are able to determine your own informed and defensible position in applying the methods of grounded theory – including that of existing knowledge. It is important to note that it is not the necessity of a literature review that is debated amongst grounded theory scholars, rather when this should be conducted and how extensive the review should be (Dunne 2011:113). Currently within the writings on grounded theory method, it appears that the consensus opinion is that a researcher cannot be the ‘tabula rasa’ that early writings by Strauss and Glaser seemed to require. The researcher does have a responsibility to hold a critical and reflective view of her/his established knowledge and perspectives such that the data is not coerced into her/his preconceived theoretical frameworks (Charmaz, 2014:306)

I came into this study with 25 years of nursing experience mostly in the discipline of critical care of which the last 10 years had been spent in an academic environment teaching critical care nursing. Thus I had a well-established broad understanding of the concepts and discipline of specialist nursing practice, my understanding having been influenced and informed by my personal and nursing experiences, literature, and interaction with colleagues both locally and internationally. Becoming consciously aware of this through acknowledging and reflecting on my established knowledge base and understanding thereof; as well as considering how this held influence in my interactions with study participants and their data was a necessary part of ensuring the rigour of this work. Through my reflections I became more mindful of my ideas as separate from the participants’ ideas, and also became more theoretically sensitive to the uniqueness within the data.

My engagement with literature occurred during two periods across the life of this study, during proposal development as is evidenced in my arguments underpinning this study in Chapter 1. My return to the body of relevant literature occurred after I had analysed

the participant data to the point of having an initial proposition of a grounded theory to explain how 'different and better' nurses are recognised by utilisers; this process underpinning my sampling, review and enfolding of literature is discussed below.

2.4.4.2 *The process of sampling, reviewing and enfolding literature*

I began the literature review process with the intention of clarifying and situating the core concern and main categories of the nascent grounded theory against the lens of published scholarship. I wanted to determine what scholarship would be relevant to compare the core concern against; and how the scholarship might further clarify the relationships between the core concern and categories. To this end, I took Charmaz's (2014:305) advice to begin with the emerging core concern and/or robust categories to determine what discipline literature would be relevant.

I used the grounded theory processes of theoretical sampling, theoretical sensitivity, constant comparative analysis and theoretical saturation to structure my engagement with nursing discipline literature and to identify relevant work. I applied theoretical sampling throughout my engagement with the body of scholarship, firstly in using the emergent explanation of what the core concern encompassed to locate potentially relevant sources and, later, to sample literature that specifically elaborated the notions in scholarship which had demonstrated particular relevance to the broader relationships of and within the first proposition of the emergent grounded theory.

My theoretical sensitivity had become heightened through engaging with the participants and analysing the collected data. Theoretical sensitivity assisted me in sifting through the published works to find those relevant for comparison with the core concern. Constant comparative analysis was applied to contrast the emergent core concern and categories with the specific ideas put forward in each paper, as well as across papers that considered similar concepts or phenomena – my purpose being to identify and understand the converging or diverging points of opinion offered by authors. I applied the principles of theoretical saturation to identify when sufficient literature had been reviewed and enfolded such that the core concern and categories were as fully elaborated as I was able to achieve within the reality of currently accessible published nursing scholarship. Table 2.4 demonstrates my application of the grounded theory method processes as I engaged with relevant literature.

Table 2.4 Application of grounded theory method processes in reviewing and enfolding literature

GT METHOD PROCESS	DESCRIPTION	USE IN LITERATURE REVIEW
Theoretical sampling	<ul style="list-style-type: none"> data sources and focus determined by emergent ideas from data analysis 	<ul style="list-style-type: none"> core concern and category led to relevant topic areas in literature initial literature review data directed and focussed ongoing engagement with scholarship
Theoretical sensitivity	<ul style="list-style-type: none"> ability of researcher to recognise and extract elements from data that have relevance to the emerging theory 	<ul style="list-style-type: none"> choice of data base search terms recognising congruence of 'good' & presence validating theoretical saturation
Constant comparative analysis	<ul style="list-style-type: none"> inductive process of comparing data with data at all levels of analysis to fully develop the properties of the emerging theory 	<ul style="list-style-type: none"> comparison of literature with literature comparison of literature with categories comparison of literature with core concern
Theoretical saturation	<ul style="list-style-type: none"> data collection continues until no new properties of a category or core concern emerge 	<ul style="list-style-type: none"> fully elaborated concepts / phenomena from literature enfolding of literature concepts/phenomena into categories and core concern fully elaborated actions, processes and relationships of the GT

To begin my engagement with the nursing discipline literature, I reflected on how the core concern of the emergent theory may be identified in terms of key words if it had already been published. I applied some of the elements that formed my theoretical sensitivity, namely my existing nursing knowledge, insight into participants' core concern, as well as clinical and research experience in nursing and critical care. Thus using the core concern as a starting point, I chose two key word terms as initial search

phrases – *authentic nursing* and *holistic nursing*. I chose these terms because I felt that these represented a broad swathe of ideas in nursing that were linked to the core concern and would offer up specific scholarship which I could then sift through to find works with which to compare the core concern of the participants as this had emerged from the data sets. The terms opened up a massive cache of published work covering a wide diversity of focus areas in nursing practice, education and research clearly requiring a more specific approach to finding literature relevant to the emergent theory.

I supplemented these terms with 'different', 'better' and 'stand out' to try to focus my search without imposing tight limiting boundaries, and chose to draw on the explanation of one of the categories that as a further filter for the published literature. I chose this category because the data seemed to show that it provided a natural beginning to the eventual experience of the core concern of this emergent grounded theory establishing this category as a reasonable indicator for theoretical sampling of literature. I first considered the titles of the articles and excluded any that were obviously irrelevant to the core concern. With the articles that seemed to have relevance to my purpose I accessed and read the abstract and compared this description to the broad explanation of the core concern. Where the article abstract indicated the author had explored or explained concepts / phenomena / ideas similar to the core concern or categories, I accessed the full articles to review and use as data for comparison with the core concern - theoretical sampling in action. I compared the reference lists of relevant articles to identify key authors or additional articles and retrieved these through either open source access or the NMMU library services.

In this manner, I accessed a body of literature that related back to two common perspectives that held an approximate resemblance to the developing core concern or categories, namely: that of 'feeling like a nurse', and that of spirituality in nursing. Once I began to review the scholarship on spirituality in nursing and compare this to the core concern, I quickly realised that this body of work represented a perspective about nursing that was too narrow to challenge this emergent theory. However, within the works I read, authors in this focus area noted that the encompassing ideas and actions of spirituality in nursing are part of what was termed 'good nursing' in these articles. Similarly the perspectives on 'feeling like a nurse' brought up this notion of 'good' in relation to nursing that stood out, as well as a phenomenon that was called

nursing presence. The article content seemed to identify 'good nursing' as a more wide-ranging foundational perspective of nursing rather than a component of nursing, and worth exploring in relation to the core concern. Thus my initial foray into discipline scholarship led me to engage in depth with the ideas encapsulated by the terms 'good nursing' and 'good nurses'. I read through each article until I felt I had grasped the author's point of view and predominant contribution of the article. I then compared the central ideas of the published work with each other and then to the emergent core concern and categories. I used questions in a similar manner to the analysis of the participants' data. I used the same technique of mind mapping to capture how I saw the literature contributing and connecting into the actions, processes and relationships of the core concern. Chapter 4, section 4.4 provides a comprehensive discussion of how this body of literature was enfolded into the emergent theory and how it verified my next step of deep engagement and analysis of the published work on nursing presence.

I had come across the word *presence* used by participants during my analysis of the study data. This word was used by participants in explaining various elements in a 'different and better' nurse's ways of nursing, an idea seeming to hold significance in the utilisers' recognition of a 'different and better' nurse. The specific use and meaning of this word in the explanation of the relationships of the categories and core concern sensitised me to the term as it was situated in the works on 'feeling like a nurse'. These authors conveyed an idea that there seems to be a particular way or manner that some nurses engage during interactions that is positively received by patients and spoken of as beneficial to both nurse and patient, they identified this as a phenomenon of nursing called 'nursing presence' - this notion resonated with my understanding of the emergent theory. Thus, the core concern and categories of the emerging theory as well as the literature on 'good' in nursing led to this phenomenon as a natural next point of comparison with the core concern. Table 2.5 provides a summarised list of some of the ways I combined the search terms to create various search phrases and used these in the listed data bases.

Table 2.5 Examples of terms and data bases used in literature review

EXAMPLES OF TERMS	DATA BASES ACCESSED
<ul style="list-style-type: none">• authentic nursing• holistic nursing• above terms +/- better +/- different +/- stand out• knowing + nursing• knowing self + nursing• ways of knowing• grounded + self + knowing + nursing• spirituality + nursing• good + nursing• nursing + presence	<ul style="list-style-type: none">• CINHAL• EBSCOhost• Google Scholar• PubMed Central• Sage• Science Direct

I applied the same processes of theoretical sampling using the core concern and categories as these had been developed by the contribution from the scholarship of 'good' in nursing to identify germane published literature on the phenomenon of nursing presence. I engaged with this literature in a similar way as I had with the work on 'good' in nursing. The outcome of my application of the grounded theory method processes of theoretical sensitivity, theoretical sampling, constant comparative analysis and theoretical saturation to achieve a full and deep explanation of how utilisers recognise 'different and better' nurse is explained in detail in section 4.5 and 4.6 of Chapter 4

2.4.5 Reflecting

The heading of this subsection speaks directly to the method I applied to create the last part of this study – I spent time reflecting on this work, what meaning it holds for clinical specialist nurse practice and how this grounded theory can be used in teaching and learning.

The study had offered up an explanation of how utilisers recognise 'different and better' nurses and nursing through the core concern and its four related categories in a grounded theory. I used this explanation to reflect on what the grounded theory revealed about the nature of clinical specialist nursing, and that which utilisers

recognised as being a unique in the experience of this way of nursing. I contemplated on how this inductive explanation reconnected with the research question, study and objectives to offer the insight I have drawn from this grounded theory.

2.5 TRUSTWORTHINESS

‘Without rigor research is worthless, becomes fiction, and loses its utility’ (Morse, Barrett, Mayan, Olson & Spiers, 2002:14). Rigor in this qualitative study is expressed in the concepts of trustworthiness; namely credibility, transferability, dependability and confirmability, as described by Guba & Lincoln (1985, as cited in Babbie & Mouton, 2006: 276-278). Trustworthiness considers the neutrality and rigour of the research – the processes as well as the findings of the study; as such the concepts described below were applied continually and consistently throughout the research process. Morse, *et al.* (2002:17-19) noted that verification mechanisms built into the grounded theory research process incrementally contribute to the trustworthiness of the study. The verification mechanisms of grounded theory are found in the processes of constant comparative analysis and theoretical sampling. The integrated nature of these processes means that the quality and substance of findings from the data are checked and rechecked against new data. Memo-writing further supports trustworthiness through sensitising a researcher to her/his own biases as these are revealed first for comparison with the data, and then to establish if these ideas have ‘fit’ with the emergent data (Cutcliffe, 2000:1480; Elliot & Lazenbatt, 2005:51-52).

2.5.1 Credibility

I applied six processes to support the concept of credibility within the context and parameters of this study namely: prolonged engagement, persistent observation, triangulation, and referential adequacy, peer debriefing and member validation (Babbie & Mouton 2006:276-277). These common processes that I elaborate on below were all applicable to my study to a greater or lesser extent, however in Chapter 6 I argue the usefulness and quality of my work using specific reference points of methodological and interpretive rigour established by scholars of grounded theory to underscore why I believe this study is a credible work of applying grounded theory method.

The processes highlighted by Babbie & Mouton and how I reflected these within the context of my study follow:

- Prolonged engagement

For the purpose of this study I applied the principle of prolonged engagement by continuing data generation until theoretical saturation indicated that no further inclusion of participants was necessary. I remained engaged with the participant data for an extended period, reading and revisiting various contributions to confirm or challenge other contributions.

- Persistent observation

Persistent observation requires constant and consistent interpretations from multiple perspectives to understand what does and does not impact on the unit of analysis. This was supported by using constant comparative analysis across a diverse group of utilisers who engaged with critical care nursing. Using more than one form of data generation tool from each participant (an intensive individual interview and naïve sketch) assisted in offering an additional perspective to each participant's insights. The ideas expressed in both the interview and naïve sketch served to challenge and then deepen the contribution of the each other. Kipling's 'Six Honest Serving Men' - what, when, where, why, who and how were consistently and constantly applied to the data lending to the work's credibility. Reframing the core concern and categories through each set of participant data as well as within each data set further added to the credibility of data interpretation and study

- Triangulation

Triangulation is described by Babbie & Mouton (2006:277) as the collection of information about different events and relationships from different points of view; namely to ask different questions, seek different sources and use different methods. Data was generated from a diverse group of people who make up the utilisers of critical care nursing, meaning that the ways and means of recognising 'better and different' nursing practice was explained from the perspective of colleagues (nurse and medical) as well as patients' significant others. Their perspectives had been formed through experiences across the private and state healthcare systems as well as in a variety of critical care environments from those offering specific super-specialist discipline services to general critical care environments, from large units catering to 20 patients

at a time to a small unit where 4 patients could be admitted. Using this diverse group allowed for triangulation of the data and underpinned the credibility of the study. Using two methods of data generation (individual interviews and naïve sketches) further supported the credibility of the study. The method of reviewing and enfolding the literature after the emerging theory has been articulated also supports the notion of triangulation as the data (theory) is again compared to the ideas held in relevant literature that came from different sources, used different methods and answered different questions within a similar study topic.

- Referential adequacy

Referential adequacy was respected through the individual interviews being recorded and transcribed. Interview notes were made during the session. The naïve sketches were created by the participant and the dialogue spoken during the process of creation was recorded. These methods supported the documenting of the data generation sessions. A detailed description of the study context, participants and study methods provided referential boundaries to the data (Chiovitti & Piran, 2003:430).

- Peer debriefing

This 'devil's advocate role' (Babbie & Mouton, 2006:277) was fulfilled by the supervisor and co-supervisor. This role required the 'debriefer/s' to have a general understanding of the nature of the study such that the person was able to interrogate my thought processes, emerging ideas and decisions. The study supervisor and co-supervisor have extensive experience in the critical care environment as well as in research and are thus well placed to conduct such an intensive probing session. Once the data generation processes (in particular the analysis process) began, debriefing was done telephonically or via Skype least monthly. These sessions lasted between 1 and 1 ½ hours with my supervisors probing and questioning my application of grounded theory methods. Once the emergent theory had been articulated I spent two days with both supervisors in a face to face session explaining, clarifying and defending my methods and articulation. We engaged in regular Skype sessions, electronic communication and four more 'in person' meetings through the process during which my processes and insights were challenged and interrogated for explanation and understanding until the supervisors were satisfied with my account of the applied methods, interpretation of participants' data and argument.

- Member validation

Member validation is traditionally used in qualitative research as a way of checking that the researcher's interpretation of the data is accurate. However, in grounded theory, checking for bias or subjective interpretation as well as support for the accuracy and quality of data is built in as an integral component of constant comparative analysis and theoretical sampling. Any additional engagement with a participant is seen as another layer of data that must be analysed, not as a confirmation of the validity of interpretation. Although I did not return to the participants once an explanation had emerged, during an interview I would repeat my understanding of what the participant had shared with me to confirm that I had understood their point. If they felt I had not grasped the idea, they elaborated further until we were both satisfied that I had understood their contribution. I challenged my own ideas in this way during each interview as well. Much of the time, this manner of checking my perception was also instrumental in triggering deeper insights from the participant which assisted in creating credible links between insights offered by the participant (Elliot & Lazenbatt, 2005:51).

2.5.2 Transferability

Transferability is the extent to which the findings of this study could be applied into other contexts (Babbie & Mouton, 2006:277). Transferability is determined by the person intending to use the study and its outcome or product, and as such my responsibility was to provide sufficient information, detail and context to support a person in making that determination. Transferability was enhanced by ensuring thick description of all methods and how these were applied through the study to enable a reader to determine the transferability of the study product. I did show how this work is assimilated with and situated in relevant scholarship, further assisting a reader to determine its transferability (Chiovitti & Piran, 2003:433).

In this study 'thick description' was achieved by thorough, detailed description, explanation, reporting and situating of the data, context and theory to allow any reader to judge the transferability of the data into another context.

2.5.3 Dependability

Dependability is the extent to which the results would be similar if this study was repeated with the same or similar participants in the same or similar context (Babbie & Mouton, 2006:278). In order to do this a clear, detailed description and explanation of the context, processes, products and incidents of this study has been provided. The same description and explanation has been interrogated by my study supervisors to their satisfaction.

2.5.4 Confirmability

Confirmability determines whether the findings of the study can be traced and found within the study data and processes, that is, are the findings supported by the data and are not founded in the bias of the researcher (Babbie & Mouton, 2006:278). The nature of grounded theory method ensures that the correct application of this method will only support findings that are grounded in the data generated for the study. The detailed explanation of how the grounded theory method was implemented in this chapter, the articulation of the emerging theory in Chapter 3 as well as the use of literature as explained in Chapter 4 demonstrates clearly how the participants' voices provide the underpinning of my analysis, deconstruction and reconstruction processes, leading to the final offering of a grounded theory to explain a way that utilisers recognise 'different and better' nurses and nursing.

2.6 ETHICAL CONSIDERATIONS

Ethical research requires consideration of the scientific integrity of the research process and fundamental ethical principles - how these were applied to and 'lived out' within a study.

The study proposal and related documents were submitted for scrutiny and approval to the following committees:

- Departmental Research Committee: Nursing Science
- Faculty of Health Sciences Research, Technology and Innovation Committee (FRTI): NMMU
- The research committees or similar functionary of three private healthcare sector companies

Permission to conduct the study was granted by the FRTI committee on 17 September 2012, reference number H12-HEA-NUR-005. This permission included ethical approval for the research to be conducted (see Appendix 1). Subsequently permission to conduct participant invitation sessions in hospitals belonging to three private sector hospital groups was requested according to the processes required by each separate group. Permission was granted by two of the three private hospital groups allowing me to access two hospitals in one group and one hospital in the second hospital group (see Appendices 2,3,4).

Brink, van der Walt & van Rensburg (2006: 31) note the three fundamental ethical principles guiding a researcher to be:

- respect for persons,
- beneficence, and
- justice.

2.6.1 Respect for persons

This ethical principle holds that an individual is autonomous with the right to self-determination; any person with diminished autonomy requires protection (Brink, *et al.*, 2006:32). All participants were treated as individuals with respect for their dignity.

Within this study, the autonomy of all individuals to decide for themselves to participate in the study was respected. Prospective participants were invited to join the study through information sessions provided either verbally during the purposive sampling phase or electronically during the theoretical sampling phase. During the purposive sampling phase, three registered nurses and one significant other declined participation after initially indicating an interest in being part of the study. All contact information regarding these potential participants was destroyed.

The individuals who chose to participate were provided with written information, and the opportunity to clarify any concerns about the study prior to signing informed consent documentation (see Appendices 5,6,7,8). They were encouraged to ask questions prior to beginning our conversation, during and afterwards. All participants had my contact details and I encouraged them to make contact with me after the interview session if needed. All participants were assured that they were able to

withdraw from the interview sessions or study at any time. No participant withdrew at this point or during the study.

2.6.2 Beneficence

Respect for this ethical principle lies in every participant being protected from discomfort and/or harm that may arise from the study as far as the researcher is able to manage the research situation. Applying the principle of beneficence begins with the design, approach and methods chosen to explore the research question and then extends through all contact with a participant to the eventual dissemination of the study findings.

The congruence and suitability of using grounded theory as the approach to eliciting an answer to the posed research question has been debated in detail at the beginning of this chapter. The primary intention of grounded theory is to develop an explanation of a social process that is rooted in the participant data; this chapter provides a clear, detailed debate that this purpose was appropriate and relevant in explaining how utilisers of critical care nursing do recognise a 'different and better' nurse.

This study was a low risk study as it did not include any intervention or invasive procedure, nor did the study expose the healthcare professionals to any stressful situation that is greater than that which they would normally experience during their daily work. However, the patients' significant others who consented to participate in the study were regarded as a separate group when applying this ethical principle as their conversations held a risk of triggering variable emotional responses related to the stressful situation of a critically ill relative.

Three significant others did participate in the study; they approached the researcher thus they circumvented the use of gatekeepers. My main concern related to beneficence during the interviews was that the participant would become emotionally distressed. My plan to manage any emotional distress was based in my experience as a critical care clinical nurse specialist; I have interacted with and supported significant others of critically ill patients in severely distressing situations throughout my clinical career. I was equipped to assist and debrief the person in the immediate period of distress. Once the acute period of distress had been managed, I intended to make contact with a person identified by the participant to assist them further. Of the three

significant other participants, one did become distressed when remembering her/his experiences in the critical care unit. The interview was stopped, the participant gently comforted and reassured. I supported the participant in expressing her/his grief and memories of the period spent in the critical care environment. After a short period the participant expressed a wish to continue with the interview. On concluding the interview I determined that the participant was feeling calmer and the participant indicated that she/he was with some-one who would provide any support needed. The participant contacted me by e-mail the following day to share that while she had become distressed during the interview, she/he was feeling more positive towards the experience of critical care because she/he had remembered the good experiences that had become engulfed by the bad memories. While neither of the other two significant others became emotional, they did share that being able to speak to some-one who really understood their experiences and knew these to be truthful evoked a feeling of relief, as if another layer of stress had been taken off their shoulders.

The consent processes were applied to ensure that each participant received the information they required to make an informed decision to participate in the study. Each participant received documents to explain the purpose of the study as well as what their participation would require, how the study data would be managed and findings would be disseminated. Prior to consent being signed, the participant was encouraged to ask any questions or raise concerns about the study; these were answered by the researcher to the satisfaction of each participant. The type of clarification requested was with respect to my own motivation for conducting this study. Through making sure that the participant's had all the information they felt necessary to make an informed choice to participate, the principle of beneficence was applied.

The interviews were conducted in venues that each participant chose and thus felt comfortable and safe within. During the interview I watched the participants closely for any signs of discomfort, distress or tiredness. I had noted during the pre-test interviews that the participants became tired after speaking for about 45 minutes and therefore tried to conclude the conversation part of the interview at that duration of time.

2.6.3 Justice

This principle embodies all interactions related to fair selection and treatment of participants, encompassing the principles of anonymity, confidentiality, privacy.

Persons were invited to participate in the study guided by the study inclusion criteria. The study inclusion criteria were developed from the research question, aim and study objectives to ensure that the most appropriate group of people would be invited to participate. Participant invitation enabled individuals to choose to engage in the study. There were no incentives offered for participation.

The identity of the participant has been protected to respect the principles of confidentiality and privacy. Individuals indicated their willingness to participate in the study privately with only myself being knowing who had agreed to participate. For the purpose of identifying the individual interview and naïve sketch, each participant chose a pseudonym to label the data during analysis and reporting. The record of the person's pseudonym in relation to their real name was only available to the researcher. The employing hospital was not be identified or linked to the pseudonym of the participant, nor were the employers informed of the identities of the study participants. All participants were made aware of my intention to disseminate the findings from this work and that in this way their words may well be placed in public view; none of the participants expressed any concern or withdrew from the study as a result of this aspect.

Data recordings and transcriptions as well as any related documents (e.g. informed consent) have been stored in a safe, locked location. The recordings and documents will be kept for a period of 5 years after which they will be destroyed by myself.

2.7 CHAPTER SUMMARY

Chapter 2 provides a detailed rendering of the underpinning philosophy, research design and method applied in addressing the research question.

Grounded theory was used as the method to explore how utilisers recognise 'different and better' nurses. I explained how I chose to use constructivist grounded theory through philosophical congruence and how the departure points of this version of grounded theory in terms of the nature of the researcher-participant relationship in co-

creating understanding were carried through the parts of this study. I have shown how the specific methodological processes of grounded theory relate into the research process and how these were respected, interpreted and applied across the parts of this evolving study.

Through Chapter 2 I have explained my efforts to establish and apply a thorough, consistent and rigorous methodological foundation for this work. Chapter 3 takes its departure from this foundation as I explore the evolution of the grounded theory from the initial coding process through to my initial proposition of a grounded theory that offers an explanation of 'different and better' nurses and nursing.

CHAPTER 3

FORMING AND SHAPING THIS GROUNDED THEORY

My intention in Chapter 3 is to show and explain how I reconstructed an explanation of 'different and better' nursing from the participants' data. Through the following pages of discussion and explanation I will convey my understanding of the meaning revealed through the insights, sentiments, feelings, beliefs, opinions, stories and ideas in the thirty eight items from the participants' data sets. Chapter 2 detailed the complexity and depth of the data generation processes, these being data collection and data analysis, as I engaged with the data sets, the codes and evolving categories to arrive at an emerging explanation of how utilisers recognise a 'different and better' nurse. This chapter adds the substance of meaning and explanation to the nuts and bolts of Chapter 2 such that the form and shape of this grounded theory in explicating categories, concepts, actions, processes and relationships of interaction or support is revealed.

The discussion is complex - each category is a multifaceted, intricate, intra-active grouping in its own right whilst also being one of four interwoven, interacting categories of the core concern. I have attempted to keep the narrative simple and concise but, with that said, this is a detailed account of a complex phenomenon that will benefit from careful and steady reading absorb the complexity and nuances of this narrative explaining how utilisers recognises 'different and better' nurses and nursing.

I have divided my account of what the data revealed into two parts. The first part I have named *Forming the Grounded Theory* and the second part, *Shaping the Grounded Theory*. I use the first part to explain how the categories became refined, focussed and linked; and how these supported the core concern of the participants to become evident. In the second part of my account I explain each category in detail, clarifying the facets and interactions of the concept groups that form each category.

3.1 FORMING THIS GROUNDED THEORY

Chapter 2 provides a detailed explanation of the coding processes (initial and then focussed coding) and the other grounded theory method principles that I applied to first fracture the data and then reconstruct an explanation of how 'different and better'

nursing is recognised by utilisers. Chapter 3 begins with the first nine broad initial categories to surface from the sea of codes during focussed coding as explained in Chapter 2.

- nine initial categories emerge

I provide Figure 3.1 as a reminder of the data generation processes that led to these first nine tentative categories emerging from data sets 1-5.

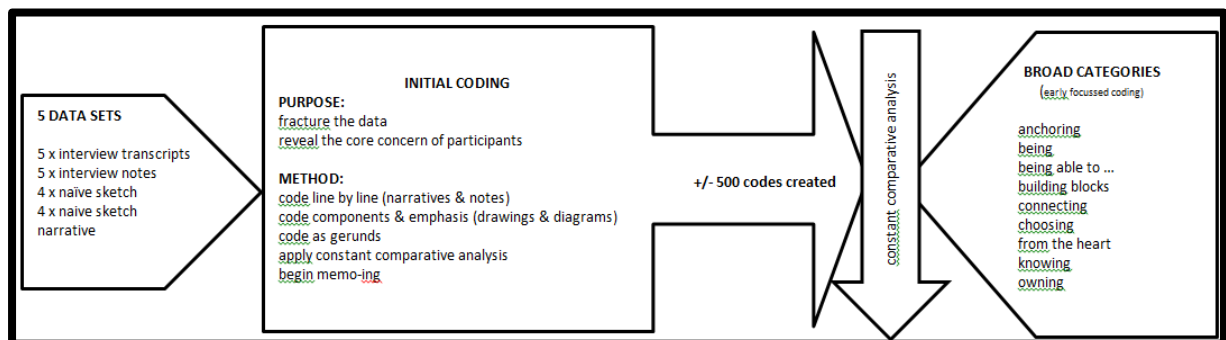


Figure 3.1 A summary of the methods through which the initial 9 broad categories emerged from data sets 1-5.

The initial coding processes resulted in more than 500 codes being elicited from data sets 1-5. Early focussed coding supported these first nine broad categories listed below to emerge from the data:

- Being able to
- Being
- Knowing
- Anchoring
- Connecting
- From the heart
- Building blocks
- Choosing
- Owning

From nine categories to seven categories

I continued to refine and develop these 9 initial categories through reflecting on and working with the data generation processes (described through section 2.3.3 in

Chapter 2). I wrote or drew memos for each category to elaborate what that category meant broadly to me and how it was grounded in the data. I then considered each category and reflected on any connections between categories that would make one become part of another. This process was informed through applying the same set of coding questions previously referred to in sections on initial and focussed coding, and in this manner, through applying constant comparison between these first tentative categories, two categories became subsumed into other categories forming seven categories.

The category 'choosing' was moved into the category of 'knowing'. 'Choosing' grouped together those codes that showed the deliberate, personal actions of a nurse to use their self and opportunities to be a different and better nurse. On reflection I felt these codes sat well within the category of 'knowing' because they showed another way that the different and better nurse understood her/himself and how to apply this insight to their interactions within the environment.

The category of 'owning' became part of the category of 'connecting'. I saw 'owning' to be the ways that the nurse showed her/his presence in an encounter; the ways of taking responsibility, accepting a situation within its particular circumstances and then working to a best outcome. The codes gathered together in the category of 'owning' offered insight into the dynamics of creating a connection with a participant which was experienced honest, real and true.

Table 3.1 below identifies the seven categories along with a brief description from my memos of what I saw that category to mean.

Table 3.1 Seven emergent categories: labels and descriptions

CATEGORY LABEL	DESCRIPTION
<i>Anchoring</i>	the actions or processes that introduced the idea of the nurse holding the participant in place in some way such that the participant felt safe and enabled to continue without losing their own power, identity or control over their life
<i>Being</i>	the qualities of the nurse's essential nature or her/his ways of being that were recognised by the participants rather than the activities or 'doing' qualities, often described as feelings
<i>Being able to</i>	the manners of engaging within the actions of nursing; the skills recognised within the nurse's ways of doing the activities or

CATEGORY LABEL	DESCRIPTION
	interactions of nursing rather than the feelings that were evoked within the utilisers
Building blocks	external support systems or elements recognised by participants as prerequisite to enable different and better nurses to develop and thrive
Connecting (codes of 'owning' assimilated here)	ways of engaging meaningfully where the participant felt they were the centre of that nurse's world; an experience of an honest, real and true connection
From the heart	intangible qualities or characteristics (for example: <i>having alive eyes</i> , or <i>her heart was like a lion's heart</i>)
Knowing (codes of 'choosing' assimilated here)	the way the nurse seemed to have insight into their true nature or concept of themselves, and their ability to use this insight intuitively during any type of interaction with a participant

The seven categories provided the foundation from which I applied focussed coding to the remaining five data sets (data sets 6-10) and moved to creating a mind map for each category with its constituent codes. As an example, Figure 3.2 shows part of the mind map for the category 'being able to ...'. The category label is depicted in the blue block with the two main concept groups in the white blocks extending from the category label. The characteristics, actions or processes related to each concept group extend from the concept group label. The small (+) signs next to some of the concept group actions indicate where additional detail is available at that level of the mind map – in the interests of ease of reading the fully expanded mind map is included as Appendix 17.

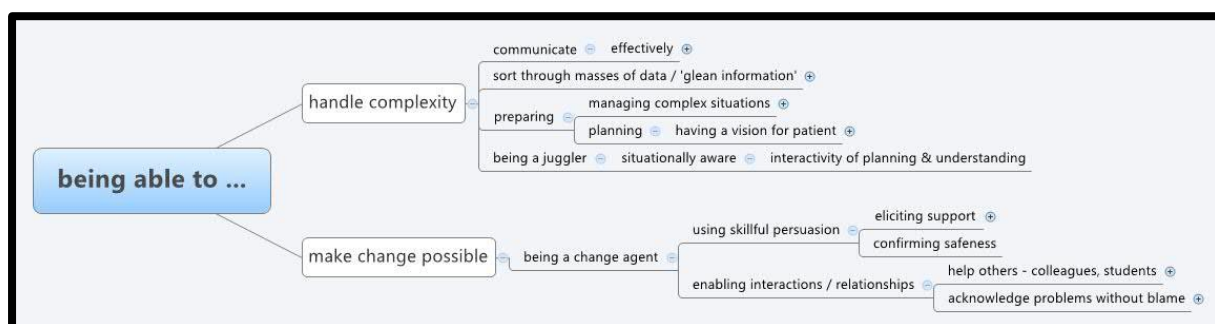


Figure 3.2 Being able to ... - an example of an early category mind map

From seven to five categories

Through applying the processes of focussed coding to the analysis of data set 6, it became apparent that the number of categories could be refined from seven to five

categories. The category of 'from the heart' merged into the category 'being'. Coding of data set 6 showed that those intangible qualities and characteristics seemed to be an expression of the nurse's humanity and thus the codes gained a better fit within the subcategory of 'offering their humanness' within the category of 'being'.

The category 'building blocks' was merged into the subcategory 'being trusted' within the category labelled 'anchoring'. The codes forming the subcategory of 'being trusted' seemed to show how the process of 'being trusted' begins with the choices and actions of the nurse her/himself. The codes of 'building blocks' form part of a broader foundation that contributed to 'being trusted' – the ways by which the nurse seemed to begin 'anchoring' a participant.

Thus after the analysis of data set 6, the five categories of seeming significance that had emerged from the participant's conversations and sketches were:

- Anchoring (codes of 'building blocks' assimilated here)
- Being (codes of 'from the heart' assimilated here)
- Being able to ...
- Connecting
- Knowing.

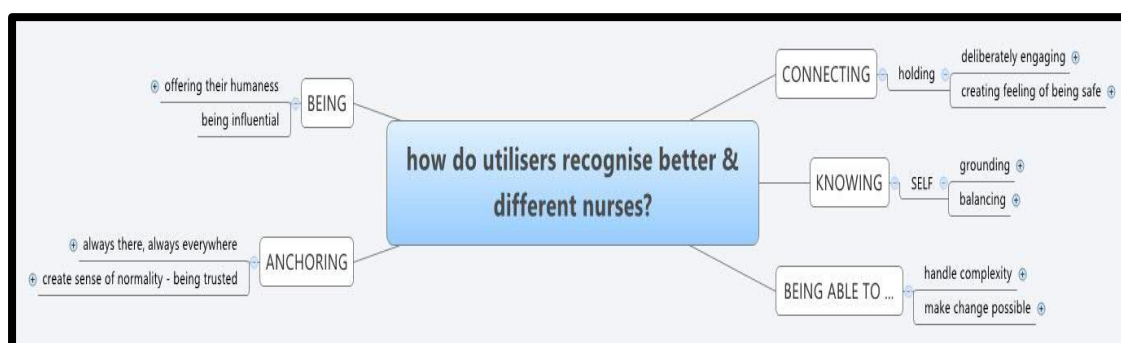


Figure 3.3 Five emergent categories with concept groups

Figure 3.3 shows each emergent category with its particular concept groups, Appendix 18 provides an expanded view of one of the categories to demonstrate the codes within that category. The interplay of the concept groups forming each of the categories began to reveal the complexity and depth of how utilisers recognise a 'different and better' nurse and nursing within their interactions. As I explained in the previous chapter, at this point in the data analysis process I used a condensed version

of the research question at the centre of the mind map of categories as I did not want to presuppose a core concern or the possible relationships between categories. In Table 3.2 I have listed the categories in alphabetical order along with the concept groups that formed each category and a short description of each concept group.

Table 3.2 Five categories with their concept groups and a description

CATEGORY	CONCEPT GROUPS	DESCRIPTION
Anchoring	<i>'always there, always everywhere'</i>	the ways the nurse was experienced as a constant and safe presence in the participant's personal environment
	<i>creating a sense of normality – being trusted</i>	the ways the nurse created trusting partnerships that enabled the utiliser to continue with the normal business of their life despite the complexity of the critical care experience; this applied to all participants
Being	<i>being influential</i>	the ways the nurse used her/himself to affect the experience or behaviours of others she/he engaged with
	<i>offering humanness</i>	the ways the nurse shared her/himself as a person within the relationship with a participant; allowing connections to be made because of the evidence of the nurse's own human frailties or imperfections; including evidence of deeply felt emotions
Being able to ...	<i>handle complexity</i>	the ways the nurse is able to work in the grey areas of care, the knowledge and skills that she/he applies in order to be comfortable with uncertainty and be able to make sense of an unpredictable situation
	<i>make change possible</i>	the ways the nurse's behaviour, attitude or manner enabled others to feel valued and able to contribute, often beyond what the participant perceived themselves to be able to do
Connecting	<i>deliberately engaging</i>	the ways the nurse shows that a person is the complete focus of her/his attention and action at that time
	<i>creating a feeling of being safe</i>	the ways the nurse establishes her/himself as a dependable constant presence in the world of the participant
Knowing self	<i>Balancing</i>	the ways the nurse integrates the sense of her/himself within her/his understanding of being a nurse, how this sense of self strengthens her/his presence as a nurse
	<i>Grounding</i>	the ways the nurse regains her/his centre of self within complex and unpredictable circumstances

Using these emergent and developing categories as a starting point, I continued into focussed coding of data sets 7 and 8 after each of these interviews were completed. My analysis of each of these data sets confirmed my interpretation and grouping of the codes within the above categories. Relationships between codes that had been tentatively established during analysis of data set 6 became more clearly established and developed. Each category matured with its particular actions and processes becoming more explicit. Interactions within and between the five categories became more obvious and formed.

Figure 3.4 depicts an example of the maturing of the category 'Being', this mind map depicting the coding after 8 data sets had been analysed. As data generation elicited the particular characteristics, actions and processes inherent to that category the mind map developed in complexity. When relationships between concepts or processes became evident, I indicated the relationship in terms of directionality with a blue dotted line and arrow (see Appendix 19 for a larger view of this mind map)

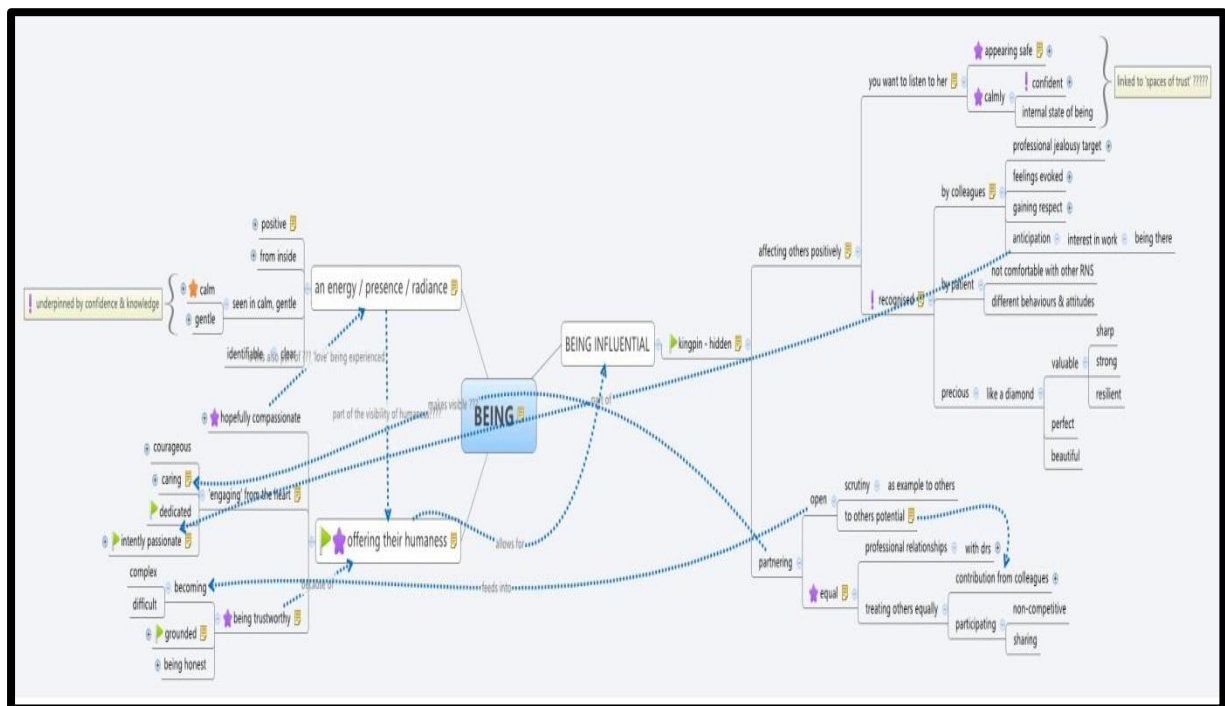


Figure 3.4 'Being' – an example of a developing category after analysis of 8 data sets.

Five categories to four plus an emerging core concern

Through continued data analysis, relationships and interactions between the categories emerged, becoming more distinct through the process of constant comparison. When eight data sets had been analysed, the focussed coding process led to the categories becoming more refined and specific in terms of internal processes of, as well as relationships between, categories. As is the nature of data analysis and category development in grounded theory method, some categories were subsumed into other categories and some were relabelled as the actions and processes within categories were developed and explicated.

‘Skilled knowing’ developed as a category to bring together the categories of ‘being’ and ‘being able to ...’. In my reflecting on the data underpinning the codes of these categories I felt that they were rather two halves of one whole and not two separate categories. By integrating the codes of ‘being’ and ‘being able to ..’, the category ‘skilled knowing’ explains tacit as well as explicit ways and means in which the nurse applies her/his deep, complex knowledge base, understanding and insight to interactions with utilisers. This left four categories, i.e. ‘knowing self’, ‘skilled knowing’, ‘connecting’ and ‘anchoring’.

The progression from four separate categories to an interrelated, albeit tentative and preliminary, first explanation of the participants’ core concern (which seemed at that moment to be ‘anchoring’) is offered below. At this time, the category ‘anchoring’ seemed to be the evolving core concern of the participants in recognising nurses who stood out in a positive way with the other categories elaborating the ways and means that facilitated this core concern.

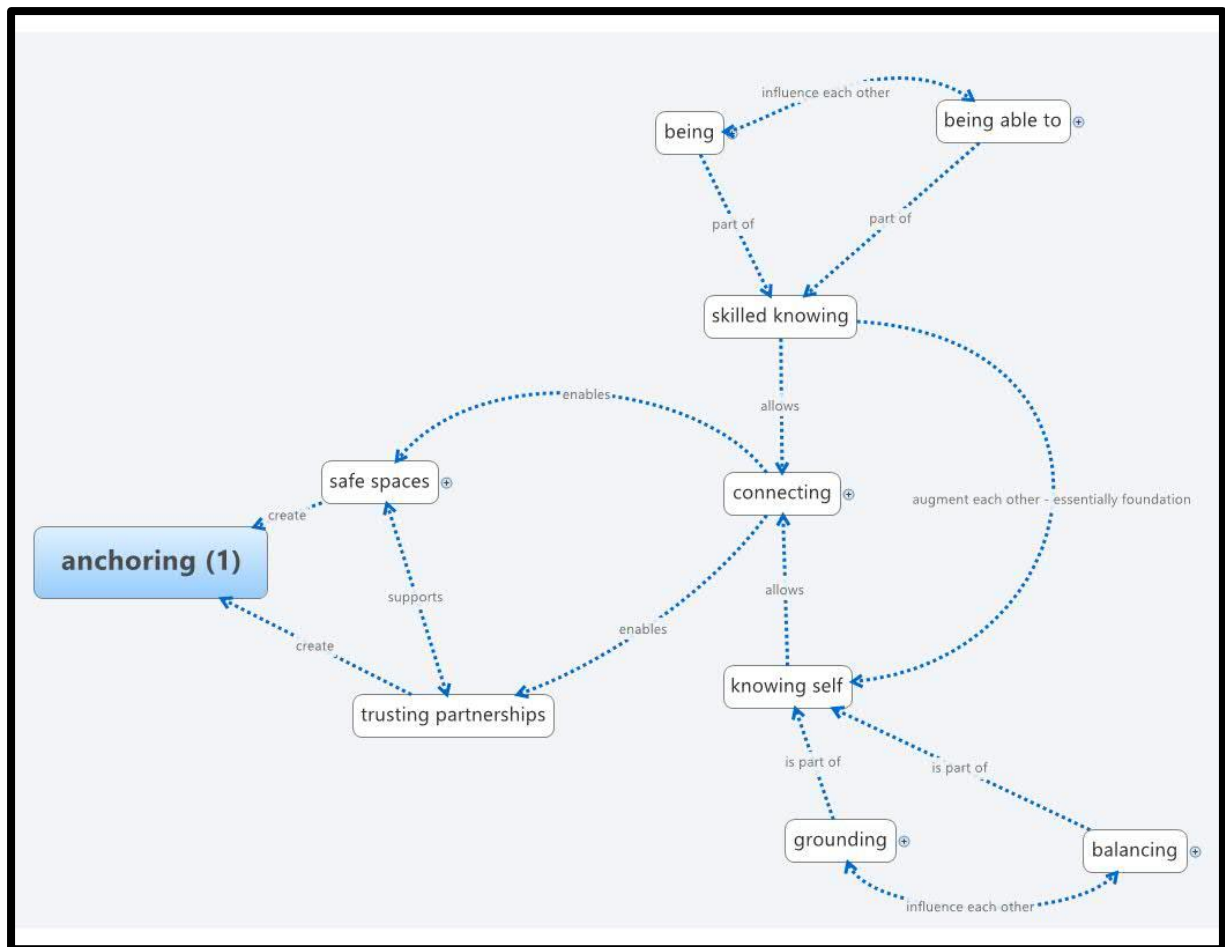


Figure 3.5 Mind map of ‘anchoring’ as the preliminary core concern – initial draft

Figure 3.5 offers the mind map of what I considered to be the preliminary core concern at this point of data analysis, i.e. ‘anchoring’; with the emerging relationships between itself and the other categories.

