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NURSES' PERCEPTIONS OF SPIRITUALITY AND SPIRITUAL CARE

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KEY WORDS

spirituality, spiritual care, nursing

ABSTRACT

Objective

The study was conducted to determine the perceptions of nurses regarding spirituality and spiritual care.

Design

This descriptive-type study was carried out in three hospitals in a province in the west of Turkey. The study's population was made up of 733 nurses working in these hospitals and the sample consisted of 289 nurses who agreed to take part in the study. The data were collected using the nurses' defining characteristics data form and the Spirituality and Spiritual Care Rating Scale.

Results

It was established that 96.9% of the nurses included in the study had not received any training regarding spirituality and spiritual healing. The Spirituality and Spiritual Care Rating Scale point average for nurses in the study was determined to be 62.43 ± 7.54 .

Conclusions

It was established that nurses do not receive sufficient training on the subject of spiritual care, both before and after graduation; but also that their perception of the topic is quite high.

INTRODUCTION

Spirituality has been known as an important aspect of holistic patient care (Martsof and Mickley 1998) and is a complex and subjective concept that can be applied in various fields.

Spirituality has been defined as a concept which: encompasses all of an individual's aspects (Strang et al 2002; Reed 1992); is more comprehensive than religion (Rennick 2005; Baker 2003); involves both interpersonal relationships and those about the meaning of life, particularly at times of crisis and illness (Baldacchino 2006). Spiritual care is a recognised field in nursing (Baldacchino 2006) and an element of quality nursing care (McEven 2005).

Sawatsky and Pesut (2005) defined spiritual care as an intuitive, inter-personal, altruistic and integral expression of the patient's reality which is dependent on the nurse's awareness of life's transcendental aspect (Sawatsky and Pesut 2005).

Spiritual care has been found to be effective in developing coping strategies for patients in times of crisis, in them being at peace with themselves and in creating a positive view of life (Kociszewski 2003; Baldacchino and Draper 2001). There are also positive effects on patients' physical and psychological health (Wong and Yau's 2009; Culifford 2002). When the patient's spiritual and emotional needs are met, patient satisfaction increases (Lind et al 2011).

Spiritual care by nurses has been identified in three areas of competence. These areas are: personal awareness and communication, the spiritual dimension of nursing procedure, and the development of quality assurance and specialisation in spiritual healing. Despite the identification of the three areas, there is confusion regarding nurses' professional responsibilities (Van Leeuwen et al 2006).

Spirituality-related nursing diagnoses can be listed as spiritual distress, risk of spiritual distress, and development of spiritual well-being. The factors associated with these diagnoses are loneliness, alienation, deprivation, anxiety, pain, life changes and changes in values and belief systems (Doenges et al 2010).

Spiritual distress is a condition in a group or an individual that suffers disruption to the belief and value system from which vitality and the will to live are derived. Sources of spiritual distress include: the loss or illness of an important person; illness in the individual; conflict between treatment and beliefs; and barriers to the carrying out of spiritual rituals originating from family, peers and health workers (Carpenito-Moyet 2006).

Among the practices related to spiritual care on the part of nurses are: showing the empathy and compassion to inspire the will to live; attending to the patient's physical, emotional and spiritual aspects; listening to the patient's fears, worries and reflections and his/her spiritual story; helping patients to carry out their religious practices; and working together with interdisciplinary healthcare team members (Baldacchino 2006; Pulchalski 2001). The literature shows that nurses' spiritual care practices are inadequate (Baldacchino 2006; Narayanasamy 2003).

Among the factors which hamper the practice of spiritual care are: insufficient management support, manpower and resources, cultural factors, increased workload, and nurses' consideration that their knowledge and skills are insufficient to administer spiritual healing (Cockell and McSherry 2012; Wong and Yau 2010).

Insufficient coverage of the subject of spirituality in nurses' training programs is the most significant barrier in the administration of spiritual care (Baldacchino 2006; Smith and McSherry 2003).

If nurses have a knowledge of spiritual care and of concepts related to spirituality and if they use spirituality in nursing, this will contribute to the application of an integrated approach and thus increase the quality of care. This study was conducted with the aim of establishing nurses' perceptions of spirituality and spiritual care.

MATERIAL AND METHODS

Study Design

This descriptive study was carried out on nurses working at three hospitals in a region in the west of Turkey.

Data Collection

The data for the research were collected using two forms: the Nurses' Defining Characteristics Data Form (prepared by the researchers) and the Spirituality and Spiritual Care Rating Scale, developed by McSherry et al in the year 2002. The scale's validity and reliability for Turkey was assessed by Ergül and Bayık Temel in 2007 and the Cronbach Alpha Coefficient was established to be 0.76. The scale contains a total of 17 items and the subsections 'spirituality and spiritual healing', 'religiosity', and 'personal care'. The scale is a 5 point likert-type scale and the scoring is done from '1' – definitely do not agree, through to '5' – totally agree. Four items in the scale are reverse scored. If the total points average is close to 5, this shows there is a high level of perception of spirituality and spiritual healing (Ergül and Bayık 2007; McSherry et al 2002). The researchers who conducted the scale's validity and reliability studies for Turkey suggest the scale is evaluated by the total scale points. The scale can be used to determine nurses'/nursing students' perceptions on the subject of spiritual care (Ergül and Bayık 2007). The nurses who agreed to take part in the research were given the Spiritual Care Rating Scale and The Nurses' Defining Characteristics Data Form to fill in. The filling in of the forms took 15 minutes on average. Permission for the scale to be used in the study was obtained from the authors by email.

Ethical Consideration

Before the research began, the necessary written permission was obtained from the Denizli Province Health Ministry to conduct the research in the three hospitals. The nurses who participated in the research were informed of the study's aims and their answers would be anonymous, and questionnaires were given to those nurses who agreed to participate.

Data Analysis

The data were coded using the SPSS 11.5 program and the figure and percentage distribution of the introductory information were calculated. The Cronbach Alpha Coefficient was examined to test the scale's reliability in this study. The One Way Anova test and the Mann Whitney U test were used to analyse the relationship between the variables, and Correlation Analysis was used to analyse the relationship between the averages. Statistical significance was accepted as $p < 0.05$.

FINDINGS

The study's population was made up of 733 nurses working at three hospitals in a province in the west of Turkey. The sample consisted of 289 nurses who agreed to take part in the study.

The average age of nurses participating in our research was found to be 35.64 ± 6.03 . Nurses' identifying characteristics are shown in table 1. The Cronbach Alpha Coefficient was established to be 0.70.

Table 1. Distribution of Nurses' Identifying Characteristics

Identifying Characteristics	n (%)
Gender	
Female	275(95.2)
Male	14(4.8)
Speciality	
Medical	90(31.1)
Surgical	87(30.1)
Intensive Care	64(22.1)
Pediatrics	12(4.2)
Other*	36(12.5)
Working System	
Night-time	100(34.6)
Daytime	16(5.5)
Shift	173(59.9)
Position	
Staff Nurse	241(83.4)
Senior Nurse	37(12.8)
Charge Nurse	11(3.8)

* Emergency Unit, Blood Collection Unit, Training and Management Unit

The study found that 96.9% of nurses had received no training on spirituality and spiritual care and that 3.1% had participated in a course on the subject.

The Spirituality and Spiritual Care Rating Scale point average for nurses in the study was determined to be 62.43 ± 7.54 .

The relation between the nurses' identifying characteristics and the The Spirituality and Spiritual Care Rating Scale total point averages was analysed. No significant difference ($p > 0.05$) was found between total scale points and gender, speciality, working system, training regarding spiritual care, level of education and position held in clinic. There was a significant relation ($p < 0.05$) between the average age of nurses who took part in the study and the The Spirituality and Spiritual Care Rating Scale total point averages.

DISCUSSION

Spiritual care is an important concept which should be included in the training of nurses (Giske 2012; Baldacchino 2008; McSherry and Draper 1997). The effect of spirituality on health has been known in nursing ever since the days of Florence Nightingale (Macrae 2001) and the concept of spirituality plays a major role in the Neuman systems model as well as in the nursing theories of Parse, Watson and Newman (Martsof and Mickley 1998).

In recent years efforts have been made to integrate spirituality into the nursing curriculum (Pesut 2003). Some researchers have targetted the teaching of spiritual care to student nurses and have brought clarity to education strategies (Cone and Giske 2012; Narayanasamy 1999; McSherry and Draper 1997).

In spiritual care training, strategies for increasing students' awareness of the fundamentals of spirituality, supporting students in overcoming personal barriers and mentoring students' adequacy in spiritual care are important. Furthermore, nurses are important role models in spiritual care training (Cone and Giske 2012).

McSherry and Drapper have stated that there are internal factors (politics, socio-economics, management, etc) and external factors (social, cultural, religious, etc) which prevent spiritual care from being included in the nursing curriculum. In order for these barriers to be overcome, a certain degree of flexibility and tolerance needs to be exhibited in educational institutions. Before the spiritual dimension is integrated into nursing programs, researched, methodologically planned pilot projects should be carried out by consultants. When the basic principles have been established, they should be integrated into nursing education programs (McSherry and Draper 1997).

Narayanasamy developed the ASSET (actioning spirituality and spiritual care education and training) model for the easy implementation of spiritual care into the nursing curriculum. This model has been effective in altering nurses' knowledge of spiritual care and in enabling them to understand patients' spiritual care requirements (Narayanasamy 1999).

In Baldacchino's study (2008), it was stated that students studying spiritual care as part of their undergraduate course have an increased awareness of patients' spiritual needs and spiritual distress and also of coping strategies for their patients (Baldacchino 2008).

The continual training of nurses in spiritual care will ensure its implementation and development (Baldacchino 2006). It was established that 96.9% of the nurses included in our study had not received any training regarding spirituality and spiritual healing. In one study, nurses who had not been trained in spiritual care stated they felt inadequate in regard to the administration of spiritual care to patients (Baldacchino 2006). Yilmaz and Okyay (2009) conducted a study aimed at establishing nurses' opinions on spirituality and spiritual care. This showed that 65.2% of nurses had not been informed about spirituality (Yilmaz and Okyay 2009). In order for

nurses to provide qualified spiritual care, it is important that they are trained as part of their undergraduate education and also in postgraduate training programs.

The Spirituality and Spiritual Care Rating Scale point average for nurses in our study was determined to be 62.43 ± 7.54 . This average shows that nurses' perception of spiritual care is high. In the studies by Yılmaz and Okyay (2009) it was stated that nurses see spirituality as a part of integrated care and that the majority considered integrated care to be important (Yılmaz and Okyay 2009).

In nursing, patient care is approached in an integrated way. Nurses evaluate the patient's physical, mental, psychological and spiritual facets when giving care. Therefore, although there is insufficient training on the subject of spiritual care, nurses are aware of its significance.

CONCLUSION

Our study's findings support the hypothesis that nurses do not receive sufficient training on the subject of spiritual care, both before and after graduation; but their perception of the topic is quite high. Spiritual care has significant effects on patients' physical and psychological recovery. A contribution will be made to the improvement of quality of care by integrating spiritual care into nursing education programs and by including the topic in post-graduate training.

Nurses' spiritual care practices can be enhanced by provision of the necessary manpower and resources for nurses by managers and by further interdisciplinary studies and studies on spirituality and spiritual care.

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Nurse satisfaction with working in a nurse led primary care walk-in centre: an Australian experience.

