The Nature of Caring by Nurses in an Intensive Care Unit (ICU):

A Focused Ethnography

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Declaration of Authorship and Originality

I, the undersigned author, declare that all of the research and discussion presented in this thesis is original work performed by the author. No content of this thesis has been submitted or considered either in whole or in part, at any tertiary institute or university for a degree or any other category of award. I also declare that any material presented in this thesis performed by another person or institute has been referenced and listed in the reference section.

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Abstract

As a concept, caring is inextricably intertwined with nursing. There is a plethora of literature devoted to the concept of caring, but it is nebulous and complex. Numerous theoretical and operational perspectives of caring within the context of nursing have emerged over time. The ongoing dialogue and debate about what constitutes caring within the ever-expanding domains of nursing practice are nowhere more evident than in the specialisation of the adult intensive care unit (ICU), where humanistic caring is juxtaposed with advanced technology.

The aim of this study was to explore the nature of caring in an adult ICU. The methodological framework underpinning this study was a focused ethnography undertaken in an adult intensive care setting in one of the private hospitals in Queensland, Australia. Purposive sampling was used to invite 35 registered nurses (RNs) to participate in this study. Multiple types of data were collected over a six-month period: socio-demographics, participant observations (1,632 hours), field notes, document reviews, formal interviews ($n = 79$), informal conversations ($n = 16$) and participants' additional notes ($n = 26$).

Data analysis explicated seven central themes: (1) nurses' perceptions of caring in ICU; (2) a culture of inclusive caring practice in ICU; (3) qualities required of the ICU nurse; (4) the unit manager as a culture carrier of caring in ICU; (5) patterns of communicating caring in ICU; (6) enablers, challenges and negative cases of caring in ICU and (7) patterns of coping with stressful moments by nurses in ICU. The thesis concludes with an examination of the findings, their implications and the generation of recommendations for nursing practice, education and research.

Keywords: Intensive care unit, critical care nurses, nature, culture, caring and care

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Glossary of Terms

CCN   Critical Care Nurse

CNM   Clinical Nurse Manager

ECG   Electrocardiogram or electrocardiograph.

EET   Endo tracheal tube

EOL   End-of-life

HCPs   Health care professionals

ICU   Intensive Care Unit

LEP   Limited English proficiency

MERTS   Medical Emergency Response Teams

PAWI   Participant's additional written information

PRISMA   Preferred reporting items for systemic reviews and meta-analysis

PPEs   Positive practice environments

PTSD   Posttraumatic stress disorder

RN   Registered nurse

SLP   Speech and language pathologist

Dedication

First and foremost, I praise and thank my creator Allah (God) Almighty, the author of all Wisdom for giving me the strength to push forward during this endeavour, who knows the challenges that I need to live. Through your graces, doors were opened and opportunities were given to me to complete my course of study. To you be glory and honour.

This dissertation is earnestly and passionately dedicated to my family. First to the memory and honour of my parents: my father Subhi and my mother Sumaia. To each, my love and sincere appreciation for their support, love, words of wisdom and smiles. Although you are not here with me in body, you are here in spirit. Second, my siblings, to whom I am deeply indebted: my sisters—Aisha, Tahani, Fedda, Fida'a—and brothers—Essam, Ahmad, Mohammad and Hussam—and their families. To my niece Ronza (6 years old), who passed away from brain cancer, and my special nephew Hakeem for being my soulmate in this journey. In addition, I would like to thank my Australian mother Vicki and her family. I offer my sincere thanks to you all for your unconditional and unwavering understanding, love, support, encouragement, listening, patience and belief in me in innumerable ways during all my educational journeys. I am truly grateful to my family for always being there for me. I love each and every one of you with all my heart. You have been my cheerleaders throughout this PhD journey and without your love and support, I really could not have done this.

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ICU Nurse: My patient, I see y♥u

i s e e Y♥U

HOLLISTICALLY

'*Sadness* can enter everybody's home for any reason, but *Happiness* will not knock at everybody's door. Therefore, *kidnap happiness* wherever you can find it because life is very short'.

Hanan Subhi Al-Shamaly

Chapter 1: Contextualising the Study

1.1 Introduction

This chapter provides a contextual understanding of why this study was undertaken. The chapter begins with a description of the researcher's personal background, which was the impetus for this study, with particular reference to professional experiences. Further, the researcher's experience as a relative of a patient in the intensive care unit (ICU) is also presented. Later sections include discussions about the nature of an ICU and the technology, nurse–patient relationship and communication in ICU. Finally, an overview of this thesis is presented.

1.2 Personal background of the researcher.

A series of different experiences led me to undertake this study. First, my professional experiences as a nurse caring for patients in ICU, as a theatre nurse working with colleagues in ICU and as a corneal coordinator working with ICU patients, their families and nurses. Second, the profound experience of being involved as a relative of a person (my father) admitted to ICU on multiple occasions motivated me to undertake this research.

1.2.1 Professional experience in working in an ICU.

I worked as a nurse in ICU for five years at Mubarak Al-Kabeer Hospital, a public hospital in Kuwait and felt I was making a meaningful contribution to the care of those who are most vulnerable. During the Second Gulf War, I was an ICU nurse-in-charge as well as being responsible for the care of four to five patients. During this time, I found myself reflecting on the type of care provided within such an acute setting, which was quite different from the general patterns of caring that I experienced in general hospital wards.

As time passed, I began to realise that there was a different configuration of what constitutes caring in an ICU.

1.2.2 Experience as a theatre nurse dealing with ICU.

I worked as a nurse in the operation room (OR) for 20 years, first in the Islamic Hospital in Amman-Jordan for almost 14 years, and then in the Princess Alexandra Hospital in Brisbane, Australia for eight years. As a theatre nurse, I was sometimes involved in ICU, when transferring patients from the OR and when conducting required surgical procedures for ICU patients. This gave me the opportunity to engage with nurses in ICU and to observe how they dealt with patients, even for short periods of times.

1.2.3 Experience as a corneal coordinator dealing with ICU.

I was a corneal coordinator for five years in the Islamic Hospital, Jordan. During this period, I worked with ICU patients, their relatives and nurses, and was responsible for convincing the relatives of deceased patients to donate their loved ones' corneas and then surgically removing the corneas (keratectomy) for transplantation. As I was also responsible for associated care before, during and after surgery and follow-up, part of my work involved daily visits to ICU for possible future donations in the event of a patient dying. In my role of corneal coordinator, I had the privilege of working with and observing how nursing staff engaged with patients and their family members during critical illness experiences, especially with those patients in an induced coma or unconscious state. The manner in which they cared for their patients and family was a point of edification for me, which ignited a desire to explore this aspect of nursing practice from an ICU perspective. Another factor that consolidated pursuing this course of inquiry was my experience as a daughter of a father admitted to different ICUs.

1.2.4 Experience of having a parent admitted to different ICUs.

My journey into the world of caring in ICU was furthered by my personal experience as a daughter whose father was admitted to two ICUs. The first occasion, involved admission to the private Islamic Hospital, Jordan. I had the privilege of caring for my father with other ICU nurses. During this period, I became increasingly convinced that a different pattern of caring existed. Emphasis seemed to be on a type of mechanical caring in which technology played a major part and nurses worked around complex apparatuses. However, despite the emphasis on technology, the manner in which the nurses interacted with their patients was one of quiet sensitivity. This was not an isolated case but seemed to permeate the ward milieu. In an environment with a separation policy between males and females, my presence as a female relative in a male ICU affected both the male staff (who appeared annoyed) and myself as I struggled with my need to be with my father in a foreign and forbidden male environment. On the second occasion, I was a visiting relative to my father during his period of hospitalisation in King Hussein Medical Center, a Military Hospital in Jordan. This period was hurtful because of restricted visiting times. The feelings generated in the first experience with my father were confirmed. Caring in ICU is different from what I understood caring to be. Therefore, there seemed to be an underlying subtle difference in the way caring was practiced in different ICUs. Reaching this realisation further motivated me to pursue this path of inquiry. The first step was to explore contemporary literature to determine if such an area of interest had been examined and reported. I questioned what the culture of caring in this type of specialised unit is, which began this journey of exploring the nature of caring in ICU. Before the resultant literature review is presented, each chapter of this thesis is outlined.

There is a great deal written about the nature of caring in general but very little concerning caring in an ICU. Contextual background literature related to the ICU

environment is paramount and required to 'set the scene' for this research. In addition, certain terms must be defined for clarity, as the consensual definitions of many of the caring-related terms used are elusive. First, the terms are defined. Then, the findings of an extensive literature review will be presented. This review covers the nature of an ICU as well as technology, nurse–patient relationships and communication in an ICU—all significant topics, which convey what it is like to work in an ICU. This literature review was undertaken prior to the second extensive literature review (Chapter Two) examining the notion of caring, the central tenet of nursing and this inquiry.

To contextualise this research however, a first extensive literature search was conducted using Academic Search Complete CINAHL with Full Text, Health Business Elite, Health Source: Nursing/Academic Edition, MEDLINE, Psychology and Behavioral Sciences Collection, PsycINFO, SocINDEX with Full Text, SPORTDiscus with Full Text, Google, books and articles. The keywords used were 'intensive care unit', 'ICU', 'critical care unit', 'nature', 'culture', 'environment', 'characteristic*', 'description' and 'caring'. The search word combinations used to maximise literature identification on the topic included 'intensive care unit'/'ICU', 'nature'/'culture'/'environment', 'intensive care unit'/'ICU' and 'communication'/'technolog*'/'patient* satisfaction*'/'patient* dis/comfort*', 'caring' and 'nature/culture of ICU'/'technology in ICU'/'nurse–patient relationship in ICU'/'communication in ICU'. The literature review revealed three essential elements relating to caring in ICU: the nature of the ICU, advanced technology, and the nurse–patient relationship (NPR).

1.3 The Nature of an ICU

The critical care setting is concerned with human physiological or psychological reactions to life-threatening problems such as traumas, major surgeries or complications of illness. The nurse in critical care focuses on patients and their families to prevent and

improve their acutely ill state (Sole, Klein & Moseley, 2009). There are several terms

associated with the critical care setting. First, the critical care unit (CCU) is defined as:

> A special unit in a hospital where patients with critical disorders or diseases of the
>
> vital physiological systems (cardiovascular, respiratory, renal, electrolytic, and
>
> neurological) are provided with the care required to sustain life. May be combined
>
> with an intensive care unit. (Blackwell's Nursing Dictionary, 2005, pp. 156-157)

The term ICU has been defined as 'a special area in a hospital where critically ill

patients who need close observation and frequent ministrations can be cared for by highly

qualified, specially trained staff' (Blackwell's Nursing Dictionary, 2005, p. 305). An ICU

deals with life-saving interventions during acute physiological crises, with a particular

focus on medical needs and access to technology (Juliet & Sudha, 2013; Kleinpell,

Barden, Rincon, McCarthy & Rufo, 2016; Marik, 2010; Wikström, Cederborg &

Johanson, 2007; Woodrow, 2012). It is also considered a 'high pressure working

environment' (Ryherd, Waye & Ljungkvist, 2008, p. 748) because of the complex and

specialised nature of the work (Backes, Erdmann & Büscher, 2015; Wikström & Larsson,

2004).

A variety of models have been used to guide practice in ICU; however, they

generally fall into two categories: the closed and the open models. In the closed or high-

intensity model, patient management is primarily undertaken by intensivists, who are full-

time, critical care medical expert physicians that provide continuous patient management

physiologically monitoring and supporting organ systems (Kim et al., 2012; Marik, 2010;

Weil & Shoemaker, 2004). The intensivist's role is to oversee all aspects of patient care

and they are responsible for managing the patient's condition (Marik, 2010). The patient's

primary physician and the healthcare team collaborates with the intensivist in the provision

of total patient management (Marik, 2010). In the open model, the primary physician

(a non-intensivist) is responsible for their patient's admission care management and discharge planning (Marik, 2010).

The nature of ICU nurses' work differs to that of nurses in general wards. For example, there is a low nurse-to-patient ratio (1:1 or 1:2) in ICU (Almerud, Alapack, Fridlund & Ekebergh, 2007; Kim et al., 2012; Marik, 2010), where nurses are continuously at the bedside and monitor all aspects of the patients' health status. The second element identified in the literature relating to caring in ICU is the use of technology.

1.4 Technology in ICU

The ICU is a hospital's most technologically advanced environment (Almerud et al., 2007; Marik, 2010; Shimizu, Couto & Merchan-Hamann, 2011). It uses technology to continuously monitor multiple physiological and clinical parameters, measured at the bedside and through to electronic documentation (Almerud et al., 2007; Marik, 2010). Healthcare staff require regular opportunities for knowledge updates and skill enhancement to manage this ever-changing technology (Thimbleby, 2013; Wikström & Larsson, 2004).

There are a range of implications associated with using technology in an ICU. On one hand, technology enhances safe, efficient and individualised care by utilising information technology (Amarasingham et al., 2007; Kleinpell et al., 2016), providing readily accessible data, evaluating the physiological response to care and supporting decision-making and compliance with quality standards (Bates & Gawande, 2003; Lapinsky, Holt, Hallett, Abdolell & Adhikari, 2008; Martich, Varon & Marik, 2002; Waldmann & Imhoff, 2004; Wilkin & Slevin, 2004). Moreover, technology improves time utilisation and delivery of care, and can reduce medical errors (Stoyanova, Raycheva & Dimova, 2012; Varon & Marik, 2002). Thus, technology makes nursing practice easier, and enhances nurses' abilities to meet patients' needs (Alasad, 2002; Nascimentol & Erdmann, 2009; Wikström & Larsson, 2004).

Conversely, using technology may be viewed as time-consuming (Alasad, 2002; Donchin et al., 2003; Radtke, Tate & Happ, 2012) and is sometimes perceived as unnecessarily complex work (Huston, 2013; Radtke et al., 2012; Strauss, Fagerhaugh, Suczek & Wiener, 1985). It is argued that technology has come to 'precede' the patient in ICUs in it can affect and even impede care if the nurses' practice and focus revolves around machines rather than the person (Almerud et al., 2007; Huston, 2013; Johns, 2005; Wikström & Larsson, 2004; Wilkin & Slevin, 2004).

Caring is a form of complex human contact in an ICU. For example, in their study of the effect of stress on the use of touch with critically ill patients, Adomat and Killingworth (1994) found that nurses can feel detached from the humanistic features of patient caring especially when time is short, technical tasks are given priority and the patient is objectified as an extension of the machine. This similar to the finding of Cadge and Hammonds (2012) that nurses in critical care settings were detached from critically ill patients. This approach has also been described as 'non-caring nursing' in Almerud et al.'s (2007) phenomenological study of being a patient in a technologically intense environment and also in Johns's (2005) discussion. Technological dehumanisation is a challenge for nurses in ICUs (Barnard, 2004; McGrath, 2008). Almerud, Alapack, Fridlund, and Ekebergh (2008a) highlight that technology is not supposed to withdraw uniqueness and dignity from patients, but its widespread use and nurses' 'technological' attitude have made the practice of nursing markedly technological. A hermeneutic phenomenology study by Alasad (2002) found that some nurses consider basic nursing care and interpersonal relationships less important than the nurse's technical role in the ICU, while others consider both caring and technology equally important. In short, technology has the capacity to significantly affect the ICU environment, patient care and nurses' abilities to provide

appropriate health care delivery. The third element identified in the literature relating to caring in ICU is the nurse–patient relationship.

1.5 The Nurse–patient Relationship in an ICU

The NPR is a significant therapeutic interpersonal process (Peplau, 1988); the use of 'therapeutic' indicates a positive or beneficial influence (Baillie, 2005; Cameron, Kapur & Campbell, 2005). The elements of a therapeutic NPR in ICU are the patient, the nurse, the patient's health and the context (Gámez, 2009; Mitchell, 2007). The NPR may be viewed as a caring partnership or companionship in which there is participation, cooperation and mutuality (Castledine, 2005; Gallant, Beaulieu & Carnevale, 2002; Henderson, 2003; V. Karlsson, Bergbom & Forsberg, 2012; O'Connell, 2008). A review of families, nurses and intensive care patients by Holden, Harrison, and Johnson (2002) and a ground theory study of the process of family integration into ICU by Hupcey (1999) indicated that the NPR is generally eclipsed in the ICU by the nurse's relationship with the patient's family, because of the critical condition of patients. Further, Åsa and Siv (2007), Blanchard and Alavi (2008), Holden et al. (2002) and Stayt (2007) all suggested that it is beneficial for the patients, families and nurses to build a good nurse–family relationship.

However, constructing a close relationship requires time and energy (Holden et al., 2002). While this is a reasonable argument by Holden and others, forming a close relationship is possible in ICU because of the constant presence of a nurse and their 1:1 ratio with patients (Deeny & McGuigan, 1999; Kim et al., 2012). Additionally, nurses' physical and psychological collaboration with patients in ICU aids the development of a trusting relationship (Wilkin & Slevin, 2004). Since communication is vital in NPR, it will be discussed in the next section.

1.5.1 Communication in the ICU.

Communication in the ICU is vital in the assessment of symptoms and in patients' participation in decision-making regarding treatment plans and the end-of-life decisions (Butow et al., 2010; Happ, Tuite, Dobbin, DiVirgilio-Thomas & Kitutu, 2004; Mohan, Alexander, Garrigues, Arnold & Barnato, 2010). Communication in an ICU may be limited to verbal responses of yes/no (Happ et al., 2004; Radtke et al., 2012) or non-verbal answers, such as eye blinking (Batty, 2009; Happ et al., 2004).

In a three-case-study report, Radtke, Baumann, Garrett and Happ (2011) used various strategies, including speech language pathologist (SLP) services and augmentative and alternative communication tools, which they believed are useful to enhance communication, incorporate technology and assist in the education of patients, families and care providers in ICU. However, another quantitative study of nurses' perceptions of communication training in the ICU by Radtke et al. (2012) found that nurses' evaluations of communication vary. Some prioritise medical treatment over communication and others consider assistive communication methods to be time-consuming and impractical, emotionally exhausting and inappropriate for ICU patients.

In summary, various environmental, psychological and workforce contexts can positively enhance caring in ICU—or inhibit it. This first review of background information highlighted the complexity of this topic and the need for an enhanced understanding of caring, particularly in the ICU.

1.6 Significance of the Study

The areas of significance of this study are as follows:

1. There is a noticeable absence of research about the nature of caring in ICU, specifically in Australia.

2. The findings of this study have the potential to contribute to extant knowledge about the nature of caring in ICU.

3. The findings of this study have the potential to inform contemporary nursing and health practice in the management of, and care in, the ICU environment.

1.7 Aims of the Research

The aims of the study are:

1. to explore the nature of caring in ICU.

2. to contribute to current theoretical understandings of the nature of caring in ICU.

3. to disseminate the findings of this study to ICU healthcare professionals for their personal reflection and practice enhancement.

1.8 Research Question

The research question that will inform this study is:

What is the nature/culture of caring in an ICU?

1.9 Overview of the Thesis

This thesis is presented as 10 chapters. Chapter 1 presents an introduction and background. Chapter 2 offers a critical review of the literature to ascertain what is known on the topic to justify undertaking this study. Chapter 3 provides a description of the focused ethnographic approach to inquiry, which is the theoretical framework underpinning this thesis. Chapter 4 describes the methods used for data collection and analysis as well as rigour and ethical considerations. Chapters 5, 6 and 7 present the findings of the study. Chapters 8 and 9 discuss the findings in relation to current literature on the topic. Chapter 10 concludes the study and considers implications and recommendations arising from the findings.

1.10 Summary

This chapter provided a contextual understanding of why this study was undertaken. The chapter began with a description of the researcher's personal background for this study with particular reference to the professional experiences as a relative of a beloved patient in ICU. It discussed the nature of an ICU as well as technology, nurse–patient relationships and communication in ICU. The chapter ended with an overview of the thesis.

Chapter 2: Literature Review

2.1 Introduction

This chapter presents an exploration of the nature of caring within the context of an ICU. The literature review was undertaken in three parts: the first concerns the origins of the word 'care' and defines both it and related terms. The second is a general exploration of caring in nursing. The third is an integrative review of the literature that specifically identifies studies undertaken on the nature of caring in ICU using preferred reporting items for systemic reviews and meta-analysis (PRISMA) to find what is known and unknown on the topic to provide justification for this study.

2.2 The Origin of the Word 'Care'

The term 'care' can be traced back to the prehistoric Indo-European period. The Indo-European 'root' is *gar* (to call, cry) from Germanic *karo* (to lament hence grief, care). The Germanic base is from the Old English *cearu*: to care. (Edenics, 2012). In Latin, to care is *caritas* which means charity, love, high price, expensiveness, scarcity, famine prices, want, esteem, regard, fondness, attachment, dearness, need and affection. 'Caritas' is used to describe the aspects of the nurse–patient relationship: means love, charity and compassion (Blackwell's Nursing Dictionary, 2005). The concept of caring is connected with that of love. The English word 'cherish' (meaning to hold dear, feel or show love for) originates from the Latin word *carus* (in English: 'care' or 'caring'), which means love.

2.3 Definitions Related to the Term 'Care'

Over time the term 'care' has developed different meanings: care is (1) the process of providing for the needs of someone or something (Cambridge Academic Content Dictionary, 2008). It is (2) serious attention (Cambridge Academic Content Dictionary, 2008; Homer & Holmes, 1998) or to be concerned, solicitous or to have thought or regard

(Bregenzer, Conen, Sakmann & Widmer, 1998; Homer & Holmes, 1998). It is (3) something that makes you feel worried or unhappy, for example, not having a care in the world (Oxford Wordpower Dictionary, 2006). Care can be (4) a burdensome sense of responsibility or imply a responsibility for safety and prosperity, (5) judicious avoidance of harm or danger or (6) a cause for feeling concern (Homer & Holmes, 1998).

'Care' may be used as a noun to denote protection as in caring for (looking after) someone's health (Oxford Wordpower Dictionary, 2006). As a verb, care embodies the actions performed as in 'to take care of' indicates a concern as in 'caring about'. (Oxford Wordpower Dictionary, 2006). In the literature, there are other meanings of care related to this topic as: 'to take thought for', 'provide for', 'look after' and 'to take care of' (English Oxford Living Dictionaries, 2018).

The association of care with other words in current nursing language has meaning when it is used in compound nouns. For example, nurses use the terms 'care giving' (Wolf, 1986), 'care plans' (Kolcaba, 1995), 'nursing care' (Tulek, Poulsen, Gillis & Jönsson, 2017) 'plan of care' (Lea & Watson, 1996), 'duty of care' (Kelly, 2010), 'health care' (Chao, 1992), 'basic, fundamental or essential care' (Crisp, Taylor, Douglas & Rebeiro, 2012) and 'intensive care' (Hogg, 1994). Caring has also has been conceptualised as 'patient-centred care', which was described as individualised holistic patient care underpinned by respect and the uniqueness of the individual who has their own values, preferences and needs (Institute of Medicine, 2003, 2010).