The foundation required for ‘anchoring’ to be recognised by a utiliser seemed to have its origin in the categories of ‘knowing self’ and ‘skilled knowing’. ‘Knowing self’ remained a separate category to ‘skilled knowing’ due to the emphasis placed on this quality by the participants, however it was clear from the participants’ data that ‘knowing self’ and ‘skilled knowing’ augment and influence each other as well as the other categories. The interaction between ‘skilled knowing’ and ‘knowing self’ seems to provide an essential foundation for the experience of ‘anchoring’ to become apparent to a utiliser. Further, the interaction of these categories provide an embedded influence in the processes and actions of ‘connecting’ and then into ‘anchoring’.

When 'connecting' was established to be a category of 'anchoring', I relabelled it as 'connecting through intentional engaging'. I felt that the new label more accurately reflected the relationships, processes and actions encompassed by the category. 'Connecting through intentional engaging' is initiated, underpinned and then facilitated through the interaction of 'skilled knowing' and 'knowing self'. 'Connecting through intentional engaging' during the utilisers' interactions with nurses they felt had stood out in a positive way enables the participant's experience of 'anchoring'. This first explanation of 'anchoring' as an emergent preliminary core concern (see figure 3.6) is offered only in brief as both the core concern and explanation evolved further with the analysis of data sets 9 and 10.

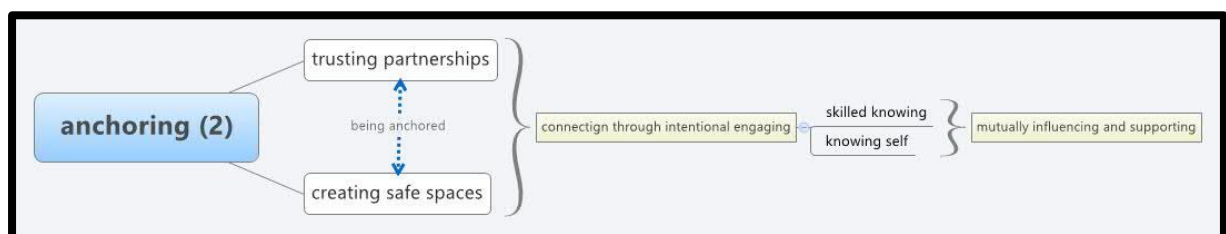


Figure 3.6 Mind map of 'anchoring' as it evolved after reflection on data

Reflecting on 'anchoring' as the preliminary core concern elicited more questions to try to clarify and refine actions, relationships and processes revealed through the data analysis process to this point. I used these questions to focus my analysis of the two remaining data sets to further uncover and explain the true nature of the core concern and related categories. Examples of questions I grappled with after reflecting on the initial core concern and its categories on included:

- does 'knowing self' really stand separate to 'skilled knowing' or are the qualities of this subcategory part of the ways of 'skilled knowing'; how are the qualities in these two categories similar and different, do they merge somehow?
- Does the category 'knowing self' actually provide the form and fibre that enables the category 'skilled knowing'?
- Does the label 'skilled knowing' really capture the essence of the subcategory?
- Are 'creating safe spaces' and 'trusting partnerships' sufficiently substantial to exist separately as supporting processes of 'anchoring' or does one create the other, i.e. I trust you because I feel safe OR I feel safe because I trust you OR I am anchored because I feel safe and I trust you OR ...?

- Does 'anchoring' fully capture the essence of recognising critical care nursing practice that stands out positively?

I used the questions during my analysis of the remaining two data sets (created with participants 9 and 10), but remained open to the possibility of different priorities coming to the fore. To this end I continued to apply the process of working through and with the data as I have described using constant comparative analysis and memo writing. Appendices 20 and 21 show how two of the mind maps developed during analysis of interviews 9 and 10 (the additions in blue and pink ink reflecting the contribution from these two interview sessions). Through reflecting on the participants' words and stories in the data sets 9 – 10, and deliberating on the meanings of the words 'knowing' and 'being', I changed the label of the subcategory 'skilled knowing' to 'skilled being'. By using the word 'being' rather than 'knowing' in the category label, I felt that this label created a more succinct embodiment of the actions and processes of the category. Thus, 'skilled being' came to illustrate the interplay between the nature of being and doing nursing that is recognised as different and better; the enactment of those qualities showing the individual's conscious existence within the roles and spaces of nursing.

The data from the interview with participant 9 included a focussed discussion on the concept of self and how this concept engaged with the participant recognising different and better practice by a nurse. I deliberately introduced the concept of self into the interview discussion as the data from the previous interviews had indicated that knowledge and understanding the nurse has of her/himself seemed to hold a particular place and importance in relation to the preliminary core concern of 'anchoring'. Through analysing the discussion with participant 9, the data confirmed that a nurse's concept of her/himself formed the foundation for all further interactions that ultimately led to that person recognising the nurse as being 'different and better'. The subcategory 'knowing self' became more explicit in terms of its fundamental influence on the participant's recognition of a different and better nurse, as well as in the detail of the particular concepts (i.e. 'being grounded' and 'being balanced') within the subcategory and the interaction between these concepts. Discussion with participant 10 about the concept of 'self' further established that the subcategory of 'knowing self' seemed to underpin all the other categories and ultimately, the core concern. 'Knowing

self' appeared to be seen as that which enabled a nurse to engage with others as fellow human beings.

Interviews 9 and 10 also contributed specifically to my refining the subcategory 'connecting through intentional engaging'. The particular ways of the different and better nurse in engaging with a participant or the participant's observation of this nurse engaging with another were developed. The influence of the subcategory 'skilled being' into 'connecting through intentional engaging' in terms of feelings and actions became more obvious. Visible or tactile evidence of the substance and quality of a nurse's skill enabled a connection to be established between the nurse and participant. Once established, the nurse seemed to use the connection intentionally to create an experience of feeling safe for the utiliser; this along with the concepts of 'anchoring' led to the creation of a trusting partnership. Through this analysis, I came to realise that 'anchoring' explained concepts that developed from 'connecting through intentional engaging' but also that these concepts were instrumental in developing and supporting the actions and processes of 'connecting through intentional engaging'. I shortened the label of the category to 'connecting with intention' for ease of use. The data from these two interviews helped me to realign 'connecting with intention' as being equivalent to 'anchoring' in the participants' recognition of different and better nurses. 'Anchoring' was repositioned as a subcategory alongside 'connecting with intention'.

Thus by realigning 'anchoring' and 'connecting with intention' as equivalent interacting categories, I had to broaden my understanding of the participants' core concern. I reflected on all the recordings, transcripts and naïve sketches again. During this process of reflection and re-engagement with all the data sets, I noticed that through the conversations and drawings there were coherent interweaving tacit expressions of the participants feeling relieved, feeling happy, feeling warm and relaxed, feeling less tangled in uncertainty and being more able to continue with the requirements or necessities of their lives through their interactions with this different and better nurse. This tacit interwoven thread through the data portrayed more than the concepts clustered in the category 'anchoring', rather evoking that the participants were experiencing a feeling of being at ease through feeling that the nurse was also at ease in her/his being a nurse doing nursing. Through this experience of being at ease in the

presence of a nurse who the utiliser felt was at ease within her/himself, they recognised that nurse as standing out positively, providing a different and better experience of nursing. Through reflecting on and comparing the idea of 'being at ease' to the data and categories that had already emerged, 'being at ease' was supported as being the core concern of the participants in recognising a different and better nurse or nursing. 'Being at ease' speaks to both the participants' feeling within themselves from their interactions with a nurse and their experience of that nurse seeming to be at ease within her/himself.

Consequently, the emerging grounded theory shifted its form and category interaction to reflect the core concern of 'being at ease' and its categories. Figure 3.7 summarises the emergence of the core category with its four related categories from the beginning point of the more than 500 codes ensuing from the initial coding process.

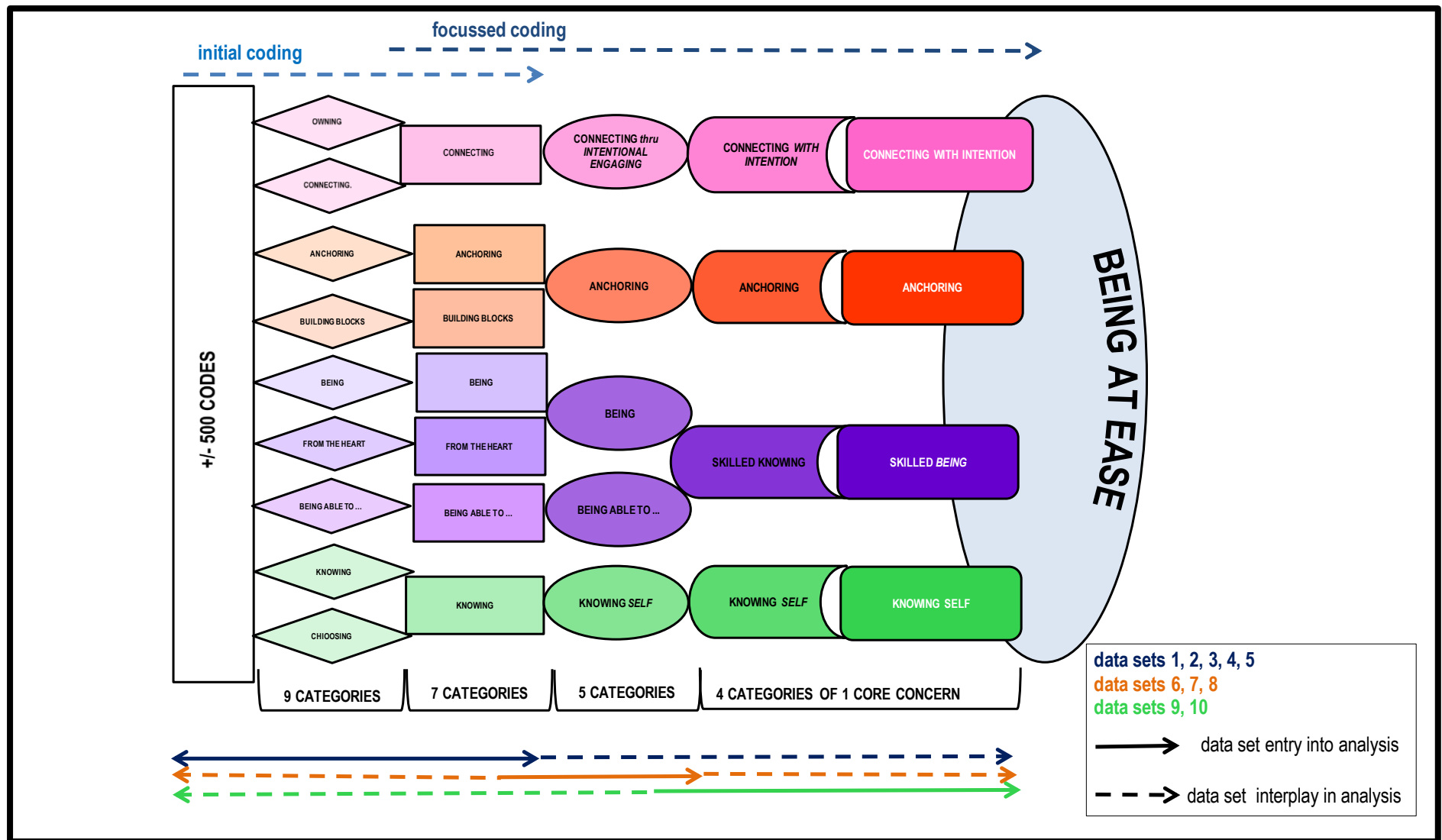


Figure 3.7 Emergence of the core concern through the grounded theory coding processes

3.2 SHAPING THIS GROUNDED THEORY - *BEING AT EASE*

The core concern (core interest or issue of importance) of participants in recognising nurses or nursing that is different and better is within their subjective feeling of 'being at ease'. This experience is felt within the participant themselves and develops from their encounter with the nurse who they experience as seeming to be at ease within her/himself.

The processes and interactions of the core concern of this grounded theory are expressed in four categories. Two categories ('connecting with intention' and 'anchoring') depict the qualities underpinning the participants' experience of 'being at ease', while the remaining two categories ('skilled being' and 'knowing self') depict the qualities that utilisers recognise as a foundation that a nurse seems to need to be able to influence the utiliser in 'being at ease'. Figure 3.8 depicts the mind map of the core concern with its related categories and linking relationships between these.

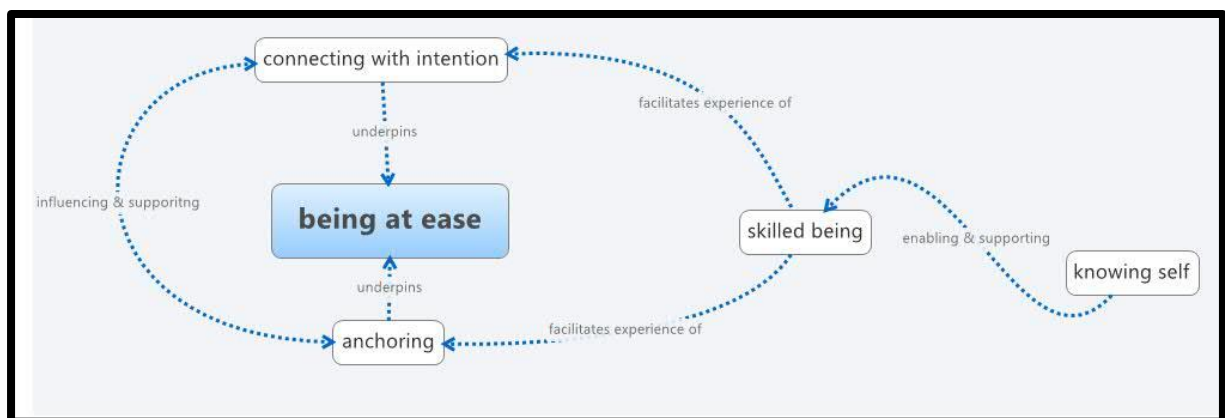


Figure 3.8 'Being at ease' – categories underpinning the core concern

The subcategory of 'knowing self' provides the beginning point from which different and better nursing begins to manifest, enabling and supporting the subcategory of 'skilled being'. It is within the interactions and influences of these categories that the nurse is experienced by the participant as 'being at ease'. 'Skilled being' then provides and enables the qualities in or of that nurse to facilitate 'connecting with intention' and 'anchoring' to be experienced by the participant – ultimately culminating in the participant's experience of 'being at ease'.

The following subsections provide a detailed rendering of each of the categories and the interactions of these in leading to the core concern of 'being at ease'. The discussion and explanation of each unfolds as follows:

- I open the discussion of each subsection with an excerpt from the participants' data, either a quote or picture from the interview or naïve sketch, which succinctly pulled together for me the essence of that particular element of 'being at ease'. I have not explained or discussed these introductory glimpses into the participants' ideas, rather wanting these to stand untouched as the mooring point between my reconstruction of meaning from our (mine and the participant's) co-created understanding of the elements that result in the utiliser's experience of 'being at ease'.
- I use mind maps to illustrate and summarise the elements within the categories and the concept groups; namely the actions, processes and relationships revealed in the data.
- I offer detailed discussions and explanations of the interactions, influences and effect these elements have on each other to shape the categories and then the core concern.
- I have included relevant quotes from the data sets to indicate how my analysis is grounded in the words, pictures or diagrams of the study participants.

3.2.1 Category - Knowing Self

What do you think is there at the beginning? Self-knowledge and understanding. (i2:055)

The subcategory 'knowing self' makes explicit the juncture between ways the nurse sees, experiences and understands their own nature with how this foundation of self-knowing effects and affects the participants' recognition of a different and better nurse. The actions and processes inherent to this category were regarded by all the participants as essential to creating a stable underpinning which enables nurse-utiliser relations to be recognised as being different and better. 'Knowing self' was seen to be the foundation required for the nurse to engage genuinely with others as fellow human beings through having insight into her/his true nature or concept of self, and their ability to use this insight intuitively during any type of interaction with a participant. 'Knowing

self' developed as a subcategory through codes from the participants' data that coalesced into two appreciable concept groups, 'knowing self' is seen in:

- grounding self
- balancing self.

Figure 3.9 shows these two concept groups, their relationship with each other and in underpinning 'knowing self'.

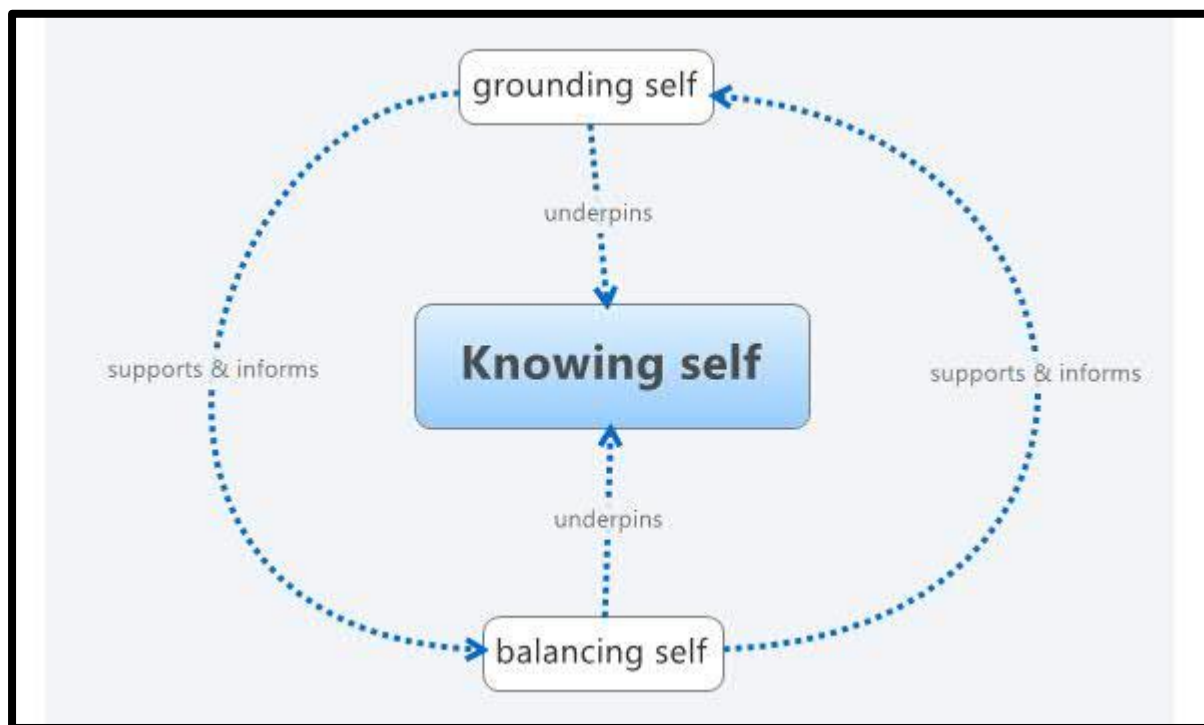


Figure 3.9 'Knowing Self' – concept groups and relationships

This conceptual skeleton emerged early in the data collection and analysis process. I was therefore able to thoroughly probe and deconstruct the actions and processes of these concepts during the interviews and following analysis processes. One particular interaction I grappled with was whether these concepts stood apart from each with a supporting interaction between them, or whether 'balancing self' was rather a process of 'grounding self'. However, through the last two interviews the data demonstrated that 'grounding self' and 'balancing self' are two separate concepts of 'knowing self'. Each concept has particular unique processes, but there is an influencing and supporting interaction between the concepts in that each one must exist for the other to be experienced. This means that the different and better nurse must be grounded

in her/himself in order to have balance in the interplay between her/his sense of self within her/his sense of self as a nurse; and vice versa.

3.2.1.1 Grounding self

It's something they know ... that they know about their own abilities or strengths, definitely sorted out, sorted out in a calm sort of way (i7:071)

Data analysed up to and including interview 6 led to my understanding of 'grounding self' as the ways the nurse regains her/his centre of self within complex and unpredictable circumstances. Through following interviews and analysis, my understanding of the participants' perception of this concept deepened, revealing that it is the nurse's sense of self as a person first that is at the core of the ways the person regains her/his centre within complex and unpredictable circumstances in nursing.

The person's sense of self is the awareness or consciousness she/he has of her/his nature – her/his intrinsic qualities and their place in the broader concept of humanity. When a person is able to couple her/his sense of self with an understanding and acceptance of these qualities, she/he is seen by the participants as being grounded.

Grounded, connected. They stand up for what they believe in but I think they have nurtured themselves, their own sense of confidence and self-worth. I think self-worth is essential, you can't ever hope to intervene if your self-worth is not pretty solid because why would you put yourself at risk, you've got to be willing to influence these connections when they are possibly broken or not quite great, - your self-worth must be pretty solid.(i2:181)

Individuals develop a sense of self through confronting and engaging with the qualities and life experiences that make them a unique individual with respect for their own humanity. In particular, the individual has been open to her/his own experiences of suffering. She/he has been able to engage with whatever the experiences of suffering were, make sense of the experience and use this personal journey to be receptive to the pain and suffering of another. The actions and processes as well as the relationships through which 'grounding self' emerges are shown in figure 3.10.

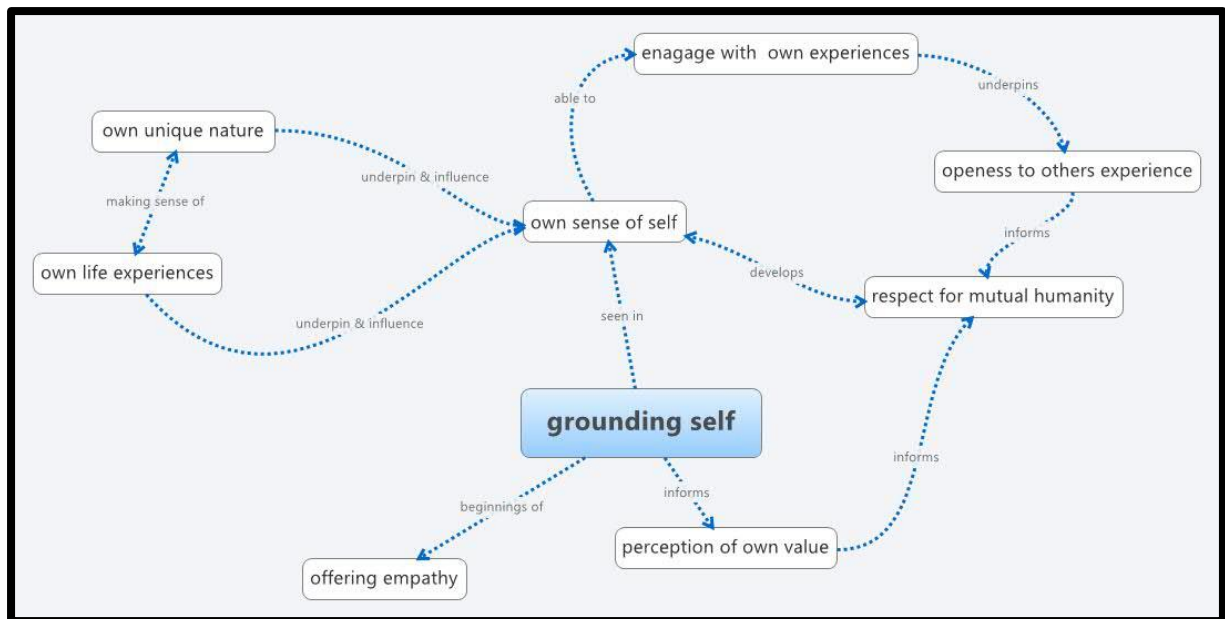


Figure 3.10 'Grounding Self' - actions, processes and relationships

The participants saw the actions of 'grounding self' to be where empathy is created, firstly empathy for the individual's own experiences which then enables the same individual in a nursing role to be empathetic to the experiences of another. By navigating a personal experience of suffering to a point of feeling healed or to an accepted outcome, an individual is enabled to imbue her/his nursing with the understanding of what sickness is and what goes with it. Thus within the individual's role as a nurse she/he can respect another's experience of suffering, recognising the humanness of the other and being open to that person's particular experience without clouding this with their own pain

... if they ever suffered something difficult, ... if they have experienced something similar because they understand the emotions that you are going through ... the openness with what she treated us and that she like respected us as the family and also as human beings and the fact that she gave a bit of herself in the sense that you know, so I understand what you're experiencing although my experience wouldn't be exactly like yours but I'm giving you space to have your experience. (i10:064 - 068)

Through confronting life experiences as well as the impact, strengths, frailties and subtleties of the qualities that form one's nature, the individual 'sees' her/himself or gains a sense of self. In gaining a sense of self, she/he is able to be more open to

respecting the experiences and responses of another person. In this way, the other is seen first as a fellow human being who currently occupies a particular role (e.g. a colleague or significant other). Thus by 'grounding self', the choices that shape any interaction between the person and another are made from respect for their mutual humanity.

'Grounding self' facilitates the separation of the person's perception of her/his value from the outcomes of interactions with patients, colleagues or significant others. She/he knows the landscape of her/his abilities and limitations, using these to inform her/his sense of self rather than be shaped by success or failure in an interaction (e.g. a poor patient outcome). A person who has developed a sense of self is seen by the participants to depend less on outside influences to support their self-esteem.

I think that also comes from a point of knowing yourself, I think it comes again back to that security and that the nurses that are able to say I know I'm okay with this, ... and I think often umm people that haven't done emotional work are not at that space and are very dependent on outside influences (i9:085)

The actions within the concept of 'grounding of self' influence the concept of 'balancing self' through providing the means to both separate the self from the role of nurse, as well as to integrate the self into the role of a nurse.

3.2.1.2 *Balancing self*

I think the nurse that does really well is able to engage fully but absolutely let it go (i9:017).

This concept is explained in the actions of the individual to equilibrate and sustain the balance between the self as an individual and the self when taking on the role of being a nurse. My broad understanding of the participants' data related to the concept of 'balancing self' remained the same through the data collection and analysis processes; this being the ways the nurse integrates the sense of her/himself within her/his understanding of being a nurse, how this sense of self strengthens her/his presence as a nurse. Figure 3.11 depicts the actions and processes through which 'balancing self' occurs and is experienced.

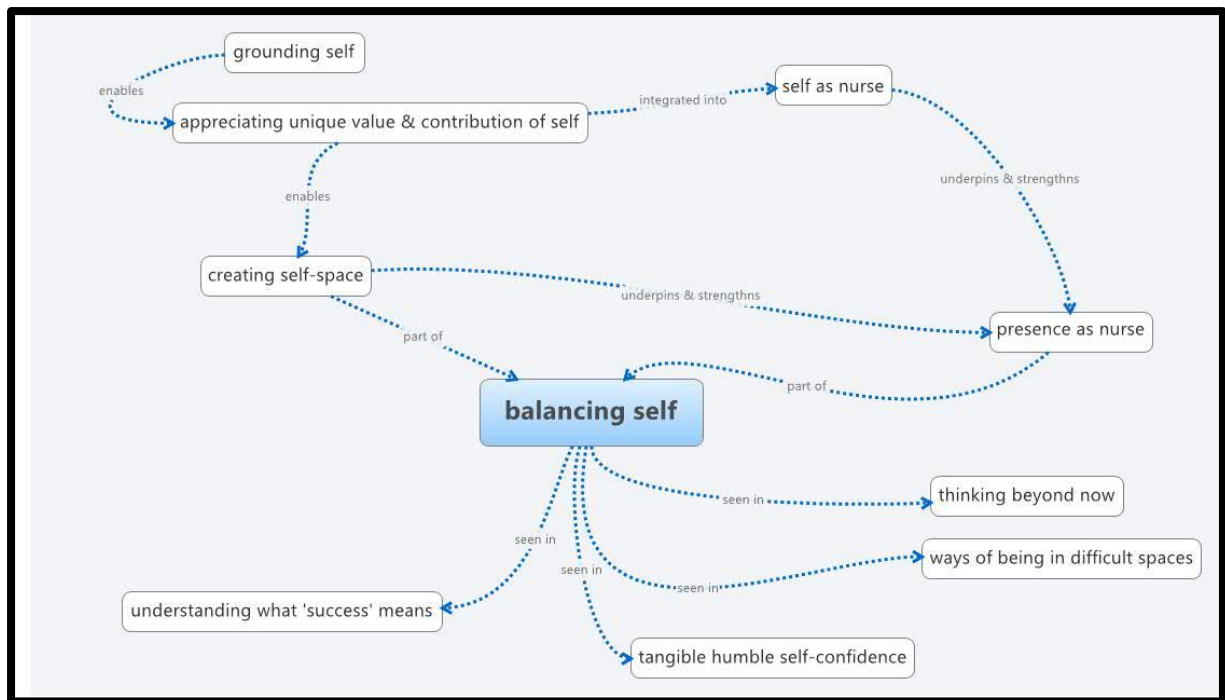


Figure 3.11 'Balancing Self' - actions, processes and relationships

The crux of the balancing actions seems to lie within the individual knowing and appreciating their value in terms of her/his sense of self (developing from the actions underpinning 'grounding self'), and what she/he brings as a unique individual to the role of a nurse as well as the world of nursing. The grounding of self as explained in the previous section leads the individual to being able to accept her/himself in terms of personal strengths and weaknesses, and work with these attributes to the benefit of a nurse-utiliser relationship. A balanced sense of her/his individual value whilst living out the roles of nursing is evidenced by a tangible self-confidence that infuses through the activities and the interaction of that person's nursing. The different and better nurse is secure and happy in her/him being a nurse, and enacts this in confidence without arrogance or competitive, comparative behaviours.

The majority of good ICU nurse are strong characters without being aggressive, they know what they're about (i5:071)

The better and different nurse doesn't think she is superior to her colleagues. She knows that okay she's good but she doesn't use that as a weapon ... She knows how she fits into this picture (i2:069)

An important manifestation of the individual's clarity of understanding of what nursing is and what nursing means to them was seen by the participants in the nurse's manner of going beyond the obvious. The different and better nurse goes beyond seeing the patient as 'just a body in the bed'. Her/his attitude is one of enquiry, curiosity and anticipation, the approach broad and deliberate to move her/his understanding of a situation beyond what is available at that moment. She/he is able to interweave the multiple sources and modes of knowledge that may be gained from patient interactions, or with others, from data, from theory, from experience and from within her/himself, to consider other possibilities. She/he understands being part of something that is greater than her/himself and that there are intangible influences at play in every interaction.

Participants' noted that the balance created by the individual between the self as a nurse and nurse as self is fundamental to the nurse being able to create distance necessary for the complexities of the environment and relationships in critical care. By creating a distance between her/his roles as an individual with the various challenges of daily living and the roles of being a nurse, a space is opened that the nurse uses to focus on her/his priority for the time in the critical care unit; usually placing the patient in the centre of this space.

Further to creating a focussed space for living out the role of a critical care nurse, the ability to establish the distance between one's self as an individual and one's self as a nurse also supports the nurse being able to tap into what I have termed a 'self-space'. The 'self-space' seems to be used by the different and better nurse as way of sustaining their link with their own humanness. Participants' spoke of noticing that different and better nurses are able to deliberately disengage from the nursing role for brief intervals, sometimes only moments, and reconnect with their core self, regaining their sense of self within the environment. Tapping into this 'self-space' supports the different and better nurse in being able to underpin interactions with compassion, be realistic when engaging without being experienced as hard or uncaring; and engage fully within the demands of the critical care environment dynamics but be able to disengage their self-worth from the outcome of those dynamics.

They certainly are realistic without being hard, they maintain their compassion but they are able to distance themselves a little bit at the appropriate times (i5:079)

The other end of 'balancing self' is within the individual's sense of self strengthening her/his presence as a nurse. Through developing a sense of self through the actions of 'grounding self', she/he is better able to appreciate the breadth and depth of being a nurse, more able to live out the often fluid world that is nursing. Different and better nurses are recognised through the actions showing that she/he views traditional or habitual borders of nursing as flexible and interpretable depending on a particular set of circumstances at a moment in time. The focus is on being what she/he understands a nurse to be and doing what she/he understands nursing to be.

The way she/he interprets her/his role within nursing is evidenced in the comfort with how she/he and nursing fit into the larger world of healthcare. From a stable sense of self, she/he is able to work with the complexity and unpredictability of the critical care environment, knowing how to apply the rules but also how to reshape the rules with respect for the patient and others involved. This ability to move beyond a rigid interpretation of the function of a nurse exposes her/his understanding of what success means in the being and doing of nursing. She/he understands the usefulness, impact and value of the role without self-importance. From this point of departure of focussing on being a nurse, a foundation is laid for equal relationships with patients, significant others and colleagues that are enacted within 'skilled being'.

They are comfortable doing what they do. They, in their own mind, feel confident and they feel as though they pretty good at what they do and that they are making a difference (i5:075)

A further aspect of 'balancing self' that has reference to the individual's presence is the perception among the participants that these different and better nurses have clarity in knowing what is needed to function wholly and effectively in the dynamics of the environment. The nurse appears to be at ease in the difficult spaces of the environment as well as the difficult spaces of critical illness. The knack of confronting difficult situations, unacceptable circumstances or inappropriate behaviours within the environment is expressed through her/his 'skilled being'. She/he does not avoid being

part of some-one else's challenging experiences, intentionally making time to engage with that experience through talking to, touching or simply being present with the person. The difficult spaces most often spoken about by the participants where these actions were shown was the suffering experienced by some patients and significant others, the violent intensity or slow excruciating passage of dying and the regular encounter with death in its many forms.

Ja, knowledge of themselves, like for example, they're not uncomfortable with the concept of death and they know that if the person was to die it's not the end of the world. You know not everyone can survive a major incident and it's not a failure as long as you've tried to limit suffering and you were there to facilitate the process so it was less traumatic for the patient and the family. But I know of only a handful of nurses who are like that (i2:041)

Participants saw the nurse's ease to be the result of the individual having faced her/his fears of difficult situations and emotions over time, and being sufficiently self-aware to choose how to behave in a situation. The nurse had learnt within her/himself to process difficult or bad experiences intensely, rapidly and effectively but without losing her/his ability to feel a sense of self within a situation. The different and better nurse seems to process the emotional upheaval within a situation in a controlled, calm manner; being able to show emotion without creating discomfort in others and then regain the centre of self to continue with the interactions at hand. She/he is regarded as functioning from the core of 'balancing self' – being a nurse grounded in her/his own humanness.

The concepts of 'grounding self' and 'balancing self' seem to have an intimate relationship in influencing and supporting each other. The actions within 'balancing self' feed back into the individual's sense of self such that that self is grounded. And it is through the actions of 'grounding self' that the individual is able to balance her/his self as an individual with that of being a nurse. It is from the interplay of these concepts that 'knowing self' emerges – the ways the individual develops and embraces insight into her/his true nature and how she/he uses this knowing intuitively in being a nurse.

The conceptual skeleton of the subcategory 'knowing self' finds active expression in 'skilled being'. 'Knowing self' underpins and permeates how the nurse enacts her/his ways of being a nurse combined with her/his ways of doing nursing.

3.2.2 Category - Skilled Being

Their actions are not based purely on knowledge so it's not only a theoretical knowledge, umm they combine that with what is best for that individual patient and their decisions are also based on what their heart is telling them is right - at this particular point in time, is this the right thing to do, not umm what the recipe is or umm what the textbook particularly says is the next step... umm the brain and the heart are of equal size if I have to quantify it (i2:007)

The subcategory of 'skilled being' developed from my understanding of the data that showed the particular ways of being a nurse and ways of doing nursing by a nurse recognised to be 'different and better'. This subcategory shows the interplay between ways of being and doing as depicted in figure 3.12, as well as how these active expressions of nursing enable the feeling of ease to be recognised within the nurse and experienced by the participant. 'Skilled being' is rooted in the subcategory of 'knowing self', interview data showed that all the participants recognised this relationship – in order to genuinely *be* a nurse who is different and better, and then *do* nursing that is experienced as different and better, the individual must progress through engaging with and exploring her/his true nature, or sense of self.

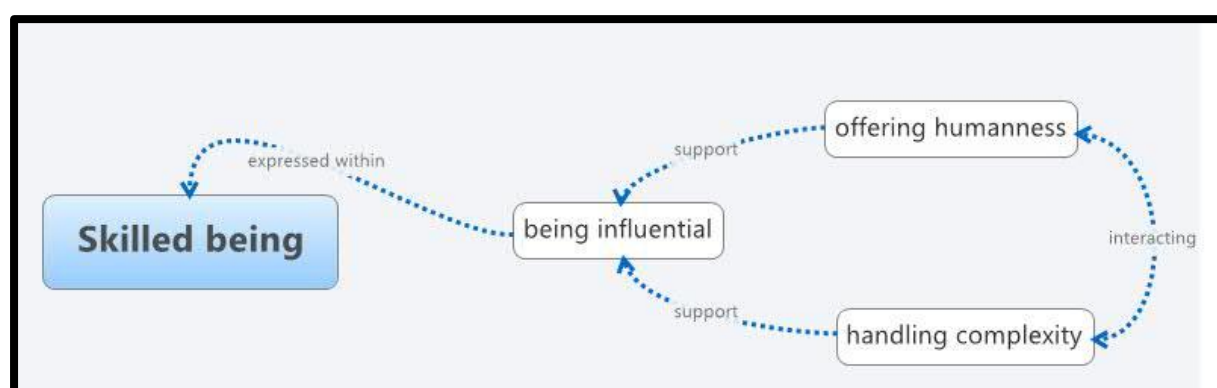


Figure 3.12 'Skilled Being' – concept groups and relationships

The word 'being' is used as a noun (in the gerund form) in the label of this subcategory. 'Being' is used to depict the ways a nurse applies her/his sense of self into nursing

that is done consciously, strengthened by the individual possessing and enacting her/his deep knowledge and understanding of the discipline. 'Skilled' expands the scope of the category by alluding to the abilities of the different and better nurse to use her/his knowledge effectively and readily in doing nursing. Thus, the category of 'skilled being' shows the actions and processes of being a nurse and doing nursing that are recognised by the study participants as standing out in a different and better way. 'Skilled being' integrates the codes of 'being' and 'being able to ...' to depict the ways and means in which the nurse applies and uses her/his deep, complex knowledge base with understanding and insight to interactions with utilisers. After contemplating how the codes of the categories may be related and mutually influential, there were three conceptual groupings that emerged. 'Skilled being' is the expression of 'being influential' which is the product of the interaction between being a nurse (revealing her/his self within the roles of nursing) – grouped here as 'offering humanness', and in 'handling complexity' – the enactment of applying the breadth and depth of discipline knowledge and skill in doing critical care nursing.

3.2.2.1 Offering humanness

(jb) So if you put words to those top three things it would be ...

(p)... umm, grounded, connected, human – HUMAN – not a machine

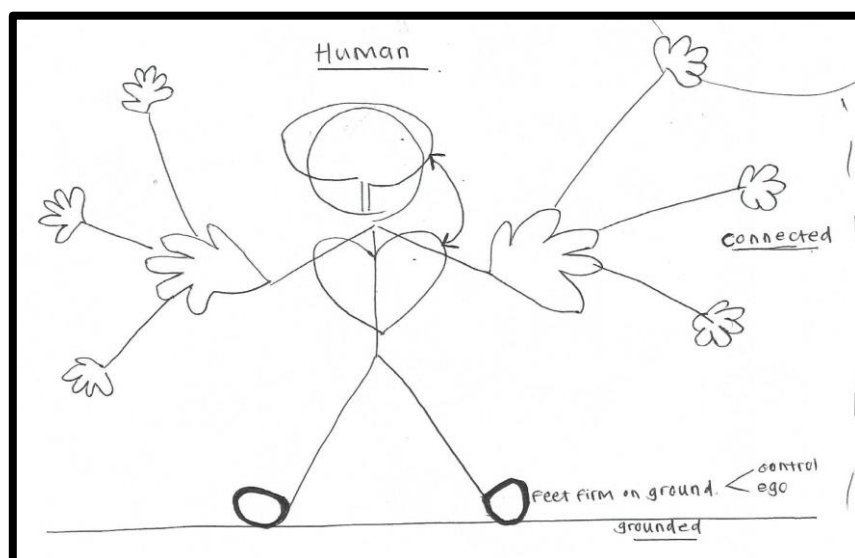


Figure 3.13 Interview 2 – clipping from naïve sketch and naïve sketch narrative

'Offering humanness' brings together the concepts that explain the ways that the recognisably different and better nurse uses her/his sense of self to establish and

permeate interactions with others. The primary feelings associated by participants with this concept group are a tangible presence of calmness and gentleness from the nurse. This calm and gentle presence underpins the nurse's skilful, direct assuredness as she/he engages with another. This presence is underpinned by the nurse's sense of self as well as confidence in her/his knowledge, ability and skill in nursing that has developed through experience. The nurse is experienced as having a presence, also described as a radiance and energy by participants, that emanates from within her/him which makes the experience of critical care environment and/or dynamics better for the other person. Figure 3.14 shows the mind map of the various actions, processes and relationships of 'offering humanness'.

.. a bit of abstract description, radiant there's radiance the person exudes some sort of energy,.. that makes it better for you or easier for you to feel part of the team and feel valued (i4:077)

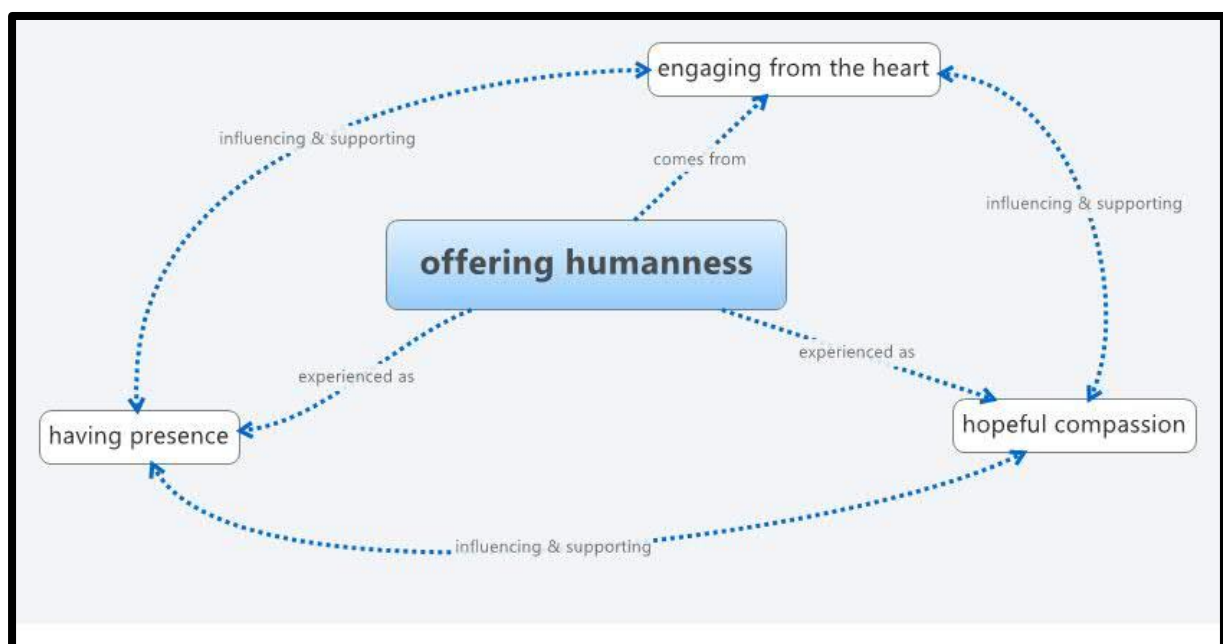


Figure 3.14 'Offering Humanness' – actions, processes and relationships

The ones that really stood out, they worked softly and they worked umm it's almost, ja I also thought of it like an energy that comes from inside (i3:011)

Part of using the sense of self as a base to interact with utilisers, is seen in the ways that the different and better nurse reveals her/himself as a person within relationship with a participant; allowing connections to be made because of the evidence of the

nurse's personality including to some extent her/his frailties or imperfections; and evidence of deeply felt emotions – 'offering humanness'. Through using these qualities, the nurse moves the interaction from the separateness of officiousness, spoken about by participants as what many nurses mistake for engaging in a professional manner; to an interaction experienced as engaging in respect for the common humanity of the other person and her/himself. The underpinning subcategory of 'knowing self' enables the nurse to offer their humanness within the interactions with others and then influence the experience or behaviours of others they engaged with ('being influential').

Within the qualities grouped together as 'offering humanness', the individual's manner of being a nurse reveals the base for her/him being experienced as calm and gentle by participants. There were two apparent threads that combined to form the concept grouping of 'offering humanness', namely: the nurse is seen to engage from the heart, this manner of engaging enables the expression of hopeful compassion in actions (in both subtle and obvious ways).

