

FROM THE EDITORS - Margaret McMillan and Jane Conway

ADOPTING TRANSFORMATIVE BEHAVIOURS TO IMPROVE PRACTICE

In this *Australian Journal of Advanced Nursing* a number of the articles centre on the concept of transition.

Begley's guest editorial challenges us to engage value transition in a way that achieves transformation. Complex change agenda require that nurses and other health professionals direct their transactional leadership attributes and relationships to transformational outcomes.

It would seem that to be in transition is to be extended beyond one's routine, moving from that to which one has become accustomed to another stage in a process or a situation. Commonly in the nursing literature, transition encompasses situations nurses manage in collaboration with, or on behalf of, clients. For example, transition can be identified in situations that focus on movements within levels and across contexts of care, in the development of changes in protocols of care, in supporting adaptation to ongoing impairment and in responding to situations involving loss and grief. Nurses seem to approach the management of these situations with particular sensitivity, intuitiveness and use schemata that accommodate the unknown and the unexpected.

These situations always involve ideals and expressions of commitment even though the transition timeframe may be limited with respect to the nurse-client contact period.

Successful movement through a transition implies a new set of social conditions and one can expect to see some evidence of transformation. Transformation in nursing practice centres on paradigm shifts that often relate to models of care or education strategies. In order to maintain changed circumstances there needs to be:

- an appreciation of what proposed changes mean in terms of quality care;
- an ongoing sense of purpose backed by values which are congruent with goals for care;
- a reliance on the available human resources to realise potential; and,
- a capacity to rise above daily affairs.

However, accommodation of new ideas has to translate into the pragmatics of everyday situations. This requires negotiation through transactions which in turn require trade-offs and power brokerage. The focus in transactional styles remains on:

- getting the job done;
- preoccupation with power and position, politics and perks;
- being subsumed by daily happenings;
- short term goals and hard data;
- tactical issues; and,
- human relations which oil human interaction.

If we are to extend our vision for making the necessary transitions to transform approaches to care, there needs to be some energy directed towards activities that seek and chart improvements as an outcome of the transactions. Historically nurses have appeared to value transaction above transformation.

Aspects of health service and education that warrant particular consideration and evidence of transformation are highlighted in this edition.

Mooney and Boxer explore the transitions of people who live with chronic heart failure and identify the need for nurses to transform their thinking about what constitutes patients' needs in the community context.

Jackson et al examine the implications of the transition within an ageing process for a workforce that is itself acknowledging the challenges in determining skill mix appropriate for the care of older people.

Peck and Lillibridge discuss the experience of rural fathers undergoing transition as they cope with chronically ill children, while Goh and Watt describe the transition from student to registered nurse.

The paper by Hills and Wilkes focuses on the potential for protocols to enable the change in practice.

The implications of changing health care service delivery such as occurs in day surgery are identified and explored in the paper by Williams et al.

If we are to see profound improvements in our work experiences nurses need to build their capacity for adopting transformative behaviours that create the conditions and opportunities to collaborate on negotiating successful transitions for their clients, themselves as individuals and the profession.

GUEST EDITORIAL - Cecily M. Begley, RGN, RM, RNT, DipNEd, DipStat, FFNRCSI, MSc, PhD, is Director of the School of Nursing and Midwifery Studies, Trinity College, Dublin, Ireland.

COLLABORATIVE CARE - A CHALLENGE FOR US ALL

Collaboration between health professionals is essential for high quality clinical outcomes (Chaboyer and Patterson 2001) and now that boundaries between the roles of different health professionals are becoming less clear, effective collaboration is even more important.

Collaboration implies interdependence and relies on mutual respect and understanding of the unique and complementary contribution each professional makes to achieve the desired care outcomes (Makaram 1995).

Relationships in the health care team are not always ideal, however. In particular, nurse-doctor relationships have a long and fraught history, typified by the 'doctor-nurse' game, described first in the 1970s by Stein (1978), and examined in detail since by others (Porter 1991; Sweet and Norman 1995). It appears to be less common now, but the underlying tension between doctors and nurses still remains, predominantly in non-acute areas. In the health care arena, doctors in particular tend to see themselves as the leaders of any team and may insist on their views having precedence.

This is wrong - not as a knee-jerk reaction by a non-physician - but because the literature shows conclusively that the best care is received by patients/clients when the *appropriate* health professional gives the care. When a number of health professionals need to be involved in order that holistic care is provided, then care given by the appropriate professionals *working together as a team, not as individuals*, will be the best (McPherson et al 2001).

It is this teamwork that sometimes falls down. We see it working to perfection during major operations in well-run theatres, during cardiac arrests in accident and emergency departments with skilled personnel, and at emergency forceps deliveries in midwifery-led units where midwives and obstetricians trust each other to fulfil their roles competently. It is this element of trust, underlying good relations and appreciation of each other's role that makes a good team work well. All the energy that in other units/departments goes into 'protecting our role', 'asserting ourselves' or 'promoting our discipline' can be channelled instead into giving the best possible care.

When professions are static, with little change to challenge the *status quo*, it is relatively easy to move outside one's comfort zone and promote good relationships and collaborative working practices with

other professions. Such endeavours are effortless when one's self-esteem is high and one's role identity is strong. In times of change, however, as the nursing and midwifery professions worldwide are experiencing at present, it is not so easy.

When change, transition or new developments are perceived to lead to added power for other professionals and a lessening of power for them, nurses' working identity is threatened. This brings out defensive behaviours such as withdrawal from non-essential work, putting down other professionals to raise one's own self-esteem and expressing envy and rivalry of co-workers in one's thoughts and actions (Hornby and Atkins 2000).

Collaborative practice cannot thrive in such an atmosphere, so the first step in improving collaboration is to work to develop good team relations. The hallmarks of collaborative practice are based in good communication and include: mutual trust, respect, use of conflict resolution skills, use of humour, and negotiation (Taylor-Seehafer 1998), and a philosophy that values autonomy, freedom and equality (Henneman 1995).

Given the history of nursing and midwifery oppression, and the continuation of such attitudes through our effective socialisation process, it is sometimes difficult to see how to move forwards to attain that autonomy, mutual respect and equality.

Nursing and midwifery's biggest mistake, worldwide, was to wait around expecting someone else to rescue them from domination. Liberation from oppression cannot be conferred by the oppressor but must be brought about by the oppressed (Freire 1971).

Nursing and midwifery need to take their legitimate place in the health care team, in order that true collaborative practice can exist. It is only then, when we become truly independent, that we will be able to become interdependent with others (Covey 1989). It is time now to set aside differences and to work with our colleagues from all disciplines towards the common goal of quality care, which will provide the necessary shared identity. In so doing, we need to look beyond our self-conscious profession-centered view, without abandoning those aspects of our heritage that we value most.

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KEEPING HEART FAILURE PATIENTS AT HOME

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ABSTRACT

This qualitative study focused on the needs of heart failure patients in relation to staying at home and out of hospital. The patient's view was seen as critical as the literature predominantly identifies patients' needs from the health care professional's perspective.

The findings highlight the fact that people with heart failure do not identify they have 'needs' in terms of living, but rather they accomplish tasks in day to day living using the knowledge they have been given.

Recommendations from this research include re-evaluation and further development of current hospital based programs, extension of these programs into the community and greater communication between the heart failure patient and the health care team.

INTRODUCTION

Heart disease is the leading cause of death in New South Wales, Australia, with 13,331 deaths occurring in 1997 (Australian Bureau of Statistics 1999). Heart failure is one outcome of heart disease. A larger number of people in today's society are surviving cardiac events as a result of advanced medical and surgical interventions.

In Australia in 1998-9 there were 50,797 deaths from cardiovascular disease; 5% (2540) of these were from heart failure (Australian Institute of Health and Welfare, AIHW, 2001). The condition results in reduced exercise tolerance, breathlessness and tiredness which in the later stages severely limits a patient's lifestyle. There are often multiple admissions to hospital for symptom management and medication review. In 1998-9 heart failure accounted for 0.7% of all hospitalisations and 10% of those for all cardiovascular conditions (AIHW 2001). The cost to the health care system of these multiple admissions is significant (AUD\$416 million in 1993-4) and will continue to be so with the trend in the ageing of the population (AIHW 2001).

These figures indicate there are more people in today's society who are living longer and requiring a range of health interventions from the nursing and medical professions, hospital and community support programs and groups. Given the substantial increase in individuals surviving cardiac events, attention must now centre on supporting the people in their own homes.

The literature provides evidence that problems do exist for patients who live with a chronic illness in the community (Winters 1997; McWilliam et al 1996), problems that if identified in hospital and addressed appropriately will provide a positive outcome for the patient. Studies have identified problems for heart failure patients that might affect them remaining in their own home (Hoskins et al 1999; Friedman 1997; Jaarsma et al 1997; Cameron 1996; Burke and Dunbar-Jacob 1995;

Fleury 1993). Strategies investigated to address these problems are the development of cardiac rehabilitation programs, heart failure clinics and support systems within community settings (Knox and Mische 1999; Woodend 1999; Imich 1997; Martens and Mellor 1997).

The literature identifies a number of educational needs of patients with heart failure from the perspective of health professionals. However, there is little published literature related to the patient's perceptions of their illness or the conditions that are needed to reduce readmission episodes.

LITERATURE REVIEW

Knowles (1990) identified educational needs of the adult learner and differentiated between the perceived (felt) needs of the learner and needs that others have set for the learner (ascribed needs). Studies to date involving patients' contributions regarding needs on heart failure show that the health care profession does not adequately meet the needs of heart failure sufferers.

Bushnell's (1992) study on the evaluation of the knowledge of older patients with chronic congestive heart failure, concluded that in order to improve their quality of life, patients need to understand their illness and participate in their own health care. Bushnell's (1992) study revealed that only 3% of the participants were able to define congestive heart failure, with 6% able to give a partial definition. Hagenhoff et al (1994) found from their quantitative study that both patients and nurses agreed that medication was the most important aspect of education. However, the results showed nurses' perceptions on what education material was more important and realistic to learn about whilst in hospital differed to that of heart failure patients. The nurses rated risk factors, medications and diet as the most important but realistic learning foci. However, patients rated medication information, anatomy/physiology and risk factors as the most important and realistic to learn about. Interestingly, nurses rated psychological factors as least important and realistic learning foci. Patients rated activity information as the least important to learn about, with psychological factors as least realistic to learn about whilst hospitalised.

Two recent studies (Wehby and Brenner 1999; Hagenhoff et al 1994) identified the perceived learning needs of patients with heart failure. These studies found an imbalance between the perceived learning needs of those with heart failure and registered nurses' perceptions of their importance and patient's ability to learn about these needs during hospital stay. Furthermore, the studies supported the idea that there needed to be a comprehensive educational plan for patients with heart failure that was initiated in the hospital setting and extended into the community setting on discharge from hospital.

The literature serves to highlight a definite need exists for developing and implementing an educational package

which will respond to the needs of heart failure sufferers and their changing condition. This is not an easy task given the variations in presentation of heart failure. The Agency for Health Care Policy and Research (AHCPR 1994) recommended eight areas for patient and family education and counselling. These are (1) general information; (2) prognosis; (3) activity recommendations; (4) dietary recommendations; (5) medications; (6) risk factors; (7) symptoms; and, (8) psychological factors. Prior to this, most studies had focused on the learning needs of medical patients with some form of cardiac disease. These studies revealed there was a difference of opinion between nurses and patients on what aspects were more important to learn first (Chan 1990; Karlik et al 1990; Grady et al 1988).

Luniewski, Reigle and White (1999) support the idea that adequate education in hospital can lay the foundations for improved self management of the heart failure patient at home. This conclusion was the result of the use of a card sort assessment tool they designed which measured the educational needs of heart failure patients.

Variation in educational needs occurred between the patients depending on the duration of time they had lived with the illness. The researchers argue that involving the patient in a card sort assessment process would lead to meeting their individual needs. These concepts are supported by McWilliam et al (1996) in their phenomenological study which explored the meanings, motives, intentions, emotions and feelings that were identified as part of their health and health promotion by individuals with chronic illness.

McWilliam et al (1996, p.4) defined chronic illness as any illness of three or more months duration and concluded that the focus could be shifted towards a patient's individual life and health, where the chronic illness was only one component. They stated that further research needed to be conducted in order to obtain more knowledge about health promotion strategies pertinent to specific chronic illnesses.

These studies address the needs of patients in hospital, but until a study conducted by Rogers et al (2000), there was little research aimed at the needs of heart failure patients in the home setting.

Stull et al (1999) studied the transition of becoming a patient with heart failure. In their qualitative study, they found five distinct phases emerged from the data in relation to acquiring a new identity from the diagnosis of heart failure. These phases were: (1) a crisis event; (2) the diagnosis; (3) the patients' and family's response to the diagnosis; (4) their acceptance and adjustment to life with this condition; and, (5) making the decision to get on with life. The key implications from their findings were that patients and their families needed information about heart failure and the normality of emotions, behaviours and changes in family life. This information can come from a variety of sources such as previous experience with heart problems, clinicians, friends or other family members.

Rogers et al (2000) explored the patients' understanding of chronic heart failure, investigating their needs related to information and issues concerning communication. Their in-depth interviews produced the results depicted in Table 1.

Table 1: Results of Rogers et al (2000) study

- Patients tend to attribute symptoms of heart failure to advancing age and believe nothing can be done about their symptoms.
- Patients have questions about their illness they feel unable to ask their doctors.
- Patients believe that doctors are reluctant to talk about death or dying.
- Some patients would welcome timely and frank discussion about prognosis.

Rogers et al (2000) believe there is little public understanding of chronic heart failure and of patients' needs. Both of these areas require more research.

The emphasis, from the small amount of research conducted to investigate the perspective of people living with heart failure, supports the involvement of the patient in the discussion and management of their condition in order to achieve the best outcome for everyone (Rogers et al 2000; Luniewski et al 1999; Wehby and Brenner 1999). This involvement includes discussion and information about the illness, medications, lifestyle changes, risk factors, availability of support if required, prognosis and death and dying issues (Davies and Curtis 2000).

Strategies aimed at decreasing the readmission rate for heart failure patients include the work of Hoskins et al 1999 and Martens and Mellor 1997. Other studies by Riegel et al 2000; McCormick 1999; Naylor and McAuley 1999; Knox and Mische 1999; Imich 1997; Jaarsma et al 1998; Jaarsma et al 1997 and Paul 1997 support the importance of keeping patients at home. These studies show that if programs are properly implemented, the patient is included in the management plan and the programs supported by all members of the multidisciplinary team, then the patient will benefit from remaining in their own home and maintaining their quality of life.

In order to best utilise the knowledge health professionals hold in regard to heart failure, we must learn from the people who live with the condition and then appropriately implement changes in conjunction with them to improve their lifestyle and quality of living.

Evidence from the literature supports the importance of involving the person in the management of their illness, allowing them to feel in control and empowering them to choose how they live their life rather than being instructed by medical and other allied health professionals (Winters 1997).

METHOD

This qualitative descriptive study sought to discover ways of meeting the needs of heart failure patients that would facilitate them staying at home. The participants were all patients affiliated with a large public teaching hospital located in the Sydney, Australia, metropolitan area. They were recruited either from the Cardiology Step-Down Ward or the Heart Failure Clinic attached to the hospital.

Participants were selected by using a purposive sampling technique, which facilitated exploration of the views of a particular group of people (Grbich 1999) - those diagnosed with heart failure and living at home. The inclusion criteria for selecting the participants were:

- 20-90 years of age.
- Male or female.
- Diagnosed with heart failure.
- Aware of diagnosis.
- Patient in Cardiology Step-Down Ward. or attending the Heart Failure Clinic.
- Able to understand and speak English.