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KEY WORDS

Walk-in centre, nurse led, nursing autonomy, advanced nursing roles, primary care

ABSTRACT

Objective

The aim of this study was to gain insight into the nursing staff's experiences and satisfaction with working at the ACT nurse led Walk-in Centre.

Design and Setting

Interviews with nursing staff working at the ACT Walk-in Centre were informed by a phenomenological approach. Questions were developed within inter, extra and intra-personal variables of satisfaction, underpinned by the principles of role theory.

Subjects

Twelve nurses were interviewed; three nurse practitioners and nine advanced practice nurses. Their ages ranged from 31 to 63 years and they had a minimum of 15 years of nursing experience. Interviews ranged from 30 minutes to two hours duration.

Results

Walk-in Centre nurses' satisfaction with a number of inter and extra-personal factors was associated with their previous education and experience (intra-personal factors). Role stressors included adapting to autonomy, role incongruity and lack of access to appropriate education, training and sources of collaboration and mentorship. Sources of satisfaction were the autonomous role, relationships with the team and the capacity to deliver quality nursing care.

Conclusion

Whilst autonomy is valued by nurses, this does not translate to isolation or independence. Autonomy is only a source of satisfaction when coupled with supportive and cohesive professional relationships with both nursing and medical colleagues. Organisations implementing advanced nursing roles must have a comprehensive understanding of the requirements of nursing autonomy to ensure effective role implementation and associated job satisfaction. These findings add impetus to the need for the development of nursing education programs tailored specifically to primary health care.

INTRODUCTION

New and innovative models of primary health care, including extended roles for nurses, are being introduced internationally in response to workforce shortages and subsequent diminished access to health care. Evidence has established that nurses can provide primary health care of a quality equal to that of doctors in terms of cost, use of resources and health outcomes (Desborough, Forrest et al 2011; Laurant et al 2005; Horrocks et al 2002; Venning et al 2000).

Nurse-led walk-in centres have been implemented extensively throughout the United Kingdom (UK) and recently introduced in the Australian Capital Territory (ACT), Australia. In the ACT a walk-in centre is defined as 'non-residential facility operated by the Territory for the treatment and care for people with minor illness or injury' (ACT Health 2010). The ACT nurse-led primary care Walk-in Centre was modelled on the Walk-in Centres in the UK. It is open from 0700 to 2300 hours seven days per week and is staffed solely by nurse practitioners and advanced practice nurses, who provide care for minor illnesses and injuries in accordance with clinical protocols. Appointments are not required, as the name suggests, patients can just walk in. In the first year of operation, approximately 1,100 patients were seen each month at the Walk-in Centre (Parker et al 2011). On opening, funding for the walk-in centre was ongoing.

In Australia nurse practitioners work autonomously and collaboratively in advanced and extended roles. They are educated to masters level (Gardner et al 2009) and the role includes the legislated capacity to prescribe medications and order diagnostic tests (ACT Health 2010). Advanced practice nurses in the Walk-in Centre have extensive knowledge and experience in the specific field of practice (Australian Nursing Federation 2009); however have no prescribing rights or capacity to order diagnostic tests.

These two levels of registered nurse have different requirements for the implementation of their roles. In the Walk-in Centre context, Advanced Practice Nurses work in accordance with pre-defined Walk-In Centre clinical protocols and are clinically responsible to nurse practitioners. In the ACT, nurse practitioners work in accordance with Clinical Practice Guidelines (CPGs). These provide a framework which guides the practitioners' autonomous practice through describing areas of clinical practice, functions of the role and referral processes (Desborough 2011). CPGs complement the nurse practitioners' defined scope of practice and if not already in place, must be developed within the first three months following recruitment to a position (ACT Health 2008). Operationally, all these nurses are responsible to the Assistant Director of Nursing.

The Australian Primary Health Care Research Institute (APHCRI) at the Australian National University (ANU) conducted an independent evaluation of the first twelve months of operation of the walk-in centre (Parker et al 2011). This paper reports on semi-structured interviews conducted with nurses at the Walk-in Centre conducted as part of this evaluation.

Nurse satisfaction

National and international literature is rich with research regarding nurse job satisfaction in the acute care sector (Hayes et al 2010; Dunn et al 2005; Bucknell and Thomas 1996; Blegen 1993; Gray-Toft and Anderson 1981). However, nurse job satisfaction in primary care and in particular, with working in nurse-led roles and in Walk-in Centres has only been observed in the UK National Health Service (NHS) (Rosen and Mountford 2002).

Understanding nurses' experiences and job satisfaction in the ACT Walk-in Centre is important in terms of this role as a new and attractive clinical career pathway for experienced nurses in Australia and its subsequent value as a retention strategy.

When higher levels of nurse job satisfaction are experienced, there is an increase in morale and commitment which makes it more likely a nurse will stay in the profession (Newman et al 2001). Nurse satisfaction is vital

for the provision of quality nursing care and subsequent patient outcomes (Bohannon-Reed et al 1983), for organisational commitment, the avoidance of staff absenteeism, turnover and workplace conflict (Cavanagh and Coffin 1992). Increasing job stress is associated with decreasing satisfaction amongst nurses (Blegen 1993).

Hayes et al (2010) identified three variables essential to nurse satisfaction; inter-personal, extra-personal and intra-personal. Inter-personal factors relate to interactions between the nurse and others. They include autonomy, direct patient care, professional relationships and educational opportunities. Extra-personal factors are those beyond a nurse's direct interactions with others and are influenced by institutional or governmental policies: pay, organisational policies such as the use of clinical protocols, routinisation and organisational constraints. Intra-personal factors refer to the characteristics nurses bring to the workplace: individual coping strategies, age and education (Hayes et al 2010).

A secondary influence on the nature of enquiry and analysis of data regarding nursing satisfaction in the Walk-in Centre is the fact that this is a new and innovative nursing role. The ways in which nurses transitioned to, and negotiated challenges to this role, and sources of role stress were of interest in this study; that is, what works and what doesn't work in the role (Handy 1993).

METHODS

Aim

The aim of this study was to gain insight into the nursing staff's experiences and satisfaction with working at the ACT Health nurse led Walk-in Centre.

Design

The methods were informed by a phenomenological approach; concerned with the study of experience from the perspective of the individual, their lived experience, and subjective analysis of that experience (Liamputtong and Ezzy 2005). This approach was considered the most appropriate to gain the nurses' perspectives. However, whilst pure phenomenology begins from a point free from preconceptions (Lester 1999), this study followed more recent approaches, clarifying the researchers' subjective views and including theoretical influences on the approach to interviews and their interpretation (Plummer 1983; Stanley and Wise 1993). The researchers were very much subjective actors in this study, adapting interviews iteratively in response to participants' experiences and emphasis on areas of concern. Regular team meetings facilitated this approach.

Theoretical framework

Hayes inter-personal, extra-personal and intra-personal variables (Hayes et al 2010) are consistent with other research on nurse satisfaction (Cortese 2007; Curtis 2007; Dunn et al 2005) and were considered suitable as a foundation for this study. Along with this, the principles of role theory (Handy 1993) informed the design of the semi-structured interviews and data analysis.

Sample

The sample was purposively chosen to include all nursing staff who had been employed at the ACT Health Walk-in Centre during its first year of operation. This included one staff member who had resigned from the centre prior to the evaluation.

Recruitment

All clinical nursing staff who had worked at the Walk-in Centre at the time of the independent evaluation (n=13) were invited to participate in this project; three nurse practitioners and 10 advanced practice nurses. Information about the project and participation was sent to nursing staff via email, addresses for whom were

supplied by Walk-in Centre management. This direct approach from the researchers was a deliberate attempt to avoid a recruitment approach through management, which might be perceived to exert pressure on staff to participate. Staff willing to participate contacted the research team via email or telephone to arrange a time and date to participate.

Data collection

Participation comprised a face-to-face interview, prior to which, participants were required to sign a consent form. The interviews took place in February 2011, at various times and locations determined as convenient to participants, with consideration made for privacy.

Interviews were conducted by three members of the research team and were audio-recorded and transcribed verbatim.

Data analysis

Interviews were transcribed by a transcribing service, and identifying information about the participants removed. NVivo 8 software (QSR International Pty Ltd., Melbourne, Australia) was used to manage the data and facilitate coding. Transcripts were analysed by one of the researchers, with a focus on identifying ideas, concepts and patterns, the way in which they fell within identified intra, extra and interpersonal variables and comparison for similarities, relationships and tensions (Braun and Clarke 2006). Analysis and interpretation was discussed with the other researchers at regular team meetings.

Ethical considerations

Ethics approval to interview the nursing staff at the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.10.407) and subsequently given expedited approval by The Australian National University Human Research Ethics Committee (protocol no. 2010/649).

Rigour

Research rigour was enhanced through respondent validation and regular team discussions (Barbour 2001). Transcripts were emailed to all participants for their perusal and comment prior to data analysis. Coding and analysis of the dataset was discussed at team meetings to ensure thoroughness of data interrogation and to discuss insights into data interpretation.

RESULTS

Twelve nurses agreed to participate: three nurse practitioners and nine advanced practice nurses. Their ages ranged from 31 to 63 years and they each had a minimum of 15 years of nursing experience. Interviews ranged from 30 minutes to two hours duration.

A number of themes emerged, most of which fell within the inter-personal and extra-personal variables. The intra-personal variable seemed to relate mostly to how the nurses education and experience influenced their perception within the other two variables. Within each variable areas of satisfaction and sources of stress were described.

Inter-personal factors

Team relationships provided support

All participants identified their nursing colleagues as their primary source of support, collaboration and mentorship. These relationships were seen to sustain them throughout their initial transition to practice in the Walk-in Centre, which many found difficult.

Respondent 8: *...we had good teambuilding in the beginning and that allowed for really strong team support.*

The challenge of autonomy

Autonomy was identified as a challenge by most advanced practice nurses, who mostly stated they had adapted to over time. The responsibility of completing an episode of care autonomously through to sending a patient home was identified as a particular source of role stress for advanced practice nurses.

Respondent 4: *The whole autonomous practice has been the hardest thing. Not having someone there to back you up. Not having someone there to ask ... not having a senior medical person, like a doctor, to consult with. That's the biggest change.*

Nurse practitioners were more comfortable with autonomy, but expressed a desire for a source of on-going consultation and collaboration, which had been available to them in previous positions.

Respondent 1: *I think that I would have a [doctor] involved for consultative processes. They don't have to be on-site but to have somebody to call, to have that kind of relationship, to bounce things off.*

Clinical protocols limited capacity to deliver quality care

Participants were satisfied with the time and resources available for them to deliver quality nursing care. At the same time this capacity was perceived to be limited by the requirement for them to deliver care in accordance with clinical protocols. A number of participants stated that they had the knowledge, education and experience which armed them with a far greater scope of practice than that provided by the protocols. Enhancing these protocols was identified as a measure which would improve satisfaction in this area.

Respondent 7: *We're limited obviously, because of our protocols [but] I think the quality that we give is awesome.*

The nurse practitioners described particular frustration in regard to this. They felt they were prevented from working to their full scope of practice through delays in the development of CPGs.

Respondent 1: *The other thing that was frustrating was that they kept on delaying, unofficially delaying the CPGs development...*

They were often required to refer patients to other health providers, when they could easily have managed themselves if their CPGs were in place.