It is a different type of compassion, a compassion with hope which has to be felt by everybody else ... and I think that that is a special quality of the best ICU nurses (i5:003)

Compassion, sorted out, again that thing of maybe having their own issues but it's not there. It's an energy, it's a confidence from inside and its radiating out on the outside, it is a sort of a knowledge, something they know (i4:071)

It is through engaging from the heart that the different and better nurse applies the emotional foundation of her/his 'skilled being'. These emotions grow from the nurse having insight into her/his nature and being able to use this sense of self as a point of departure for choosing her/his own behaviours and responses in a situation; but also to choose how to approach others' behaviours and responses. Further to these emotions growing from the sense of self, these are strengthened by that nurse's consciousness of the depth and breadth of her/his discipline knowledge and skill. It is in the combining of these two aspects that 'engaging from the heart' is recognised - in the nurse being courageous, being caring, and being intently passionate in the ways and means of nursing.

The different and better nurse is courageous in her/his involvement with the environments and interactions of critical care nursing. She/he is recognised as being able to stand her/his ground firmly because of the strength of her/his insight and ability to apply her/his knowledge and skill to each patient's unique circumstances. Detaching her/his self-worth from the outcome of an interaction or intervention supports this nurse in being courageous in engaging with people or circumstances surrounding a patient. Participants' recognised the nurse as being courageous in situations where conflict with colleagues or significant others seemed a likely outcome, but also in situations where her/his vulnerabilities were displayed; such as knowing when the limit of their knowledge or skill has been reached, when to ask for help and how to accept offered help. Using humour appropriately to defuse or refocus situations is part of the different and better nurse's enactment of courage.

a lot of good humour and a lot of response to humour even with family in the ICU and I think that for that to happen everybody needs to take the job very seriously but not themselves too seriously and again that is a particular quality I think that nurses are very good at laughing about things or with people so but I think without humour in an ICU you won't last long (i5:055)

While caring and nursing are often used so interchangeably that these terms could almost be regarded as synonyms, the nurse who stood out was recognised for her/his manner of being caring that was different to the caring by other nurses. The manner of caring was experienced as genuine and the experience of the caring as true due to the nurse being emotionally open and available to others in the environment. It was in the experience of being cared for, being cared about or observing caring of another that the nurse most clearly revealed her/his own humanness. Being caring begins through the nurse using her/himself as a conduit through which actions and interactions of care were filtered. Behaving as a conduit of care means that each exchange from the nurse to another are filtered first through values such as mutual respect, patience, honesty, integrity and empathy. The value-infused actions are then expressed in the doing of nursing that is motivated from the perspective of what is in the best interest of the patient. This values-infused care underpinning an exchange is recognised in the way the nurse touches a patient, the spoken preference of a patient

to be attended to by a particular nurse and the ways this nurse protects patients, significant others and colleagues.

The way she presented herself and the way she treated my father she would, if she would turn him, she would turn him softly. You know it's not like a circus movement you now drrrrp over, it was like helping him in a softer way to turn, then speaking softly to him when she changes his medicine - if he understood what she said I don't know, but always having a type of a conversation and treating him like a normal human being, not a ill human being (i10:020)

The different and better nurse expresses care through protecting the patient by always placing the patient's best interests at the forefront and then in the core of decisions or interactions. An obvious expression of this caring protection is in the balancing of the risks and benefits of a particular intervention. The significant others experience this caring protection in the ways that they are regarded as being an integral part of the patient's experience but their encounter with the critical care dynamic is influenced by the nurse to make it somehow less scary and more tolerable.

In 'engaging from the heart', the different and better nurse shows her/his intently passionate personal engagement with the fullness of her/his profession and discipline. Participants' speak of the visible nature of this intent passion that reflects in the nurse being courageous and reinforces her/his being caring. Interactions are characterised by the utilisers' experience of the nurse as being highly engaged through her/him living out the substance of her/his knowledge and skill with respect for her/his nursing role. The nurse offers evidence of this high engagement through focussed probing into care decisions and making contact with utilisers with 'alive eyes'. The 'alive eyes' show that the different and better nurse is excited by the possibilities of nursing, and was also seen as one of the potential pointers to a young, inexperienced nurse being able to become a different and better nurse over time.

The way eye contact is made and the showing of genuine concern and that kind of integrative understanding... they have alive eyes, willing to make eye contact with you and excited by the possibilities (i2:069)

Through the nurse 'engaging from the heart', a feeling is created within the utiliser of a connection between themselves and the nurse. This feeling of connection is

underpinned by the nurse having a settled sense of self and a profound understanding of the spaces of suffering, pain and loss. When the nurse 'engages from the heart', the utiliser experiences that nurse as having empathy – as understanding the complexity of what the utiliser needs within their experience and able to facilitate that experience without needing to control it. With the nurse 'engaging from the heart', utilisers find it possible to feel humour, happiness and joy in often times desperate situations.

... the openness with what she treated us and that she like respected us as the family and also as human beings and the fact that she gave a bit of herself in the sense that you know she, I can't remember all the things but I mean she would I think she had a close relative that was also very sick but you could feel that she had gone through similar stuff that we went through ... she wasn't telling us that she understands how we feel it was more like empathy ... understand what we're experiencing although her experience wouldn't be exactly like ours but she's giving us space to have our experience and not giving us advice on how we should treat the situation (i10:064)

By the different and better nurse 'engaging from the heart', the utiliser experiences the expression of hopeful compassion. Hopeful compassion is the experience of the nurse being able to balance her/his 'knowing self' within the knowledge and skill of being a nurse, being able to balance hard facts of reality with genuine comfort and humanness. The nurse expresses hopeful compassion in her/his ways of balancing reality and hope through her/his use of language and the detail of sharing difficult news about a patient. The different and better nurse is able to express hopeful compassion because of creating space for her/himself within the role of being a nurse. The better an different nurse is recognised as generally being able to experience and acknowledge strong or negative emotions, use her/his insight into her/his self to filter and manage the emotion without the utiliser feeling punished by the nurse's experience. This means that the nurse is experienced as authentic in actions of reassuring and comforting utilisers despite her/him (the nurse) feeling angry, disappointed, afraid or exhausted.

Thus 'offering humanness' speaks to the way that the different and better nurse shows her/himself as a person within the role of being a nurse.

3.2.2.2 Handling complexity

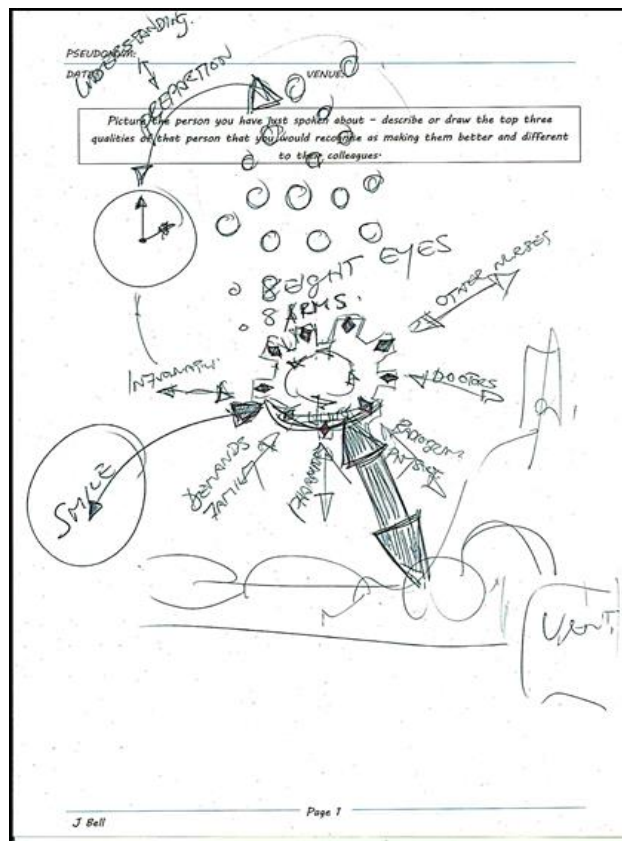


Figure 3.15 Interview 5 - clipping from naïve sketch

The codes gathered within this concept group speak to the abilities of the different and better nurse to use her/his knowledge effectively and readily in doing nursing. She/he smoothly combines her/his knowledge and skill into relevant actions or activities required in a situation. The depth, breadth and complexity of the nurse's knowledge and skill abilities, as well as her/his capacity to apply these safely and appropriately were noted by every participant. Having, using and constantly developing disciplinary knowledge and skill was recognised as the entry point to establishing one's self as a different and better nurse. The mind map in figure 3.16 shows the actions, processes and relationships of this concept group.

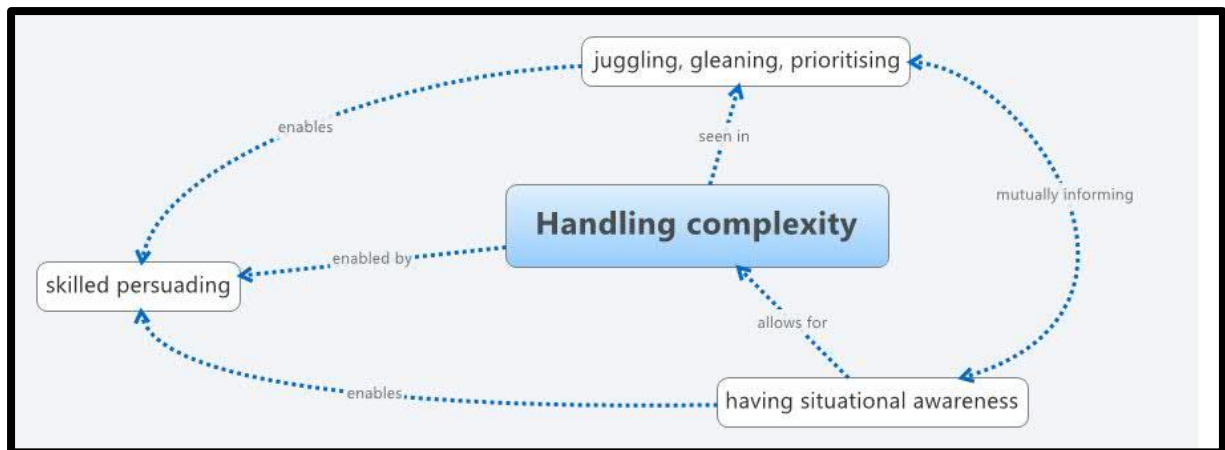


Figure 3.16 'Handling Complexity' – actions, processes and relationships

'Handling complexity' offers an explanation of the first part of the subcategory label – skilled in 'skilled being' - it is from this foundation of knowledge underpinning skill, skill informing knowledge and then the combined considered application of this within the actions of 'offering humanness' that 'skilled being' evolves.

The knowledge that she's got is like jo! ... one of the patients will say they've got pain and a sister will say ja but I gave you pain pills, I gave you morphine you must just settle down, she won't do that - she'll like be 'okay you've got pain, where is the pain, score the pain, but why have you still got pain, I gave you something for the pain why have you still got pain'; and then like when she evaluates the patient's pain score and goes deep into the pain, then she realises it's not really the pain that's bugging the patient it's more like emotional, he's scared (i8:007)

Participants recognised the nurse's ability to work with her/his knowledge and skill in the actions and processes of 'handling complexity'. They reiterated that broad and deep discipline knowledge and skill is already in place, and it is rather the nurse's proficiency in using this base to gain insight into a particular set of circumstances and to persuade others to appreciate her/his perspective of the circumstances that shows different and better nursing. The nurse seems to engage in two processes when 'handling complexity'; initially locating appropriate data and juggling multiple sources of data to glean and prioritise information. She/he then uses actions of skilled persuasion to access resources she/he has deemed to be needed or to convince others to consider her/his view in order to manage the identified priority.

... the ability to prioritise and sort of the clarity of understanding there are some people who have the ability to immediately pick up what's important and to glean information and process it and communicate it for all members of the team and also to get people in their side (i8:067)

Successfully locating and juggling data from various sources is the outcome of the nurse having what a participant named situational awareness – deliberately being aware of and engaging with the dynamics of the environment intelligently and efficiently. The nurse scans the various data and sources from her/his base of skill and knowledge, thus able to identify what is important and essential in a complex situation. She/he prioritises information through the filter of what is best for the person at the core of the situation, this person usually being the patient. Distraction or distractors are managed by delegating or stopping less important activities. She/he notices cues and moves with the changing nature of nursing a critically ill patient. This process of gleaning and prioritising information is applied consistently through the activities of critical care nursing. Having situational awareness was explained by some participants as the nurse being completely present in the interactivity of developing understanding the complexity of a situation whilst acting within the circumstances unfolding at any moment in time. The nurse is cognisant, through situational awareness, of potential and unfolding problems whether these are tangible in the sense of a patient developing cardio-respiratory collapse or more subtle problems brewing in the spaces of superficial communication or inadequate nursing ability.

Situational awareness is also developed through the nurse having a vision for a patient. This vision is how the nurse sees the outcome of her/his interactions with a patient or other utiliser over a shift. The nurse guides her/his patient and/or utiliser interactions with this vision. It is the way the different and better nurse facilitates the processes of care to assist the other to the best outcome they, the nurse and patient/utiliser, can achieve. The vision is not static and evolves through the activities of problem solving, thinking through actions or choices; and accessing, combining and using resources.

An important action in juggling information and situational awareness is the ability of the different and better nurse to pause. Her/his ability to pause to make sense of

information, to consider a choice or to stop blindly doing things to a patient sets their nursing apart from other nurses.

The nurse's ways and means of intelligently, efficiently gleaning and prioritising information is in part fundamental to their use of skilled persuading to accomplish what they deem necessary to achieve the best outcome in an interaction. The different and better nurse is able to use skilled persuading without appearing manipulative or controlling because of the respect others have for her/his proven discipline knowledge and skill, ways and means of engaging with others and through obviously centring the patient at the core of a discussion. The different and better nurse is able to communicate effectively with all utilisers through the actions of 'engaging with humanness'. Another key aspect of skilled persuading is that the different and better nurse is recognised as being an equal of the other person in the interaction. Interacting on an equal footing begins within the nurse's sense of self, coupled with understanding the purpose and value that nursing brings to a relationship of care. The equality of individuals in these relationships and the influence of this equal standing develops further in the subcategory of 'connecting with intention'.

... this one nurse I mean she's just an ICU nurse but they consulted her, the doctor consulted her, they were working together as a team, with the doctor, not the doctor on this pedestal ... there was no difference between the doctors and that nurse (i3:011)

With the information gleaned about a situation, clarity about the core focus of the situation and the nurse's insight into how the situation has unfolded and may progress, an interaction between the nurse and a utiliser supports communicating for urgent intervention if necessary but also communicating with reciprocity in sharing and learning about the situation at hand. A central process of skilled persuading is the nurse's way of keeping perspective in complex situations. The process begins again in the deep, broad discipline knowledge and skill of the nurse that has been informed and tweaked through experiences of critical care nursing in all its forms. The ability of the nurse to match the nature of her/his response to the current need of the situation develops from this established base of knowledge, skill and insight. This enables the nurse to present a convincing argument for intervention or support, change tack when new information is revealed and defuse tense situations using humour appropriately

and without appearing to be antagonistic or disrespectful to patients, colleagues or significant others.

Skilled persuading is enhanced by the nurse being able to share information and experiences in a manner that is accessible to those she/he is engaged with. Additionally she/he is experienced by a utiliser as honestly receptive to listening to information, learning through experiences of others and acknowledging contributions from others. Thus the different and better nurse is open to the voice of another in an interaction, contributing to equality in a care relationship. This reciprocal interaction influences the utiliser becoming open to trusting the nurse through.

“Handling complexity’ exposes the ways and means that the nurse understands, harnesses and focusses her/his multi-layered discipline knowledge and skill in the doing of nursing.

3.2.2.3 *Being influential*

... for one she's humble so you will listen to her, she won't come with that attitude of a loud husky voice or come to you and demand things, she will remain calm and then just ask don't you think ...; she gives you as a person also some way that you can give input ... she don't just come across and say something and that's it.... yes she's assertive, mm and then she's like, I don't know how to explain it to you, but she's - you want to listen to her, you want to listen to her when she speaks (i8:083)

The combination of ‘offering humanness’ and ‘handling complexity’ enables a particular effect on utilisers recognised in the different and better nurse ‘being influential’. ‘Being influential’ is seen in the ways utilisers respond to the nurse, and shows how ‘offering humanness’ and ‘handling complexity’ shape the space of care and the nature of relationships within and around this space, shown in the mind map below (figure 3.17).

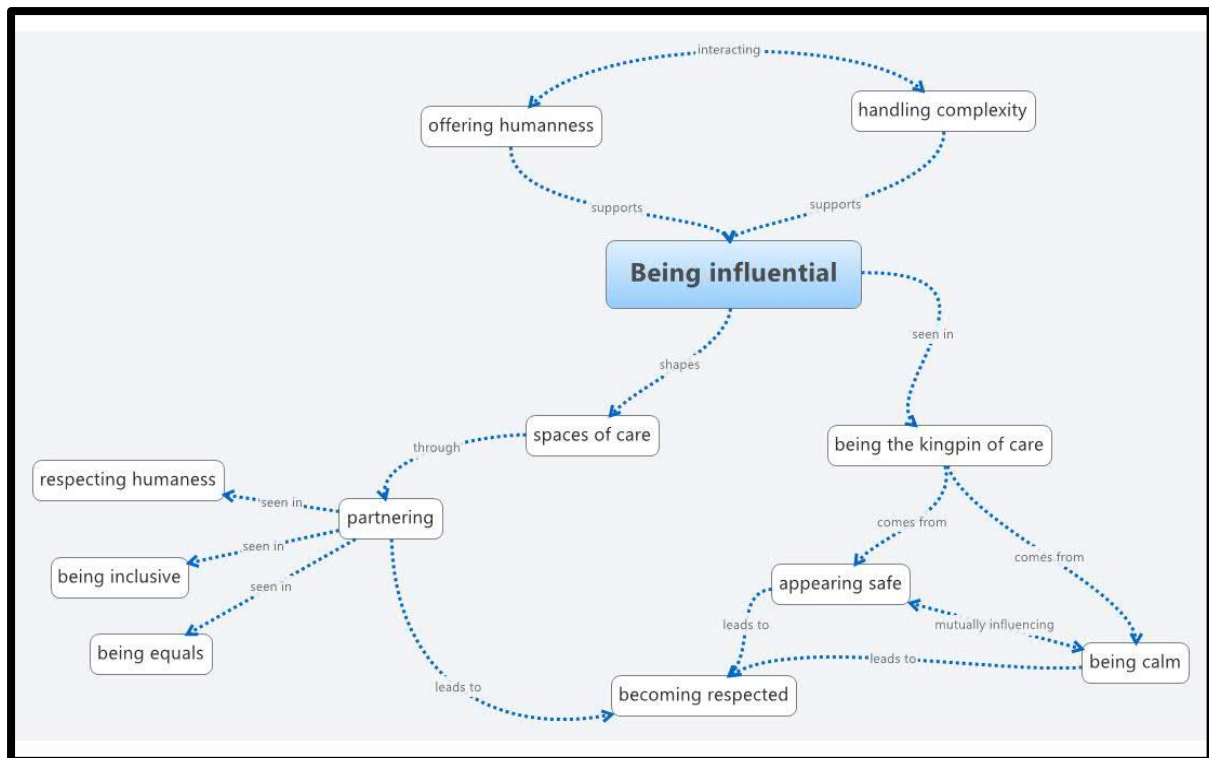


Figure 3.17 ‘Being Influential’ – actions, processes and relationships

Relationships are positively affected by the nurse revealing her/his self in being a nurse whilst doing nursing that clearly is immersed in her/his profound understanding of the discipline of nursing in critical care. The different and better nurse becomes the authentic kingpin of the care interface. She/he creates this effect of through appearing safe and being calm. Participants reiterated that this influence is founded in their knowing that the nurse has the patient’s (or utiliser’s) best interests at the core of her/his decisions and actions, and in her/his interacting from empathy.

... the ICU nurse is the cog at the patient’s bedside, almost everything that happens there, that happens around to or with the patient involves the ICU nurse and it’s the nurse who actually places herself there and is aware of the importance of the role that is effective in that role – not running away from the situation or avoiding that type of responsibility which isn’t in the patient’s best interests ... almost as a conduit of care, ... the interface and they are also the holder of the most information about the patient (i5:103),

The nurse appears safe through seeming to have a metaphorical *hand on everything* (i2:079). In this manner she/he is almost like a safety net, using her/his developed situational awareness to consider the full dynamic of an occurrence. Actions of taking

cognisance of the larger picture, thinking things through and thinking ahead enable the nurse to be in control of her/his responses and decisions. Rather than having to have tight control over the detail of how a situation unfolds, situational awareness allows her/him to influence, guide or manage a situation that is inherently unpredictable, and also be able to separate her/his sense of self-worth from the outcome of a situation.

the hands are massive and although I am going to struggle to draw everything that she has a hand on, I'm going to draw it with dotted lines because um this nurse has more than her hand on the pulse, not only does she have her hand on what's happening with this particular patient and integrating everything ... but it's a distant hand on every single other patient and nurse in the unit ... with a huge environment al involvement and to do so calmly (i2 nsn:079)

Being calm is the visible reflection of the nurse's internal sense of confidence. The internal sense of confidence is seen to seed from the nurse's sense of self and then a feeling of certainty in using her/his knowledge and skill in doing nursing. The internal confidence is visible in the nurse's ways of showing her/his developed knowledge and skill whilst carrying out the activities and interactions of critical care nursing. Utilisers experience this manifestation of internal confidence as convincing because the nurse is approachable and inclusive in the activities of care with her/his openness grounded in empathy. She/he is accepted as being the kingpin of the care interface because of particular feelings that are evoked in utilisers, or the absence of feelings evoked by those recognised as not being different and better nurses.

... she made me feel positive and she made me feel not incompetent but still learning. I can be open with what my suggestions also are and if she has that attitude it will motivate them and keep them positive and at the end of the day you have better treatment of your patient at the bedside because of a happier feeling, a more positive feeling (i6:036)

... whereas when other people are on duty it's kind of like there's a tension like if you get to the end of the shift and there hasn't been a disaster then it's like thank God for that and its not to say there's always disasters and there aren't

*it's that inability to relax and in a way that's almost a prediction of disaster
(i9:149)*

A prominent feeling experienced amongst participants in their stories about a 'different and better' nurse was that of respect. The different and better nurse gains respect through evidence of her/his reflective knowledge and skill consistently visible in her/his actions and interactions. This respect is further enhanced by the nurse being humble about her/his abilities in being and doing nursing. Whilst she/he exhibits confidence in her/his abilities, the nurse is cognisant of her/his knowledge and professional limits, asking for and accepting assistance as she/he needs to. Interestingly, the negative behaviours of some nursing colleagues towards these nurses increased the nursing participants' respect. These behaviours were seen to be a way of identifying someone's potential to become a different and better nurse. Respect for the different and better nurse grew from the manner in which she/he engaged with and moved past the negative behaviours associated with professional jealousy that are displayed by other nurses.

Through the foundation and actions of 'handling complexity', different and better nurses tend to create sound professional relationships with medical colleagues and seem able to facilitate change within the environment. These actions result in the nurse being sought out by other colleagues to discuss patient issues, to offer an opinion, etcetera; with the outcome that a less able nurse (particularly one who has worked in a single critical care unit for many years) feels displaced and undermined. Feelings of anger and frustration exhibit in petty, nasty, malicious behaviours by the less able nurse towards the different and better nurse. The participants' respect for the different and better nurse is increased through the ways of handling the experience by disengaging from the personal attack, refocussing actions with the patient at the centre and continuing with her/his work.

...I must say they really can get to her sometimes but what stands out about that lady is that she's ignoring it, she's just turns her back and just does what she's supposed to do in a way that's best for the patient and that's it (i8:107)

Another feeling evoked through all the participants was experiencing a feeling of relief coupled with optimistic anticipation when knowing they will be on a shift with the

different and better nurse. Younger colleagues and significant others spoke particularly of feeling relieved in terms of the calmness and sureness of this nurse, while older colleagues experienced relief in terms of being able to focus on and enjoy the time in the environment knowing that this nurse is capable and adept. The positive feelings are evoked through their experience of being valued for what they are able to contribute to the space of care and feeling that they are supported by a safe, skilful nurse. The time spent on a shift where a different and better nurse is present seems to be experienced as having low levels of tension, there is a feeling that the team will be able to manage any situation may arise; whereas when this nurse is not present, there is an air of uncertainty and wariness amongst the group.

I'm not going to have to interfere to protect the patient from this nurse (i2:023)

Significant others felt that in the presence of a different and better nurse their loved ones were less agitated and seemed better even when the patient was physiologically brittle and unstable.

I had a funny feeling that A always knew the nurses. When X was around here or working with her, A was difficult but when S or M or B was with her then A was calm, she was happy, she was relaxed (i3:098)

The spaces of care are shaped through the partnerships initiated and sustained in the critical care environment. The different and better nurse influences these interactions through the ways she/he treats the other person or people in any interaction. She/he shapes the space of care by partnering with the other person rather than attempting to control interactions. The process of partnering begins in the nurse's respect for the humanity of the other and is a way that caring is made visible. Openness to partnering means that colleagues and significant others are included as valid and valuable contributors in care interactions. This extends to include the different and better nurse being open to scrutiny by her/his colleagues and others. Through accepting others' scrutiny of what she/he is authentically capable of doing, the different and better nurse creates the ways others then interact with her/him. From here, partnering provides a foundation for professional relationships to form where each individual is treated as an equal. Partnering shapes the space of care by supporting inclusivity and working together, the different and better nurse influences partnering by using non-

competitive, non-comparative, inclusive behaviours to engage with the dynamics of the critical care environment.

... also this assuredness that the person knows what they are doing so there's a confidence without being cocky, umm there's not this over confidence that often just betrays uncertainty and there's an easy assuredness ... they're not even necessarily comparing themselves with others; they seem to be doing what they are doing because they need to be doing it and that's how they do it, without thinking I must be competitive, I must be better than this one or worse than that one (i9:061, 113)

An outflow of partnering is found in the value of the enabling relationships that can develop. By modelling nurture and care in her/his doing of nursing - 'being influential', the different and better nurse opens the possibility for the utiliser to stretch the perception they have of their own abilities and then become more than what they saw themselves to be capable of. For significant others, this may be realising that they are able to make some sense of the chaotic experience of critical illness, for colleagues it may be doing an intervention that they had not considered themselves capable of, or influencing colleagues to consider how a different approach to patient care could be realised. She/he becomes a point of reference that the utiliser, particularly younger colleagues, measures themselves against and aspires to be similar to. There seem to be three strands that intertwine to support enabling relationships or interactions. The first of these strands is the way that the nurse assists and supports another to work through fear. Because of the qualities lived out by the different and better nurse from 'knowing self' into 'offering humanness', the utiliser feels they have permission to learn through engaging.

There is a space available where the utiliser can express and work through their fears; for example of a piece of equipment, of death and suffering, of their abilities, without being concerned of backlash from the different and better nurse. The nurse opens this space by helping the other to make sense of experiences in part through allowing for mistakes as part of the reality of the critical care environment. Mistakes are used as opportunities to learn to take responsibility without being judged or blamed. This is achieved by the different and better nurse keeping the focus of the experience on the patient, engaging with the utiliser in a manner that helps the utiliser to balance and

make sense of an experience, the second strand of an enabling relationship. The different and better nurse is able to find a balance between what a utiliser needs to make sense of their experience to facilitate moving from incorrect or inadequate interactions to appropriate, informed interactions.

The third strand is the focus on moving forward together by placing an experience in context, allowing for learning to happen and to establish better interactions, reinforcing the current appropriate ability of the utiliser and also making that ability visible to the utiliser. This interaction also confirms that the nurse sees the value of the utiliser's experience and knowledge which feeds back into partnering.

when she's on duty I am peaceful, although it's very busy I can go to her ask her anything she would never be mad and I would ask her over and over. She's the only the one who will ask, when she can see I'm thinking and I'm red in the face and I don't know which way to go and I don't know this ICP drain thing but they've shown me and I have to deal with this now with this patient... and she'll just come to me and say okay come let's go through it slowly now - this and this and this this is all that doctor is saying but you have to look out for this and this is very important so don't forget about the rest but just remember that these two points are very important (i7:016)

3.2.2.4 *Knowing Self and Skilled Being*

'Knowing self' provides the beginning point from which different and better nursing begins to manifest, enabling and supporting the subcategory of 'skilled being'. It is within the interactions and influences of these categories that the utiliser begins to open up to the possibility of trusting the nurse through the experience of the nurse trusting her/himself, and then experience 'being at ease' (figure 3.18 reproduced for ease of reference).

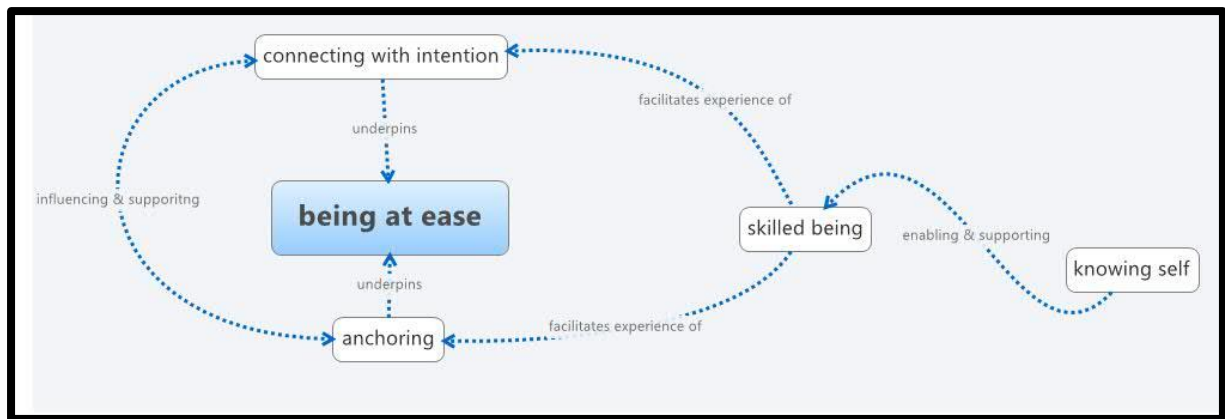


Figure 3.18 'Being at ease' – categories underpinning the core concern

The external reflection of the nurse trusting her/himself at a profound level that is expressed through her/his ways of being a nurse and doing nursing fashions a sense experienced by utilisers that the different and better nurse is at ease with her/himself. The experience of the nurse being at ease with her/himself initiates the actions and processes of 'connecting with intention' and 'anchoring' which then lead to the sense in the utiliser of 'being at ease'.

3.2.3 Category - Connecting with Intention

'Connecting with intention' as a subcategory of 'being at ease' offers an explanation of how the different and better nurse creates and shapes the linkage between her/himself and a utiliser. The ways and means this nurse uses to first engage with a utiliser, then interact and communicate develops the initial fragile, brittle linkage to a meaningful connection. This meaningful connection is experienced as honest, real and true by utilisers.

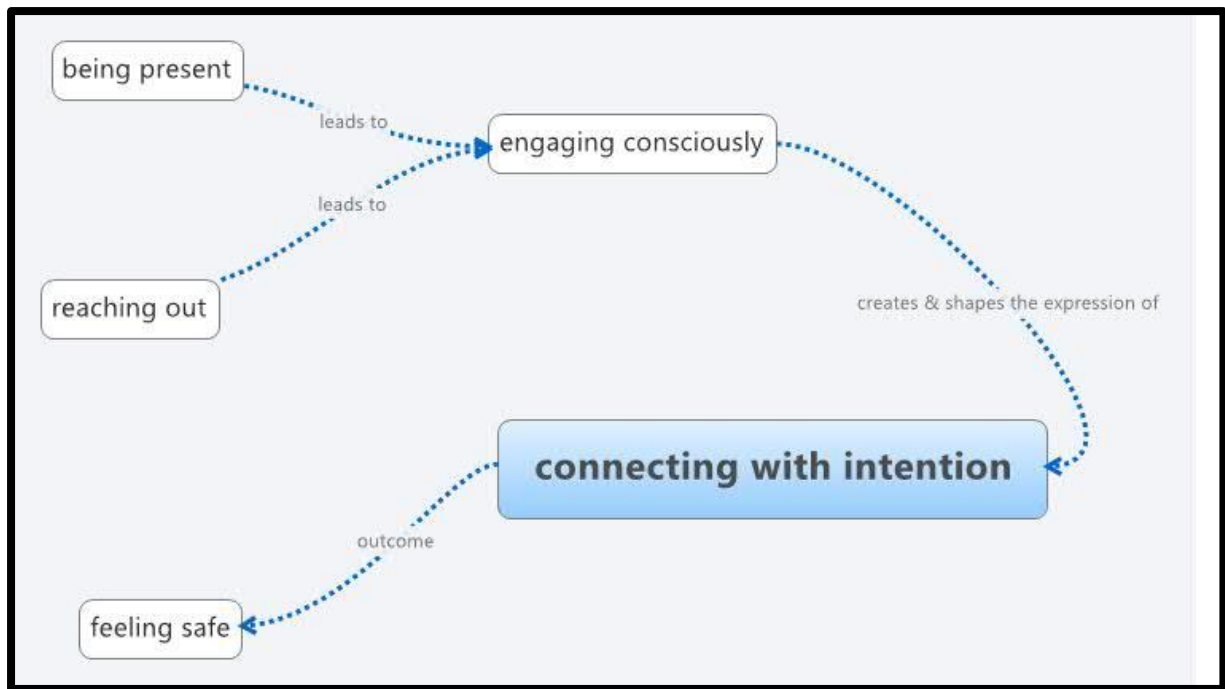


Figure 3.19 ‘Connecting with Intention’ – concept groups and relationships

‘Connecting with Intention’ is seen in the way the different and better nurse deliberately lives into the utiliser’s experience of the environment and dynamic of critical care through ‘engaging consciously’. The nurse seems to do this in two particular ways - through ‘being present’ in the spaces of nursing relative and relevant to that utiliser and then by ‘reaching out’ to the utiliser in a manner that shows insight into what the utiliser needs. The outcome of ‘connecting with intention’ is the utiliser ‘feeling safe’. Figure 3.19 summarises the subcategory and concept groupings as a mind map. Where a meaningful connection does not become established, the utiliser experiences an imbalance in the interactions with a nurse; there is no stable centre to their experience of critical care and the overarching feeling about their experience is bad.

3.2.3.1 *Being present*

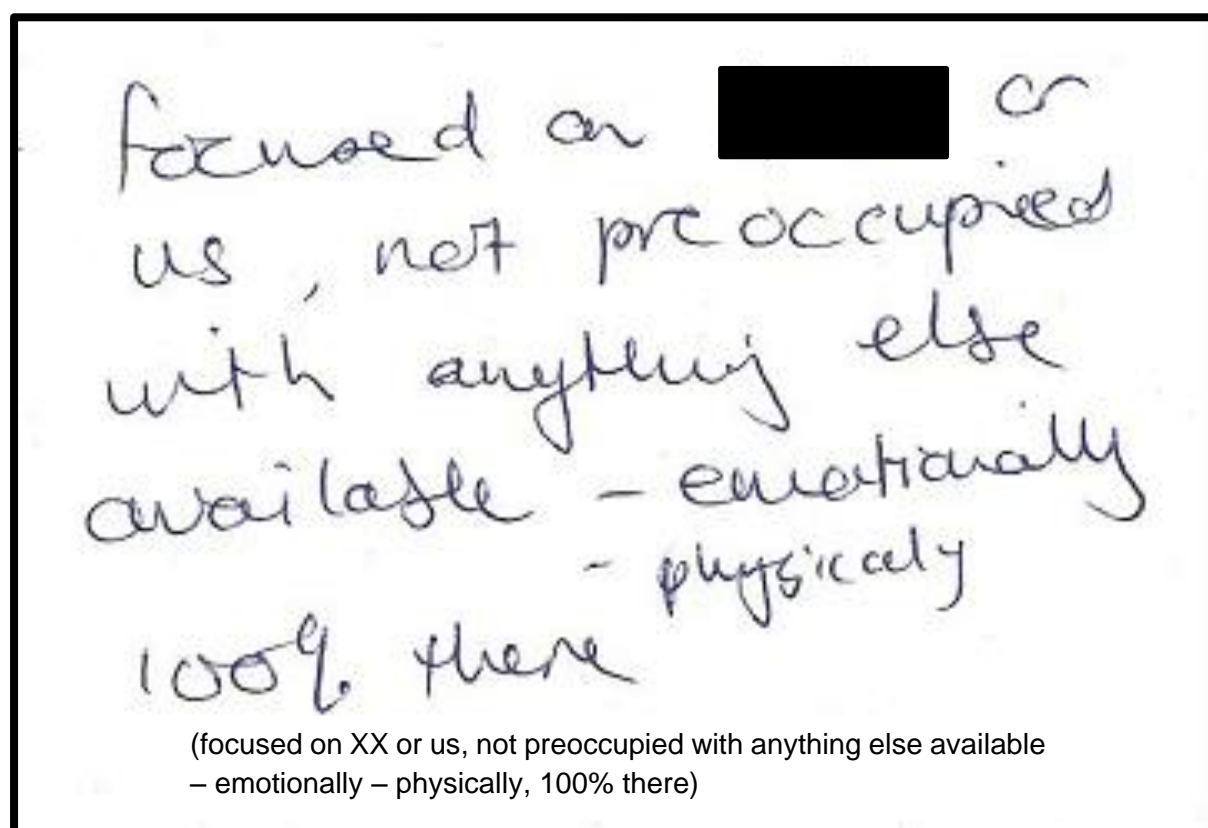


Figure 3.20 Interview 3 – clipping from naïve sketch

The concepts grouped together in ‘being present’ explain the ways that the different and better nurse creates the space for a connection with a utiliser to develop from (see figure 3.21 for this concept group’s mind map). The foundation of this concept grouping lies in the nurse showing the utiliser that she/he owns the spaces of nursing. The evidence for owning the spaces of nursing comes from the nurse’s living out of the qualities, and processes of ‘skilled being’ particularly, but also influenced by ‘knowing self’.

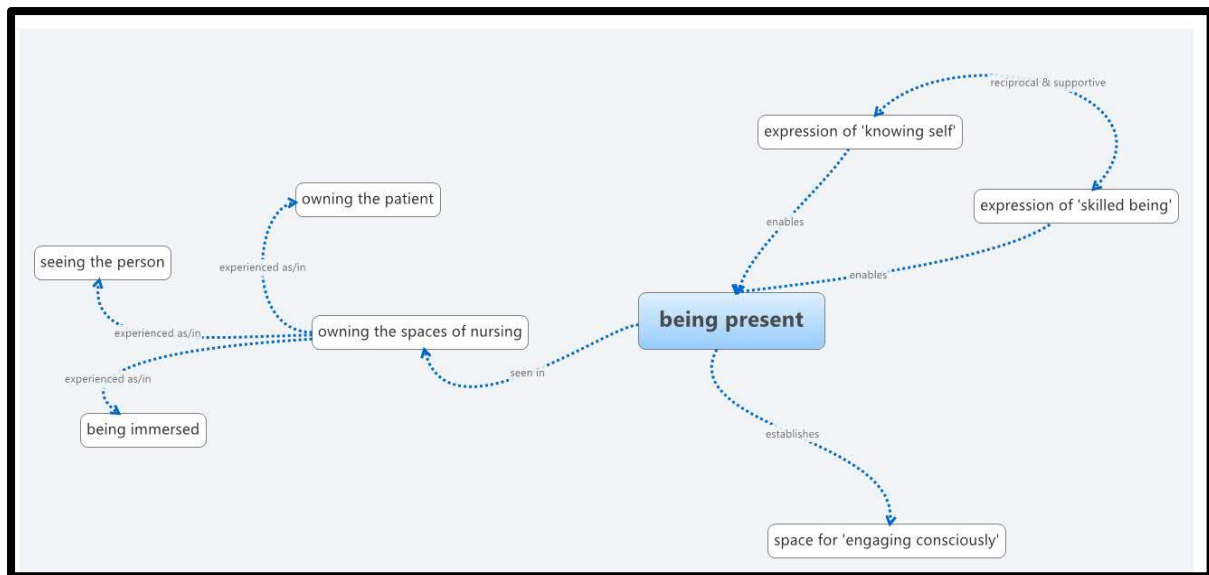


Figure 3.21 'Being Present' – actions, processes and relationships

The expression of 'being present' is experienced in the manner a different and better nurse engages and immerses her/himself fully within the environment and dynamic of critical care. She/he deliberately engages her/himself from the foundation of 'knowing self' to create the space for connecting with a utiliser. The different and better nurse offers her/himself by displaying her/his humanness as the initial link in 'connecting with intention'. Utilisers recognise this as part of the nurse engaging with empathy, that the nurse cares deeply about their present situation, and is also invested in the utiliser's immediate future in terms of their experience of critical care. Through the nurse demonstrating a sureness of her/his sense of self, the utiliser is able to see the possibility of a different, deep and mutually rewarding linkage that enables 'connecting with intention' to take form.

...she speaks to them (patients and family) continuously, continuously make them part of the whole nursing process and decision process, umm understanding creating understanding of what's happening and why things are happening and umm transferring knowledge ... in such a way that they also understand. When they understand, immediately they sort of open up more and are more approachable umm or open to new ideas or therapies or different doctor or umm having hope. (i4:249)

The different and better nurse shows that she/he wants to be working in the discipline of critical care. During the period of a shift, the nurse is immersed in this world –

maintaining focus on her/his patient and the dynamic of the unit. 'Being present' is most clearly recognised in the ways the different and better nurse concentrates her/his expression of 'skilled being' during interactions with a patient. This expression of 'skilled being' is individualised and characterised by the nurse's personal standard of achieving what is right for a particular patient and situation in each instance. The patient always comes first in the attention of the different and better nurse, her/his attention then widens to include significant others, colleagues and other people. The premise of each interaction is respect for the other's humanness. This is experienced in the utiliser feeling they are seen as a person; as a unique, separate individual as opposed to the generic encompassing labels of patients, nurses, doctors, family. The different and better nurse expresses this individualising through knowing the person detail about the patient or utiliser

(p) She didn't treat us like family of the patient, she recognised that we were worried and that we had a life of our own umm and you know that we were busy with that life also trying to balance everything.

(jb) So she had an appreciation for you as your dad's daughter but also you as a separate person?

(p) Ja I think she saw both. (i10:44-48)

Individualising is further experienced in the nurse understanding what to do and being able to do what is needed in an interaction rather than hiding in routine or habit. The patient as primary focus was explained by participants as a type of ownership of the patient. While owning the patient may ring with negative connotations of possession, the participants rather meant that the different and better nurse takes personal ownership of the time and interaction with a patient. By taking personal ownership, the nurse created movement within the processes of 'situational awareness', from having a particular vision for the patient to guiding and working with the patient to achieve the outcome most beneficial for the patient.

I mean the ones that don't have it don't listen, don't engage they just say come on you have to get out you have to walk or they say the doctor says you have to or they make a disconnect - they are just following orders rather than fully being present and engaging with that patient. Because the ones who stand out

are able to acknowledge to the patient, I understand that you are sore and that this is really painful and difficult and that you just want to lie in bed and disappear under your blankets and wake up when you're feeling fine and that this is really hard work, but I also know that I care enough for you to want you to get well (i9:025)

Personal ownership is characterised by the different and better nurse's ability to look beyond the obvious and the present, to know how and when to bend the rules of nursing to the needs of a patient. Personal ownership is further differentiated from patient possession by the different and better nurse working from the fundamental space of her/his own humanness. She/he works from this space to delve into what really matters for the patient, showing that she/he sees their interactions as partnering rather than the nurse directing the patient in the interactions and activities of healing or dying.

In these ways, the nurse establishes a part of the link required for 'connecting with intention' to become established. The other part of the link of 'engaging consciously' happens in the different and better nurse's ways of 'reaching out' to the utiliser. Together 'being present' and 'reaching out' forge the linkage that enables 'connecting with intention' to be established with the outcome of the utilise 'feeling safe'.