The participants ranged in age from 62-89 years. Eight lived with another person (spouse, relative or friend) and four lived alone. All participants had a support network (family, friends, community groups, government groups) on which they could rely if they required help. Time spent living with heart failure since diagnosis ranged from a few months to 20 years. All participants were classified under one of the four New York Heart Association Classification groups. Three were Graded I, four Graded II, two Graded IV and two Graded II-III or III-IV.

Semi-structured interviews were conducted to collect data because this approach allowed the interviewer to gain insight into the participant's perspective, but still maintain some control over the interview, so the purpose of the study could be achieved and the research topic fully explored (Clarke 1999; Holloway and Wheeler 1996). The interviews were audio taped, preserving the words of the participants as accurately and completely as possible (Holloway and Wheeler 1996). In conjunction, field notes were made by the interviewer at the completion of the interview to add clarity and depth to interview data. Interviews were transcribed and analysed by theme extraction. Ethical clearance was obtained from participating institutions and consent sought from participants prior to commencement of data collection.

RESULTS

The major and minor themes emerging from the data are depicted in Table 2.

Table 2: Major and minor themes identified

Major theme	Minor theme
Trying to make sense of their illness	<ul style="list-style-type: none"> - Taking a philosophical approach to the illness - Frustration with their illness - The impact of other conditions on living with heart failure
Measures of wellness	<ul style="list-style-type: none"> - Activities of living/exercise - Social functions/interactions/commitments - Shortness of breath and tiredness
Maintaining independence and control over illness	<ul style="list-style-type: none"> - Recognition of one's own limitations and working around them - Support systems - Information
The finality of death	<ul style="list-style-type: none"> - Reference to death - Near death experiences - Preparing/organising to die
Doctor/patient relationship	<ul style="list-style-type: none"> - Patient expectations/listening to the patient - Gratitude/respect/trust - Conflicting advice/polypharmacy

When 'Trying to make sense of their illness', the participants explored the effect their illness had on their activities of living and social functions. The minor themes identified the philosophical approaches that the participants used in dealing with and understanding their illness, the frustration they experienced from the heart failure and the way in which other conditions impacted on living with heart failure.

'Measures of wellness' was a representation of what each participant was physically able to achieve depending on how well or sick they felt. This was demonstrated by their ability to perform activities of living or exercise independently, the social functions they could attend, interactions with other people and being in a position to keep commitments made to other people (ie family, friends, doctors' appointments). The influence of shortness of breath and tiredness on their activities was a measure of whether to seek readmission to hospital or medical treatment.

'Maintaining independence and control over their illness' represented dignity, self-esteem and respect for themselves. Through knowing one's own limitations and working around them, having support systems in place and having the information concerning and relating to heart failure helped this group of participants achieve independence and control over their illness.

The recognition of 'the finality of death' emerged from the data because each participant knew that it would eventually happen to them and they had to accept this reality. Each participant approached this in a different way, some philosophically, others by organising their affairs and achieving goals before their death.

The 'doctor/patient relationship' was seen as an important aspect of participants' management of their illness. Participants were concerned their doctor was treating them correctly, according to the patient's

expectations and expected appropriate communication between themselves and the doctor. However, although there were feelings of gratitude, respect and trust between the doctor and the participants, confusion remained as a result of conflicting advice to the patient from doctors relating to polypharmacy.

The findings from the data indicated that a number of factors had influenced the person living with heart failure in their own home. These factors related to the participant's acceptance of the illness, how they were feeling on a daily basis, whether they were experiencing symptoms of shortness of breath or tiredness, and the expectations they placed on themselves. Other factors related to the family, health care team and community support the participant received, plus the perceptions of the community at large toward people with heart failure and their lack of understanding about this illness. Helping identify these factors allows the health care professional to act accordingly to increase patient's knowledge, understanding and acceptance of their illness, and to increase the awareness, understanding and implications of heart failure in the larger community.

CONCLUSION

Prior to the study, the researcher had believed the participants would know what they needed in order to make living with heart failure at home easier. The findings show participants generally did not think about 'needs' in relation to living, but rather accomplished tasks, and managed on a day-to-day basis using information they already had or what they felt was the best way to deal with life for them personally. This was achieved by working out their limitations through a process of trial and error.

When looking closely at the findings, areas of need could be identified by comments the participants made.

Those identified by the researcher were generally supported in the literature, mainly from the health care team's perspective, and included: educational needs, information on lifestyle changes, consultation by the health care team with the participant about how they are treated (Donovan 1995; Donovan and Blake 1992) and lastly an area which has not received much recognition in the literature, that of death and dying.

This was an unexpected finding and one not identified in the literature. The interviews did reveal there was little discussion, if any, occurring between the patient and the doctor or other members of the health care team concerning death and dying. It was an area that caused concern and anxiety and something that was perceived as inevitable which had to be dealt with and accepted in some way. Further communication between patients and members of the health care team in relation to death and dying may assist the patients to develop a more positive outlook on life and toward their illness. If the patient developed a more positive attitude to their illness, then this may have positive repercussions on their lifestyle management and compliance to treatment.

Death and dying is a psychological issue which warrants further research to discover whether addressing patient needs for psychological care would benefit the patient in the long term and whether that would influence their coping mechanisms with the disease process. Through addressing psychological needs, the patient may feel a sense of hope, develop the confidence to manage their condition, not become too frustrated with their limitations and maintain their quality of life. If patients have hope, they may manage heart failure more effectively at home even though they know there is no current cure.

No studies have been conducted involving patients with heart failure in terms of hope, but parallels could be drawn with other chronic illnesses (Foote et al 1990; Miller 1989; Greene, O'Mahony and Rungasamy 1982). Gibson (1999) conducted a study determining the level and predictors of hope involving people diagnosed with a condition of uncertain cause and prognosis and for which little treatment was currently available. This study highlighted that the contributions of perceived social support, medical intervention, fatigue associated with the illness, personal growth since diagnosis of the illness, and the person's age were significant in fostering hope. Such studies for patients with heart failure may reveal similar findings.

There have not been many studies on the patient's perspective of living with heart failure (Rogers et al 2000; Luniewski et al 1999; Stull et al 1999). This research study moves one step closer to discovering, from the perspective of the heart failure patient, what they perceive they need in order to stay at home and out of hospital. There are still areas of need to be addressed for this patient population: greater communication between the

patient and health care team; discussion on death and dying; and, providing details of programs that exist for heart failure patients.

Recommendations include the need to evaluate the current cardiac rehabilitation programs for capacity to meet the needs of heart failure patients. Utilising what is already in place and building on this may assist the heart failure patient to maintain independence and control over their lives. Programs commenced in hospital should continue in the community to provide ongoing support. In a controlled environment within the hospital, help is always available, but at home that security does not exist. This is when the patient with heart failure becomes most vulnerable. If the support continues in the community, then the transition from hospital life to home life could become smoother.

Part of the problem for some of the participants in this study was the communication of treatment and management options between various doctors and the patient, which lead to confusion. Inclusion of the patient in discussion about treatment and greater communication between health care workers, especially doctors, may lead to less confusion for the patient. Improving the communication between the patient and the health care team regarding diagnosis, medications and death and dying would help the patient's transition from hospital to home. Effective communication with the health care team may also reduce the number of readmissions to hospital.

Given the nature of this qualitative research study, the findings may not be generalised to the wider population. The limitations of this study were that it did not include the needs of family members and/or their support people and it was limited to English speaking participants.

Recommendations for future research would be to conduct a study aimed at identifying the needs of heart failure patients from non-English speaking backgrounds as their needs may be confounded by language and cultural issues.

Further study is needed to determine what it is like for family members or support people, what their needs entail and whether this is beneficial in helping the person live with heart failure.

Another issue requiring attention is increasing public knowledge about heart failure and what it represents, as supported by the Rogers et al (2000) study. Greater community awareness may generate more positive and accepting opinion of heart failure and allow people diagnosed with this condition to feel all is not lost and there is treatment available.

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FROM 'DEPENDENT ON' TO 'DEPENDED ON': THE EXPERIENCE OF TRANSITION FROM STUDENT TO REGISTERED NURSE IN A PRIVATE HOSPITAL GRADUATE PROGRAM

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ABSTRACT

There has been increasing interest in the issues around the transition from university student to registered nurse (RN). This transition period is acknowledged as a time of significant stress as graduates endeavour to consolidate their nursing knowledge and gain mastery of clinical skills in a working environment. They require support and guidance to effect a successful transition. There has been little published research on the transitional experience of graduates in Australian hospitals.

This study explored the transitional experiences of nurses who had completed their first year of clinical practice after graduation in a Victorian private hospital graduate nurse program. A qualitative approach using techniques of the Grounded Theory method was utilised. Five volunteer graduates were interviewed using a semi-structured format. Interviews were transcribed and analysed to identify emergent themes and categories.

Three major themes were identified that described the transition experience for the participants. These were: 'developmental first steps' which described the unexpected shock and feelings of being unprepared on entry to the work setting along with the reality of the unrealistic expectations of colleagues; 'developmental stumbling blocks' which described the multiple role and personal stressors that challenged the participants; and 'striding ahead' which described the factors that facilitated the participants adaptation to the RN role.

INTRODUCTION

Since the transfer in Australia of nurse education from hospital based schools of nursing to universities, there has been an increasing focus on the issues around the transition from university student to RN. This is a time of adjustment to a new work environment, shift work and working as part of a team, as well as acquiring new skills, knowledge and accepting increased responsibilities (Nurses' Registration Board of New South Wales, NRBSW 1997).

While there is little uniformity of approach across Australia to graduate nurse transition, there is general agreement that new graduates need supportive entry to the clinical setting of some kind (Commonwealth Department of Education, Science and Training, DES&T, 2001; Winter-Collins and McDaniel 2000; Victorian Department Human Services, DHS, 1997).

The discussion in nursing literature about the experience of graduate transition mostly originates from overseas. Little published research focuses on the experiences of Australian graduates in structured graduate nurse programs (GNPs) and even less focuses on those who experience transition in a private hospital. This study provides a beginning exploration of the transitional experiences of a group of Australian graduates who participated in a structured private hospital GNP.

LITERATURE REVIEW

The period of graduate nurse transition is characterised by rapid self-development, high anxiety and reality shock (Greenwood 2000; Godinez et al 1999; Cobal 1998; Buckenham 1994). This is due in part to the educational values conflicting with those in the workplace (Winter-Collins and McDaniel 2000; Tradewell 1996; Buckenham 1994). There is general agreement in the literature that if graduates do not receive adequate support they experience

reduced job satisfaction which has significant influence on professional commitment, staff retention, turn-over rates and ultimately the cost of quality patient care (DES&T 2001; Greenwood 2000; Duncan 1997; DHS 1997).

The first year after graduation has been examined from a number of perspectives including: reality shock (Phyland 1994; Moorhouse 1992); the implications for staff turn over (Munro 1983); socialisation of the beginning professional nurse (Buckenham 1994); the perceived stressors experienced by graduates (Schultz 1994; Phyland 1994; Buckenham 1994); expectations of beginning RNs in the workforce (NRBNSW 1997); the effectiveness of preceptored GNPs (Oermann and Moffitt-Wolf 1997; Smith 1997); student pre-entry and first year of employment and graduate satisfaction (Winter-Collins and McDaniel 2000; Franklin 1997); the nurse's experiences of a graduate year (Cobal 1998; Buckenham 1994; Phyland 1994); role transition (Godinez et al 1999); and, a critique of the graduate nurse from an international perspective (Greenwood 2000).

A theme in much of the literature is that graduates expect support from experienced nurses but many did not receive it. Indeed, many graduates actually perceived they were badly treated by their nursing colleagues and that the transition was significantly stressful, or a negative experience (DES&T 2001; Cobal 1998; NRBNSW 1997; Buckenham 1994; Phyland 1994). The importance of a positive graduate transition experience was noted in the current *National Review of Nursing Education Discussion Paper* (DES&T 2001).

Various views of transition from student to RN are offered in the nursing literature, some of which are conflicting. However, a supportive environment, the ability to fit in and positive constructive feedback appear to be significant factors that influence the graduates' experience. It is therefore necessary to seek ways to improve their experiences and help the profession encourage and retain nurses to provide future health care.

METHOD

A qualitative method informed by the work of Glaser and Strauss (1967) was utilised in this study. The aim was to present some initial categories and codes that described how the graduates who were interviewed perceived the transition experience and to identify some directions for future research on the subject.

Method

The mode of data collection was that of semi-structured interview. Areas that were explored during the interviews included the participant's expectations of the graduate program, the transition experience, and their perceptions of the support they received. One person conducted all the interviews. This person had been in

contact with the participants in their graduate year in a support role and as program coordinator. The interviews lasted approximately one hour and were audio-taped with the permission of the participant.

Data analysis started within the transcription of the first two interviews. Transcripts were examined for emerging themes and coded to assist in the analytic process. Comparison of the early data yielded some initial codes that gave further direction to the subsequent interviews (Strauss and Corbin 1998). As the interviews progressed and analysis continued, similar codes became beginning categories which were then grouped together under three themes. The interviews were completed within three months.

Ethical issues

Ethics approval was obtained from La Trobe University. Institutional approval was also obtained from the hospital at which the research was conducted. Each participant was fully informed verbally, and through use of a consent form. Confidentiality for the group of participants was maintained by conducting interviews away from the ward location in a private office and no discussion was entered into regarding the participant's participation.

The participants

The participants were drawn purposefully from a group of RNs who had recently completed their GNP. The study site was a large Melbourne metropolitan private hospital that had conducted GNPs for a small cohort of nurses for 10 years. Meetings were organised to inform the nurses about the study and the potential nature of their involvement in project.

Four female nurses and one male nurse volunteered to participate in the study. Their ages ranged from 22-28 years. Three had previous work experience as casual nurse assistants in nursing homes during undergraduate studies, one had retail experience and one had worked in the hospitality industry. One participant had completed an undergraduate clinical placement at the research venue. The participants gained their nursing qualifications from two Victorian universities.

Participants completed a 44-week full time graduate program (in a group of 10). Preceptors were available on every shift in all four rotations offered. Two weeks of the initial rotation consisted of orientation and supernumerary clinical practice followed by a gradual increase in nursing workload to full case load by the end of the first month. Six paid study days were spread throughout the program.

FINDINGS AND DISCUSSION

Participants commented on the stresses involved in the lead up to finishing their nursing degree, including decisions about the venue for their graduate year. There

was a perception that this decision would affect the rest of their careers, as a supportive transition via a graduate program was considered necessary to facilitate future progress in the workplace. This belief was also noted by other authors (Glover et al 1998; Reid 1994).

Participants carried out extensive investigation into the various GNPs through advice from colleagues who had completed programs, tours and open days at the prospective facilities, printed matter and attendance at a Royal College of Nursing, Australia 'Nursing Expo'. The most significant factor in the decision making process for this group of nurses, however, was based on prior positive or negative undergraduate clinical experience in the workplace. Positive private hospital experiences compared favourably with negative undergraduate clinical experiences in public hospitals. Another significant factor was the opportunity for several rotations to different ward and specialty areas. They all believed the variety of experience increased their awareness of potential career prospects. This concurs with studies by the NRBNSW (1997) and Duncan (1997) who found the opportunity for graduates to choose specialty placements achieved the highest rating on a job satisfaction rating scale in the first year of employment.

Most of the participants wanted a program that treated them as individuals. To this end, they actively sought programs in smaller sized hospitals with smaller graduate intakes. A supportive environment primarily through the contribution of preceptors was a factor highly valued by the participants when making program choices. Additionally the support of clinical educators, in-service education opportunities, peers and supportive general staff willing to teach were viewed favourably and expected, a finding also noted by Heslop et al (2001). The participants all felt they began their graduate year with high expectations of their ability to competently perform the role of a beginning RN.

Themes

Three major themes that describe the experience of transition from student to RN were identified: developmental first steps; developmental stumbling blocks; and, striding ahead.