Relationships with medical staff

Relationships with the medical staff at the nearby emergency department was important to participants. Protocols requiring the nurses to contact doctors with issues that were either un-resolvable by telephone or inappropriate for referral were a source of frustration for both the nurses and doctors.

Respondent 11: *I think there were times we were required to send patients because of our [protocol] to Emergency, and the Admitting Officers didn't feel it was appropriate and so they'd get a little bit stroppy and we'd say well I agree with you, we don't really particularly feel it's necessary but we don't have a choice. So that was embarrassing I guess and probably made them a bit stroppy.*

Some of these issues had been resolved, through changes to protocols, whilst other issues had been managed through development of new approaches and a consolidation of relationships between medical and Walk-in Centre staff.

Participants only contact with general practitioners was through the referral of patients to them; they did not have any direct professional dealings. However the advent of referrals from GPs was perceived as a sign of support.

Respondent 5: *We haven't had many dealings with GPs except that what is great is that they are referring in to our clinic now and so if they can't see a patient they recommend, and it's a minor thing, so to me that's, barriers are breaking down.*

Extra-personal factors

Training and on-going education was inadequate

All participants strongly expressed their belief the preparatory training for their role in the Walk-in Centre was inadequate.

Respondent 9: *Touched on information. I sort of felt that it needed to go a lot more in-depth.*

This belief extended to a perceived gap in training for new employees, whose training was largely comprised of informal arrangements with existing staff in the centre as opposed to participating in a formal training program.

Respondent 12: *My biggest issue is there's no clear-cut training guidelines for new staff...*

A number of participants expressed frustration with the difficulty in accessing study leave due to the absence of relief staff, and at times the availability of education in-services that were not appropriate to their clinical needs.

Intra-personal factors

Nurses' qualifications were associated with satisfaction with autonomy

There was great variety in both levels of experience and education of the nursing staff. All but three had tertiary level post-basic nursing qualifications, three were currently studying towards graduate degrees and one towards a certificate qualification. There was a direct association between this variable and participants' experiences of autonomy within the new role. Increased education and experience were associated with satisfaction and autonomy, yet at the same time dissatisfaction associated with a desire to utilise a broader scope of practice, and a desire for a medical source of clinical advice and mentorship. The opposite was observed for nurses with less education, training and experience.

DISCUSSION

Similar to the nurses in our study, NHS walk-in centre nurses' confidence with autonomy reflected the degree to which they had previously been practising this way (Rosen and Mountford 2002). Our findings that those with higher levels of education and experience were more comfortable and satisfied with autonomy might imply a link between educational preparation and critical thinking, as suggested by Zurmehly (2008), who also identified this link as important in terms of registered nurse job satisfaction (Zurmehly 2008).

The Advanced Practice Nurses' satisfaction reflects the provision of adequate supports for the implementation of their roles at the Walk-in Centre, including clinical protocols and collaboration and mentorship with nurse practitioners. However, implementation of the Walk-in Centre nurse practitioner roles was not supported. Similar to evidence from previous research (Gardner et al 2009), a significant barrier to implementation was the delay in development and approval of CPGs, the timely implementation of which is known to optimise nurse practitioner role implementation (Desborough 2011). Secondary, was the absence of a source of clinical collaboration and mentorship, a known enabler to the implementation of nurse practitioner roles (Desborough 2011; ACT Health 2007).

Previous research has highlighted the influence of leadership styles and support for the implementation of new nursing innovations (Eckhardt Wilson 1989). Mentorship could be of benefit to nurse practitioners in the implementation of their Walk-In Centre roles. The benefits of mentorship are well documented and include improved nurse satisfaction, clinical competence and empowerment (Mills et al 2005). These benefits also extend to patients, whose outcomes and satisfaction are also enhanced (Mills et al 2005). Literature regarding mentoring tends to focus on novice nurses (Beecroft et al 2006; Smith et al 2001), rather than more experienced nurses. Another area of nursing innovation in Australia is the development of practice

nurse (PN) roles. Mentoring for PNs was found to be important for role development and implementation; however dependant on organisational support and infrastructure (Smith et al 2001). Mills et al believe that acknowledgment of the role of clinical supervision for nurses in Australia is lagging behind other countries (Mills et al 2005). The experience of the nurse practitioners at the ACT Walk-In Centre highlights the importance of clinical supervision and its implementation to support these innovative roles.

In the absence of a source of clinical advice and mentorship, autonomy can be a source of role stress. This finding raises the question, What does professional autonomy in nursing mean and what are the requirements of this? Holland Wade (1999) states that one critical element of professional nurse autonomy is intercollegial interdependence (Holland Wade 1999). Whilst autonomy is valued by nurses, this does not translate to isolation or independence. Autonomy is only a source of satisfaction when coupled with supportive and cohesive professional relationships with both nursing and medical colleagues. The Walk-in Centre nurses were very clear on their defined scope of practice and sought out a source of advice and mentorship when dealing with clinical issues at the boundaries of this scope of practice.

Common to all participants' satisfaction were barriers to access on-going education and role ambiguity. Meeting the training needs of nurses with diverse education and experience was found to be a significant challenge for managers of Walk-in Centres in the United Kingdom (Rosen and Mountford 2002; Salisbury et al 2002). This raises the need for inter-sectoral collaboration to ensure that parallel with health sector reforms which expand roles for nurses in primary health care, is the development of nursing graduate capacity to match these reforms (Desborough et al 2011; Keleher et al 2010).

Sources of satisfaction common to both groups were the ability to provide quality nursing care, a manageable workload and relationships within the team. The description of a cohesive and supportive team was significant to their satisfaction levels; in fact teamwork and professional relationships are as important to nurse job satisfaction as autonomy (Cortese 2007; Dunn et al 2005).

Previous research indicates that a combination of factors impact nurses' overall level of satisfaction or dissatisfaction in the workplace (Hayes et al 2010). Our research indicates that some aspects of nurse job satisfaction are closely tied to intra-personal factors, specifically previous education and experience.

LIMITATIONS

Some intra-personal factors were not examined in this study; affectivity, behavioural disengagement and positive reframing are coping strategies that have been associated with nurse job satisfaction (Hayes et al 2010). The research team did not feel qualified to explore these factors with the nurses at the walk-in centre, and with already quite lengthy interviews, this would have added considerable time and complexity.

Pay, an extra-personal factor, was not raised in the interviews, which was an oversight of the research team. This might have been due to an assumption that the staff was happy with their pay, as this staff is paid at the highest level available to nurses in the ACT. The results are limited due to this omission.

CONCLUSION

Nurse-led walk-in centres provide an opportunity to improve access to primary health care; however integral to their success is the considered implementation of nursing roles. Examination of nurses' experiences of transitioning to and working in advanced roles at the ACT Health Walk-in Centre and their associated satisfaction highlights issues that influence nurse job satisfaction in this role.

The Walk-in Centre nurses' job satisfaction was strongly influenced by their experience of the autonomous

role, having implications for organisations implementing these roles. A comprehensive understanding of what autonomy means for nurses is essential. Once an understanding of autonomy is established, the requirements of autonomous nursing roles need to be met. These include the provision of relevant and adequate education and training, and an avenue to work to one's full scope of practice supported through access to clinical mentorship and collaboration. This is essential for both nurse satisfaction and the outcomes for patients accessing these services.

Provision of education and training presents a challenge to health care services, considering the variety of backgrounds and experience of nurses working in Walk-in Centres. These findings add to the impetus in Australia for the development of nursing education programs at a tertiary level, specific to primary health care.

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Understanding compliance with protective eyewear amongst peri-operative nurses: a phenomenological inquiry

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KEY WORDS

qualitative, personal protective equipment, protective eyewear, nurses, peri-operative, compliance

ABSTRACT

Objective

The objective of this study is to obtain an in-depth understanding of the phenomenon of peri-operative nurses' use of protective eyewear in the operating room (OR), and to understand nurses' attitudes and beliefs towards protective eyewear.

Design

Data was collected via one-on-one interviews with eight peri-operative nurses working in a private hospital in Melbourne. The data collected underwent rigorous thematic analysis using an extended version of Colaizzi's method of phenomenological inquiry.

Setting

The participating site is a large, private, metropolitan hospital that has 420 beds and employs 1,100 nurses and midwives, of which 31% are peri-operative nurses.

Subjects

Eight registered nurses were recruited. They were all female, aged between early 20s to early 60s, ranging in experience in the peri-operative setting from more than six months to approximately twenty years.

Main outcome measure

The investigation of the phenomenon of peri-operative nurses' use of protective eyewear in the OR with information to help further understand peri-operative nurses' attitudes and beliefs towards protective eyewear.

Results

For nurses, being compliant with protective eyewear is a combination of intrapersonal, environmental and professional factors, including protecting self, risk appraisal, beliefs, previous experiences, fear, comfort and functionality, professionalism, leadership, forgetting versus routine, time pressure and accessibility, alternatives and patient-centred care.

Conclusion

Individual nurse's beliefs towards protective eyewear and its impact on work, life and patient care influence their decision to use protective eyewear. Peri-operative nurses are more compliant when they are well informed and are in a supportive work environment.

INTRODUCTION

Personal protective equipment (PPE) is a part of standard Precautions (SP) – a set of guidelines used to prevent hospital-acquired infections in patients and healthcare workers. SP works in the context of the assumption that no patient or healthcare workers can be 100% certain they do not carry blood-borne viruses (Siegel et al 2007). PPE, which consists of gloves, gowns, aprons, surgical facemasks, protective eyewear, and face shields, is especially important in the operating room (OR).

Nurses working in the OR – scrub, scout, and anaesthetics nurses – are at risk due to the close proximity to large open surgical sites (Nagao et al 2009), having to deal with bloody sponges, specimens and instruments (Taylor 2006), and assisting with intubation and extubation. Recovery nurses looking after patients post-anaesthesia are also at risk of being exposed due to the frequent patient coughing in the recovery room and post-operative vomiting (Neo et al 2012). PPE is therefore an essential part of the nurses' regular attire in the OR setting. In an Australian study, 95% of the nurses who have experienced occupational exposures (OEs) worked in the theatre setting (Knight and Bodsworth 1998). More recently, a study in South Australia also found the peri-operative environment to be one of the departments with highest rates of OEs to mucous membranes or skin (Bi et al 2006).

Despite global guidelines around PPE (National Health and Medical Research Council [NHMRC] 2010), compliance with protective eyewear is relatively low in comparison with other forms of PPE (Gammon et al 2008; Jeong et al 2008; Nichol et al 2008). A review specific to peri-operative nursing and use of protective eyewear revealed that rates of compliance with eyewear were low compared to other forms of PPE (Mills et al 2011). However, only a small percentage of the quantitative literature available focused specifically on peri-operative nurses as a study population (Chan et al 2008; Jeong et al 2008; Hunt and Murphy 2004; Osborne 2003; Kim et al 2001).

While quantitative evidence provides empirical evidence related to use of protective eyewear in the OR and cost of OEs, qualitative research allows a deeper understanding of the experience from the nurses' perspective and can illuminate the motivations related to choosing to use protective eyewear. Only 11 articles of 991 returned abstracts were identified as using qualitative means to investigate nurses' use of PPE in an acute care setting, with only three of these studies specifically mentioned peri-operative nurses or nurses working in the surgical setting. Notably, no qualitative study investigated the Australian context. Therefore, this study aimed to explicate an in-depth description of the phenomenon of peri-operative nurses' contemplation in using protective eyewear.