3.2.3.2 Reaching out

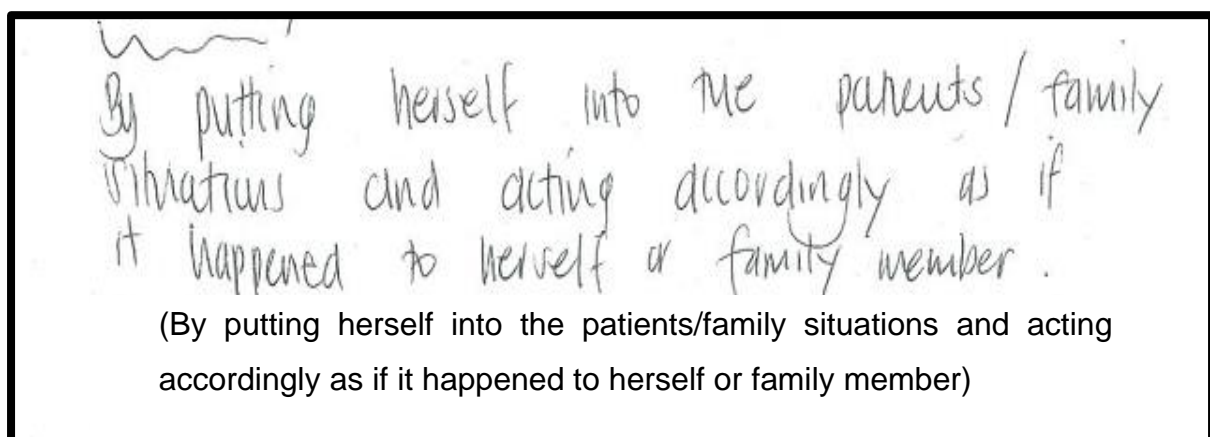


Figure 3.22 Interview 8 – clipping from naïve sketch

The different and better nurse creates the other part of the linkage in 'engaging consciously' through the process of 'reaching out'. 'Reaching out' is the enactment of 'engaging consciously' within the space created through the actions of 'being present'.

Figure 3.23 shows how the utiliser sees 'reaching out' in the way the different and better nurse appears to feel their experience and in this way understand what they need - another way that the nurse engages with empathy. The ability of the nurse to engage with empathy is seen to emanate from their 'offering humanness' and 'knowing self'. The expression of the nurse feeling the experience of another (part of empathy in the view of the participants) is revealed in her/his insight into the dynamics of engaging and her/his manner of engaging; as well as how choices made by the nurse are grounded in the other's experience.

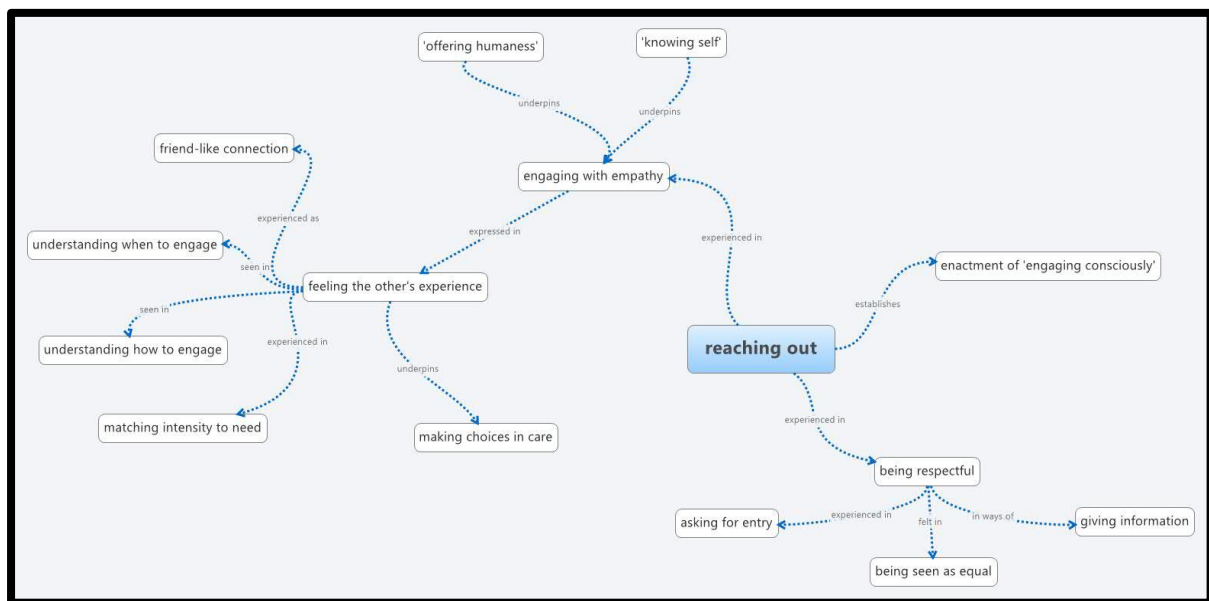


Figure 3.23 'Reaching out' – actions, processes and relationships

The different and better nurse is able to recognise the other's need to engage or, as it may be, not to engage. Being able to know when and how to engage with a utiliser comes from the nurse 'being present' in the spaces of care, working from their own humanness in conjunction with respecting the other as a unique individual and individualising the interactions of nursing. The manner of engaging speaks to knowing how to reach out; how to initiate an interaction with a utiliser such that it may become sustained and meaningful.

The fundamental starting point for any interaction is respect, the utiliser experiencing the interaction as genuine and respectful, but also that the utiliser has respect for the nurse. Genuine and respectful engagement is key in opening the door to any interaction and is mostly established within the different and better nurse's way of speaking to the other. The utiliser sees that the nurse respects them as an equal

person by the way she/he asks for entry into the utiliser's space rather than assuming right of entry simply because of the epaulettes on her/his shoulders.. Utilisers' note the appropriateness of voice tone and manner as well as the use of body language and humour by the nurse which demonstrates whether the nurse values the other person. They evaluate the quality and quantity of information the nurse provides against the context and possibilities they already understand (from other conversations with nurses or doctors or friends, television or 'googling') to decide whether or not to begin to trust the nurse. Within the actions of being respected as a person and developing respect for the 'skilled being' of the nurse, groundwork is laid for sustained and meaningful connecting between the utiliser and the nurse.

... the way she speaks to the patient, the way she speaks, she won't speak down and like attack the patient when he wants something she will speak in a nice approachable voice and she'll go down to the patients level and she'll ask the patient what is wrong. (i8:131)

The intensity of engaging is also conducted with care and respect for the individual as well as the context of the interaction. In complex critical care situations that are experienced by utilisers as difficult or desperate, the nurse enables the opportunity for intense engagement to happen quickly through 'being present'. The intensity changes with the variability of the situation, tapering off or deepening as needed by the utiliser. Despite its rapid development and intensity, this interaction and communication is experienced as substantial, sufficient and appropriate by utilisers.

Out of all the participants, it was the significant others who explained this process in detail and labelled it a friend-like connection. This connection develops from the significant other's need to know about and justify what is happening to their loved one. The nurse's visible commitment to the patient, expressed in being open to questions and allowing the significant others into the space of care, as well as a skill of filtering her/his own fears to soften the significant others' suffering provides an underpinning of meaning and substance to this friend-like connection.

... so they, more than us, knew she very close to going (but) they didn't say that to us. So afterwards when we saw they were all crying we realised this must have been horrible, but they kept that away from us through their way of totally

blocking out the thought and not even thinking that way but if it were to happen I know it would have been bad, because we had been there two months you know spending every day, really actually being friends and they are the only ones who can help us. (3:130)

Furthermore, the focus of the nurse on the family as an inseparable part of the patient also underpins the depth of the connection. The connection happens quickly and intensely as described in the previous paragraph, but despite the intensity diminishing over time, the connection survives, often for years, after the critical care experience. The foundation of the friend-like connection is emotional – described as being ... *warm and umm touchy-feely umm caring umm nurturing not that she nurtures but I think she nurtures emotions* (i10:132). The different and better nurse seems able to meet the significant others' needs appropriately and sufficiently through this connection. The significant other participants contrasted *friend-like* against *being a friend*. They indicated that the difference lies in the nurse knowing how to use ways of communicating to share enough of her/himself to 'offer humanity' without becoming overly familiar

...we were almost like friends, but I never felt that she overstepped that barrier (i3:111)

A further expression of the different and better nurse feeling the experience of another is in her/his use of the other's experience in making choices related to nursing care and other interactions. The nurse is able to connect in a manner such that what the other is going through influences the nurse's choices and decisions. The particular quality of not being personally attached to an outcome of a decision supports the nurse being able to place the other person in the centre of a choice (see 'hopeful compassion'). Separating her/his sense of self from the outcome means that she/he is able to consider all possibilities that are in the best interests of the patient and not become confused by those that will make her/him look good in the eyes of colleagues or reduce physical work.

The ability to separate her/his sense of self from an outcome is supported by the balancing of the nurse knowing and performing her/his discipline thoroughly within 'skilled being' and with the nurse's expression of presence and care in 'offering

humanness'. Within this ability is the nurse's grasp of the meaning this critical care experience holds for the utiliser and the fears that person may have of the course and outcome of the experience. Recognising the truth of the meaning attached to and fear of the utiliser's experience as valid facilitates the nurse in being able to place the utiliser's need at the heart of a choice or decision.

'Being present' and 'reaching out' interweave to form the experience of 'engaging consciously' – the expression of 'connecting with intention'. The outcome of 'engaging consciously' is in the utiliser 'feeling safe'.

3.2.3.3 *Feeling safe*

...there's one sister that if she's there I feel safe, I feel like okay, if she's there I can ask my questions but when she's not I feel kind of lost I don't know who to ask, where to go. (i7:012)

The concept grouping of 'feeling safe' draws together the ways the nurse establishes her/himself as a dependable, constant presence in the world of the utiliser. 'Feeling safe' appears to be established for the utiliser in two broad ways, namely: through the different and better nurse 'being on top of things', and through experiencing the nurse as a 'compassionate presence' – see figure 3.24 below.

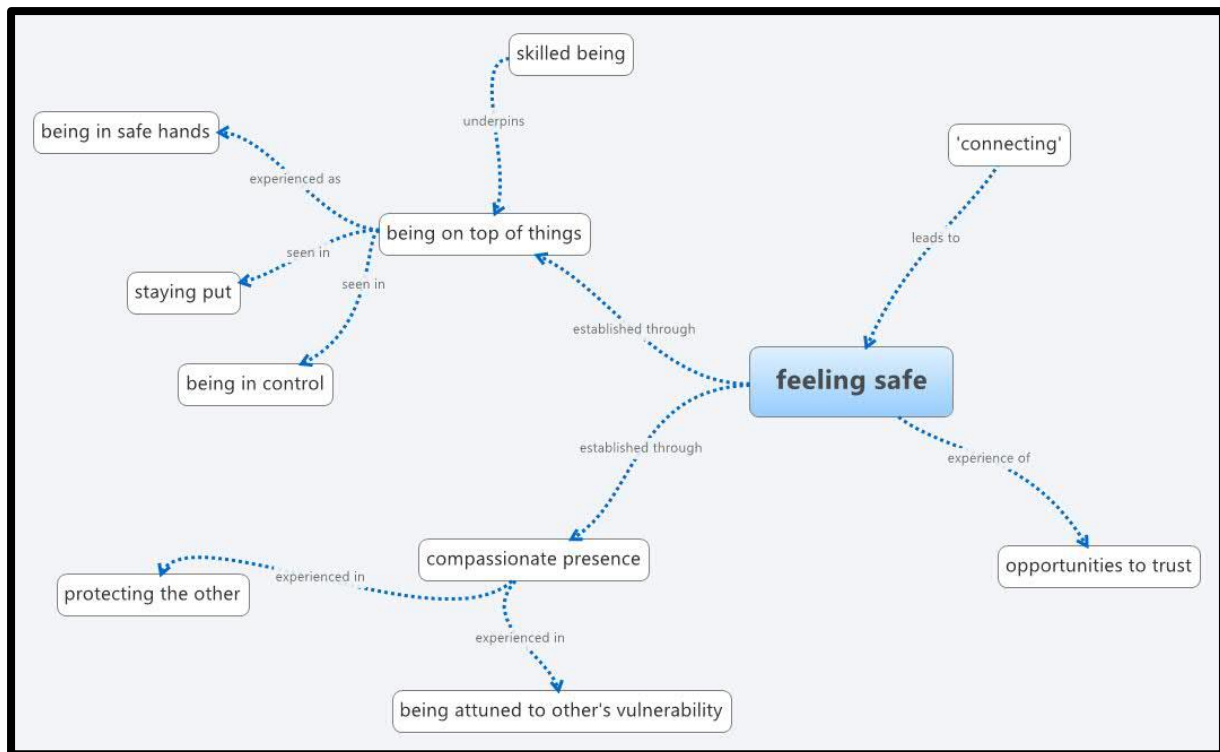


Figure 3.24 ‘Feeling Safe’ – actions, processes and relationships

The utilisers’ experience the expression and impact of the different and better nurse’s ‘skilled being’ and ‘being present’ in the concepts gathered in ‘being on top of things’. Where ‘skilled being’ offers an explanation of how the nurse lives out her/his being and doing of critical care nursing, ‘being on top of things’ offers insight into how this living out actually impacts on and is felt by the utiliser thus establishing the nurse as constant and dependable in that utiliser’s experiences.

‘Being on top of things’ is a way of knowing felt by the utiliser that they, and the patient, are in safe hands. This knowing emanates from their being convinced through experiences in the critical care unit that show the nurse appreciates what needs to be done (through ‘skilled being – handling complexity’), initiates what needs to be done (through ‘skilled being – being influential’), and then stays put through whatever process or activity is implemented.

... they are comfortable speaking about death, they are in a situation where it is apparent that the patient is dying and they don’t run away from it, in fact they will avail themselves to assist and to be there for the family, they don’t avoid the situation, (i2:045)

The utiliser’s conviction is fostered by observing the nurse’s ability to convince the patient to accept and participate in therapy to achieve a better outcome even when

the patient is not able to appreciate the value of an activity or refuses co-operation. A key quality supporting the nurse's way of persuading the patient lies within her/him taking personal ownership of that relationship. The enactment of personal ownership shows in the nurse being in control of patient's space and dynamic, but without controlling the space and dynamic - in the words of one participant *a respectful enactment of the nurse's vision for the patient*. Evidence of this quality being lived out is found in the nurse enabling the patient to take the lead in determining how a day plays out, in letting go of the routine of day, rigidity of charts and surface neatness in a manner experienced by the patient as authentic and meaningful.

... an ability to let the patient have some control over what they do, connected to patient in a way that they, within limits, they're able to (let go). ICU nurses often want to do things on the charts and be ordered and this is what happens at 1 o'clock, this is what happens at 2 o'clock, don't mess with my charts because I'm in charge here and I need all the lines to look the same and so on and I'm not sure that that's all that's needed, there needs to be an ability to let that go (i9:013)

The utiliser experiences 'being on top of things' in the nurse's perceptive articulation of her/his deep knowledge, skill and self within the realities of any situation. The sense that the nurse is using and showing her/his knowledge and skills consistently in a manner that enables another to connect with, understand and be reassured of what is unfolding during a patient's illness progression feeds into the utiliser's feeling of the nurse 'being on top of things'. Being able to understand and feeling reassured are supported in the way the nurse translates the complexities of critical illness and critical care into a language appropriate to a particular utiliser which makes the environment and/or its dynamics accessible to that person. The different and better nurse does not hide behind confounding or obfuscating words or actions further establishing the utiliser's experience of her/him as constant and dependable.

Uuhhuh even though it was a difficult message she would say well he hadn't had a good day today and we were fearing for his life and whatever and we've tried this and this and this and she would explain in layman's terms what they were doing (i10:008)

Participants did offer observations that it is possible for a nurse to create the feeling of 'being on top of things' even though this nurse did not stand out in a positive way to them. A different and better nurse was differentiated by the participants' experience of her/him as being a 'compassionate presence'. Thus, to be recognised as a different and better nurse it is necessary to have and apply deep discipline insight from a place of compassion when connecting with utilisers. 'Compassionate presence' is the utilisers' experience of the nurse enacting 'hopeful compassion'. Utilisers see 'compassionate presence' in the ways and means the nurse displays caring and empathy in action – how they see and feel the *being a nurse* by the different and better nurse.

'Compassionate presence' is the way that the nurse co-exists in the space of another person such that she/he is allowed to enter and remain in that space without causing disquiet to that person. Co-existence is enabled through the nurse's awareness and acceptance of that person's vulnerability and through her/him protecting the person's dignity and humanness through ways of handling an interaction. The underlying value of co-existence in another's space is respect for that person. Respect is experienced through the manner and behaviours of the nurse in opening up and sharing the world of critical care so that it becomes manageable and almost normalised for a utiliser.

The nurse shows respect for a person through the expression of feeling and caring in her/his voice and body language. Utilisers experience being seen as a person rather than an inconvenience in the ways a nurse expresses genuine concern for their situation through eye contact, touch, facial expression, gentleness and her/his way of speaking softly. The nurse is able to balance the harshness of critical care with hope. This shows the person that the nurse acknowledges their experiences of a situation as real and valid while offering a stable core to that experience. Co-existence is founded in respect and is then sustained by the person developing confidence in a nurse from the interactions between them. The utiliser's experience of 'compassionate presence' leads them to seek out the different and better nurse, to choose to engage with that nurse even if she/he is not filling the role of primary care provider for a patient or shift leader for that day.

She would explain it in terms where you could understand it and she was open if you would ask a question to explain it again, she never got irritable umm and

she always gave us space when we visited him she would be there when we arrived umm to answer questions or whatever then, I won't say disappear she was always somewhere, but not into our space so we could spend time with him and then she would come around and see that he's okay and then walk out again (i10:12)

The absence of 'feeling safe' was spoken of as a bad experience. When 'connecting with intention' is not established, the ways of a nurse engaging, whether physically or verbally, cause distress and sometimes even fear to be experienced by the utiliser. Participant's spoke of a need to in some way protect the patients from such a nurse and not being able to trust that nurse. For colleagues this led to being distracted from their own patient and feeling insecure, unsure and indecisive, while significant others were afraid for their loved one and felt that they (as family) were more vulnerable.

I physically sit with the allocation book have a look at the names and then literally decide okay which patient is the one where the least damage can be done and that creates endless stress (i4:165)

But the nurses there I didn't have any connection with them, had absolutely no connection with them because they were in a panic and it was bad (i3:086)

When 'connecting with intention' does happen successfully between a nurse and a utiliser, a completely different outcome results. The utiliser feels they no longer have to struggle or fight for attention because of the way the nurse is present and her/his manner of reaching out. They experience the nurse as alive, thoroughly and appropriately involved; they do not have to work at protecting the patient and can focus on what they need to do. By 'connecting with intention' the nurse assists a person to engage and work through that current experience, usually enabling them to move through it successfully.

You get a warm happy feeling working with people like that because you feel you are not dealing with robots, not dealing with people who have just come on duty to work and to get it over with so they can take their pay check home.(i2:019)

‘Feeling safe’ results from the nurse ‘engaging consciously’ in her/his ways and means of ‘being present’ and ‘reaching out’. Through the nurse establishing her/himself as constant and dependable, more groundwork is laid to motivate the utiliser from considering the possibility of trusting to experiencing actual opportunities where they begin to trust the nurse – moving the utiliser closer to ‘being at ease’.

‘Connecting with intention’ is a subcategory of ‘being at ease’ that explains the ways the different and better nurse engages meaningfully with a utiliser such that they felt they are safe in the centre of that nurse’s world; an experience of an honest, real and true connection.

3.2.4 Category - Anchoring

She made it possible for me to become calm, centred, feel safe and let go of my fear, she gave me space to be without judgment, she gave me what I needed so I could give it to him. (i1: notes.)

‘Anchoring’ provides the final subcategory of the core concern ‘being at ease’. ‘Anchoring’ shows the actions and processes whereby the different and better nurse seems to hold, or anchor, a utiliser in some way such that the person experiences being safe and feels enabled to cope in a situation without losing power, identity or control over their life. As depicted in figure 3.25, ‘anchoring’ plays out in the actions of ‘always there, always everywhere’ and the processes of developing ‘trusting partnerships’.

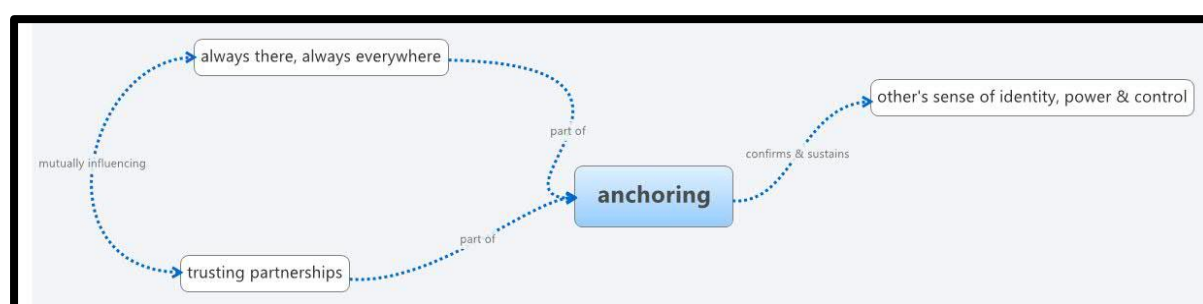


Figure 3.25 ‘Anchoring’ – concept groups and relationships

The categories of ‘connecting with intention’ and ‘anchoring’ are grounded in ‘knowing self’ and ‘skilled being’. ‘Connecting with intention’ and ‘anchoring’ reciprocally create and influence each other - the one leads to and from the other, and vice versa. Definite

subcategory boundaries were difficult to establish as often times a concept seemed to hover in both categories with only subtle distinctions in emphasis expressed by the participants. This challenge was particularly true of the concept grouping 'always there, always everywhere' as on the surface it seems to be the same as 'connecting – feeling safe'. However, the participant's data revealed subtleties that do distinguish the concept groupings from each other. 'Connecting – feeling safe' explains the ways the nurse establishes her/himself as a dependable, constant presence in the world of the utiliser, while 'always there, always everywhere' explains the outcome for the utiliser of that constant, dependable presence being established.

3.2.4.1 *Always there, always everywhere*

These hands are everywhere, so is the brain. The hands are everything because your hands tell you a lot of what is happening with the patient and the family, how scared are they, what is their perfusion, then there is also your feeling that something is not going quite right, you might not have a hand on that particularly or you haven't had time to look at that, but you have a concern that you don't have a hand on it but yet there's that feeling. So for me, having a hand on it but without 'brrrrrrrr' running around in circles (I2:095, 103)

This concept grouping gathers together the ways that the utiliser experiences the nurse as an encompassing presence in their encounters within the critical care environment, see figure 3.26. A common thread across all the participants was the way they saw the different and better nurse as seeming to be constantly present and in touch with everything in the critical care environment, including patients, colleagues, family, technology, relationships, outside environments, and so forth.

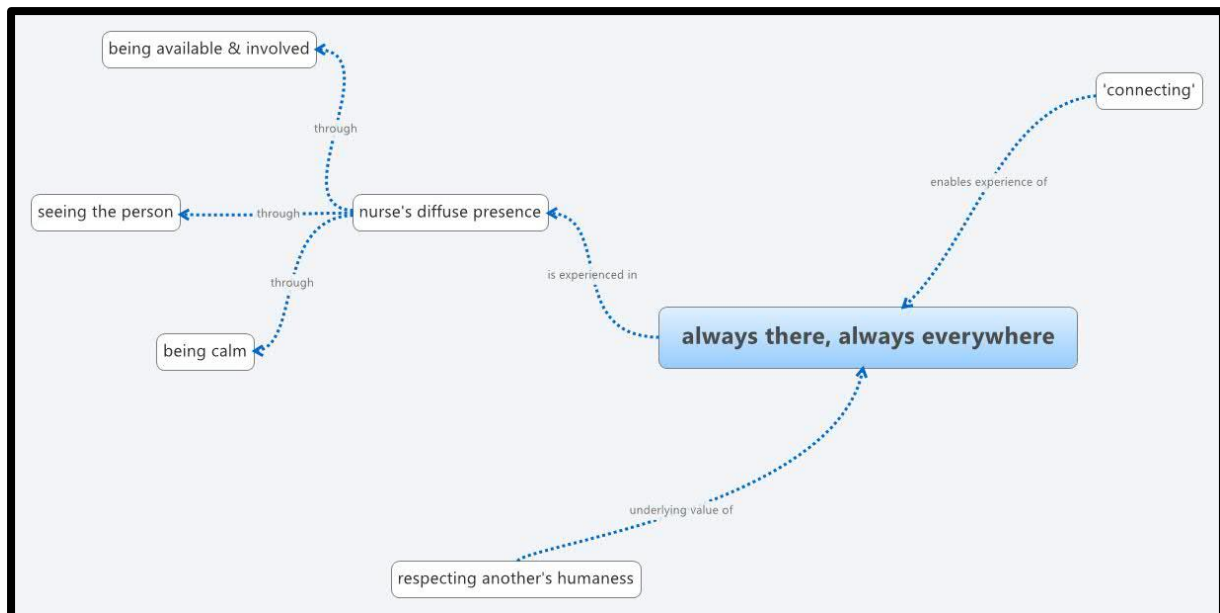


Figure 3.26 'Always There, Always Everywhere' – actions, processes and relationships

The nurse's ability to generate this experience of being an encompassing presence for the utiliser begins with establishing her/himself as constant and dependable through 'connecting with intention'. 'Connecting with intention' changes the initial fragile linkage between a nurse and a utiliser to a meaningful connection. The utiliser then experiences the critical care environment, its role players and challenges through this meaningful connection. 'Always there, always everywhere' moves that process further through to what the utiliser actually experiences as a result of 'connecting with intention' – the experience of the nurse as an encompassing presence in the utiliser's personal environment, this reinforces and builds their 'feeling safe' to their experience of being safe. Figure 3.18 summarises the processes and actions of 'always there, always everywhere' in a mind map.

The essence of 'always there, always everywhere' lies in the nurse respecting the humanness of the patient and that of the utiliser. Through observing the nurse, the utiliser sees that the nurse's respect for the humanness of a patient is the value underlying her/him conducting the activities and interactions required in the care of a critically ill patient. The nurse declares her/his commitment to this value by becoming involved with the complexity of combining all aspects of caring for the person who has become a patient. The utiliser sees and experiences that it is the person who is the focus of the different and better nurse's abilities, rather than the list of mechanical,

technical, pharmacological or administrative work to be done. Through synchronising and balancing the nurse demonstrates being able to sense subtle changes, and shows she/he is at ease in the grey areas of suffering and distress. In this way, the utiliser comes to know that the nurse's interactions will be consistent in focus, openness, depth and composure however a situation may present itself or unfold.

The doctors saw numbers, she saw my husband (i1:notes)

She saw him as a human being and not just a patient and the whole feeling is that they see the person they don't see a number (i10:031)

As such 'always there, always everywhere' is an expression of the utiliser experiencing the diffuse influence a different and better has on and through the environment and dynamics of critical care. The utiliser gains access to this influence in the ways and means the nurse makes her/himself available to and involved in the utiliser's experience. Through the different and better nurse consistently showing that she/he is able to pre-empt disaster, respond proactively to changes and be accessible in a calm, gentle, person-focussed manner, the utiliser confirms for them self that their 'feeling safe' is an authentic experience. By knowing that 'feeling safe' is authentic (real and sustainable), the utiliser experiences being safe which seems to be necessary as a forerunner to the utiliser being willing to create a 'trusting partnership' with the nurse and then live in that partnership during the critical care experience.

3.2.4.2 *Trusting partnerships*

A good nurse will be trusted by the patient and the family and by the doctors who work there and the development of trust is enormously important for patients, particularly patients and it's not something that's easy to get, it's not automatically given to people so I think a nurse has to be very, very aware of the role of trust, that the patient needs to be confident that what the nurse is doing is the right thing and knows what she's doing or he's doing. (i5:007)

'Trusting partnerships' reveals both the outcome of the actions and processes of the previously discussed categories as well as how this concept grouping contributes to 'anchoring'. 'Trusting partnerships' are the outcome of the ways the different and better nurse has created opportunities for being trusted by a utiliser, mostly through 'skilled

being' and 'connecting with intention'. With the utiliser embracing these opportunities, a 'trusting partnership' results between the nurse and the utiliser. The 'trusting partnership' provides a way for the utiliser to make sense of and work through the circumstances they are living within. It becomes easier for the utiliser to continue with the normal business of their life because they know that the different and better nurse can be trusted with their particular interests, anxieties or fears. Figure 3.27 offers the actions, processes and relationships of this concept grouping.

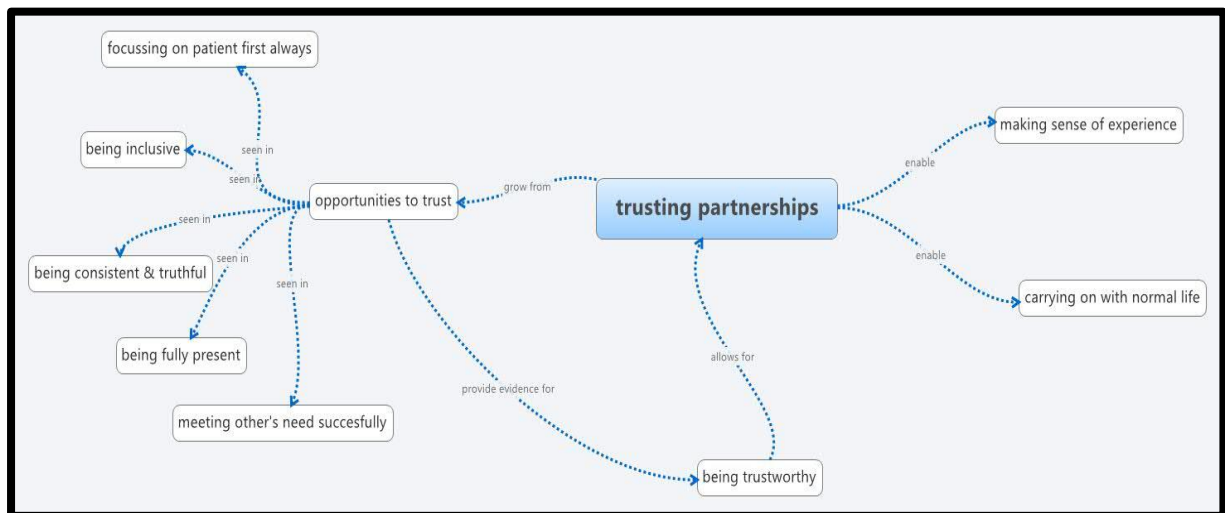


Figure 3.27 'Trusting Partnerships' – actions, processes and relationships

The development of a 'trusting partnership' is well rooted in the attitude, behaviour and manner of the nurse. The nurse's visible expression of 'knowing self' and 'skilled being' seems to have a pronounced influence in laying the groundwork from which a 'trusting partnership' grows. Utilisers can see and feel the nurse's expression of being at ease with her/his sense of self and sense of fit in the roles of nursing. The nurse is able to convince a utiliser of she/he is a specialist practitioner (or has the potential to become a specialist practitioner) by openly exhibiting evidence of her/his ability to think, engage and behave at a more complex level than other nurses in the environment. This evidence is provided in the nurse showing confidence in and connection with her/his knowledge and skill in the manner she/he communicates with colleagues, patients and significant others verbally, physically and emotionally.

... this particular nurse is so confident in her skill that if the family has any questions he or she would be able to answer them without feeling threatened,

without getting defensive and it wouldn't be a problem, in fact it would probably enhance their sense of trust, ja. (i2:015)

The actions and processes of 'skilled being' seem to be elemental in grounding a 'trusting partnership'. Through the person showing ease in the being a nurse and the doing of nursing, she/he is able to focus her/his attention on being fully present in the moments that collectively make up each interaction, whether these are moments of activity or moments of simply being still with that utiliser. In visibly expressing her/his discipline knowledge and skill in ways that move beyond the politics, habit and routine of nursing, the nurse reinforces the footing that underpins a utiliser becoming able to create a 'trusting partnership' with her/him.

The groundwork laid by the different and better nurse through the visible expression of being at ease with her/his sense of self as well as the utiliser's experience of this expression allows for the person to recognise the different and better nurse as being trustworthy. With the utiliser experiencing being safe through the nurse's ways and means of 'connecting with intention' and then 'always there, always everywhere', the utiliser seems to reconcile opportunities for trusting into a type of a mental portfolio where their requirements for a nurse to be deemed trustworthy are gathered. The utiliser appears to organise and reflect on these opportunities for trusting against their own priorities to decide whether or not a nurse is showing that she/he is trustworthy.

The most common priority amongst the study participants in deeming a nurse to be trustworthy was them feeling that the patient always came first and was safe in the care of that nurse. The utiliser watches the nurse's way of engaging and then working with the patient, they want to see an ease and equality in the relationship, showing that the patient trusts the nurse. The utiliser needs to know that the nurse is 'being present' for that patient. The nurse must provide evidence that her/his actions are geared towards helping the patient to the best possible outcome in a situation. How the nurse limits the patient's suffering by achieving a balance between her/his need for information and the patient's experience of related interventions influences the utiliser's assessment of the nurse being trustworthy.

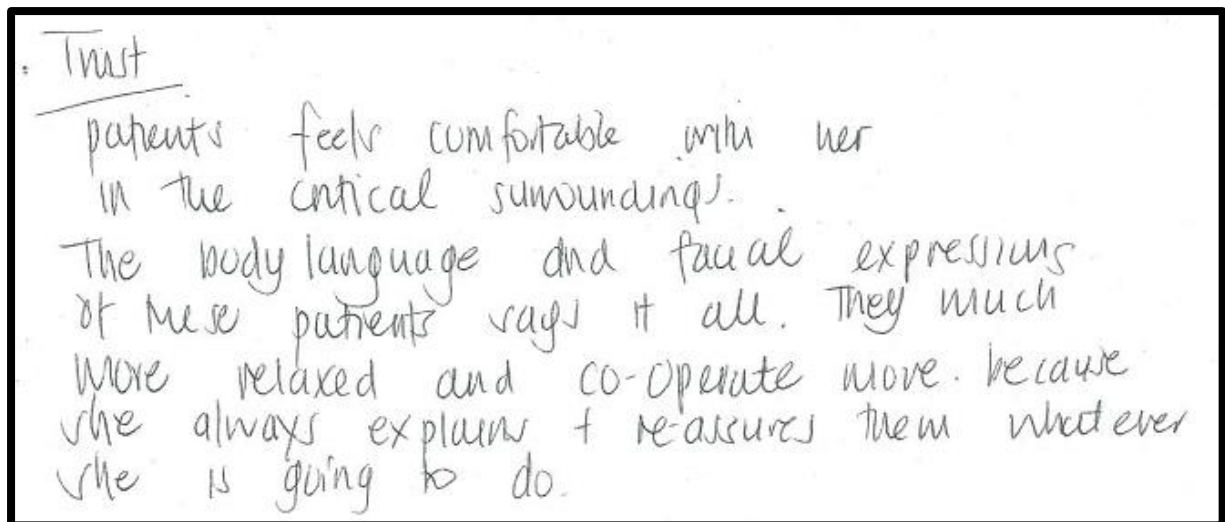


Figure 3.28 Interview 8 – clipping from naïve sketch

The utiliser looks for signs that the nurse is aware of what it means for the person to trust the nurse, to create and sustain a 'trusting partnership'. The utiliser reflects on the manner of communication and interaction used by the nurse. Consistency and truthfulness in message content offered by the nurse, and then the rest of the team is considered, along with the manner of how information is contextualised and the time taken to ensure the utiliser's need for information is met. Consistency and truthfulness in the way the nurse conducts the activities of nursing that are expected by different utilisers is necessary in the nurse demonstrating her/his awareness of what it means to be trustworthy.

She was totally honest in a very, very kind way (i3:027)

Utilisers have diverse expectations of how the doing of nursing happens in their particular context; however there is a common requirement that the nurse is fully present in a situation, showing she/he is able to pre-empt disaster, respond to needs and be flexible in moving with unanticipated events.

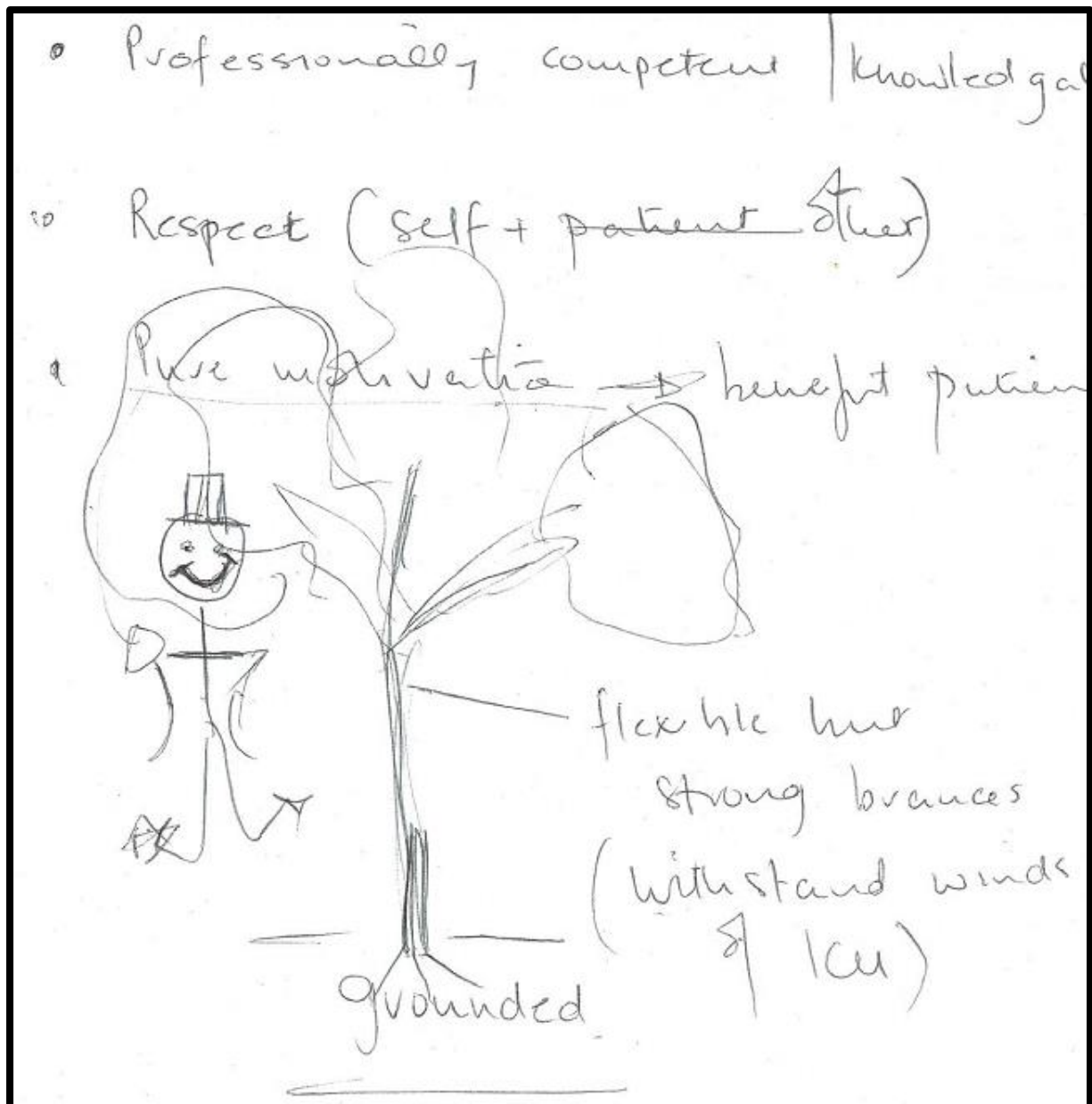


Figure 3.29 Interview 9 - clipping from naïve sketch

Additionally, the utiliser wants to be seen as part of the patient, that the nurse is able to make room for the utiliser in the spaces of care. While this consideration is particularly true for significant others in terms of them needing to be integrated into the care and progress of their loved one, it was also noted by colleagues. Colleagues notice how a nurse engages with and treats a patient's significant others, using these interactions as part of deciding whether a nurse is trustworthy. Colleagues also want to be seen as an integral part of the patient experience, a partner with the nurse rather than an external service provider or some-one who has to be tolerated. A utiliser who

is welcomed into the spaces of patient care by the nurse feels confirmed as a valid and valuable contributor to the progress of a patient.

The final common priority that a utiliser seems to consider in determining the trustworthiness of a nurse is whether their needs were successfully met. Successfully meeting a utiliser's needs flows from the priorities of the previous three paragraphs and the utiliser appears to finally consider the following:

- whether a safe and supported space has been created for them to be with the patient in the context of their role as a colleague or significant other;
- whether the nurse has helped the patient and/or the utiliser to manage the difficult and complex spaces in critical care, and
- whether the nurse has proven that she/he consistently and continuously works from a foundation of respect.

If the nurse has succeeded in meeting the priorities and needs of a particular utiliser, the possibility of a 'trusting partnership' evolves into an actual partnership. The nurse is trusted to completely fulfil her/his role in critical care with the utiliser then freed to make sense of and work through their current circumstances and be able to continue with other requirements of activities that make up their normal life.

Ja no when those persons were there, there were two; I felt that I could breathe, I could go for a quick coffee, I could go to the loo, I could relax. Umm they were doing their work, just sitting there doing their work but smiling and being in control of whatever they were doing (i3:059,063)

The utiliser's experience of the different and better nurse being 'always there, always everywhere' is necessary for a 'trusting partnership' to root and gain momentum. The interplay between these concept groupings leads to the utiliser feeling a sense of 'anchoring' in the complex and unpredictable world of critical care and critical illness. 'Anchoring' explains the ways the different and better nurse seems to hold, or anchor, a utiliser (to a greater or lesser degree depending on the severity of a situation), such that they are able to cope in or manage the situation without losing their power, identity or control over their current role in the critical care environment and its dynamic.

3.2.4.3 Connecting and Anchoring

A consequence of the nurse trusting her/himself at a profound level as is expressed through her/his ways of being a nurse and doing nursing is that the utiliser senses the nurse is at ease with her/himself. From this point of departure the utiliser becomes able to open up to the possibility of trusting the nurse. As the utiliser becomes convinced that the nurse is a constant, dependable, encompassing presence through the nurse's ways of 'connecting with intention' in an interaction and 'anchoring' that interaction, experience or situation; the utiliser moves to a place of accepting the nurse as being trustworthy. The culmination of the nurse being trusted by the utiliser is the sense experienced by the utiliser of 'being at ease'.

3.2.5 Core concern – 'Being at Ease'

Immediately at ease, at ease knowing that whatever comes today we'll deal with it how hard or tough whatever its going to be, its dealt with (i4:161)

The core concern of the participants when recognising a different and better nurse was their sense of 'being at ease' in the presence of this nurse (figure 3.30 reproduced below for ease of reference).

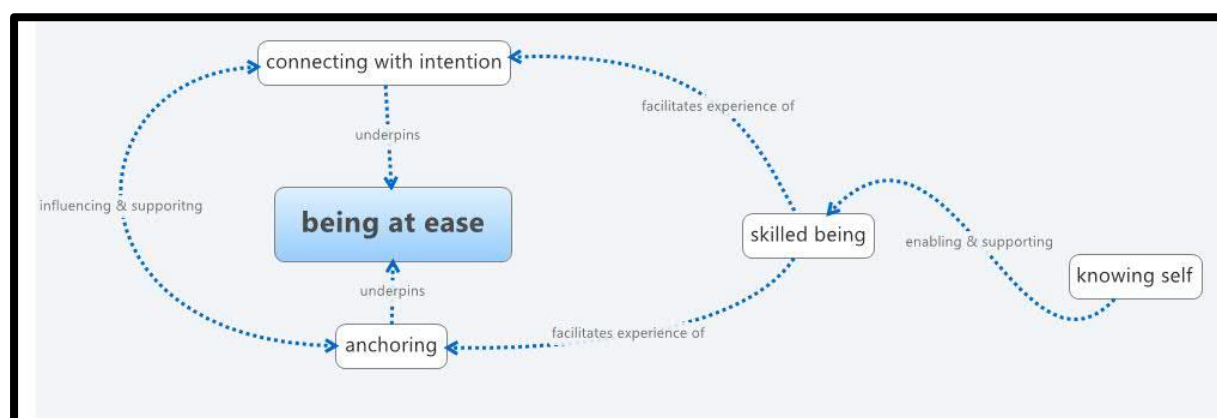


Figure 3.30 'Being at ease' – categories underpinning the core concern

When a utiliser accepts a nurse as trustworthy, they are able to release their fears of being powerless and of needing to somehow control the situation (or the nurse). They recognise that they do not have to work at protecting the patient or themselves because the nurse has shown that she/he will naturally live out her/his role in the being a nurse and the doing of nursing in its entirety. Through feeling that the nurse is at

ease, the utiliser is able to gain perspective of feeling at ease within the situation they are experiencing. Participants spoke of being able to breathe, or take a big breath.

For the utiliser, 'being at ease' is supported by the nurse's talent in creating a space where that nurse is trusted completely. The utiliser knows that the nurse is genuinely interested in the patient and themselves, whether a colleague or a family member. Genuine interest is recognised in the nurse taking time to care and being accessible in caring, along with her/him being prepared and able to do what is necessary in a situation. The space of trust is supported in the reassurance felt by the utiliser when the nurse stands her/his ground and stays fully present in difficult or unsettling circumstances. The utiliser recognises a sense of there being a stable core in an unpredictable world as a nurse naturally blends a calm heart, a skilled hand, a thinking brain into intuitively working from a grounding value of respect, thus aiding the utiliser to experience 'being at ease'.