Developmental first steps

This theme describes the feelings of surprise or in some cases shock the participants experienced as they tentatively, but nevertheless confidently, entered the work setting for the first time. Three categories in this theme were identified:

- a) 'Feelings of being unprepared' - the realities of the work as a graduate.
- b) 'Unrealistic expectations' - the participant's perceptions of the expectations that some hospital staff had of them and the expectations the participants held of themselves which initially impacted negatively on their personal and professional development.

c) 'No time to care' - the frustration and disillusionment experienced when the participants were confronted with a system of work values incongruent with those learned and internalised at university.

a) Feelings of being unprepared: Of major concern for the participants on entering the work setting was overwhelming workload. Despite the fact they were initially optimistic about their ability to undertake the RN role, after commencing their graduate position, they felt inadequate and ill-prepared for the realities of the nursing role. One participant stated: *'It hits you like a ton of bricks'*.

Several of the participants felt their clinical experience as a student had not aided them in the transition and reality of working as an RN. Others felt they had contributed to their own feelings of inadequacy. As one participant stated: *'Gee I wish I had listened more in that lecture or... more in that class'*. It would, however, be unrealistic to expect new graduates not to feel anxiety some of the time as they settle into a new environment (Gerrish 2000). A point highlighted by one participant: *'I think I was anxious, the whole thing in general just starting a new job'*.

b) Unrealistic expectations: A number of participants reported feeling stress generated by the expectations of more experienced nurses, a topic extensively discussed in the literature (DES&T 2001; Cobal 1998; Brown and Olshansky 1997; Tradewell 1996; Buckenham 1994). There was a perception that experienced nurses expected them to 'hit the ground running' and be a fully functional and competent RN very quickly after entry to the workplace. As one participant commented: *'As a student you are there to learn something, but when you start as an RN they expect you to work as well. To put that all into practice in the real situation is a bit of a challenge because the expectations are high'*.

Brown and Olshansky (1997) make the point that industry expects new graduates to move directly from student to the RN role. This expectation increased the participants' feelings of inadequacy and guilt that they were not up to expectations. Feelings about the adequacy of support by experienced staff were, not surprisingly, dependent on the particular ward allocation and their supernumerary status in the first month. The allocation of a 'realistic' workload by senior colleagues gave them a feeling of confidence and acceptance that their needs were being taken into account. A study by Gerrish (2000) also found a gradual increase in workload over four weeks was beneficial by increasing graduate confidence and facilitating independence.

c) No time to care: All participants commented on the stress created by dealing with competing work demands. This aspect of their work was variously described as: *'very difficult'*, *'stressful'*, *'too busy'*, *'challenging'*, and *'frustrating'*. As one participant commented: *'You start your graduate year and you'll have five or six patients in the morning and say three of them may be full feed and all require assistance in the shower; they might be*

incontinent, they may require regular toileting, you name it, as well as three pages of medications and stuff like that, and at the end of the day you have done all of that basic care for them. I just found that, I didn't feel that I was meeting their needs and providing adequate care'.

This excerpt described a typical participant experience. Williams (1998) describes quality care as providing physical, psychosocial and 'extra' care needs. Basic nursing care on the other hand is defined as the provision of physical care needs only. In the current work context these beginning nurses struggled to achieve their goal of providing quality nursing care, feeling they were only able to provide very basic care. The inability to provide quality care presented the participants with a value system incongruent with that learned in university (Winter-Collins and McDaniel 2000). While very stressful, the participants appeared to accept the situation as normal, potentially leading to dissatisfaction and guilt. This is in keeping with the findings of Cobal (1998) that the socialisation process leads novice nurses to believe everyone else does it - so must they. The participants felt they were not in a position to make any changes.

The first three months of the first year have been identified as particularly stressful for new graduates (DES&T 2001). In the current health care context increased nursing efficiencies are expected to help offset burgeoning health service costs related to increasingly expensive medical technology, increased patient throughput, and increasing patient acuity. Thus, there is growing pressure on graduates to be fully functional as soon as possible. However, the health industry needs to understand role transition requires guidance, practice and most importantly, time to care, so that new graduates can gain confidence, leading to professional development and job satisfaction (Gerrish 2000). Nurses may perceive they do not have a lot of control over their work environment. However, all RNs have the ability to provide adequate and unconditional support to the new graduate during this important transition period.

Developmental stumbling blocks

This theme describes the challenging experiences after entry to the work environment. The three major 'stumbling blocks' identified are the stressors the participants believed effected their development:

- a) 'Assimilation anxiety' - the need to 'fit in' as part of a team, the need to 'prove' to themselves and their colleagues that they are worthy of the being called a 'good nurse', and the need to conform.
- b) 'Role stress' - management of time and fear of personal accountability.
- c) 'Personal stress' - the fear of making mistakes and asking questions, power relationships, and negativity of colleagues.

a) Assimilation anxiety: Fitting into the ward team was identified by most of the participants as an overwhelming need: *'you just want to fit in comfortably'*, and: *'I need to be part of the team'*. Indeed, one participant perceived it was: *'the key [to successful transition] for me'*.

Becoming part of a ward culture and fitting into the team was contingent on adopting 'socially acceptable' behaviour. This required time in order to learn ward routines and build professional working relationships. Rotating to new departments interrupted this process creating concern for some participants, a finding also identified by Cobal (1998). As one participant said: *'I loved my first rotation, I loved it, and you feel at the end of it, you feel confident then you move. That's the bad thing about rotations; you have to move'*.

Another felt: *'I'd just be feeling comfortable and just coming to work and not worrying and then I would be moved to another ward and starting all over again'*.

The relationships that helped to build confidence were suddenly terminated on rotation, leaving participants yet again feeling alone and isolated (Moorhouse 1992). This finding is interesting in light of the high value the participants placed on a graduate program that offered several rotations when choosing a program. While the rotations were perceived as long enough to feel comfortable and confident by some participants, one felt that: *'...you need longer [than three months] to be able to prove what your capabilities are and what your strengths are to the team'*. Adopting socially acceptable behaviour was contingent on proving themselves as 'good nurses' and conforming or *'not rocking the boat'*.

The pervasive feeling of needing to prove they were good nurses to themselves and their colleagues to gain professional acceptance created stressful situations. This was compounded by the belief that future employment opportunities depended on professional acceptance. The following excerpt illustrates the constant threat to self these new graduates experienced: *'... that sick feeling I had every morning I went to work, not sick [literally] but the worry I experienced every day about what type of patient I would be looking after and whether I'd be able to prove myself. I felt like I had to prove myself all the time'*.

In fact in an attempt to impress ward staff, when asked if they needed help participants would frequently say *'... oh no I'll do this, I'll do that, and so you take everything on'*. It is not surprising the perception of constantly needing to 'do everything' at a high level of competence was damaging to the graduates' professional development leaving them emotionally and physically drained: *'... you need to prove yourself and that's one thing that got me down'*.

The concept of a 'good nurse' or the 'idealised nurse' is, according to Moorhouse (1992), a composite image of many nurses that the novice regards as worthy of emulation and is internalised during the student nurse

role. Images of how others regard their performance makes up a major part of their professional self-perception. The participants were well aware that those who somehow did not fit the image expected of them by others in the group risked being labelled as 'bad nurses' or worse 'troublemakers'. These new graduates spent considerable time and energy trying to prove they were 'good nurses' in order to gain acceptance within the social milieu of the ward (NRBNSW 1997; Buckenham 1994).

One way in which the participants found they could 'fit in' to the ward environment, was to conform and '*not rock the boat*'. Performing procedures their preferred way, as opposed to the ward way of doing things was not always viewed favourably. '*Staff put down my ability in front of other staff... I knew how it was done, I'd done it safely but I hadn't done it the way they do it*'. Rather than risk being labelled a 'bad nurse' or a 'troublemaker', the participants conformed to the wishes of the department staff. The NRBNSW (1997) report also found new graduates tend to perform procedures the way the ward does rather than the graduates' preferred way in an effort to fit in.

Graduates have few alternatives with regard to socialisation. They either fit in and assume the beliefs and behaviours of the organisation, or they can leave or tolerate rejection (Godinez et al 1999). Despite this pressure, Buckenham (1994) found graduates did not forfeit their professional values in the work environment, but that this is a major issue in the transition period causing high anxiety and emotion, often damaging the graduate's personal and professional self-concept. This potentially results in a reduction in satisfaction and professional commitment that has implications for new graduates' careers and of the nursing profession in general.

b) Role stress: There were two major sources of role stress identified: time management and fear of personal accountability.

Time management is discussed at length in the nursing literature (DES&T 2001; Gerrish 2000; Godinez et al 1999; NRBNSW 1997). Despite recognising their lack of experience in time management, participants constantly compared themselves with experienced nurses. This magnified feelings of inadequacy, reducing their self-esteem and confidence. Time management was often perceived as overwhelming: '*there were times when I first started I thought, "I don't know how I will get through this shift"*'. All felt pressurised to complete routine ward tasks constantly racing against the clock to finish before the next shift, '*I had to push myself beyond, making sure that absolutely everything was done before 3pm*'. They were reluctant to hand over tasks to the next shift for fear of being labelled incompetent.

The second major role challenge for the participants was adjusting to being legally and ethically responsible for someone else's life. This was identified as an '*extremely scary*' and overwhelming experience. In particular, these participants were afraid the condition of the patients under their care would deteriorate and they would '*overlook something*' important. The implication of not recognising deteriorating patient conditions is in itself terrifying. Add to this the legal implications and the potential you '*could end up in a court of law*', it is not surprising this is an issue that causes considerable stress for new graduates.

c) Personal stresses: There were three major personal stressors in the transition experience. These were the fear of making mistakes and asking questions, not wanting to be seen as a troublemaker and the negative attitudes of nursing colleagues.

Many studies show that new graduates report a fear of making mistakes and being seen as incompetent or stupid (Gerrish 2000; Cobal 1998; NRBNSW 1997). The following comments highlight participants experiences: '*I would have a fear of finishing... and there will be something I've missed. The more I got anxious and uptight about it the worse it got*', and: '*If something went wrong... I was quickly seen as a bad nurse*'.

Not surprisingly, any rebuffs from staff, even when unintentional, were demoralising and led to self-doubt and a questioning of their ability. The fear and anxiety was based on a lack of clinical experience: '*I hadn't had the experience to pick up on what others picked up on*'.

As Moorhouse (1992) explained, when unsure about patient care, graduates are confronted with a choice between the safety of the patient and revealing their shortcomings by asking questions of staff who might embarrass them or remember the incident for future reference. The participants did not risk patient safety, they preferred appearing stupid rather than risk making a mistake: '*I still ask questions that I think may sound stupid*' and: '*I also learnt that no question is stupid*'.

The participants were very aware of the power structures in the workplace and saw themselves as being '*at the bottom of the ladder*'. One said: '*...some nurses did things to patients that I wouldn't do*'. It was difficult for the graduate to address the issue: '*It's difficult to speak up because you don't want to be seen as a troublemaker or cause waves*'. Another simply stated: '*You have to be careful*'.

Buckenham (1994) found that despite the imperative to comply with the hierarchical culture of the ward, graduates maintain their professional values on important matters such as patient advocacy. One participant commented: '*If it hurts people or if it makes people upset then I will speak up, but if it's more to do with skills I wouldn't really mind unless I had a deep reason to raise the issue*'.

Trying to ignore issues engendered feelings of guilt and disappointment and undermined professional self-image. Such situations potentially prevent the exchange of new ideas and raising of professional nursing standards (Cobal 1998; Kelly 1996).

Nurses' negativity is seen as one of the most significant issues in unhappy transition experiences (DES&T 2001). This includes the attitudes of nurses to their new graduate colleagues and the negative attitudes of experienced nurses to nursing as a profession. As one participant commented: *'I did not expect to encounter nurses who did not enjoy what they were doing. I guess it's a naïve view but I just assumed everyone would like nursing and I know it's naïve to think that, but I guess I thought coming out of uni, I love nursing so I thought everyone else who does it must as well. To encounter negative people, I had not thought about that'*.

Clearly participants were shocked to find 'negative nurses' who openly stated they did not enjoy nursing as their chosen career. Graduates, who are still 'outsiders' in the profession, perceive nurses who express cynical views about nursing as betraying the nursing profession. Therefore, as good nurses are caring, by association nurses who do not care are in the eyes of the new graduate 'bad nurses' (Moorhouse 1992). These 'trade secrets', which are not usually made public, are learned early in the workplace and quickly destroy the ideal view of nursing and can potentially damage professional commitment.

Striding ahead

This theme describes the factors that facilitated the transition and adaptation from student being 'dependent on' to the RN role and being 'depended on'.

Preceptor support was identified as a significant factor in assisting the participants to cope with learning and adapting to the beginning RN role. As one participant commented: *'there is always someone there you can ask... a lot of them are fabulous resource people'*. Preceptors varied in the way in which they provided support by: *'encouraging me and giving me the right sort of support needed'* or: *'by treating me more like a friend'*. There were also several preceptors who did not perform the role as well as expected.

On balance, the participants saw their preceptors as supportive. Research by Gerrish (2000), Godinez et al (1999), and NRBNSW (1997) also reported that the vast majority of graduates were very positive about the support they received from their preceptors. Several studies (Cobal 1998; Franklin 1997; Dolling 1997; Buckenham 1994) identified inadequate support as a major source of anxiety and stress during the first year of practice. This is an interesting finding, as it could be postulated that many of the other stresses identified by the

participants in this study should have been minimised by a supportive preceptor.

The need for feedback from colleagues was highlighted by the participants as not only important, but essential, for self-development and adaptation to their new work role. One participant felt: *'As a graduate I needed them to say "you did well"... you need constant feedback'*. The participants valued any form of feedback, one stating: *'I am the sort of person who needs to be told how I am going whether it be good or bad'*. Positive informal feedback and encouragement was the most frequent form of feedback referred to by participants in this study. *'In my first placement I was always being told "You've done a fantastic job"'* or: *'they always gave great feedback and I got a huge card at the end saying thank you for your hard work, you've done well'*. But negativity exists: *'In one placement I did not get that positive feedback. There was no acknowledgment for the good work you'd done. It was always an acknowledgment of what you hadn't done'*.

Negative feedback of this nature does not provide an environment that nurtures new nurses. However, positive feedback has significant impact in raising graduate confidence and helps them learn and adapt to the new role adding to job satisfaction (Cobal 1998; NRBNSW 1997).

Outcomes of a supportive transitional process included: consolidation of skills taught and learned at university; gaining self confidence; becoming a respected and trusted member of the nursing team; gaining competence in clinical and technical skills; and, being able to initiate, plan and deliver safe care for clients. Notwithstanding the stressful challenges faced by the nurses, the overall graduate year experience was a positive one:

'I think it surpassed what I expected overall. I didn't have specific expectations but the main expectations were to practice as a safe nurse to learn as much as I could and to take it from there. I had a fabulous year, I was well supported, I was looked after...'

CONCLUSIONS AND IMPLICATIONS

The acute shortage of RNs currently being experienced in Australia and overseas has highlighted the need to retain RNs within the profession. Levels of job satisfaction in the first year of clinical practice is documented in current nursing literature as a major influence on professional commitment and staff retention.

In light of this, it is essential health care organisations provide an environment that meets the needs of the health industry and satisfies new graduates. The first year of nursing clinical practice is a period of rapid self-development, high anxiety and reality shock. This study has contributed to our understanding of the experience of transition from student to RN in a private hospital graduate program.

It is clear the experience of transition was greatly affected by the participants' expectations of themselves, although often unrealistic, in the performance of the RN role. Their transition experience was also affected by their expectations of the RN role itself, the consequence of the 'reality shock' they experienced, their ability to cope with stress especially in the first three months and the individual participant's capacity to adapt to new circumstances and the environment. These participants experienced similar stresses that have been found in other studies of graduate transition.