These global terms are common nouns in nursing literature and, in essence; they portray the activities of the nurse. Historically, it has been noted that the terms 'caring' and 'nursing care' may be used interchangeably (Lea & Watson, 1996; Leininger, 1981b). In the literature, the words 'nursing', 'nursing practice' and 'nursing care' can be readily interchanged (Kozier, Erb & Bufalino, 1989). Nursing literature is replete with various

definitions of caring (Benner, 1984; Bradshaw, 1998; Leininger, 1985b; Morrison & Burnard, 1997; Morse, Solberg, Neander, Bottorff & Johnson, 1990; Warelow, 1996; Watson, 1979) resulting in incongruities in the term (Huch, 1995).

2.4 Caring in Different Contexts and Perspectives

Caring is a universal concept that manifests in different cultures across the world, and each of those contributes to understanding the nature of caring in nursing from distinct cultural perspectives. For example, Western nursing evolved in the nineteenth and twentieth centuries, when professional caring emerged from the writings of Florence Nightingale and was formalised by conceptualisations of caring by Westerns theorists (Gaut, 1983; Leininger, 1991; Watson, 1988b). In addition to nurse theorists, many nurses have made substantial contributions to understanding what constitutes care/caring. Contributions have been in Australia and New Zealand (Chaboyer et al., 2013; Mitchell, Coombs & Wetzig, 2017; Storesund & McMurray, 2009), in China (Pang et al., 2004), Korea (Shin, 2001), the Philippines (Spangler, 1991), Hong Kong (Yam & Rossiter, 2000), India (Maggs, 1996; Somjee, 1991) and by Middle Eastern nurses in Saudi Arabia (Al Helwani, 2001; Lovering, 2013; Mebrouk, 2008), Jordan (AbuGharbieh & Suliman, 1992) and Iran (Fooladi, 2003).

Caring has different meanings for different religions, beginning with the various primeval religions and in the sacred writings of the prophetic and mystical religions (Judaism, Christianity, Islam, Confucianism, Taoism, Hinduism and Buddhism) (Ray, 1981b). However, common interpretations of caring include the notions of goodness, mercy and graciousness of the divine, which have evolved into models of behaviour towards fellow humans (Kung, 1975).

In an examination of the literature over time, caring has been explored and described from a variety of perspectives, beginning with Aristotle (Curzer, 2007) and going

through to Florence Nightingale (1859). It has been examined historically (Gustafson, 1984; Leininger, 1981c), anthropologically (Aamodt, 1978; Leininger, 1981a), psychologically (Fromm, 1956; Rogers, 2004), sociologically (Illich, 1976; Parsons, 1951; Zola, 1972), philosophically (Buber, 1970; Fromm, 1956; Heidegger, 1962; Marcel, 1981; Mayeroff, 1971; Noddings, 1984; Webster, 1990) and psychoneuroimmunologically (Ader, 1981; Cohen & Syme, 1985), and also into the context of nursing, as discussed in the next section.

2.5 Caring in Nursing

While there is a plethora of literature devoted to the concept of caring, it remains nebulous and complex. Caring is both an everyday activity and a professional attitude within the discipline of nursing. Numerous theoretical and operational perspectives of caring in nursing have emerged over time including nursing science, philosophy, ethics and social, physical and biomedical sciences (American Nurses Association, 1995). For example, philosophical writings have influenced research on caring (Watson, 2000). Mayeroff's (1971) seminal work on the notion of caring has influenced nurses' writing and researching of the topic. Mayeroff presented caring as helping the other to grow and acknowledged eight key elements of caring: knowing, honesty, humility, trust, patience, hope, alternating rhythms and courage. In the nursing literature, Mayeroff's (1971) conceptions of caring have been adopted by a number of nurse scholars (Walters, 1994; Wolf, 1986). In addition, aspects of the philosopher's work (Buber, 1970) that focused on human relationships between the self and others (I and You) is evident in the language of caring theorists (Leininger, 1985b). The works of Heidegger (1889–1976) also influenced nurse scholars (Benner, 1984; Benner & Wrubel, 1989; Dunlop, 1986; Walters, 1994). For example, Heideggerian thought is visible in Watson's writings on the 'ontology of being caring' (Watson, 1990, p.21) and 'caring as a mode of being' (Watson, 1985a, p. 58). The

work of Noddings (1984), who writes from a feminist perspective, described caring in the context of teaching relationships. Another author outside the field of nursing was Gilligan (1982), who identified the 'voice of care'. Such a notion was at the core of many women's thoughts about morality. This contrasts with a 'voice of justice', which is more typical of the responses received from men and has led to a re-examination of the 'ethic of care' (Bowden, 1997), and the ethical significance of caring (Fry, 1989). Caring can be traced through semantics, anthropology and the history of ideas (Eriksson, 1994), where the concept of caring is connected with that of love (Eriksson, 1994), as reflected in the work of Wolf (1986).

Creasia and Parker (1996) explored caring from an emotional perspective and proposed that the intellectual, humanistic and existential component of nursing can only emerge as central to nursing practice by devaluing the scientific and instrumental activities of nursing primarily concerned with technical skills. Leininger (1981a, p. 101) differentiated between humanistic caring and scientific caring in that the former is 'the subjective feelings, experiences and interactional behaviours between two or more persons (or groups) in which assistive or enabling acts are performed generally without prior sets of verified or tested knowledge'. Conversely, scientific caring is 'those tested activities and judgments in assisting an individual or group, based upon verified and quantified knowledge related to specific variables' (p. 101). Alternatively, Warren (1988) considered caring in terms of numerous activities such as providing information, listening and communicating, demonstrating respect, performing tasks and helping.

Benner (1984) considered that nurses care by displaying clinically competent and caring attitudes in the nurse–patient relationship. Campbell (1984) preferred to use the term 'skilled companionship' instead of 'carer' or 'caregiver' to describe the relationship between the *paid* health professional and the patient. Campbell (1985, p. 1) proposed that

care is about 'help[ing] people to know love, both as something to be received and as something to give'. However, there is an argument about this point: Campbell (1984) and Rogers (2004) agree that it is a mutual relationship, while Buber (1966) believes it can never be such because the patient comes to the health professional seeking help.

Brilowski and Wendler (2005) identified five elements of caring that are imperative to the nurse's understanding of the concept of caring: 'relationship', which refers to the ability to establish a trusting atmosphere, identify areas of concern and be motivated to provide assistance; 'action', which refers to doing things for or being with the patient; 'attitude', which provides a positive environment, 'acceptance', which refers to giving the patient dignity and respect and 'variability', the facet of caring with growth and change as the nurse gains experience and knowledge.

Larson (1986) defined caring as the intentional attitudes and activities that carry emotional concern and physical care and also support a sense of safety and security. Watson (1988a) characterised caring as the moral ideal of nursing: an intention and a commitment. Similar sentiments were expressed by Fry (1993, p. 176), who defined human caring as 'a moral concept when caring is directed toward human needs and is perceived as a duty to respond to need'. Ray (1981a, p. 10; 1999) believes that caring is social, transcultural and 'communal moral caring'. Ray (1981a, p. 32) further suggests that caring is a 'form of loving ablative or other-directed love, where co-presence in human encounter is a mystery rather than a problem to be solved'.

Parse (1981) conceptualised caring as risking being with somebody in a moment of joy. Caring is considered a natural state of being but is simultaneously a skilled, learned art that requires abundant forethought, education and moral integrity (Jolley & Gosia, 1992). Sutherland (1980) noted that care, when dedicated to individual growth and wellbeing,

included factors like living with a sense of wholeness and accountable autonomy, of feeling/being somebody to others and of fulfilment in the use of one's abilities.

Leininger (1991, p. 4) defined caring as 'those actions and activities directed toward assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway'. Similarly, Thomas (2003, p. 8) defined caring as 'those assistive, enabling, supportive, or facilitative behaviours toward or for another individual or group to promote health, prevent disease, injury, and facilitate healing'. Schubert (2003) also viewed caring as those assistive, enabling, supportive or facilitative behaviours for another person or group to support health, avert illness or injury and expedite healing. This definition was extended from caring for an individual to caring for others in the community who also require a holistic standpoint, where principles of wholeness, harmony and healing are recognisable in the nature of health (Holden et al., 2002; Schubert, 2003). As Younger (1995) suggests, existential care is an abstract form of caring in which care and compassion are outcomes of consciousness of the common bonds of humanity, fates, experiences and feelings.

Others have attempted to define professional caring as the application of discipline-specific knowledge—involving science, theory, art and practice—to the relevant circumstance, but it is the activity of the whole person (Creasia & Parker, 1996). Neither the skills nor the activities are sufficient alone. Compassion without knowledge and competence is similarly insufficient, which means that all contributions of art and science are required to achieve professional caring in the discipline (Creasia & Parker, 1996).

Adding to the confusion of what it means for nurses to care, the nursing literature does not always differentiate between caring and nursing. Caring as a concept is intertwined with nursing and at times, the literature considers the synonymous (Hayes & Tyler-Ball, 2007; Wilkin & Slevin, 2004). Indeed, a number of nurse authors go so far as

to suggest that nursing and caring are inseparable. Euswas (1993, p. 323) has forcefully proclaimed that 'not only is caring an essential component of nursing, but nursing in the full sense cannot be separated from caring'. To some nurses, owning care is imperative (Leininger, 1988; Watson, 1979). However, other health professionals and lay persons claim care as an approach to health and healing (Watson, 1999) and therefore, state that care cannot belong to nurses alone (Huch, 1995). Nevertheless, the concept of caring is criticised for not being unique to nurses (Swanson, 1991), for having contradictory meanings (Rolfe, 2009) or for the fact that nurses' knowledge about caring is knowledge of what is said about it (Paley, 2001). Another point underlying the debate on the nature of caring as the essence of nursing is the need for an agreed theoretical perspective. As elucidated by Morse, Bottorff, Neander and Solberg (1991), if caring is the essence of nursing, the question to be answered is which theoretical perspective of caring best captures this essence.

Although caring is a central construct for the nursing profession, as hypothesised by nursing theorists (Leininger, 1984a, 1995; Watson, 1985b), not all theorists agree on the proclamation that 'caring is the essence of nursing'. As indicated by Huch (1995), some theorists, including as King, Parse, Peplau and Rogers, did not accept caring as the body of knowledge for nursing. For example, Huch (1995, p. 38) highlights Parse's statements:

> Caring is a ubiquitous term; it is not the central phenomenon of nursing. The human-universe-health process is a central phenomenon. The definition of caring is 'to be concerned for something or someone' and I think many people in many disciplines are concerned about others … Caring in the human health experience is not the proper way to state the phenomenon of concern to nursing and 'most theories and frameworks in nursing do not address caring as a central focus'.

Arguing for caring as central to nursing, Wikberg and Eriksson (2008) purport that it is the subject of nursing science, while nursing itself comprises what nurses do. Eriksson (1997) further discusses nursing and caring relations when describing the three different perspectives of nursing: first, caring as the innermost core of nursing; second, nursing based on the nursing process, and third, the structure of the nursing care plan. All three perspectives are key to good nursing care, although nursing does not necessarily involve caring (Eriksson, 1997). One assumption is that these three perspectives could be viewed as different cultures in the clinical nursing reality that represent different clinical, educational and scientific traditions.

Since caring is the essence of the nursing profession (Balzer-Riley, 1996; Bavis, 1981; Halligan, 2006; Leininger, 1991; Watson, 1988b), nursing has the responsibility to elucidate, measure and value caring; if it fails to do so, caring will be an underestimated aspect of the developing economic and societal structure (Valentine, 1991).

Not only are definitions of caring diverse but how it is conceptualised also varies in the literature. Rafael (1996) considered caring as either 'ordered caring', concerned with following orders and devoid of knowledge, power or ethics; 'assimilated caring' in which the feminine construct of caring is grounded in male scientific discourses or 'empowered caring' in which it is grounded within a feminist perspective that involves using knowledge, ethics and power. Williams (1997) identified four dimensions of caring: physical, interpretive, spiritual and sensitive, which is akin to the notion of holism. Kyle (1995) suggests that caring is more than a set of behaviours; it is a process that includes culturally derived cognitive, moral and emotional components. Wolf et al. (1994). suggests that nurse caring has several dimensions, comprising professional knowledge and skill, attentiveness to others' experiences, assurance of human presence, respectful deference to others and positive connectedness. Similarly, Kapborg and Berterö (2003) proposed that caring has

intellectual and emotional aspects and Pepin (1992) suggests there are two dimensions of caring: first is love that consists of affective concepts as compassion, emotion, nurturance, altruism, presence, connectedness and comfort. Second is labour, which consists of knowledge, tasks, toil, functions, service and roles.

Two caring aspects are consistently identified: the instrumental/technical aspects and the expressive/affective/psychological aspects (Arthur et al., 1999; Bégat & Severinsson, 2001; Watson & Lea, 1997). Similarly, Kuhse (1997) pointed out that care has two connotations: first, it is an 'emotional response' such as worry and inclination. For example, Johnstone's (1994) description of caring as a feeling parallel to sympathy, empathy and compassion. Second, it is 'providing for': doing something for another person. For example, Griffin (1983) describes caring as seeing to somebody's needs. Bourgeois (2006) identified that an 'archive of caring' exists for nursing as 'caring as knowing', 'caring as being' and 'caring as doing'.

Roach (1991) conceptualised caring as a human mode of being and describes nursing as a profession in which a human cares through the acquisition and application of the knowledge, behaviours and skills appropriate to the nursing role. In addition, Roach (1991) proposed five dimensions of caring (the five C's): compassion, competence, confidence, conscience and commitment. (Boykin & Schoenhofer, 1993). He outlined caring as 'the intentional and authentic presence of the nurse with another who is recognized as a person living caring and growing in caring' (p. 25). Delaney (1990) suggested that caring includes the knowledge and skills to identify needs and nursing activities to achieve positive outcomes (the protection, enhancement and preservation of human dignity). Miller (1995) defined caring as 'intentional action that conveys physical and emotional security and genuine connectedness with another person or group of people. Caring validates the humanness of both the care giver and the cared for' (p. 32). Balzer-

Riley (1996) agreed that caring is holistic, considering the entire person and respectfully treating them as people, not just bodies demanding nursing interventions. Snyder, Brandt, and Tseng (2000) noted that patient care by nurses is a multidimensional phenomenon that involves physical, emotional, spiritual and mental aspects.

The word 'care' implies at least four meanings in health professions: compassion by being concerned for another person, doing for others what they cannot do for themselves, taking care of the medical problem and taking care by caring out all the essential procedures, both personal and technical (Bishop & Scudder, 1985). Alternatively, McCance, McKenna and Boone (1997) classified caring into four characteristics: knowing and providing for the patient, serious concern and serious attention. They also argued that the actual intention to care is necessary.

The literature reveals a range of definitions that perceive caring through different lenses and view it as a: phenomenon (Boyle, 1984; Leininger, 1984a), science (Parse, 1981; Watson, 1985a), process (Dossey & Guzzetta, 2000; Griffin, 1983; Guthrie, 1981; Quinn, 1989; Uhl, 1981; Watson, 1985a), value (Fry, 1989), moral ideal (Castledine, 2005; Quinn, 1989; Watson, 1985a), ethic (Gadow, 1990), virtue (Brody, 1988; Knowlden, 1990), intervention (Benner & Wrubel, 1989; Creasia & Parker, 1996; Noddings, 1984), therapeutic intervention (Gaut, 1983; Leininger, 1991), interpersonal intervention (Wolf et al., 1994), skill (Timby, 2001), form of healing (Engebretson, 1994), behaviour (Leininger, 1984b), attitude (Ajzen, 1988; Cronin & Harrison, 1988; Griffin, 1983), life force (Bavis, 1981), principle (Frankena, 1983), knowledge and practice (Leininger, 1981b), emotion (Ray, 1981a), interpersonal relationship (Pearson, 1991), philosophy (Rawnsley, 1990) and as the core/essence of nursing (Benner, 1984; Leininger, 1984a; Paterson & Zderad, 1976; Ray, 1981a; Watson, 1988b).

Bizarrely, the same author sometimes perceives caring differently. For example, Leininger (1981b, 1981c, 1984a) once considered caring as a behaviour, then as an essential domain of knowledge and practice in the nursing field and finally, as a phenomenon. Watson (1985a) also once viewed caring as an ideal and then as a possible science. If leading authors consider caring differently, then it surely has no universal definition, which necessitates further research to define it.

This lack of understanding, definition or agreed theoretical perspective is a common theme in the caring literature and underpins the debate about the centrality of caring within the nursing paradigm. In their meta-analysis, Morse et al. (1990, p. 2) attest to this view and state that:

> From the nursing literature it is difficult to discern the differences between the terms caring, care, and nursing care. Care or caring may specify the actions performed, as in to take care of, or the concern exhibited, as in caring about, the former having a more general one.

In summary, caring in nursing remains contentious, making it difficult to reach a consensus regarding the definitions, perspectives, components and process of caring (Paley, 2001; Smith, 1999). Nurses are urged to advance contributions from new directions that incorporate and extend the knowledge of caring to create advanced theory. New practice models that unite ideas, instead of locking theories into fixed boxes and inhibiting their application and evolution, are needed. This review will now focus specifically on a number of relevant theories.

2.5.1 Theories of Caring in Nursing

Over time, nursing has been viewed from a range of theoretical perspectives explanatory models and networks of meaning in an attempt to identify central or core concepts of what constitutes caring in the context of nursing. Despite a multitude of

publications, the meaning of caring for many nurses continues to be a confusing (Paley, 2001) even though it is the subject of multiple theoretical debates, conference proceedings, journal publications, dissertations and professional policy developments (Swanson, 1999). Nursing theorists have positioned caring as a fundamental element of nursing (Benner, 1984; Gaut, 1983; Leininger, 1984a; Sumner, 2008; Swanson, 1993; Watson, 1985b). This section presents an overview of those theorists who have been a critical influence in knowledge development about caring. Particularly, Leininger and Watson have published models espousing caring as central and fundamental to nursing. They are the most cited by other nurses within the literature (Watson & Smith, 2002). In an outline of the theorists and their contributions to contemporary understanding of caring are presented in Table 2.1.

Table 2.1

Caring in Nursing Theories (Adapted from Harkreader & Hogan 2004, p. 77)

Theorist	Description of theory
Nightingale (1859)	The first nursing theorist who believed that environment influences health, Nightingale and her colleagues cared for patients through their presence and support. Nightingale hypothesised illness as a reparative process (Creasia & Parker, 1996) and that environmental manipulation is critical to health and the patient's capability to recover. Caring provided by trained nurses is more than and different from the nurturing provided by mothering. Nursing care uses the environment to benefit the patient's health.
Hall (1959)	This is the first theoretical model that discussed the caring concept and presented nursing as care, core and cure circles. Care was represented as the nurturing component of nursing and nurturing was defined as the care and comfort of the individual and educating them. The central focus of this theory is rehabilitation, including nursing autonomy, as a therapeutic use of self, treatment within the healthcare team in curing, and nurturing in caring (Taylor, Lillis, LeMone & Lynn, 2008).
Wiedenbach (1964)	The central theme in this theory considers nursing as an art. It is delivering nurturing care to patients and focusing on a specific purpose to fulfil the patient's perceived healthcare requirements (Taylor, Lillis, LeMone & Lynn, 2008).
Levine (1967)	A comprehensive method of patient care was developed, which theorised that the aim of nursing activities is to preserve the patient's energy as well as their personal, physiological or structural and social integrity.
Orem (1971–2007)	This theory highlighted the importance of maintaining one's own wellbeing, with interventions considered to act on behalf of others by guiding and supporting individuals incapable or limited in their abilities. Orem's general theory of nursing has three related parts: theory of self-care, theory of self-care deficit and theory of nursing system. For example, the theory of self-care includes self-care, self-care agency, therapeutic self-care demand and self-care requisites.

Leininger (1978–present)	Caring is the central theme in nursing knowledge and in culture-specific and culture-universal nursing practice (now known as the theory of culture care diversity and universality).
Watson (1979–present)	The theory of transpersonal caring seeks to connect with and embrace the spirit of the client through caring and healing processes. From the original 10 creative factors have emerged 10 caritas processes that guide nursing practice. Watson ties the future of nursing to Nightingale's sense of 'calling', a sense of deep commitment to human service (Watson, 2001).
Newman (1979)	Nursing is defined as caring in the human health experience and caring is an essential moral in nursing. In nursing interventions, the total-person approach is used in patient care to help individuals, families and groups to achieve and maintain wellness (Taylor et al., 2008).
Benner (1984-present)	This phenomenologically describes caring as a common bond between people in a meaningful situation or relationship, which is essential to nursing (Harkreader & Hogan, 2004; Taylor, Lillis, LeMone & Lynn, 2008). The primacy of caring theory was created by Benner and Wrubel (1989), who were concerned with assisting patients to deal with the stress of illness.
Eriksson (1987-present)	Caring science focuses on the phenomenon of caring, not on the profession. Caring implies alleviating suffering in charity, love, faith and hope. Natural, basic caring is expressed through tending, playing and teaching in a caring relationship. In contrast, caring science is to relieve human being suffering and to reserve health and safety life (Eriksson, 2002).
Boykin & Schoenhofer (1993-present)	Caring nursing involves living and growing in caring. 'The intention of nursing as a practice discipline is nurturing persons living in caring and growing in caring' (Boykin & Schoenhofer, 2001, p. 393). Caring is comprehended as a process of daily becoming, not a purpose to be achieved (Boykin & Schoenhofer, 1993). In this theory, everybody is caring and caring is a relational responsibility for the self and others. In the caring relationship, the connections between individuals are significant.

First, Leininger's (1978) theory of culture care developed her conceptualisation of caring from nursing and anthropological perspectives (Leininger, 1981a), underlining the notion that care and culture are inseparably linked in nursing (Leininger, 1988). Leininger developed her theory from the perspective that patients have the right to have their sociocultural backgrounds understood (Reynolds & Leininger, 1993). She combined the two concepts, caring and culture, and constructed the term 'cultural care' in her theoretical work within the ethnonursing research approach. This is translated into two types of care: transcultural nursing, in which a nurse specialist practices, teaches, and performs research for a select or distinct culture, and cross-cultural nursing, where nurses use anthropological concepts in practice (Leininger & McFarland, 2002). The epistemological perspective embedded in Leininger's model is that of caring as a human trait (Morse et al., 1990). Leininger (1991, p. 11) indicated that 'human caring is a universal phenomenon, but the expressions, processes and patterns of caring vary among cultures' and propose that the core of nursing is care, and that it is the dominant, unique and unifying feature of nursing. Leininger (1991) also created the Sunrise Model to illustrate the theory. In this model, health and care are affected by social structure, including religious and philosophical factors, technology, kinship and social systems, cultural values, political and legal factors as well as educational and economic factors. Three intervention modes were presented by Leininger (1991) to enable nurses to assist people from diverse cultures: culture care for preservation or maintenance, for accommodation, negotiation or both and for restructuring or re-patterning.