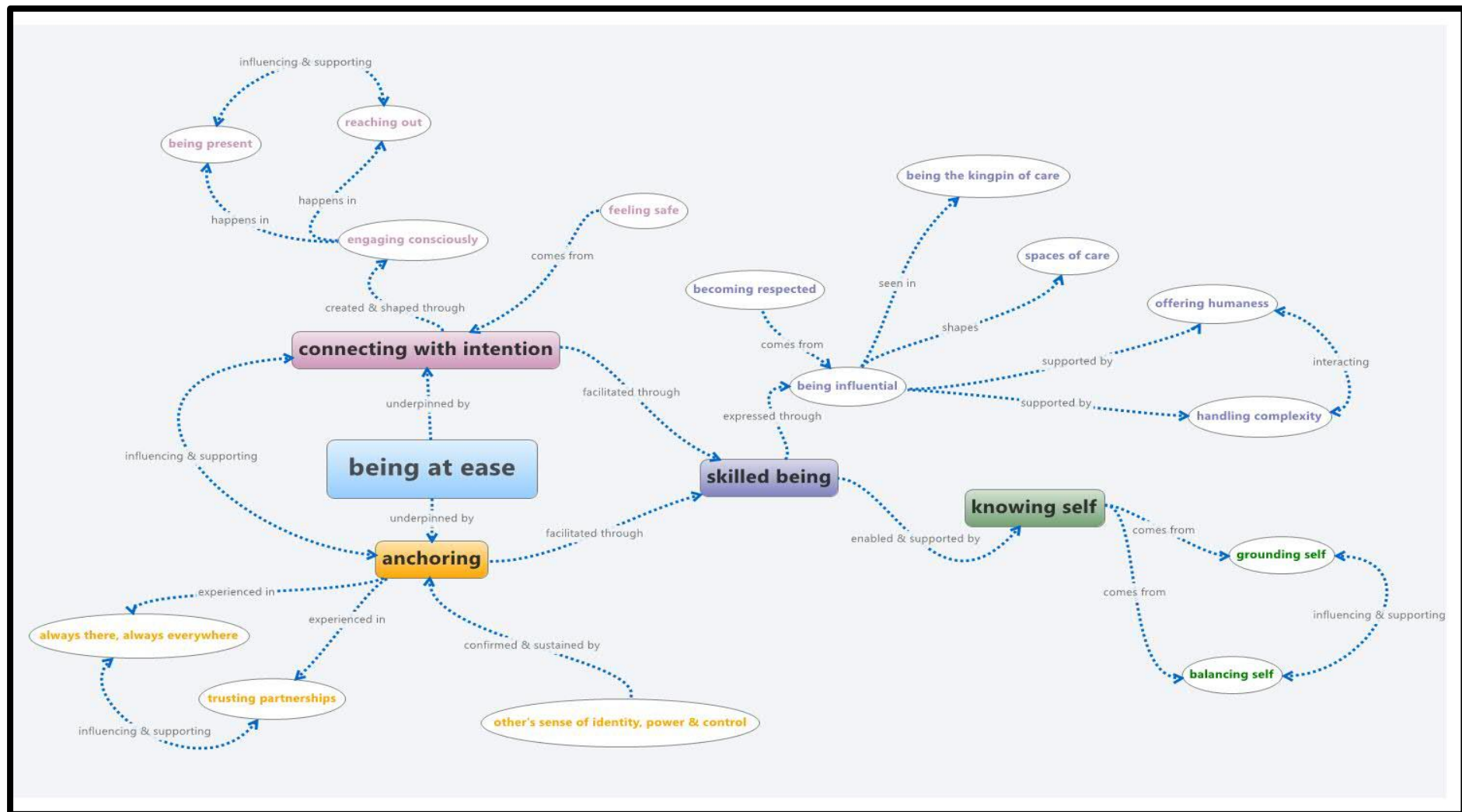


Figure 3.31 *Being at Ease* – core concern, categories, concept groups and relationships

Figure 3.31 shows a mind map of the relationships between the categories and each of their conceptual groupings that ultimately result in the utiliser 'being at ease'. In this mind map directionality of the relationships work from the core concern outwards to the categories; and from the categories outwards to the conceptual groupings. My intention with this choice of presentation is to show how the core concern of a utiliser in recognising a different and better nurse develops through and from each of the categories. Accordingly the mind map can be read as - 'being at ease' is underpinned by the mutually influential and supportive effects of 'connecting with intention' and 'anchoring'. 'Connecting with intention' and 'anchoring' are facilitated through 'skilled being', with 'skilled being' enabled and supported by 'knowing self'. The mind map can also be read from 'knowing self' inwards to 'being at ease' – where 'knowing self' enables and supports 'skilled being'; 'skilled being' facilitates 'connecting with intention' and 'anchoring' which together underpin 'being at ease'.

While it is necessary to deconstruct this complex social process to allow us to explore its nature, gain insight into its fundamentals and consider its possibilities, I am concerned that when viewed as a mind map the categories seem to have a fairly linear and specific relationship with each other. As the data has shown, these relationships are far less exact and specific than the lines depicting these relationships suggest. Perhaps it is helpful to consider the relationships between the categories themselves and then with the core concern within an analogy of the earth and its atmosphere. The core concern ('being at ease') would be the earth. The 'being at ease' earth is surrounded by an atmosphere that is a complex combination of various gases (the categories). While we know the name, properties and significance of each of the gases (for example: nitrogen, oxygen, argon, carbon dioxide, water vapour) making up the atmosphere, we cannot easily differentiate between these gases as we go about our daily life as these do not flow in specific streams, rather they merge into a complex, reasonably stable mix that supports life on earth. The categories of 'being at ease' have a similar nature to the atmospheric gases, each has actions and processes that makes it essential, unique and identifiable in contrast to the others; but the manner of how each subcategory underpins, influences, supports, facilitates and enables another subcategory to be experienced is not one dimensional or unidirectional.

The culmination of all the actions and processes explained in the four categories that combine to create this sense in the utiliser of 'being at ease' is that a person is able to relax, feel peaceful and function at a more optimal level. The utiliser feels confidence in their own ability to fulfil the role they need to in a situation. In this way, the utiliser recognises a feeling of 'being at ease' within her/himself. This feeling of 'being at ease' means the utiliser is able to regain or recognise their own sense of self, feel in control of their experiences and use their personal power to support the nurse and patient in moving towards the best outcome for the patient.

3.3 CHAPTER SUMMARY

In chapter three I have provided a detailed and comprehensive account of how applying the methodological processes of grounded theory to the participant data sets led the emergence of an initial proposition of grounded theory that offers an explanation as to how utilisers recognise a different and better nurse.

The core concern of the participants was that of 'being at ease'. A utiliser recognises a different and better nurse through their experience of 'being at ease' in the presence of that nurse. 'Being at ease' is rooted in the different and better nurse's 'knowing self' which is experienced by a utiliser through that nurse's 'skilled being'. Within the expression of the actions, processes and interactions of these two categories, the utiliser experiences the different and better nurse as being at ease in her/his being and doing of nursing. Through the experience of the nurse at ease in her/himself and the dynamics of critical care, 'connecting with intention' and 'anchoring' are enabled and facilitated. Ultimately these lead to the utiliser recognising that they are at ease in themselves and with the dynamics of critical care.

Chapter four introduces and explains how I sampled and compared relevant nursing scholarship to this emergent grounded theory. My assimilation of scholarship into the categories and core concern leading to a well-developed and situated grounded theory is explained.

CHAPTER 4

ASSIMILATING AND SITUATING THIS GROUNDED THEORY

Chapter 4 provides insight into how relevant literature in nursing scholarship was considered, interpreted and enfolded into the nascent grounded theory. The focus of engaging with literature in grounded theory methods is to use germane literature as data. Used in this way, literature served to extend, challenge or confirm my analysis of the participants' data through engaging the ideas and findings of other authors with the emerging theory of this study.

4.1 THE LITERATURE REVIEW IN GROUNDED THEORY

One of the defining precepts of grounded theory method is the deferral of an in-depth literature review until after data collection and data analysis has been completed. This underpins a fundamental principle of grounded theory, namely that the participants' contributions are the most important voice in the emergent theory, with the eventual product of the study being discernibly grounded in the participants' data. Thus, engaging with relevant literature later in the research process supports the researcher in articulating the participants' understanding or experiences of a social process without importing or imposing preconceived ideas from the existing discipline knowledge base into the interview data or analysis thereof (Charmaz, 2014:307; Urquhart, 2013:136; Stern in Bryant & Charmaz, 2007:123).

Twenty five years of being a nurse, including time in an academic environment, meant I could not engage in data collection and analysis from a personal place of 'not knowing'. However, once the study proposal was completed I respected this grounded theory precept through deliberately focussing any engagement with literature on my learning about the philosophy, method and implementing of grounded theory and did not read further in any nursing discipline literature until after the core concern 'being at ease' and its categories had been articulated from the participants' data sets.

Another precept regarding literature in grounded theory method is that the identified, relevant works are used as a further source of data and are not preferenced above the participants' stories. As such, each piece of literature must 'earn' its place in

contributing to the emergent theory through the processes of theoretical sampling and constant comparative analysis.

In Chapter 2, I explained how I used the core concern - 'being at ease' - to determine a relevant point of entry into the published scholarship. I provided a detailed explanation of the processes I applied in identifying, sampling and reviewing the literature that related to the emergent theory. Through this chapter I will show how I have understood the relevant ideas and concepts in literature to have engaged with, developed and challenged the core concern and categories of 'being at ease'; as well as vice versa. Throughout my engagement with the particular literature identified through theoretical sampling, I posed similar questions of the article contents as I had to the participants' data, namely:

- What is going on here in terms of who, when, where, why and how?
- How is this idea / concept and 'being at ease' similar?
- How is this idea / concept and 'being at ease' different?
- Is this the only way the parts and whole of 'being at ease' may be understood - how else may it be understood?

It was through engaging with the published germane literature in this way that I was able to view the established body of knowledge as part of my data set, with the articulated emerging theory providing the anchor to the discussions that follow. The literature became a contributor to the emergent theory through developing and settling the concepts and constructs, rather than overriding or diminishing the voice of the participants (Urquhart, 2013:137; Birks & Mills, 2011:22).

Charmaz (2006:167) speaks of the literature review as the place where the researcher creates a dialogue with which to enter into the current conversation in the field under study. Consequently my intention in this chapter is to weigh my participants' insights articulated in 'being at ease' on the scale of scholarship such that I can clarify and balance ideas through comparison and debate. This chapter is therefore an invitation to a theoretical discussion to show and debate how 'being at ease' fits into, extends and is developed through the knowledge underpinning and developing nursing.

4.2 OPENING THE DIALOGUE

Charmaz (2014:305) advises that the participants' core concern, as well as the robust categories explaining this concern, should be used to guide the researcher's entry into discipline literature. My intention in this part of my study was to consider and challenge 'being at ease' with literature at the level of the core concern with its four categories and not at the level of the concept group detail within each category. At this point I wanted to weigh the nascent theory as a whole on the scale of germane nursing scholarship rather than possibly losing the impact of the theory's full explanation in the details of each concept group within each category.

Section 2.7 of Chapter 2 offers a comprehensive explanation of how I followed Kathy Charmaz's (2014:305) advice in beginning my review of published work, but in order to provide a foundation to the following discussions I offer a brief recap. I began my engagement with literature by reflecting on how the core concern of 'being at ease' may be considered in nursing scholarship. On realising that the search terms I had used were too broad and offered up a diversity of work that did not resemble the span of the explanation within 'being at ease', I tapered the search through using the category explanation and concept groups of 'knowing self'. I used 'knowing self' because the participant data had shown this category to provide a natural beginning to the eventual experience of the core concern. The outcome of my search resulted in a brief journey through the literature encompassing spirituality in nursing; to then engage more deeply with the notions of 'good' nurse and 'good' nursing' and finally, to a comprehensive exploration of the phenomenon of nursing presence (see section 2.7.2 for an explanation of the process I applied in identifying, sampling and analysing this literature).

In the following sections I explore and debate how the ideas of 'good' nursing and the phenomenon of nursing presence are relevant to 'being at ease', as well as how these phenomena challenge, extend and develop the core concern and four categories of 'being at ease'. The final contribution in this chapter is a succinct explanation drawn from this assimilated and situated substantive grounded theory. I have chosen to name this theory *Being at Ease* after the core concern that emerged from analysis of the participants' data. *Being at Ease* offers an explanation of how utilisers recognise 'different and better' nurses and nursing.

4.3 GOOD NURSING

I used the category 'knowing self' to taper the search phrases that were submitted into various data bases. Initially, these data bases offered up a body of literature elaborating the concept of spirituality and nursing. Whilst I did find congruence in this scholarship in terms of the essential element of the nurse having an own sense of understanding her/his spirituality to underpin her/his ability to support the patient's spirituality (Cockell & McSherry, 2012:961; Timmins & McSherry, 2012:20; Kociszewski, 2003:141), this body of literature did not resonate with sufficient fullness to the explanation of how 'different and better' nurses are recognised through the utiliser's experience of the core concern 'being at ease'. These ideas within the scholarship on spirituality seemed to reflect a slice of the actions, processes and relationships within 'knowing self' rather than the fullness of this grounded theory's explanation.

However, within these works on spirituality, various authors linked a concept of 'good' with a nurse or nursing. A nurse being able to support a patient's in meeting spiritual needs was highlighted as an indicator of a 'good' nurse doing 'good' nursing (Biro, 2012:1003; Cockell & McSherry, 2012:959; Rankin & DeLashmutt, 2006:282; Swinton & McSherry, 2006:801). As I explored this literature, the descriptions and explanations around the notion of 'good' in nursing seemed to be analogous to some of the fundamental ideas of 'being at ease. Through my engagement with the notion of 'good' as used in the language of nursing in this body of literature, the notion of 'good' in nursing became the first point of comparison between the published nursing scholarship and 'being at ease' with its categories of 'anchoring', 'connecting with intention', 'skilled being' and 'knowing self'.

4.3.1 The notion of 'good' in nursing

The word 'good' in the phrases 'good nurse' and 'good nursing' functions as an adjective – a word that describes an attribute of a noun. When used as an adjective, 'good' then describes a nurse or nursing as having or demonstrating those attributes that are desired or approved of in a 'good nurse or 'good' nursing. Biro (2012:1005) notes that the word 'good' is used more in nursing literature than in that of any of the other health professions and its use in nursing implies an inherent ethical value to the word it describes.

The notion of a 'good' in nursing traces its roots back through history to the influence of Florence Nightingale and her various contemporaries in their identifying that for good nursing to happen, it was important for the person to have good moral character (Biro, 2012:1002; Smith & Godfrey, 2002:303). The notion of what the qualities and attributes of a good nurse are have been influenced by a slow evolution in historically and habitually established perceptions of what the phenomenon of nursing means, as well as differing ideas and ways explaining what nurses actually do. Through the history of nursing to as recently as the 1980's the attributes of a good nurse were concordant with the idea of nursing being a calling for an individual and 'good' was circumscribed by qualities associated with being virtuous – an ideal of goodness encapsulated in moral purity. A few examples of qualities that were considered as desirable in this literature included chasteness, obedience, stoicism, servility, modesty and humility (Begley, 2010:527, Fealey, 2004:651). However, more recently, in the work of Biro (2012:1002-1011), Catlett and Lovan (2011:54-63), Begley (2010:525-532) and Smith and Godfrey (2002:301-312) amongst others, the notion of 'good' as this relates to a nurse and nursing are most often considered within constructs of virtue ethics theory where 'good' is situated within the notions of excellence of character and intellect.

Virtue ethics theory has its origin in Aristotelian philosophy within the question 'What is the good of man?' and Aristotle's answer – 'an activity of the soul in conformity with virtue'. The central questions in thinking on moral behaviour from this perspective are about the character of man and how man's character balances action or desire (Rachels & Rachels, 2012:157; Morrison, 2004:84-87). Virtue ethics theory thus takes a position that it is the character of the person, that internal part of one's identity, that determines behaviour - the base of virtue ethics being that a person wants to do good, be good and to act on the good (Armstrong, 2006:113; Biro, 2012:1005; Smith & Godfrey 2002:303).

Within the context of Aristotelian ethics, a good person is one who demonstrates moral virtues of character. Moral virtues are defined as 'traits of character evident in habitual action that are good for anyone to have' (Rachels, *et al.*, 2012:159); Armstrong (2006:115) adds to this that these moral virtues have effect in 'disposing one to act, think and feel in morally excellent ways'. Despite our different-ness as individual

human beings, cultures, societies and so forth in interpreting and valuing virtues, there are common virtues that are seen to be needed by all people. The character virtues encompassing the idea of a good person flow from our spirit of common humanity, marking the midpoint between excesses and deficiencies of this human spirit. Some examples of these common virtues of a good person are courage, honesty, generosity and loyalty. While each virtue has a particular reason in a community or culture for having value, virtues are regarded as generally valuable because they describe qualities that people need in order to be successful and flourish in living life.

From this broad perspective of who and what a good person is, we use our purpose of engaging with a particular person to refine an understanding of the virtues of good in that relationship, for example virtues exemplifying a good nurse (Rachels, *et al.*, 2012:159,166-167, Morrison, 2004:85). Arries (2005:66) translates the definition of good into nursing by suggesting that the traits of a good nurse are those characteristic habits that allow the nurse to become a good practitioner who behaves well, raising a question as to what particular virtues constitute good nurse character and thus good nursing conduct.

Virtues are seen to be those qualities or attributes of an entity that are desirable or beneficial; as such a good nurse and good nursing will show those qualities or attributes deemed desirable or beneficial within the context of being a nurse and doing nursing. Biro's (2012:1005) translation of these constructs of virtue ethics into nursing claims that a nurse's behaviours and actions occur as a result of her/his personal character and values rather than professional standards and rules; as such 'good nursing' then happens in the wholeness of the person, this idea also supported in the breadth of work by Smith and Godfrey (2002:301-312), and Catlett & Lovan (2011:54-63). According to Begley (2010:527), a good nurse is a nurse who does nursing well; maintaining high standards in all areas of practice and governance. Current opinion in this scholarship reflects an alignment of the notion of a good nurse with virtues that demonstrate excellence of character and intellect (Begley, 2010:529). This contemporary view of a good nurse has led authors to engage with what constitutes those essential virtues that exemplify this excellence in character and intellect in the present day. Begley drew from work by various authors in this focus area in collating personal virtues that have been linked with 'good nurse' and 'good nursing', offering

this in three broad themes. Table 4.1 below shows the three themes and examples of the virtues grouped within each theme (Begley, 2010:526-529).

Table 4.1 Theme groups and related personal virtues of contemporary good nursing

THEME	VIRTUES
Intellectual & practical	Competence, art/skill, scientific knowledge, intuition, imagination, cleverness, discernment, judgement
Dispositional	Tolerance, sensitivity, courtesy, approachability, diligence, empathy, kindness, benevolence, compassion, genuineness, patience
Moral	Courage, integrity, justice, fairness, honesty, veracity, fidelity, trustworthiness

Begley thus situates a contemporary view of the notion of good in nursing through these thematic groupings. The virtues within each thematic grouping are offered as hallmarks of excellence of personal character and intellect that then enable a nurse to do nursing well. Importantly, this author notes that it is in the balancing of the virtues embraced within these three themes that excellence of character is formed, and by extension then, that 'good' nursing occurs - "The 'good' nurse requires a synthesis of science and sensitivity. Excellence cannot be achieved without a balance between the Intellectual and Practical, Dispositional and Moral" (Begley, 2010:529).

From these themes, Begley (2010:527) then goes further to extrapolate a framework to identify four attributes of good contemporary professional practice - the Four As' framework. This framework identifies professional attributes, with underpinning virtues of each, that differentiate the contemporary understanding of good nursing from earlier interpretations of the good nurse and nursing. Table 4.2 shows the Four As; four contemporary attributes of good professional conduct along with the related underpinning contemporary virtues of each attribute:

Table 4.2 Four attributes of good contemporary professional practice and enabling virtues

ATTRIBUTES	ENABLING VIRTUES
Advocacy	compassion, courage, commitment, empathy, intuition
Accountability	practical and theoretical wisdom, integrity, honesty, trustworthiness, veracity, moral courage
Assertiveness	tolerance, sensitivity, courtesy, approachability, diligence, empathy, kindness, benevolence, compassion, genuineness, patience, moral courage
Autonomy	discernment, judgement, wisdom

She concludes that being a good nurse happens in the interplay of the personal virtues exemplifying good character (Table 4.1) and these attributes (in Table 4.2) embodying good contemporary professional nursing practice. The interplay of personal virtues of good and professional attributes in effect form the keystone of a modern understanding of being a good nurse doing good nursing (Begley, 2010:531).

4.3.2 Uncovering good nursing in ‘being at ease’

Studies with a focus on the notion of ‘good’ in nursing suggest that good nursing can be understood through the interaction of a nurse’s character and her/his professional attributes in the relationship between the nurse and the patient (Bjorkstrom, Johansson & Athlin, 2006:506, Biro, 2012:1007, Catlett & Lovan, 2011:58-59, Begley, 2010: 529-530, Rush & Cook, 2006:384, Smith & Godfrey, 2002: 308-309).

Personal virtues are brought into the nurse-patient relationship in the expression of that nurse’s character, the essence of who she/he is as a person. These virtues are lived out in the expression of the nurses’ respect for self and others; her/his manner of communicating and how caring is demonstrated; for example - compassion, understanding, kindness, gentleness. Professional attributes are those that are established through the person being part of the nursing profession; and are expressed through qualities such as critical thinking, applying discipline knowledge and skill competence, problem solving, efficiency and so forth (Begley, 2010:528, Catlett & Lovan, 2011:58).

When comparing the notion of 'good' nursing to the core concern and categories of *Being at Ease*, the points of congruence between these two ideas are apparent. In Chapter 3 I explain how the core concern 'being at ease' is seen by a utiliser to begin in the juncture of the nurse's insight and acceptance of self. This then underpins the expression of that self within the roles of being a nurse and doing nursing. The categories 'knowing self' and 'skilled being' seem to have resonance with the personal and professional attributes of good nursing highlighted in current scholarship.

The understanding of 'good' offered by scholars in this focus area establishes that it is the person's expression of her/his character virtues that underpin the articulation of 'good' nursing attributes, similarly I reason that 'knowing self' is the necessary beginning point for 'being at ease' to characterise a nurse-utiliser/patient interaction. The person's ability to engage in the actions of 'grounding self' and 'balancing self', the two conceptual groupings in 'knowing self', is firstly entrenched in the virtues of her/his character, that character perhaps inherently geared with the virtues that support a person becoming and being a 'good' nurse. Thus, within the actions, processes and relationships of 'knowing self', it is the essence of her/his character, those virtues seen as typifying 'good' in nursing, that will enable and guide that person to find meaning in their sense of self and to express her/his identity within their nursing.

The premise that 'being at ease' apparently begins with 'knowing self' is further supported by studies that have engaged with the notion of 'good' in nurses and nursing. This work has included the perspective of student nurses, registered nurses as well as a review of literature that included samples of patients and nurses across a variety of disciplines, roles and hierarchy. Collectively, these studies provide the insight that whilst seeing professional attributes as undeniably indispensable to 'good nursing', study participants tend to emphasise personal attributes over professional attributes as the essential nucleus of 'good nursing' (Bjorkstrom, *et al.*, 2006:506; Biro, 2012:1005; Smith & Godfrey, 2002:309).

The enabling and supporting role of 'knowing self' to 'skilled being' is similarly reflected in the described interaction between the nurse's personal and professional attributes when doing 'good' nursing. Good nursing is described as developing within the interplay of an individual's qualities of good character and those professional attributes seen to depict a contemporary view of the good nurse, with the person's character

underpinning this interplay of qualities and attributes. So too does 'knowing self' enable and support the actions, processes and relationships of 'skilled being'. The category of 'skilled being' explains the interchange between a person's ways of being a nurse and ways of doing nursing, the active expression that utilisers see in her/him being at ease as a nurse doing nursing. This active expression of being at ease within the roles, responsibilities and requirements of nursing requires that a person has first engaged with and embraced their sense of self.

In comparing the ideas describing contemporary good nursing to 'being at ease' through the lens of published scholarship in this focus area, I can infer that the actions, processes and relationships explained through the particular categories of 'knowing self' and 'skilled being' are an expression of 'good' as this notion is currently understood in nursing. 'Knowing self' firmly situates a nurse's ability to engage genuinely with another person as a human being within that nurse's way of seeing, experiencing and understanding her/his own nature; that is, within the essence of her/his character as expressed through her/his virtues. Whilst through the actions, processes and relationships detailed in 'skilled being', the contemporary professional attributes of good nursing can be elicited. In Figure 4.1 below, I use the elements of contemporary 'good' nursing, as offered by Begley (2010:526), to assimilate the virtues and attributes of 'good' nursing with the two categories of 'being at ease', namely: 'knowing self' and 'skilled being'. Before elaborating on the figure, it is necessary for me to offer a caution - while this type of representation does provide a précis of the concepts under discussion; it also oversimplifies the relationships and underrepresents the complex interactivity between these concepts. Thus, in a most simplistic form, Figure 4.1 attempts to show how those character virtues noted as necessary for a nurse to become and be a good nurse ground the concept groupings of the category 'knowing self'. The attributes of professional practice (or the doing of good nursing) are infused by that nurse's engagement with the essence of her/himself and are expressed in the actions, processes and relationships of the concept groupings of 'skilled being'. The indistinct separation between each element is done deliberately to show that while each element seems to have a particular place in the consequence of a good nurse doing good nursing, neither the boundary of each element's influence nor the directionality of that influence can be determined.

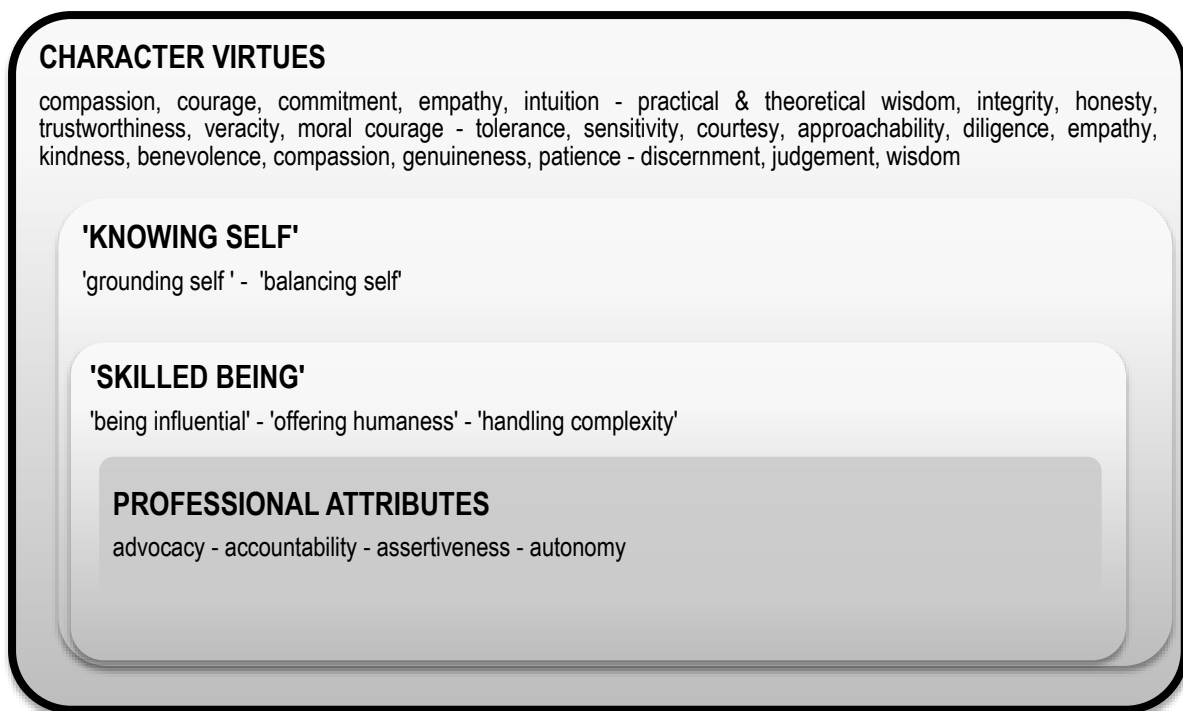


Figure 4.1 An assimilation of the elements of good nursing, 'knowing self' and 'skilled being'

Biro (2012:1007) claims the nurse-patient relationship as the 'key to healing', further elaborating that this relationship is determined by the interplay of personal character virtues (determining the quality of this interaction) and professional practice attributes (establishing, maintaining and ending the interactions). Reflecting on the discussion offered in the previous paragraphs of this section, it is fair to offer that 'being at ease', as established in the interplay between 'knowing self' and 'skilled being', also implies that the utiliser recognises the embodiment of a 'good' nurse doing 'good' nursing. A nurse seen as 'being at ease' with her/himself as explained through the actions, processes and relationships of 'knowing self' and 'skilled being' conceivably personifies the notion of a 'good' nurse doing 'good' nursing.

The notion of 'good' as understood in contemporary nursing assisted me in deepening and confirming my understanding of the participants' explanations that culminated in the categories 'knowing self' and 'skilled being'. The scholarship available to me provided insight into how 'good' may be understood in contemporary nursing, confirmed the nurse-patient relationship as the space within which 'good' nursing manifests, and notes that it is the interplay of personal and professional attributes that create the space for 'good' nursing to be experienced. However, the published work

in this focus area did not sufficiently extend the notion of 'good' into how this may characterise and influence a relationship between a nurse and another such that the person's encounter with nursing is recognised and articulated as 'different and better' by that person as the emerging grounded theory indicates. If the first two categories of 'being at ease' reflected an embodiment of 'good' nursing, then it appeared through comparing the other categories of 'being at ease' (i.e. 'connecting with intention' and 'anchoring'), that while the notion of 'good' nursing contributes to deepening the explanation of 'being at ease' it does not fully capture the breadth and depth of the utilisers' encounter in terms of the connections and the consequences of this way of nursing.

Biro (2012:1007) establishes through her remarks on the nurse-patient relationship that good nursing respects and validates the other person's intrinsic value through the actions, behaviours and presence of a good nurse. I reflected on this statement in the light of feeling that the current insight detailing 'good' in nursing was not sufficient to capture the fullness of 'being at ease'. Through this statement, I reasoned that the author had expressed a sense that 'good' nursing has a way of being lived out from the attributes described previously and beyond the physical enactment of the activities of doing nursing; and that 'good' nursing then has a particular consequence. This author used the words 'actions', 'behaviours' and 'presence' in that sentence. I was readily able to ground the words 'actions' and 'behaviours' in the content of the article, but I was not able to the same with word 'presence'. My understanding of the word from the conversations with the study participants did not easily fit in the narrative of the article. Participants had spoken of presence in terms of it being a 'different and better' nurse's way of being, influencing her/his ways of 'connecting with intention' and of 'anchoring', suggesting through their various examples that presence had a deep and broad influence in their recognition of these nurses.

The concept of nursing presence had also emerged through the writings that I had engaged with in reading the scholarship on 'good' nursing. Wilson (2008:308) reflected on whether the experience of good nursing stemmed from a nurse enacting presence. Presence was described as a nurse's way of being with another such that the relationship is founded in shared humanness, creating deep connections. Nursing presence seemed to enable a patient to experience a sense of healing and was seen

as being beneficial to the nurse and patient (Wilson, 2008:308; Covington, 2005:172; Covington, 2003:301,313). This body of literature showed that patients are innately aware of whether a nurse is authentically with them rather merely going through the motions of nursing, as well as, the idea that 'something special about a nurse' was a concept that can be recognised (Wilson, 2008:304; Covington, 2005:169). These elements from the literature were similar to those expressed in the anecdotes that triggered this study as well as in my conversations with study participants.

This initial reading and its potential for contributing to the emerging grounded theory focussed my attention during the ongoing literature review to developing my understanding of the concept of presence in nursing. I intended to determine how this concept may challenge, extend and develop the core concern or categories of *Being at Ease*.

4.4 NURSING PRESENCE

The phenomenon of nursing presence surfaced through the literature on good nursing. With the core concern as the springboard from which I engaged with literature on this topic, my initial reading around presence convinced me of some fit between the emergent theory of my study and how nursing presence is understood in the practice and academic environments of nursing. Through the processes described in detail in Chapter 2 and summarised in section 4.1 above, I engaged with the content of the sampled articles with the purpose of understanding what insights on presence the various authors had offered to the nursing discipline; how they had viewed, described and situated presence within nursing. Furthermore, I deliberated on how the thoughts and findings of these authors may clarify and develop my emergent grounded theory.

4.4.1 The slowly unfolding discourse on nursing presence

Presence is identified as significant and desirable in nursing as it is seen to benefit both the patient and nurse (Bright, 2012:12; Finfgeld-Connet, 2006:709,712). Because presence is seen to have value within the core relationship of nursing, that between a nurse and a person who needs nursing, efforts to understand and use this phenomenon in nursing have been described from the late 1950's through to the present day, with suggestions that presence has been part of nursing's lexicon since

Florence Nightingale and her contemporaries interacted with soldiers in Crimea (Zyblock, 2010:121, Doona, Haggerty, Chase, 1997:5).

The earliest works of nursing scholars, as identified by the various authors referenced later in this paragraph, where the idea of presence in nursing was tentatively formulating were published in the late 1950s and 1960's. Scholars such as Peplau, Vaillot and Black applied philosophical concepts related to the idea of presence into the ambits of nursing through the influence of the writings from philosophers such as Buber, Marcel and Heidegger. Indications of the idea of nursing presence can be elicited in Peplau's middle range theory 'Interpersonal Relations in Nursing' (1952), where she proposed that assisting another to identify their difficulties requires that a nurse understand her/his own behaviour. Further to this, she was concerned with the nurse-patient relationship and how the nurse engaged in this space. Vaillot's work on commitment in nursing, published in 1967, considered the notion of presence within her ideas of the nurse placing her/his whole self at the disposal of another. Black engaged with the ideas of Buber in applying ways of relating in the nurse-patient space, proposing that the 'I-Thou' way means to relate to the other as a whole in true presence. Through the ideas offered by these authors as well as a growing influence of existential philosophy into nursing, the discourse on presence and its development as concept in nursing was stimulated (Bright, 2012:14; McMahon & Christopher, 2011:72; Zyblock, 2010:121; Doona, Chase & Haggerty, 1999:55, Doona, Haggerty, Chase, 1997:7).

From these beginnings, presence has been included both implicitly and explicitly as part of several nursing theorists' work. From the 1970's to late 1990's various scholars' conceptualisation of nursing included the notion of presence as a mutual, intersubjective experience between a nurse and a patient (McMahon & Christopher, 2011:72). Presence featured in Paterson and Zderad's theory, Humanistic Nursing (1976), in Watson's Theory of Human Science and Human Care (1988) and in Roger's Science of Unitary Human Beings (1990). In Benner's work from the 1980's beginning with the notions of skill acquisition in clinical practice and developing to her contribution entitled 'From Novice to Expert. Excellence and Power in Clinical Nursing Practice', she notes presence to be an existential practice of being with a patient, and is seen to be an important competency forming part of the helping role of the nurse (Benner,

2001:57). Parse's Human Becoming Theory (1981/1992) encapsulated presence as a nurse's intentional, reflective way of being with others. The work of these and other nurse scholars supported the concept being introduced into nursing science textbooks during the 1980's and 1990s where presence was depicted as a therapeutic modality. With presence identified as a kind of nursing intervention, research in the latter 1990's into 2000's exploring the possibility of classifying and measuring the phenomenon gained ground. During this period, presence was depicted by Osterman and Schwartz-Barcott (1996, as cited by Bright, 2012:19) as having different levels, by Easter (2000:364) as having four modes and by Godkin (2001:13) as a hierarchy. On the flipside of this more structured approach to describing presence, other researchers worked to characterise the behaviours, attitude and emotions related to the experience of presence (Doona, *et al.*, 1999:64; Covington 2003:312).

Perceptions of ambiguity and vagueness in the various ways of interpreting, labelling and mixing this phenomenon of presence led to researchers applying the methods of concept analysis in attempts to explain and delineate presence as a concept of nursing. Conceptual analysis was applied to clearly formulate presence as a concept of nursing and make it distinguishable from other concepts in nursing, such as caring, as well as to create a common use of the concept of nursing presence in the practice and research domains of nursing (McMahon & Christopher, 2011:72; Finfgeld-Connett, 2006:709; Tavernier, 2006:152; Zyblock, 2010:120)

Currently, the controversy around nursing presence still lies in the contrast of considering presence as a technique in nursing against presence as a quality of a nurse. Bright (2012:18) comments that if presence is a technique of nursing, then it follows that it is possible to teach a student how to be present in an interaction with a patient. It is within this perspective that McMahon and Christopher (2011:74) proposed what they termed a mid-range theory on presence. The purpose of this theory is to facilitate students' conceptual understanding of presence and its use as a relational skill, proposing that presence is 'dosed' out from the nurse to the patient as an intervention. Bright (2012:18-19), who applied a critical hermeneutic perspective to nurses' own stories of enacting presence, then points out that all authors including McMahon and Christopher, whether trying to quantify presence or reveal the its essential nature, agree that the ability to enact presence is something that a nurse

develops over time, that she/he matures to being able to enact presence. This reveals a common appreciation that nursing presence is not a series of actions, but rather a humanistic, interpersonal phenomenon.

4.4.2 Nursing presence and 'being at ease'

Table 4.3 below illustrates how presence has been defined in nurse scholarship across three different decades. Bearing in mind that scholars of these decades will have had particular ways of thinking about nursing that were influenced by different profession and healthcare priorities, as well as political, social and economic developments, and that each definition is founded in a different type of source; it is remarkable that the phrasing used across the definitions is as consistent as is evident.

Table 4.3 Definitions of nursing presence across three decades

SCHOLAR/S	DATE	DEFINITION	SOURCE
Paterson & Zderad	1976	A mode of being available or open in a situation with the wholeness of one's unique individual being; a gift of self which can only be given freely, invoked, or evoked.	Theory of Humanistic Nursing
Doona	1997 / 1999	An intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend her/himself on the patient's behalf.	Comparison of three separate data sets on nursing judgement
Tavernier	2006	<i>A mutual act of intentionally focusing on the patient through attentiveness to their needs by offering of one's whole self to be with the patient for the purposes of healing'</i>	Concept analysis

Through the years, each definition has been tweaked from the previous version through development and application of research methods that open up different ways of considering ideas, and through the insights gained from within the nursing profession and related professions; but the core meaning has remained the same. When reflecting on the thread running through the definitions that have been offered over time, I see the common substance of these definitions in the following; namely, presence is:

- an interacting between two people
- the nurse engaging in the fullness of her/his humanness and identity

- an openness to the unique being and need of the other person.

With my increasing understanding of presence as a nursing phenomenon, it became clear to me that much of what I had read about presence looked and felt similar to that which the participants' had shared in articulating 'being at ease'. In taking a bird's eye view of the meaning of nursing presence as conveyed in a phrase or expression it is also possible to condense the complexity of nursing presence and that of 'being at ease' to display the congruence of these as a starting point of this discussion. I have chosen to use an expression of nursing presence from Covington's (2003: 307,312) delineation of this concept within the context of caring and holistic nursing. I use this to illustrate how the categories underpinning the core concern of 'being at ease' fit this broad meaning of the concept of presence. Within her reflection and discussion of various conceptual perspectives of presence, the following core expression of presence can be elicited from her proffered working definition:

Presence is a nurse's way of being with another such that an opportunity is created for a deep and safe connection to develop where the person and nurse are able to verbalise and interpret distress or suffering to discover meaning in this human experience (Covington, 2003:307,312).

Table 4.4 below shows the above expression of presence disassembled into its broad phrasings, and the categories of 'being at ease' that show a relatable fit with each phrase.

Table 4.3 Finding the fit: nursing presence and 'being at ease'

COVINGTON'S DISASSEMBLED PHRASING OF PRESENCE (2003: 307,312)	FIT WITH CATEGORIES OF 'BEING AT EASE'
... nurse's way of being with another...	<i>'knowing self'</i>
... opportunity is created for a deep and safe connection to develop...	<i>'skilled being'</i>
... person and nurse are able to verbalise and interpret distress or suffering...	<i>'connecting with intention'</i>
... to discover meaning in this human experience.	<i>'anchoring'</i>

'Being at ease' appeared to have a reasonable link to the body of knowledge on this topic and so my orientation to the literature was then defined by the following question:

- how does the phenomenon of nursing presence converge with and diverge from 'being at ease' and its related categories?
- are 'different and better' nurses recognised through the utiliser experiencing the enactment of nursing presence?

I reflected on these questions by considering how presence has been conceptualised as a phenomenon in nursing and compared this literature to the core concern of 'being at ease' and its robust categories as drawn from the study participants' conversations. The following discussion lays a foundation for understanding how the conceptualisation of nursing presence has developed in the literature on this topic. I then clarify how and why I chose to use a particular published concept analysis meta-synthesis of presence as the initial lens of to compare 'being at ease' and nursing presence. The final discussion in section 4.5.3 attempts to explain the place of presence in 'being at ease' and how 'being at ease' adds to a more profound understanding of presence enacted between a nurse and another.

4.4.3 The concepts of nursing presence

Concepts are tools that assist in classifying phenomena. Clearly formulated concepts are necessary in developing a common understanding and usage of a phenomenon which is useful in developing the knowledge base of a profession. The use of the phenomenon is explored and relationships between concepts proposed. In formulating the concepts of a phenomenon, the core characteristics of it are identified and isolated through the regularities and commonalities of its use as well as in the exceptions or contraries of its use (MacDonald du Mont, 2002:2).

An initial conceptualisation of presence as a nursing phenomenon was offered by Fuller in 1991 in her PhD dissertation entitled 'A conceptualisation of presence as a nursing phenomenon' (Fuller, 1991). In this study Fuller applied thematic analysis methods to descriptions of presence from nurses in acute care settings as well as relevant literature. This process led her to a definition of presence as well as its identifying its defining characteristics. As a nursing phenomenon, she saw presence to be a therapeutic nursing process that occurred in the context of a nurse sharing an

experience of illness or suffering with another. The defining characteristics of a nurse being present were tentatively identified as: engagement, physical proximity, availability for any contingency, confirmation, and therapeutic effect (Fuller, 1991:110). This concept analysis formed the basis for further studies that explored and developed presence as a concept of nursing.

Doona, Chase and Haggerty (1999:56) provided an interpretive account of nursing presence as a phenomenon after conducting a secondary analysis of data sets from three studies on nursing judgement in different disciplines of nursing. These authors noted that context for presence is created through choice; choice on the part of the patient to invite the nurse into her/his situation, and choice on the part of the nurse to make her/himself available to the patient. Doona, *et al.* (1999:64) view nursing presence as existing as a whole or not at all. These authors identified the following as features of presence, whilst clarifying that they view these as 'logical distinctions rather than exclusive parts':

- Uniqueness
- Connecting to the patient's experience
- Sensing
- Going beyond the scientific data
- Knowing: what will work and when to act
- Being with the patient

The most recently published accessible articles analysing presence as a concept in nursing were published in 2006, these being a conceptual analysis of presence by Susan Tavernier (2006:152-156) and a meta-synthesis of the concept of presence by Deborah Finfgeld-Connet (2006:708-714). The purpose of Tavernier's (2006:152-156) conceptual analysis was to develop a definition of presence that could be used in theory development and measurement. She differentiates this contribution from those of earlier authors by situating it as an evidence-based conceptual analysis. Tavernier (2006:152-156) applied an identified methodology; that of Walker and Avant, to conduct the conceptual analysis using thirteen published articles that looked at presence as the primary focus in the study. This conceptual analysis of presence in nursing proposes the antecedents that must occur or exist for presence to realise, five defining attributes of the concept along with the consequences that flow from presence

occurring. Tavernier (2006:152-156) contributed to the discourse on this topic through explicating the concept in terms of antecedents, attributes and consequences using a recognised conceptual analysis method.

The meta-synthesis of presence put forward by Finfgeld-Connet (2006:708-714) undertook to clarify the concept of presence. The purpose of the study was to synthesise the substantive research findings that centred on presence as a single notion such that this concept could be well defined and differentiated from other concepts that seem to be used in a similar fashion – examples include the concepts of caring, empathy, therapeutic use of self, support and nurturance. Eighteen studies meeting specific inclusion criteria formed the data set for analysis; this included the study by Fuller from 1991, as well the published work of Doona, Chase and Haggerty in 1997 and 1999. The author used Walker and Avant's broad process categories of antecedents, attributes and consequences to structure the analysis.

I chose to use Finfgeld-Connet's (2006:708-714) meta-synthesis as the lens through which I compared nursing presence with the emergent core concern of my study. Tavernier's 2006 analysis was not included in this meta-synthesis as the article was also published in 2006 and as such, it would not have been available for possible inclusion in Finfgeld-Connet's (2006:708-714) meta-synthesis. Thus, the table below (table 4.5) juxtaposes the outcomes of each author's engagement with the literature on presence in nursing. The purpose of this summary is to show how Tavernier's (2006:152-156) conceptual analysis aligns with Finfgeld-Connet's (2006:708-714) meta-synthesis of the concept of presence. Table 4.5 arranges each author's analysis in terms of how the concept was defined, and then the antecedents to, attributes and consequences of presence as ascribed to the concept by each author.