LIMITATIONS OF THE STUDY

The main study limitations relate to retrospectivity, the small sample size from a single venue, and single mode of data collection, all of which restricted the level of analysis. The fact the interviewer had been in contact with the participants during their graduate program also may have affected the findings. The participants had the opportunity to look back on the first year in its entirety which may have resulted in enhanced feelings of satisfaction (Franklin 1997).

IMPLICATIONS AND RECOMMENDATIONS

Improvements to GNPs may assist graduates to experience greater satisfaction during the transitional year, enhancing professional commitment and retention of nurses. Further studies are needed to examine the possibility that continuity of both clinical undergraduate and graduate experience may prevent or alleviate 'reality shock'.

There appears to be disagreement in the literature as to the effectiveness of the preceptor experience in giving the new graduate positive support and appropriate role modelling. Some participants reported a positive and supportive preceptor experience but still felt overwhelmed by unrealistic staff expectations, the need to prove themselves as 'good nurses', a fear of making mistakes, and the negativity of some colleagues. Clearly, the preceptorship model of support was not always protecting them from these stressors. This issue needs further investigation.

The nursing profession and the health system in general needs motivated and committed nurses. A successful transition experience has the potential to be a powerful motivator for the graduate nurse as is the nurturing and encouragement by RNs. There is evidence that adequate support leads to confidence and satisfaction with the RN role.

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RURAL FATHERS' EXPERIENCES OF LOSS IN DAY-TO-DAY LIFE WITH CHRONICALLY ILL CHILDREN

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Key words: fathers, chronically ill children, rural, qualitative research, lived experience

ABSTRACT

The aim of this qualitative study was to gain insight into the experiences of fathers living with their chronically ill children in rural Australia. Data were collected via unstructured interviews with four fathers. Analysis followed the procedural steps for phenomenological data as outlined by Colaizzi (1978). Fathers described their experience of living with their chronically ill child as being filled with progressive losses for themselves and their child, including loss of: 1) pre-conceived expectations of future life; 2) a normal parenting relationship with their child; 3) normal partner relationship; and, 4) control of time and freedom. Findings contribute to knowledge and understanding of the complex nature of fathering a chronically ill child in rural Australia.

INTRODUCTION

Improvements in current medical treatments have extended the lifespan of children who suffer from chronic, progressive and life-threatening illnesses. Many of these children now live for an extended time with complex conditions (Martin and Nisa 1996). Chronic illness is characteristically defined as an illness, long in duration, progressive in nature and relatively incurable (Cohen 1999; Clawson 1996). Variables that impact on the experience of chronic illness are based on functional limitations, symptom prediction, threat to life and the need for external assistance (Stein and Silver 1999).

Ample evidence exists to support the importance of family in the maintenance of the health of its members during periods of childhood chronic illness (Canam 1993). This fact in conjunction with the current trend towards home care means parents are now adopting the role of surrogate health care worker.

The notion of family as being central to the care of its members has provided much impetus for the inclusion of family members, specifically mothers, in the care and research of childhood chronic conditions (Canam 1993). However, for nursing, a best practice model for care delivery also includes the father. Therefore, nurses require a greater understanding of how fathers experience the chronic illness of their children.

LITERATURE REVIEW

The majority of available research regarding fathers has generally relied on mothers' reports of the impact the chronic illness has on the father and her perceptions of his attitude, thereby creating a paucity of first hand accounts from fathers (Violi 2000; Eiser 1993; May 1996). Despite

the stoic and uninvolved portrayal of fathers throughout the literature, increasing evidence indicates that childhood illness has a powerful impact on them (Heaviside 2000; Coe and Neufeld 1999; Cohen 1999; May 1996). Katz and Krulik (1999) believe fathers of children with chronic conditions were profoundly affected by their child's illness and appeared to have more difficulties than mothers in adjusting to the realities of their limitations.

Some literature contends that fathers with chronically ill children enjoy their children less and find parenting less rewarding than fathers of healthy children. Fathers have reported lower self-esteem; feelings of incompetence, failure, guilt and helplessness; and, a sense of low satisfaction and gratification from their ill child (May 1996; Hauenstein 1990). According to May (1996), fathers distance themselves from their ill child as they are embarrassed by the child's appearance and inability to perform the physical, visually pleasing tasks of healthy children. Although the literature presents a plethora of negative emotions and challenges for fathers with chronically ill children, depression is less frequently reported (Hauenstein 1990).

The father's role is commonly described as one of support, especially for the mother of the chronically ill child (Violi 2000; Cohen 1999; Eiser 1993). Nagy and Ungerer (1990) propose that the support fathers provide is crucial in buffering the effects of childhood chronic illness on the mental health of the mother. It is suggested fathers feel a sense of guilt when their partner becomes stressed, believing their support has not been sufficient. Despite spending very limited hours of attendance within the hospital during illness exacerbations, fathers believed they contributed greatly to the childcare practices at home (Hentinen and Kyngas 1998; Hauenstein 1990; Nagy and Ungerer 1990).

The overall body of literature pertaining to rural health is limited. There is an assumption that certain health benefits arise from living in rural areas. These include clean air, fresher food, better housing, less stress and a greater sense of community cohesion. However, rural areas have been shown to have higher incidences of mortality and morbidity than suburban comparisons and suffer from decreased access to health care services (Dixon and Welch 2000). Research in the area of rural health suggests rural areas tend to describe health in the negative, as an absence of disease, therefore their main concern is a cure (Dixon and Welch 2000; Long and Weinert 1992). In light of this, the need for primary care in rural areas is low because of the tendency of rural dwellers to define health as one's ability to perform in the face of adversity (Coster and Gribben, 1999). Men are at particular risk of mental and physical ill health, with greater rates of suicide in small rural areas than those of urban communities (Dixon and Welch 2000). In addition, evidence suggests that although cohesion and support is high in rural areas, it is not necessarily effective. Rather, Stevens (1998) proposes that rural cohesion may actually

operate to limit a man's behaviour and reduce opportunities for support seeking behaviour.

Given the paucity of research about fathers' parenting experiences of their chronically ill children while living in a rural environment, this study contributes to the nursing body of knowledge regarding this complex phenomenon.

THE STUDY

This interpretive qualitative study used in-depth interviews to discover how rural fathers perceived the day-to-day experiences of living with their chronically ill children. Findings related to loss are reported in this paper.

Aim

The aim of this study was to gain insight into the experience of being a rural father with a chronically ill child.

Methodological design

This interpretive research, informed by existential phenomenology for data analysis (Denzin and Lincoln, 1998), explored the day-to-day experiences of rural fathers and their chronically ill children. This approach was chosen to facilitate understanding by acknowledging and valuing the meanings people ascribe to their own existence - their lived experience. It stresses the importance of personal experience in gaining understanding (Walters 1994; Munhall and Oiler-Boyd 1993).

Study participants

Four fathers with one chronically ill child each were recruited using purposive snowball sampling. Inclusion criteria were that fathers: must have been the biological father of the child(ren), have been living with the child(ren) and a partner for a minimum of two years and living in a rural area. Fathers in the study formed a relatively homogeneous sample ranging in age from 36 to 44; all were married and all had other healthy children. All participants lived in a rural area for an extended time and were embedded within the rural culture. The chronically ill children formed a heterogeneous sample. Children ranged in age from two to nine years and their illnesses were vastly different, from those of the respiratory system to those of the central nervous system.

Data collection

Fathers of chronically ill children living in the rural area were relatively few in number, somewhat isolated from mainstream society and therefore difficult to recruit. Contact with the first participant was gained through a father who volunteered for a pilot interview. During the pilot interview it became apparent the participant was reluctant to openly engage in personal discourse, offering only brief descriptions of his experiences and then remaining silent despite careful probing techniques. This

is consistent with the literature that contends unless men have a specific problem to solve they are likely to remain silent and disengaged, finding it difficult to engage in discourse about their personal feelings (Shaw and Beauchamp 2000; Verrinder and Denner 2000). This awareness enabled the researcher conducting the interviews to use this information to develop trigger questions and topic areas to explore should the participants have difficulty talking about their experiences. This recognition highlights the importance of research that explores the perceptions and experiences of men and may help to explain the relative paucity of literature pertaining to men.

Interviews ranged in length from 45-75 minutes and continued until each father believed he had completed his discussion/description of his experience. All interviews began with the statement: *Tell me what it is like for you living with a chronically ill child?* Careful probing questions, such as: *Can you explain that further?* and: *Do you recall how that made you feel?* were employed to engage the participants in continued reflective discussion.

Ethical considerations

The purpose of the study was explained to all fathers who volunteered and written consent was obtained prior to the interview. Ethics approval was obtained from the relevant university committee prior to data collection. Given the nature of rural communities and small available sample, careful steps were taken to protect confidentiality, such as limited demographic information about both the participants and their children.

Data analysis

A member of the research team transcribed all interviews verbatim. Colaizzi's (1978) phenomenologic technique for data analysis was used for thematic development in order to uncover the hidden, ambiguous and mysterious nature of the experience of the fathers interviewed. In-depth contact with the transcripts through phenomenological reflection, allowed the researchers to examine the parts of the whole by extracting significant statements and phrases about the phenomenon. Meanings were formulated from the statements, which were clustered to illuminate the themes or structures that encompassed the experience of rural fathers living with their chronically ill children. Results of each cluster of themes were integrated into an exhaustive description. This paper presents four themes resulting from this analysis process.

Achieving rigour

Written transcripts were compared with the recordings to assure accuracy of data used for analysis. Issues relating to rigour can be complex when research topics are sensitive in nature. Because fathers in this study often struggled to share their feelings and experiences, it was not considered appropriate to return transcripts or findings to them for verification. However, member checking to

enhance rigour (Sandelowski 1986) was achieved by providing three fathers with chronically ill children, who were not part of the research, with a summary of the research findings. These fathers were able to recognise their own experience within the findings provided.

FINDINGS

This paper reports the four themes related directly to the experience of loss encountered by fathers living with their chronically ill children in the rural environment, including: 1) loss of pre-conceived expectations of future life; 2) loss of a normal parenting relationship with their child; 3) loss of normal partner relationship; and, 4) loss of control of time and freedom.

Loss of pre-conceived expectations of the life they had hoped for

Fathers described an intense sense of frustration and sadness when they learnt of their child's condition. They described losses that occurred at different developmental stages because of the inherently progressive nature of chronic illness. The fathers' desire to be a parent, to perform parental roles and to receive the rewards parents of healthy children do, was lost. Their lives became something they had not foreseen for themselves nor expected for their children.

'...Before one has a child we have high expectations of a normal child and then when the child is born... those expectations are dashed.'

Compounding the emotions fathers felt with regard to the hopes and expectations for their child, was the progressive and 'in your face' nature of chronic illness.

'It's all this pumping stuff into her body, you know we are all basically a healthy family and you know just seeing her, you know it's in my face all the time it's in our faces.'

One father described the 'in your face' nature of the illness as coming from the negative connotations of society.

'...I don't know if he gets much embarrassed but we sort of... you don't like people staring at him but he doesn't notice that... but that's probably the hard bit.'

Another father described feeling inadequate in light of the progressive nature of his son's illness. Having preconceived ideas of the expectations on him as father and husband, he was left feeling inadequate in his role as family provider.

'I feel inadequate because I can't help him. I feel inadequate because I'm unable to fully care for my family the way I'd like to as a husband, a father and a... and a man.'

It was evident through their voices that their experiences were filled with loss. The loss of normalcy, the loss of social acceptance of their child and the loss of

adequacy as fathers. In combination, these losses equate to a loss of the lives these fathers had anticipated for themselves and shattered the preconceived expectations they had for their future roles as fathers.

Loss of a normal or typical relationship with the chronically ill child

These fathers tended to compare their children and their developmental milestones with those expected of children without a chronic illness. A prominent component of the experience accentuating the loss was the inability of their child to perform physically in the same way as healthy children. A significant feature of the father-child relationship, especially the father-son relationship, is often sport and physical activity. Fathers within the study expressed their desire to have this relationship with their children and experienced a feeling of inadequacy in not being able to do so.

'...Well it's difficult not being able to do normal things that normal kids do... just probably not being able to get up and run around like a normal kid... that's probably... the hardest thing.'

'I love my sport so I like him to play sport... so as long as I keep him going, you know, playing sport.'

Compounding the emotions of loss involved seeing other fathers fulfilling the roles they had anticipated for themselves.

'...a lot of jealousy. You've seen other mates of mine with their little boys running around at the footy and that sorta thing and we've gotta carry [son] and I can't go and have a kick of footy with him and... and there's other blokes doing it. You get a fair bit jealous I suppose.'

Fathers described having lost or abandoned their preconceived expectations for their chronically ill child. In light of a desire to feel good about their child's developmental achievements fathers appeared to change their expectations for their ill child. The joys of fathering came from small, unexpected achievements parents of healthy children might take for granted. These fathers learned not to expect giant leaps but rather consider small developmental tasks and the ability to learn simple acts as great achievements for their child and something to feel good about for themselves.

'... you just take little things... for instance [son] can't do a hell of a lot of things. But for him just to shut the microwave door. I've taught him how to do that and that's probably like oh, I don't know... when he first done that for me, it was like a normal kid taking his first steps I suppose. I do get a lot of joy out of him, but it's very basic things but you learn not to expect too much I suppose.'

'Every now and then you will get something really special... you have these special moments... moments where you think that this child is so chronically ill, yet they've still got a lot of this love... and that unconditional

love to give and that's good. You tend to take... precious little things more preciously.'

For these fathers, a change in expectation led to increased positive feelings of achievement for fathers and their children. By changing their expectations these fathers placed on their child, they inevitably maximised the potential for desired achievement and created a feeling of satisfaction for themselves as teacher and caregiver, enabling a positive relationship to develop between child and father.

Loss of the pre-child relationship with their partner

Fathers accepted they shared the burden of the illness experience with their partner, but also acknowledged it impacted on their relationship in ways not expected by the normal parenting experience.

'It affects my personal relationship with my wife... in terms of intimacy and in terms of time with each other.'

Although fathers believed they were unable to enjoy the typical aspects of a relationship (as a couple or as parents) because of the shared vigilance required by chronic illness, they described their spousal relationship as crucial to their stability.

'The time I spend with my wife is very limited and for us it's been our relationship that kept us going.'

'She's [wife] a very good support for me... having her as a support in a way helps me cope.'

One father goes on to describe the teamwork required when caring for his chronically ill child, stating the value of the longevity of such teamwork as a means of coping.

'...If it wasn't for the team effort... one of us would have conked out.'

Fathers also recognised a sense of pressure on the spousal relationship to maintain the familial equilibrium in order to cope with the chronicity of the situation.

'How I cope is how she copes and how we both cope living through this together.'

It is evident these fathers lost a sense of individuality within their spousal relationship. Fathers describe becoming one strong team as a couple rather than two separate individuals in order to share the rigours of ongoing daily management of the child. These pressures seemed to limit fathers sharing the usual pleasures and joys of a spousal relationship in a manner akin to their pre-child relationship.

Loss of control of their own time and freedom

All fathers discussed the willingness to sacrifice both intra and extra familial activities to facilitate the emotional and general mainstay of the family and daily running of the household. The experience encompassed fathers describing their 'duty of care' for their child. They discussed sacrificing their personal desires for the

wellbeing of their child, their partner and other children, and felt obligated to their supportive role.

'... I'm not doing what I want to do with my life... I'm not doing what I would like to do, I'm doing what I have to... and I have a sense of obligation and a sense of duty to see this through... but it's a matter of priorities... [son] at this stage... [son is] more important.'

'On a day like today I would like to be outside and do things and but I've gotta have [son] cos [partner] has him for the other six days so you feel as though you've gotta do that but then it is stopping me doing things I would like to do... just normal things I suppose.'