Second, Watson's (1979) Human Caring Theory focused on the humanistic aspects of nursing by creating a balance between scientific and caring perspectives. Watson's contribution to nursing is widely credited with development of the ten 'carative' factors, the human science of caring and more recently, caring-healing. Watson

put forward a philosophy and science of caring that proposes it as the essence of nursing practice. It is a moral ideal and includes the actual caring occasion and the transpersonal human relationship between the nurse and the patient (Barnhart, Bennett & et al, 1994). Watson proposed a caring-healing theoretical framework that is considered a philosophy, a theory and an ethic to return nursing to its human foundation, seeking to restore human values at all levels in the healthcare setting (Watson, 1994). Watson has continued to redevelop her theories and ideas associated with caring, health and healing with the advent of a new world view for nursing (Watson, 1999, 2002). The emergence of a new nursing paradigm is what she calls a 'transpersonal caring-healing model' (Watson, 1999). According to Watson (1985a), caring is a term to describe how nurses give care to patients. Approaching each person as a unique individual, the caring nurse perceives and responds to their specific needs (Watson, 1985a). Therefore, Watson's conception of caring portrays the nurse as providing individualised care to patients. Her theory of human caring (1988b) provides nurses with ten carative factors to guide nurses in intentional and holistic care of patients. These include: formation of a humanistic-altruistic value system; instillation of faith and hope; cultivation of sensitivity to self and others; development of helping trust relationships; promotion and acceptance of positive and negative expression of feelings; utilisation of scientific problem-solving methods for decision-making; promotion of interpersonal teaching and learning; provision for a supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment; assistance with human-need gratification and lastly, allowance for existential phenomenological forces (Watson, 1988b).

According to Watson (2008), caring both distinguishes nursing from other professions and facilitates interactions between nursing and interdisciplinary members of the healthcare team (Foster, 2006). Watson acknowledges that caring as a central

construct to nursing dates back to the time of Nightingale, but also views the science of caring as a means for nursing to advance as a profession. As she notes, 'nursing cannot move forward with any sense of survival and maturity as a distinct discipline and practicing profession if it does not ground its evolution in a meaningful philosophical-ethical foundation for its science and practices' (Watson, 2007, p. 14). Watson (1990, p. 21) considered caring from a philosophical, transpersonal and spiritual perspective and claimed that 'caring is the fundamental ontological substance of nursing care and underpins nursing's epistemology'.

There is a trend for nurses to unite their ideas rather than keeping theories as separate entities that inhibit their application to practice and to future changes in nursing (Watson & Smith, 2002). Rogers (1992) has informed the nurses' research of a unitary view of what it means to be human. Watson's work is searching for what she calls a 'unitary caring science'. That is, a merging of two discourses is developed and through this synthesis, a 'distinct unitary view of human with a relational caring ontology and ethic that informs nursing' is produced (Watson & Smith, 2002, p. 452). Here, Watson is transporting her thoughts about caring science into another dominion of nursing. She asks nurses to combine and develop opinions in the form of a synthesis rather than resorting to a compartmentalisation of ideas and knowledge (Watson & Smith, 2002).

2.6 Caring in ICU

To gain an understanding of what has been researched in relation to ICUs, a literature review was undertaken to identify the types of research that have been conducted from a broad range of perspectives. The search engines used were Academic Search Complete CINAHL, Medline, PubMed and Google Scholar. The results were subsequently refined using inclusion criteria for the literary review: availability of a full text of the article, English language and peer-reviewed articles published from 2000 to

2017. General key terms used were (care OR caring), ('intensive care unit' OR 'critical care unit' OR 'ICU') and 'nurs*'. There is a plethora of nursing studies in neonatal ICU (Cricco-Lizza, 2014; Marcotte, 2017; Nelson, 2014; Sisson, Jones, Williams & Lachanudis, 2015; Spence et al., 2006; Spruill & Heaton, 2015; Trajkovski, Schmied, Vickers & Jackson, 2012) and pediatric ICU (Aldridge, 2005; Collet et al., 2014; Lago et al., 2011; Mahon, 2014; Mattsson, Arman, Castren & Forsner, 2014), but these were excluded and only adult ICU was included in this study. Although, there is extensive literature about studies conducted on the lived experiences of patients, families and nurses in adult ICUs (Cypress, 2011), this research aims to investigate the nature of caring in an adult ICU only.

A wide range of literature discusses ICU caring in regard to different identities from various perspectives. For example, several studies were conducted about patients' perspectives and experiences of their care (Adamson et al., 2004; Cutler, Hayter & Ryan, 2013; Hofhuis et al., 2008; Samuelson, 2011; Stein-Parbury & McKinley, 2000), patients describing nursing art (Gramling, 2004) and patients' perceptions of nursing care quality, as evidenced by nurse caring behaviours (Reiss, 2005).

From the perspectives of family, a number of studies were found (Eggenberger & Nelms, 2007; Høye & Severinsson, 2010; Hughes, Bryan & Robbins, 2005). The topics included family members' satisfaction with critical care (Karlsson, Tisell, Engström & Andershed, 2011), family needs (Buckley & Andrews, 2011; Higgins, Joyce, Parker, Fitzgerald & McMillan, 2007; Verhaeghe, Defloor, Van Zuuren, Duijnstee & Grypdonck, 2005), family presence (Charlton, 2015; Olsen, Dysvik & Hansen, 2009) and family involvement in ICU (Mackie, Marshall & Mitchell, 2017; McAdam, Arai & Puntillo, 2008; Mitchell, Kean, et al., 2017a, 2017b; Reeves et al., 2015). Visiting hours and balance among patients, families and staff needs have also been explored (de Boer,

van Rikxoort, Bakker & Smit, 2014; Hinkle, Fitzpatrick & Oskrochi, 2009; Nyholm & Koskinen, 2017).

Several topics have been researched based on nurses' experiences in critical care settings. These have included nursing care of chronically, critically ill patients (Alasad, 2000; Butt, 2010), older adults (Happ, 2010; Winters, 2012) and ICU nurses' experiences and perspectives caring for obstetric (Engström, 2014; Kynoch, Paxton & Chang, 2011a; Pollock, 2006) and obese patients (Hales, Coombs & de Vries, 2017; Hales, de Vries & Coombs, 2016; Robstad, Söderhamn & Fegran, 2018). Nurses' management of patients' health conditions in ICU (such as hyperglycaemia, pressure ulcers, pain management, cancer and disabilities) have also been examined (Elliott, McKinley & Fox, 2008; Hull & O'Rourke, 2007; Osburne et al., 2006; Welch & Barksby, 2011). Research has investigated critical care nurses' perceptions of end-of-life care (Morton, Fontaine, Hudak & Gallo, 2005; Taylor et al., 2008), providing post-mortem care for the body, family and other patients (Calvin, Kite-Powell & Hickey, 2007; De Swardt, 2015; O'Connor, 2016; Ranse, Yates & Coyer, 2012) as well as their perceptions of, and responses to, ethical and moral distress decisions (Iranmanesh, Rezaei, Rafiei & Eslami, 2013; Shorideh, Ashktorab & Yaghmaei, 2012; Spence et al., 2006) and withdrawal/withholding of treatment in the ICU, which are significantly sensitive topics (Hov, Hedelin & Athlin, 2007; Kongsuwan & Locsin, 2011; Templeman, 2015).

A number of studies were found that pertained to nurses as a workforce and ICU. These covered nurses' psychological stress, burnout, grief and debriefing experiences in ICU (Akinwolere, 2016; Garwood, 2015; Mealer, Jones & Moss, 2012), ICU nursing practices (Abbey, Chaboyer & Mitchell, 2012; El-Soussi & Asfour, 2017; Milhomme, Gagnon & Lechasseur, 2018) and nurses' professional autonomy and job satisfaction (Hoonakker et al., 2013; Ntantana et al., 2017; Tao, Ellenbecker, Wang & Li, 2015).

Nurses' management, leadership and challenges in a CCU have also been considered (Cortes, 2004; Ogle & Glass, 2014; Rosengren, Bondas, Nordholm & Nordström, 2010). Health professionals' perspectives on communication in critical care settings (Handberg & Voss, 2018) have been considered in terms of nurses' communication and interactions with doctors (Manias & Street, 2001a, 2001b), their perspectives of interprofessional work in ICU (Kendall-Gallagher, Reeves, Alexanian & Kitto, 2017), nurse communication with patients (Happ et al., 2014) and families (Adams, Mannix & Harrington, 2017; Ahrens, Yancey & Kollef, 2003; Söderström, Saveman & Benzein, 2006) and nurses' work hours (Aveyard, 2016; Richardson, Turnock, Harris, Finley & Carson, 2007).

The ongoing debate about what constitutes caring within the ever-expanding domains of nursing practice is nowhere more evident than in the specialisation of the ICU, where humanistic caring is juxtaposed with advanced technology (Alasad, 2002; Nascimentol & Erdmann, 2009; Wikström & Larsson, 2004; Wilkin, 2003). The question that informed the literature review was: what is the essential nature of caring within the context of an adult ICU, as revealed in the literature? However, to include the full body of literature in this limited thesis will be impossible. Therefore, as the focus of this study is on the nature of caring in one ICU, a specific integrative review of literature was undertaken.

2.6.1 Search Strategies Used in the Literature Review

Considering the plethora of ICU-related studies identified, an integrative review of the literature was undertaken to explore a contemporary understanding of the nature of caring within the context of an adult ICU using electronic bibliographic databases with full text availability: Academic Search Complete CINAHL, Medline, PubMed and Google Scholar. The initial search, which was limited to 2007–2017, was extended to

include the years 2000–2017 due to the scarcity of literature. The results were subsequently refined using inclusion criteria: a full text of the article, English language, peer-reviewed articles published from 2000 to 2017. The abstracts of each citation were assessed to refine the review and in relation to a focus on caring for human beings rather than on objects of caring such as a diagnosis. All duplicates were then removed. The reference list of the final number of articles selected was evaluated for any further literature that could form part of the literature review. The process by which the searches were undertaken is presented in Table 2.2 below. Search strategies in the literature review included key words with quotation marks: caring, nurs*, (nature OR culture), ('intensive care' OR 'critical care' OR 'ICU') and 'Focused Ethnograph*' to ensure a search for this specific word combination. The asterisk at the end of search terms ensured that the search included other possibilities for each term's ending. Boolean operators such as 'AND' and 'OR' were used. A gradual elimination of studies was done according to PRISMA is presented in Figure 2.1.

Table 2.2

Search Strategies for Literature Review Related to Discussion of Theme 1

	Number of papers				
Search terms/process	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to topic
Caring AND Nurs* AND ('intensive care' OR 'critical care' OR 'ICU')	0	1	0	140	2
(Nature OR culture) AND Caring AND ('intensive care' OR 'critical care' OR 'ICU') AND Focused Ethnograph*	21	81	0	1,481	7
Duplicates removed					1
Total after removal of duplicates					8
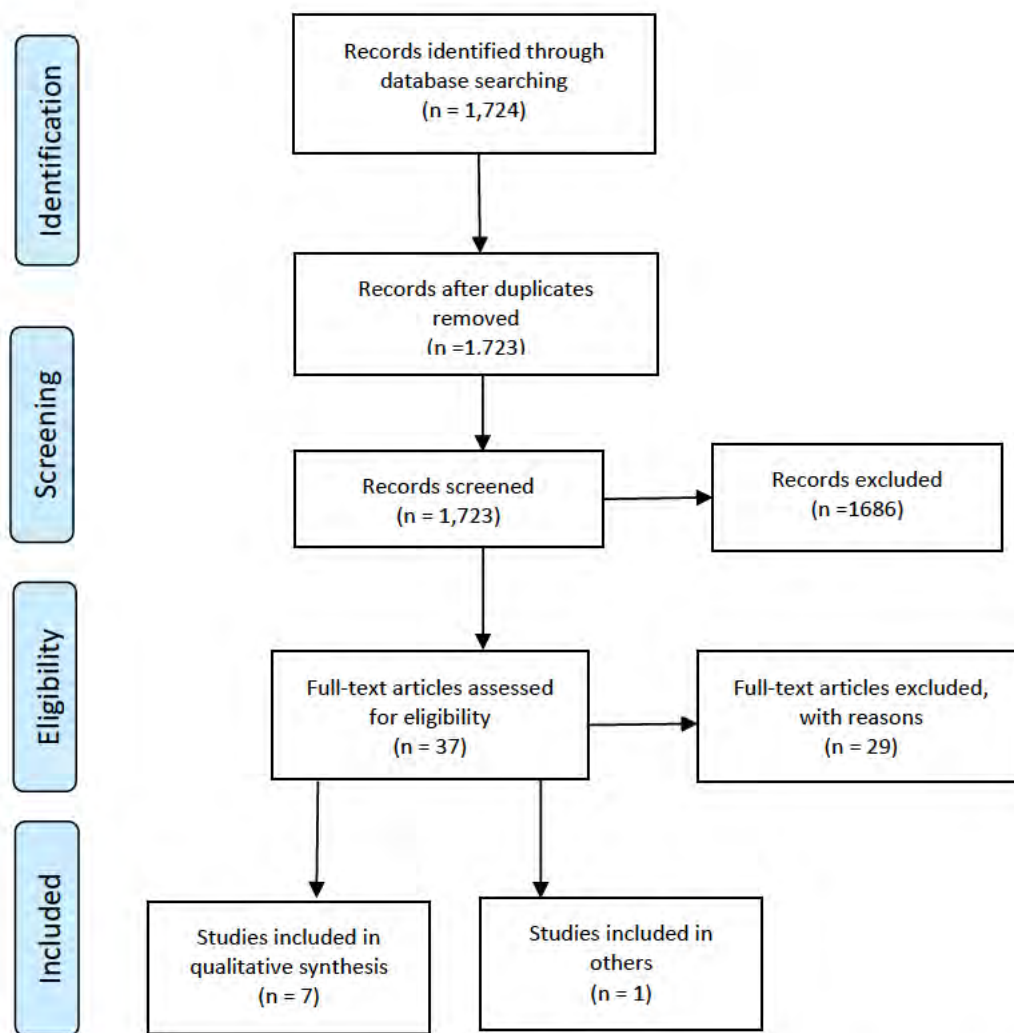
Figure 2.1. PRISMA flow diagram of the literature review related to discussion of theme one.

After a careful analysis of all available data, only eight resources were identified that specifically related to with the nature of caring within the context of adult intensive care nursing. Of the eight resources, only seven studies discussed caring in the ICU (see Table 2.3).

Table 2.3

An Integrative Review of Selected Studies on Caring in ICU

Study Title Author/s (Year)	Location	Purpose	Design	Participants	Findings	Limitations	Strengths
Caught in an artificial split: a phenomenological study of being a caregiver in the technologically intense environment. Almerud et al. (2008b)	Sweden	To uncover the meaning of being a caregiver in the technologically intense environment.	Phenomenology	10 participants. of different occupations, ages, genders and experiences in ICU. 4 RNs and 4 enrolled nurses, 2 physicians.	Mastery or servitude under technology. To be secure in insecurity and insecure in security. To make the human technological and the technology human.	Clinician and the charge nurse chose participants (could be by coercion, not voluntary). The physician number is small. It is a suggestion to do a separate study for physicians' point view to obtain their insights about the topic. Results cannot be generalised to other settings.	Different lived experience from different occupations. No sufficient demographic data about participants.
Spiritual care: A phenomenological study of critical care nurses. Kociszewski (2004)	New England	To describe critical care nurses' lived experiences of providing spiritual care to critically ill patients and their families.	Phenomenology	10 critical care nurses (9 female and 1 male)	Six themes emerged: meanings of spirituality, out of tragedy: spiritual awakening; mutual knowing: a bridge to spiritual assessment, the 'everydayishness' of spiritual care; prayer and beyond: letting go to the mystical and spiritual caring: from suffering to blessing.	Only one male participated; possible gender bias present in insights on the research topic.	Sufficient participant demographics. The disadvantages of interviews by phone. The findings cannot be generalised to other settings.
ICU nurses' experiences and perspectives of caring for obstetric patients in intensive care: a qualitative study. Kynoch et al.(2011b)	Australia	To gain an understanding of the experiences and perspectives of ICU nurses caring for critically ill obstetric patients.	Descriptive qualitative design. (Used two focus groups)	10 female RNs from ICU	Three themes were identified: competence with knowledge and skills for managing obstetric patients, confidence in caring for obstetric patients and acceptance of an expanded scope of practice perceived to include fundamental midwifery knowledge and skills.	All the participants were female, no male insights. Possibility of the researcher's bias (was working in the study setting). The time frame for each focus group interview was one hour, and the focus group interview should last around 1.5–2 hours (Holloway & Wheeler, 2002). A longer interview may have generated more information. The study is not representative of rural and remote health care facilities, where resources and support may limited or where settings may have greater ratios of midwifery-trained ICU staff. The findings cannot be generalised to other settings.	The researcher's clinical experience could contribute to an understanding of the phenomenon studied and the context.
Spiritual care provided by Thai nurses in ICUs. Lundberg & Kerdonfag (2010)	Thailand	To explore how ICU nurses provided spiritual care to their patients.	Explorative qualitative study	30 nurses (29 female and 1 male). All participants were Buddhists.	Five themes emerged: giving mental support, facilitating religious rituals and family participation, assessing spiritual needs and showing respect, communicating with patients and families.	The data were obtained from a relatively small number of RNs who do not represent the whole population of nurses in Thailand. The results should not be extrapolated to Thai RNs in general.	The participant number (30) for a qualitative research is more than sufficient to obtain their views about the topic.

Caring and technology in an ICU: an ethnographic study. Price (2013a)	United Kingdom	To explore the aspects that affect registered healthcare professionals' ability to care for ICU patients within the technological environment.	Ethnography	19 participants, 16 nurses,1 doctor, 2 physiotherapists	An overarching theme of the 'crafting process' with subthemes: 'vigilance', 'focus of attention', 'being present' and 'expectations', with the ultimate goal of achieving the best outcomes for the individual patient.	The researcher was a critical care nurse and did not notice aspects of the research process that were biased and subjective. Only nurses were observed. Only 5 of the 8 nurses were interviewed (possibility that what they say is different from what they do). Issues of trustworthiness of the study for qualitative data were not fully addressed. The study cannot be generalised to other settings.	Data collection involved participant observation, document review and semi-structured interviews to triangulate methods, which aids rigour in this approach.
Quality of practice in an intensive care unit (ICU): a mini-ethnographic case study Storesund & McMurray (2009)	Australia	RNs' perspectives on practice quality in ICU	Mini-ethnography	10 RNs	Three themes affected the nursing quality: maintaining cohesiveness in ICU, rapid, effective and respectful communication and specialist knowledge obtained by formal learning and experience.	The study was limited by the informants' demography; all female informants are old (might raise different insights on practice quality). The study utilises only interviews; participants' actions might differ from what they say and there is a possibility that the participant responds only to please the interviewer.	The methodological approach precludes generalisability of findings, but it is likely that the findings would have some transferability to other settings.
The meaning of caring to nurses: an investigation into the nature of caring work in an intensive care unit. Wilkin & Slevin (2004)	United Kingdom	To explore the meaning of caring to ICU nurses; whether the meaning of caring has potential for altering nursing practice, and to gain an insight into how caring experiences were evident.	Descriptive qualitative design	12 RNs	One central theme: 'concept of care' and three related themes: 'nurses' feelings', 'nurse' knowledge' and 'nurses' skills' emerged from the data.	This study is limited by the assertions that were made about patients and relatives; however, none were interviewed. Consequently, reports about patients and relatives in this study are 'second-hand' from the nurses. There is a need for further research that includes data collection from patients and relatives.	Assertions were made about patients and relatives; none were interviewed and reports about patients and relatives are 'second-hand' from the nurses. There is a need for further research that includes data collection from patients and relatives.

In their phenomenological study, Wilkin and Slevin (2004) utilised a semi-structured interview guide with 12 ICU nurses to explore the meaning of caring in a British intensive care setting. They found that nurses viewed caring as a process comprising professional knowledge, skill, competence, feelings and nursing activities. Wilkin and Slevin (2004) explicated one central theme, 'the concept of care', and three related themes: 'nursing knowledge', which refers to the technical competence, knowledge and professional experience that makes the nurse confident to care; 'nursing skills' that include the therapeutic nurse–patient interaction, basic nursing care, providing emotional support, appropriate staffing and time management and finally, 'nursing feelings', which refers to the motivator of nursing action. The research suggested that caring in the ICU involves understanding the technology, identifying what the patient wants and establishing a trusting relationship to act as an advocate on behalf of the individual. Caring behaviours exhibited by participants accounted for their patients' vulnerabilities, taking the time to notice the subtle cues through the patient's change in health status and working together with the health team to enhance the patient's quality of life during their critical illness. Caring was described by participants as synonymous with nursing. The participants also indicated that caring is a process. The authors identified the use of assumed knowledge of how the patients and relatives were feeling as a limitation. Questions could be raised as to why such data was included in the first instance when the focus was on the nurse participants' lived experiences. Reference to further research to include patients and relatives is stated in broad terms with no direction or focus.

Wilkin (2003, p. 1178) noted that ICU nurses posited that 'care and caring are predominately used to describe the inherent work and value of nursing'. Wilkin further suggests that although the notion of caring has been extensively researched, there is still a lack of clarity about its relevance in nursing. Caring, suggests Wilkin, is more than a summation of demands and needs and extends to the whole person. Within the context of an ICU, Wilkin further argues that the presence of technology—with the potential to

enhance or impede care—can comprise the humanistic caring of nurses. Therefore, the challenge for nurses is to strike a balance between technical competence and the provision of humanistic care. These findings are supported by Wilkin and Slevin's later work (2004).

An Australian descriptive qualitative study was conducted by Kynoch et al. (2011b) to gain an understanding of the experiences and perspectives of ICU nurses caring for critically ill obstetric patients. The researchers conducted two focus groups with ten female ICU RNs. The study identified three themes: competence with knowledge and skills for managing obstetric patients, confidence in caring for obstetric patients and acceptance of an expanded scope of practice perceived to include fundamental midwifery knowledge and skills. Several limitations were acknowledged: all participants were female, providing no gender balance insights. The potential for bias was raised by the authors as they worked in the study setting and the interview time was limited to one hour, although focus groups normally require 1.5–2 hours to collect in-depth information (Holloway & Wheeler, 2002). As the research was conducted in a metropolitan facility, extrapolation of findings to facilities in rural and remote care facilities (where resources and support may be more limited in other settings) is not possible.