Table 4.4 A juxtaposition of Tavernier's and Finfgeld-Connett's work on nursing presence

	TAVERNIER (2006:152-156)	FINFGELD-CONNET (2006:708-714)
PRESENCE IS ...	<i>'... a mutual act of intentionally focusing on the patient through attentiveness to their needs by offering of one's whole self to be with the patient for the purposes of healing' (Tavernier, 2006:154)</i>	<i>'... an interpersonal process that is characterised by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances. It results in enhanced mental well-being for nurses and patients and improved physical well-being for patients. In keeping with the nature of a process the consequences of presence go on to influence its enactment in the future' (Finfgeld-Connet 2006:710)</i>
ANTECEDENTS (conditions for presence to be realised)	<ul style="list-style-type: none"> no specific reference to patient 	<ul style="list-style-type: none"> patient has need for & openness to presence
	<u>Environment</u> is conducive to & supportive of presence in terms of: <ul style="list-style-type: none"> technology staffing skill mix and numbers time 	<u>Work environment</u> is conducive in terms of: <ul style="list-style-type: none"> supportive colleagues adequate time adequate staffing balance between technology & time with psychological & spiritual
	Having and using <u>knowledge & skill</u> to support healing needs of recipient in terms of: <ul style="list-style-type: none"> communication support decision making 	<u>Professional maturity</u> : <ul style="list-style-type: none"> clinical competence expertise
	Nurse has <u>awareness of self</u> such that the other is seen as: <ul style="list-style-type: none"> 'sacred' having value knowing what healing means for her/himself 	The nurse: <ul style="list-style-type: none"> is willing to engage in being present has personal maturity: <ul style="list-style-type: none"> self-knowledge & acceptance well balanced & centred moral underpinnings: <ul style="list-style-type: none"> commitment to help respect for individual differences
ATTRIBUTES (presence is characterised by ...)	<u>Intentionality</u> : a conscious step and an awareness of purpose for interaction by the nurse	<u>Sensitivity</u> : appreciation for and focus on the uniqueness of the individual and their need.
	<u>Mutuality</u> : between people, infused with shared humanity, trust, honesty, availability, openness and emotion	<u>Holism</u> : integrating the physical, psychological and spiritual aspects of an individual. Person is the subject rather than the object of interaction

	TAVERNIER (2006:152-156)	FINFGELD-CONNET (2006:708-714)
	<u>Patient-centeredness</u> : nurse is fully focussed on the patient within that moment	<u>Intimacy</u> : close physical proximity involving availability, touching and attending to needs; verbal & non-verbal engagement
	<u>Individuality</u> : nurse and patient are authentic to self in interaction each other	<u>Vulnerability</u> : reciprocal openness to another and sharing of self to develop trust such that risk taking becomes possible
	<u>Attending</u> : listening, touch, sharing, expertise and mindfulness	<u>Uniqueness</u> : ability to flexibly adapt to a moment in time with a person within a context, enabled by viewing each individual with unconditional appreciation and acceptance of her/himself
CONSEQUENCES (outflows of presence)	<u>Relationship</u> : trust, intimacy & safety increase <u>Reward</u> : mutual sense of support, advocacy & meaning <u>Healing</u> : holistic outcome	Experience of presence influences its enactment in future. Enhanced mental & physical well-being for recipients & nurses

Through careful reading of Tavernier's (2006:152-156) work it is readily possible to incorporate this analysis into the broader conceptual categories of Finfgeld-Connet's (2006:708-714) contribution, thus the exclusion of her work from the article does not alter the understanding of presence in nursing as extended through the meta-synthesis. Finfgeld-Connet's (2006:708-714) article provided a useful structure and broad conceptualisation to support the introduction of the concept as additional data into my study. I thus chose to use this 2006 meta-synthesis as the initial lens through which to compare the core concern and robust categories of 'being at ease' with the concept of presence as it is currently understood as a nursing phenomenon.

4.4.4 Comparing 'being at ease' with the concept of presence

The structure of Finfgeld-Connet's (2006:708-714) metasynthesis in terms of the particular antecedents, attributes and consequences conceptualising presence in nursing are used the starting point in this discussion. Where appropriate for clarity, emphasis or development of a thought, specific contributions from other authors, particularly those contributing after 2006, published within the body of literature on presence are included.

4.4.4.1 Antecedents to presence

Antecedents to a concept delineate the conditions that must be in place for the phenomenon to realise and may affect the existence of the concept (Tavernier,

2006:154). The antecedents to nursing presence are mostly located within the individuals who link in an encounter, but are also related to the environment within which the encounter occurs.

The potential for presence to be embodied in an encounter requires an interaction between a nurse and another person. 'Being at ease' is grounded in the interactions of a nurse and another person; particularly a significant other or a colleague (specifically nurses and doctors). While the 'other person' is most often identified as the patient in literature, presence has been described in the encounter between a nurse and a patient's significant other but not specifically in the encounters of nurses and colleagues (Finfgeld-Connett, 2006:711).

- needing presence and being open to presence

Antecedents associated with the person are the need for nursing presence within that person and her/his openness to experiencing presence. The person displays a need for presence through the experience of physiological or psychological distress. Within this experience of suffering or distress, the person makes a choice to be open to nursing presence. Through her/his choice to be open to presence, the person actively invites and allows the nurse to enter their experience of a situation (Doona, *et al.*, 1999:57; Bright, 2012:72-74; Finfgeld-Connett, 2006:711).

- personal and professional maturity

The complex nature of enacting presence requires that the nurse is personally and professionally mature (Finfgeld-Connett, 2006:711). *Being at Ease* shows that the utilisers' first feel the nurse is at ease with her/himself before they experience 'being at ease' in themselves as utilisers. The different and better nurse is recognised as being at ease in the ways and means of 'knowing self' and 'skilled being'.

Finfgeld-Connet's (2006:708-714) metasynthesis offers an understanding of personal maturity being evident in the nurse's self-awareness, knowing and accepting her/himself such that she/he is a balanced and centred individual. Bright (2012:92-93) confirms this understanding in her findings that presence requires a nurse to be self-aware and to have done work of self-healing such that she/he is able to meliorate any feelings that may distract her/him from being present with another person. The subcategory of 'knowing self' explains the ways the nurse sees, experiences and

understands their own nature, the ways the individual develops and embraces insight into their true nature and how she/he uses this knowing intuitively in being a nurse. Within 'knowing self' the nurse is experienced by utilisers as grounded and balanced. Being grounded is explained in the nurse's respect for her/his own humanness coupled with her/his understanding and accepting of the unique intrinsic qualities that form her/his sense of self. While within 'balancing self', the nurse integrates the sense of her/himself within her/his understanding of being a nurse, and uses this sense of self to strengthen her/his being a nurse. 'Knowing self' was regarded by all participants as essential to creating a stable underpinning to the nurse – utiliser relationship. Within the literature, self-knowing is seen to be important in meliorating the demands of being present (Tavernier, 2006:154). Through the nurse engaging in activities that enable healing from suffering or distress, and developing self-awareness she/he is better able to manage overwhelming feelings that arise when witnessing human suffering. Within a grounded and balanced sense of self, the nurse is better able to choose action that is consistent with their sense of solicitude for the other person.

Fingeld-Connett (2006:711) determines in her meta-synthesis that professional maturity as an antecedent to enacting presence speaks to the experience, clinical skill and competence of the nurse. A sense of professional maturity is found within the category of 'skilled being'. This category establishes that a better and different nurse is recognised in her/his ability to meld experience, clinical skill, competence and self-insight to engage more thoroughly in the doing of nursing rather than merely performing the tasks and actions of nursing practice. 'Skilled being' explains how the nurse has, uses and constantly develops discipline knowledge and skill. With broad, deep discipline knowledge and skill in place, the nurse's proficiency in using this to gain insight into a particular set of circumstances and to persuade others to appreciate her/his perspective of the circumstances contributes to the utiliser 'being at ease'.

The final personal qualities established through the metasynthesis as antecedents to enacting presence on the part of the nurse are her/his commitment to help and respect for differences between her/himself and another. Within 'being at ease', the utiliser recognises that the different and better nurse is open to respecting the experiences and responses of another person – the space of difference. The other person is seen first as a fellow human being who currently occupies a particular role with the choices

that shape any interaction between the nurse and the other made from respect for their mutual humanness (Finfgeld-Connett, 2006:711; Melnechenko, 2003:20).

- environmental antecedents

Enacting presence happens in a physical space, as such, this space must be conducive to presence being enacted in terms of supportive colleagues, sufficient and suitable staffing, adequate resources and time available such that the person is the focus of an interaction rather than the completion of tasks (Finfgeld-Connett, 2006:711-712; Tavernier, 2006:154). On revisiting the participants' data with this specific antecedent as a filter, I found that some participants had made reference to the role of the environment within which the different and better nurse practices and how this influences the nurse being able to do 'different and better' nursing. The influence of environmental elements in 'being at ease' is mostly found in the conceptual groupings of 'handling complexity' in the category 'skilled being'. Environmental elements identified by participants were similar to those found in Finfgeld-Connett's synthesis of antecedents required for nursing presence. I include excerpts from interview 5 here to illustrate this point.

... firstly it's the system or the organisation that must allow the opportunity for preparation and the nurse must demand the opportunity for preparation but then they must do it as well ...then there's a feeling gosh this nurse knows what he or she's about and that whole positive energy is maintained (i5:023).

Specific elements noted by participants were found in the support required from the hospital or company management personnel in creating the opportunity for 'different and better' nursing to become possible. The consequence of these providing these elements is a suitable, well- equipped and functional physical environment to support smooth, rapid responses by nurses in critical moments, along with limiting and containing non-nursing activities that distract from and diminish nursing -

... you know getting things moving umm rather than doing household chores ... if you have a sick patient you don't need to be distracted from that by other menial administrative tasks or chores which are in fact detracting from what you are trying to do ... it's also detrimental to care to have to focus on a whole lot of trivial things like

trying to get drugs from the pharmacy or answer a telephone for somebody else or the list is endless (i5:043).

In effect, the environmental antecedents have a particular purpose in enabling a 'different and better' nurse to actually do 'different and better' nursing; to create the best possible circumstances that the nurse must first require and then use in her/his 'skilled being' that influences the utiliser's eventual feeling of 'being at ease'.

- choosing to be present

In the same way that the person chooses to allow the nurse into an experience, so must the nurse choose to enter that person's situation and immerse her/himself within the person's experience such that presence can be enacted. The utiliser experiences this choice made by the different and better nurse as explained in the category 'connecting with intention'. Utilisers recognise that the better and different nurse deliberately lives into their experience of the critical care environment and dynamic mostly through 'engaging consciously'. The different and better nurse engages from the foundation of 'knowing self' to create the space for connecting with a utiliser through offering her/his humanity as the initial link in 'connecting with intention'. Utilisers recognise that the nurse cares deeply about their present situation, and is also invested in their immediate future in terms of their experience of critical care. Literature describes the nurse as entering the person's experience with the intention to spend time and encounter that person's difficulties, to share her/his energy to reduce the person's distress or suffering in ways that are meaningful to that person. When entering the experience of another, a nurse must let go and give in to the interaction, be willing to risk entering a place where anything can happen - nurses see this choice as the way of moving an interaction from one that is sensed to be superficial to one where a connection is created with the person. In 'being at ease' the effect of 'engaging consciously' - through the nurse being sure of her/his sense of self and demonstrating this; is that the utiliser is able to see the possibility of a different, deep and mutually rewarding linkage that enables 'connecting with intention' to take form (Bright, 2012:94; Covington, 2005:171; Doona, *et al.*, 1999:56; Finfgeld-Connett, 2006:711; Tavernier, 2006:154)

Doona, *et al.* (1999:64) write that the context for presence is created when these choices are made as the person then becomes present to the nurse and the nurse

becomes present to the patient. A balance is achieved between the internal (or self) environment and the external environment to enable a choice that initiates an interpersonal, intersubjective process that is characterised by particular attributes.

4.4.4.2 *Attributes of presence*

The attributes of presence as synthesised by Finfgeld-Connet (2006:710) are interpersonal sensitivity, holism, intimacy, vulnerability and uniqueness. Each of these attributes are first elaborated on below and then later discussed in the context of 'being at ease'.

- interpersonal sensitivity

This attribute describes the characteristic of connecting into the patient's experience through an intense focussing on their needs. This is a space of collaboration permeated with high sensitivity to the patient and without hierarchy (Bright, 2012:93), the nurse is aware of her/himself and the patient in an interaction within that moment as well as within a broader space of their context. The nurse has a desire or need, to engage with a patient within the commonness of their humanity - at a level deeper than only technical expertise to relieve suffering. The nurse discovers the patient - sifting, balancing, and combining multiple pieces of data to connect into the person's unique experience, to grasp the totality of the person and make her/his needs comprehensible within the 'whole person'. In addition, the nurse almost suspends her/his own personal situation to fully focus on the person as they present themselves within that moment (Bright, 2012:65-67; Tavernier, 2006:154).

- holism

Presence is characterised through holism – the person is the subject of the interaction rather than an object; holism encompasses the physical, psychological and spiritual dimensions of the person and her/his well-being. The person is accepted as the 'expert' in their own life, thus any interaction is underpinned by respect for how that person works out, defines and lives their meaning of health experiences (Melnechenko, 2003:18, 22-23). It is through this intense focus on understanding the person's whole-ness that the nurse is able to empathise with a person and facilitate their experience of a situation.

- intimacy

Intimacy describes the quality of closeness to the person in enacting presence. This can include using physical proximity in ways of touching or attending to needs – Easter (2000:354) termed this body to body presence, as well as in the nurse's manner of using verbal and non-verbal communication sensitively – termed mind to mind presence (Easter, 2000:366). Intimacy is further enhanced through the nurse's ability to disconnect from distractions and other demands to connect in the moment with the patient (Bright, 2012:90)

- vulnerability

Vulnerability means an authentic openness of self to the other to support reciprocal sharing and experiencing of each other's feelings. The nurse and person each lower their defences to develop trust and support risk taking. As such this interaction is influenced by each person's perceptions of shared humanity, trust, honesty, openness, emotion and availability (Bright, 2012:84-86; Doona *et al.*, 1999:63; Tavernier, 2006:154; Finfgeld-Connett, 2006:710-711).

- uniqueness

Presence is unique to each set of circumstance within which it is enacted. A nurse adapts her/his enactment of presence within the context of the uniqueness of her/himself, the person and their need at that moment in time. The nurse is able to do this through her/his unconditional respect for and acceptance of that person's humanity.

4.4.4.3 *Teasing out the attributes of presence in 'being at ease'*

These attributes of presence are visible in the actions and processes of 'being at ease'. Within each of the categories of 'being at ease', there seems to be a mixture of the attributes identified in Finfgeld-Connet's metasynthesis (2006:708-714) where one or some may be more readily apparent than others depending on what the person needs within that moment. 'Different and better' nurses perhaps become recognisable through the way they combine or emphasise any attribute of presence in responding to the person in a manner that carries meaning for that person. For example, when reflecting on the category and concept groupings of 'skilled being', I see the most apparent attributes of presence threading through these actions and processes to be those of holism, intimacy and vulnerability. Holism in the way the nurse creates a full

understanding of a person and a situation, such as explained the processes and actions of 'handling complexity'. Intimacy is in the manner she/he uses throughout 'skilled being' in terms of touch, eye contact, encouragement, self-confidence, gentleness, calmness and so forth to underpin her/is doing of nursing, be it in interacting with a patient or another person. The better and different nurse's manner of being able to pause in the midst of business to refocus her/his being a nurse and doing of nursing to connect with the person's need in that moment underpins intimacy. Vulnerability in how she/he reveals her/himself to the other as a person with frailties and emotions, thus shaping the space of care and nature of the connection.

Independent of which ever concept grouping I focus on within 'skilled being'; the expression of these attributes of presence can be distilled within in the concepts of the category but also across fullness of the category. The three attributes, namely holism, intimacy and vulnerability, can be fleshed out within the actions and processes of that group, while the attributes of interpersonal sensitivity and uniqueness are apparent as a more subtle influence. I do note though that these attributes of presence are not always easily distinguishable as being one or another, rather they seem to be entwined through each other in the stories told by participants supporting the comment offered by Doona, *et al.* (1999:64) that presence exists as a whole or not at all and these attributes are more 'logical distinctions' than discrete attributes.

4.4.4.4 Consequences of presence

The consequences of presence being enacted are broadly synthesised by Finfgeld-Connet (2006:712) as enhanced mental well-being for the person and the nurse, and improved physical well-being in terms of recovery, remission or a better experience of death for the person. These consequences of presence influence its enactment in future in that the person will be more readily open to nursing presence and the nurse.

Mental well-being is enhanced through the experience of being heard and understood with the person having a heightened sense of feeling safe and secure, her/his coping skills are strengthened, less stress is experienced and self-esteem increases (Tavernier, 2006:154). The consequences of knowing you, as the utilisier, are safe; feeling your own strength and being able to do what is necessary in your particular context or role are established through the reciprocal interacting, merging and influencing between the four categories of 'being at ease'. For example, the

participants' conversations reflect that a feeling of being safe is formed in their sense that the nurse is at ease within her/himself through those actions and processes of 'knowing self' and 'skilled being'. The effects of melding self-knowing and acceptance within ways of being a nurse and doing nursing gently consolidates how the person comes to feeling safe and enabled through the ways and means 'connecting with intention' and 'anchoring'.

Whilst the personal consequences of presence experienced by nurses was not a focus of my study, it may well be that utilisers can see or feel the effects of personal consequences for the nurse. In Finfgeld-Connett's (2006:712) metasynthesis, she identifies that enactment of presence is influenced by the consequences experienced, that having experienced the consequences of presence the patient is more likely to be open to presence but also that through experiencing the consequences of presence nurses are enabled to engage in enacting presence again. The participants, all nurses, in Bright's study indicated experiencing personal reward, affirmation, greater satisfaction and heightened self-confidence as personal consequences of enacting presence (Bright, 2012:86). Some of these consequences they identify describe or relate to qualities highlighted by participants throughout 'being at ease' as the ways, means and manner that contribute to their becoming and then 'being at ease'. This offers an interesting idea for further consideration in the realm of presence in nursing.

Personal growth and personal revitalisation is experienced as a consequence of nursing presence (Finfgeld-Connett, 2006:712; Tavernier, 2006:154). Synonyms for the word revitalisation include the words restored, fortified, strengthened and rejuvenated, all indicating some way that a person is re-energised and their power revived. The essence of the core concern 'being at ease' lies in the utiliser regaining or recognising their own sense of self, being able to relax, feel peaceful and function at a more optimal level in a situation.

The question posed at the beginning of this discussion was how 'being at ease' converges with or diverges from the phenomenon of nursing presence and therefore, a natural follow-on question arises - are different and better nurses recognised through the utiliser experiencing the enactment of nursing presence? Through comparing the grounded core concern and related categories of 'being at ease' with the metasynthesis of nursing presence as a concept, it is readily evident from the

discussion above that the actions and processes of 'being at ease' appear to have congruence with the described antecedents, attributes and consequences of nursing presence as offered by Finfgeld-Connet in 2006.

As such when the congruence of fit between the antecedents, attributes and consequences of presence and the categories of 'being at ease' is considered as well as within the statements of what nursing presence means and how this can be understood in nursing, this phenomenon seems to be a necessary influence in the utilisers' experiences of 'being at ease'. It is also reasonable to consider that 'being at ease' offers a rich theoretical explanation of nursing presence being lived out in the relationship between a nurse and another.

4.4.4.5 *How 'being at ease' may extend nursing presence as a concept*

There are particular differences between the current published understanding of the concept of presence and the explanation of 'being at ease'. Within the notion that concepts can change over time and with new insights, these differences do not disqualify 'being at ease' as an enactment of presence, but rather serve to broaden and deepen our understanding of what nursing presence is, as well as the 'how, when, where, why and who' aspects of presence as a concept in nursing.

The first point of difference between *Being at Ease* and the published literature on presence lies in the experience of the core concern ('being at ease') also develops for people other than patients in a relationship with a nurse. The accessible literature shows that study samples mostly comprise nurses and patients as participants. In these studies, the nurse participants were described how they enacted presence themselves rather than how they recognised presence occurring, while the patients were asked to describe their experience of nursing presence. The participants in my study included significant others and colleagues (nursing and medical) who contributed stories from their perspective of utilising the nursing ability of a 'different and better' nurse in their particular relationship with that nurse.

Within the diversity of stories and experiences offered by the participants, their recognising a 'different and better' nurse was always located and described within two types of relationships, namely the relationships that the utiliser observed between the nurse and another person (for example: the nurse-patient, nurse-colleague or nurse-

significant other), and then the relationship between the nurse and the utiliser her/himself. The utiliser recognises the experience of 'being at ease' as this coalesces from the four categories of this core concern confirming for each utiliser the nurse's authenticity in both types of relationships. While nursing presence has been written about mostly within the context of the nurse-patient relationship with little work establishing this in the nurse-significant other relationship, it has not been considered in terms of characterising the relationship between a nurse and her/his colleagues. When reflecting on 'being at ease' as an explanation of nursing presence, this emerging grounded theory offers up for consideration that nursing presence may characterise the relationships that a 'different and better' nurse creates with any other person, whether that person is a patient or a significant other, or with nurse and medical practitioner colleagues as has been shown in 'being at ease'.

Furthermore, from the participants' stories and explanations of how they recognise the 'better and different' nurse, it appears possible for a third party to discern the enactment of nursing presence between a nurse and a person. This enactment of presence between a nurse and another person, most often identified as a patient, was described by a participant from their perspective as a third party observer. The utiliser seems to discern the enactment of nursing presence in that relationship mostly within the actions; processes and relationships of the categories of 'knowing self' and 'skilled being'. Through the utiliser discerning the manifestation of nursing presence in that nurse-patient, or other person relationship, the utiliser appears to be perhaps supported in becoming open to presence and to allow this phenomenon to characterise her/his relationship with that same nurse. This characterising their relationship as it develops through 'connecting with intention' and 'anchoring' to the utiliser knowing the feeling of 'being at ease' in her/himself. The attributes of nursing presence can be distinguished as these permeate through the actions, processes and relationships of these two categories. It seems that being able to discern nursing presence within a relationship between a nurse and another person is a part of the utiliser recognising a 'different and better' nurse.

For nursing presence to be realised, a person must have a need for this phenomenon. As nursing presence has most often been described within the relationship between a nurse and patient, the need for presence is regarded as being due to a patient's

experience of physiological or psychological distress. The unpredictable nature of critical care lends itself to chaos and anguish at times, thus supporting the need for nursing presence being founded in a significant other, nursing or medical colleague's experience of psychological or emotional distress as well. However, within the stories offered by nursing and medical colleagues a possibility that it is not always distress that determines the person's need for nursing presence was elicited. Colleagues recognise 'being at ease' within their feelings of knowing they can trust the 'better and different' nurse in her/his being and doing of nursing such that they themselves can perform optimally with self-confidence in a situation). The need for and openness to nursing presence by nursing and medical colleagues may well be more related to their desire to be able to do their own job well rather than the experience of distress. The data did show that the absence of a 'better and different' nurse, and thus perhaps the absence of nursing presence, made a nursing or medical colleague's experience of work unpleasant and stress filled.

The scholarship that has developed the concept of presence in nursing has offered two broad approaches to the phenomenon. One approach suggests that presence is composed of a concrete series of actions that are in some way measurable and thus quantifiable (Kostovich, 2012:167), while the other approach rather reflects the notion that nursing presence is a way of being in nursing; an example being Bright's critical hermeneutic analysis of presence in nursing practice in 2012. When contemplating nursing presence as a concept within the explanation of 'being at ease', the data seems to echo the notion of presence as a natural way of being, imbuing the actions, processes and relationships that create the space of 'being at ease' for a utiliser. From the perspective of 'being at ease', nursing presence does not fit the suggestion that it comprises a series of discrete steps or even a deliberate choice to enact presence on the part of the nurse.

As discussed in this section, 'being at ease' appears to extend our current understanding of nursing presence, while the concept of nursing presence substantiates and deepens the explanation of 'being at ease'. Through a complex meshing of actions, processes and relationships explained in 'being at ease' and its related categories that underpin a utiliser recognising nurses who offer 'different and better' nursing, the concept of nursing presence as currently understood in nursing

scholarship permeates each category and influences the utilisers' feeling of 'being at ease' and thus their recognition of a 'different and better' nurse.

4.4.5 Refining 'being at ease'

To refine something means that an entity is improved through small changes to make it more effective. The scholarship elaborating 'good' in nursing and nursing presence, as presented in this chapter, provided the whetstone on which 'being at ease' was refined. The following points summarise the ways in which I see the explanation of how 'different and better' nurses are recognised through a utiliser's core concern of 'being at ease' to have been refined and deepened through assimilating this grounded theory with relevant literature:

- Those virtues seemingly associated with excellence of character and intelligence underpin a person's capacity to be a 'good' nurse doing 'good' nursing that is then recognised by others as 'different and better' nursing
- These virtues influence and characterise a person's sense of self, in this way underpinning the category 'knowing self', the core concern of 'being at ease' and thus the way a utiliser recognises a 'different and better' nurse.
- The permeation of 'knowing self' through the other three categories of 'being at ease' rests on that person's capacity to live out these virtues within her/his relationships with others to create the space and character of 'different and better' nursing
- Ways of being and doing in relationships between 'different and better' nurses and utilisers, in terms of her/his choice of attitude, manner and behaviours, are seated in the conceptual groupings of 'knowing self' and are thus deeply influenced by the 'different and better' nurse's character virtues rather than merely her/his observance of to professional rules
- Literature positions contemporary 'good' nursing within the ambit of ethical nursing practice. The current understanding of 'good' as applied to nursing seems to be embodied within the conceptual groupings of 'knowing self' and 'skilled being'. The core concern 'being at ease' results from the influence of 'knowing self' and 'skilled being' into 'connecting with intention' and 'anchoring' thus situating 'being at ease' as a possible consequence of ethical nursing practice

- The actions, processes and relationships within and between the categories of 'being at ease' show the enactment of nursing presence with the core concern of 'being at ease' being demonstrative of the positive consequences of nursing presence being enacted, thus the phenomenon of nursing presence infuses through the categories of 'being at ease', influences the utilisers' feeling of 'being at ease' and seems instrumental in utilisers' recognising 'different and better' nurses doing 'different and better' nursing.

4.5 SITUATING BEING AT EASE'

The method of grounded theory appears to turn the research process almost upside down. A researcher begins exploring a social process guided by wanting to know 'What is going on here?' from the perspective of the people experiencing or living out that process. Through following participants' conversations, their insight and experiences of the social process, detailed patterns in the narrative of those participants begin to show how they make sense of that particular part of their life. These patterns reveal and then underpin broader generalisations about the social process and, gently an explanation of the social process emerges from their data. Relevant scholarship used as a further source of data gears the researcher to extend, challenge and substantiate this explanation and finally, a theory emerges as an explanation of that social process. This theory is grounded in the collective reality and voice of the people who participate in that social process, and can then provide a springboard for further research questions or hypotheses to broaden and deepen our understanding of the phenomena elicited within the theory.

4.5.1 Settling the- core concern and categories

At this point I offer an explanation of how utilisers' recognise 'different and better' nurses in terms of my current understanding of the core concern and main categories of *Being at Ease* that emerged through applying the methods of grounded theory to participant and scholarship data.

Fundamentally the actions, processes and relationships between the categories, as shown in the figure below, reproduced from Chapter 3 for ease of reference, remained the same as those discussed at the end of Chapter 3. As a consequence of the discussions offered in this chapter, the scholarship on 'good' in nursing and nursing

presence confirmed that the actions, processes and relationships of the category 'knowing self' are fundamental in an individual becoming a nurse who is recognised to be at ease in the broad and complex spaces of critical care nursing, and in enabling an interaction with another person to be infused with that nurse's presence. Nursing presence seems integral to a utiliser recognising a 'different and better' nurse as this phenomenon's attributes and consequences were noted through all the categories of 'being at ease'.

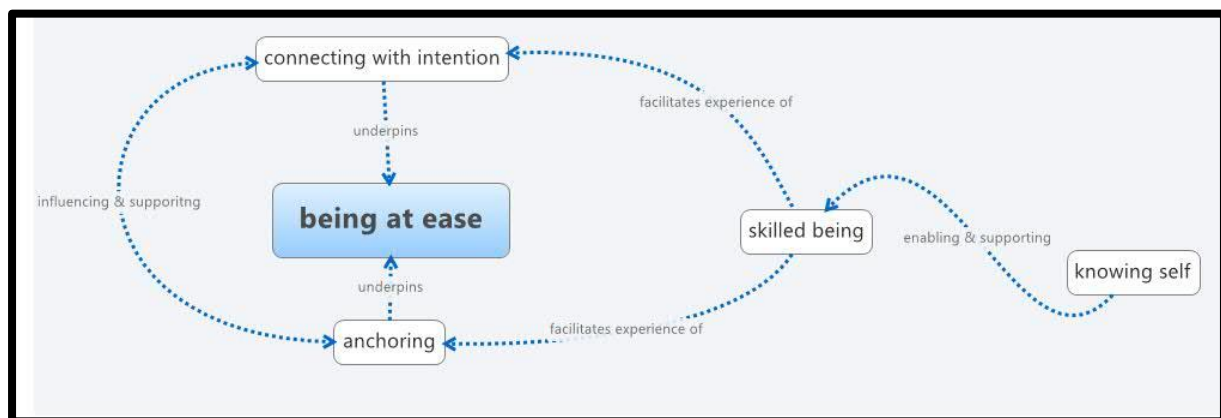


Figure 4.2 'Being at ease' – categories underpinning the core concern

Thus, the while the core concern and its four related categories appear outwardly unchanged, after reviewing and enfolding the scholarship as discussed in this chapter, I have deepened my explanation with two broad additions that have a pervasive influence through the grounded theory. The first addition to the explanation of 'being at ease' is that the genesis of 'different and better' nursing possibly lies in the person already having the character virtues associated with 'good' in nursing. These virtues can be seen as the underpinning of a person's potential to become and be a 'different and better' nurse through the actions, processes and relationships of the four categories of 'being at ease'. Further to this, I add that the phenomenon of nursing presence can be identified in many of the actions, processes and relationships of 'being at ease' in explicit and implicit ways, thereby establishing this phenomenon as an integral, ubiquitous influence in the utiliser experiencing 'being at ease' and thus recognising a 'different and better' nurse.

In each of the following boxes I provide a condensed description of the core concern and then each of the four categories of the emerged grounded theory I have named *Being at Ease*. I also indicate the categories for the core concern and concept groups

for the categories that create the form and shape of each broader element in this grounded theory.

Box 4.1 The core concern - ‘being at ease’

BEING AT EASE is a feeling of personal composure and strength a person develops as a consequence of the trusting partnership created with a nurse who authentically and passionately lives out the ways and means of being a good nurse doing good nursing.

This core concern evolves through the actions, processes and relationships in:

- Knowing self
- Skilled being
- Connecting with intention
- Anchoring

Box 4.2 ‘Knowing self’ – a category of the core concern

KNOWING SELF... speaks to an ongoing journey of self-discovery nurtured through a person’s efforts to gain insight into her/his true nature or virtues to create a strong sense of self as an individual within her/his understanding of what nursing encompasses. She/he is able to use this insight intuitively in living out her/his understanding of nursing to create a foundation from which she/he is able to authentically engage with others within the role of being a nurse, but retain her/his sense of self as a unique individual within the broader concepts and meanings of being human.

This category evolves through the actions, processes and relationships in:

- Grounding self
- Balancing self

Box 4.3 ‘Skilled being’ – a category of the core concern

SKILLED BEING... speaks to the ways a nurse creates influence in her/his relationships with others through the interplay between her/his ways of being a nurse and ways of doing nursing. In revealing her/his sense of self through conscious, deliberate and correct application of deep knowledge and skill in a relationship, the nurse demonstrates a profound level of trust in her/his nursing ability and lays the groundwork for the other person to be open to trusting the relationship.

This core concern evolves through the actions, processes and relationships in:

- Being influential
- Being respected

Box 4.4 ‘Connecting with intention’ – a category of the core concern

CONNECTING WITH INTENTION... speaks to the ways a nurse crafts and shapes linkages with another person to create a meaningful connection underpinned by respect for shared humanness. This meaningful connection provides the space within which the other person experiences feeling safe

This core concern evolves through the actions, processes and relationships in:

- Engaging consciously
- Being present
- Reaching out

Box 4.5 ‘Anchoring’ – a category of the core concern

ANCHORING... speaks to ways a utiliser experiences being safe in an interaction with a nurse and thus enabled to assert their own power, retain their own identity, and feel in control of their life despite the chaotic or unbearable situation playing out around them

This core concern evolves through the actions, processes and relationships in:

- Always there, always everywhere
- Trusting partnerships

In order to accentuate the intricately linked and dynamic nature of this complex phenomenon, I return to my previous analogy of the earth and its atmosphere to illustrate how I view the virtues of 'good' in nursing and nursing presence as part of the actions, processes and relationships of 'being at ease'. The core concern, 'being at ease', is the earth. The 'being at ease' earth is surrounded by an atmosphere that is anchored by gravity, nursing presence, and is made up of a complex combination of various gases, the categories and virtues. While we know the name, properties and significance of each of the gases; for example: nitrogen, oxygen, argon, carbon dioxide, water vapour, making up the atmosphere we cannot easily differentiate between these gases as we go about our daily life. These gases do not flow in specific streams rather they merge into an atmosphere, a complex, reasonably stable mix that supports life on earth. Each of the gases comprises a unique combination of atoms held together by tight bonds. Gravity is the force that affects every gas, in effect, holding the gases around the earth. Both the tight bonds and gravity are invisible yet these are essential in maintaining the atmosphere and thus life on earth.

The categories of 'being at ease' have a similar nature to the atmospheric gases, each has actions and processes that makes it essential, unique and identifiable in contrast to the others; but the manner of how each subcategory underpins, influences, supports, facilitates and enables another subcategory to be experienced is not one dimensional or unidirectional. The tight bonds creating the form of each atom of gas are analogous to the virtues of 'good' in nursing. These virtues of character and intelligence provide the form on which a nurse's attitude, manner and behaviours are fashioned. Nursing presence is similar in nature to gravity in that presence permeates every category, anchoring the shape of these categories as they evolve and interact.

The core concern of people in recognising 'different and better' nurses in critical care was confirmed as that of 'being at ease'. Figure 4.3 is repeated below for ease of reference.

This chapter has shown how I weighed the articulated explanation developed from the study data on the scale of relevant nursing scholarship with the purpose of refining an explanation of how utilisers recognise 'different and better' nurses, and exploring how nursing scholarship relevant to the core concern of 'being at ease' extended and deepened the explanation articulated within the participant data, and how the current understanding of 'good' in nursing and nursing presence may be extended by my explanation of 'being at ease', and I offer a summary of how I see the relevant scholarship to have refined my explanation of 'being at ease' as this stood at the end of Chapter 3.

In the last section of Chapter 4 I provided a succinct depiction of 'being at ease' as I currently understand this to be by offering a grounded theory I have named *Being at Ease*. I gave this grounded theory the same name as that of the label given to the core concern to be reflection of the words used by participants. The core concern 'being at ease', explains that the recognition of 'different and better' nursing is situated in the utiliser feeling personal composure and strength as a consequence of her/his trusting partnership created with a nurse who authentically and passionately lives out the ways and means of being a good nurse doing good nursing.

CHAPTER 5

REFLECTIONS ON BEING AT EASE

This chapter provides the space for the third part of this study to be articulated. Through the sections of this chapter I use the explanation held in *Being at Ease* to reflect on my path with this work, to contemplate the meaning *Being at Ease* may hold for clinical specialist nursing practice and to begin reconnecting *Being at Ease* with the study's stimulus.

The purpose of Chapter 5 is to convey my reflections on the complexity revealed in *Being at Ease* and how insights revealed within this complexity may be applied to clinical specialist nursing practice as well as teaching and learning encounters.

Note – for ease of reading and clarity, in the discussions of this chapter and Chapter 6, the grounded theory is denoted as *Being at Ease*, whilst the core concern of the theory is denoted as 'being at ease'.

5.1 REFLECTION AS AN INTEGRAL ELEMENT OF GROUNDED THEORY

My role as researcher using constructivist grounded theory positions me (in the most whole sense of my being) within the data collection, analysis and theory development processes. Thus my personal history, my professional knowledge, experience, skill; and my way of making sense of the worlds I live in contributed to my co-constructing this explanation from the conversations between myself and each participant individually, and across the broader study data set. Being in a position of co-creating or co-constructing an explanation held particular responsibilities for me. I needed to be sensitive to how my life experiences and, in particular, my nursing experiences were part of how I engaged with each participant in eliciting their opinions and experiences, how I engaged with the data through the analysis process including enfolding the literature and the grounded theory that emerged through all these processes.

While my personal and professional history informed my theoretical sensitivity and strengthened my ability to apply the methods of grounded theory, that same personal

and professional background held potential to skew this explanation through me inadvertently forcing the emerging explanation into the theoretical frameworks I had engaged with through my career as a postgraduate nursing student and academic. I used reflection to try to minimise this possibility through becoming more consciously responsive to my assumptions, preferences, and experiences that frame how I understand nursing.

I sat down and thought about why this particular research question was important to me, how I recognised nurses who I felt were 'different and better' to their contemporaries, and which conceptual frameworks of nursing resonated with me and why. By being deliberate in exposing and understanding my points of departure throughout this study, I was better able to use this insight to co-create an explanation with my study participants and limit imposing my way of seeing the world onto their contributions. I was better able to engage with the nursing scholarship outside the concepts of specialist nursing practice that I had used as an argument in proposing this study.

I used my reflections as a means of constant comparison during interviews to elicit how and why my perspective was similar or different to that of the person I was engaging with, how each of our experiences may build, deepen or challenge the other; or where a completely new idea emerged for further exploration. In this way my voice was challenged during data collection and analysis, resulting in what I brought to the interviews either becoming naturally immersed into the developing ideas revealing through the data or naturally excluded from the growing collective explanation when the data showed that my assumptions were not congruent with the developing ideas. Similarly as the grounded theory emerged through the data analysis and literature engagement processes, I used my personal framework to challenge my analysis and vice versa; I challenged my personal framework against the emerging theory, such that the emerged grounded theory reflected an integrated explanation that was co-constructed through the collective insight of the study participants, nursing scholarship and myself.

I have practiced reflection throughout this study - during the processes of developing this study proposal, from before meeting the first participant, through the interviews, through engaging with the data and literature, and now as this work moves to find its

final words. In the following discussions I share my thoughts on *Being at Ease* in relation to expertise and professional artistry, the nature of 'different and better' nursing, clinical specialist nursing and the encounters of teaching and learning, and in relation to my shaping and forming through this work.

5.2 BEING AT EASE, EXPERTISE AND PROFESSIONAL ARTISTRY

An assumption in my personal framework of understanding specialist discipline nursing is that I believe the natural extension of clinical specialisation in nursing to be that a specialist nurse wants to become and be an expert in that discipline, and that it is in being an expert that utilisers would recognise 'different and better' nurses.

This assumption is evident in the argument underpinning my rationale for doing this study and has informed the way I practised as a clinical specialist as well as the way I guided postgraduate students of critical care nursing. In reflecting on this assumption, I recognised its deep influence on my ways of thinking about specialist nursing and as such tried to be deliberate in challenging this assumption through constant comparison during interview sessions, data analysis and enfolding of scholarship. In applying my mind in this way, I came to realise that my assumption was not sufficient in breadth or depth to explain the social process under study. In having claimed nursing practice expertise and professional artistry as an argument underpinning the rationale for the study, I must reflect on how the current understanding of nursing practice expertise, professional artistry and the emerged grounded theory of *Being at Ease* may speak to each other.

The scholarship of nursing expertise had its beginnings in the work of Patricia Benner and her colleagues in the 1980's on the development or acquisition of expertise as a nurse moves through various levels of proficiency and articulation of knowledge embedded in nursing practice (Benner, 2001:31-38; Benner, Tanner & Chesla, 2009:137-169). From these beginnings research in the focus area of expertise has tended to fall into two broad groups, one group comprising studies that have drilled into separate elements of expertise and the other encompassing the work that considers expertise as a whole, complex dynamic (Titchen & Hardy in Hardy, *et al.*, 2009:57). While the insight offered by studies examining elements of expertise are useful in developing our understanding and application of the knowledge base of

expertise, the work exploring the fullness of expertise in nursing is more relevant to this chapter's discussion, and as such I move to this work that has influenced my ways of thinking about clinical specialist nursing and expertise.

The body of work that has probably had the greatest influence on my thinking about expertise began with a report for the Royal College of Nursing (RCN) on 'Changing patients' worlds through nursing practice expertise' (Manley, *et al.*, 2005). The authors of the report defined nursing expertise as 'the professional artistry and practice wisdom inherent in professional practice', noting professional artistry to be the central attribute of expertise in their conceptual framework for nursing expertise in the United Kingdom. In the conceptual framework for nursing expertise offered by this group, professional artistry was suggested to be the ways an expert nurse uses professional judgement in applying science and skill through various forms of knowledge in nursing practice; and to use her/himself to connect therapeutically with the humanity of a patient (Manley, *et.al.*, 2005:25-27). Subsequently in 2009, after further work engaging with this idea, these same authors re-presented the notion of professional artistry as the overarching enabler of nursing expertise, suggesting that professional artistry is pivotal in the nurse being able to create a unique experience of nursing with another person through blending and melding of the attributes of expertise (Hardy, Titchen, McCormack & Manley, 2009:67).

Attributes of expertise described as part of a concept analysis of nursing expertise underpinning the RCN project were confirmed and then expanded on as scholarship in the focus area of nursing expertise developed through the early 2000's. These attributes are currently determined to be (Hardy, *et.al.*, 2009:8):

- Knowing the patient / client / colleague / organisation
- Holistic practice knowledge
- Saliency: knowing what matters and picking up on it
- Moral integrity
- Skilled know-how
- Acting as a catalyst
- Creative, innovative and challenging behaviour
- Self-awareness

Professional artistry is the primary enabler through which the nurse flexibly engages these attributes in response to the particular needs of a person. Professional artistry comprises various dimensions that interplay, balance and synchronise with each other, these dimensions are seen to include different kinds of knowledge, ways of knowing, multiple intelligences, creative imagination and use of self (Hardy, *et.al.*, 2009:221). In summary, professional artistry can be simplistically understood as the ways that a nurse creates a unique coalescence of the attributes of expertise to craft a unique nursing experience with a unique person in a unique context of need.

My understanding of nursing expertise had been shaped through the theory and scholarship on this topic that I had engaged with during my experience of being a clinical specialist nurse and more deeply as an academic. However, in comparing my understanding of expertise with what had been revealed in *Being at Ease*, I realised that my assumption that utilisers recognise a 'different and better' nurse through her/his demonstration of expertise was not a complete understanding of this social process. Through constant comparison and reflection I came to understand that the nurse's expertise was more probably an integral part of the form and nature of this complex system revealed through *Being at Ease* that leads a utiliser to recognise 'different and better' nurses through a personal or subjective feeling of being at ease.

The attributes of expertise are evident in actions, processes and relationships of all the categories of the core concern of *Being at Ease*, but possibly most explicit in the category of 'skilled being' that explains the ways that a nurse creates influence in her/his relationships with others through the interplay between her/his ways of being a nurse and ways of doing nursing. When thinking about how nursing presence is situated within the explanation offered within *Being at Ease* and how professional artistry has been articulated as an enabler of expertise, it seems that there are connections linking these concepts. It is possible that professional artistry offers a way that nursing presence may be enacted. It will be useful to elicit a deeper understanding of the relationship between these concepts to further our understanding of the nature of clinical specialist nursing practice.

In drawing the thread of nursing expertise through my current understanding of the actions, processes and relationships that form *Being at Ease*, I see nursing expertise and professional artistry to be a necessary part of creating a utiliser's experience of

that feeling held in the core concern. Expertise and professional artistry are integral contributors to the explicit form and implicit nature of that experience. Ultimately, the utiliser recognises a 'different and better' nurse in that utiliser's own experience of feeling at ease. This personal, subjective, feeling is a consequence of the various actions, processes and relationships that constitute *Being at Ease*, with expertise and professional artistry evident as threads running through the actions, processes and relationships that illustrate the categories and core concern of this grounded theory.

5.3 *BEING AT EASE* AND 'DIFFERENT & BETTER' NURSING PRACTICE

Part of the purpose of this study was to understand the nature of different and better nursing practice through the eyes of the people who have engaged with the nursing ability of critical care nurses. Through applying the inductive methods of grounded theory, the intrinsic, fundamental qualities that together seem to make up the nature of this way of nursing were elicited and explained in a grounded theory. This emerged grounded theory takes the name of the core concern of the study participants, namely *Being at Ease*.