METHOD

The study undertook a phenomenological approach to obtain an in-depth understanding of the phenomenon of peri-operative nurses' decision to use or not use protective eyewear. Phenomenology is a rigorous and systematic methodology of explicating elements related to the lived experiences of a phenomenon (Streubert and Carpenter, 2011). It enables researchers to develop a deep and holistic description and understanding of the phenomenon of day-to-day activities, which may be routine, taken for granted and yet complex and situational, as lived by the participants themselves instead of what is observed by investigators (Streubert and Carpenter, 2011). A purposive sample of peri-operative nurses was recruited. The participating site is a large, private, metropolitan hospital that has 420 beds and employs 1,100 nurses and midwives, of which 31% are peri-operative nurses.

Data was collected via one-on-one semi-structured interviews. For the purpose of this study, protective eyewear was defined as protective goggles or masks with visors. The focus/opening question of the interview was "Can

you describe what influences your decision to use or not use protective eyewear?" Other recursive questions to encourage the discussion included – *"Can you recall a time when you think you should have worn eyewear but did not?" "What happened?" "What was the situation like?"* Since the phenomenological method used for this study also involved the interpretation of symbolic representations, questions such as – *"When you think about wearing protective eyewear, what image do you have in your mind?"* were also included. The interviews lasted an average of 30-40 minutes. The interviews were also audio-taped to facilitate transcription later. The narrative data is the focus of this article.

Ethical clearance was obtained from both the hospital and university Ethics Committees. Informed, written consent was obtained from each participant before data collection. All transcripts were de-identified after the individual participants validated the accuracy of their individual transcript. The data was analysed using an extended Colaizzi's method established by Edward and Welch (2011), as seen in table 1.

Table 1: Extended version of Colaizzi's method (Edward and Welch 2011)

Step One	Transcribing all the subjects' descriptions.
Step Two	Extracting significant statements [statements that directly relate to the phenomenon under investigation].
Step Three	Creating formulated meanings.
Step Four	Aggregating formulated meanings into theme clusters.
Step Five	Developing an exhaustive description [that is, a comprehensive description of the experience as articulated by participants].
Step Six	Additional Step – Researcher interpretative analysis of symbolic representations - from the articulation of the symbolic representation (which occurred during participant interview).
Step Seven	Identifying the fundamental structure of the phenomenon.
Step Eight	Returning to participants for validation.

To ensure credibility, the transcripts of the interviews were referred back to the participants for validation to determine if they found the findings to be accurate – also known as member checking (Streubert and Carpenter 2011). As part of investigator triangulation and peer debriefing, the researchers reviewed the findings to address any possible prejudices, crucial omissions, inaccurate interpretations and failure to identify all of the important themes (Polit and Beck 2010). The fundamental structure of the phenomenon from the narrative was compared with that from the symbolic representations to ensure consistency and rigour in the results – a form of method triangulation.

To ensure dependability an audit trail for this project was kept and included documentation of the data, methods, and decisions made throughout the entire research process and the end product (Gibson and Brown 2009; Schwandt et al 2007). Part of the data in the audit trail included a reflexive journal, which included a log of day-to-day activities and reflections and thoughts regarding each step of the research process. In terms of transferability, provision of sufficient description of the research context, participants and methods used such that readers can judge for themselves whether the findings can inform their own context.

FINDINGS

Eight registered nurses were recruited. They were all female, aged between early 20s to early 60s, ranging in experience in the peri-operative setting from more than six months to approximately twenty years. Three participants worked in anaesthetics/recovery and five in scrub/scout roles. Four participants also added that they held some form of senior management or education role.

Statements that were directly related to the motivations and barriers of nurses' use of protective eyewear were considered significant statements. According to the modified method, 194 significant statements were extracted from the interview transcripts (Edward and Welch 2011). Table 2 presents examples of the significant statements.

Table 2: Examples of Significant Statements

<p><i>[I use protective eyewear because] I don't want to have anything in my eye that doesn't need to be there. "I've seen blood flicked to the back of the room. Your ability to experience a splash is wherever. ...It [wearing protective eyewear at all times in a theatre] is a precautionary thing regardless of what you're looking at, but what's going on around [you in the theatre] as well."</i></p>
<p><i>"I just wear my normal reading [glasses] everyday, day in, day out. Makes no difference. To me, it's still eye protection."</i></p>
<p><i>"I had to go through quite a little bit of nasty treatment I wouldn't wish that treatment on anyone, it was ghastly. As a result of that [my experience of eye splash], I [now] always wear these spectacles and a mask with a shield on it."</i></p>
<p><i>"I feel a little bit more responsible for wearing stuff like that [protective eyewear] than I did before [the change in my personal life], because of the responsibility of looking after someone else."</i></p>
<p><i>"I don't have many choices [if they run out of disposable goggles], because not all the [protective] eyewear fit over my glasses."</i></p>
<p><i>"I've tried the goggles and they steam up. I can't see and if I'm scrubbed, it's terrible because I just cannot see anything and a couple of hours with steamed up goggles is.. [I] can't do it."</i></p>
<p><i>"You have a list that you have to get through in a certain time and you have to make through at a certain rate. The last thing you want to do is half way through a list is running down and getting some more masks [with visors]."</i></p>
<p><i>"When I'm there over a patient and assisting [with extubation], I'm needed in that space. I can't say, 'Stop. Don't pull that tube out, I'm going to get some eyewear.'"</i></p>
<p><i>"Maybe it takes that other person just to hand you a pair [of protective eyewear in case of an emergency, for one to use it]. You go, 'oh, that's right, I forgot', or 'oh thanks', [when someone hands you a pair of protective eyewear in an emergency]."</i></p>
<p><i>"If I don't have eyewear on, I feel naked in the theatre. It's like if I don't have a mask on in theatre I feel naked. I've got to have it [protective eyewear] on."</i></p>
<p><i>"There are other ways of covering up, like if the person's coughing, [to have] something over their face."</i></p>
<p><i>"You'd be so worried about them [your patients in an emergency situation], you wouldn't want to be the one that do[es] something detrimental to your patient because you wanted to get eyewear."</i></p>
<p><i>"I think when you're greeting a patient, it's nice for them to see your face and not to see a mask [with eyewear]. They're nervous and [wearing PPE] just brings that whole theatre environment straight into their face right at the holding bay. So it's nice to have that smiling communication with the patient."</i></p>

Meanings for each significant statement were then formulated and clustered into themes. Twelve themes were explicated from the data; they were- Protecting self; Risk appraisal; Beliefs; Previous experience; Fear; Comfort; Time; Professionalism; Leadership and education; Forgetting versus routine; Alternatives; and Patient-centred care. The themes were checked against the significant statements and transcripts for validation. The formulated meanings were integrated into a comprehensive description of each theme that arose. The major themes that emerged from the analysis included *Protecting self; Risk appraisal; Beliefs; Previous experience; Fear; Comfort; Time; Professionalism; Leadership and education; Forgetting versus routine; Alternatives and*

Patient centred care. The subsequent fundamental structure related to compliance with protective eyewear amongst peri-operative nurses emerged from the data.

From the nurses' perspective, the overarching principle regarding their contemplation of using protective eyewear is to be protected, as much as possible. Using protective eyewear is a key procedure in the theatre environment to protect themselves from the numerous hazards found in the workplace, which is viewed as a high-risk environment involving drugs, body fluids and chemical hazards. Thus, even if protective eyewear may not be 100%, protective, the nurses rather use them than not and tend to choose options that allow more facial coverage. Being compliant with protective eyewear is a combination of intrapersonal, environmental and professional factors.

Nurses' compliance with protective eyewear depends on intrapersonal factors such as their personal preferences, habits, and beliefs towards protective eyewear, risk appraisal, previous experiences, and the fear of consequences of a blood splash. From the nurses' perspective, they are more compliant with protective eyewear when the eyewear are comfortable, functional and available, when the eyewear are believed to provide sufficient/more protection, when the nurses have become used to using them routinely, have previous experiences with biological splashes (personal experiences, near-misses or, others' experiences), and when the nurses are aware and afraid of the personal, social and financial consequences of blood splashes. Nurses are also more likely to comply with protective eyewear in situations that they deem as high-risk. However, some may have differing ideas on what is risky and what is not. An under-estimation of risk may lead to untoward biological splashes. However, sometimes nurses are not compliant with protective eyewear due to forgetfulness, especially during a time-critical moment.

For nurses, environmental factors can make compliance with protective eyewear challenging. Nurses find it difficult to comply with eyewear when they are unable to access the eyewear when immediately needed, aggravated by the time pressures in the theatre environment, such as the need to progress with a surgical list. When environmental factors interrupt access to protective eyewear, nurses protect themselves by standing back, closing their eyes or covering the patient's face, or by borrowing a pair from others.

Professional factors also influence compliance with protective eyewear. For nurses in the OR, compliance with protective eyewear is part of being a professional and accountable nurse. Nurses are more likely to comply with protective eyewear when there is good team camaraderie, frequent managerial reminders, professional education related to protective eyewear, and when being a role model for others in the theatre team. Compliance with protective eyewear is influenced by the nurses' desire to provide what they think is best for the patient in the theatre environment.

DISCUSSION

Most participants said that wearing protective eyewear was the norm for them and that using protective eyewear as PPE was part of their peri-operative training and continuous education. However, for one participant, her definition of protective eyewear did not conform to the Standard Precautions definition. That is, this participant believed her prescription glasses were sufficient protection. This lack of awareness could reflect a need for more top-down approaches such as in-services or small posters (Chelenyane and Endacott 2006), as suggested by current literature findings, where nurses reported a lack of awareness of what constitutes PPE and how they will protect nurses (Neves et al 2011; Efstathiou et al 2011).

The current literature identifies embarrassment in using protective eyewear as a contributor to poor compliance (Efstathiou et al 2011; Neves et al 2011). However, in this study, the nurses did not suggest embarrassment as a reason for non-compliance. An inability of the nursing team to work together is also a motive quoted in

current literature for low compliance with protective eyewear (Neves et al 2011; Chelenyane and Endacott 2006), in that, nurses were more motivated to use PPE if their colleagues did (Efstathiou et al 2011). The participants in this study, conversely, expressed that if nurses work as a team, and if there is support from each other and from the management, they are more likely to comply with use of protective eyewear. Support could come in a form of having managers reminding nurses when necessary, or handing them a pair in the middle of an emergency. Accountability to one another as a team in theatre also relates to each person restocking supplies of protective goggles after taking the last one. The literature supports that nurses were more willing to change their practice if senior staff were excellent role models (Efstathiou et al 2011; Lymer et al 2003).

The findings of this study also support the current literature in that nurses will assess the level of anticipated risks when contemplating the use of protective eyewear, as recommended by the guidelines for PPE (NHMRC, 2010). Underestimation of risk level is cited in the literature as a common reason for non-use of PPE (Melo et al 2006; Wu et al 2008). Importantly, different nurses have diverse ideas related to risk and their appraisal of risk in the theatre environment. To some participants in this study, risk was present anywhere in the theatre – such as, when the unconscious patient is on the table, when dealing with specimens or chemicals, or even when cleaning up post-surgery. To others, the risk level was situational and dependent on the type of patient or the procedure the nurses are about to perform.