A phenomenological study was undertaken by Kociszewski (2004) to explore critical care nurses' lived experiences providing spiritual care to critically ill patients and their families in New England. Participant selection was purposive in nature, consisting of nine females and one male, who participated in in-depth individual interviews by phone. Data analysis used thematic analysis and six themes emerged: 'meanings of spirituality', 'out of tragedy; spiritual awakening', 'mutual knowing; a bridge to spiritual assessment', 'the everydayish-ness of spiritual care', 'prayer and beyond; letting go to the mystical' and 'spiritual caring; from suffering to blessing'. The limitations of this study were that only one male participated, which could introduce gender bias. A further limitation was the disadvantage of interviewing by phone, as researchers were unable to

observe queues in body language. Finally the findings cannot be generalised to other settings.

A similar study was undertaken by Lundberg and Kerdonfag (2010) and explored how Thai ICU nurses provided spiritual care to their patients. The study was qualitative explorative in design and involved 30 Buddhist nurses (29 female and 1 male). Participants were purposely selected and interviewed using a semi-structured, open-ended questioning approach. Thematic analysis was undertaken, resulting in five themes being explicated from the interview transcripts: giving mental support, facilitating religious rituals and cultural beliefs, communicating with patients and their families, assessing the spiritual needs of patients and showing respect and facilitating family participation in care. Although the sample size was considerable for a qualitative study and provided the opportunity for rich in-depth descriptions of the study's phenomena, generalisability of findings is unlikely.

Another phenomenological study was undertaken in Sweden by Almerud et al. (2008b) to uncover the meaning of being a caregiver in the technologically intense ICU environment. Data was gathered through unstructured open-ended interviews with 10 participants of different occupations, ages, genders and experiences, including four RNs, four enrolled nurses and two physicians. The study findings revealed the following participant experiences: 'mastery or servitude under technology', 'to be secure in insecurity and insecure in security', 'to make the human technological and the technology human'. The study has a number of limitations: selection of participants was through the clinicians and the charge nurse, which had the potential to introduce bias and possible coercion. The number of physicians was small, limiting interpretation of data. Given the range of different healthcare practitioners involved, there was no mention of triangulation of the findings, which would have strengthened the study.

Similarly, an ethnographic study by Price (2013a) was conducted to understand how technology affected caring practices in an ICU in the United Kingdom. A total of 19

participants took part in the study (16 nurses, 1 doctor and 2 physiotherapists). Data collection involved a process of triangulation involving participant observation, semi-structured interviews and document reviews to enhance the study's rigour. Participant recruitment was done through selective sampling. The study findings identified one overarching theme ('crafting process') and four subthemes. This first is 'vigilance', which refers to maintaining safety, responding to warnings and relaying abnormalities to other health care team members. This is similar to Wilkin and Slevin's (2004) 'nursing knowledge' theme. The second sub-theme, 'focus of attention', refers to balancing the physical stability of the patient and providing psychological support. 'Being present', the third sub-theme, refers to building a relationship with the critically ill patient and their family. This is similar to Wilkin and Slevin's (2004) theme 'nursing skills'. The fourth sub-theme, 'expectations', refers to the need to keep busy, whether by providing patient care or documenting progress. Wilkin and Slevin (2004) and Price (2013b) both stressed that it is in the patient's best interest for the concepts of caring and technology to be synchronised without compromising either. Nurses in ICU need to understand and appreciate the patient's quality of life, while advocating on their behalf to provide the best medical and technological support. Price's study has a number of limitations. The critical care practices and pressures have already changed since the data were collected in 2008–2009. As the researcher was a critical care nurse, some research aspects were missed because of not being able to assume an objective stance. Only nurses were observed—and only five nurses were interviewed from the eight nurses observed. This suggests the possibility that what they say is different from what they do. Further, issues of the study's qualitative data trustworthiness were not fully addressed.

An Australian study was undertaken by Storesund and McMurray (2009) using an ethnographic case study to examine how quality is embedded in the culture of ICU nursing in a major teaching hospital in Queensland. Data was gathered via semi-structured interviews with 10 informants. There was no observation of participants. The interview

questions followed Spradley's (1979) format for ethnographic investigations. The study identified three themes that affect nursing quality: maintaining cohesiveness in ICU, rapid, effective and respectful communication and specialist knowledge obtained by formal learning and experience. The study was limited by the informants' demographics (only one female informant and nine males), which may raise different insights on practice. The mean age of informants was 42 years, which may have also skewed the findings. The absence of a period of participant observation limits the overall quality of the findings, given that the study is ethnographic in nature. A further concern was that the researcher was a staff member in the unit, and there was no mention of how they avoided making other staff feel coerced to participate or how the researcher ensured rigour.

The literature review on the subject of caring uncovered rich discussion on the topic. Although there is a range of studies with various foci concerning caring in ICU, there is a paucity of literature concerning the nature of caring within the ICU environment (Wilkin & Slevin, 2004). Several caring studies were conducted overseas (the United States of America, Britain, Thailand and Sweden), which provides different contexts, healthcare provider philosophies, facilities and practices (Morrison & Burnard, 1997). Thus far, the published research on caring in Australia has been limited (Donoghue, 1993).

A review of literature from the last 10 years was unable to locate any studies that explored the nature of caring in an adult ICU from the focused ethnography perspective in an Australian context, specifically in Queensland. The closest approximation that has some similarities to the intensive nature of care in an ICU is an American study by Nelson (2014) that examines the neonatal ICU culture of care for infants with neonatal abstinence syndrome using a focused ethnographic methodology. Therefore, this study and its focused ethnographic approach (discussed in Chapter 3) is fully justified.

2.7 Summary

This chapter presented an exploration of the nature of caring within the context of an ICU. The literature review was undertaken in three parts. First, the origins of the word

'care' and definitions of it and related terms were studied. The second literature review explored caring in nursing in general. The third was an integrative review of the literature, which focused specifically on identifying what studies were undertaken on the nature of caring in the ICU context using PRISMA to identify what is known and unknown on the topic to justify this study. The next chapter presents a discussion of the methodology underpinning this work.

Chapter 3: Methodology

3.1 Introduction

This chapter provides a description of focused ethnography, the methodology underpinning this research. The chapter commences with a review of the definitions of focused ethnography, followed by an overview of the evolution of ethnography as a mode of inquiry and the different forms of ethnographic inquiry that have evolved over time. Central tenets of ethnography and focused ethnography are described, followed by a discussion of the place of focused ethnography within the context of nursing. The chapter concludes with a discussion of the rationale for the use of focused ethnography in this study.

3.2 Definition of Focused Ethnography

The term 'focused ethnography' (FE) consists of two words: focused and ethnography. Over time, the term 'ethnography' has been conceptualised in various ways, which has created some ambiguity about its essential nature (Hammersley, 1990; Hodgson, 2000; Malagon-Maldonado, 2015). First recorded between 1825 and 1835, it has been defined as a branch of anthropology dealing with the scientific description of individual cultures (Ethnography, 2017b). Linguistically, the term ethnography (ethno + graphy) originates from the Greek *ethno*, meaning custom, culture or group, and the Latin g*raphia* or 'graphein', meaning drawing, writing or description (De Chesnay, 2015; Schneider, Whitehead, Elliott, LoBiondo-Wood & Haber, 2007; Willis & Anderson, 2010). Thus, ethnography is concerned with describing a custom, group or culture (Schneider et al., 2007) and a direct description of people within a cultural group or community—a 'writing of culture' (Holloway & Wheeler, 2010, p. 153). Ethnography is 'the practice of writing an anthropological description of an individual human society or a situation within a society' or 'an anthropological description of a society or situation' (Blackwell's Nursing Dictionary, 2005, p. 218). Further definitions posed include 'the

scientific description of peoples and cultures with their customs, habits, and mutual differences' (Focused, 2017a) and 'a scientific description of the culture of a society by someone who has lived in it' (Ethnography, 2017a).

According to Spradley (1980, p. 3), 'ethnography is the work of describing culture' and Fetterman (1998, p. 1) defined it as 'an art and science that describes people's culture'. Spradley (2016, p. 205) suggests that writing ethnography is 'a process that "brings the culture to life" ' and is written in everyday language (Sandelowski, 2000). Harris and Johnson (2006, p. 5) defined ethnography as 'a written description of a particular culture - the customs, beliefs, and behaviour - based on information collected through fieldwork'. Leininger (1985, p. 33) posits that ethnography is indigenous to peoples' viewpoints and practices within a cultural group, leading to the collection of 'substantive, empirical, and abstract data in the field'.

Ethnography can be a research technique itself or the product of research techniques (Creswell, 1998). Polit and Beck (2010), Roper and Shapira (2000), Spradley (1980) and Oliffe (2005) all highlight that ethnography is learning *from* people and is distinct from studying or learning *about* people. Roper and Shapira (2000) further assert that ethnography, as a research methodology, delivers an effective a means to learn about people by learning from them. Goodson and Vassar (2011, p. 2) described ethnography as 'a social research method occurring in natural settings characterized by learning the culture of the group under study and experiencing their way of life before attempting to derive explanations of their attitudes or behaviour'. Muecke (1994, pp. 189–190) provides a succinct yet comprehensive description of ethnography as:

A written description of a people that focuses on selected aspects of how they lead their routine, remarkable, and ritual lives with each other in their environment and of the beliefs and customs that comprise their common sense about their world.

The second word ('focused') means 'directing a great deal of attention, interest, or activity towards a particular aim' (Focused, 2017a, para 1) and 'giving a lot of attention

to one particular thing' (Focused, 2017b, para 1). Knoblauch (2005) used the term 'focused' because FE concentrates on small elements of a culture. Muecke (1994) used the term to describe time-limited exploratory studies in a fairly discrete community or organisation with a limited number of key informants having knowledge of problem or phenomenon of study. For the purpose of this study, Muecke's (1994) definition of FE was adopted as this exploratory study focused on a particular culture or phenomenon— the nature of caring in an ICU—within a limited time frame and with a limited number of participants.

3.3 Evolution of Ethnography

The origins of ethnography lie in anthropology (Borbasi & Jackson, 2012; Holloway & Wheeler, 2010; Polit & Beck, 2017; Schneider et al., 2007; Speziale & Carpenter, 2007), where it is the primary research tradition (Burns & Grove, 2005; Moule & Goodman, 2009; Polit & Beck, 2004). Ethnography has often been considered synonymous with anthropology, which is dedicated to the descriptive study of cultures (Speziale & Carpenter, 2007). For this reason, a brief discussion of the underpinnings of anthropology is provided.

Anthropology is defined as 'the science that deals with the origins, physical and cultural development, biological characteristics, and social customs and beliefs of humankind' (Anthropology, 2017, para 1) or 'the science of humans and their works' (Anthropology, 2017, para 3). Thus, anthropology refers to the study of humankind (Moule & Goodman, 2009; Schneider et al., 2007). As a mode of study, it originated in the mid-nineteenth century, initially to search for and understand people's ways of living, believing and adjusting to changing environmental conditions (Burns & Grove, 2005). Having such an understanding was considered important in providing a conceptual lens for anticipating future directions of cultures and their developments (Leininger, 1970). Culture is the main concept in anthropology (Leininger, 1970; Polit & Beck, 2004), which is defined by Leininger (1970, pp. 48–49) as:

A way of life belonging to a designated group of people … a blueprint for living which guides a particular group's thoughts, actions, and sentiments … all the accumulated ways a group of people solve problems, which are reflected in the people's language, dress, food, and a number of accumulated traditions and customs.

Culture has been defined by Helman (1994, pp. 2–3) as:

A set of guidelines that individuals inherit as members of a specific society which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces or Gods, and to the natural environment.

The debate continues around the emergence of ethnography as a mode of inquiry. Sanday (1983) posits that it began with Herodotus (485–425 BC) who recorded variations in the cultures to which he was exposed, while Rowe (1965) suggests ethnography was initiated as a research method in the Renaissance period. Malinowski's (1922) study of Trobriand Islanders has been viewed by many ethnographers as the beginning of ethnography as a research method, while Atkinson and Hammersley (1994) purport that the contemporary origins of ethnography occurred in the nineteenth century, when people began to recognise cultural differences and began to study them. At that point, anthropologists were apprehensive that tribal groups in developing nations were disappearing. Researchers of the time, including Malinowski (1884–1942), Boas (1858–1942) and Mead (1901–1978), felt the need to study human behaviour within the context of a culture to entirely understand their cultural patterns, rules and routines (Holloway & Wheeler, 2010). Atkinson and Hammersley (1994) identified two phases in the development of ethnography. First came the work of the founders of modern anthropology such as Malinowski (1913, 1922), Boas (1928), Mead (1928), Benedict (1934, 1946) and Radcliffe-Brown (1952). They were dedicated to recording descriptions of 'primitive cultures'—'a term which demonstrates the patronising stance of many early

anthropologists' (Holloway & Wheeler, 1996, p. 82). These early social anthropologists believed that traditional science was insufficient to learn the nuances of people who live together and share similar experiences. This led to the emergence of ethnography as a mode of critical inquiry (Speziale & Carpenter, 2007). Holloway and Wheeler (2013, p. 154) provide a succinct account of how ethnography originated from anthropology:

> When cultures became more linked with each other and Western anthropologists could not find homogeneous isolated cultures abroad, they turned to research their own cultures, acting as 'cultural strangers', that is, trying to see them from outside; everything is looked at with the eyes of an outsider.

Second, in the 1920s and1930s, the Chicago School of Sociology challenged the natural sciences by questioning their relevance as a methodological model for social research (Atkinson & Hammersley, 1994; Holloway & Wheeler, 2013). Atkinson and Hammersley (1994) noted that scientists in this school of thought attempted to connect scientific and hermeneutic philosophies with pragmatic philosophies.

3.4 Forms of Ethnographic Inquiry

Over time, different approaches to ethnographic inquiry have emerged, resulting in the development of a sophisticated methodology; however with its evolution has come a growing fear of losing some of its primary features such as extensive and long-term fieldwork (Rashid, Caine & Goez, 2015).

Sanday (1983) proposed three traditions within ethnography. The first is holistic, which involves studying the culture as an integrated whole. The second is semiotic, which involves obtaining access to the insider/native's viewpoint, but without sharing epistemologies. The third is behaviouristic and reveals covarying forms in observed behaviour. Further, Holloway and Wheeler (2013), Leininger (1985a), Patton (2002b), Polit and Beck (2017), Speziale and Carpenter (2007) and Welch (2014) classified ethnography into two main types. The first is 'macro/maxi ethnography' or 'large-scale ethnography' and is concerned with broadly focused or defined cultures, as in studying

a complex society such as an institution or hospital (Holloway & Wheeler, 2010; Polit & Beck, 2017) over a lengthy period (Speziale & Carpenter, 2007). The second is 'micro/mini-ethnography' or 'small-scale ethnography', which is narrowly defined and limited to a specific group and can be performed within a relatively short period of time with minimal resources (Holloway & Wheeler, 2010, 2013; Polit & Beck, 2017; Speziale & Carpenter, 2007). The micro/mini approach to ethnography can focus on a subculture or single setting, such as a group of specialist nurses or a hospital unit (de Laine, 1997a; Polit & Beck, 2012)— or the ICU, as in this research.

There is a wide range of ethnographic forms used in health research (Borbasi & Jackson, 2012; De Chesnay, 2015; Holloway & Wheeler, 2013; Robinson, 2013; Speziale & Carpenter, 2007). These include descriptive or conventional/traditional ethnography, which focuses on the description of cultures/subcultures or people. Another type is critical ethnography, which involves the study of power and politics to change a culture. Auto-ethnography is when the researcher focuses on their experience instead of those of others. Interpretive or hermeneutic ethnography explores the meanings of social interactions. Systemic ethnography defines the structure of a culture, rather than describing its people's interactions, feelings and materials. Feminist ethnography (in which gender is the primary focus of the research) is concerned with questions about power and interests and how they shape women's experiences. Finally, institutional ethnography studies the organisation of professional services with a focus on social and institutional work processes leading to organisational change. Other forms of ethnography include: naturalist, realist, modernist, postmodernist, social constructionist, particularistic, sketch, ethno-historical, structuralist, ecological, cross-sectional, visual, cognitive, deconstructed disrupted, performance, practitioner, reflexive, specialist, internet ethnographies and ethnonursing. Ethnonursing can be described as a mini-ethnography and uses Leininger's Sunrise Model as a guide or domain of inquiry, defined as 'a small scale focus or narrow area of inquiry' (De Chesnay, 2015, p. 188). The final form of ethnography and the chosen approach to inquiry for this

study is FE, which is concerned with exploring a particular phenomenon within a single setting and with a limited number of people. Briefly, the most commonly used ethnographic forms are described in Table 3.1.

Table 3.1

Forms and Aims of Ethnography

Form	Foci/Aims
Classical Ethnography	Obtaining a complete description of all aspects of a cultural group including the living patterns of the people that make up a cultural group.
Systemic Ethnography	Defining the structure of culture, rather than describing a people and their social interaction, emotions and materials.
Interpretive Ethnography	Discovering the meanings of observed social interactions, understanding human behaviour and discovering the meaning behind the person's actions.
Critical Ethnography	Studying society with particular attention to uncovering social inequalities, oppression and injustices, with the aim of raising social awareness and instituting change.
Institutional Ethnography	Seeking to understand the social determinants of people's everyday experiences, especially work processes. The focus is on social organisation and institutional processes to play a role in organisational change.
Auto-ethnography	Studying one's own culture through personal experience, which provides the means of exploring and gaining insights into the culture in which one lives.
Focused Ethnography	Focusing on a distinct problem within a single setting and a limited number of people.
Visual Ethnography	Using photos and films, this subspecialty ethnography studies culture.
Performance Ethnography	Interpreting culture through scripted and staged re-enactments of ethnographically derived notes.
Feminist Ethnography	Questioning power and interests and how they shape women's experience; gender is key to this research.

Internet Ethnography	Analysing data from a chat room or blog site to study illness experiences using the internet, a rich source of interactive and socially mediated data.
Ethnonursing	Studies nursing care and generates nursing knowledge using the Sunrise Model.

3.5 Central Tenets of Ethnography

As FE is a branch of ethnography, the central tenets of ethnography are presented first, followed by a discussion of what constitutes FE. The central tenets of ethnography include:

- providing an in-depth understanding and explanation of behaviours, beliefs, opinions and emotions from the participants' perspectives (Hennink, Hutter & Bailey, 2011)

- undertaking a systematic study of a culture or subculture by identifying and describing the social and cultural perspectives of groups of people in society (Borbasi & Jackson, 2012; Willis & Anderson, 2010)

- exploring, investigating and comprehending the culture of the person's experience (Holloway & Wheeler, 2010; Murchison, 2010)

- identifying the 'common sense knowledge of the culture studied by revealing what the social worlds mean for the person and what they mean as insiders acting within them' (Wolf, 2012, p. 285)

- elucidating accounts of phenomena, including related contextual information using thick descriptions (Geertz, 1973; Goodson & Vassar, 2011)

- understanding an individual's experience and culture within their day-to-day natural environment, as well as how they feel and think (O'Reilly, 2012)

- discovering, understanding, explaining and accurately representing the observed social phenomena (Hammersley, 2002)

- identifying practical knowledge embedded in discursive forms of written and verbal communication (Emmerson & Pollner, 2002)

- identifying cultural implications of spoken messages (what people say), cultural behaviour (what people do), cultural artefacts (things that people make and use) and tacit knowledge (information recognised by members of the culture but not articulated directly) (Polit & Beck, 2017).

3.6 Focused Ethnography

An FE inquiry has been described as 'exhaustive, fine grained studies of small units within a group or culture' (Polit & Beck, 2010, p. 265). Cultures and subcultures exist everywhere and may be relatively boundless (Mayan, 2009). FE usually deals with a distinct problem, concern or inquiry into a specific context and is conducted within a sub-cultural group (Knoblauch, 2005; Mayan, 2009; Richards & Morse, 2013; Roper & Shapira, 2000). Such a mode of inquiry recognises that participants within a sub-cultural group have specific knowledge about the identified problem, inquiry or concern (Higginbottom, Pillay & Boadu, 2013). Wall (2015) proposed using an FE approach with a context-specific and problem-based framework, which was confirmed by Richards and Morse (2013), indicating that FE provides information about the subculture of the culture under inquiry, as well as the specific topic or shared experience (Richards & Morse, 2013).

According to Knoblauch (2005), FE is an applied research methodology when conducting social research in highly fragmented and specialised fields of study. Participants may not even know each other but the researcher focuses on their common behaviours and shared experiences and works from the assumption that the participants share a cultural perspective (Cruz & Higginbottom, 2013; Mayan, 2009; Richards & Morse, 2012). FE is a focused and efficient approach to understand a particular topic or issue, as it is situated in the cultural, behavioural and social clinical context in which it occurs (Knoblauch, 2005; McElroy et al., 2017). In FE, the ethnographer examines cultural factors in a narrower scope of inquiry—instead of trying to understand the entire

culture (De Chesnay, 2015; Knoblauch, 2005)—to better understand the experiences of specific aspects of people's way of life (Cruz & Higginbottom, 2013). A focused interaction can be understood in terms of how, when and why it occurred in the manner observed (McFeat, 1974) and this provides an understanding of each person's perception of that occasion or event.

FE has been used by many researchers across multiple fields (Heath, vom Lehn & Knoblauch, 2001; Jirotka & Goguen, 1994; Muecke, 1994; O'Byrne, 2012)including business (Moore, 2011), social work (Palomares & Poveda, 2010), and nursing (Aagaard, Laursen, Rasmussen & Sorensen, 2016; Barreto, Marcon & Garcia-Vivar, 2017; Hales et al., 2017; Heydari, Vafaee-Najar & Bakhshi, 2016; Salman, Zoucha & Nawafleh, 2016; Young et al., 2017). According to Boyle (1994, p. 172), FEs help nurses to 'understand cultural rules, norms, and values and how they relate to health and illness behaviour'. Similarly, the present study focused on cultural norms, values and practices of the nature of caring in ICU.

3.7 Central Tenets of Focused Ethnography

As a branch of ethnography, FE shares the same tents of ethnography methodology discussed previously as well as the ontological and epistemological foundations of reality and how the knowledge of reality is attained. In addition, FE has specific tenets underpinning the approach:

- This approach explores a discrete issue or shared experience in a cultural group or people in specific settings instead of entire communities. The use of FE is appropriate when focusing on individualised instead of group experience (Cruz & Higginbottom, 2013; De Chesnay, 2015).