Being at Ease offers an explanation as to how different and better nursing practice is recognised as a consequence of a utiliser experiencing a personal feeling of ease in the presence of a nurse and in the space of her/his nursing. The person appears to first recognise that the nurse seems to be at ease in the complex, messy reality of clinical practice and trusts her/himself in nursing. Through a multifaceted, interrelated blend of actions, processes and relationships, a different and better nurse seems able to convince the person that she/he, the nurse, will naturally and authentically live out the role being a nurse and doing nursing in its entirety. The person comes to recognise that this nurse is worthy of trust and becomes open to creating a trusting partnership with the different and better nurse. The trusting partnership lays groundwork for the person to act within their individual identity and power, and to feel in control despite the circumstances playing out around them – the feeling of 'being at ease'.

As I noted previously, the core concern of *Being at Ease* is a consequence of a multifaceted, interrelated blend of actions, processes and relationships. The nature of the core concern is revealed in the interactions and connections between four categories; namely 'knowing self', 'skilled being', 'connecting with intention' and

‘anchoring’. In teasing out the essence of each of these categories, the tacit nature of ‘different and better’ nursing became discernible within the interplay of personal qualities in the make-up of an individual, and then in the way the individual uses these qualities in her/his interactions with the people she/he nurses and within the spaces of nursing.

Through considered reflection on *Being at Ease* and the nature of ‘different and better’ nursing, I offer my view of the expression of qualities I believe are essential for a nurse to be able to craft the relationship and space within which a utiliser realises the core concern. The list below highlights the expression of qualities that I think traverse all four categories of ‘being at ease’ and are seen by a utiliser to enable a nurse to form the essential frames of self-trust (explained in ‘knowing self’ and ‘skilled being’), becoming trustworthy (explained in ‘skilled being’ and ‘connecting with intention’) and then being trusted (explained in ‘anchoring’) - the frame enabling ‘being at ease’ to manifest for that utiliser. I see *Being at Ease* able to reasonably support the following extrapolation of personal qualities that characterise the nature of a nurse or nursing recognised as ‘different and better’:

- having a sense of who she/he is as a person, knowing how to use and develop this sense of self to ground but also define her/his being a nurse and doing nursing;
- being able to craft a meaningful nursing experience for the other person and her/himself through creative and intelligent blending of profound knowledge, clinical skill and technical savvy across the range of a person’s unique need;
- having internalised values of integrity and respect for mutual humanness within the breadth and depth of being a nurse doing nursing;
- having an intuitive calm openness in connecting with people across all the spaces of her/his nursing ability;
- allowing another person to assert their own power, retain their own identity, and feel in control of their life however complex, unpredictable, mundane, difficult or desperate a situation may be

Looking through the lens of *Being at Ease*, the genesis of ‘different and better’ nursing is situated in the person’s sense of self, a respectful appreciation of humanness; and a developed, deeply held, personal engagement with the fullness of being a nurse.

5.4 BEING AT EASE AND CLINICAL SPECIALIST NURSING PRACTICE

Being at Ease offers that different and better nursing has genesis in the ways and means that the nurse is centred in her/his own humanness as she/he nurses another human being, and within her/his respect for each utiliser as a unique person.

Humanness is recognised by utilisers in the nurse living out the multifaceted role of being a nurse from her/his personal identity and her/his appreciation of the common space of being a human being. Rather than creating some type of separation between being her/himself and being a nurse and using this separate nursing identity as a shield to distance or protect her/himself from another person, the different and better nurse seems adept in making her/his humanness visible and palpable within her/his ways of nursing. The eventual consequence of a this nurse interacting with another from these beginnings is their co-creation of a space of trust within which the doing of nursing can be done respectfully, whether this is with a colleague, a significant other or observed with a patient.

In critical care environments this space of trust is imbued by an extraordinary dependence between people in that each person is depended on to properly and completely fulfil her/his role such that the other is able to do the same – each person in this complex space being pivotal in moving an interaction towards a reasonable outcome for her/himself and others. Utilisers recognised that a primary influence on the way a different and better nurse engages in an interaction is that nurse's respect for mutual humanness, the different and better nurse focusses on the person they are interacting with rather than prioritising a task at the expense of the person. This experience means they, the utilisers, can continue in their role at ease that whatever happens, the nurse is able to situate the person at the centre of insightful decisions or skilled actions in navigating this complex, integrated physiological, physical, emotional and social space to achieve a good outcome for the person / people affected.

As I reflected on clinical specialist nursing from this point of view, a thread of argument that I offered as part of the rationale for this study was brought into focus. I noted in Chapter 1 nurses seem to have difficulty in articulating the place of nursing and the particular value we bring as nurses to a complex healthcare system. We seem hesitant to speak about and engage with the enigmatic aspects of nursing, perhaps because these appear somehow insubstantial when compared with the hard facts that

evidence-based nursing practice stands upon, or that reflecting on (thinking about) nursing feels more like a theoretical exercise than a clinically useful activity. However, *Being at Ease* has highlighted that these enigmatic qualities that we struggle to articulate and embrace in the language and being of nursing are essential in a utiliser's experience of nursing that she/he recognises as 'different and better'; nursing that meets their expectations and needs.

And therein lies a challenge to each of us in the make-up of our being a nurse – the challenge to think and speak about what being a nurse doing nursing means to us in our various disciplines. These tacit aspects that *Being at Ease* has revealed can be further explored and substantiated as core essential elements of different and better nursing practice. I learned through this study that people are able to clearly articulate their thoughts, opinions and experiences of nursing despite their initially telling me that different and better nursing it is too difficult, too diffuse or too intangible to describe or explain. It seemed that all the participants really required to be able to offer their view on this apparently difficult, diffuse, intangible phenomenon was the opportunity to deliberately stop, reflect and speak to some-one interested in listening.

In my experience of clinical practice and academia, we tend not to deliberately create an opportunity to stop, reflect and speak about the intangible elements of nursing. However, from the perspective of those using the clinical specialist nurse's knowledge and skill, *Being at Ease* has shown that these enigmatic, tacit, intangible elements are essential in creating a mutually rewarding nursing interaction for the people involved in that moment. *Being at Ease* therefor challenges us to figure out how to deliberately stop, reflect on and speak about the nature of what we do as nurses every day in the critical care environments. Creating and using such deliberate opportunities in our varied nursing settings will begin to illuminate and slowly validate these embedded elements of humanness in the ways of being a nurse doing nursing.

By using these deliberate opportunities we may begin to develop a common language through which we can show the manifold complexity inherent in providing different and better nursing care. We need to create a language with which we can express the invisible skilfulness of being a nurse that underpins our visible practices of doing nursing such that we can speak confidently about these enigmatic elements of nursing,

taking these conversations beyond the realm of academia and into the reality of clinical practice.

5.5 BEING AT EASE AND TEACHING AND LEARNING ENCOUNTERS

- teaching and learning encounters

Being at Ease suggests that the purpose of teaching and learning in a specialist nursing programme should be to nurture the potential of a student to become a 'whole' specialist. I use the term 'whole' specifically to encapsulate the idea that a graduate of a clinical specialist learning programme will have been guided to engage with whole spectrum of becoming a clinical specialist nurse. In terms of *Being at Ease*, this means that the graduate has been guided during the programme to discover and explore the qualities of different and better nursing that lead to a person 'being at ease' in space of that graduate's nursing. The graduate has been supported through the programme to engage with her/his sense of self, and gain confidence in how to combine this insight with the knowledge, skill and technical doing of specialist nursing such that her/his potential for becoming a different and better nurse is nurtured.

Being at Ease suggests that the genesis of different and better nursing lies in the character virtues of a person. This implies that in order to develop a graduate's potential to become a nurse capable of being 'different and better', a programme must support a student to explore who she/he is, and move to understand how this insight underpins her/his ways and means of being a nurse doing nursing. The programme should provide opportunities for the student to engage with her/his sense of self, but also to engage this sense of self into nursing interactions such that she/he can sustain her/his personal identity in the complex, unpredictable world of healthcare created and mutated by complex unpredictable humans.

The purpose of postgraduate programmes must be to provide almost calculated opportunities to nurture fertile possibility in students such that beyond the learning platform she/he is able to continue in becoming an expert who can support another person in experiencing 'being at ease'. Broadly I see *Being at Ease* to be challenging us to develop programmes that nurture a student to develop a personal awareness of who she/he is an individual, how she/he sees this self within nursing, what the meaning of being a nurse holds for her/him and how she/he sees this meaning playing out in

everyday interactions in care environments. In establishing the student's sense of self as necessary in wholeness becoming a different and better clinical specialist nurse, she/he is given permission to bring that self into the spotlight to tease out which qualities require nurturing to allow her/him to expose that sense of self within the spaces of being and doing nursing.

I think that a programme that supports students to become 'whole specialists' – nurses able to use a calm heart and thinking head to fully engage with a person in a unique moment of nursing, requires openness, courage and creativity in teaching or learning. *Being at Ease* emphasises respect for humanness and integrity as core elements of different and better nursing. As such learning the ways and means of 'being' a specialist nurse must be developed and sustained in tandem with learning the 'doing' of specialist nursing throughout the programme. The ways and means of 'being' a specialist nurse requires that the nature of the programme must gently guide both the teacher and the student to encounter her/his self as a unique person within her/his teaching or learning the theory, skills and technology of doing specialist nursing. I believe this encounter requires personal courage from both the teacher and the student.

The philosophy underpinning the postgraduate programme needs to be congruent with guiding a student in developing these elements of humanness and integrity within the varied interactions and challenges of specialist nursing. The underpinning philosophy should require and allow a space of learning to be formed that students trust. I imagine that a trusted learning space is one that is characterised by openness and creativity that encourages the student's honest reflection on, challenging of and debating through sticky questions about being a nurse and doing nursing. Within this learning space, teaching and learning strategies that encompass the breadth and depth of different and better nursing will require a creative teacher and an open student (and probably vice versa - an open teacher and a creative student).

Through my reflections on what *Being at Ease* offers in terms of enhancing teaching and learning in postgraduate programmes, I think a programme should be designed to nurture the following in a student to facilitate her/his potential to become a different and better nurse:

- a) self-confidence – the teaching and learning encounters should assist the students to develop a sense of who she/he is as a person, as well as knowing how to use and develop this sense of self to ground but also define her/his being a nurse and doing nursing.
- b) openness - within the structure of the programme a student should be guided to find ways to feel and establish an intuitive calm openness in connecting with people and contexts across all the spaces of nursing however complex, unpredictable, mundane, difficult or desperate these may be;
- c) humanness – the programme must be designed with a person centred focus to enable the student to become deliberate in living out her/his developing understanding of humanness within the breadth and depth of being a nurse doing nursing;
- d) conscious practice – the purpose of teaching and learning encounters must facilitate a student becoming able to craft a mutually meaningful nursing experience through engaged, creative, intelligent blending of profound knowledge, clinical skill and technical savvy that is framed by the uniqueness of that person needing nursing.

- teachers

Reflecting on how the insights revealed in *Being at Ease* may augment teaching and learning brought into sharp focus for me the influence and power that is held by the person who teaches nursing. I believe that a teacher cannot make a student change any behaviour, but holds the potential to influence a postgraduate student.

I see a teacher having influence through the skill, knowledge, experience, personal conviction and passion she/he brings to a teaching and learning encounter. These elements underpin the credibility of that teacher for a student, and support that student to become open to being influenced, to consider her/his current behaviours and to choose to alter these. The power to decide how the graduate is shaped through the programme lies with the teacher. There are many different layers of power in a teacher-student interaction; for my purpose in this discussion, I use the word 'power' to reflect that which is at the disposal of the teacher to decide on and control - in the sense that it is the teacher who interprets, designs and then brings a programme to life in her/his ways and means of engaging with students in teaching and learning interactions.

She/he decides what to include, to emphasise, to ignore, to criticise and to follow. She/he decides how the experience of learning will unfold, where learning can happen, who is allowed to be part of the learning and so many more aspects. She/he also wields significant power in the ways and means she/he chooses to reveal her/himself to the students within the various contexts that are used for teaching and learning purposes.

So when thinking about the power and influence of teachers in the context of *Being at Ease* to consider how a teacher may influence a student in her/his becoming able to create a meaningful, connected, trusted experience of nursing for another person, it seems that the same beginning point can apply to teachers as it does for students. A teacher needs to have a formed sense of who she/he is as a unique and valuable individual, a sense of how she/he has learned and continues to learn how to balance this self within the roles she/he has occupied as a clinical nurse and as a teacher. From this foundation of 'knowing self', a teacher is able to show the worth of coming to know more clearly 'who you are' and be a credible guide for a student navigating her/his way through the beginning of this journey.

I think that to be able to ignite the potential in a student to become a different and better nurse you, as a teacher, have to be humble in your power to influence but strong in your ways of influence. By being humble in your power to influence I mean that a teacher must recognise and regularly challenge her/his own attitudes towards teaching and nursing, and her/his perceptions of what it means to be a teacher in nursing as this creates the framework within which her/his teaching occurs. For a teacher to have power to influence she/he needs to have a reasonably steady idea of what informs her/his ideas of who she/he is as a person, a nurse, a teacher; and then reflect on how these may augment and limit her/his influence as a teacher. I believe that in exploring your own philosophy of nursing and teaching you better understand how you affect your students through your own ways of being and doing the teaching of nursing. The power of being a teacher must be used carefully, respectfully and gently.

In being strong in your ways of influence I mean that there must be congruence between the teacher's requirements of the students with what the teacher requires of her/himself in teaching and learning encounters. *Being at Ease* shows that the different and better nurse engages with the person first before becoming concerned with the

labels defining that person at that moment, e.g. doctor, diagnosis, problem. If teachers intend to guide a student to becoming a different and better nurse, then *Being at Ease* suggests that the core of that intention must be the person rather than the anonymising label of 'student'. This requires that we grapple with the underpinning philosophy of a learning programme, how do we reconfigure learning programmes to place humanness at the core, how do we teach students about being a nurse as an essential foundation to the doing of nursing?

I think that part of the answer to these questions may lie in a teacher honestly embracing the notion or philosophy of being a guide for a student rather than an instructor. In choosing to guide a student a teacher must let go of controlling an encounter and recognise the fine line between instructing and guiding, forcing and shaping. Power to influence lies in a sensitivity on the part of the teacher to know enough about the individual behind the label of student to understand how and when to stretch that student beyond a current level of understanding, when to act as an anchor and hold that student, when to challenge a student's practice, and so forth – possibly creating the feeling of 'being at ease' in a learning encounter for that individual student.

In coming to teaching and learning encounters from a personal choice of guiding and shaping rather than instructing and forcing, a teacher shows a student that there is more than one way of being a nurse; assisting the student to use her/his sense of self to shape her/his nursing skill appropriately into a mutually beneficial experience for her/himself and another person. A teacher who is able to engage in a teaching and learning encounter from a balanced sense of self underlying her/his being a teacher of nursing will be comfortable in letting a student share or be in control of learning moment, be able to follow the student's lead and help them to self-shape their knowledge and skill to fit a situation, and show how rules can be appropriately shaped to a situation.

I see an influential guide as a teacher who remains flexibly in control of teaching and learning encounters rather than controlling these encounters. A teacher needs to find a manner of engaging that supports the student to learn in a way that makes sense to her/him but still reinforces the high level cognitive engagement, advanced clinical skill competence and technical proficiency that are a requisite part of creating the

experience of 'being at ease' for another person. In coming to teaching from the perspective of guiding a student I feel you become more sensitive to and creative in using moments in encounters to facilitate a student's ability to think about the unique individual she/he is while learning to become a specific professional entity – a clinical specialist nurse. As the student experiences you connecting with her/him as an individual within the midst of volume of work, fears, uncertainty, ego and so forth that are part of studying to earn a professional label, she/he learns to connect with the person who needs nursing care.

Being at Ease shows that when the focus of a teaching and learning encounter is only on skill competence, opportunities to influence a student to consider the breadth and depth of her/his nursing ability is lost. Each encounter has many opportunities that can be used to encourage a student to become self-confident in their nursing, to be open to using their sense of self and connect with another from an understanding of mutual humanness and to be conscious in their nursing practice. Used creatively these opportunities give the student permission to think about her/himself, challenge her/his preconceptions gently, and encourage them to stretch their thinking and assumptions. Opportunities are wasted because teachers do not, cannot or will not engage with a student, perhaps because a teacher is unable to recognise these moments of influence in an encounter, is perhaps afraid of using these moments or is perhaps too comfortable in her/his current teaching persona. These wasted opportunities lessen our power to influence students as we lose the moment of engaging with the student's potential of becoming different and better nurses recognised in *Being at Ease*.

- two ideas

I have not done a formal review of the literature to identify any particular strategies of teaching and learning that have been proven to develop a student's potential to become a 'whole' specialist, but felt that it may be useful to offer two ideas to explain how I think the above listed qualities can be nurtured in students. These are ideas that have germinated from my reflection on *Being at Ease*, my time as a teacher, as a clinical nurse and the work I have done to broaden my understanding of who I am as Janet.

I think that there are two important elements that a student in a clinical specialist programme needs in order to move to becoming a 'different and better' nurse, these elements are:

- a) knowing what her/his own strengths are and learning to use these within the role of being a nurse doing nursing;
- b) and developing her/his ability to think critically and deeply.

I think that learning to work within your strengths is powerful way of developing self-confidence, and learning about your personal strengths is a gentle but effective way of beginning to engage with your sense of self. In my experience, working from a strengths-based approach somehow legitimises the idea of bringing your personality and by extension, your humanness, into the science-focussed world of critical care. There are accessible, tested ways of discovering personal strengths that students can use, for example: the Gallup StrengthsFinder assessment. Once equipped with this knowledge, the student can be guided to use it in her/his ways and means of being a nurse doing nursing. This approach also helps to individualise the student's experience of learning and focus the teacher's way of guiding that student.

The other element is the skill of being able to think deeply and critically. I believe that this skill should be nurtured as a personal habit to gain grip and become a natural part of that person's being a nurse. If you, as a teacher, approach wanting to nurture the skill of thinking in terms of it becoming a habit, it means that you must be open to consider and use strategies that help a person to develop a positive habit in a healthy way – an unusual approach to prioritising what is taught and how it is taught in a postgraduate learning programme. One part of developing a habit is to deliberately practice, so a way of stimulating deep and critical thinking in any encounter between a student and a teacher is to pepper the interaction with Kipling's Wise Men - Who, What, When, Where, Why and How. The purpose of using these questions is to stimulate a student's potential for deep and critical thinking, and facilitate the practice of this skill in simple almost unobtrusive ways. The student also learns to challenge her/his own thinking with Kipling's Wise Men, and develop her/his ability to 'speak nursing'. This approach is portable and cost-effective as it can be applied wherever a student and teacher interact, whether at a patient's bedside, in the classroom, in small groups, in assessments, in the clinical skill laboratory and so forth.

Whilst appreciating that neither of these ideas is fully formed, tested or feasible in every instance; I offer them as point of contrast to stimulate discussion about the focus of teaching and learning practices that tend to be implemented in programmes aiming to develop clinical specialist nurses. Every single participant in this study commented to the effect that 'different and better' nurses are scarce and a rare but special find in the critical care practice environments, this observation alone should be sufficient to cause teachers to pause, reflect on and use their power to influence the development and presentation of these postgraduate programmes.

5.6 GROUNDED THEORY - *BEING AT EASE* - ME

I use this final section of Chapter 5 to reflect on myself, my forming and learning through this study, not what I have learnt in an academic sense through the nuts and bolts of the study or what the method revealed about nursing and *Being at Ease*, but rather a personal sense of what I have learnt about and for myself. I have chosen to write this section in the style of a journal entry so the tone of the following reflection will be less formal than the previous sections and chapters.

I am almost at the end of this beginning, I have realised this doctoral study really is my beginning rather than a culmination of my learning. I know that this statement is not particularly unique or profound because this is what I was told by others who had tackled this academic challenge before I began. But this experience feels vaguely similar to becoming a mother in that no matter how many people told you that you would be irrevocably changed in this experience, you cannot truly appreciate how completely you are changed until you are in this space and glance back at who you were and where you were when you began.

One of the biggest realisations I came to through the work of this study was to confirm for myself that thinking is also work - hard work, and that quality thinking work requires layer upon layer upon layer of reasoning, reflecting, deliberating and cogitating. It sounds like a strange comment to come from some-one who spent 10 years working in an academic environment – the place of thinking (?), and had completed a few other degrees, but I had never applied my mind as thoroughly to the demand of deep and complex thinking as what I did in the past few years. That may just be part of 'doing a PhD', but I think there is more to this experience of engaging so thoroughly in thinking.

I am not sure that in the forming stages of becoming a nurse that we really value and challenge our potential to think in complex ways - something that needs more thinking about. I am grateful to the grounded theory method processes, in particular constant comparison, which required me to keep thinking about my thinking and then think more. I learnt through this study how to really think and came to realise that I am far more capable of complex thinking than I had imagined.

I make a claim early in Chapter 2 based on a comment by Mills, *et al.*, (2006a:26) that essentially to be able to do a decent piece of work, the chosen research method must 'fit' well with person's beliefs about the nature of reality and so forth. On the surface Mill's comment seems easy to apply, but it was as I went about trying to understand the nitty-gritty detail of grounded theory, then in applying this method in my study and constantly justifying what I had done that I realised what that comment truly entailed in real life. So while I have enjoyed (mostly) figuring out what to do, why to do it and how to do it, here follows a word or two of advice on a less philosophical level than Mill's comment to those who may be considering grounded theory as the method of exploration in a study.

I realised through the course of this study that I have a few personal attributes that probably improved the fit between grounded theory and me. I prefer to work without tight fitting structures that force me to move in predetermined directions and do not allow for wonder. I usually enjoy the unexpected and am not disconcerted when I do not know what my next step should be. I can let my mind wander in many different directions without becoming lost or too overwhelmed and can let go of ideas that cannot fit even when I want them to. I am comfortable in chaos and the fluidity of emergence because I have learnt that I can see patterns, even if these may take a little while to become clear. This is going to sound, in the words of a colleague - slightly off beam, but within the mass of words in the data I could see the links, similarities, differences, nuances; and I have learnt how to work with these respectfully to give them shape and voice in the theory that emerged from the words. I was able to learn how to articulate what I had done in a way that others could recognise the landmarks of the research process and I have become better at defending my decisions from a position of knowledge and insight rather than defensiveness; although this was a steep learning curve and one I am still definitely climbing.

From my experiences then, some questions to reflect on when considering grounded theory as research method for a study:

- Can you let go of what you know - your research comfort zones, your discipline knowledge; can you uncover and explore your assumptions sufficiently to go with the data without becoming distressed or resistant?
- Are you tenacious and resilient, can you learn to defend what you want to do, what you have done, where you have ended and why – over and over again to yourself and others, and then still be open to alternatives?

But perhaps the most useful question to spend time thinking deeply about when considering if there is fit between grounded theory and you is –

Can you revel in a complex hazy journey based on a fairly imprecise question without any concrete idea of where you may end up?

Ending with a slightly philosophical thought; this PhD journey has redefined the way I see and know myself; and I did cringe as I employed that overused imagery! While I ostensibly began this work as a natural next step in my academic career, it became the vehicle with which I rescued myself out of what for me were a desperate set of circumstances. That does sound a bit overly dramatic but it is my truth in this experience.

In all the planning, thinking, creating, reflecting, writing, arguing, justifying, accepting, challenging, frustrations and successes that define the space and scope of doing doctoral work; I found my voice, came to appreciate my particular abilities and grew a metaphorical backbone.

CHAPTER 6

RE-CONNECTING - CONCLUSIONS AND RECOMMENDATIONS

This study presents a substantive grounded theory that elucidates how 'different and better' nursing practice is recognised from the perspective of some of the people who have used the nursing capability of a critical care nurse. In this final chapter I consider the usefulness and relevance of the study findings in terms of my stated aim and objectives. I offer what conclusions I see may be drawn from these findings. I also indicate how I see this work to contribute to the knowledge base of nursing and where further exploration may be of benefit.

6.1 IS THIS WORK A USEFUL GROUNDED THEORY?

Charmaz (2014:337) reflects that it is the audience who judges the usefulness of a grounded theory work by the quality of that work's product – the way the constructed theory renders or portrays the data. In this section I highlight the methodological and interpretive components that can be used to appraise the rigour of a work claiming to be grounded theory, and how I see these within *Being at Ease*. Appraising the quality and usefulness of this work is necessary to establish it as a worthwhile foundation from which conclusions can be drawn and recommendations can be offered.

6.1.1 Methodological and interpretive rigour

Urquhart, *et al.*, (2010:182-186) identify five methodological components of a grounded theory they regard as good reference points against which a study claiming to have produced grounded theory can be appraised. The components these authors identified are:

- constant comparison,
- iterative conceptualisation,
- theoretical sampling,
- scaling up
- theoretical integration.

Table 6.1 below shows how I see my work and the product *Being at Ease* in relation to these components.

Table 6.1 Methodological reference points of rigour within *Being at Ease*

URQUHART & COLLEAGUES' COMPONENTS (2010:182-193)	BEING AT EASE
<p><u>Constant comparison:</u></p> <p>'The process of constantly comparing instances of data that you have labelled as signifying or belonging to a particular category with other instances of data in the same category to see if these categories fit and are workable.' (Urquhart ,<i>et al.</i>, 2010:182)</p>	<p><u>Constant comparison:</u></p> <p>Was applied as the manner of data analysis during initial coding as data was fractured to reveal early common conceptual threads and possible conceptual groupings, during focussed coding as the conceptual threads became more substantial to enable one core concern with four related categories to emerge from the data and then in enfolding relevant literature to deepen this explanation and situate it within scholarship. Constant comparison also underpinned my personal reflection as to how <i>Being at Ease</i> was both similar and different to my pre-study assumptions.</p> <ul style="list-style-type: none"> • See Chapter 2 for my explanation of how I applied the logic of constant comparison in data analysis, Chapter 3 explains how this manner of analysis underpinned the emerging theory and in Chapter 5 I reflect on my established assumptions using constant comparison.
<p><u>Iterative conceptualisation:</u></p> <p>Building theory through the iterative application of coding and memo writing to increase the level of abstraction and reveal the relationships between categories (Urquhart, <i>et al.</i>, 2010:183,185)</p>	<p><u>Iterative conceptualisation:</u></p> <p>Occurred through the length, breadth and depth of the study, but is particularly clear in the processes of focussed coding, theoretical sampling, and the enfolding of literature.</p> <ul style="list-style-type: none"> • see Chapter 3 to follow how the GT evolved through iterative conceptualisation from over 500 codes to reveal the participants' core concern)
<p><u>Theoretical sampling:</u></p> <p>'... deciding on analytic grounds where to sample from next ... to focus on developing theory and ensures that the developing theory is truly grounded in the data.' (Urquhart, <i>et al.</i>, 2010:184)</p>	<p><u>Theoretical sampling:</u></p> <p>Was applied once data analysis (initial coding) had revealed early conceptual groupings and common ideas and to guide my decision regarding relevant literature</p> <ul style="list-style-type: none"> • see Chapter 2 for my explanation of how I applied the principles of theoretical sampling in this study • see Chapter 3 and 4 for my explanation of how this core component of GT was applied in inviting participants to contribute and in identifying relevant scholarship
<p><u>Scaling up:</u></p> <p>'The process of scaling up a theory to a sufficient level of abstraction in order to engage it with other theories on the field.' (Urquhart, <i>et al.</i>, 2010:193)</p> <p>'... having one or two core categories ... to get the theory to a reasonable level of abstraction.' (Urquhart, <i>et al.</i>, 2010:185)</p>	<p><u>Scaling up:</u></p> <p><i>Being at Ease</i> emerged as the core concern in how utilisers recognise 'different and better' nurses and nursing.</p> <ul style="list-style-type: none"> • See Chapter 3 for my explanation of how the GT <i>Being at Ease</i> became more abstract through constant comparative analysis and iterative conceptualisation from more than 500 codes to one core concern with four related categories.

URQUHART & COLLEAGUES' COMPONENTS (2010:182-193)	BEING AT EASE
<u>Theoretical integration:</u> '... systematically relate the emergent theory to the wider literature.' (Urquhart, <i>et al.</i> , 2010:185)	<u>Theoretical integration:</u> Was achieved through comparison of my initial proposition of a GT against relevant literature. <ul style="list-style-type: none"> • See Chapter 4 for my explanation of how <i>Being at Ease</i> was both developed by relevant scholarship and extended this scholarship.

As I demonstrate in Table 6.1, my application of the methodological processes of grounded theory method in this study resonate with the reference points of grounded theory as identified by Urquhart, *et al.* (2010:182) and thus establishes that the work can be defined as a grounded theory. However, whilst measuring my work using these identifiers of grounded theory confirms that I respected the distinctive methodological processes of this research method, this forms one part of the information needed by a reader to determine the quality of the work and then by extension, its usefulness.

Charmaz (2014:337) offers that the quality of a grounded theory product can be considered in terms of its credibility, originality, resonance and usefulness – these intertwine elements of both method application rigour and interpretive rigour. I offer a summary of these criteria in relation to my work below such that readers can make a decision about the quality of *Being at Ease* as an explanation of how utilisers recognise 'different and better' nurses and nursing.

- credibility

This criterion speaks to the way that I have disclosed the logic and conceptual grounding of the work through my argument and explanation of how this grounded theory came together from the research question through to *Being at Ease* (Birks, *et al.*, 2011:152).

As I began to unfold the story of *Being at Ease* in Chapter 2, I established that my choice to apply constructivist grounded theory was founded in two important considerations. Firstly, the nature of grounded theory method to enable an inductive explanation of a social process to emerge from data made this an appropriate method with which to explore the broad question that triggered this work. My second consideration was that the philosophical underpinning of constructivist grounded

theory held congruence with my personal worldview, how I view knowledge and its creation.

Through the chapters of this thesis I have been transparent in providing detailed explanations as to how I have interpreted the methodological processes of grounded theory, how I applied each of these in my work and why I applied them in a particular way. I have shown that the categories and core concern emerged from the data contributed by the study participants, and how these were formed and shaped through the processes of the grounded theory method. I provided evidence of the participants' words, pictures and emphasis, and how I used these in shaping the emerging theory. In the narrative of how this co-constructed understanding was revealed within the participants' conversations, through the iterative analytic processes of my engaging with the data and in weighing this analysis against nursing scholarship, I believe I have provided sufficient verification of the 'strong logical links' (Charmaz, 2014:337) between the data and my rendering of the data in the shape of *Being at Ease*.

- originality

Charmaz (2014:337) equates this criterion with the newness of the interpretive rendering of the data within the grounded theory, as well as the significance of this study in challenging, extending or refining current ideas and practices. When considering the originality of *Being at Ease* I use these questions from Charmaz as a guide - she asks 'Are your categories fresh? Do they offer new insights?' and 'Does your analysis provide a new conceptual rendering of the data?'

Each category of *Being at Ease* provides detailed insights into the elements that are part of a utiliser coming to recognise 'different and better' in a nurse's being a nurse and doing of nursing. The explanation of each category as a self-contained entity, as well as each category's contribution to the core concern, as offered mostly in Chapter 3, offers new insights that can develop some known elements of nursing; examples being presence and professional artistry. However, I see the most significant newness of *Being at Ease* to lie in the emerged understanding of what it means to a significant other or colleague to engage in the nursing space of a 'different and better' nurse. Through this explanation of *Being at Ease*, the way people recognise a 'different and better' nurse or nursing, we have a different impetus to provoke our thinking about what nursing is, how we do nursing, and who we are as a nurse.

- resonance

Resonance refers to the need of the theory to have meaning and scope for those to whom the theory has relevance (Birks, *et al.*, 2011:152). Whether *Being at Ease* achieves this criterion can only be determined by the reader as she/he considers whether the theory explains the social process 'as it is' and if the reality of this is truthfully represented within the researcher's explanation.

In respecting my role and responsibilities as author of this co-constructed theory *Being at Ease*, I have provided a detailed, rich, vibrant account of the manner I engaged with participants, the way I worked with their data, the forming and shaping of the theory as the concepts and categories evolved, the enfolding of scholarship, and the influence of my assumptions. I have also shown where and how the participants' own words and drawings contributed to and grounded this study. I have attempted to contextualise this work through generating full descriptions, arguments and explanations of the participants, methods and my thinking as the study evolved such that the reader can visualise the individual parts as well as the integrated whole of this work (Cooney, 2011:21).

Through the rich and complex explanation of the actions, processes, relationships and interactions within *Being at Ease*, I have offered a co-created insight into the meaning and manner of how a utiliser recognises a 'different and better' nurse and nursing. It now lies with the reader to decide whether the theory developed in this study explains the phenomenon in a way that they recognise as an accurate, reliable and authentic rendering of the data.

- usefulness

This criterion speaks to the capacity of the grounded theory to contribute to knowledge development and the applicability of the interpretation for people in their day to day life (Charmaz, 2014:338, Birks, *et al.*, 2011:152).

In Chapter 5 I use the core concern of 'being at ease' and its four categories as a point of departure to reflect on what this grounded theory may mean in terms of nursing and what it says about 'different and better' nursing. I then continued by focussing my reflection to consider the implications of *Being at Ease* in the realm of teaching and learning in postgraduate nursing programmes. These reflections show that this theory

has usefulness in challenging the everyday world of nursing and has the capacity to stimulate further questions as the ideas within this explanation become more widely encountered and debated.

6.1.2 *Being at Ease* – my claim of its quality and usefulness

Being at Ease is a substantive grounded theory that offers an understanding of what ‘different and better’ means to utilisers when engaging with nurses and nursing. A substantive theory is one which interprets and explains a delimited problem or phenomenon in a particular area or situation (Charmaz, 2014:344, Birks, *et al.*, 2011:176).

Being at Ease emerged through my exploration and interpretation of how utilisers recognised ‘different and better’ nurses in critical care environments. The ways and means that utilisers recognised a ‘different and better’ nurse comprised the phenomenon that was explored and interpreted. The situation or area that situated the phenomenon was nursing that occurred within the disciplines and environments of critical illness and care. In the above discussions I have shown how I see *Being at Ease* to have met the appraisal criteria for rigour in a grounded theory study. In applying the methodological reference points of Urquhart, *et al.* (2010:182-186), I have demonstrated that *Being at Ease* has met each of these, similarly I have shown that this grounded theory is able to hold its ground in terms of Charmaz’s (2014:337-338) criteria of credibility, originality, resonance and usefulness.

Based on my arguments offered in these discussions I contend that *Being at Ease* is a reasonable and sufficient foundation from which I can draw realistic conclusions in assertion of achieving the aim of this study and then offer recommendations of substance for practice, education and research.

6.2 DRAWING CONCLUSIONS

The end of a study brings it back to its beginnings and it with this in mind that I return to the aim of this study to formulate the conclusions that may be drawn from this work. As much as I accept the of myriad theoretical explanations from many, many authors of research method texts as to why the statement of a study aim is an essential element of any study, I came to understand that this stated aim held two essential

purposes for me as a researcher. These two essential purposes were that the study aim indicated to me where to begin, albeit in a very indistinct fashion and later it indicated where I should draw the study to a close for now.

In a way, the study aim formed the precinct within which this work evolved. Although it may seem to be a strange choice, I use the word 'precinct' deliberately as its definitions allow for the word to mean both a boundary marking out an area and an area around a particular building. With respect to the first definition, the boundaries marking out the area of this study were established by the study aim, these boundaries being there to enable exploration and interpretation without this being unduly constrained but also without becoming lost in the potential breadth of the data. The study aim also provided a more or less defined 'building area' or specific core to guide my decisions and sustain the focus of this work within my circumstances and constraints.

The aim of this study was to elucidate an understanding of the qualities that a utiliser of critical care nursing recognises as 'different and better' critical care nursing practice in order to enhance the teaching and learning encounters between nurse educators and postgraduate students in learning programmes aiming to develop clinical specialist nurses

Within the precinct of the study aim, the study demonstrated that 'different and better' nursing practice is supported as a phenomenon that can be distinctly recognised by a person, a significant other or colleague, in their experiences of critical care. My conversations with participants mirrored the anecdotes that in part stimulated this work where people had spoken to me of nurses who were able to connect with them in a manner that transcended the combination of knowledge and competence alone to create a unique experience of nursing. Given the opportunity to reflect on, explore and delve into their experiences, participants were able to identify and flesh out the qualities as well as the ways and means that cumulated in their recognising a nurse as being a 'different and better' nurse doing 'different and better' nursing'.

The overarching realisation of the study aim lies firmly within the grounded theory that I have titled *Being at Ease*. I gave this grounded theory the same name as that of the label given to the core concern, the label of the core concern was drawn from the

participants' words. The core concern 'being at ease', explains that the recognition of 'different and better' nursing is situated in the utiliser feeling personal composure and strength as a consequence of her/his trusting partnership created with a nurse who authentically and passionately lives out the ways and means of being a good nurse doing good nursing.

Being at Ease establishes that the utiliser's recognition of 'different and better' nursing in her/his subjective experience of personal composure and strength begins to form in the ways and means a nurse grounds and balances a developed sense of self and use this intuitively within the roles of nursing as explained through concepts and connections within the category of 'knowing self'. This creates a foundation from which the nurse can engage authentically with another as a fellow human being. This sense of self then is seen within 'skilled being' to permeate the nurse's application of her/his profound discipline knowledge and skill in an interaction, demonstrating visibly to the utiliser that the nurse trusts her/himself. In this way the nurse seems able to create an opportunity for a trusting relationship to develop with that utiliser. From this foundation, 'connecting with intention' leads the utiliser to experience the nurse as being able to craft a meaningful connection through which the utiliser begins to experience feeling safe in the space of the nurse. As the utiliser gains evidence of the consistency and dependability of the nurse, a trusting partnership develops between the nurse and utiliser. In this trusting partnership the utiliser has an experience of being safe and thus able to retain a sense of personal power and feel in control of the circumstances playing out at that time as expressed through the concepts and connections of 'anchoring'. Thus, within the four categories, namely: 'knowing self', 'skilled being', 'connecting with intention' and 'anchoring' that influence and interact with each other to result in the core concern of 'being at ease', the emerged grounded theory of *Being at Ease* reveals an explanation of the elements which encompass an understanding of the ways and means of how 'different and better' is recognised by utilisers as they engage with critical care nurses and nursing.

In Chapter 5 I shared my reflections on what I think *Being at Ease* reveals about 'different and better' nurses and nursing per se. These ideas had germinated and incubated as I engaged with the participants' contributions; and had evolved, becoming richer as I assimilated and enfolded literature. In speaking to the study aim

and objectives, I offer through my reflections that are founded within the study findings, that the nature of 'different and better' is grounded in the person's ways of being a nurse rather than in that person achieving generic identifiers of a single type of nursing. These ways of nursing have genesis in the mingling of personal qualities that the person being a nurse expresses in the form and shape of her/his nursing. This allows for a utiliser to be able to participate with a nurse in a space of safety and trust which ultimately underpins the utiliser's own experience of the core concern 'being at ease' in the presence of that nurse and her/his nursing.

In the bulleted list below, I reiterate my current understanding of the nature of 'different and better' nursing practice (see Chapter 5) as revealed by the participants and explained through the four categories and core concern. From within the complexity of *Being at Ease*, I have come to understand that the wholeness of an experience of *Being at Ease* for a utiliser is crafted in the expression of nursing by a nurse who has:

- a sense of who she/he is as a person, knowing how to use and develop this sense of self to ground but also define her/his being a nurse and doing nursing – self-confidence;
- become able to craft a meaningful nursing experience for the other and her/himself through creative, intelligent blending of profound knowledge, clinical skill and technical savvy across the range of a person's unique need – conscious practice;
- internalised values of integrity and respect for mutual humanness within the breadth and depth of being a nurse doing nursing - humanness;
- an intuitive calm openness in connecting with people across all the spaces of her/his nursing ability - openness;
- become able to allow and support another person to assert their own power, retain their own identity, and feel in control of their life however complex, unpredictable, mundane, difficult or desperate a situation may be – self-confidence, humanness and openness within conscious practice.

In contemplating the second part of the study aim, I considered the meaning of *Being at Ease* for a utiliser, a nurse and nursing, and how *Being at Ease* may be applied to enhance teaching and learning encounters. I concluded that in order to nurture the potential of a postgraduate student to be able to craft 'different and better' nursing

practice, it is necessary for the philosophy of postgraduate programme and the teacher of that programme to enable a student to develop as a 'whole' specialist.

Supporting a student to develop as a whole specialist means that she/he can engage with her/his sense of self, and gain confidence in how to combine this insight with the knowledge, skill and technical doing of specialist nursing. This requires that the teacher and the learning programme are similarly grounded in the humanness and integrity that permeates the core concern and categories of *Being at Ease*. Thus, I conclude that a teacher needs to have a formed sense of who she/he is as a unique and valuable individual, a sense of how she/he has learned to balance this self within the roles she/he has occupied as a clinical nurse and as a teacher in order to be a credible guide for a student learning the complexity of becoming a whole specialist. The philosophy underpinning the postgraduate programme must enable a teacher to guide a student in developing these elements of humanness and integrity within the varied interactions and challenges of specialist nursing such that her/his potential to mature into being a 'different and better' nurse doing 'different and better' nursing is cultivated.

6.3 CONTRIBUTION

There are two broad areas that I consider to have contributed to through conducting this study – one being research method application and the other being the developing understanding of the nature of clinical specialist nursing practice in critical care.

Through the chapters of this document I have provided a comprehensive, dense account of how I understood and then applied grounded theory method in this study. I have explained and argued my interpretation of the published works on grounded theory method. I have endeavoured to clarify how and why I applied the grounded theory methodological processes as I did within the particular circumstances and context of the study as well as within my research understanding and ability from developing the study proposal through to this point of drawing the study to a close. In this way I have presented a reasonably structured example of my way of using grounded theory methods in answering the research question that guided this study for others to consider, scrutinise and critique in developing their own understanding of

how grounded theory method may be applied to answering their questions concerning a particular social processes.

The second broad area I see this work to be contributing to is in offering a further perspective into the discourse on the nature of clinical specialist nursing. *Being at Ease* adds another view to discussions that contemplate the meaning of being a good nurse doing good nursing and how to translate this meaning into the messy reality of clinical specialist nursing practice.

Furthermore, I see that this work to some extent lays bare the complexity of nursing – the detail in each category underlines how many different elements need to interface, integrate and work in synchrony such that a utiliser comes to know the whole experience of *Being at Ease*. In highlighting the complex nature of clinical specialist nursing, I see *Being at Ease* as an invitation to begin thinking about being a nurse and doing nursing as a complex integrated whole system rather than thinking of nursing as a series of small separate slivers that must somehow be cobbled together.

6.4 LIMITATIONS

The nature of research means that every study has limitations that influence the findings of the study as well as the ways the work may be interpreted and applied. In acknowledging the limitations in this study, the work is enriched by opening my assumptions and arguments to others critique.

The findings of this study were drawn from 38 data items created through conversation with 10 participants, further these data were interpreted by me within my personal and professional history and were then viewed through the lens of particular nursing scholarship. This study was interpretive and contextual in nature and as such I do not claim that these findings are representative of all utilisers of critical care nursing, or that these findings are generalisable to all instances of nursing. Rather I offer this work as an understanding of a phenomenon in a specific context by a particular group of people – that of understanding how a ‘different and better’ nurse and nursing is recognised in critical care by significant others, nurse colleagues and medical colleagues. I have provided a detailed discussion of quality and credibility of this work to enable others to transfer these findings, or perhaps rather the ideas of these findings, into their own spaces with confidence.

The findings of this work are limited within the confines of my own developing ability and skill as a researcher. In claiming this limitation on my work, I am acknowledging that this research was conducted as a process of learning and as such my ability to make sense of and apply the theory of grounded theory and its method processes influenced this study at every turn. As I have noted previously in this chapter I have provided a detailed account of the way in which I applied the principles and methods of grounded theory as I understood these from engaging with the scholarship of authors in grounded theory. This will enable a reader to decide how my research skills and the evolution of these may have influenced the outcome of the study.

This study was conducted in fulfilment of the requirements to attain the degree Doctor of Philosophy in Nursing as such the study was limited by the time constraints necessitated in my respecting the time deadline and academic requirements of this degree programme. Time constraints possibly held the biggest influence as a limitation on this work as grounded theory studies are known to be time intensive in terms of data generation processes and I did modify these processes somewhat to better use my time in the concurrent data collection and analysis process. However, in tweaking the process I did respect the principle of concurrency in using the data collected in one interview to guide the focus of the following interview/s.

6.5 RECOMMENDATIONS FOR PRACTICE AND RESEARCH

Recommendations emanating from the findings of this study relate to nursing education and clinical nursing practice and research, and then looking beyond our nursing precinct.

My recommendations arising from this work centre around the assurance within *Being at Ease* that for 'different and better' nursing to happen, the tacit elements of being a nurse are as equally essential as the visible elements of doing nursing. With this idea forefront, I offer the following recommendations with respect to research, education and clinical practice:

- research

Engaging with the complexity of *Being at Ease* in further studies will assist in moving this work towards a simple understanding of its complex whole from what currently may seem to an outsider to be a mixture of complicated actions and processes. It is in

a simple understanding of this complex whole that the work will become more readily accessible for people to use in education and practice environments.