As well as providing support for the individual members of the family singularly, these fathers believed they were obligated to support the family as a whole. This was accomplished by achieving financial stability obtained through employment and the maintenance of the household during an illness crisis. Although they often did not support the ill child directly (while in hospital) they viewed their critical contribution as maintaining and supporting the household.

'... I'd still be up having to go to work and maintain the rest of the family and she [partner] would keep a bedside vigil and I'd pop in... That's where the other stresses come into it, it affects the rest of the house, everybody suffers.'

'When he's in hospital I feel that I need to be focusing and be at his side and focusing on the family needs as well as what my wife needs and what [other son] needs... so there's always little tasks to be done on an ongoing basis.'

The sacrifices these men made as fathers of chronically ill children and their self-appointed obligation to support their family meant they lost a sense of satisfaction and adequacy every time their child was ill or their partner became distressed. One father left paid employment to be with and support his family because of the impact the chronically ill child had on family cohesion. He expressed feelings of satisfaction when he talked about being able to effectively care for his family and buffer the distress inherent in their day-to-day lives. However, his loss of employment equated to a loss of personal satisfaction previously gained through employment, as well as lost identity amongst other men.

'It's difficult as a man because we generally identify ourselves through our work. In conversation one of the first things you say is 'I'm a this', 'I'm a that'. I've long since learnt not to do that but it's still something that rankles in the back of one's mind. Just everything involving men is structured around being at work during the day and I'm not.'

The fathers in this study saw their fundamental role as providing support for the entire family. Fathers were willing to sacrifice employment, leisure time and goal

attainment to ensure their families received needed support. They found being able to provide effective support personally rewarding despite experiencing a sense of inadequacy in times of disequilibrium (within the family) if their efforts were not successful.

DISCUSSION

This study explored the experiences of rural fathers living with their chronically ill children. The experience expressed by these fathers was one of continual adversity, rich in emotion and filled with progressive losses for themselves and their child. Losses included the life fathers had hoped for their child and for themselves and a loss in the ability to share in the usual experiences of fatherhood. Most prominent in their experience was the loss of their child's physical functionalism. Fathers had a 'burning desire' to experience the physical performances of their children in the ways parents of healthy children do. The potential to enjoy the physical achievements of their children in both play and competitive sport was lost to the illness experience. Their child's loss of physical ability created a sense of embarrassment, jealousy and inferiority among fathers in their rural community, a community that values the physical health of its members. This finding supports May (1996), who found many fathers are embarrassed by their chronically ill child's appearance and subsequent inability to perform the typical activities of a healthy child. Cummings (1976) found the esteem fathers lost to the illness experience left them with a sense of inferiority. Fathers within this study described feeling inferior and experienced a myriad of losses, but also described receiving a sense of enjoyment and satisfaction from their children, which contradicts some previous research in this area by May (1996), Hauenstein (1990) and Cummings (1976), who found fathers with chronically ill children enjoy their children less than fathers of healthy children.

Rural areas have a tendency to define or describe health in terms of the amount of value to the community a member contributes with regard to labour division and level of independence, rather than the absence of disease or infirmity (Dixon and Welch 2000; Humphreys 1999 and 1998; Weinert and Burman 1994; Long and Weinert 1992). Incidents when their children had endured the 'ill health' stigma of society generated feelings of inadequacy and sorrow in fathers. The child's stigma manifests the ongoing nature of their illness, bringing the associated losses of the illness and lack of societal acceptance to the forefront of these fathers' minds. Consequently, fathers within the study described the stigma that was directed at their child as having emotional implications for themselves, directly impacting on their self-esteem. This finding is consistent with Rubin (2000) and Katz and Krulik (1999) who found that the stigma commonly attributed to chronically ill children generated feelings of lower self-esteem in fathers when compared to fathers of healthy children.

These fathers perceived their primary role within the chronic illness experience as having to provide beneficial support to the entire family, particularly their partners. Consequently, fathers described a loss of personal freedom that evolved from the provision of such support. Cohen (1999) and McKeever (1981) also found fathers clearly interpret their role as one of familial support, especially for their partner. Katz and Krulik (1999) support this position, adding that fathers also believe any display of personal weakness that interfered with providing support was not acceptable. Fathers described feeling a sense of role conflict during periods of hospitalisation for their children. They felt a need to be at the child's bedside although concurrently perceived their place was maintaining the well being of the family at home. This strongly supports earlier findings of McKeever (1981) who found fathers spent limited hours at the bedside of the ill child. However, they believed they provided needed support through the maintenance of other family members wellbeing and the everyday activities of the household.

Fathers' perceived need to support other family members created a loss of achievement many individuals gain from employment. Available literature provides little insight into the relationship between employment, self-esteem and the illness experience of fathers. However, Sabbeth (1984) suggests fathers accustomed to working actively to achieve, may be particularly 'undone' by their lack of control over a child's illness. Katz and Krulik (1999) found fathers of chronically ill children were reluctant to take employment promotions out of an unwillingness to spend extended periods away from home.

Limitations

Within the limits of a small sample size, the aim of gaining insight into the experiences of rural fathers with chronically ill children was achieved. Additional research with a larger sample would enable a richer and more inclusive description of how rural fathers manage parenting in the face of adversity. This larger sample of fathers would consequently include a larger sample of children. This in turn would shed light on differences of experience related to the specific nature of the chronic illness.

CONCLUSIONS AND RECOMMENDATIONS

Utilising the interpretive paradigm, rural fathers' experience is revealed to be one filled with a myriad of losses for themselves and the life they had hoped for their children. One important finding of this study is the pivotal role fathers of chronically ill children perceive they have in maintaining the emotional and general mainstay of the family and in supporting their spouse as the primary care giver. Their self appointed obligation to support and maintain the stability of the family meant fathers relinquished their normally taken personal time and

freedom fulfilling this supportive role. Most confronting, however, was the loss experienced by these fathers of the normal relationship with their ill child. Further research is needed to build on current findings and illuminate the fathers' experience from different perspectives, such as comparing it with the mothers' experience, exploring it at various stages of the child's development and examining the experience specific to different chronic illnesses. Research in these areas will strengthen the current knowledge that exists on fathers, giving voice to the previous silence about fathers and their chronically ill children.

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OCCUPATIONAL EXPOSURE OF NURSES WORKING IN HIGH RISK AREAS: AN AUSTRALIAN STUDY

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ABSTRACT

This study aimed to explore the incidence, reporting and management of occupational exposure among nurses working in high-risk areas in two major hospitals in the western suburbs of Sydney, Australia. A structured questionnaire with a mixture of open and closed ended questions was developed to survey the nurses. The responses to each question was analysed using either a quantitative approach for closed ended questions, or a qualitative approach that compared frequency of themes for the open-ended questions. Under reporting of exposures, concern following an exposure and dissatisfaction of nurses with the reporting process were identified. This paper emphasises the need for organisations to have user-friendly protocols for immediate reporting and management of exposures by knowledgeable assessors.

INTRODUCTION

Exposure to the blood and body fluids of other people is a significant occupational risk for health care workers and nurses in particular. Occupational exposure is the term used to describe inadvertent exposure in the workplace to the blood or body fluid of a patient. Such exposure may put the person at risk of acquiring blood borne infection. Of greatest concern is the possibility of exposure to one of the three blood borne viruses, Human Immunodeficiency Virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV). Each of these can be transmitted following a needle stick or mucous membrane exposure.

Although the rate of transmission of blood borne viruses to health care workers in Australia is low, the social and emotional cost of perception of risk is reported as high (Central Sydney Area Health Service, CSAHS, 1992).

Australian studies examining nurses' experiences with occupational exposure are scarce with only one study found examining nurses' perceptions and practice of blood and body fluid precautions (Knight and Bodsworth 1998). The large body of overseas literature is mostly concerned with knowledge and attitudes to 'standard precautions' or blood borne viruses, with few studies describing in the nurses' own words the experience of reporting and management of occupation exposures (Levin 1995; Roup 1997; Burke and Madan 1997; Leliopolou et al 1999).

The practices to prevent or minimise the exposure of health care workers at risk of transmission of HIV or other blood borne viruses are legislated in Australia under the WorkCover Code of Practice (WorkCover 1996). Further guidelines and responsibilities of area health services are set out under New South Wales Department of Health (NSW DOH) circulars. The management of health care workers who have had an occupational exposure was extensively reviewed in 1997/98, culminating in NSW DOH Circular 98/11, setting out best practice in this area.

This paper reports a survey of nurses working in higher risk areas in two hospitals in outer western Sydney after a subsequent review of policy and practice to reflect the new guidelines articulated in NSW DOH Circular 98/11 (NSW DOH 1998). The survey took place six weeks after the official launch of the revised area health service occupational exposure policy.

LITERATURE REVIEW

'Standard precautions' is the term used to describe the personal protective equipment and practices that are available for health care workers to use where exposure to blood or body fluids of a patient is anticipated (Australian National Council on AIDS, ANCA, 1996). This includes gloves, masks, goggles, gowns, safety needles and cannulas, and the strategic positioning of sharps containers. 'Standard precautions' were originally termed 'universal precautions', a phrase invented by the Centers for Disease Control (CDC 1982) in the United States of America (USA) while they were developing strategies to prevent the spread of the newly discovered HIV (Parsons 1995). Because of the long three-month window period from exposure to seroconversion to HIV, it became impractical to test all inpatients for HIV. In addition, as the epidemic was increasing, confining people with HIV/AIDS to specialised units was not feasible. The shift to isolating the body substances that are implicated in the transmission of the virus, such as blood, semen, vaginal fluids or other blood-tinged body fluids, rather than the isolation of the person, was a much more practical solution (Parsons 1995).

In 1996, the Australian National Health and Medical Research Council (NHMRC) and ANCA jointly reviewed the *1988 Infection Control Guidelines* to bring them in line with new terminology adopted by the CDC. While it was acknowledged that 'universal precautions' had provided a high level of protection from transmission of blood borne viruses, there was some concern the term 'universal precautions' was ambiguous in its application and should be changed to a two-tiered infection control approach which uses 'standard precautions' as a first line approach and 'additional precautions' where 'standard precautions' might not be sufficient to prevent transmission of infection (ANCA 1996, p.1). 'Additional precautions' are used for patients known or suspected to be infected with potentially highly transmissible pathogens that cause infections and are applied in addition to 'standard precautions' (ANCA 1996).

Despite the introduction of 'standard precautions' practices almost two decades ago, studies of health care workers continue to reveal varying levels of adherence to the use of equipment such as gloves, gowns, masks or eye goggles designed to prevent or reduce exposure to the blood or body fluids of patients (Levin 1995; Gershon et al 1995; Burke and Madan 1997). Knowledge of either blood borne virus transmission or 'standard precautions'

does not reflect levels of adherence to 'standard precaution' practice (Gershon et al 1995; Knight and Bodsworth 1998).

Adherence to 'standard precautions' is associated with a wide variety of factors such as the type of patient contact, the emergent nature of the situation (Levin 1995), the perception that a patient is in a lower risk group for HIV, HBV or HCV (Williams et al 1994; Kim et al 1999), the appearance of the client (Henry et al 1992) or a belief that using 'standard precautions' interferes with the practitioner-patient interaction (Willy et al 1990; Burke and Madan 1997). Contrary to legislation in Australia, a common finding in the literature is the belief by health care workers that they have the right to know the HIV status of their patients. This is reflected in the expressed statements of nurses in a number of studies that they would definitely use 'standard precautions' if they knew the person was HIV, HBV or HCV positive (Willy 1990; Levin 1995; Roup 1997; Leliopoulou et al 1999; Beltrami et al 2000).

Knight and Bodsworth (1998) reported that only 50% of nurses in Australia, at an inner city hospital with a high prevalence of HIV, always wore gloves to take blood samples or remove cannulas. It could be expected that nurses who are aware of their higher risks of exposure would be more diligent, yet a study about the rates of adherence to 'standard precautions' in critical care nurses, by Roup (1997) in the USA, found levels of adherence at around 67% with a range of 25% to 100%. Other groups considered at high risk of exposure to blood and body fluids include midwives and nurses working in emergency departments. However, a large study of midwives in the USA reported only 55% of the 1784 respondents used 'standard precautions' routinely in their work, and of those 55% (n=9812), 13% (n=128) reported recapping needles (Willy et al 1990). Needle recapping was also high in an observational study by Henry et al (1992), which found rates of 51% in a hospital emergency department. These researchers observed that of the needles that were recapped, 73% were recapped by the use of two hands, a technique that puts the health care worker at highest risk of exposure (ANCA 1996; NSW DOH Circular 98/11).

Staff in emergency departments have cited numerous reasons for non-adherence to 'standard precautions' and these include: the emergency of a situation (eg lack of time to don protective apparel); occupational exposures are to be expected when working in emergency situations; 'standard precaution' apparel is bulky; glove use and other safety devices interfere with dexterity (Henderson 1995; Kim et al 1999; Evanoff et al 1999; Moran 2000). Staff have also stated there is a practice of selectively applying 'standard precautions' based on patient demographics and/or appearance (Henry et al 1992).

A common feature of the Australian studies, which have examined occupational exposures, is the low rate of

exposure reporting (CSAHS 1992; Mallon et al 1992; Bowden et al 1993; MacDonald et al 1995). Knight and Bodsworth (1998) found in their study that of 192 nurses surveyed, 76% (n=146) had an exposure in the prior six months with only 27% of those exposed reporting the incident. Although the risks of becoming infected with HIV, HBV and HCV are small, the consequences of infection are extreme and hence organisations must not only insist on the use of 'standard precautions', but must also provide a confidential, time efficient procedure to encourage workers to report their exposures promptly (Mallon et al 1992).

Gershon et al (2000) found a lack of research in the area of health care workers' experiences of post occupational exposure management. In their descriptive study of 150 health care workers in the USA who had recently sustained an occupational exposure they found many health care workers perceived a lack of support during the lengthy follow up period, wanted faster assessment following the initial exposure and felt sometimes they (the health care workers) were better informed about the management of an exposure than the person doing the assessment.

AIMS OF STUDY

This study aimed to explore the incidence, reporting and management of occupational exposure among nurses working in high-risk areas in two hospitals in outer western Sydney.

METHOD

This study was a descriptive survey utilising a structured questionnaire. For the management of occupational exposures a 24-hour system exists in both hospitals for the immediate reporting of incidents. This is done either by using a 24-hour pager at the 420-bed tertiary hospital (held by Staff Health Monday to Friday 8am-4pm and a senior nurse manager after hours) or to the director (or assistant director) of nursing at the smaller 95-bed hospital. All members of staff have the procedures to follow on a laminated tag attached to their identification label if an occupational exposure occurs.

Sample

A purposive sample of nurses (247) was accessed from those working in the designated areas of the hospital considered at high risk for occupational exposure - intensive care unit (ICU), critical care unit (CCU), high dependency unit (HDU), accident and emergency department (ED), neonatal intensive care (NICU), delivery suite (DS), operating theatre (OT), sexual health unit (SHU) and maternity.

Questionnaire

The initial questionnaire was developed from the literature examining the complex problem of under-

reporting of occupational exposure and the lack of adherence to 'standard precautions' (eg Bowden 1993; Burke 1997). The questionnaire developed had a mixture of open and closed-ended questions to encourage respondents to write about the experience in their own words. The questionnaire was trialled on 10 nurses and minor changes to text were made before the final questionnaire was distributed. The final questionnaire consisted of 35 items related to:

1. Nurse's position title and clinical department, number of occupational exposures sustained, length of time since last exposure, reporting of exposures, awareness of source, patients' blood borne virus status, whether exposure took place during a routine or urgent procedure, which were closed ended questions; and,
2. Experience of sustaining an exposure (thoughts that went through their mind, concern or lack of concern, how exposure was managed and how confident they felt with the management of their exposure) and any suggestions the nurses had that could improve the management of occupational exposures in the area health service, which were open-ended questions.