Time is also cited as a factor for nurses when it came to compliance behaviours related to donning protective eyewear, that is, nurses found they did not have adequate time to use PPE/protective eyewear (Formozo and Oliveira 2009; Ronk and Girard 1994). In support of previous literature related to time, time pressures in the OR environment was a theme that emerged in this study, such as the lack of time to restock and to obtain a pair because of the pressure to get on with a surgical list, or the high-turnover rate between patients causing an inability to get a pair in between cases. The emergency nature of certain procedures in the OR, a high acuity environment, has been related to forgetting to use protective eyewear (Ronk and Girard 1994). The lack of time as a theme in this study was attached to inaccessibility of the equipment, that the eyewear are kept a distance away from where required, the main store being too far from the clinical areas or having run out of stock in the main store. This finding is congruent with the evidence in the current literature (Formozo and Oliveira 2009; Ronk and Girard 1994).

STUDY LIMITATIONS

The limitations of the project include focusing on only one type of PPE (protective eyewear). Nurses may have different attitudes towards other types of PPE that are commonly used in the theatre environment and exploration of the variations related to other types would be valuable. Additionally, the participants were recruited from one hospital (selection bias); the experiences, attitudes and beliefs of other nurses of other hospital environments may differ from the participants in this study. Finally, as with most qualitative studies, the findings are not generalisable to the OR nursing population as a whole. However, these findings do offer new knowledge related to the motivations of nurses to don protective goggles in the OR.

CONCLUSION

This study has produced new and valuable insights into experiences with choosing to don protective eyewear that is specific to peri-operative nurses and will contribute to existing knowledge regarding compliance with protective eyewear. These insights can offer a foundation from which to develop a quantitative study to determine effectiveness of particular interventions related to compliance and PPE; such as sustainable in-services regarding protective eyewear and risk assessment, improving accessibility to protective eyewear in the theatre and recovery, enhancing the team spirit and camaraderie within the theatre team to improve

compliance with protective eyewear. This information can influence the establishment of policies and protocols regarding assessment of risk of blood splash in the theatre. In addition, the findings of this study can form the basis of research related to further examination of the experiences of the two categories of peri-operative nurses (nurses in the scrub/scout role or peri-anaesthesia role), and the experiences of other healthcare professionals in the peri-operative setting, including theatre technicians, surgeons and anaesthetists.

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Adolescents and youth in adult hospitals: psychosocial assessment on admission – an evaluation of the youth care plan

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KEY WORDS

adolescent, admission, adult hospital, psychosocial assessment, care plan

ABSTRACT

Objective

The study was undertaken to evaluate the effectiveness of our previously published Youth Care Plan (YCP) as a tool for the psychosocial assessment of adolescents and young adults admitted to hospital.

Design

A comparative study of a quasi-convenient sample of two pre-defined groups

Setting

Young people aged 12-24 years admitted to a university teaching hospital in Sydney, New South Wales (NSW), Australia.

Subjects

Group 1 had a completed YCP on admission and a HEADSS assessment during their admission. Group 2 had no completed YCP and had a HEADSS assessment during their admission. Group 1 n = 20 (15F) with a mean age of 18.8 yrs; Group 2 (7F) with a mean age of 20.1yrs.

Main outcome measure

Group 1 tests the hypothesis that the YCP is capable of identifying most psychosocial issues in a brief assessment, compared to the formal HEADSS interview. Group 2 tests the hypothesis that a significant proportion of young people admitted to hospital have some psychosocial issues that may impact on management.

Results

The psychosocial risks detected with the YCP are 72.5%, of those identified by HEADSS interview. Young people with a standard care plan have the same number of risks identified as those with the YCP. Risk issues that YCP was less likely to identify were drug use and depression.

Conclusions

The YCP provides an opportunistic screen for lifestyle risks in adolescents on admission to an acute adult care facility that can be undertaken by nurses in their routine care. Training may be necessary to provide confidence to ask about more sensitive risk issues.

INTRODUCTION

Young people aged 12-24 years have specific health care and developmental needs that differ from those of children or adults. The enormous changes in psychological, cognitive, emotional, spiritual and social development, together with puberty, have unique implications for the delivery of health care, including in acute care settings. (NSW Department of Health 2010; Tylee et al 2007).

Both negative and positive health behaviours may develop in adolescence, and risk taking during this time is often exploratory and part of normal development (Irwin 2010). Higher risk behaviours often cluster together and have both short and long consequences (Hair et al 2009; Suris et al 2008; Bender 2006; Viner and Macfarlane 2005; van Amstel et al 2004; Zink et al 2003; Carr-Gregg et al 2003). Thus risk behaviours may not only have an impact on acute health in the 'well' adolescent, but also have a significant impact on disease management and therapy compliance in adolescents with a chronic illness (Suris et al 2008; Dieppe et al 2008; Bender 2006; Rosina et al 2003).

Acute adult care facilities are often ill equipped to deal with the complex developmental issues of adolescence and youth. A growing body of literature highlights the need for adult hospitals to provide training to staff, health risk screening and develop appropriate adolescent friendly services (Tan et al 2009; The Royal Australasian College of Physicians 2008; Sawyer et al 2007; World Health Organization 2002; Yeo et al 2005). Adult care facilities frequently deal with young people with chronic illness transitioning from paediatric care (Steinbeck et al 2007) and in whom risk taking may be greater than their non-illness peers (Suris et al 2008).

Primary health care settings and an admission to hospital should be viewed as an opportunity to assess broader psychosocial health (Booth et al 2008). The reason for hospitalisation will not be primarily psychosocial, but psychosocial issues may have an impact on medical and surgical outcomes or may need to be addressed in addition to the presenting problem.

Nursing care plans are universally used and are seen as an essential tool in the delivery of nursing care (Björvell et al 2000; Mason 1999). In Australia, nursing care plans are the primary means of documenting, communicating and structuring patient care (O'Connell et al 2000). The age appropriateness of care plans are acknowledged by paediatric plans which emphasise the need to mimic the home environment, and adult plans which concentrate on issues relevant to an older demographic such as falls, drug interactions, multiple co-morbidities and cognitive impairment.

The authors have previously published on the development of a Youth Care Plan (YCP) which acknowledged that information necessary for optimal care of young people was not being routinely collected on admission in adult facilities (Sturrock et al 2007). The YCP addressed the psychosocial profile of the adolescent and young adult in the context of health care delivery and provided an opportunistic screen for lifestyle risks and protective factors on admission, as well as filling the requirements of a standard care plan. Questions relevant to psychosocial wellbeing were based on the HEADSS interview (Goldenring and Rosen 2004).

An extensive literature review using Medline, CINHALL and Embase, over the past 20 years, was conducted by the authors and revealed no published research where the HEADSS interview has been used as a comparator for some other risk assessment format on admission to hospital.

The first aim of this evaluation research was to demonstrate the effectiveness of the YCP to identify psychosocial issues not necessarily related to the admission but potentially relevant to its outcome, when compared to a formal HEADSS interview. The second aim was to demonstrate that using a standard care plan instead of the YCP in young people would fail to detect psychosocial issues of consequence to health and wellbeing. We hypothesised that a completed YCP on admission to hospital would identify at least 75% of any psychosocial

issues present in that adolescent, when compared to a lengthy HEADSS interview. Furthermore, we hypothesised that young people who had a standard care plan completed would have psychosocial issues that may impact on treatment, as frequently as those who had a YCP completed.

METHODOLOGY

Participants were young people aged 12-24 years admitted to the acute hospital wards of Royal Prince Alfred Hospital, Sydney, Australia. Exclusion criteria included a psychiatric or obstetric admission, lack of facility with spoken English, too seriously ill to take part, and if they were already known to the investigator. A quasi-convenience sample was recruited from the daily census list (alphabetical) of age defined group admissions. Young people were sequentially approached from the list. The recruitment of subjects required meeting adolescents for the first time during their admission in hospital and the establishment of rapport. Participation required written consent from the young person and parental consent if under 16 years of age. After recruitment and consent the participant's notes were viewed to ascertain presence of YCP (Group 1) or standard non YCP care plan which did not address any of the HEADSS categories (Group 2).

Research tools: The details for the YCP have been previously reported (Sturrock et al 2007). It combines a modified HEADSS data collection within a traditional care plan structure. The HEADSS is an established tool for the performance of a full psychosocial assessment in the adolescent (Goldenring and Rosen 2004), which uses a semi-structured interview technique, and usually take 30-40 minutes to perform. **H**ome, **E**ducation, **E**ating, **A**ctivities & peers, **D**rugs & alcohol, **S**uicidality & depression, **S**exuality and **S**leep are all covered.

Outcome measures

In order to be able to compare information written on the YCP by a third party, with the information obtained on oral HEADSS interview and because there was no published precedent, the authors developed a schema to allow objective comparisons between the two groups. Interview responses were documented on the Youth Health Risk Assessment form as qualitative data, as this format does not provide for any quantitative data (Chown et al 2004). The researchers had to develop a quantitative approach to compare the HEADSS information with the Youth Care Plan data. The researchers were unable to find any reference to such a methodology in the published literature. Our approach was based on selection of key risk behaviours which were considered age appropriate, well-recognised and relevant to a hospital admission and management. These risk behaviours were recorded under eight categories: Home Environment, Employment, Education, Exercise, Peer related Activities, Sexuality, Suicide/Depression and Sleep. and each category was given a score. Details of why and how risk behaviours were identified are provided in Appendix 1, together with literature references. A positive risk behaviour response to each category was scored as one point. Adolescents who reported no risk behaviour in a category were given a score of zero. Those who reported risk behaviour in the category Drugs were scored with a maximum of three points. Individual scores were given to no/risk behaviour involving tobacco, alcohol and other drugs with either zero or one point. These numbers are binary indicators (see Appendix 1) and not quantitative scores. To avoid bias, information from the YCP for Group 1 was only collected after the HEADSS interview and a random sample of YCP scores were reviewed and coded to ensure reporting integrity. Interviews were carried out, between March 2010 and September 2010.

Data analysis

Participant details were entered into an Excel spread sheet and exported to SPSS (Version 19) for analysis. Two sets of t-tests were conducted: 1) a paired sample t-test to compare the two different risk assessments for Group 1 – YCP and HEADSS; and 2) an independent samples t-test to compare the HEADSS assessment for Group 1 and Group 2. Results are reported as mean + SD and significance level set at $p < 0.05$.

Ethics

The Ethics Review Committee, Research and Development Office at Royal Prince Alfred Hospital, Sydney, Australia, approved this study: protocol number X07-030.

RESULTS

A total of 40 young people took part in the study. Group 1 (n = 20; 15F), who had both the YCP filled out and the HEADSS interview completed, had a mean age of 18.8 years (Range: 14–22 years). Sixty percent of Group 1 had a chronic illness. Group 2 (n=20; 7F) who had HEADSS interview had a mean age of 20.1 years (Range: 16-23 years). Sixty five percent of Group 2 had a chronic illness. The overall age and gender distribution for the total sample was similar to the general adolescent population seen in the acute tertiary facility as recorded in hospital admission statistics and Adolescent Service database. The main reasons for not obtaining consent were not feeling well enough at the scheduled time to complete the interview and not having enough time available as a result of investigations and/or therapy.

The average time spent on each HEADSS interview for Group 1 and Group 2 was 41 minutes (Range: 20-60 minutes) and 39 minutes (Range: 30-60minutes) respectively. It took an average of two visits (Range 1-4 visits) to establish enough rapport to obtain consent for an interview with a young person in both Groups.