- This inquiry is conducted by a single researcher who usually has background knowledge of the culture before entering the natural setting.

- This approach focuses on a concern or context-specific aspect of a culture, within a discrete community/organisation/social phenomenon.

- This inquiry is informed by a specific research question that guides the research process.

- The study involves a limited number of participants who usually hold specific knowledge, which is the emic perspective of the specific issues, situations and actions.

- The approach involves episodic participant observations, which generally involve a shorter period of fieldwork with more intermittent immersion in the culture. This is compensated by intensive methods of rigorous audio/visual data collection and with the intensity and scrutiny of coding and sequential data analysis (Cruz & Higginbottom, 2013; De Chesnay, 2015; Higginbottom, 2011; Higginbottom et al., 2013; Knoblauch, 2005; Leininger, 1985a; Millen, 2000; Morse & Richards, 2002; Muecke, 1994; Streubert & Carpenter, 2011; Willis & Anderson, 2010).

- The researcher is as instrument with cultural immersion involving direct face-to-face interaction and examination of specific social phenomena. This involves relative submersion in the natural setting and small sample sizes, which may include a single case.

In conjunction with the tenets of ethnography and FE, the key elements are the emic and etic perspectives of the culture being studied and the process of reflexivity undertaken by the researcher.

3.7.1 Emic and etic perspectives.

Ethnographers consider that cultures contain symbols and patterns derived from their members' subjective views of reality (Creswell, 2007). This relativistic view delivers insight into group members' culture where knowledge is regarded as having many truths that occur within the context of that culture, which gives rise to multiple views of reality (Munhall, 2007). Culture involves people in a group who interact with each other over a period of time (Creswell, 2007). The strength of the ethnographic method become

obvious when the ethnographers tried to understand and explain behaviours and cultural patterns when there was a discrepancy between 'what people said they do' and 'what they do', both of which are captured in ethnography (Morse, 1994)**.** With ethnography, a holistic perception is achieved by observing all aspects of the phenomenon under study as parts of a unified whole (Padgett, 2012). To understand the nature of caring in ICU, it was important to address both the emic (insider) and etic (outsider) perceptions of the phenomenon.

The emic view represents the participants' views (Polit & Beck, 2017). As Boyle (1994), Field and Morse (1985), Morse (1994) and Spradley (1980) point out, this is the purpose of an ethnographic approach to inquiry—to describe and understand another way of life or behaviours from the 'native's point of view' or their perspectives of reality. The emic view reveals the values and beliefs of the individual and culture being studied in their own terms (Spradley, 1979). That is, one gains an understanding of cultural concepts and behaviour patterns of individuals and groups within a particular cultural context (Borum, 2007; Craig & Cook, 2007; Goulding, 2005).

The emic perspective is studied through what participants say in interviews, informal conversations and journaling (Hammersley, 1992). Seeking to understand the emic perspective is the driver that shapes the questions posed to participants during interviews and informal conversations during the period of fieldwork (Griffiths & Bridges, 2010; Keele, 2011; Rebar, Gersch, Macnee & McCabe, 2011). Simmons (2007) suggests that nurse researchers already have an emic view. This is advantageous as it allows them to rapidly immerse themselves in the context of the field as participant-observers (Fetterman, 1989).

The 'etic' (outsider) view represents the researcher's perspectives and interpretation of the social phenomenon studied within the culture under examination (Polit & Beck, 2017) and leading to the development of a theoretical explanatory framework on the phenomenon (Hammond & Wellington, 2013). As an objective outsider,

the role of the researcher is to note behaviour patterns of group members during the observation period and to rationalise those behaviours through discussions with those involved (Hammersley, 1992; Holloway & Wheeler, 2010; Morse, 1994; Rebar et al., 2011).

Both perspectives are essential to understanding the meanings underpinning participants' behaviours, as elucidated through observations and interviews (Boyle, 1994). The ethnographer is a mediator between the emic and etic worlds (Lambert, Glacken & McCarron, 2008) and attempts to gain knowledge from both perspectives.

3.7.2 Reflexivity and the researcher's position.

Reflexivity is an important tool in ethnographic studies because it functions as a reminder that the researcher is an important part of the social world being studied (Ersser, 1996; Hammersley & Atkinson, 2007). Murphy (2017, p. 195) suggests that 'qualitative research calls for a level of self-conscious reflection upon the ways in which the findings of research are inevitably shaped by the research process itself and for an analysis that takes this into account', as in this FE study. Finlay (2002, p. 532) described reflexivity as 'thoughtful, conscious self-awareness', while (Davies, 2008, p. 4) defined it as 'turning back on oneself, a process of self-reference'. Polit and Beck (2017) and Doyle (2013) described reflexivity as the constant critical process of a researcher's self-reflection on personal biases, preferences, values and preconceptions that could affect the processes of data collection and analysis. According to Denzin and Lincoln (1998, p. 278), 'researchers are obliged to delineate clearly the interactions that have occurred among themselves, their methodologies, and the settings and actors studied'. This can be achieved through the use of reflexivity.

Mulhall, Le May and Alexander (1999) recommended that researchers address three questions during through the research process. These enable them to position themselves within the process while collecting and analysing the data and publishing the

study. These questions are: how have I affected the process of the research, how has the research affected me and where am I now?

3.8 Focused Ethnography and Nursing

The use of ethnography as a mode of inquiry within health research has increased in the last three decades (O'Byrne, 2012). This is because healthcare researchers view it as providing a valuable conceptual lens to explore cultural knowledge about health and illness (Hodgson, 2000). Ethnography is generally an appropriate approach for a wide variety of research in healthcare environments and medical education because of its flexibility in responding to local circumstances (Goodson & Vassar, 2011; Hammersley & Atkinson, 2007).

The aim of ethnography is to discover cultural and contextual patterns of knowing, which leads to a better understanding of social and health issues (Duffy, 2005). When applied, ethnography focuses on explicating the meanings in social relations to understand the 'what, why and how' of social behaviours (Hammersley & Atkinson, 2007; Hammond & Wellington, 2013).

An ethnographic methodology was first used in nursing in the 1960s (Boyle, 1994; Leininger, 1970). The first nurse ethnographers such as Leininger (1978, 1985a) and Morse (1991, 1994) implemented the anthropological methods to study phenomena they assumed were irreducible, unquantifiable or unable to be objective (Speziale & Carpenter, 2007). According to Taylor, Lillis, LeMone and Lynn (2008) and Borbasi and Jackson (2012), ethnography has been used to investigate issues of a specific culture that are of interest to nursing, and often focused on single health-related issues (Rashid et al., 2015). In this FE study, the identification of a phenomenon of interest within this defined culture is the nature of caring by nurses in an ICU.

Baillie (1995) purports that ethnographic research can enhance nursing practice by promoting an appropriate culture of care. Further, ethnography has been used in nursing to increase ethnic cultural awareness and to enhance the provision of quality healthcare

from a cultural perspective. (Germain, 2001; Laugharne, 1995) with the aim of understanding the cultures of the patients and care providers (Morse & Field, 1996). Ethnography assists nurses to understand cultural roles, norms and values, and their relationship to health and illness behaviours (De Laine, 1997b). This essentially provides a portrait of a people as it involves writing about people and culture, such as intensive care nurses and their work culture, routines and customs (Burns & Grove, 2005, 2011; Moule & Goodman, 2009; Munhall, 2012; Polit & Beck, 2004).

Ethnography in nursing can provide resources for scientific inquiry, assist in assessment, strengthen intervention programs and influence public policy development (Schensul, Schensul & LeCompte, 1999). For example, Cleary, Hunt, Horsfall, and Deacon (2011) assessed the nursing care provided in mental health facilities by reviewing ethnographies that were conducted in these institutions. They found that the nature of patient-centred nursing care was at times chaotic from an insider's perspective.

Nurse ethnographers have argued that ethnography as a mode of inquiry is appropriate for nurses because they have well-honed observation, documentary and analytical skills (Oliffe, 2005). Moreover, ethnography can be employed by nurses in a diverse range of settings. For example, it has been applied to an exploration of the symptoms of woman with ovarian cancer (Ferrell, Smith, Cullinance & Melancon, 2003), to explore the healthcare experiences of Bosnian and Soviet refugees (Lipson, Weinstein, Gladstone & Sarnoff, 2003), in an exploration of families' long-term renal illness experiences (Waters, 2008), for observation of social processes in relation to patient and staff experiences in a fertility clinic (Allan, 2006), for examination of the experiences of families when a child with cancer relapses (De Graves & Aranda, 2008) and for identification of the factors affecting rural African women's participation in HIV prevention (Duffy, 2005). Other examples include interpreting the nature of communication between nurses and patients (Mallett, 1997), nurse-nurse interactions

(Payne, Hardey & Coleman, 2000) and nurse-surgeon communication in the OR (Gardezi et al., 2009).

FE is increasingly recognised as a relevant methodology within nursing research to discover how people from various cultures incorporate health beliefs and practices into their lives (Cruz & Higginbottom, 2013). According to Higginbottom et al. (2013, p. 1), FE is an appropriate approach in healthcare research because it provides 'pragmatic and efficient ways to capture data on a specific topic of importance to individual clinicians or clinical specialties'. FE has meaningful and useful applications in primary care, community or hospital healthcare practices, and is frequently used to determine ways to enhance care and care processes (Higginbottom et al., 2013). This approach offers an opportunity to gain an enhanced understanding and appreciation of nursing as a profession and the role it plays in society (Cruz & Higginbottom, 2013) by examining the patients' and practitioners' specific beliefs and practices of particular illnesses or healthcare processes (Magilvy, McMahon, Bachman, Roark & Evenson, 1987). An FE methodology can also be applied to explore how a dynamic contemporary subculture of nurses and patients (within an organisation that is usually made up of differentiated, competing and fragmented cultures) experience a specific topic within that context (Meeussen, Delvaux & Phalet, 2014; Wall, 2015). This is consistent with the proposal of Roper and Shapira (2000) that most nurse ethnographers focus on a distinct problem, concern or phenomenon within a particular context and among a small group. Thus, the nurse ethnographer tends to focus on discrete health-related problems in particular contexts with a small number of participants, within a certain period of time (Chuang & Abbey, 2005; Cruz & Higginbottom, 2013; Muecke, 1994; Roper & Shapira, 2000). Roper and Shapira (2000) outlined three foremost purposes of FE in nursing. They include learning how people from different cultures use health beliefs and practices in their lives, understanding the meaning of the native's experiences to assist in the provision of nursing care and studying the practice of nursing as a cultural phenomenon.

Numerous nursing FE studies have been published. For example, Hales et al. (2017) examined the challenges that ICU nurses experienced when engaging in the care of critically ill morbidly obese patients. In this study, the focused observation of this specific aspect altered some participants' behaviours. Another limitation is that the findings cannot be generalised due to the nature of the qualitative inquiry approach. Similarly, non-generalisable findings from another FE study are those of Kitchen et al. (2017). This study aimed to first identify the methodological and organisational factors relevant to the design of a randomised control trial RCT for youth depression in a Child and Adolescent Mental Health Service environment. Second, it aimed to describe the culture and patient care pathways surrounding depression in this service. The reflection of the researchers on the use of FE permitted the team to allocate trial resources efficiently. The FE approach provided important insights into the individual, practical and organisational limitations into which a trial would need to be deployed. Further, the FE allowed staff knowledge to be expressively contextualised and to consider personal, interpersonal, managerial and social impacts on behaviour. Conversely, Kitchen et al. (2017) noted that the nature of FE might preclude the inclusion of useful data in analysis.

The behaviour patterns of relatives of critically ill patients admitted to the emergency room was studied by Barreto et al. (2017). The findings recommended promoting comprehensive care by inviting relatives to be with the patient and involving them in patient-centred care. This study was criticised for its brief observation period (only 40 hours in the field), though the researchers justified this weakness, citing the variability of observation time. In a focused ethnographic study, Heydari et al. (2016) explored ICU beliefs and their effects on nurses' practices and behaviour patterns regarding health economics. The outcomes of this study identified the importance of ICU nurses' involvement in decision-making regarding unit cost management, in becoming familiar with healthcare economics, in productivity and in implementing hospital-related strategic plans and management systems. Flood (2017) used FE to understand the Hawaiian

community's breastfeeding service and support issues. Aagaard et al.'s (2016) FE study, explored the interactions between patients and nurse anaesthetists, focusing on the time interval between patient entrance into the OR and induction of general anaesthesia. Kelley, Parke, Jokinen, Stones and Renaud (2011) assessed the environment of an emergency department and its influence on adult care, using a 'senior-friendly' conceptual framework. Spiers and Wood (2010) explored the perceptions and actions of community mental health nurses in building a therapeutic alliance and the factors that helped or impeded its development. Smallwood (2009) explored the roles of cardiac assessment team members in caring for patients with acute coronary syndrome. Finally, the practice of nursing as a cultural phenomenon was studied by Scott and Pollock (2008) who used FE to explore the effect of unit culture on nurses' general research use.

3.9 Rationale for the Choice of Focused Ethnography

FE is widely acknowledged in healthcare as a research method for studying behaviours and social interactions (Roberts, 2009). It captures the voices of experiences that go beyond surface appearances and focuses on understanding the complexities of what occurs in a particular social situation (Jeffrey & Troman, 2004).

The researcher's significant insider knowledge and experience of the nature of ICU nurses' clinical practice meant that she had a background understanding of ICU work processes and clinical matters in general. As a researcher, this insider knowledge assisted her in narrowing the focus and delineation of the research question and study. FE was chosen because of its congruence with the research question posed in this study, which centres on describing experiences within a cultural context (Higginbottom et al., 2013; Richards & Morse, 2013).

3.10 Summary

This chapter provided a description of the chosen methodology underpinning this research. The chapter commenced with a review of FE definitions followed by a discussion of the historical origins and the emergence of the various forms of

ethnographic inquiry. The chapter continued by presenting the central tenets of ethnography and FE before positioning FE as an appropriate mode of inquiry for this study. The next chapter provides a description of the methods involved in conducting this study.

The other grow

Chapter 4: Methods

4.1 Introduction

This chapter discusses the methods used in this ethnographic study. It is divided into six sections as follows: the first section provides a description of the study setting. The second describes the participants' inclusion criteria and recruitment, number of participants and demographic details. The third section outlines the data collection methods used in this study to explore the nature of caring by nurses in intensive care, while the fourth details the data analysis. The fifth section discusses the ethical considerations for this thesis and finally, the sixth section discusses the means by which rigour was achieved in this study.

4.2 Study Setting

This FE was undertaken in a single ICU of a Queensland metropolitan hospital. The ICU was built in 2000 and is one of the largest private ICUs in Australia. It provides a wide range of tertiary-level services and facilities to accommodate an extensive range of systems and procedural support corresponding with the functions of the hospital.

4.2.1 Physical layout of the ICU.

The ICU area starts from the entrance site. There is a volunteer clerk outside the unit, who cooperates with the ICU staff and receptionist to arrange relatives' visiting times. There is a welcome statement from the unit manager hanging on the wall behind the volunteer desk (see Figures 4.1 and 4.2). Next to the entrance door, there is a waiting room for visitors with facilities and self-service coffee, tea and other refreshments.
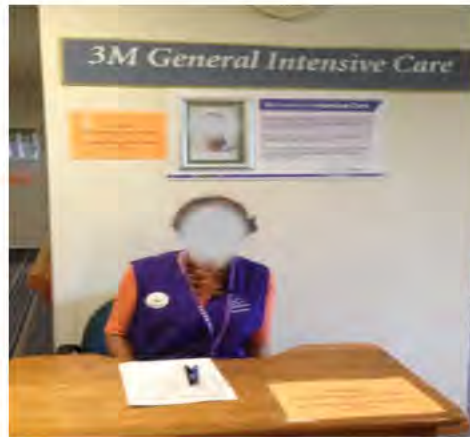
Figure 4.1. Volunteer clerk in front of the ICU area.

Figure 4.2. The Clinical Nurse Manager's welcome statement.

In addition to utilities, the room offers a kettle, microwave, small fridge, sink, handwashing liquid and disposable hand towels. Further, there are two tea tables, two sofas, five chairs, three vases of artificial flowers, books and magazines (see Figure 4.3). On the wall opposite this room, there are brochures, leaflets and other educational materials for visitors such as information about visiting hours and where to get help, if required (see Figure 4.3).

Figure 4.3. Waiting room for ICU visitors (left), facilities and services provided to visitors (middle) and visitors' educational brochures and leaflets (right).

This ICU consists of 19 beds (17 in open rooms and 2 in isolated rooms), divided into two wings. The right wing includes bed numbers 1–13. There are six beds in the left wing: beds 14–19, which includes the isolation rooms 18 and 19 (see Figure 4.4). Room 14 is the only room that has a window with an outside view, which offers abundant natural light. Beds 1–6 are allocated to conscious patients because they are away from the nurses' station and experiences the least noise from staff activities, especially at night. There are a number of offices in the left wing for the medical staff, as well as a rest room for the medical officer on-call for the unit. Patients' rooms are all similar; all beds are electrical and there is a locker on wheels alongside with each bed (see Figure 4.4). Each room has oxygen and suction units and a ceiling-mounted computer for nurses' usage. There is also a TV on the wall of each patient's room and each room can be closed by a disposable curtain (of a comfortable blue colour) to create privacy for the patient (see Figure 4.4). In front of each bed, there is a desk and chair with space for the nurse to sit and write their records and notes.
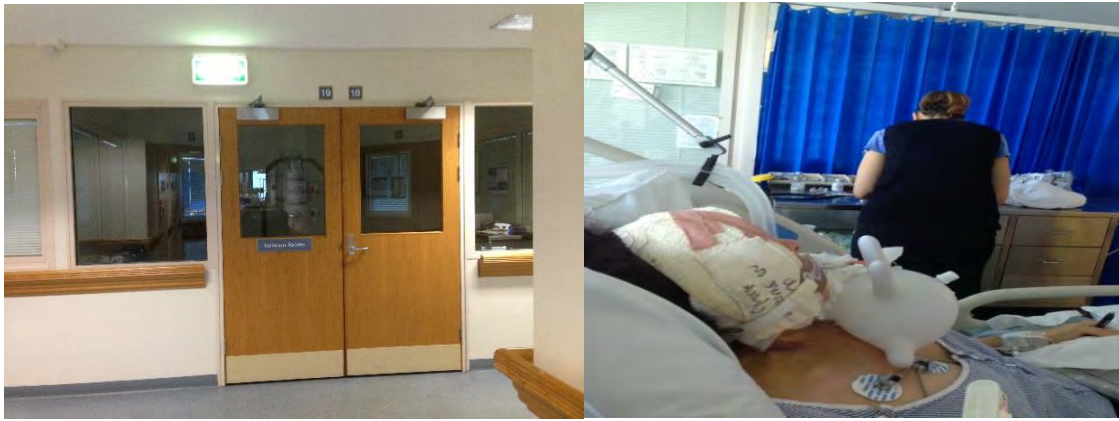
Figure 4.4. Isolation rooms in ICU (left) and an ICU room with a nurse preparing medication for her patient (right).

There is the staff tearoom at the end of the right wing, which faces the respiratory room with an arterial blood gas (ABG) machine. There are two nurses' stations: the main one is the largest and faces the Clinical Nurse Manager's (CNM) office; and the small one is located in front of the first six beds of the right wing. Sometimes nurses use it to write their documentation. The main nurses' station includes the in-charge nurse's desk, reception desk and the doctors' desks. These have computers for doctors and nurses to find any information, procedure or results. The receptionist is stationed there during office hours, greeting visitors and responding to their enquiries, and performing duties for nursing staff. In the nurses' station, there is an X-ray machine (where the X-ray technician can obtain X-ray films) and X-ray screens for doctors to view these films. There is a whiteboard where the patients' names are allocated to their room number along with their specialist, the anaesthetist and the MO who are on duty or on-call for the day (see Figure 4.5). As observed by the researcher, information on the board was frequently updated as changes occurred. From the nurses' station, there are exits to the utility room, where basins, urinals and bedpans are stored, and the clean room where medications are dispensed. There are two separate medication rooms in the unit: one for IV fluids and IV medications and the other for oral medications. As the unit manager P1 indicated, 'neatness is comfortable, and order reduces risks' [P1: field notebook 1]. There is another exit from the main nurses' station to an additional storeroom for other equipment and

tools. The middle of the unit has another clean utility room and bathrooms. The conference room is at the exit of the unit. It is used for family meetings when it is necessary to discuss patients' health with relatives or to undertake patient-related decisions.

For staff, the hub of the unit is the main nurses' station, where all staff movements originate and return on a regular basis. The station is rarely vacant and on several occasions, as many as 30 staff could be present at a certain time. This could include bedside, float and in-charge nurses, doctors and other health professionals, hospital aids and unit clerks, all engaged in different group interactions simultaneously. The nurses' station area can be accessed from either corridor and can be viewed from both through glass.

There are desks with five computers and two mobile telephones with security video calls. The receptionist (or present staff) responds to the entry bell by pressing a button on the telephone to open the door for the caller. In addition, there is a landline telephone only used for emergency calls. In the nurses' station, staff talk to their colleagues and/or complete their documentation (see Figures 4.5 and 4.6). The main nurses' station also holds cabinets with drawers of numerous folders and forms for doctors', health professionals' and nurses' requirements. On the shelves, there are many 'thank you' letters to staff and the staff communication book is located in the in-charge nurse's space.

Figure 4.5. The information whiteboard in the nurses' station for patient allocations, in-charge doctors and on-call doctors in ICU (left) and the unit manager and receptionist in the nurses' station (right).

Figure 4.6. Doctors and a physiotherapist in the nurses' station.

Nursing staff start their shift by entering the station and checking the allocation book to see who their patients for the day are. They then accept handover from the nurse of the previous shift. The physical layout of the unit provides a clear picture of how things are done in this ICU (see Figure 4.7).