There are research opportunities within the categories of the grounded theory for concepts and elements to be studied further in terms of comparison with literature, in developing understandings of various concepts and how these may be brought into teaching and learning encounters. This work will benefit from and develop through comparison with higher level nursing models and theory. I additionally recommend studies that move beyond the obvious precinct of nursing theory to apply the work of other disciplines, for example in using the lens of complex adaptive systems theory. In this way gaining a deeper understanding of complexity and nursing, how complexity theory may offer additional insights into *Being at Ease* and possibly contribute to an alternate understanding of nursing in that theoretical space.

The depth and breadth of this study may be augmented by engaging with patients using the same springboard question to ascertain as to how their ways of recognising a 'different and better' nurse may develop this work. The opportunity to understand how this work would resonate with nurses identified as 'different and better' by significant others, colleagues and patients would also provide useful insights into elaborating this work further. Expanding the context beyond that of critical care would also result in additional insights to develop this grounded theory further.

- education and clinical practice

Being at Ease situates an encounter with a 'different and better' nurse as a positive experience for a utiliser which requires us to take note of what this means in our practices and how we can position this way of being a nurse and doing nursing as the norm in our environments.

As I have noted through my writing, the genesis of that utiliser's feeling of 'being at ease' when interacting with a nurse lies within a nurse's sense of self and the meaning she/he ascribes to the spaces of being and doing in nursing. In order to develop a sense of one's self, we need to develop a habit of thinking, a norm of thinking. We need to encourage a habit of reflection - thinking about who we are as a person, how we fit in the idea of a nurse and the ways that nursing can be tweaked to fit that self in a better way. We must become creative in fashioning opportunities and grabbing

openings to speak about what being a nurse and doing nursing means to ourselves such that we become comfortable that these tacit, 'touchy-feely' elements are an essential and valuable part of what we do as nurses, and reveal these elements as essential and valuable to others in healthcare. These opportunities may be found during handover sessions in hospital, or in a bedside teaching moment, or in a conversation with a colleague during a quiet moment, or a congress presentation or in any other of the myriad moments that constitute a space of nursing.

6.6 CONCLUSION

This study set out to address my need to understand the nature of 'different and better' nursing practice such that the particular tacit elements of this way of nursing could be made explicit and then used to enhance teaching and learning encounters in postgraduate programmes aimed at developing students into clinical specialists.

Through the application of grounded theory method, a substantive grounded theory named *Being at Ease* revealed that 'different and better' nurses were recognised through a subjective experience for the utiliser of 'being at ease', the core concern produced through the complex interaction of four categories. *Being at Ease* formed the foundation for my reflections on the experience and meaning revealed in this grounded theory, and how I see this being useful in enhancing teaching and learning encounters.

The study has revealed the incredible complexity of clinical specialist nursing as seen from the perspective of people who have in some way utilised a critical care nurse's nursing ability developing our practice narrative in articulating the nature of clinical specialist nursing to explain what good nurses do and how good nurses do good nursing. *Being at Ease* suggests that the promise held in the idea of 'clinical specialist nursing' is kept in the complex wholeness of a person authentically and passionately living out being a good nurse doing good nursing.

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APPENDICES

APPENDIX 1: Letter of study approval and ethics clearance from FRTI

	 Nelson Mandela Metropolitan University <i>for tomorrow</i>
Copies to: Promoter: Prof RM van Rooyen	Summerstrand South Faculty of Health Sciences Tel. +27 (0)41 5042121 Fax. +27 (0)41 5042854 Nouwaal.Isaacs@nmmu.ac.za
Student number: 188051310	
Contact person: Ms N Isaacs	
17 September 2012	
Ms JD Bell 68 Murray Street Durbanville 7550	
FINAL RESEARCH/PROJECT PROPOSAL: PhD NURSING SCIENCE ARTICULATING THE NATURE OF CLINICAL NURSE SPECIALIST PRACTICE	
Please be advised that your final research proposal was approved by the Faculty Research, Technology and Innovation Committee subject to the following amendments/recommendations being made to the satisfaction of your Supervisor/s:	
<u>COMMENTS/RECOMMENDATIONS</u>	
FRTI RECOMMENDED TITLE: Deletions [xxx] Additions xxx [ARTICULATING THE NATURE] <u>QUALITIES</u> OF CLINICAL NURSE SPECIALIST PRACTICE	
<ol style="list-style-type: none">1. The proposal was well prepared.2. Cover page It must be stated that it was a research proposal.3. Supportive literature The researcher originally indicated that she would use the theoretical framework (grounded theory) but on p9 she indicated a conceptual framework. This was contradictory.4. p2 The bullet points lose some impact because of the vagueness of the initial group that defined these challenges. It was recommended that the candidate should make the statements clearer by indicating where the conversation was raised and who she spoke with.5. p13 - Data collection The three probing questions overlap with one another. It was presumed that as "examples", not all of them would be used with a particular participant.6. p22 - Budget The technology estimation of R20 000 were very high. The researcher must be able to include the breakdown and defend the high costs.7. p22 - Time schedule The proposal submission to FRTI dates in May-July 2012 was incorrect. The proposal served at the FRTI meeting in August. The completion date of November 2013 seemed tight for a doctoral study.	
FRTI grants ethics approval provided that the relevant authorities granted approval for the research to be done at their institutions. The FRTI committee reference number for the proposal is H12-HEA-NUR-005.	

Please be informed that this is a summary of deliberations that you must discuss unpack with your Promoter.


Kind regards

A handwritten signature in dark ink, appearing to be 'Ms N Isaacs', written in a cursive style.

Ms N Isaacs
Manager: Faculty Administration
Faculty of Health Sciences

APPENDIX 2: Request for permission to conduct research in hospitals

• PO Box 77000 • Nelson Mandela Metropolitan University
• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za



**Nelson Mandela
Metropolitan
University**
for tomorrow

[insert date]

The Research Co-ordinator
Provincial Health Research Committee

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN TERTIARY HOSPITALS IN CAPE TOWN

Dear

My name is Janet Bell, and I am a PHD student at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I intend to conduct for my doctoral thesis aims to elucidate an understanding of how utilisers of critical care nursing recognise 'different and better' nursing practice in order to inform the design of teaching and learning strategies for nurse educators to use in postgraduate preparation of clinical nurse specialists. This project will be conducted under the supervision of Professor RM van Rooyen (NMMU, South Africa) and Dr P Jordaan (NMMU, South Africa).

I am hereby seeking your consent to access the tertiary hospitals in the Cape Town area (i.e. Groote Schuur Hospital and Tygerberg Hospital) to explain the study to potential participants and invite them to contribute to the study.

I have provided you with a copy of my thesis proposal which includes copies of the information session guide, interview guide and consent forms to be used in the research process, as well as a copy of the study approval letter from the NMMU Research Ethics Committee (Human) and the required application forms for the Provincial Health Research Committee.

Upon completion of the study, I undertake to provide participating institutions with a summary copy of the full research report as well as details of any published articles or oral presentations. If you require any further information, please do not hesitate to contact me on bell.janetd@gmail.com or 0825637683. Thank you for your time and consideration in this matter.

Yours sincerely,

Janet Bell
Nelson Mandela Metropolitan University

APPENDIX 3: Letter of permission to access a particular group of hospitals

5 February 2013

Ms JD Bell
68 Murray Street
DURBANVILLE
7550

Dear Janet

PERMISSION TO CONDUCT RESEARCH AT [REDACTED]
[REDACTED]

Your research proposal entitled "*Articulating the nature of clinical nurse specialist practice*" refers.

It is in order for you to conduct your research at [REDACTED]
[REDACTED], and I wish you success with this project.

Yours sincerely



ESTELLE JORDAAN
Nursing Executive

APPENDIX 4: Letter of permission to access another group of hospitals

RESEARCH OPERATIONAL COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2013-0005

Ms Janet Bell

E mail: bell.janetd@gmail.com

Dear Ms Bell

RE: ARTICULATING THE NATURE OF CLINICAL NURSE SPECIALIST PRACTICE

The above-mentioned research was reviewed by the Research Operational Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Committee.
- ii) All information with regards to Company will be treated as confidential.
- iii) Company's name will not be mentioned without written consent from the Committee.
- iv) All legal requirements with regards to patient rights and confidentiality will be complied with.
- v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability
- vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist
- vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)
- viii) Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.



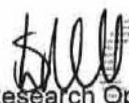
- ix) A copy of the research report will be provided to Company once it is finally approved by the tertiary institution, or once complete.
- x) Company has the right to implement any Best Practice recommendations from the research.
- xi) Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.
- xii) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER.

We wish you success in your research.

Yours faithfully


Prof Dion du Plessis

Full member: Research Operational Committee & Medical Practitioner evaluating research applications as per Company Policy


Shannon Nell

Chairperson: Research Operational Committee

Date: 15/3/2013

This letter has been anonymised to ensure confidentiality in the research report.
The original letter is available with author of research

APPENDIX 5: Information session guide sheet

INFORMATION SESSION GUIDE SHEET

- Introduce self
 - Contextualise own critical care experience
 - PhD, NMMU, study supervisors
- Broad outline of study
 - Problem
 - Aim & objectives
 - Qualitative study
 - Ethics and facility approval
 - Eventual outcomes of study
- Invite participation
 - Need 1 hour for interview & naïve sketch
 - Will contact individually to arrange convenient date and venue
 - Explain participation form
- Complete participation form

- TAKE WITH:
 - participation forms
 - pens
 - box for completed forms
 - thank you notes for hospital management & critical care units

APPENDIX 6: Form to indicate interest in participating in this study

Study Title: Articulating the Nature of Clinical Nurse Specialist Practice

Thank you for taking the time to read this note about the research I will be conducting.

In short, what I am hoping to achieve through this study is an understanding of the qualities of critical care nursing practice that are recognised, by those who work or engage with critical care nurses, as standing out in a positive way.

I intend to use this data to develop our understanding of what clinical specialist nursing in critical care is by explaining how those who engage with critical care nurses recognise practice that meets or surpasses their expectations. This knowledge will continue to develop our understanding specialist clinical practice and practice expertise. The study findings will also be applied to designing teaching and learning strategies that may possibly refocus the manner in which clinical specialist nurses are educated.

You can contribute to this study by telling me your stories and giving me your opinions about a critical care nurse or nurses you have worked with somewhere whose nursing practice stood out positively for you in some way.

If you are interested in participating, I will need the following from you:

- An hour of your time outside of working hours at a time and venue that suits you
- Completion of a consent form
- Participation in an individual interview and completion of a naïve sketch

I appreciate your considering contributing to this study, your stories are valuable in developing specialist nursing practice in South Africa and beyond our borders.

Thank you

Regards

Janet

✕

THANK YOU FOR YOUR TIME

PLEASE TICK THE APPROPRIATE BOX TO INDICATE YOUR PREFERENCE FOR PARTICIPATING IN THE STUDY DESCRIBED TO YOU:

☐ YES, I would like to participate in this study,

• My name is _____

• Preferred method of contact:

☐ Cell phone number: _____

☐ E-mail address: _____

☐ Other telephone number: _____

☐ NO, I don't want to participate in this study.

PLEASE FOLD AND PLACE YOUR COMPLETED SLIP INTO THE 'REPLY' BOX.

APPENDIX 7: Letter for participants

Faculty of Health Sciences

NMMU

Tel: +27 (0)41 504-2121 Fax: +27 (0)41-504-2854

E-mail Faculty Chairperson: Rosa.durandt@nmmu.ac.za

February 2013

Ref: H12-HEA-NUR-005

Contact person: Janet Bell

Dear

You are being invited to participate in a research study. I will provide you with the necessary information to assist you to understand the study and explain what would be expected of you. These guidelines will include the risks, benefits, and your rights as a study participant. Please feel free to ask me to clarify anything that is not clear to you.

To participate in this study you will need to provide written consent that will include your signature, date and initials to verify that you understand and agree to participate in the study. I will provide this consent form and assist you to clarify any aspect that you may be concerned about. The informed consent statement has been prepared in compliance with current statutory guidelines.

You have the right to query any concerns or problems regarding the study at any time. My contact telephone number is provided.

It is important that you are aware that the ethical integrity of the study has been approved by the Research Ethics Committee (Human) of the university. The REC-H consists of a group of independent experts that has the responsibility to ensure that the rights and welfare of participants in research are protected and that studies are conducted in an ethical manner. Studies cannot be conducted without REC-H's approval.

Queries about your rights as a research participant can be directed to the Research Ethics Committee (Human), Department of Research Capacity Development, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031. If you are not satisfied with the assistance offered, you may write to: The Chairperson of the Research, Technology and Innovation Committee, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.

Participation in this study is completely voluntary. You are not obliged to participate and if you choose not to participate, you will not be affected or penalised in any way. If you do choose to participate in this study, you have the right to withdraw at any time without negative consequences.

Your identity will at all times remain confidential, this includes when the results of the research study are presented at scientific conferences or in specialist publications.

Yours sincerely

Janet Bell

APPENDIX 8: Participant information & consent form

NELSON MANDELA METROPOLITAN UNIVERSITY INFORMATION AND INFORMED CONSENT FORM

<u>RESEARCHER'S DETAILS</u>	
Title of the research project	Articulating the nature of clinical nurse specialist practice
Reference number	
Principal investigator	Janet Bell
Contact telephone number	0825637683

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT			Initial
I, _____, the participant and undersigned			
HEREBY CONFIRM THAT:			Initial
I, the participant, was invited to participate in the above-mentioned research project			
that is being undertaken by	Janet Bell		
from	Department of Nursing, Nelson Mandela Metropolitan University		
THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:			Initial
1.1	Aim:	<ul style="list-style-type: none"> The researcher is studying how nurses, medical practitioners and patients' significant others recognise 'different and better' nursing practice in the clinical critical care environment. I have been invited to participate because I work with, or have had contact with, professional nurses (or 'sisters') while they care for critically ill patients. The information from this study will be used as a foundation to design teaching and learning strategies for nurse educators to use in postgraduate preparation of clinical nurse specialists. 	
1.2	Procedures:	<p>I understand that:</p> <ul style="list-style-type: none"> my participation requires me to be interviewed and to write a short descriptive note the researcher will guide my interview and the short note using statements. She may ask questions to clarify how she understands what I have said. the interview will be recorded on a digital audio recorder and will be transcribed. the interview recording and transcription as well as the short note will only be available to the researcher and her study supervisors. I will choose a pseudonym to identify my data my real name will not be linked to any recording, transcription or brief note. 	
1.3	Risks:	There are no risks identified in these procedures or the study. This study has been approved by the NMMU Research Ethics Committee (Human).	
1.4	Possible benefits:	My participation in this study will help to develop a better understanding of the nature of 'better and different' critical care nursing. This information will be used to develop teaching and learning strategies to influence the way that postgraduate nursing students are taught, and will contribute to their being equipped to mature into clinical practice experts.	
1.5	Confidentiality:	My identity will not be revealed in any discussion, description or scientific publications by the investigators.	
1.6	Access to findings:	<p>Any new information or benefit that develops during the course of the study will be shared as follows:</p> <ul style="list-style-type: none"> Findings will be developed into journal articles for publication 	

		in scientific journals. • Findings will be presented at relevant workshops and conferences		
1.7	Voluntary participation / refusal / discontinuation:	My participation is voluntary	YES	NO
		My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle	TRUE	FALSE
THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:				Initial
Janet Bell				
in Afrikaans English				
and I am in command of this language, or it was satisfactorily translated to me by				
Janet Bell				
I was given the opportunity to ask questions and all these questions were answered satisfactorily.				
No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.				
Participation in this study will not result in any additional cost to me, nor will I be paid to participate in this study.				
A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:				
Signed/confirmed at		on		20
Signature		Signature of witness:		
		Full name of witness:		

B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)				
I, Janet Bell, declare that:				
1.	I have explained the information given in this document to			
2.	He / she was encouraged and given ample time to ask me any questions;			
3.	This conversation was conducted in Afrikaans English			
	And no translator was used			
4.	I have detached Section C and handed it to the participant	YES	NO	
Signed/confirmed at		on		20
Signature of interviewer		Signature of witness:		
		Full name of witness:		

C. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant

Thank you for your/the participant's participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study

Kindly contact	Janet Bell
at telephone number	0825637683

APPENDIX 9: Interview preparation sheet

<i>INTERVIEW PREP SHEET</i>	
<ul style="list-style-type: none">• Introduce self• Study<ul style="list-style-type: none">○ Aim & objectives○ Ethics and facility approval○ Eventual outcomes of study○ Participant information & Consent forms• Interview• Naïve sketch• Permission to re-contact• Any other insights from participant	
<ul style="list-style-type: none">• TAKE WITH:<ul style="list-style-type: none">○ Forms: information, consent, interview guide, naïve sketch○ pens○ tissues○ thank you note for participant	
<hr/> <i>J Bell</i>	<hr/>

APPENDIX 10: Interview guide & record sheet

INTERVIEW GUIDE & RECORD SHEET:

DATE:

VENUE:

Think about your experiences in this/any critical care environment - is there a professional nurse (or nursing sister) who, for you, has stood out from other professional nurses? Tell me what you think makes her/his nursing stand out from the other nurses.

APPENDIX 11: Naïve sketch sheet

PSEUDONYM:

DATE:

VENUE:

Picture your ideal critical care nursing specialist – describe and explain the top three qualities you would want in that ideal critical care nurse-

APPENDIX 12: A screenshot of early initial coding in ATLAS-ti (interview 2)

The screenshot displays the ATLAS-ti software interface. The main window shows a transcription document titled "P 4: int 2 transcription.docx". The transcript text is as follows:

003 Okay, I think that they, their actions are not based purely on knowledge so it's not a theoretical knowledge where they're absolute fundies on haemodynamic monitoring, umm they combine that with what is best for that individual patient and their decisions are based on what their heart is telling them is right, not umm what the recipe is or umm what the textbook particularly says is the next step so

004

005 *So when you talk about what their heart is telling them, what do you mean by that?*

006

007 If you, umm quite difficult to put into words, but you have to stand up for what is right and ... you know your heart represents many things, not only do you have a particular, you have a sort of a relationship with the patient and family where it is a, almost a relationship where there is love. You feel such empathy but your heart is also like where you are quite courageous, so when something is not right you feel that you can, you do actually speak up. Umm ja, it's a different kind of an emotive connection with a patient it's not just a body lying in a bed and irritating family visiting. It's umm, its feeling what that patient is going through. So when you need to do an arterial stab, you know you need to do an arterial stab because they don't have an arterial line in situ yet, but you, you also know how much it hurts. You rationalise the reason for doing it, it's not just a routine thing, there's no other way that you know what that patients metabolic state is, you have to do this particular procedure and it weighing up that. It's not a routine, it's not that all patients who come in in respiratory distress we draw an ABG it looks at the patient as an individual – what they've already gone through, can they handle another invasion like this right now in their current state. I mean when I pictured what I would do for my naïve sketch it was umm the brain and the heart are of equal size if I have to quantify it, umm

008

009 *So by that you mean the brain is like the thinking skill side that's almost like a checklist's there and the heart is the side that is saying – is this right for this patient now.*

010

011 Ja, at this particular point in time, is this the right thing to do, ummm

The right-hand pane shows a list of codes (glitches) applied to the text. The codes are:

- other foundation for action
- combining knowledges
- skilled knowing
- being able to - complexity - know when to ask for help
- individualising
- working beyond the rules
- difficult to describe
- owning the space of nursing
- nursing with heart - many meanings
- connecting into pt/family experiences
- deeply connected - empathy
- deeply connected to pt & family
- standing ground
- engaging courageously
- connecting - emotional connection
- connecting into pt/family experiences
- seeing beyond the 'body in a bed'
- rationalising with feeling
- balancing pt experiences with need for data
- individualising
- balancing pt experiences with need for data
- individualising
- thinking & feeling intersect to make choices
- thinking things through

APPENDIX 13: A screenshot of later initial/early focussed coding in ATLAS-ti (interview 5)

P13: int 5 transcription.docx

002

003 I don't think it's one particular thing, I think there are probably a number of key components which will allow a nurse to move in that direction and obviously any ICU nurse has to be highly committed and I think the majority of ICU nurses won't go into ICU nursing unless they are highly committed because the demands are enormous the psychological and emotional demands are enormous the time demands are enormous and there's a lot of and the physical demands are also quite big so there is a huge initial commitment that is required and they a huge amount of enthusiasm is necessary for effective ICU nursing umm because it is only thru commitment and involvement that they will have a positive experience and that will be very much felt by all that they work with or the people that they work with and particularly their pt. so I think that that is the first and then secondly I think they need a very high level of understanding of what and why they are doing things umm and it is something which grows out of quite a lot of academic pursuit as well as experience umm cos without understanding what they're doing they will never achieve that high standard of nursing so they need not only understand what's going on but they need to know why it is going on and they need to be able to anticipate what's going to happen next umm and that is a process that requires a lot of concentration as it were so they need to be focussed on what they are doing and also they need demand and be given the opportunity to nurse in that way I think that often the system that they work in doesn't allow them to do that and I think that is a source of frustration and I think that the development of so called situational awareness and maintaining that situational awareness is enormously beneficial to both the patient as well as dealing with people who are also involved with the patient like other drs or physiotherapists or the family and so I think that's a second component, umm I think a third area really is cos they dealing with pts who often don't have happy outcomes and who are by the nature of things critically ill is an inordinate amount of compassion is required so it is a different type of compassion a compassion with hope which has to be felt by everybody else I the team and I think that that is a special quality of the best ICU nurses, umm I think those three major areas are the what I would consider exceptionally important I think the good ICU nurse because of how vulnerable the pt is really becomes the pts main advocate and not only cares for the pt but prevents the pt from being exposed to any form of danger whether technological danger or too many people or fear or umm bugs like all the various hazards that are involved with ICU, the most effective person in protecting the pt from those hazards is in fact the involved nurse so I think they've got to be very aware of that role as well and umm to some extent that requires the nurse to be quite sometimes even forceful or certainly stand their ground and to take a stand on the pts behalf and I think that that's a brief summary from my perspective I see #00:05:34-5#

- many qualities
- many qualities
- beyond what is obvious
- growing process
- obvious quality
- obvious quality
- obvious quality
- obvious quality
- obvious quality
- affecting others
- outcome of obvious quality
- being knowledgeable
- developing over time
- combining knowledges
- skilled knowing
- developing over time
- obvious quality
- living the skillful knowledge
- skilled knowing
- skilled knowing
- being focussed
- requiring space to nurse this way
- requiring space to nurse this way
- frustrating to not be allowed
- being situationally aware~
- being situationally aware~
- situationally aware - outcome
- being okay with the difficult spaces of critical illness
- being compassionate
- reassuring all through hopeful compassion
- being hopefully compassionate
- being hopefully compassionate - special quality of the best
- understanding focus of being a nurse
- creating a feeling of being safe
- understanding focus of being a nurse
- connecting as foundation for knowing pt
- standing ground
- standing ground

APPENDIX 14: A screenshot of a written naïve sketch coded in ATLAS-ti (interview 3)

PhD_27june2013 - ATLAS.ti

Project Edit Documents Quotations Codes Memos Networks Analysis Tools Views Windows Help

P-Docs P 8: int 3 naive sketch.pdf Quotations Codes {0-0} Memos becoming trusted {0-Co-F} - Super

P 8: int 3 naive sketch.pdf

PSEUDONYM: AM

DATE: 7/3/2013 10am

VENUE: Stellenbosch Botanical Gardens

Picture the person you have just spoken about - describe or draw the top three qualities of that person that you would recognise as making them better and different to their colleagues.

Dejana - passionate - committed, loud, firm
 - same level as dr. friends
 - kissing feet

- meelwend -> feels your emotion connects (head)
 knowing / seeing
 that she sees
 or understands
 what I mean or

top quality-
 creating a trusted space for family~

having a friend-like connection - commitment
 equality in professional relation
 owning the space of nursing
 understanding fit in space

connecting through touch
 showing care~

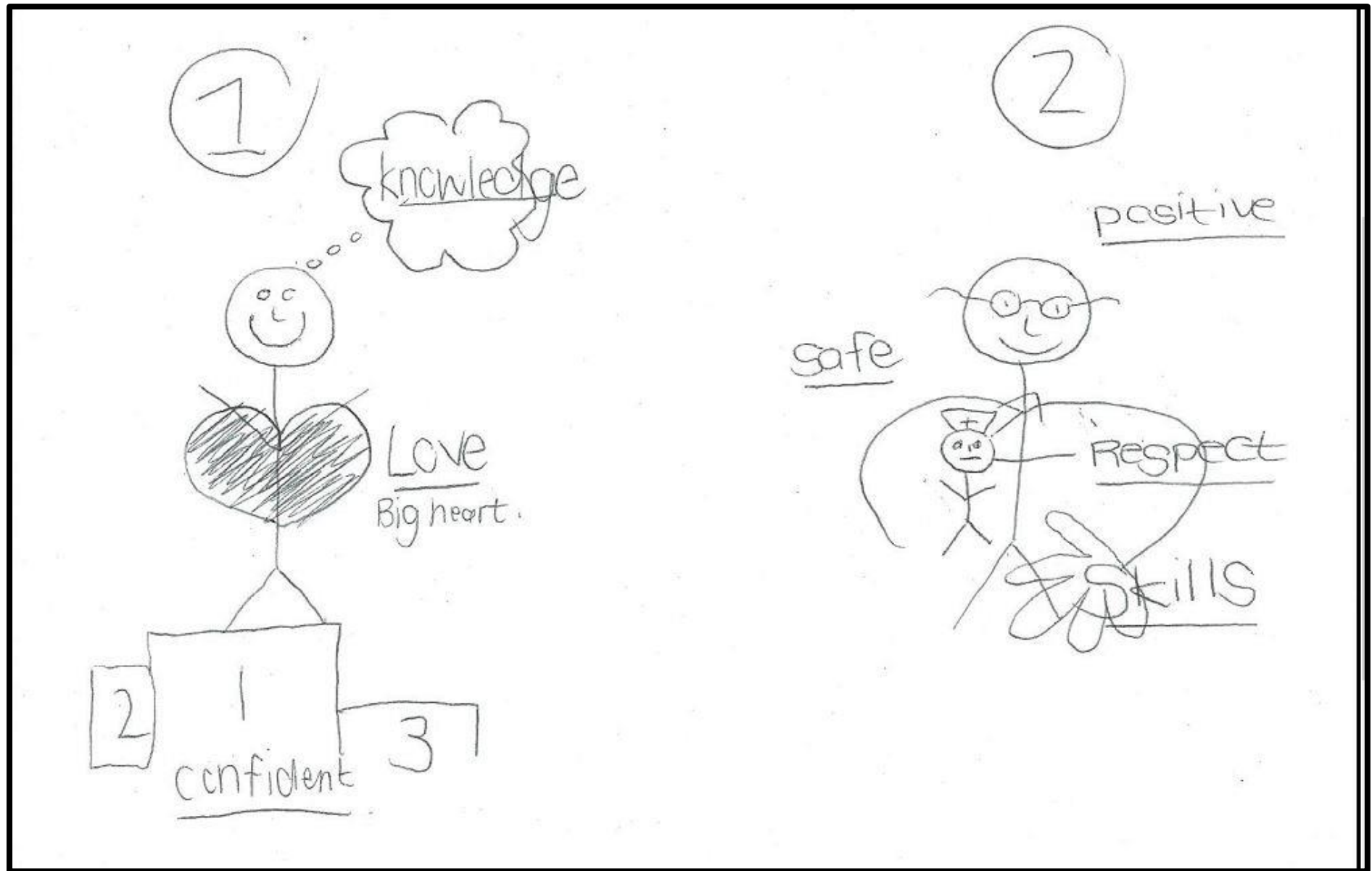
top quality-ur emotion

connected - offering evidence of connection
 connecting into pt/family experiences

P 8: int 3 naive sketch.pdf -> My Library

Page: 1 of 1 Size: 126% PDF Default

APPENDIX 15: An example of a drawn naïve sketch (interview 7)



APPENDIX 16: A screenshot of later focussed coding in ATLAS-ti (interview 10)

P30: int 10 transcription.docx

116 #####00:23:22-2#

117

118 *what do you think that is where do you think it comes from #00:23:21-2#*

119

120 I don't know about the other two if they ever suffered something difficult we didn't have that type of conversation with them but its definitely its for me a type of personality its like a cancer nurse I think you have to have something within you to deal with that type of emotional drainage everyday and I think its the same with the ICU nurse umm I think with my psychology background I think they will be a better ICU nurse if they have experienced something similar because they understand the emotions that you are going through so if they've lost some-one or had some-one very sick close to them I think that would make them a more caring person not that I say people aren't caring but ja but I also think that people that do ICU should be cool headed people you know they must stay calm in a quite a difficult situation umm and have the patience to deal with the patient's family because its part of that patient where in a normal ward I don't think the sisters feel that much its a closer relationship I mean you walk in and you see the faces and you say hi but you don't have a close relationship with those people and they change I mean today there's two faces you know and tomorrow there's no-one you know so it must be people than can have deep relations for a short term #00:25:16-9#

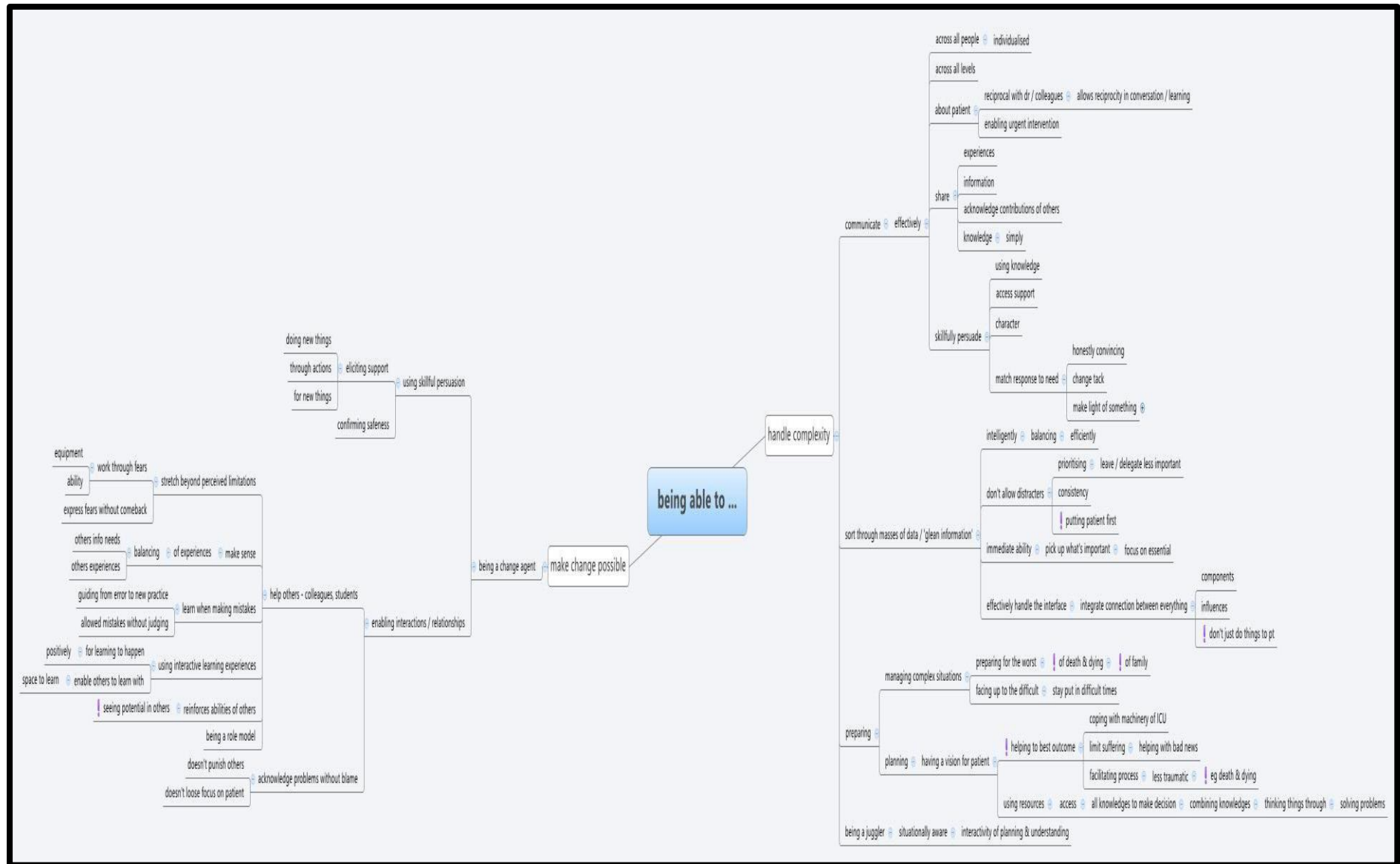
121

122 *okay so able to develop something substantial in the knowledge that it only lasts for the time that the patient is in and the other thing that you're saying is recognising that the family and patient are essentially one unit #00:25:31-6#*

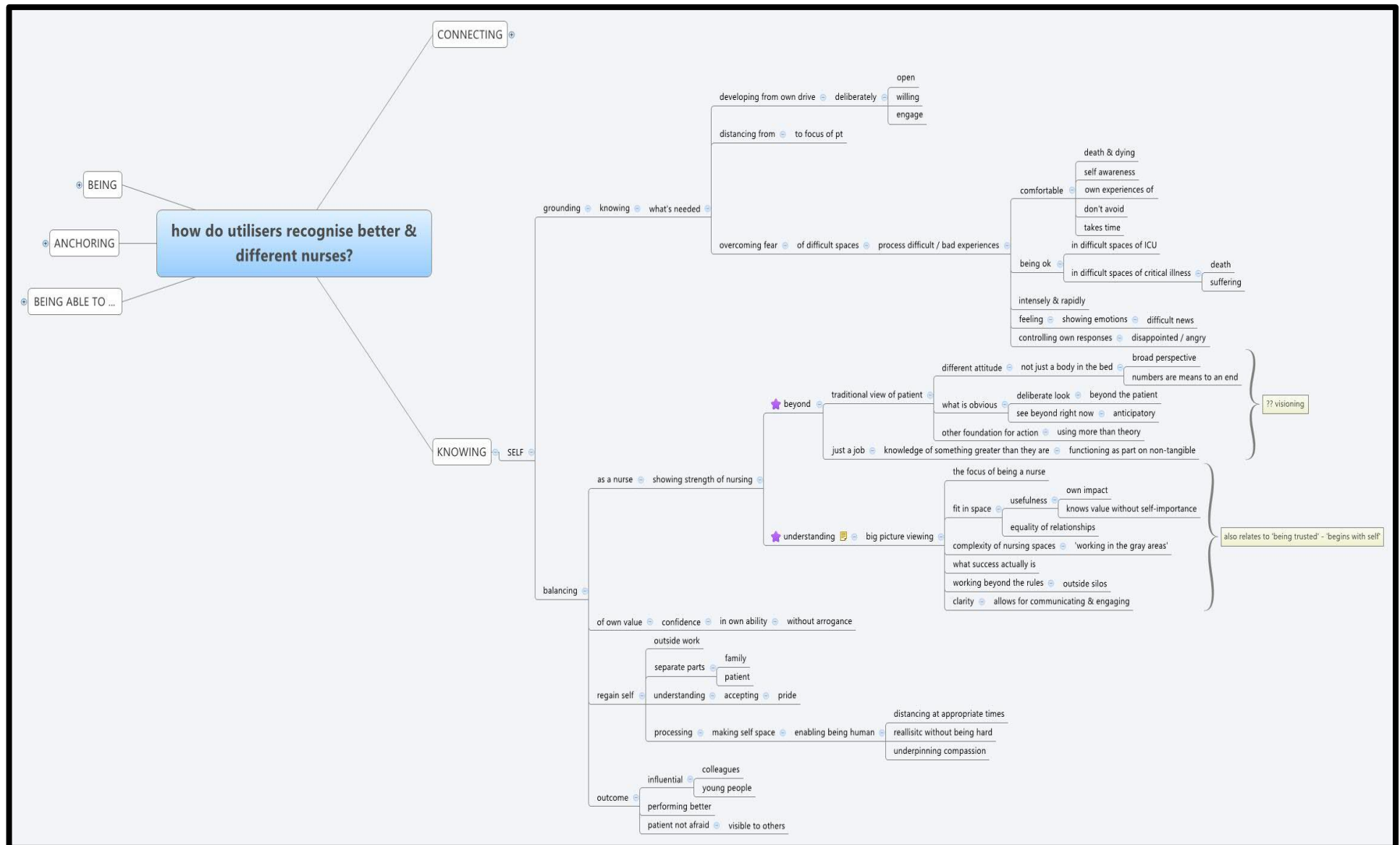
123

- || being - an energy - presence
- || knowing - grounded - wounded healer
- || knowing - balanced - complexity of nursing
- || knowing - balanced - self
- || connecting - engaging - deep and quickly
- || anchoring - being trusted - family - space in care
- || connecting - being highly engaged - spaces of nursing
- || being able to - change - relationship building

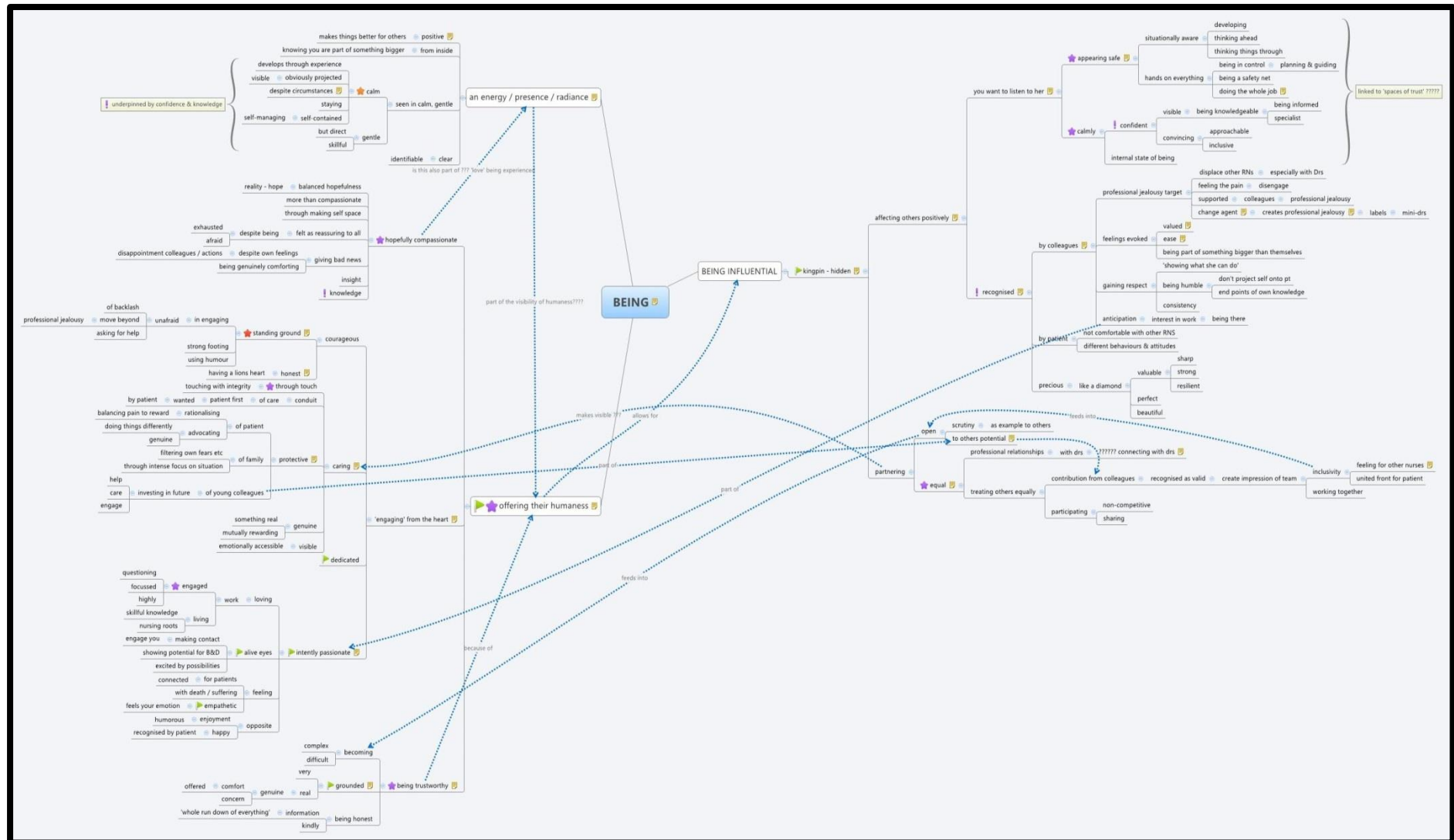
APPENDIX 17: Expanded mind map of 'being able to...'



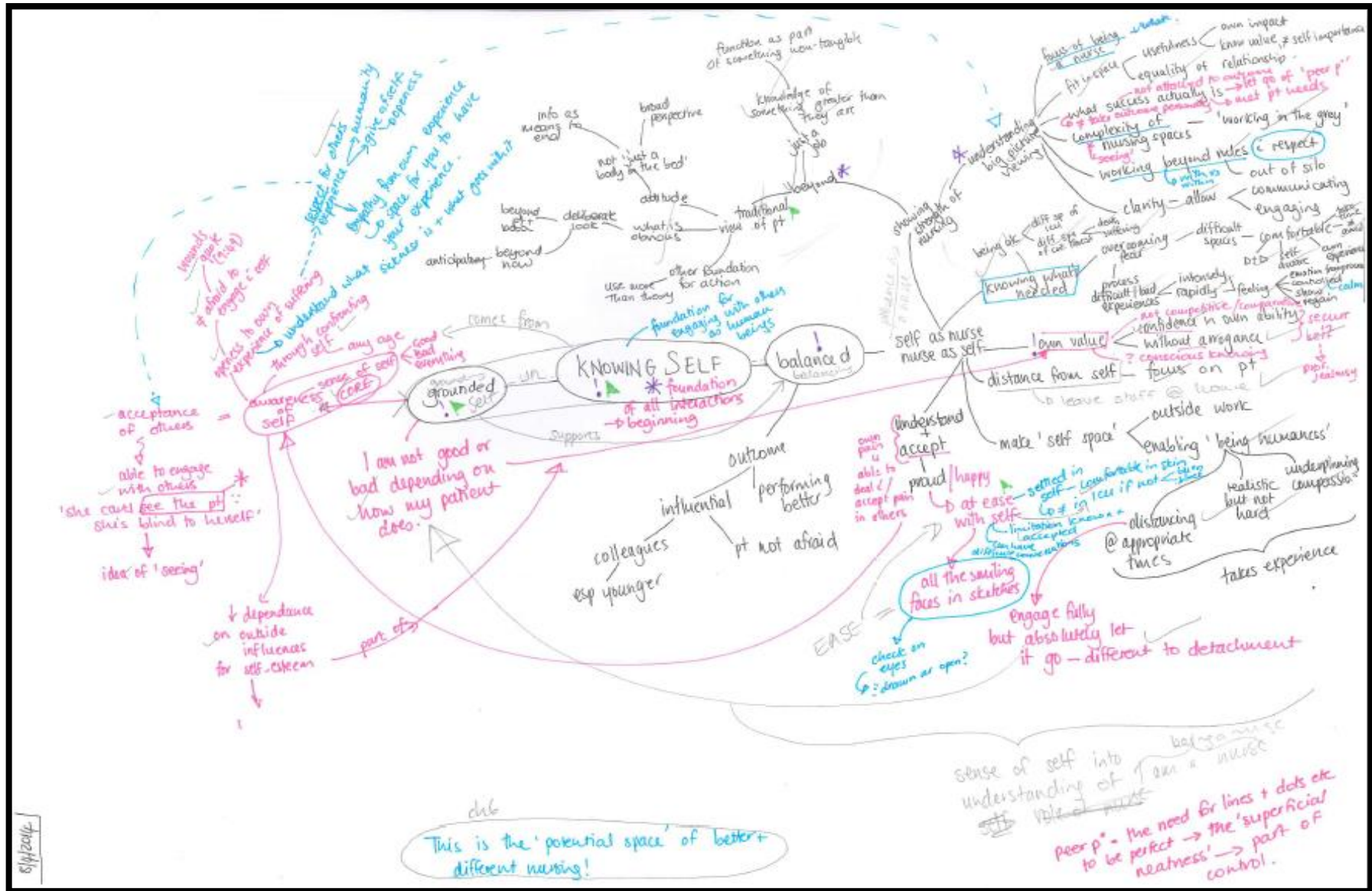
APPENDIX 18: Mind map of early emergent categories linked by the research question with 'knowing' fully expanded



APPENDIX 19: Fully expanded mind map of 'being' showing developing relationships between concepts (blue lines)



APPENDIX 20: Hand drawn mind map of 'knowing self' after 10 interview sessions



APPENDIX 21: Hand drawn mind map of 'anchoring' after 10 interview sessions