The major groups identified for hospitalisation with a chronic illness were cystic fibrosis, cancer and congenital cardiac disease. The major groups identified for an acute hospitalisation were trauma, abdominal pain and infection post trauma. When all participants were grouped according to the presence or absence of chronic illness, those with chronic illness had a total of nearly three times the number of risk behaviours as identified by the HEADSS interview (31 versus 11).

The YCP takes an average of six to eight minutes to complete, as it is a tick box system with room for text. Eight of the twenty YCPs were missing some information, generally from the second page of the plan. Table 1 shows the individual and total number of risks identified in both Groups. The total number of participant risks identified in Group 1 using the YCP was significantly different from the number of participant risks identified by the HEADSS psychosocial assessment in the same group. For the YCP, the mean number of individual risks identified was 1.5+1.36. In Group 1, the mean number of individual risks identified by HEADSS interview was 2.0+1.59. The paired samples correlation was 0.708 (p=0.0) and the absolute percentage 72.5%. The paired sample t-test showed a significant difference between risk number identified by the two tools, p =0.045. Looking at table 1 Drugs and Suicidality/Depression are where the main discrepancies exist. The one area where the risk number was higher on YCP compared to HEADSS was sleep, but absolute numbers are low.

Table 1: Combined risk data identified for Group 1 YCP and HEADSS assessment and Group 2 HEADSS assessment

	Home	Education/ Employment	Exercise	Peer- related Activites	Drugs	Sexuality	Suicidality/ Depression	Sleep	TOTAL
Group 1 YCP	3	5	6	2	7	0	1	5	29
Group 1 HEADSS	4	5	7	2	13	0	7	2	40
Group 2 HEADSS	4	6	7	3	14	1	5	2	42

The summary data for the HEADSS interview for Group 1 (table 1) is no different to Group 2, revealing a similar detection of risk behaviours in number and type for those young people who had the standard adult care plan completed. The mean number of individual risks was 2.1+1.86 and no different to Group 1 HEADSS data using an independent sample t-test ($p=0.86$)

DISCUSSION

This is the first study of which the authors are aware which attempts to validate an in-patient risk assessment tool for youth, which is incorporated into a standard care plan. Our sample of young people was admitted to an acute care facility and had both chronic and acute conditions.

There are two key findings. First, when compared to the gold standard HEADSS interview a youth specific care plan identifies close to 75% of the risks identified by the HEADSS. Drug use and suicidality/depression were less likely to be identified by YCP. Secondly, in the sample of youth (Group 2) who had a standard adult care plan which did not address youth relevant risk behaviours, their risk profile was identical to that of Group 1.

Drugs and suicidality/depression sections in the semi-structured HEADSS assessment allow a broader discussion about drugs usage, as well as around mood and coping mechanisms. This discussion comes after the less sensitive areas of home, education and peers have been addressed. Young people may feel more comfortable discussing these topics with a stranger during the latter part of the assessment when rapport is better established. It is likely that the reverse is true for the YCP where young people may answer no to drug and suicidality/depression questions because, although these are at the end of the questions, the whole session has lasted 10 minutes and perhaps in the rushed environment of admission. Another reason for this apparent under-reporting is that the Drugs and Suicidality/Depression categories in the YCP appear on the second page of the care plan, which in 40% was not filled out properly. The third reason is that nursing staff may simply feel uncomfortable or unprepared to ask these questions.

Unsurprisingly, there is a focus in hospital on sleep and adolescent sleeping patterns (Crowley et al 2007), which often go against a hospital timetable. The YCP asks a number of questions about sleep which appear in both paediatric and adult hospital care plans, including usual bedtime and waking time and ability to fall asleep. Concerns about sleep were more frequently identified by the YCP, but whether these relate to depression or normal adolescent delayed sleep onset is not answerable from the data.

These findings have some limitations. The sample is a relatively small one, although represents a time consuming study and a study where there were a large number of refusals (three for every four approached), with a young person being too unwell to interview, in surgery or undergoing treatment or simply asleep. Despite this, the sample is representative of youth in hospital.

Since the implementation of the YCP in 2005, when it was mandated by the Hospital Executive, there has been a gradual increased uptake of the YCP use on the wards. High staff turnover with lack of awareness and time poor staff have been cited as factors influencing the changeover to the YCP when admitting adolescents.

According to the authors of the HEADSS assessment (Goldenring and Rosen 2004) a psychosocial assessment can generally be done well in around thirty minutes. To achieve a comprehensive assessment in thirty minutes one must be well trained in a HEADSS assessment and adolescent health. The YCP allows any admitting nurse, with little adolescent experience, to collect information from an adolescent at admission. A well-completed YCP is able to give a snapshot of the psychosocial health and wellbeing of a young person and in turn allows the health care professional to assess the balance of health risks and protective behaviours.

Research has found that adolescents are keen and willing to discuss a broad range of health concerns with

health professionals, provided sensitive questions are asked directly and confidentially (Parker et al 2010; Royal Australasian College of Physicians 2008). Health professionals do have a role in health promotion in their clinical interactions with young people (Viner and Macfarlane 2005). There are limited opportunities during an admission for a health professional to undertake a brief psychosocial assessment of a young person. We have shown that the YCP can pick up on psychosocial issues that affect a hospital stay and about which health carers need to know.

Experimentation and risk taking is a normal part of adolescent and youth psychosocial development. In the context of a hospital admission these are important factors to identify, particularly if risk behaviours might have contributed to the admission. The association of depression, drug use and unintentional and intentional injury is one example. Poor adherence to therapy in chronic illness because of depression is another. Having a tool such as the YCP, which can highlight close to 75% of the risks that the young person may be engaged with, and which with education might well increase ascertainment, is essential to providing optimal care. If these risks are not highlighted on admission and appropriate referral and intervention organised, such risks may interfere with the whole admission, wellness, recovery, rehabilitation and possible re admission.

RECOMMENDATIONS

Nurses are often the first clinician a young person meets during a hospitalisation and with their frequent and ongoing contact throughout the hospitalisation they are in a pivotal position to undertake routine psychosocial screening (Rosina et al 2003).

Since the inception of the YCP there have been numerous changes with the general care plan in the hospital and the YCP needs to consider and make changes according to hospital admission policies. The YCP evaluation highlighted at times poor completion of the second page of the YCP. The second page of the YCP contains more sensitive questions and there is a risk that this page is often rushed through. The authors have suggested that encouraging staff to return to these questions at a later time could help with better completion of the form. Also, education with knowing how to ask some of the more sensitive questions to adolescents would also see better completion of the form. Ongoing education for staff who work in acute adult care facilities with regards to adolescent health and development, the risks that these young people undertake and the long-term benefits of identifying these risks on admission to hospital is paramount to effective usage of the YCP.

APPENDIX 1

Home Environment

In a hospital admission it is relevant to identify to where the young person is to be discharged. Living arrangements of adolescents and young adults have been found to be important predictors of health behaviour (Rossow and Rise 1993). Risk was considered if the young person was <18yrs and living alone or >18yrs living alone with no connection to a supportive adult.

Education and Employment

Young people who are not involved in education, training or employment may have fewer opportunities to participate fully in society and are considered to be at greater risk of personal and social stresses, which may impact on their ability to self-manage (Long 2006). Risk was identified if the young person was <18 years and out of school or >18 years with no formal education, training or employment.

Exercise

Physical exercise for young people is important in maintaining cardio-respiratory fitness and positive self-image (Hills et al 2007). Exercise risk was self-report of undertaking physical activity less than two times a week.

Peer-related Activities

These activities improve social competencies and assist individuation from the family of origin, both important to adult functioning (Moody et al 2010; Goldenring and Rosen 2004). Risk was defined as limited peer related activities and/or limited friendship network.

Drugs

Substance use was measured by self-report of tobacco, alcohol and illicit drug use. Tobacco usage is associated with the greatest disease burden in Australia and there is a high correlation of cigarette smoking in adulthood if smoking commences at a young age (Australian Institute for Health and Welfare 2004 and 2006). Tobacco use risk was defined as cigarettes Yes/No. The acute harms of excess adolescent consumption are well documented (Bonomo 2005) and alcohol use risk was defined as underage or early onset and/or binge drinking (>5 standard drinks in one sitting). Illicit drug usage was defined as current usage of any drug.

Sexuality

Risky sexual behaviour was coded if the young person identified as homosexual/bisexual, had multiple partners or was practicing unsafe sex.

Suicide/Depression

Anxiety and depression are the major causes of prevalent years lived with disability in 10-24 year olds and account for the majority of mental disorder disability in females in Australia (Mathews et al 2011). A risk was identified if the young person stated that they suffered from anxiety or depression/low mood for more than six months.

Sleep

Delayed sleep onset is well reported for the adolescent and young adult (Crowley et al 2007). Sleep disorders and deprivation can impact the health and wellbeing outcomes of a young person by reducing their capacity to undertake normal everyday activities (Australian Institute for Health and Welfare 2010). Risk was identified if the young person identified with insomnia or delayed sleep onset that was significant enough to interfere with illness management or routine activities.

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Changing philosophies: a paradigmatic nursing shift from Nightingale

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non-positivist, received view, positivist, perceived view, theoretical construction, nursing theory.

ABSTRACT

Objective

To consider the changing philosophical and theoretical construction of nursing which has moved from an initial focus on positivism and science, and undergone a paradigmatic shift so that it is now being interpreted by some nursing theorists in alternative ways.

Primary Argument

A theoretical review of some nursing theorists and a critical consideration of the wider concepts which have been influential in theoretical constructions gradually moving from the received (positivistic) to the perceived view. The perceived view encompasses the emergence and influence of non-positivist philosophies, which shift the theoretical focus away from causation to a more interpretive, unscientific standpoint, with foundations in phenomenology, humanism, holistic care and qualitative research. The paper demonstrates that many of the theories offered are esoteric, complicated and constructed in an academic way that tends to escape the everyday nurse practitioner.

Conclusion

That multiple options which capture the philosophies and ideologies of both paradigms should/could be considered.

INTRODUCTION

This paper examines the influence of non-positivist philosophies on the theoretical construction and practice of nursing. In tracing this influence the work and philosophical assumptions of some nursing theorists are critically examined, questioning the relationship between their theories and the intellectual, socio-cultural, and developmental contexts in which their ideas arose. This examination demonstrates the major intellectual and socio-political influences on which specific nursing theorists draw, and place their nursing theories in a wider context showing that the movement away from positivist philosophies enables them to be more clearly understood and used in clinical nursing practice into the 21st century.

The term positivist recognises observable phenomena and facts, whereby knowledge is derived from experience. Holmes (1990) refers to positivism as a general orientation according to which the world can only be known through observable entities, with demonstrated regularities and general laws verified through their measurement and quantification. Non-positivist philosophies take an alternative stance to the scientific method, with this alternative view shifting the focus from causation and measurement to a more qualitative, unscientific, and interpretive, standpoint, with its foundations in phenomenology, humanism, and holistic care. These new views find favour across a broad range of theoretical publications (Meleis 2012; Reed et al 2004; Blattner 1981).