Figure 4.7. The physical layout of the 3M ICU.
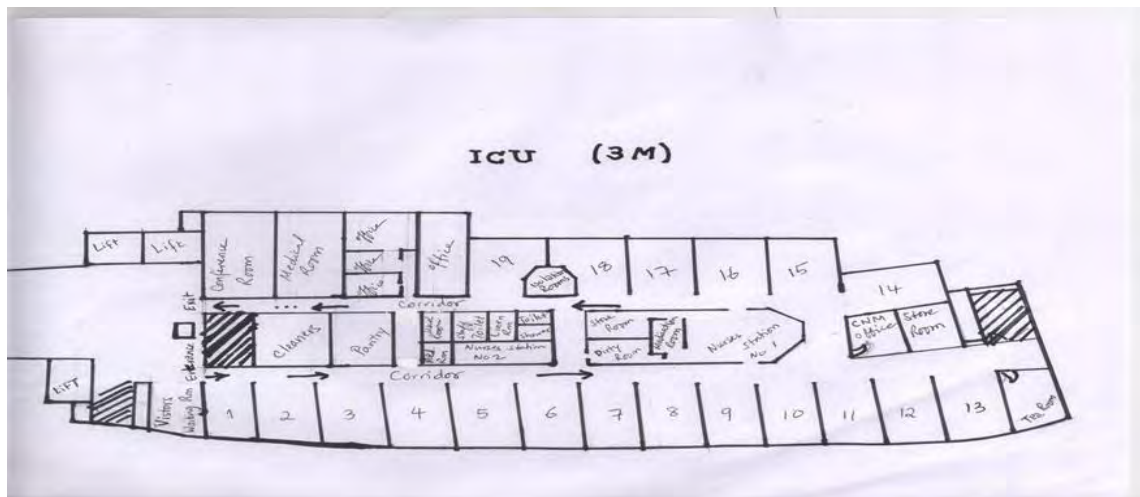
Different shifts are available to nurses in ICU and there are a variety of day, evening and night shifts of 6, 8 and 12 hours. There is a ward man/orderly during evening and night shifts in the ICU. Regarding nurses' uniforms, the hospital and casual staff wear blue shirts and navy trousers or skirts and the agency's staff wears the agency uniform.

4.2.2 Description of the ICU staff.

Apart from patients in ICU, there are people regularly coming and going in this unit. The main groups of people dominating the area are nurses, medical staff and other health professional as well as auxiliary staff, including care assistants and cleaners.

During the fieldwork period, there were 65 RNs employed in the unit: 56 females and 9 males. In this ICU, nurses are from different ethnic backgrounds: Australia, New Zealand, the United Kingdom (UK), Ireland, Indonesia, China, the Philippines, Thailand and India. Nurses' levels in this unit include one unit manager (CNM), 19 Clinical Nurses (CNs) and 45 RNs (see Table 4.1), whose ages range between 22 and 60 years. A number of nurses work part-time and some only work specific shifts such as morning or night duties. Generally, the nurse population has a very low turnover. There was a wide range of experience among these nurses; some had been working in the unit for longer than 18 years and others were new graduates. Some nurses were engaged in postgraduate studies. During this study, nursing students from local tertiary education institutions (Queensland University of Technology and Australian Catholic University), were placed in the unit for

their training and clinical experience (Figure 4.8). Generally, 4–6 students were in the unit at the same time. Students usually completed the same shifts as their mentor nurses and worked only morning and evening shifts. Each student was paired with an RN and practiced alongside with them, assisting with patient care. The Educator Registered Nurse (ERN) was responsible for those students and at times, the student's university clinical supervisor visited them in the unit.

Figure 4.8. An ICU RN teaching one of the students about the ventilator.

Medical staff and other health professionals (physiotherapists, dieticians and pharmacists) visit the unit as required to see patients. Some health professionals were their own ordinary/street clothes and are usually well-known to the ICU staff. Generally, they positioned themselves in the nurses' station where they had access to patient notes.

The auxiliary staff comprised two receptionists/clerks. Every day, one worked office hours and was based in the reception area of the nurses' station. There were also hospital aides who usually worked the day and evening shifts. Their duties included managing the kitchen/dirty utility, assisting staff with bed-making and tidying the ward.

4.3 Number of Nurses Working in ICU

The number of nursing staff in this ICU is 65 and all are registered with the Australian Health Professional Registration Agency (AHPRA), the registration authority for health professionals in Australia. The various positions held by the 65 nurses are given in Table 4.1.

Table 4.1

Intensive Care Nursing Staff

Position	Count	Comments
Clinical Unit Manager (CNM)	1	Works as a unit manager, in-charge, and assists as bedside/allocated nurse.
Clinical Nurse (CN)	19	Works as an in-charge, float and bedside/allocated nurse.
Registered Nurse (RN)	43	Works as bedside/allocated nurse and sometimes works as a float or in-charge nurse.
Educator RN (ERN)	1	Works as an educator and sometimes assists and relieves bedside nurses during their meal breaks (generally a former bedside RN in the unit).
Equipment RN (ERN)	1	Works in checking and following up all types of equipment, instruments and machines and sometimes assists and relieves bedside nurses during their meal breaks (generally a former bedside RN in the unit).
Total Nursing Staff	65	

4.3.1 Inclusion criteria for participation in this study

Inclusion criteria for participation in this study were:

1. RN, either male or female

2. Employed full-time

3. Employed for a minimum of one year in the unit

4. Working rotating shifts (morning, afternoon and night)

5. Willing to be interviewed and observed within the practice setting

4.3.1.1 Recruitment process

To ensure transparency and to verify that accurate methods and processes were undertaken throughout this study, a detailed description of the recruitment process undertaken by the researcher follows.

4.3.1.1.1 Initial contact with ICU

Prior to commencement of data collection, approval from both the Human Research Ethics Committee (HREC) at the university and hospital were obtained (see Appendices A and B). Entry into the ICU was initiated by telephone calls with the Director and CNM. In these initial phone calls, a brief description of the purpose of the research and the activities to be undertaken by the researcher (periods of observation, informal discussions with participants, formal interviews with participants and an audit of nursing notes of participants) were provided. In-principle approval was obtained from both the Director and CNM of the unit contingent on formal approval from the hospital administration. A starting date was agreed on and the staff were informed about the research by the CNM.

4.3.1.1.2 Recruitment strategies

On 1 April 2014, the first day of the study, the researcher met the CNM who introduced her to the staff and Director of ICU. Discussions took place about the most appropriate means of recruitment of participants into the study. It was agreed that the researcher would provide the CNM with letters of invitation, which she in turn would distribute to ICU nursing staff along with placing advertising flyers (Appendix C) around the unit, in the nurses' stations and the staff tearoom. Each letter of invitation included a plain language statement outlining the aims and purpose of the study, how data would be gathered, the time commitment of participants and a request to return acceptances to the 'Research Box', which was located in the main nurses' station (see Figure 4.9).

Figure 4.9. The Research Box for collection of participants' positive responses.

Those who accepted the invitation to participate in the study were subsequently contacted in person by the researcher. At this time, further information about the study was provided along with an opportunity to ask questions of the researcher. Participants were also provided with three sheets. The first was the Information Sheet, which included a research overview and participation procedures (see Appendix D) to ensure that they could make an informed decision to participate in the study or not. Ethical considerations were discussed, including anonymity, confidentiality, risk level, time commitment, data storage and right to withdraw from the study until data analysis commenced (see ethical considerations for more detail). The second sheet was an informed consent form to obtain participants' signatures (see Appendix E), and the third was a demographic questionnaire (see Appendix F).

4.3.1.2 Number of participants

Thirty-eight RNs consented to participate in this study. Of the 38 initial respondents, three participants withdrew for different reasons: one withdrew because of a family crisis and the other two withdrew because of work commitments and lack of time to participate. Subsequently, the total number of RNs participating in this study was 35 (29 females and 6 males). Table 4.2 provides a breakdown of participant demographics.

Table 4.2

Basic Demographic Data Sheet for Study Participants

Age	Gender	Marital Status	Ethnic background	Languages	Religion	Education	Years' experience in ICU
22–60	F: 29	Married	Australian	English	Catholic	Masters	Range 3–34
	M: 6	25	25	Indian	12	6	3 y = 1
		Partner	New Zealander	Mandarin	Protestant	Bachelors	4 y = 1
		1	1	Chinese	3	17	5 y = 1
		Engaged	British	Tagalog	Anglican	Diploma	6 y = 4
		1	4	Malayalam	1	2	7 y = 1
		Divorced	Irish		Church of	Postgraduate	8 y = 4
		1	1		England	certificate	9 y = 1
		De facto	Indian		1	7	10 y = 3
		3	1		Buddhist	Graduate	12 y = 2
		Single	Filipino		2	certificate for	13 y = 1
		4	1		Hindu	critical care	14 y = 1
			Thai		2	3	15 y = 4
			1		Pentecostal		16 y = 1
			Chinese		1		19 y = 1
			1		Honours &		22 y = 1
					respects all		25 y = 1
					religions		28 y = 1
					1		30 y = 2
					No religious		32 y = 1
					affiliation		34 y = 3
					12		

Total participants   35

4.4 Data Collection

4.4.1 Data methods and triangulation.

Triangulation refers to the use of data from multiple sources to draw conclusions about what represents the truth, which validates the conclusions.

Triangulation was described as the support of findings by at least two or more independent methods (Mays & Pope, 2000; Miles, Huberman & Saldaña 2014; Polit & Beck, 2017). Collecting data from a variety of sources within the culture ensures that the data obtained is dense and information-rich (Munhall, 2007). Triangulation assists the capture of a comprehensive and contextualised portrait of the matter studied (Polit &

Beck, 2017). It does this by addressing the research questions from multiple angles using several datasets to provide a broad picture of the nature of a phenomenon under study (Denzin & Lincoln, 2003; Hammersley, 2002; Richards & Morse, 2013).

In this study, the researcher gathered different data from multiple sources including observations, document reviews, interviews and literature reviews (to justify and contextualise the study, see Data Collection Resources and Process Model, (Figure 4.1). Triangulation improved the data quality and the precision of ethnographic findings (Fetterman, 2010). Bouchard (1976) noted that the use of two or more data collection methods strengthens the validity of the research—and makes the researcher, as an ethnographer, more confident about the accuracy of the findings (Fetterman, 2008). Triangulation can reinforce the confidence, credibility and trustworthiness of the conclusions (Jones & Bugge, 2006; Lambert & Loiselle, 2008). These are described under rigour in Section 4.6.

As presented in Figure 3, the researcher was instrumental in all data collection processes. The data plan was involved conducting the observation phase first, then interviewing participants, followed by documentation review. Practically, it did not work in this way. It began with the participant observation, then the researcher needed to check the participants' documentation in patient files, nurses' notes and charts, followed by interviews with participants. At times, the researcher needed to collect certain information as a result of a review of documentation. A similar process was undertaken with analysis of the participants' transcripts, which required the researcher to compare what was said with what was documented by the participant. This approach was essentially cyclic in that it provided opportunities to move between data sources to identify similarities and differences, which were followed-up in subsequent informal conversations or second interviews with participants.

The analysis process did not stop after explication of the findings, but continued into the literature review. The initial findings of the study warranted further comparisons

with extant knowledge, which allowed for identification of what is known and unknown—and what contribution to new knowledge was made. The processes of data collection are discussed in detail below.

Figure 4.10. Data collection resources and process model.

4.4.1.1 Participant observation.

Participant observation is considered the fundamental ethnographic research method (Fife, 2005) and is characteristic of most ethnography studies (Fetterman, 2008) examining people's behaviours in everyday contexts (Hammersley, 1990). Observation without participation can be used to gain a rich description of the setting, activities and the participants to describe and explain their actions in context (Hennink et al., 2011). This assists in both understanding the important issues in the designated setting (Boswell & Cannon, 2011) and interpreting the experiences of the studied group (Holloway & Wheeler, 2010).

There are four observer roles in the observation methodology: complete participant, participant-as-observer, observer-as-participant and complete observer. In this study, the researcher determined that the most appropriate role was as a complete observer. This role removes the researcher completely from interaction and is confined to observations only (Elliot & Schneider, 2004). This allowed her to remain relatively unobtrusive and to obtain flexibility in observing the place, events and the time length of the day while not disrupting the normal flow of the nurses' activities (McKechnie, 2008; Simmons, 2007; Richardson-Tench, Taylor, Kermode & Roberts, 2014). Particular attention was paid to not interfere or intrude in the everyday practice of the nurses. Further, professionalism was maintained at all times during the field observations.

Fieldwork commenced on 1 April 2014 and concluded on 31 September 2014. In the early stage of the observation period, the researcher focused on exploring the physical and social structure of the unit and experiencing the everyday running and routines of the ICU, as Holloway and Wheeler (2010) recommended. She mapped and filmed the physical layout to gain a sense of the cultural patterning of participants. After becoming familiar with the ICU, the researcher began to visit the participants in their allocated areas, whether they were bedside nurses assigned to patients, floats or in-charge nurses (as planned and agreed between the researcher and participants). During the first week of observation, the researcher was based in the main nurses' station and attended the in-charge handovers to gain an overview of what was happening in the unit. The researcher then accompanied participants when they left the station to attend to their work or if they were attending a specific situation as Blue Codes or medical emergency response teams (MERTs). Afterwards, the researcher shadowed/followed the participants which gave her the opportunity to observe them interacting with patients, relatives and colleagues.

In the initial period in the unit, it was apparent that some nurses who were not part of the study were uncertain of the researcher's presence and role on the unit. To allay their apprehension, she assured the RNs that the study had been approved by the hospital and

university's HRECs, that the researcher had permission to study and observe only those RNs who agreed to participate in the research and that all observations were confidential.

It was vital to establish rapport and trust with the participants before collecting data (Hennink et al., 2011; Lambert et al., 2008). Within the first month, participants felt comfortable with the presence of the researcher in the unit. As time progressed, the researcher noticed that participants became increasingly relaxed and were happy to converse with her when she was 'hanging around', especially at the nurses' station when they invited the researcher to share refreshments with them. One day, two nurses told the researcher: 'Hanan, now you are like part of the furniture in the unit' [P5 & P8, informal conversation]. This indicated that the staff had fully accepted the researcher's presence.

Being accepted as part of the unit allowed the researcher to immerse herself in the ward culture. This enabled her to explore 'cultural patterning' in seeking repeated, identifiable thoughts and behaviours in various situations with different participants, and also in the researcher's interpretation of specific contexts, meanings and events (Lambert, Glacken & McCarron, 2011). This level of immersion allowed the researcher to gain an understanding of the cultural context of nurse–patient/family/colleague interactions. Staff, patients and their relatives became accustomed to having the researcher in the unit as an outsider (in a research role and not a medical role) (Bolton, 2000).

Observation assisted the researcher in contextualising the attitudes, values and emotions of the participants (Holloway & Wheeler, 2010). An unstructured observation method was used to obtain detailed descriptions of behaviours as they occurred or shortly afterwards by completing a reflective journal or field notes (Borbasi & Jackson, 2012). Examples of engaging in unstructured observations are: the physical ICU layout (e.g., how many people were in the nurses' station); characteristics of participants (e.g., the participants' roles); activities and social interactions (e.g., how people interacted with each other); frequency and duration of events (e.g., duration of the Blue Codes); precipitating factors (e.g., stressful moments as participants were very busy when there

was a shortage of staff); organisation (e.g., discharging ICU patients to the wards) and incidents (e.g., giving a patient a wrong blood transfusion).

In the observation period, the researcher observed, asked questions, listened and wrote field notes, which allowed her to know the roles of nursing staff and leadership as well as the contextual factors that enable and hinder the nurses' ability to care in the ICU.

As previously arranged, participants were observed for two shifts that suited them. At times, they were observed closely and continuously; at other times they were observed intermittently and from the nurses' station from a close distance, according to the circumstances. Sometimes the participant was observed for a half or full shift or for between 6 and 12 hours per shift, depending on events in the unit. At times, the participants were observed for more than two shifts because they were interacting with other participants and events. Overall, the researcher spent 1632 hours over six months in ICU: 10–12 hours per day, five days a week and 12 hours per day for 16 weekend days. RNs typically work a variety of shifts within a 24-hour period; therefore, the observation was timed to be coincide with their normal roster and at their convenience. Participant observations were undertaken during day, evening and night shifts. Data collection was undertaken in a flexible manner over the six months. The researcher spent time observing and interacting with participants as planned (Table 4.3). Her prolonged engagement and persistent observation enhanced in-depth understanding of the participants, testing misinformation and distortions, ensuring data saturation, building trust and rapport with participants, which enriched the data (Polit & Beck, 2017). Moreover, the researcher's prolonged engagement enabled her to appreciate the complexity of the subject under examination (Marx, 2008). These interactions provided the researcher with insight into the nature and culture of nurses' caring in ICU.

Table 4.3

Examples of the Researcher's Activities with Participants in This Study

Participant Code Number	Information Sheet	Informed Consent	Demographic Sheet	Observations		Field notes	Participant Documents Review	Informal Conversation	Interviews						Participant Additional Written Information (PAWI)	Comments
				1	2				1	2	3	4	5	6		
P1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	Rich data resource: experience, different nursing roles, caring carrier model
P2	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓	Different nursing roles, hard worker, fast
P3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					✓	Long work experience, different roles, hard worker
P4	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓	Religious, sense of humour, different nursing roles, easy person, flexible
P5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	Expert, different nursing roles
P6	✓	✓	✓	✓	✓	✓	✓	✓	✓							Expert, different nursing roles, fast
P7	✓	✓	✓	✓	✓	✓	✓	✓	✓							A researcher nurse, different nursing roles, usually floats
P8	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	Expert, sociable sense of humour, easy person
P9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					✓	Expert, different nursing roles, easy and calm, funny, performs the CNM role at times.
P10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	Different nursing roles, very active

4.4.1.1.1 Field notes.

Fieldwork is a hallmark of ethnographic research and involves both the entrance of the researcher to the setting and the actual conducting of the study (Fetterman, 2010). During fieldwork, the researcher's observations were recorded as field notes to provide a context for the domain of inquiry. Field notes are the core data log for analysis in observational research (McKechnie, 2008) and can stand alone as a source of data (Given, 2008).

The field notes had three forms (Angrosino, 2005b). The first form was the 'descriptive' in which all details observed were recorded. Roper and Shapira (2000) advised researchers to avoid evaluating and judging what they observe in the environment at the beginning of fieldwork. This type of note-taking was written during the non-observation period as noted by Dewar and Mackay (2010) as only involving the transcription of field notes. The notes were written in the field as events occurred to record

exactly what happened in a textual and visual account (Dewar & Mackay, 2010). A description was added at the beginning of each observation account, which helped to create a comprehensible record of what was observed (Dewar & Mackay, 2010). Description of the contexts was useful to understand people's lives and their circumstances (Taylor et al., 2006).

The second note form used was focused observation whereby only material closely related to nurse–patient/relative/colleague interactions was observed, concentrating on specific categories of interactions. The third form was selective observation, which focused more specifically on rituals and patterns of caring (Angrosino, 2005a). One of the priorities of participant observation was probing the surface to test the social meanings and cultural motives that underpinned the caring actions (Geertz, 1973).

The researcher recorded details of the 'big picture' of the unit, such as the sounds, smells and colours (Emmerson, Fretz & Shaw, 1995) as well as how many people were present, who they were and what they were doing at any one time. The researcher noticed who was interacting with whom and what they were discussing, as well at their tone, expressions, behaviours and what was occurring around them (Borbasi & Jackson, 2012; Rebar et al., 2011). Field notes included what happened, when it happened, who was involved and what the consequences were (Taylor et al., 2006). Bourgois and Schonberg (2009) discussed the 'artisanal practices' of ethnography, in which the researcher merges into the environment and participates in everyday life, while always mentally racing to note the importance of what occurs, any special circumstances (Fife, 2005; Taylor et al., 2006) or general comments on the participants observed and their activities (Wolf, 2007). This allowed the researcher to systematically record notes, yet remain intuitively open to what should be recorded (Emmerson et al., 1995). In addition, the researcher's personal feelings, experiences and thoughts were recorded in her reflective journal and memos (Appendix G). After leaving the site, any additional thoughts, comments or reflections regarding the observation were recorded and labelled as a memo in the researcher's

reflective journal. These memos were key tools during the observation period and allowed focus and identification of events that may be related to previous observations or interviews.

At the end of each visit, the researcher read her notes for the day, reflected on her observations and analysed what she had written. In addition, the researcher made notes of anything she needed to investigate further in the next visit. Re-reading the field notes, proved a powerful trigger for the researcher's memory and assisted her in recalling specific times, places and events.

4.4.1.2 Documentation review.

The second data collection method used in this study was reviewing documents in the unit. It was important to review documents such as written texts, records, policies and procedures as these allowed the researcher access to data that was difficult to acquire by direct observation, interviewing and questioning (Hammersley & Atkinson, 2007; Holloway & Wheeler, 2010). Document reviews occurred concurrently with the participant observation period; as the researcher took field notes, she also examined documents as the study progressed. Documentation in the unit was extensively read and noted in the field notes to obtain greater insight into nurses' responses to patients and their relatives. The documentation that was reviewed included nurses' notes, charts, patients' files, the communication book, memoranda, posters, brochures, leaflets, pictures, posters policies and procedures (hard and electronic copies), awards and 'thank you' letters. The researcher read the narrative nurses' notes, which contained patient observations, statements to specify the nursing care pertinent to each patient and their response to this care, the progress of the patient's condition, any issues that the patient experienced and the nurses' response. To review these documents, the researcher obtained confirmation from all participants—both verbally and through written informed consent—regarding the importance or relevance of the documents to the provision of care. Examples of the documents were photographed and saved in the NVivo 11® Software Package.

4.4.1.3 Interviews.

Interviewing was another key technique of data collection for this study and allowed for the exploration of unique cases and unexpected responses that might have given profound insights into the phenomenon being studied (Taylor et al., 2006). Ethnographers depend on interviews to understand the participants' personal worlds (Wolf, 2012).

In interviews, the researcher is mentally projected into the ethnographic experiences described by the participants (Bauman & Adair, 1992). Moreover, interviews may be the only method available to collect certain data that are difficult to obtain through participant observation (Hammersley & Atkinson, 2007; Polit & Beck, 2017). Therefore, the use of interviews was considered by this researcher to be essential and complementary to the other forms of data collection for this study.

To gain a deeper understanding of the underlying cultural norms and structures within the setting (Holloway & Wheeler, 2010), 35 participants were interviewed after they were observed in this study. The locations of the interviews were varied and generally chosen to suit the convenience of participants and minimise interruption of their schedules (Holloway & Wheeler, 2010). Some participants preferred to conduct their interviews at during work hours and in either the CNM's office or the family conference room; however; most interviews were conducted in the CNM's office with her permission during weekends. It was a serene area allowing for complete quiet, privacy and confidentiality. Some short interviews were conducted in the smaller nurses' station when it was quiet, while other participants preferred to have their interviews out of their work hours. Three participants were interviewed at home with one at a restaurant and another two interviews at coffee shops. The researcher was available for the entire day to be flexible to conduct interviews.

Even though rapport and trust had been established during the observation period of the study, the researcher began each interview with an informal talk to establish further

rapport with participants and to relax them. The researcher opened all interviews with a brief reminder to participants about the research, their voluntary participation and the possibility of terminating the interview at any time at the participant's request. She also confirmed the participant's understanding of the information supplied to explain the research. The researcher took into account that a need for counselling could arise in the course of interviews because they could provoke distress or strong feelings (Holloway & Wheeler, 2010). Prior to the commencement of the study, the researcher arranged a counselling service and a referral process was established (Appendix H).