Data collection

Following ethical clearance in June 2000, data were collected over September and October 2000. Each ward or unit was visited by the researchers and where possible, a verbal explanation of the research given to the nurses at a ward meeting. A package consisting of the questionnaire, with a pre-labeled internal mail envelope for return, and an information sheet explaining the research and the guarantee of confidentiality was left with the nurse unit manager of each unit to hand out to as many staff as possible over a two-week period. The nurses were informed that return of the completed questionnaire was considered as consent to be involved in the study. All respondents were volunteers.

Data analysis

The quantitative data from the questionnaires were entered into SPSS Version 10.0 (SPSS Inc. 1999). Data were collated, frequencies and percentages calculated and cross-tabulation of variables performed. The written answers to the open-ended items were transcribed and the text content analysed for themes related to specific questions. The frequency of themes was collated and the themes compared and contrasted for each item to gain an overview of the nurse's opinions and comments. Descriptions of their viewpoints are included in the findings.

FINDINGS

Respondents

Of 247 questionnaires left in the wards and units which were all distributed either by the researchers or the nursing unit managers, 104 responses were returned, giving a 42%

Table 1: Cross-tabulation of nurses' areas of work and number of occupational exposures (n=65) reported by respondents

Area of work	Number of nurses (n=104) working in the area (number exposed, % exposed)	1-5 exposures	6-10 exposures	11-20 exposures	>20 exposures
ICU	25 (18, 72.0%)	11	3	1	3
OT	18 (17, 94.4%)	10	3	2	2
NICU	27 (9, 33.3%)	6		2	1
DS	7 (6, 85.7%)	5			1
ED	11 (5, 45.5%)	4		1	
Maternity	10 (5, 50.0%)	3			2
SHU	4 (4, 100%)	2			2
HDU	2 (1, 50.0%)	1			

ICU: Intensive Care Unit; OT: Operating Theatre; NICU: Neonatal Intensive Care Unit; ED: Emergency Department; SHU: Sexual Health Unit; HDU: High Dependency Unit

Table 2: Nurses' knowledge of patients at risk and blood borne status of source patients when occupational exposure occurred (n=65)

Nurses' knowledge of status	Any risk factor in source patient (% response)	HIV status of source patient (% response)	HBV status of source patient (% response)	HCV status of source patient (% response)
Always	12 (18.5%)	8 (12.3%)	13 (20.0%)	9 (13.8%)
Sometimes	35 (53.8%)	22 (33.8%)	25 (38.5%)	27 (41.6%)
Never	18 (27.7%)	35 (53.8%)	27 (41.5%)	29 (44.6%)

response rate. This is considered a reasonable response rate for a survey that includes a number of open-ended questions (de Vaus 1995).

Of the respondents, 102 (98.1%) were RNS and two (1.9%) ENs. Eighty-one percent of the nurses (84) stated they were aware of the current policy on occupational exposure. The findings reported here relate to those nurses who reported having an occupational exposure.

Nature of occupational exposures

Sixty-five (62.5%) of the respondents reported they had an occupational exposure and of these 28 (43%) had occurred in the last 12 months. Of those occurring in the last 12 months, seven (25%) had occurred in the last month. Table 1 depicts the cross tabulation of any occupational exposure and approximate number with the clinical areas in which the nurses were working. This table also shows the percentage of nurses exposed in each clinical area. The three work areas with high exposure rates over the past five years were NICU, ICU and OT with most occurring in ICU.

Thirty-four of the nurses (52.3%) reported that more than half of their exposures had occurred during routine procedures while only 15 (23%) nurses stated that more than half of their exposures had occurred during urgent procedures. The nurses' knowledge of the blood borne virus status of the source patients is depicted in Table 2.

Twenty percent or less of the nurses reported always knowing of any blood borne virus risk for the source patient and 53.8% (n=35) sometimes knew of some source patient risk factor. While 27.7% (n=18) of the nurses reported they never knew of any source patient's risk factor, over 40% of the nurses reported never knowing the blood borne virus status of the source patient. When the status of the source patient was known the nurses were aware of this either from the patient's self disclosure, patient notes or a verbal report from the doctor.

Table 3 depicts the types of occupational exposure experienced by the nurses. The most common type was body fluids with non-visible or visible blood. Fifty-six nurses cited procedures in which the exposure occurred. Of these the most common were venepuncture or cannulation associated procedures (36%, n=20), operative procedures (23%, n=13), suture removal or attending surgical wounds (14%, n=8). Other procedures mentioned were resuscitation, cleaning up after procedures, delivery of a baby, and recapping needles. Sixty-nine percent (n=42) of the nurses reported they had been wearing gloves when exposure occurred. Ninety-one percent (n=47) of the nurses' last exposures occurred 10 or less minutes into the procedure. Reasons nurses gave for not wearing gloves were: they did not have the time to put them on; and, they felt it was not necessary; and, they did not anticipate coming into contact with blood or body fluids.

Table 3: Frequency of types of occupational exposure reported by nurses (n=65)

Type of exposure	Never (% responses)	1-5 exposures (% responses)	6-10 exposures (% responses)	11-20 exposures (% responses)	>20 exposures (% responses)
Needlestick - visible blood (n=60)	30 (50.0%)	28 (46.7%)	1 (1.7%)	1 (1.7%)	
Needlestick - nonvisible blood (n=60)	23 (38.3%)	36 (60.0%)	1 (1.7%)		
Penetrating skin injury – visible blood (n=57)	51 (89.5%)	6 (10.5%)			
Penetrating skin injury – nonvisible blood (n=55)	4 (80.0%)	1 (20.0%)			
Body fluids – visible blood (n=59)	22 (37.3%)	26 (44.1%)	3 (5.1%)	1 (1.7%)	7 (11.9%)
Body fluids – nonvisible blood (n=55)	17 (30.9%)	20 (36.4%)	6 (10.9%)	2 (3.6%)	10 (18.2%)

Reaction to occupational exposure

When the nurses were asked to rate their concern at being exposed to a potential infection risk 56 (35%) were very concerned or concerned. The nurses who were not concerned stated that their exposure was minimal or no risk. The thoughts that went through the nurses' minds (63 written responses) when exposure occurred were most frequently shock, with only one nurse feeling it was their own fault. Some nurses commented that dealing with an exposure was a nuisance and a waste of their time. The following statement typified their comments: *Shock, dismay. Oh no, I have to go to Cas... [emergency department] and sit there for ages, what a waste of time.*

Reporting

Of all the occupational exposures experienced 58.3% (n=35) of the nurses reported all or most of them. Seventy-four percent (n=48) of the nurses reported their last exposure. The nurses' reasons for not reporting the exposure included: there was insignificant risk; exposure happened so frequently it had become the norm; and, reporting the incident was a waste of time as there was no follow up. Fifty nurses nominated the person to whom they reported exposure. In most cases this person was their nurse unit manager (54%, n=27) with others reporting the incident to the senior nurse manager (40%, n=20), director of nursing (4%, n=2) and staff health (4%, n=2).

Management of occupational exposure

Following their last exposure 51 (78%) of the nurses were assessed for possible risk of infection with a blood borne virus by the end of their current shift. However, only 21 (44%) of the nurses were assessed within an hour of exposure.

At the assessment, many of the nurses felt that uninterested medical staff treated them and that the procedure was inadequate. During assessment most of the nurses (68%, n=44) had blood taken with 30 (46%) reporting that source blood was also taken. Few (5%, n=3) nurses reported they had pretest counselling. The nurses also commented that the health professional they consulted sometimes did not know the policy or procedures for occupational exposure.

When asked what treatment options were discussed with them, most of the nurses reported that no information was given. Some of the few treatment options in the nurses' responses were: *'use condoms and wait for blood results, have a hepatitis booster, drug treatment, azidothymidine (AZT), all treatment options were discussed but until results come back they cannot do anything as per policy'*.

A typical response from the nurses in the questionnaire was: *'no options were discussed nor well counselled, no follow up. I had to ring and find out and they would not give me any answers, it was like nothing ever happened'*.

The nurses who normally reported an exposure, felt the management of the occupational exposure could have been improved by having experienced personnel doing assessment, being seen immediately and with better follow up. Immediate counselling and reassurance could have been better. The overall feeling of the nurses is typified by one of their responses to this question on management of the occupational exposure: *'The initial four hours after the injury was frightening and I felt a sense of abandonment in emotional terms. The staff were very clinical and objective, the nurse supervisor was mildly critical of my carelessness. I could have cried if only a hug or shoulder was provided'*.

DISCUSSION

Overall, this study has shown that the nurses under-reported occupational exposure, they were concerned afterwards and they were often dissatisfied with the post-assessment and treatment processes. It is of concern that only 81% (n=84) of the nurses were aware of the health area policy, despite the publicity surrounding its launch, the requirement that all staff attach an occupational exposure card to their identity tag, and more particularly as the nurses were working in high-risk areas for exposure to the blood and body fluids of patients. However, it has been found in previous studies that knowing policy makes health professionals comply (Gershon et al 1995; Knight and Bodsworth 1998).

Similar to earlier studies, (Kim et al 1999; Moran 2000) the nurses stated the reason they did not follow 'standard precautions' was that they did not have time to put gloves on, or the procedure was an emergency. However, in this current study the majority of exposures occurred during routine procedures, which suggests that further investigation of work practices and other risk factors is warranted. Audits of the placement of glove containers together with practical demonstrations of gloving up in a number of different situations could be useful strategies to decrease this perception.

Similar to the findings in a study of nurses in critical care by Roup (1997), for a majority of exposures, the source patients' risk factors or blood borne virus status was not known, yet only 69% of the nurses were wearing gloves when they had their last exposure. Reasons given for not wearing gloves are consistent with the 'standard precaution' dilemma (did not think it was necessary, did not anticipate coming into contact with blood). As suggested in the literature (Sulzbach-Hoke 1996), when the actual probability of acquiring an infection with a blood borne virus is low, despite the consequence of an infection, the risk tends to be discounted almost entirely.

The majority of the nurses in the study reported being concerned or very concerned following their last exposure. This again highlights the difficulties of occupational exposure practice and protocols - the nurses were concerned, yet did not always wear gloves or report their exposures. Anxiety following an exposure is a common occurrence, with fear of contracting HIV usually causing the greatest anxiety (Armstrong et al 1995).

The nurses stated that the reporting of occupational exposures was a major hassle for them and this was reflected by only 58.3% (n=35) reporting all or most of their exposures, although 74% (n=48) reported their last exposure. This is higher rate of reporting than Knight and Bodsworth (1996). The nurses suggested that sub optimal reporting occurred because of the perceived difficulty of the process (too time consuming, a waste of time). This has serious implications for effective and safe systems for the management of occupational exposures. Circular 98/11 (NSW DOH 1998) requires all exposures to be

promptly reported to enable assessment of the injury type and source patient status, in the event that administration of prophylactic treatment to prevent an HIV infection is required (CDC 1998). Timely assessments (within one to two hours) were experienced by only 21 (44%) of the nurses and this rate is similar to that reported by Mallon et al (1992). The finding that many of the nurses reported being assessed by inexperienced staff who seemed to know less about the procedure than the exposed person also highlights the need to ensure access to appropriately trained staff.

CONCLUSION

Although this study provides insight into the reporting and experience of occupational exposures of nurses working in high-risk areas, the findings need to be interpreted with caution. The study took place relatively (and coincidentally) soon after the introduction of the area policy and procedures. Much of the experience of the nurses had occurred in the 12 months previously. However, occupational exposures are not a new phenomenon and it is important organisations have in place evidence based protocols for the immediate management of staff, including knowledgeable assessors, assertive follow up and more accessible reporting procedures.

Further research into how nurses make a risk assessment at the time of exposure could provide insight into developing education strategies or exposure protocols. A follow-up study is being planned by the researchers to see if time has improved nurse and area health practices in the two years since introduction of the occupational exposure policy in the area health service.

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ASSESSING PATIENT SATISFACTION WITH DAY SURGERY AT A METROPOLITAN PUBLIC HOSPITAL

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Key words: day surgery, patient satisfaction, survey, nursing care, quality

ABSTRACT

With the advances in health care technology, many surgical procedures are performed as day surgery cases. The provision of day surgery is considered to be a cost effective method of utilising resources, but it does challenge nurses to provide optimal patient care during the patient's short stay in hospital. Patient satisfaction is considered to be an important indicator of quality nursing care. This paper reports on an investigation aimed at assessing patient satisfaction with day surgery in an Australian metropolitan public hospital. One hundred and seven patients completed a recently developed survey assessing patient satisfaction with day surgery. The response rate was 41%. Waiting times, communication, pain management and discharge planning were major areas of patient dissatisfaction. Directions for improvement in day surgery services are discussed.

INTRODUCTION

The rapid advances in health care technology worldwide have made accessing elective surgery on the day of surgery admission increasingly common. The Victorian Government in Australia, Department of Human Services Patient Management Taskforce (2000) has found no evidence that admitting people on the day of surgery delays discharge or increases mortality or morbidity. Day surgery is considered by many to be a cost-effective method of utilising resources as it contributes to reduced waiting lists for elective surgery, as well as reduced lengths of stay for hospital in-patients. With the increase in day surgery cases, nurses are being challenged to provide quality patient care during short patient stays (Cleary et al 1999). The aim of this project was to assess patient satisfaction with day surgery at a large metropolitan public hospital in Melbourne, Victoria, Australia, (Hospital A), and to simultaneously re-test the reliability of a recently developed survey assessing patient satisfaction with day surgery.

Because patients prepare for day surgery procedures at home and return to their homes on the same day the procedure is performed, the potential exists for problems associated with day surgery procedures to be less visible than they would be for in-patients. Additionally, the rapid throughput of patients in these types of services makes auditing of patient satisfaction of the service delivery quite imposing both to patients and to health professionals. However, patient satisfaction is an important indicator of quality of nursing care delivery (Attree 2001). It is therefore important the tools used for measuring patient satisfaction are examined (Attree 2001; Merkouris et al 1999; Walker et al 1998; Lin 1996).

The reliability and validity of patient satisfaction tools utilised by Australian hospitals have never been formally

established (Ching and Ung 1997). The proliferation of untested tools could provide a misguided assessment of patient satisfaction. Additionally, major funding cuts to health care in Australia and the introduction of case-mix funding in the 1990s have had a detrimental effect on patient care. Toy and Davies (1998) have reported that patients are spending more time on trolleys, there is less time for nursing staff to talk to patients, and there has been a reduction in patient privacy, all of which affect patient satisfaction.

BACKGROUND

The aim of this study was to assess patient satisfaction with day surgery using survey methodology in a large public metropolitan hospital (Hospital A) in Victoria. In most western countries, day surgery as a mode of health care delivery is considered to be an efficient approach to addressing increasing surgical caseloads and cost containment in acute care services (Dougherty 1996; Hutson 1996). Despite an increase in day surgery in Australia (Cleary et al 1999; Dodson and Ellis 1996), the majority of research relating to day surgery has been conducted in other countries, typically by telephone interview.

Some findings relating to patients' satisfaction with day surgery highlight the minimal disruption day surgery causes to patients' personal lives (Law 1997; Otte 1996; Davies and Tyers 1992). Reasons for patients' discontent with day surgery include long periods of waiting for surgery on the day of admittance (Bain et al 1999; Law 1997); unsatisfactory discharge planning (Dougherty 1996; Noon and Davero 1987); and, inadequate communication, or difficulty in remembering verbal advice (Brown and Duxbury 1997; Lancaster 1997; Sigurdardottir 1996). Negative experiences after discharge, such as inadequate pain control, have also been highlighted in literature (Coll et al 1999; Stoker et al 1999; Waterman et al 1999; Mackintosh and Bowles 1998; Salvage 1998; Oberle, Lewin and Razis 1995; Allen and Lynkowski 1994; Hawkshaw 1994; Firth 1991; Fraser et al 1989).