Holmes (1990) and Martin (2000) support this alternative by describing the term *verstehen* as a Neo-Kantian view which promotes understanding gained through empathic imagination, as opposed to objective knowledge gained through observation. *Verstehen* explanations aim not to give causal explanations (as in positivism) but to deepen and extend one's understandings about why social life is perceived and experienced as it is. *Verstehen* is a German term meaning understanding or comprehension. However, in late nineteenth-century German academic circles it came to be associated with the view that social phenomena have to be understood from within. This approach to social inquiry tended to be qualitative rather than quantitative and was opposed by positivists who stressed external, experimental and quantitative knowledge. Although this position has been modified over time, the dispute between positivists and non-positivists has persisted and still defines many of the theoretical debates in the field today. Positivism is no longer as popular, with this view and way of knowing being seen as indefensible by many contemporary philosophers of social science. Instead of appealing to *verstehen* in describing their preferred approach, anti-positivists today speak about interpreting meaning or hermeneutical understanding (Martin 2000). These alternative views have found some favour in nursing and are arguably more readily applied across clinical situations as nursing groups seek particular understandings and appear more comfortable with philosophical concepts which incorporate a more postmodern humanism/holistic basis to their care.

NARROW FOCUS

Carper's (1978) analysis which questioned the need for such a narrow theoretical focus on the empirical method identified four patterns of knowing in nursing: 1) empirics, the science; 2) aesthetics, the art; 3) personal knowledge; 4) ethics, moral knowledge. Carper (1978) clearly felt that none of these patterns alone should be considered sufficient, suggesting that the teaching, learning and application of one pattern should not require the rejection/neglect of any of the others. Carper's typology set the scene for significant future epistemological movement and change by acting as a catalyst or bridge by alerting nurses that science alone will not answer the significant questions in our discipline.

A multi-paradigmatic view is consistent with the position taken later by Sarvimäki (1988), who depicted nursing as a moral, practical and creative co-action, highlighting the role of nurses as having meaning in

respect to other people and that this should be the starting point of all nursing action and be used as its theoretical foundation. These thoughts reflect Habermas' (1981a, 1981b) work on theories of communicative action, and supports his notion of knowledge as an outcome of activity in which humans engage because of a natural need or interest. This suggests an acceptance of knowledge derived from a holistic and humanistic perspective. These views are compatible with nursing being seen as an art form rather than a science, and a focus for many contemporary nursing theorists (Chinn and Kramer 1991; King 1981).

Nolan et al (1998) notes the need for separate disciplines to have their own theories, Holmes (1991) decries the positivist (empirical), scientific method of nursing's theoretical basis, as being analytic, mechanistic and reactive, concentrating like medical science on the illness-cure paradigm, and instead champions a more humanistic, person-centred method, highlighting its dialogical, interactive and holistic and human perspective within the health-care paradigm. This paradigm is favoured by nursing scholars/theorists where emphasis is directed toward concepts such as empathy, rapport, intuition, personal meanings and therapeutic-relationships (Benner and Wrubel 1989; Travelbee 1966; Peplau 1952). This would require university based nursing programs to take a more interpretive or postmodern view of these values (Meleis 2012). In so doing students will therefore be exposed to a multiplicity of theoretical positions.

As healthcare moves towards adopting multidisciplinary approaches to practice, nursing continues to strive to establish its own unique body of knowledge and to maintain its professional boundaries. This issue is blurred further because the boundaries between nursing, medicine and other discipline specific roles are never static with nurses increasingly extending their scope of practice and occupying discipline specific status in university programs and have begun to perform clinical tasks previously carried out by doctors with many of their own traditional roles being passed on to healthcare assistants. Nursing theory development plays a significant role for clinical practice as it retains a close linkage to research, and therefore, integration to practice is much more positive in the sense that the linkage to research provides solid grounds for further evidence based theoretical development and the specifics will help facilitate and strengthen the linkages between theories, research and practice (Im and Chang 2012).

RECEIVED TO PERCEIVED

The dichotomy between science and humanism (Meleis 2007) suggests that the guiding paradigm for nursing practice has been the received view, described as a label for empirical positivism, which amalgamates logic with the goals of empiricism in the development of scientific theories. The received view signifies a set of ideas that are not challenged, suggesting these ideas had almost been reified or set in stone (Meleis 2012). The received view has reductionism, objectivity, measurement, quantification and validity as central building blocks (reflected within the medical model) are task oriented and which still strongly influence the manner in which nursing care and practice has been theorised.

Science in this sense is considered as value free and most positivists regard traditional metaphysics and ethical considerations as relatively unimportant with non-positivist investigation being considered emotive and as being cognitively meaningless (Meleis 2012). On this basis, nursing's progress in theoretical development which has relied on the received scientific view has made slow progress and its development perhaps seen as the poor cousin to other academic disciplines such as medicine and science. This progress and reliance by nursing on reducing a problem to its smallest part and stripping it of its contextual background and taking away its humanistic life perspectives hints at reductionism. This model often means that how the problem emanated has been discounted and treating the symptoms rather than the underlying problem and has meant that nursing often struggles in developing meaningful theories and this has got in the way of nursing's

aspirational goals of being a scientific discipline. That being said, nursing is working hard at fostering the development of more meaningful theory and promoting a move toward non or post-positivistic theory, which Meleis (2012) calls the perceived view.

The perceived view bases the theoretical constructions of nursing around alternative methods, which accept values, subjectivity, intuition, history, tradition and multiple realities although does retain some scientific knowledge and broadly harnesses this by calling it evidence based practice, itself highly contentious in nursing and for traditional science (Meleis 2012). This view extends the positivist medical model and is more congruent with nursing containing a caring commitment to human beings and treating the person with the illness rather than just the diagnosis/pathology.

The emergence of postmodernism and some of the literature, like the post modernistic movement as a whole, tends to challenge or reject the principles, dogma and practices of established modernism. The emergence of postmodernism as a movement tends to encompass what I have described as the paradigm shift from the received to perceived view whereby nursing as a profession is now looking to move away or deconstruct from singular theoretical constructions of nursing and how these constructions determine the care nurses give and govern their overall philosophy of nursing. Indeed, the convergence of postmodern literature with various modes of critical theory and deconstructionist approaches, and the subversions of the implicit contract between the author, the text and the reader's understandings have come to characterise its theoretical construction and therefore its application to practice.

Using a holistic framework, utilising phenomenological and philosophical approaches, tends to encompass a view based on the perceptions of both the client's experiences and those of the nurse/theorist suggesting that the influence of the positivist method slowly infiltrated the nursing theory field, because nursing tended to borrow and utilise theories from other disciplines, such as the natural and social sciences. These borrowed theories guided, almost directed, theory development in nursing away from the world of human interaction by accepting a method/theory designed to explain phenomena of the physical world. This concentration and/or acceptance of the scientific method tended to promote the science of nursing at the expense of the art, neglecting that portion of nursing (a problem for economic rationalists) that does not readily lend itself to quantified results (King 1981). How can care be measured, given, and costed using a fiscal formula (Ray 1989). Measuring and costing nursing care, leads to prescriptive standardised care which fails to take into account the need to incorporate the variables significant in each patient situation. This is symptomatic of returning to treating the part rather than the whole, or the illness rather than the person.

THEORETICAL NEOLOGISMS

Many of the most widely read theorists are American, with the exception of Nightingale, all having the use of material from earlier theoretical works, elucidating different descriptions and revised theoretical viewpoints. Some create neologisms or word salads to refer to similar theoretical constructions of nursing outlined by their earlier contemporaries, almost engaging in theoretical plagiarism. Marriner-Tomey (1989 p.58) refers to this as a 'coined word explosion, ...[with] this profusion of definitions [creating] further confusion'. Clearly, there are no universally acceptable approaches, and, perhaps the esoteric, abstract nature of many theories means that their relevance will never be fully acceptable to many practising and/or academic nurses.

All nursing theories and theorists are clearly products of their time, all seeking explanations of knowledge development in nursing, and having the advantage of earlier theorists' claims/ideas. All people/nurses are embedded in, and the subjects of, their own personal histories and the specific histories relating to the contexts in which they work. Nursing is certainly influenced by its history, a history which has involved medical

and patriarchal domination, oppression, gender and economic means and by the construction of nursing harnessing a range of socio-cultural, politico-economic and developmental concepts that have gone before. Clearly, there are tensions between the humanistic positions described above, with many theorists arguing that caring is common to all nurse-patient settings.

These aforementioned points must be significant for the theoretical construction of nursing, where more recent practice theories have had the benefit of trial and error through clinical practice. Many contemporary theorists have experience as registered nurses, some with additional experience and qualifications in psychiatry, holding a different, more encompassing focus in terms of holism than those without and all with the exception of Nightingale, although well educated, had the benefit of academic preparation. This point is emphasised because in practice, nurses do, prior to developing their theories, lay claim that academic theorising has little to do with day to day nursing and this debate is a dilemma for those nurses who theorise, those nurses who say they 'just' practice and the majority of nurses who do both without thinking about it – working intuitively (Meleis 2007; Cody 2003; Benner 1984). This allows some nurses to point their finger at academia, suggesting that their theories are too complex and questioning what academics know about everyday clinical practice.

To understand the influence of non-positivist philosophies on the theoretical construction of nursing, one needs to ascertain the movements of that construction as nursing moves from one paradigm to another. The two epistemologies are different and Watson (Holmes 1990) refers to this as a junction leading in two different directions. Surely we would have difficulty embracing one philosophy without understanding the dichotomy and movement between the two.

NIGHTINGALE'S IMPORTANCE

Much of the nursing literature uses Nightingale as its theoretical figurehead. The general public endear a mythical vision to this enigmatic character, holding this vision aloft as caring, comforting, the ideal woman and nursing matriarch. Nightingale (1969) believed that disease was a reparative process, a belief founded on the premise that disease is nature's effort to remedy poisoning/decay, and a reaction against the conditions in which the person was placed. The Nightingale environmental legacy promulgated the belief that nursing could therefore improve the environment for the patient's benefit. Manipulating the environment in terms of cleanliness was also considered part of societal expectations of the role of women in the Victorian era and was a significant factor in Nightingale's vision for nursing.

Nightingale sought to make nursing and a woman's role respectable at a time when poverty and suffering were commonplace. This philanthropic benevolence not only made Nightingale more acceptable to the masses but made her a powerful and noteworthy figure. Pearson and Vaughan (1986 p.20) concur, saying her role was to 'attach nursing to medicine'. This notion of attachment highlights a folly of the Nightingale era, that of observation, where nurses were trained to observe the patient's condition, and report changes to the doctor. This elevated the doctor and placed nursing in a secondary role, with this position tending to find favour in terms of gender roles through the church, where 'Marian qualities of domesticity, subordination to man, purity, devotion ... motherhood and asexuality ...paraded as ideals' (Holmes 1991, p.9).

From a current feminist perspective, Nightingale's adherence to the medical model and following doctor's orders tended to place nurses (women) into the handmaiden role, a position often accepted by them in the past and with the advent of feminism - less so now. From a different perspective, Nightingale's story is evidence of a woman's ability to make important contributions in a male dominated 19th century cultural setting, by wielding political influence at a time when women were subject to the constricting influences of Victorian society. The intended or unintended Nightingale legacy attached nursing to the medical model,

reified through the hospital apprenticeship/educational system, and passed on without significant challenge until nursing moved away from the hospital apprenticeship system to university settings.