The researcher used the Nurses' Interview Guide (Appendix I), which included asking participants' permission for a digital audio recording of the interview prior to its commencement, as taping interviews increased their credibility as a data source. The researcher digitally recorded the interviews, which ensured accuracy in the wording of the information and allowed her to show consideration of participants by maintaining eye contact with them (Holloway & Wheeler, 2010). Recording the interviews also freed the researcher to think inventively while the interviews took place, which allowed her to concentrate on the intent behind what the participant communicated.

The researcher conducted pilot interviews with a list of semi-structured questions, which enabled pre-testing and improvement of the interview guide and process prior to full implementation (Bryman, 2012). The pilot was conducted with four participants. During these interviews, the researcher examined questions in the guides for clear wording, bias and collection of appropriate information for the research (Polit & Hungler, 1997), including structure and flow. Following the pilot, the interview guides were revised to ensure clarity, appropriateness, order and flow of the questions. No revisions were required for this pilot interview questions list guide (Appendix J). The interview questions list was modified as data collection and analysis progressed, which allowed for confirmation of content discovered in earlier interviews. The use of a semi-structured

interview questions list allowed consistency in data collection and the ability to explore new information as it became evident in this process.

Each interview started with broad, general questions to encourage participants to discuss their experiences (Spradley, 1979), for example: 'what do you believe constitutes caring in ICU?' or 'tell me about caring in ICU'. They then progressed to more specific questions. The researcher asked questions in an open and empathic way that motivated the participants to tell their stories (Hennink et al., 2011). Probes and prompts, such as 'tell me more about that', 'can you think of an example' and 'what happened next' were used to clarify content and augment the information provided. Overall, these questions focused on what participants believed constitutes caring practices, behaviours and attitudes in ICU. Questions concerned the factors that influence caring (and whether they are facilitators or obstacles); the documentation of caring; communication with patients and their relatives in different situations; nurses' likes and dislikes in their caring and what participants recommended for the enhancement of caring in ICU. There were two specific questions for the CNM about her evaluation of the quality of caring delivery in the unit and what strategies she utilised to maintain a culture of caring in the stressful environment of this ICU.

The researcher took notes before, during (e.g., of non-verbal clues like looking encouraging and smiling or avoiding eye contact and turning the body away) and after the interviews (e.g., the researcher's impressions of the participants' interviews and their body language) (Holloway & Wheeler, 2010). Non-verbal communications offered the researcher a comprehensive understanding of the participants' issues and emotions, specifically with less verbal participants (Keegan, 2008). Further, she preserved brief reflexive notes of the important aspects of these interviews and related research matters, which later provided contextual information to support data analysis (Higginbottom et al., 2013). At the close of all interviews, the researcher asked the participants if they had any questions and summarised and confirmed some of the major concepts revealed in the

interview. Then, the researcher asked the participants to complete a Participant's Additional Written Information Form (PAWIF) (Appendix K) if they had any further information or comments they would like to add.

4.4.1.3.1 Participant's additional written information form (PAWI).

In addition to the interviews, participants were asked to write their experiences of caring in the ICU (Rebar et al., 2011). In a PAWIF, the participant writer captures emotions, introspections and self-reflections, especially when they involve sensitive issues (Smith-Sullivan, 2008). In addition, a PAWIF allows the participants to feel comfortable about self-disclosure in private and at a comfortable and convenient time (Smith-Sullivan, 2008). Of the 35 participants, 26 recorded their reflections and PAWIFS were only collected on completion of the data gathering process. Some participants handed them directly to the researcher, others dropped them in the Research Box in the main nurses' station and some emailed them to the researcher. The length of participants' PAWIs varied; the shortest one was a single paragraph while the longest consisted of seven pages. The researcher thanked participants for their contribution to this study and notified them how they will receive the final findings (Nieswiadomy, 2012).

4.4.1.3.2 Informal conversations.

The researcher had ongoing informal conversations with the participants, encouraging them to share reflections on their practices. As she observed, the informal conversations avoided rigid questioning and enabled natural discussion of 'here and now' experiences (Lambert et al., 2008).

During the observation period, the researcher conducted 16 digitally recorded informal conversations with nine participants following observations of nurse–patient interactions or important incidents involving participants. These informal conversations added depth to the researcher's data and enabled her to have a greater understanding of the caring cultural norms, experiences and practices in the unit.

Moreover, informal conversations gave the researcher the opportunity to share, check and receive feedback on her own initial observations and interpretations with participants. For example, one evening the researcher was shadowing participant P3, who was a float nurse that time and who received a Code Blue call. The researcher accompanied the participant on this call for more than two hours. Participant P3 was extremely busy with the Code Blue team, assisting doctors, taking ABG samples and returning to ICU to check the results. He performed the most tasks of the available nurses in this Code Blue. When the emergency was resolved, the researcher asked participant P3: 'why the ward's nurses did not do any of the other tasks such as administrating medications and hooking intravenous (IV) drips, and most of the time they only relied on you?'. His response was: 'we as ICU nurses are well-trained and confident to assist in these situations more than ward nurses. In addition, the Code Blue team, as anaesthetists and medical officers, are used to us in such situations' (P3 & researcher, field discussion, notebook 2).

4.4.1.4 The researcher as an instrument.

The researcher in this study was considered a key and primary data gathering instrument (Borbasi & Jackson, 2012; Griffiths & Bridges, 2010; Holloway & Wheeler, 2010; Keele, 2011) and, as in all qualitative research, played an integral part in the research process. The decisions made by the researcher are affected by her views, values, beliefs, feelings, assumptions, age, gender, race and sexual orientation (Norum, 2008). To ensure that the researcher's personal biases did not interfere with the research process, she constantly monitored her personal attitudes and values concerning the phenomenon under study. The researcher's self-awareness and her reflection on methods will be discussed in detail in the reflexivity section.

4.4.1.4.1 Researcher journaling.

As the researcher was considered as an instrument in this study, one of the tools that she used was journaling. There is an increasing practice of researchers keeping their

own journals while conducting their research (Smith-Sullivan, 2008). The researcher recorded her reflections in her field notes relating to different phases of observing, interviewing and reviewing documents. Journaling was an effective instrument in this study.

The next section presents the data analysis approaches applied in this study. Data analysis commenced with a review of the content of each of the data sources. In this FE research, data captured the researcher's lived experience (Smith-Sullivan, 2008) and data analysis and collection were undertaken concurrently, (Borbasi & Jackson, 2012; Holloway & Wheeler, 2010; Nieswiadomy, 2012; Robinson, 2013).

4.4.2 Data preparation.

The data collected from observation field notes, memos, interviews and informal conversations, audio and video recordings, documents and reflective journaling were stored in NVivo 11® on the researcher's computer and external hard drive to assist with data management during collection and analysis. The NVivo 11® program provided a repository for all data, assisted the researcher in organising the considerable amount of data collected as a part of the analysis process (Bernard & Ryan, 2010; Jones & Watt, 2010; Rebar et al., 2011). The computer was password protected and the external hard drive was stored in a locked cupboard. All audio recordings of participant interviews were de-identified with pseudonym codes and sent to a qualified transcriber for verbatim transcription. Documents were entered electronically into the NVivo 11® (Hennink et al., 2011) (Figure 4.11). The researcher checked all interview transcripts against the audio files for accuracy as they were received.
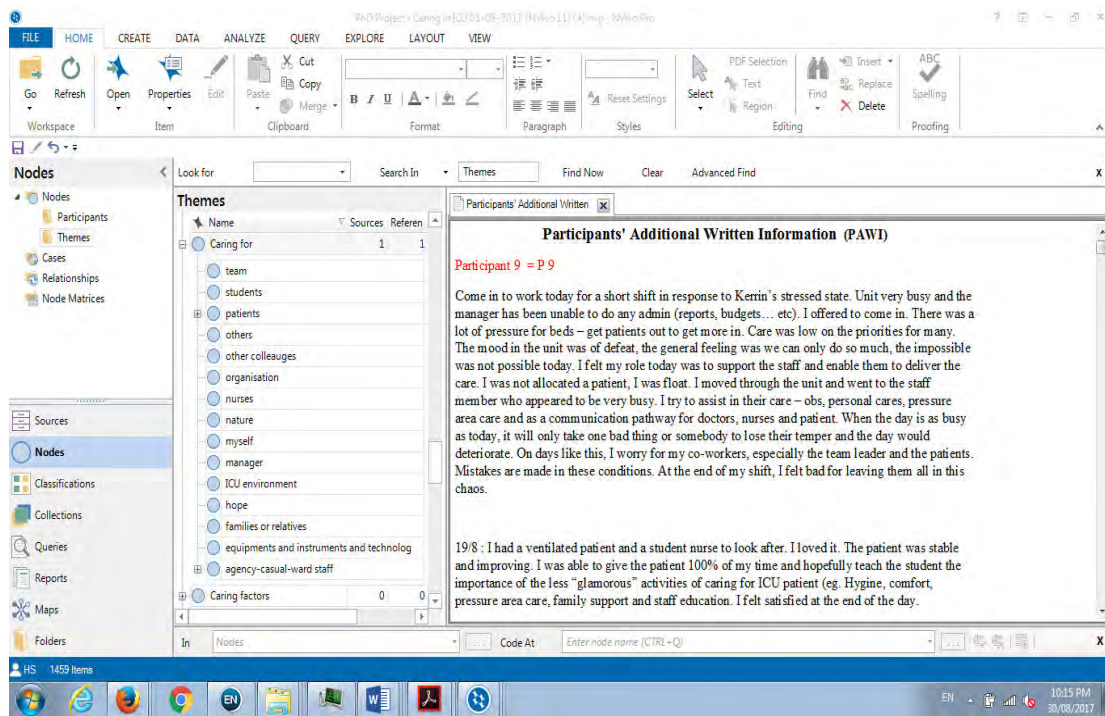
Figure 4.11. Screenshot of NVivo 11® software used for data collection and analysis for theme two, 'caring-for'.

4.4.3 Thematic analysis phases.

The primary focus in ethnographic research is the study of culture and therefore, the thematic analysis focused on identifying the beliefs and behaviours that reflected the unique caring culture of the group (Holloway & Wheeler, 2010). Since there is no specific protocol for analysis in ethnographic research, the researcher reviewed a number of approaches used by different scholars (Braun & Clarke, 2006; Chuang & Abbey, 2009; Graneheim & Lundman, 2004; Le Compte & Schensul, 1999; Miles et al., 2014; Miles & Huberman, 1994; Padgett, 2012; Polit & Beck, 2017; Vaismoradi, Turunen & Bondas, 2013; Whitehead, 2013). From this, emerged a modified six-phase analysis process. In this thematic analysis, the data were segmented, compared, contrasted, synthesised, categorised and conceptualised to identify common codes, categories/subthemes and core themes from which a mental map of the findings was constructed (Hennink et al., 2011; Mateo & Kirchhoff, 1999; Omery, 1988) and reconstructed to capture the core concepts in the dataset (Ayres, 2008) (Figure 4 and Figure 5). In addition, further analysis was undertaken by the researcher. This involved an examination of the literature related to the

nature of caring in ICU (Padgett, 2012). Each phase of this thematic analysis is discussed in detail below.

4.4.3.1 Data immersion.

In the first phase, the researcher's immersion in data through multiple readings is important for qualitative analysis (Braun & Clarke, 2006; Ritchie & Spencer, 2002) because it enables the researcher to develop a sense of the broad findings within and across the study participants. The researcher familiarised herself with the data through reading, watching, listening, transcribing recorded audio/video materials, organising and indexing data for easy retrieval and identification. She read the raw data a number of times. This process involved what Padgett (2012, p. 166) described as a 'sweep[ing] back and forth' and 'swoop[ing] in and out' of the data. The researcher analysed and re-analysed the emerging data throughout all data collection periods—an ongoing process (Richards & Morse, 2012).

4.4.3.2 Coding.

The second phase of data analysis was coding. The first reading of the transcribed data focused on checking the transcript against the recorded interview and then re-reading it to identify general topics (Ayres, 2008). During this process of reading and re-reading, patterns in the data were identified (Braun & Clarke, 2006). Further, additional analysis was undertaken with particular attention to what is termed the foreground and background (Carspecken, 1996). The foreground of 'what is said' and the background of 'what is not said' in study participants' meanings in interviews were essential in critical analysis of the data. The iterative process of coding involved the constant re-reading of the data while questioning it (Brewer, 2000) and the identification of coding portions—words, sentences or paragraphs (van den Hoonaard & van den Hoonaard, 2008)—which were extracted from the original text and labelled. As the codes were developed, checking and comparison with the researcher's principal supervisor took place.

According to Richards and Morse (2012), there are three types of coding: descriptive, topic and analytic. Descriptive coding was used in the early stages of this research and analysis to store aspects recognised about information with slight interpretation (Richards & Morse, 2012). Topic coding was used to identify materials from the topic to be retrieved later for description, categorisation and reflection. Analytic coding was used to illustrate and develop categories theoretically. It was labelled analytic because it created categories that were built upon by linking them to the data and interrogating the data for new ideas developing in the new codes. Analytic coding is usually was used by researchers who develop theories; here, it was used to develop the conceptual model created from the study findings. In this FE study, descriptive, topic and analytic codes were attached to the data to clearly define features within the text from observations, field notes, interviews, informal conversations, document reviews and PAWIs. These codes were then reviewed and re-coded into categories/subthemes (Whitehead, 2013).

4.4.3.3 Categorising/sub-theming.

The third phase was the development of provisional data categories (Whitehead, 2013). A category is described by Morse (2008a) as a gathering of coded data that is similar and arranged into a collection for a description of its characteristics. The categories assigned here were further compared back to the raw data and clustered together for review to identify emergent concepts, typification or patterns (Germain, 2001).

4.4.3.4 Theming.

The fourth phase of thematic analysis in this study was generating themes. Guest, MacQueen and Nemy (2012) indicate that thematic analysis requires input from the researcher beyond simply counting words and phrases. The developed categories were grouped and inductively synthesised into themes (Whitehead, 2013). These themes emerged from constant iterative questioning and movement back and forth of the categories. They were reviewed and immersed in the original, rich descriptive accounts to

remain close to the data context (Morse, 2008a). As a result, the individual was retained within the textual representation of that theme while maintaining a contextualised description with meaning (Morse, 2008b).

Further refinement of the themes and categories/subthemes that captured and described the nature of caring (and the meanings reflected by the themes) was undertaken to develop a coherent articulation of the nature of caring (Boyatzis, 1998; Braun & Clarke, 2006). Divergent themes were studied as they provided a contrast to the dominant themes that emerged from the analysis (Braun & Clarke, 2006; Patton, 2002a). The understanding of divergent themes was necessary to provide relevant information on participants' responses to unexpected outcomes, which contributed to understanding the boundaries of participants' lives and experiences (Hammersley & Atkinson, 2007). The researcher reviewed all categories sequentially as well as their relationships to each other across the whole dataset. Figure 4.12 shows the analysis of one category and PRISMA in Figure 4.13 shows the whole process of analysing Theme 7.

Raw data material (word, phrase, sentence) ➡ Coding ➡ Category ➡ **Theme**

'I do not think there is anything wrong with crying if we become stressed' *[Interview]*

'I could have a brief time out to gather my emotions. My colleague was also crying'
[Interview] ➡ Crying ➡ Emotional response **Patterns of Coping with Stressful**

to stress **Moments by Nurses in ICU**

The researcher saw one participant crying for her husband is being in the hospital *[Observation]*

Figure 4.12. Analysing one category of Theme 7.

Process — **Inductive Data-Reduction**

Theme

Patterns of Coping with Stressful Moments by Nurses in ICU

Categories

| Emotional response to stress | Avoidance and withdrawal from stressful situations | Responding to stress through communication | Being there for each other | Time reduction in dealing with stress | Choosing and rejecting roles and acquired competencies | Management strategies | Expecting and accepting the worst scenario |

Coding

Emotional response to stress:
- Crying
- Sense of self-control
- Sucking it up
- Being professional
- Displacing feelings on to others
- Swearing
- Emotional detachment

Avoidance and withdrawal:
- Withdrawal
- Avoidance
- Ignoring

Responding to stress through communication:
- Speaking up
- Open-door policy
- Assertive
- Using the blanket effect
- Talking behind each other's back
- Remaining silent
- Maintaining an atmosphere of light-heartedness

Being there for each other:
- Working as a team
- Seeking assistance and support

Time reduction in dealing with stress:
- Reduction in work hours
- Change of shifts to have sufficient time between shifts
- 'Time off the unit'

Choosing and rejecting roles:
- Being selective in the role
- Not competent in certain procedures

Management strategies:
- Delegating work
- Doing work
- Managing staff
- Managing time
- Postponing or rushing some caring activities
- On-call Roster

Expecting and accepting the worst scenario:
- Expecting and accepting the worst scenario

Raw Data

- The researcher saw one participant crying for her husband being in the hospital [Observation/Field note]
- 'A natural response to stress but you quickly pull yourself up and take a deep breath' [Interview]
- 'you just have to suck it up for it is not going to last' [Interview]
- 'We need to be professional   we have to get along with each other for the sake of the patients [Interview]
- 'Some in-charge nurses get a bit narky when stressed and that is their usual response when they get stressed' [Interview]
- 'She swears a lot' [Interview]
- I have developed a thick skin, which I needed to protect myself from disasters that occur from somebody nearly every day' [PAWI]
- 'I could not stay there I just had to get away before I started to breakdown' [Interview]
- As observed by the researcher, the nurse was emotionally distressed The nurse was given an opportunity to debrief with the in-charge nurse, P11, who advised her to leave the unit for a while as stated: 'have some time for yourself' [Observation/field note]
- 'there are times when you reach a point where you feel your ability to care for the person is slipping   you need to step away and ask a colleague to take over' [Interview]
- 'I would just rather ignoring and avoiding them than dealing with them and the extra stress they cause' [Interview]
- 'Some nurses simply cannot cope with the stress of taking a leadership or management role All they want to do is to care for their allocated patient load'[Interview]
- 'I will have a chat with them' [Interview] 'they leave lots of work for next person' [Interview]
- 'It was such a sad experience We just talked about it and people were supportive to each other' [Interview]
- 'Kerrin has an open-door policy She will listen to you and be sympathetic if you are in trouble' [Interview]
- 'We do not get on and I am not going to ask her Well, then it looks like you would not get a break because that is your choice So, they had to suck it up and do it' [Interview]
- 'A lot of the times, we do a blanket effect when we find one or two nurses keep on doing something is not in a proper way' [Interview]

- 'nurses from time to time engage in a little backstabbing   it is easier for them to whinge about something after the person has gone home than to deal with it at the time' [Interview]
- 'Staff   try to take over by telling you what should be done   it is difficult to say anything as you know it would only inflame the situation; sense says 'say nothing and just keep quiet' [Interview]
- 'The unit gets busy and heavy with lots of things, so it is nice to have a bit of a joke, and most of the staff have a good sense of humour' [Interview]
- 'if you are able to joke with the patient and/or their family can make a difference in how they see themselves within the unit' [Interview]
- 'Our staff care about each other We have a good teamwork' [Interview]
- 'if we see colleagues are experiencing difficulty with their patients, we swap patients' [Interview]
- 'I have stopped working 12-hour shifts because it is too much to do and too much stress' [Interview]
- 'There are times when the to be with the patient is their doctor or counsellor' [Interview]
- 'We need to support them workload-wise and emotionally as well' [Interview]
- 'We have some nurses who request a change of shift for personal reasons, especially if they have no accrued leave pending' [Interview]
- 'we just delegate one of the float nurses to do it' [Interview], 'We [in-charges] do things because sometimes people are just too busy' [Interview]
- Some nurses on the unit who have never been certified to cannulate nor do they wish to be, because they may be continually sent to the wards to undertake such procedures
- 'to give those particular nurses some extra workload to do' [Interview]
- With my time management, flexibility   every task should be done at the right time' [interview]
- 'We are going to establish an on-call roster for nursing staff in our ICU' [PAWI]
- 'I try to prepare myself for the worst that could happen' [Interview]
- 'you end up doing things in a rush' [Interview]

Figure 4.13. PRISMA flow diagram of thematic analysis example for Theme 7.

4.4.3.5 Conceptual model development.

In the fifth phase of thematic analysis, the themes were refined and relationships between them were developed to build a conceptual model (Whitehead, 2013). The researcher was mindful that this process could only provide descriptions of the data and that it was limited in relation to interpreting the themes without using a theoretical framework (Braun & Clarke, 2006). The generation of the conceptual model is presented in Figure 4.14.
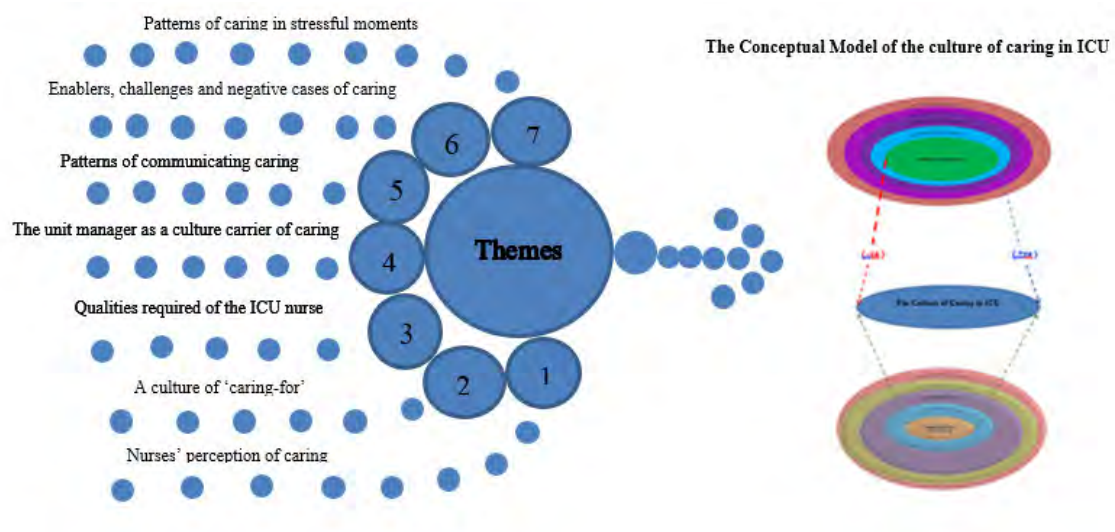
Figure 4.14. The generation process of the conceptual model.