The definition of patient satisfaction is diverse (Bond and Thomas 1992; Lin 1996), although it has been argued that patient satisfaction is an indicator that informs health professionals as to whether patients' needs have been met (Cleary et al 1999; Merkouris et al 1999; Edmondson 1995; Long and Greeneich 1994). Satisfaction with care relates to, and is dependent upon, patient expectations (von Essen and Sjoden 1991), which may be influenced by age, gender, culture, previous experience, health status, communicative ability of health professionals and patients' ability to understand information given to them (Bond and Thomas 1992; Otte 1996). However, it may be argued that meeting patient expectations does not equate to quality of care, although it may correlate with patient satisfaction.

Description of 'Hospital A' day surgery context

At the time the study commenced in April 1999, day procedures were temporarily housed in a joint medical/surgical ward where patients were admitted, assessed, and taken directly into the operating theatre for the procedure. Recovery and discharge took place in the same area. The design of this unit was less than ideal. There were limited changing facilities or interview rooms and patient privacy was difficult to maintain. In July 1999, day procedures moved to a refurbished, although not purpose-built, day surgery unit. The environment adequately suited day procedure needs, with large rooms for waiting and recovery, and four private rooms for admitting and assessing patients. The Day Procedure Unit (DPU) currently admits up to 42 patients per day, including multi-day stay patients who are admitted on their day of surgery, day surgery patients and patients for endoscopy.

METHOD

A Patient Satisfaction Survey designed by Ching and Ung (1997) was utilised for this study. The survey was informed by the work of Courts (1995) and included specific items relating to the patient's pain management, education and decision-making. There were six sections that addressed demographic data, satisfaction with admission, the operation (including pain management), the environment, discharge and general rating of satisfaction. Each section was explored by a series of questions broken into 'items' or sub-questions that addressed a distinct aspect of services. For example, the section titled 'satisfaction with admission' explored patient satisfaction with information received before and after surgery, reception, nursing and technical staff, and waiting times.

Questions were answered using a Likert-type 5 point scale ranging from poor, good, very good and excellent to not applicable, yes/no responses, and the opportunity to make additional comments to elicit quantitative and qualitative data from patients. Qualitative information was extracted and content analysis performed according to Ely et al (1996). The survey tool was found to have 'Cronbach's α ' co-efficients of 0.85 to 0.96 (mean=0.92, SD=0.1511) when it was first piloted in another institution, suggesting an acceptable degree of internal consistency. Factor analysis revealed only one construct per question, while significant Pearson correlation co-efficients were observed in almost all questions.

Two hundred and sixty-seven patients attending day surgery who met the selection criteria out of a total pool of 2512 agreed to be mailed a package that was sent to them approximately one week after discharge for consideration. The selection criteria stipulated that the participant had to be over 18 years of age; be able to read and understand English; and have undergone day surgery and been discharged home on the same day. The package

included a plain language statement of the survey, a consent form with separate envelope, a questionnaire and a self-addressed, stamped envelope for return to the researcher.

A total of 107 patients responded, representing a response rate of 41%. Given that expected return rates for this type of survey can be as low as 20-30% (Dillman 2000; Salant and Dillman 1994), and that ethical clearance for this study did not permit reminder letters to be sent out, the response rate was high, and reflected patient interest in contributing to this area of research. However, selection bias is recognised. The non-respondents may have been a group who were satisfied with the services, but did not think the survey was an important feedback mechanism for quality assurance. Of course, it is equally plausible the non-respondents were dissatisfied with the services and dismissive of the survey as a feedback mechanism. Additionally, it is relevant to note half way through data collection, day surgery patients were relocated to a refurbished day procedure unit, effectively dividing the data into two parts. Forty responses were returned from participants attending the original day surgery unit, and 67 participants commented on their experience of the refurbished day surgery unit.

QUANTITATIVE FINDINGS

The age, gender break-up and occupation of patients who responded to the survey are summarised in Table 1.

To determine whether overall ratings of satisfaction were affected by the age, gender and occupational status of patients, a 2x2x6 analysis of variance was performed. There were no significant differences between overall ratings of satisfaction for occupational status ($F(1, 87)=0.00, p>0.05$), gender ($F(1, 87)=0.78, p>0.05$) and age ($F(5, 87)=0.70, p>0.05$). See Table 2 for means and standard deviations.

Interactions between age and gender ($F(5, 87)=0.40, p>0.05$), gender and occupational status ($F(1, 87)=0.06, p>0.05$), age and occupational status ($F(4, 87)=0.29, p>0.05$), and age, occupational status and gender ($F(2, 87)=0.08, p>0.05$) were also not significant. These results indicate that there were no differences between age, gender and occupational status on overall ratings of satisfaction. Therefore, these demographic variables did not seem to contribute to overall ratings of satisfaction.

Data collection included the period in which the DPU moved premises. As a result, a series of independent t-tests were calculated to determine whether there were any significant differences between patient satisfaction levels in the old and new environments. It was found there were no overall significant differences ($p>0.05$) between patient satisfaction levels prior to and after the change of environment in this data. Examination of individual survey items indicated that at no time, either before or after the change of environment, did patients' average ratings of satisfaction with services provided by Hospital A fall below a rating of 'good'. Average ratings of individual survey items indicated that patients considered

Table 1: Age, gender and occupation of patients

Patient demographic variables	Number of patients	Patient demographic variables	Number of patients	Patient demographic variables	Number of patients
Age (years)		Gender		Occupation	
18-25	12	Male	47	Paid employment	42
26-35	21	Female	50	Unemployed	9
36-45	14	Total	97	Home duties	16
46-55	18	Missing	10	Retired	30
56-65	16	Total respondents	107	Other	8
66+	23			Total	105
Total	104			Missing	2
Missing	3			Total respondents	107
Total respondents	107				

Note: Unequal total numbers for age, gender and occupation are due to patients omitting to fill in the information requested in the survey.

Table 2: Overall ratings of satisfaction in gender, age, and occupational status

	Male	Female	Paid employment	Not employed	Age					
					18-25	26-35	36-45	46-55	56-65	66+
	4.06	3.82	4.46	4.59	3.83	3.85	3.92	3.59	4.06	4.32
SD	0.87	0.96	0.65	0.53	0.72	1.09	0.62	1.06	0.68	0.95
n	47	51	42	63	12	21	14	18	16	23

Note: The 'not employed' included those who were unemployed, involved in home duties, retired and other. The total numbers for gender, employment and age do not always add up to 107 participants due to patients omitting to fill in the information requested in the survey.

the courtesy and respect shown by nursing staff to be even better after the change of environment. Patients also considered doctors' knowledge and skills to be excellent.

Overall, the admission section demonstrated a rating of 'good' on the Likert scale, with a mean of 3.45 and a standard deviation of 0.73; the operation section had a rating of 'very good', with a mean of 3.9 and a standard deviation of 0.88; the environment section bordered between 'good' and 'very good', with a mean of 3.65 and a standard deviation of 0.77; and, the discharge section had a rating of almost 'very good', with a mean of 3.89 and a standard deviation of 0.90.

Factor analysis and reliability of the instrument

A principal components factor analysis with oblique rotation was performed to determine the factor structure of the Patient Satisfaction Survey responses for Hospital A. Eigenvalues pattern and structure matrices indicated that a one factor solution was the best fit for the data. The highest loading question was overall satisfaction with admission, operation, environment and discharge, which coupled with the eigenvalues suggested that the Patient Satisfaction Survey taps into a general satisfaction construct.

As shown in Table 3, the 'Cronbach's a' co-efficients were quite high, except for questions 6, 8 and 13. These questions have 'Cronbach's a' co-efficients lower than 0.7, which is the lowest coefficient that has an acceptable degree of internal consistency (Nunnally 1978). The differences in these items could be attributed to the complex social differences in the population group that may have influenced perceptions about quality of care (Walker et al 1998).

Many of the questions listed in Table 3 have a coefficient greater than 0.9, which could be regarded as too high by some researchers, and might even be an indication that items within each question provided similar information to the study. However, the sample size was relatively large. It is well known that an increase in person-to-person variation will result in higher values (Nunnally 1978). Moreover, a closer inspection of the question items reveals that they are not quite the same. Each of the question items address a distinct aspect of the services. Hence, it is reasonable to conclude that the questionnaire has an acceptable degree of internal consistency.

QUALITATIVE DATA ANALYSIS

Despite severe funding cuts to public health care resulting in staff shortages and limited resources, at no time did our sample of patients' ratings of satisfaction fall below 'good'. Consistency of services was also noted in the qualitative data: *'This was my 5th procedure at [Hospital A] - as usual, everything was excellent.'* However, content analysis (Ely et al 1996) of the data revealed some significant areas of patient discontent before and after the move into the new unit that are discussed under the following four major headings.

Admission

The majority of patient dissatisfaction regarding admission related to long waiting times. Fourteen percent of respondents had experienced waiting times of between two and nine hours. For example, one respondent noted: 'Had to arrive at 6.30am, but didn't have operation until after 2pm. Long waiting periods.' This comment exemplifies a persistent and major concern raised by patients attending day surgery centres. The location in

Table 3: Reliability analysis of the Patient Satisfaction Survey

Section	Question	Item*	Sample size	a**	No. factors***
B Admission	4	a-f	42	0.80	1
	5	a-d	89	0.85	1
	6	a-g	91	0.57	1
	7	a-f	93	0.95	1
	8	a-c	96	0.36	1
C Operation	12	a-j	86	0.96	1
	13	a-g	93	0.67	1
D Environment	22	a-d	106	0.90	1
	23	a-d	102	0.93	1
	24	a-d	90	0.95	1
E Discharge	30	a-d	61	0.93	1
F General	32	a-d	100	0.87	1

* Each question consists of a subset of questions from three to 10 items. **Cronbach's a. ***Number of factors identified using principal components analysis with oblique rotation.

which the patient had to wait was also important. Waiting for long periods in an uncomfortable chair or on a trolley in a particularly vulnerable period was seen to be problematic: *'Left on trolley outside theatre for at least three hours waiting for my operation. The nurses were lovely and caring but the wait was long and tedious.'*

The operation

Unsatisfactory communication with medical staff regarding the operation was an area of dissatisfaction. Those patients who managed to see their surgeon pre-operatively thought their discussions may have been overheard by others, which threatened their privacy. A few did not know who their surgeon was, or were offered no explanation of their surgery. However, comments relating to the operation period itself revealed some respondents received excellent explanations from their surgeon and anaesthetist. Some comments, though, were made about medical staff demonstrating a lack of compassion: *'The only thing the surgeon said to me was: "Which leg are we operating on?". I told him. And then he said: "We won't be long now"! No explanation of the operation, no time for questions. Very cold and mechanical!'*

Anaesthetic staff were also noted to lack sensitivity at times: *'The anaesthetist was very blunt and to the point. Extremely rough when putting the drip in (it took two goes). I explained that pethidine made me sick and they made me feel ridiculous.'*

Specific complaints about nursing staff related to inaccurate or confusing information given to patients, and failure to respond to patient needs post-operatively. For example: *'Nurses - short staffed - patients not given considerable time and attention as required - I felt very sorry for older patients who could not help themselves nor reach the buzzer - sometimes I had to buzz for them as they were yelling and no-one cared to hear or attend until I buzzed. It was too late sometimes. Very poor attendance.'*

Postoperatively, a significant number of respondents stated their pain was poorly managed in that the attending nurses withheld analgesia or failed to provide stronger analgesia at the patients' request: *'Even though I protested that panadeine would not touch the sides, this was all I was given.'*

Environment

Qualitative data revealed a different story to the statistical analysis, in that some patients thought the waiting room was dull and too small for the number of patients. Comfortable seats and up-to-date reading materials were seen by some patients to be important factors in reducing the anxiety of waiting: *'We spend a long time in the waiting room. To me it was very sterile, with seating that was quite uncomfortable, after three, four, five hours. Liven up the area up a bit. Plants, posters, more interesting reading material, better colours etc.'*

Another concern raised was the lack of privacy. Temperature and noise levels were additional concerns:

'When you have been raped of all your clothes you feel not very comfortable sitting in a public visiting room with the thin gown and slippers on. I felt very bad and at one stage even cried.' This demonstrates just how helpless some patients feel having day surgery, and the importance of being aware of individual patients' needs, such as privacy and warmth, when providing patient care.

Discharge

Patient comments that were consistent with the literature review included that there was inadequate discharge planning. Specifically, respondents felt there was inadequate information given on the details of the operation, follow-up appointments, and potential problems and their management, including pain and wound management. When written information was provided, some patients thought it difficult to understand, incomplete or included medical jargon that needed explanation: *'[I] was given no contact details if a problem arose, and very, very poor instructions about managing at home.'*

Respondents also requested education on pain management, such as what to expect, what complications might occur, types of analgesia and their actions and strength: *'I would have liked post operative instructions [about] what pain killer etc [strength] I could take and what other care and medication to take. After a couple of days, I went to the chemist to ask for help.'*

Other patients' analgesic requirements were neglected because they had been given regional analgesia, but when this wore off, they were left in pain: *'Because foot was still numb, I was not given any pain killers to go home with after the numbness had worn off.'*

DISCUSSION

It was of interest that the statistical data gleaned from utilising a survey tool with an acceptable degree of internal consistency gave a very positive view of day surgery, and that patient demographics and the move mid-data collection to the refurbished day surgery unit did not affect the overall ratings of patient satisfaction. The qualitative data, however, indicated a negative view of day surgery. This seemingly paradoxical situation is hard to understand and one can only speculate as to why this was so. Perhaps some explanation may be that the scale utilised a rating where 'good' equated with 'satisfactory', and that qualitative responses tend to draw more information from the participant. Whatever the case, because the qualitative data revealed a different picture, the development of survey tools that include personal comments will enable researchers to obtain a broader picture of patient satisfaction.

The qualitative findings were consistent with those in the literature review, suggesting that despite research, little has changed in relation to day surgery discontent. The persistence of unacceptable waiting times (Bain et al

1999; Law 1998; Otte 1996), poor communication (Brown and Duxbury 1997; Lancaster; 1997; Sigurdardottir 1996) and pain management (Coll et al 1999; Waterman et al 1999; Mackintosh and Bowles, 1998; Salvage 1998; Lewin and Razis 1995; Hawkshaw 1994; Firth 1991; Fraser et al 1989) was particularly problematic. Most of our respondents said the wait, whether in day surgery or in the preoperative holding room of the operating suite, was unpleasant and enhanced feelings of anxiety and discomfort, such as pain, hunger, thirst, loneliness and a lack of privacy.

Long waiting times are often unavoidable due to emergencies, unforeseen delays and re-scheduling of operating lists. Nevertheless, proactive management can put strategies in place to reduce waiting times. Often patients attending day surgery are admitted either all at once in the morning, or, at best, in two streams - around 7 am and 12 midday - to meet estimated operating times. Staggering patient admissions or simply booking operation times would ensure a more prompt service.

Prior to surgery, patients need to be clearly forewarned there may be delays in their planned surgery times. Some patients in this study were under the illusion they would be operated on soon after admission. Keeping patients informed of delays as they occur may also help them manage the wait better and not feel forgotten. Bringing along a friend, a good book, a hobby, a personal music system, or a laptop or computer game may help patients during this period. Patients also need to know before the day that there is secure storage for their valuable belongings. In the absence of the above, pleasing surroundings in day surgery offering diversion opportunities such as TV/videos with earphones, and a variety of reading material may help ease patient stress over long waiting periods.

Issues relating to a lack of privacy were also significant in this study. It has been shown that even though patients are only in hospital for one day, they consider the experience far from minor (Salvage 1998) and require the same attention, respect and privacy any major operation or hospital stay engenders. For example, patients need not change into a gown until immediately prior to surgery when the previous case has been completed, and should they choose to walk to theatre, a dressing gown is essential. Additionally, confidential discussions between patient and doctor are a basic right and are to be respected in all health-care contexts, including day surgery.