Over time, theories have changed significantly, with parallel changes in society, and this appears manifest in all contemporary theoretical constructions. In Nightingale's case, the environment of war was a primary factor in her theoretical construction; similarly, at the other end of the nursing spectrum, space travel, significant in Rogers' (1986) visionary view of aerospace nursing, where during the 1980s, the advent of the space shuttle program brought the idea/theories of living in outer space, closer to a supposed reality for everyday people. Nursing theories constructed during the 1950's and 1960's outline widespread acceptance of specific paradigmatic origins, perhaps indicative of the acceptance at that time which viewed nursing as a science rather than incorporating its other more humanistic qualities.

SECOND ORDER CHANGE

Peplau's (1952) theory (Marriner-Tomey 1989) is part of the second order change in nursing, where patient needs were more the focus of her theoretical assertions and helped move nursing toward a more non-positivist philosophy and stands in stark contrast to the medical model/positivist position expounded by Nightingale. Its interpersonal and developmental aspects suggest a move away from disease processes, to the meanings of events, feelings and behaviours. Other theorists such as Neuman (1989, 1982) and King (1971) both use a systems theory platform, with King's theoretical assertions, maintaining a collection of statistical data as its main scientific foundation; both appear to endorse nursing as fulfilling a deliberate action along positivistic lines, but, start to show the beginnings of a more humanistic base. Neuman (1982 p.1) reinforces this point declaring we should '... refuse to deal with single components, but instead relate to the concept of wholeness'. Neuman's reliance on a systems theory had changed significantly, showing her movement from one paradigm to another, as she developed and refined her theoretical position in 1989.

Interestingly, many nursing theorists changed their orientations over the years in respect to their theoretical assertions. Neuman (1989, 1982), and King (1981, 1971) originally both working within a systems theory and gradually assuming more of an interpersonal theoretical position. Although Orem's (1971) work has a needs orientation, it could also be tied to both an interaction and systems theoretical base. The author is not sure if this was the theorist's initial intent or whether description by contemporary authors of today, have different interpretations (and therefore understandings) of each theorist's theoretical construction. Travelbee's (1971, 1966) theoretical construction of nursing moves toward changing the focus of nursing, by endeavouring to humanise both nurse and patient (Holmes 1990) and, with Rogers (1970), moved the process of theoretical construction in nursing toward a more humanistic, non-positivist standpoint. These points are exemplified by Rogers (1970) considering man as a unified whole and moved her original theory toward a more humanistic model which were then influential in Parse (1981), who grounded her theoretical construction of nursing upon existential-phenomenological views, as explicated by Heidegger (1968), and Merleau-Ponty (1962). This combination demonstrates a paradigmatic change by espousing humanism at the expense of positivism (Limandri 1982).

PARADIGMATIC SHIFT

As nursing began to adopt a more humanistic science, for which methodologies had been devised to supplement, enhance and transcend positivist approaches in the search for understanding (Rogers 1970), perhaps nurses and nursing has become more accepting of a changed theoretical construction of nursing, a paradigmatic shift from Nightingale which includes more non-positivist philosophies. Examination of the theories offered by Newman (1986, 1979), Benner (1984) and Watson (1985, 1979) who endorse non-positivist philosophies, may shed some light on this paradigmatic shift.

NEWMAN

Newman's theory/model of health (1986, 1979) has been positioned as an expansion of Roger's theory, in which the goal of nursing is based on health as the undivided wholeness of the person in interaction with the environment. Thus, the nursing aim is not to make well or to prevent illness, but to help people use their power within as they evolve toward a higher level of consciousness. Embedded in this construction is the idea that illness reflects the life pattern of the person and recognition of the pattern and an acceptance of the illness for what it means to that person (Newman 1986).

These concepts of consciousness according to Newman (1986) are time, movement and space. Time is an index of consciousness and a function of movement. Movement is the means in which time and space become reality, with space and time having a complementary relationship. Without movement time and space are not real, and there is no change at any systems level. Movement mirrors the organisation of consciousness and therefore reflects health. The implied aim is consciousness expansion and therefore expansion of health and life (Chinn and Kramer 1991).

It is certainly a new way of considering health via the none traditional concepts of movement, time, space and consciousness. It asks its readers not to try and change another person's pattern but to recognise and relate to it in an authentic way. The theory draws on some of Newman's contemporaries (Rogers 1986, 1970), and includes Nightingale (1969), although it's difficult to relate the two, because Newman (1986) appears to move away and have no major positivistic philosophical indicators in her work. Newman's theoretical construction presents as particularly abstract, almost an exercise in mental gymnastics, wherein one is required to fit the pieces of the nursing paradigm (man, health, environment and nurse) into place.

BENNER

Benner (1984) focussed her philosophical and theoretical ideas about nursing by using descriptive accounts of clinical practice to discover/examine the knowledge embedded in nursing practice by outlining the differences between practical and theoretical knowledge, the doing from the knowing ('knowing how' versus 'knowing that'). This knowledge construction draws on the work of Dreyfus (1979), whose model of skill acquisition is aimed at classifying students' levels of proficiency, moving from novice to expert. This skill acquisition is the moving from formal models which depend on rules to guide action, like training wheels, to the intuitive grasp of situations where nurses no longer rely on models/rules to guide their understandings of situations. Benner (1984) captures the holistic nursing practice perspective by using a phenomenological approach, in which nurses systematically record what they learn from their experience, using these exemplars to see the situation as a whole rather than its parts.

Polanyi (1969) describes this as an understanding of the differences between actual knowledge (knowing that) and knowing how, or knowing the theory and being able to apply the theory to practice. Polanyi uses riding a bicycle to make this point, saying this does not mean that I can tell how I manage to keep my balance, although he states I can always ride my bicycle without problem or conscious thought.

Benner (1984) suggests that as experience is gained, clinical knowledge becomes a blend of practical and theoretical knowledge. This premise implies that there is more to any situation than a theory could ever predict, and in this sense the skilled practice of nursing exceeds the bounds of formal theory. This line of reasoning is wedded to Benner's assertion that theory is required and relevant as a starting point for nursing and is developed with experience and extends to knowledge embedded in practice which helps discover and interpret theory, precedes and extends theory and then synthesizes and adapts theory into intuitive nursing practice. Benner's philosophical ideas would be more appealing, understood and accepted by nurses in clinical practice because they move away from academic, 'scientific jargon' and encompass basic humanistic care.

WATSON

Watson's (1985, 1979) theories also hinge on a more phenomenological and holistic view, using a combination of psychology and humanism and advocating nursing as promoting/restoring health, preventing illness, and caring for the sick. These views advance the person as a unity (Holmes 1990) who requires holistic care, which promotes humanism, health and quality living. Marriner-Tomey (1989) describes Watson's theories (1985, 1979) as an attempt to understand how health, illness and human behaviour are interrelated. Watson's theoretical focus is on caring which, as a body of knowledge, distinguishes nursing from medicine as a separate science. Holmes (1990) refers to an epistemology that allows not only for empirics, but for advancement of aesthetics, ethical values, intuition and process discovery saying Watson's explicitly phenomenological approach operates alongside the positivism of traditional medicine. This position views the human science of nursing, and the natural science of medicine, not as mutually exclusive but rather as two different ends of a continuum along which clinical practice can travel.

CHANGING FOCUS

There is a changing focus in the theoretical and philosophical developments in nursing. This change moves away from all inclusive to a more post-modern theorisation. This development has moved from a position which promoted nursing as a science, reliant upon observation and adherence to the medical model and specific patient needs as the goal of nursing, to a position where a more holistic/humanistic focus became the currency of practice. Movement through this period shifted the theoretical construction of nursing to interpersonal relationships, where nurse-patient interactions were viewed as being clinically more significant than in the past. Systems theories were introduced, although it is difficult to make clear distinctions between the philosophies that distinguish systems theory from interpersonal relationships, with many contemporary authors defining these fields differently. For example, the work of Rogers (1970) is classified as systems theory in Torres (1986), energy fields in Marriner-Tomey (1989) and outcome theory by Meleis (1985). This diversity of opinion is not helpful and demonstrates a lack of clarity in the original theories and is a topic of much debate in nursing curricula. Clearly, we need a combination of theories/models which incorporate the complexity and diversity of nursing and patient care situations.

Many of the theories today appear somewhat dated and esoteric. I have argued here for nursing to move toward a multiple model, capturing the philosophies of both positivist and non-positivist paradigms (in a triangulated/overlapping way). This multiple model embraces evidence based practice where we read all of the incoming patient data in devising diagnosis and developing treatment strategies. Evidence based practice at the moment appears to be focused on the primacy of the randomised clinical trial as the only legitimate source of evidence. According to Fawcett et al (2001) most discussions of evidence based practice treat evidence as an atheoretical entity which tends to widen rather than close the theory practice gap. Pearson (1987) articulates this thought saying we need to peruse multiple options and to value them all, in this way we could perceive practical theory as legitimate theory; practice as theoretical; practitioners as theorists; and at the same time acknowledge those scholars whose expertise lies in developing theory from outside the practice world.

We have to be careful in this process that as we embrace non-positivist philosophies and begin to combine these changed philosophies with management initiatives such as case-mix and diagnostic related groups that we do not go full circle and begin to embrace nursing care driven by bureaucracy and fiscal policy. If we do this, it will be like returning to our 'nursing shift with Nightingale' where we once again practice and rely on observable entities, with demonstrated regularities and general laws verified through their measurement and quantification, embracing the medical model; self-fulfilling the handmaiden role and incorporating the mandates of positivism.

SUMMARY

Meleis' (2007) work outlines the pull between the received view of science and the perceived view. The former provided grounds for acceptance and rejection of the process that nurses have taken in theory development and is a more acceptable approach to analysis and evaluation of work within the context of justification. The perceived view, the guiding paradigm for nursing practice, nursing theory and, for that matter, nursing education, has been more open, more variable, relativistic, and subject to experience and personal interpretations. This perceived view encourages a holistic outlook and approach, based on the perceptions of both patient and nurse theorist/practitioner, encompassing their descriptive exemplar experiences. These notions are the building blocks to the context of discovery in philosophical and theoretical knowledge construction. The highlighting of Newman (1986, 1979), Benner (1984) and Watson (1985, 1979) emphasises the role of the nurse and the caring endeavour as being distinct, equal, if not more valuable and important in terms of patient outcomes as cure (the dictate of the medical model). This position champions holism which insists that all aspects, the whole of natural phenomena must be admitted to nursing practice in order to gain a more meaningful bigger picture of patient care in determining diagnosis and then care. The three theorist's examined are certainly products of their respective times, where their own personal histories influence aspects of their theoretical constructions. The idea of energy fields (Newman 1986) is in stark contrast to Nightingale's manipulation of the environment; the notion from Rogers (1986) that nursing in space needs consideration is not something that practising nurses will readily grasp, and we need to be careful that any theoretical construction of ideas such as this should be discouraged simply because they fascinate (Holmes 1991). Our theories should be distinguished by intuition and insight as distinct from guess-work founded on ignorance (Holmes 1991). Extending this point, some nursing theories are rather abstract and esoteric and appear to have little to do with everyday nursing. Analysis of many theoretical constructions shows them to view specific phenomena and/or theoretical positions from a variety of different perspectives, rather than offer substantial paradigmatic alternatives. Clearer definitions rather than 'word salads' will help practising nurses accept, understand and engage the move toward more non-positivist philosophies in respect to the theoretical construction and practice of nursing. The lesson from this research is to encourage the marrying of science and art to capture real nursing practice going forward in the 21st century.

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