The issue of postoperative pain is a common problem, as reported in the literature review, and requires urgent attention. Strategies to meet this area of concern include: regular staff development sessions in pain management informed by evidence based practice; implementation of a pain management group to ensure patients receive adequate analgesia and education; development of a pain algorithm for nurses to use in pain assessment; and, development of a pain management protocol for patients after discharge. Given regional or local anaesthetic techniques are becoming more popular, it is imperative

patients receiving this type of anaesthetic are given adequate pain relief for when the anaesthetic agent wears off. Multimodal analgesia, pre-emptive analgesia (Goodwin 1998), and analgesia specific to an operation (Marquardt and Razis 1996) are also helpful in managing postoperative pain. Essentially, day surgery nurses must have current knowledge of analgesic practices to meet optimal standards of patient care.

Discharge planning is an essential component of the day surgery nurse's role (Dougherty 1996). As verbal advice is not always remembered after surgery, information for each type of surgery, including relevant phone numbers and follow-up appointments, was developed during this study to meet the post discharge needs of patients. The development and routine utilisation of a simple check list (Noon and Davero 1987) or possible day surgery 'pathway' (Baker et al 1999) ensuring all details have been attended, such as communication covering surgery, pain management and discharge planning, may be worth pursuing in order to ensure a holistic approach to patient care. Additionally, 'hospital in the home' support may be necessary for following up on patients who are experiencing difficulties in their homes. Indeed, it may have been that some of the patients in this study would have liked to stay in hospital overnight. In a study on patient satisfaction with day surgery, Law (1997) found that some patients would have liked additional time to recover in hospital prior to going home.

Paramount to effective nursing practice is patient comfort and care informed by individual assessment (Coll et al 1999). Two nurses were commended on their caring approach by a number of respondents in this study, which offers evidence of standards of excellence. However, patients indicated they had experienced poor communication. In particular, medical staff need to be aware of patients' specific concerns regarding communication and be prepared to alter their practices accordingly.

CONCLUSION

With the continual improvement and utilisation of the pre-admission clinic of hospitals, together with changes in surgical techniques and support services such as those offered by the 'hospital in the home', programs the numbers of patients being treated on a day-stay basis will continue to increase. This justifies the need to regularly monitor and improve the services available to these patients for the short period of time they are in hospital. In order for nurses and the health care team to meet advances affecting health care delivery and patient satisfaction, the continual review of documentation and processes together with the development of and improvement in patient satisfaction tools is paramount.

Data obtained from this survey indicate overall patient satisfaction pre and post relocation of the unit. It is anticipated the Hospital A nursing staff will aim for increased throughput and expansion of the day surgery

service together with improvement in the problem areas highlighted in the survey. Waiting times, communication and pain management were particularly problematic and require urgent attention. Improvements in these areas have already been implemented based on the findings of this study.

Nevertheless, it was disappointing to see previously reported areas of patient discontent such as long waiting times continue to be a problem, suggesting there have been insufficient resources to provide patient satisfaction. This study also suggests that nurses continue to poorly manage pain. The development of clear guidelines for novice staff and on going staff development would inform better pain management practices. Additionally, a multidisciplinary approach to develop specific strategies addressing pain management would also be of benefit, as would the development of a specific day surgery pain management team. Further research would help to clarify why problem areas previously identified in the research have not been addressed.

Readers should be mindful the responses presented in this study represented less than half of those invited to participate at Hospital A. However, this survey provided some insight regarding the services provided to patients in a day surgery centre. This research also highlighted that beneath statistics lies more detailed information that can be used to inform and improve nursing care and patient satisfaction.

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NURSING STAFF SHORTAGES: ISSUES IN AUSTRALIAN RESIDENTIAL AGED CARE

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ABSTRACT

Like many other countries in the world, Australia is grappling with a chronic shortage of registered nurses (RNs). All areas of nursing are currently affected by shortages and high care residential aged care services are no exception. Selection, recruitment and retention of suitable staff to meet the complex needs of residents in aged care facilities are becoming increasingly challenging and must be addressed as a matter of priority. This paper explores the current nursing shortage, looks ahead to identify future threats to a viable nursing workforce in residential aged care, and raises some issues for future consideration.

INTRODUCTION

Residential aged care services present special challenges for nurses. With few exceptions they provide long-term residential care for frail older people. Though today's residents in aged care facilities require unparalleled levels of skilled nursing care, the staff mix is quite different to that found in hospitals and other health care settings, with markedly fewer RNs and most direct care provided by assistants in nursing or to a lesser extent, enrolled nurses (Jackson and Raftos 1997).

However, the increasingly complex nature of care required by residents in aged care facilities can put pressure on nursing staff. The literature hints at some tensions related to staff mix (Jackson and Raftos 1997; Nazarko 1997), and Edgson and Caird (1998) acknowledge that recruitment difficulties can make it difficult to establish an ideal skill mix in individual aged care facilities. Furthermore, RNs in aged care facilities can experience a sense of professional isolation as they frequently operate in a sole RN setting. Thus, it can be very difficult to access the benefits of collegial support from other RNs.

Issues relating to job security, prospects for professional advancement and a belief they will be asked to put profits ahead of patients are identified as contributing to problems associated with the recruitment of RNs in aged care settings (Nazarko 1997). Skilled RNs are vulnerable to being deemed redundant because of costs associated with their employment in residential aged settings (Fine and Stevens 1998) and this in itself may be a disincentive for nurses looking to choose a career path in aged care. Yet, despite the fact that an estimated 57% of direct care to older people is provided by untrained staff (Fine and Stevens 1998), there remains a high demand for skilled RNs in residential aged care settings.

IMAGE OF AGED CARE

Nursing in aged care has some image problems and these problems pervade nursing as well as the wider community. Residential aged care is caring focussed more than curative, and Happell (1999) refers to a dichotomy in which caring aspects of nursing practice are considered to be subordinate to the curative aspects of health care. The long-term nature of residential aged care means there is a low turnover of residents and discharge is not normally a realistic option - thus there is a view the care of older people is boring and without reward (Happell 1999).

Ageism is undoubtedly also an issue in-so-far as nurses who opt for a career in a residential aged care setting may feel they are seen as being less skilled and having a lower status than other nurses (Nazarko 1997; Happell 1999). Lueckenotte (2000) describes ageism as a form of prejudice against older people characterised by bigotry, intolerance and negative stereotyping. Perhaps a form of ageism can also taint people associated with aged care, as Nazarko (1997) states that nurses who work in aged care are considered to be less skilled than other nurses and are lowly placed in the nursing hierarchy.

According to the literature, educational programs have fostered a climate of negativism towards aged care (Eliopolous 2001) and this is supported by research evidence suggesting Australian undergraduate nursing students hold very negative perceptions about working with older people, and most place it at the very bottom of their list of preferences (Happell 1999). They cite issues such as boredom, repetition and negative past experiences for their reluctance to enter aged care (Happell 1999).

Aged care facilities themselves are considered undesirable work settings by some, because of perceptions they are very difficult in terms of physical work, and unrewarding in terms of job satisfaction (Nazarko 1997).

There is also the perception that aged care facilities are somehow isolated from mainstream nursing so opportunities to give and receive collegial support is reduced (Jackson and Raftos 1997). Regular media reports highlighting poor standards of care in residential institutions do nothing to enhance aged care, particularly residential aged care, as a career option for nurses.

VIOLENCE AND OCCUPATIONAL INJURY

Aged care is physically demanding and as with most types of nursing there is always a risk of occupational injury. Risks associated with mobilising residents, needlestick injuries and other environmental hazards are well known. However, violence against nurses is also a significant problem for aged care and has been linked to nurse absenteeism and resignation (Nabb 2000). Nurses are more likely to experience workplace assault than other health professionals (Carter 1999/2000), and the level of violence and assault against nurses is under-reported and

increasing (Erickson and Williams-Evans 2000). Though violent outbursts and aggressive incidents may be related to perceptual or behavioural difficulties of residents, violent or hostile attacks are not limited to residents themselves. Nabb's (2000) study of nurses (n=82) working with older people revealed that visitors were a major source of violence and aggression, with 59% of nurses in the study reporting at least one episode of verbal abuse in the previous 12 months, and 20% reporting physical violence from visitors on up to five occasions in the same period. This physical violence was most commonly in the form being pushed, hit or grabbed (Nabb 2000). Respondents in Nabb's (2000) study felt violence and aggression from visitors was associated with organisational issues such as low staffing levels and unachievable visitor expectations.

JOB SATISFACTION

Job satisfaction is known to be a significant factor in staff retention and though it is subjective in some ways there are certain issues that have consistently been associated with nurses' job satisfaction and retention of nurses in the workplace. These include factors such as workplace values, prospects for career advancement, workload and working conditions, nurse/patient ratios, professional autonomy, input in decision making, management styles, supportive and positive workplace relationships and a sense of belonging (Missener et al 1996; Leveck and Jones 1996; McNeese-Smith 1997; Mills and Blaesing 2000; Sheilds and Ward 2000; Winter-Collins and McDaniel 2000).

In nursing, job dissatisfaction has been associated with feeling unsupported and unrecognised, dislike of management styles, emotional fatigue, lack of opportunities for career progression, pay issues, workload and workplace relationships (Leppa 1996; McNeese-Smith 1997; Sheilds and Ward 2000; Aiken et al 2001). Quality of leadership, perceived managerial shortcomings in addressing problems and conflict with other nurses are also revealed as work-based stressors (Healy and McKay 1999; Fletcher 2001).

Organisational change can have a detrimental effect on nurses' job satisfaction. Restructures resulting in downsizing or revision of work practices can result in nurses feeling devalued (Droppleman and Thomas 1996; Fletcher 2001). Droppleman and Thomas (1996) describe nurses feeling powerless, and comment that many nurses 'feel caught in the maelstrom of today's health care environment - tossed about by forces we have no control over' (p.26). They go on to say that the nurses in their study felt excluded from momentous decisions and unable to effect change, and position these issues as a major source of job dissatisfaction (Droppleman and Thomas 1996). There is evidence to suggest that this is certainly true in aged care settings, and Nazarko (1997) describes several examples of nurses resigning from aged care

facilities, citing disillusionment and an inability to perform to their desired level because of organisational changes that had made their working lives untenable. When considering the costs associated with staff replacement and recruitment, it is surely false economy to initiate changes that will result in loss of skilled and experienced staff.

LOOKING AHEAD

There are two major threats to the future supply of nurses. Firstly, nursing is experiencing declining enrolments in undergraduate programs, and this is a worldwide phenomenon (STTI 2000; Fletcher 2001). Secondly, the nursing workforce is ageing. Worthington (1990, p.190) used the term 'nursing's demographic time bomb' to capture the crisis facing nursing. The ageing workforce is also an area of international concern, with evidence suggesting that 50% of RNs in the UK are aged 40+ (Wells and McElwee 2000) and the average age of employed RNs in the US is 42.3 years (Peterson 1999). Australia has a similar demographic, with 1995 figures suggesting that the average Australian nurse was then aged 39.3 years (Williams, Chaboyer and Patterson 2000). These figures suggest that a large number of nurses, perhaps as high as 50% of the current workforce will reach retirement age in 15 to 20 years. In some parts of the world 30% of the nursing workforce are expected to retire over the next six to eight years (Purnell et al 2001).

WHERE TO FROM HERE?

Like nursing generally, the aged care sector has many challenges ahead to ensure adequate supplies of skilled RNs. In view of the ageing nursing population, there needs to be a steady stream of newly graduated nurses entering aged care to replace nurses who are approaching retirement. Currently, it seems that new graduates are reluctant to enter aged care because of negative perceptions (Happell 1999). These must be challenged and replaced with positive perceptions about aged care as a valid and dynamic career choice. These negative perceptions are firmly entrenched, but there are various ways they may be challenged.

Eliopolous (2001) suggests undergraduate educational programs for nurses have contributed to the general negativity towards aged care. There is an onus then to critically review the way ageing, aged care and nursing in aged care are presented to students. Education providers also need to ensure their educational materials challenge pervading stereotypes and present a range of relevant images. Care must be taken to avoid contributing to ageism, both through educational materials and teaching/learning activities. Happell (1999) also suggests that students are reluctant to enter aged care because of negative past experiences, so there is also an onus on aged care facilities themselves to create more stimulating and dynamic learning environments for undergraduate

students on clinical placements. Thus, the stereotype that aged care nursing is boring and unrewarding may be undermined. Nursing students of today are RNs of tomorrow, and giving them a positive learning experience is an investment in the future.

Job satisfaction is a key variable in staff retention and as noted earlier in this paper, the opportunity for career development is identified strongly in the literature as being a crucial aspect of job satisfaction. It is important that nurses working in the aged care sector are availed of support and opportunities to develop professionally. There are many ways this can be achieved and, indeed, considerable efforts are already being made in this area by some organisations. Nazarko (1997) reports there are benefits to be had by investing in staff and supporting them in their educational and professional development. It is important nurses experience the workplace as a place of learning and professional development, because while people are learning and developing their skills, there is less likelihood boredom will become a problem.

Though not yet widespread, some aged care facilities have developed links and partnerships with educational providers and have conjoint staffing arrangements, even to professorial level, as a means of fostering a learning environment in the workplace. In the future these partnerships will continue to develop, and it may be possible that industry will contribute further to the professional development of their staff by providing scholarships for nurses who wish to progress their qualifications while remaining substantively employed in the aged care setting.

Workplace values are also identified as being an important aspect of job satisfaction. Nazarko (1997) identifies a belief that they will be asked to put profits before people as being one reason nurses cite for being reluctant to work in aged care facilities. This is a very important workplace value and there is a clear challenge to aged care proprietors and managers to demonstrate that people do come before profits. It may be timely for a comparative study of job satisfaction in 'for profit' and 'not for profit' facilities to be undertaken, to examine any differences in nurses' perceptions of satisfaction, as well as other indicators such as turnover of RNs.

Encouraging positive professional interactions between nurses employed in acute, community and residential aged care can only help nurses in these sectors to develop stronger professional identities and avail themselves of peer support opportunities. It may also reduce the sense of professional isolation that can occur for RNs in aged care facilities and contribute to positive workplace dynamics. This can be facilitated by providing opportunities for nurses to network through seminars, conferences and other workplace based meetings. Community nurses and nurse consultants can be invited into aged care facilities to assist in planning care for challenging residents and provide other support to staff.

There is also a challenge to develop strategies to reduce the risks arising from aggression and violence. Research findings suggest this issue is not getting enough acknowledgement or attention (Nabb 2000). Staff need to say no to violence in the workplace. Facilities should initiate measures to identify the frequency and explore the sequelae of aggression and violent incidents against staff. All attempts must be made to reduce episodes of violence and aggression, and to minimise negative sequelae. Aggressive residents should be managed in a way to minimise risk to staff and visitors who assault staff should be subject to criminal charges.

There is also a need to adopt managerial policies that are inclusive of nurses and to avoid organisational change that will negatively influence nurses' job satisfaction. Evidence from the literature suggests that non-consultation in change processes, particularly those that influence how nurses work, or the amount of care that can be given is likely to result in loss of staff (Dropleman and Thomas 1996; Nazarko 1997). This means nurses must be consulted in change processes and managers need to be mindful of the risk of loss of staff and consider this when doing cost benefit analysis.

CONCLUSION

Residents in aged care facilities require increasingly complex care and the need for qualified and skilled nursing staff has never been greater. Currently, nursing is experiencing difficulties in maintaining an adequate workforce and the ageing population (including the nursing workforce) means more challenges lie ahead. Innovative and creative strategies are urgently needed to improve the image of aged care nursing and promote aged care as a career specialty for nurses. Failure to do this will result in a crisis of care that will jeopardise the health and well-being of those requiring residential aged care.

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