4.4.3.6 Report/discussion writing.

The sixth and final phase of thematic analysis was writing the report (Braun & Clarke, 2006). In an ethnographic study, writing is a significant part of the research process (Hammersley & Atkinson, 2007). The analysis did not stop with the explication of findings but continued until a final review of literature was undertaken in relation to each identified theme. In this phase, the researcher moved from describing to interpreting and engaging with the reviewed literature (Braun & Clarke, 2006) to identify common findings within the literature and uncover what new knowledge was generated by this study.

It is noteworthy that the researcher purposefully wrote in the third-person, which is one approach to reporting ethnographic accounts (Hammersley, 2002). Writing in the

third-person enabled the researcher to take a detached approach to reporting, suggesting

that the ethnographic account is authentic in presenting reality (Konecki, 2008).

Further, a conceptual model of the ongoing dynamic relationships between data

collection, data analysis and the study findings was created by this researcher to provide

a conceptualisation of how these processes were undertaken (see Figure 4.15).
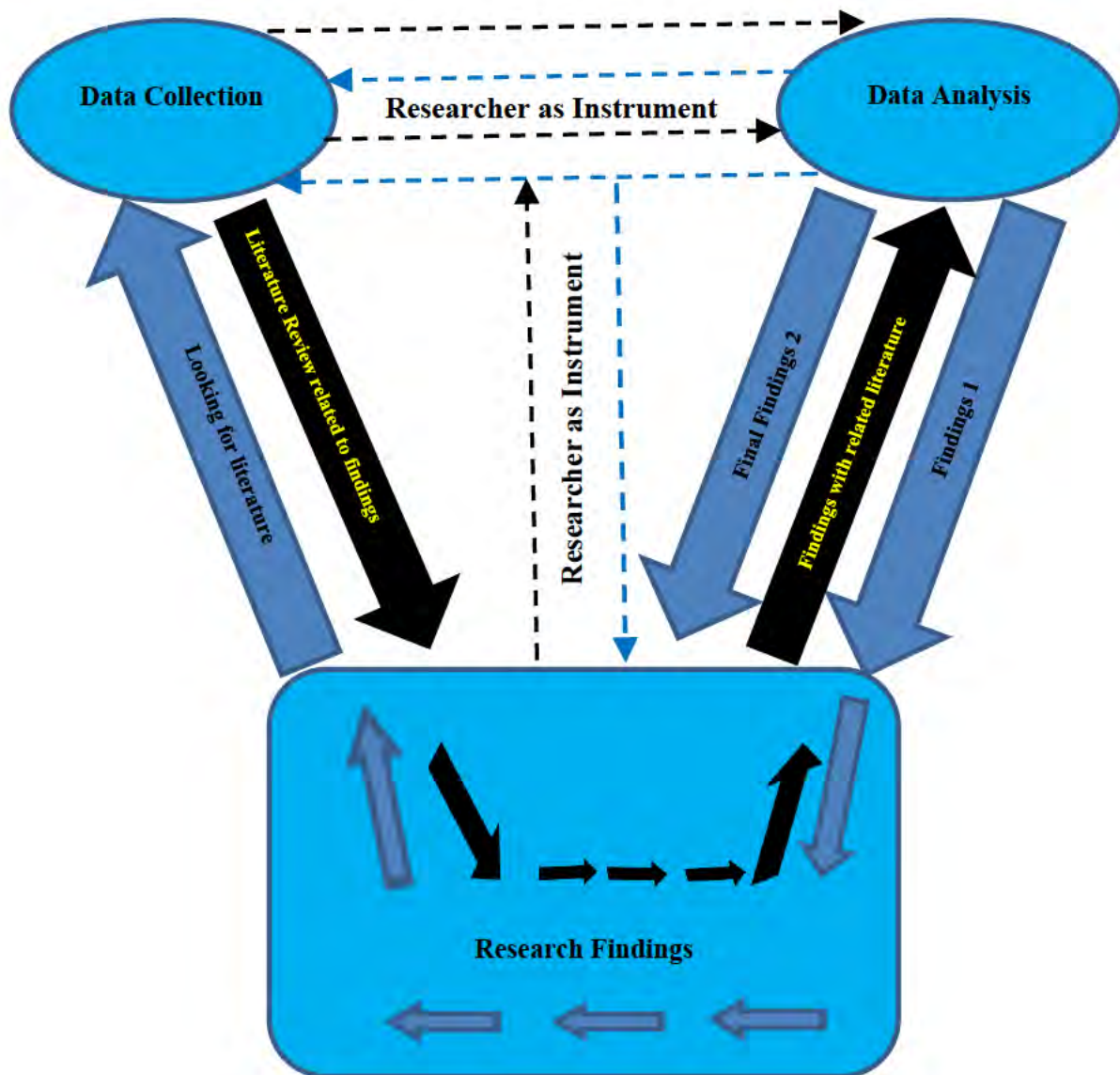
Figure 4.15. Conceptual model of the ongoing dynamic relationships between data collection, data analysis and findings in this focused ethnographic study.

The conceptual model involved three processes: data collection, data analysis and

results generation. These processes were ongoing, dynamic, interrelated and concurrent.

In this component of the study, it was important to not collect all the data and then begin

the analysis but to rather ensure data collection and analysis occurred simultaneously.

This involved the collection of some data followed by analysis and then further data collection to compare with the first phase of the analysis process; it was essentially a 'lego' approach were data was continuously analysed and compared to previously analysed data. This interchange between these two approaches allowed the research to engage in a compare and contrast process to identify key elements or central themes that captured the nature of caring in the unit. For example, during the period of observation, the researcher took field notes of what was observed. These were then followed by informal conversations with participants, along with reviews of the nurses' documentation of the care provided. This process allowed comparing and contrasting of data and generated questions for the formal interview process. Upon completion of the analysis process and identification of core themes (Findings, Part 1, see Chapter 5), a review of literature in relation to the uncovered themes was undertaken, resulting in Findings, Part 2 (see Chapter 6).

After six months of the fieldwork, it became apparent that no new or different data was forthcoming and that the study had reached data saturation, which meant that data collected did not add to the understanding of the nature of caring in ICU (Creswell, 2007; Polit & Beck, 2017). Thus, the fieldwork was subsequently discontinued. The researcher advised the CNM and nursing staff that she would be leaving the following week and gave the date of her final visit. At the last visit to the unit, the researcher thanked and said goodbye to everybody in the unit and had an afternoon tea with a number of staff to thank them for having her in the unit.

4.5 Ethical Considerations

The researcher adhered to certain ethical principles throughout the study: non-maleficence and beneficence (the right to freedom from harm and discomfort and the right to protection from exploitation), respect for human dignity (the right to autonomy/self-determination and the right to full disclosure) and justice (the right to fair treatment and privacy) (Atkinson, Coffey, Delamont, Lofland & Lofland, 2007; Polit &

Beck, 2017). In undertaking this research, there were several ethical considerations: ethics approval, informed consent, anonymity, confidentiality, data storage and risk level. Therefore, the following procedures and protocols were tracked to guarantee that ethical principles and due diligence were observed in relation to the rights of participants (Mayan, 2009).

4.5.1 Ethics approval.

Prior to the commencement of the study, ethics approval was initially granted by the ethics committees of both CQU Australia and the hospital.

4.5.2 Informed consent.

Permission from each participant was obtained prior to observing, reviewing documents and interviewing participants. The researcher asked participants who met the selection criteria and agreed to participate in the study to give written informed consent and provided them with the research Information Sheet, which includes the objectives of the study, methods of information gathering, the expected level of participant involvement, risk level and assurances of confidentiality and anonymity. The participants were advised that participation was voluntary and that they could withdraw up to the point of data analysis without prejudice (Taylor et al., 2006). Consequently, each participant gave verbal and written approval.

4.5.3 Anonymity.

Assurance was given by the researcher that the participants' identities would not be revealed in terms of the interview contents, informal discussions and field notes taken by the researcher in the course of observations (Holloway & Wheeler, 2002). However, given the nature of the period of observation, the researcher informed participants that anonymity could not be assured due to their participation in front of other colleagues.

The only person to have access to the original transcripts was the researcher. Her supervisors only had access to the transcripts with the pseudonym codes—all identifiers

were removed prior to being shared with the supervisors—used for guiding the researcher and monitoring rigour in the analysis process.

4.5.4 Confidentiality.

Participant confidentiality can be ensured by maintaining ethical standards (Liamputtong & Ezzy, 2005). Interviews were transcribed by a secure party who only had access to transcripts that were de-identified. The transcriber was required to keep in confidence any content of the transcribed interview tapes.

4.5.5 Data storage.

Secure data storage is significant and protects the confidentiality and anonymity of the research participants. The researcher stored all participants' information in both hard (paper) and soft (electronic computer files) copy. The tape-recordings of interviews were kept until the completion of the research. The researcher kept these and paper copies of the interviews in a locked filing cabinet in her office (Speziale & Carpenter, 2007). The electronic computer files were password protected and regularly backed up to reduce the risk of damage or data loss (Corti, 2008). All information pertaining to the study will be kept for a period of five years after the final publication of results. Electronic data will then be deleted from the computer system, and participants' contact details and consent forms will be destroyed in accordance with the CQU University policy and procedures for destruction of confidential information.

4.5.6 Risk level.

The participants have the right not to be harmed physically, psychologically, emotionally, socially or financially (Hennink et al., 2011; Taylor et al., 2006). The Human Ethics Committee of CQU and Queensland Health Ethics Committee deemed this study to be low-risk, as the types of information to be gathered were from everyday professional conversations part of clinical practice. However, there was a possibility that participants could experience some level of discomfort in recalling their experiences. If such a situation occurred, the researcher planned to stop the interview and give the

participant an opportunity to discuss their concerns. Then, if the participant wished to discontinue, their decision will be respected and the interview, terminated. In addition, the researcher considered that some participants may indicate the need to have follow-up support at the end of the interview. If such a situation was to arise a referral process was in place through a counselling service (Holloway & Wheeler, 2010). At no time during any of the interviews did the participants display or verbalise any concerns; throughout all data collection, there was no need to refer any of the participants.

Colbourne and Sque (2004) discussed a variety of ethical issues that should be considered, such as the ethnographer having conflicting roles as both a researcher and a professional RN. Therefore, the researcher made every effort to not interfere with what took place in the unit.

In anticipation of participants potentially feeling that the researcher was judging their nursing practice, it was imperative to reiterate to the participants that they were free to withdraw from the study without any consequences. The researcher encouraged participants to discuss any concerns about the research with her to alleviate their anxieties. Further, given the possibility of observing behaviours with the potential to breach professional or ethical boundaries, the participants were informed that if such behaviours were observed, the researcher (as a professional nurse) would be required to report them to the CNM. Throughout the fieldwork, the researcher did not witness any unethical behaviour.

4.6 Rigour

Polit and Beck (2017) and Klopper (2008) explained the significance of establishing rigour throughout qualitative research. Rigorous research processes are of higher quality and produce more trustworthy findings (Gerrish & Lathleen, 2015; Higginbottom et al., 2013; Saumure & Given, 2008). Rigour is related to careful and reflective interpretation of the data and to clarity and accuracy in communicating the findings (Liamputtong & Ezzy, 2005).

Threats to rigour can be minimised through different strategies such as data saturation, peer debriefing, expert panels, triangulation (Keele, 2011; Murchison, 2010), and auditing, where care is taken concerning design planning, sampling, data collection and analysis (Schneider, Dean, Geri & Judith, 2013). These strategies will be discussed further in the following sections.

4.6.1 Trustworthiness.

Trustworthiness in qualitative research relies on methodological soundness and adequacy (Holloway & Wheeler, 2010), and can be ensured by meeting the criteria for evaluation of rigour (Guba & Lincoln, 1994; Holloway & Wheeler, 2010; Lincoln, Lynham & Guba, 2011; Polit & Beck, 2017). The aim of trustworthiness is to represent participants' experiences precisely (Speziale & Carpenter, 2007). It is important to use a consistent protocol for data collection as it can support trustworthiness (Rebar et al., 2011). To evaluate the rigour of the study, the researcher employed certain criteria: credibility, dependability, confirmability, transferability and authenticity (Guba & Lincoln, 1994; Holloway & Wheeler, 2010; Lincoln et al., 2011; Polit & Beck, 2017). The first trustworthiness criterion to be discussed is credibility.

4.6.1.1 Credibility.

Credibility was described by Polit and Beck (2017) as confidence in the truth of the data and its interpretations. Credibility established the link between the constructed realities of participants and the realities that are represented by the researcher (Guba & Lincoln, 1989). It is the truth of findings as arbitrated by participants and others in the discipline (Schneider et al., 2007) and includes activities that raise the trustworthiness of the results (Lincoln & Guba, 1985).

In this study, the credibility was enhanced using various procedures: disclosure of the researcher's credentials as a PhD candidate were submitted to the hospital administration and ICU gatekeepers prior to commencing the research. The prolonged engagement of the researcher in the field also added to her credibility (Polit & Beck,

2017). Further, the researcher used data triangulation to provide converging conclusions (Miles et al., 2014) and used multiple sources for data collection to support credibility (Guba & Lincoln, 1989; Jensen, 2008; Mayan, 2009; Rebar et al., 2011; Tappen, 2011). In this study, triangulation involved the investigation of the nature of caring from different positions and perspectives by examining nurses with different positions/roles: bedside RNs, float nurses, in-charge nurses and the unit manager. The researcher was able to compare, contrast and confirm their viewpoints by testing of one source of data against another and seeking convergence and divergence of findings of the research participant groups. This ensured that all angles were covered in obtaining a holistic perception of the phenomenon in ICU (Fetterman, 2010; Jensen, 2008; Jones & Bugge, 2006; Tappen, 2011).

Another strategy used by the researcher was looking for both positive and negative cases. Searching for negative cases was important because it illustrated that the researcher was not just looking for cases to support her perspectives and assumptions (Brodsky, 2008; Saumure & Given, 2008) because negative cases presented data that contrasted with the researcher's expectations and assumptions (Brodsky, 2008). These deviant cases assisted in refining the data analysis (Mays & Pope, 2000). Negative cases strengthened data analysis by running the gamut from rebutting to refining the findings. They also reduced the potential for researcher bias in how the data were examined and reported. These negative cases are discussed in Theme 6 (see Chapter 7).

To further increase credibility, the researcher employed various 'good interviewing' strategies such as seeking clarification by probing, paraphrasing, using open-ended questions and listening with an interpretive intent during interviews (McConnell-Henry, Chapman & Francis, 2011). Rigour was achieved through verbatim transcription of interviews, and all transcripts were checked against the recordings for congruency (Polit & Beck, 2017). Through persistent observation, comprehensive field notes and the various methods of data collection, the researcher was able to provide rich

and vivid descriptions and thereby enhance credibility (Polit & Beck, 2017). Careful documentation of reflexivity and quality-enhancement efforts by the researcher (e.g., keeping a reflective journal during data collection) further assisted the credibility of this study and reduced the potential for bias (Polit & Beck, 2017). Another strategy used to achieve credibility was debriefing, which occurred with the researcher's supervisors at regular intervals to review and critique the data analysis process (e.g., Intercoder check) (Jensen, 2008; Polit & Beck, 2017; Tappen, 2011). The compilation of a codebook to record decisions during the coding process was another tactic to enhance credibility during data analysis. The NVivo 11$^®$ data management software facilitated the development of a coding phase of analysis. The last strategy the researcher used to enhance credibility was the collection of data related to the study findings from existing literature. This is compared, contrasted, synthesised and critiqued in the context of the findings in the discussion chapters (8 & 9).

4.6.1.2 Dependability.

The second trustworthiness strategy was dependability, which in qualitative research may be viewed as parallel to reliability in quantitative research (Guba & Lincoln, 1989; Houser, 2012). The results of a study are dependable when they are consistent and accurate over time and different conditions (Holloway & Wheeler, 2010; Polit & Beck, 2017). This means that 'the adequacy of the analysis can be evaluated by following the decision-making process of the researcher' (Holloway & Wheeler, 2010, p. 303), which means that if the same methods in the same context with the same participants were repeated, the results would be similar (Tappen, 2011). However, the quality of ethnographic research cannot be entirely reflected by reliability because of the influence of temporal changes in this research field (Konecki, 2008). In this FE study, dependability was achieved through consistency in the methods of data collection and analysis (Germain, 1986) and triangulation (Polit & Beck, 2017). To meet the requirements for dependability, a detailed account of the data collection and analysis

methods was employed. The researcher's reflections, thoughts and ideas were carefully documented in a reflective study journal, which enabled her to trace the decision-making process, as suggested by Lincoln and Guba (1985), and document discussions with her research supervisors. To further increase dependability, an audit trail was kept (Holloway & Wheeler, 2010) by the researcher's supervisors (Munhall, 2012). Both supervisors provided this trail by analysing and evaluating each stage of the research to ensure that correct processes were adhered to.

4.6.1.3 Confirmability.

The third strategy was confirmability, which may be seen as a parallel to objectivity in the quantitative approach (Guba & Lincoln, 1989; Houser, 2012; Polit & Beck, 2017), which addresses the accuracy of the data and its meanings. It refers to the congruence of two or more independent assessments of the data accuracy, relevance or meaning (Polit & Beck, 2008) such as checking the codes and analysis with supervisors. The integrity of a qualitative inquiry requires that the participants' descriptions of their experiences are reflected in the findings of the research (Guba & Lincoln, 1989). For the duration of this study, an audit trail was created where all steps taken within the research process are outlined and made available in this document for scrutiny.

4.6.1.4 Transferability.

The fourth strategy was transferability (Guba & Lincoln, 1989), which refers to the degree to which research findings in one setting can be transferred to a similar situation (Holloway & Wheeler, 2010; Polit & Beck, 2017; Speziale & Carpenter, 2007; Tappen, 2011). Transferability is different from generalisability, which concerns generalising the findings to the broader group from which the sample was taken. Such a practice is the domain of quantitative research (Polit & Beck, 2017).

To achieve transferability in this study, a number of strategies were utilised. First, the researcher clearly outlined the context of the study and the rationale for its undertaking. Further strategies included visibly signposting the processes of gaining

ethics approval, establishing the participant inclusion criteria, accessing the research site, working with staff in the selection of participants, clearly outlining the process of gaining rich data saturation through triangulation and reviewing documentation methods. In addition, the process of analysing the data has been clearly articulated. Issues arising throughout the study have also been carefully documented for transparency.

4.6.1.5 Authenticity.

Authenticity is viewed as an important component for establishing trustworthiness in qualitative research (Denzin & Lincoln, 2005). It refers to the extent that the researcher honestly and faithfully adheres to the designed structure and processes of the research (Polit & Beck, 2017).

In this study, authenticity in this study was achieved through prolonged engagement and persistent observation in the unit, obtaining dense and vivid descriptions beyond the researcher's reflexive journal (Polit & Beck, 2017). Established protocols and procedures of the research design were followed with the primary aim of giving voice to the participants' experiences. This was achieved by having each step of the research process monitored by both supervisors to ensure rigour in adhering to stipulated processes. The authenticity of a qualitative descriptive study relies not only on the ability to capture participants' perceptions, but on how the researcher accurately analyses and represents them in impactful writing (Milne & Oberle, 2005; Polit & Beck, 2017). Accurate representation commenced with a transcription of each interview, continued with coding and categorising, and involved ongoing consideration in relation to context (Milne & Oberle, 2005).

Finally, the rigour of this study was built on reflexivity. The researcher's presence as a chief research instrument had some effect on the participants and findings, which will be discussed in detail in the reflexivity section. Using these criteria to build a rigorous study enabled the researcher to report findings that are considered both useful and credible by the researcher's supervisors (Saumure & Given, 2008).

4.6.2 Reflexivity.

Rigorous ethnographic research is built on the notion of reflexivity, where the researcher accounts for the fact that her presence had some effect on the research findings (Saumure & Given, 2008). Polit and Beck (2017) defined reflexivity as the process of reflecting on oneself, analysing and nothing one's value, perception and assumptions that might have impeded the processes of data collection and analysis. This was to reduce the effect of the researcher as an instrument during the collection, analysis and interpretation of the data (Borbasi, Jackson & Wilkes, 2005).

Reflexivity was an important strategy to ensure that rigour was preserved throughout this ethnographic research process (Hammersley & Atkinson, 2007) and serves as a reminder that the researcher becomes a part of the social context. This study applied 'epistemological reflexivity', which refers to the monitoring of decisions made in relation to data collection processes and findings. The brief reflexive notes made were important as they allowed the researcher to question her influence throughout data collection and analysis, management and final writing. For example, the researcher maintained reflexive notes of her assumptions and behaviours that might have influenced the interviews (Dowling, 2008).

The researcher used reflexive practices as a tool to increase self-awareness and to monitor interactions between herself and the study participants. Reflexivity also assisted her in examining the contextual factors that constrained the relationships between herself and the participants (Finlay, 2002). The researcher also maintained a reflexive journal to record her own thoughts about her role in this ICU. As a part of reflexivity, she consciously identified her role as a researcher collecting data from the unit. Therefore, reflexivity allowed her to be aware of her own personal characteristics, previous work experiences, age, gender and education, which had the potential to influence her relationships with the participants. The researcher worked with her supervisors continuously to evaluate her role as a PhD researcher.

Reflexivity is a critical self-reflection about preconceived biases, preferences and preconceptions that the researcher may have and which could influence a situation or interpretation of an observation (Dowling, 2008; Polit & Beck, 2017). Critical reflection was required by the researcher to consider how she could influence the data given her presence in the setting, existing power structures and the nature of her social interactions with the participants (Brewer, 2000). Scott-Findlay and Estabrooks (2006) declared that documentation of personal bias and expectations before and during the fieldwork is required when undertaking ethnographic research. Reflexivity was also achieved in this study through the use of reflective journaling to document critical thinking and facilitate reflection (Borbasi et al., 2005).

The researcher undertook reflective journaling before, during and after conducting data collection and analysis. The resulting journals created an account and an audit trail that outlined the progress and research journey throughout the data collection period (Dowling, 2006).

4.6.2.1 Researcher reflections.

During the research, it was important that participants' experiences took precedence over the researcher's own expectations (Roberts, 2007). Therefore, the researcher focused on aspects of the interactions that participants appeared to find hard to articulate. The researcher was mindful of how she presented herself, aware of social positioning within long-term care. For example, there was a situation where one of the participants communicated with a dying patient even though she was gasping for air until the last moment of her life. She then communicated the news of his wife's death to the patient's husband. The researcher discussed the participant's verbal and non-verbal communication (with both the dead patient and her relative) with the participant and also relayed her own interpretation to get feedback.

The researcher used a reflective journal to document experiences, fears, problems and general activities surrounding events in the field (Spradley, 1980). In this journal, the

researcher wrote about her experiences of what happened in the unit and reflected on data collection and analysis methods. She also entered her reflections from supervision meetings into this journal.

4.6.2.1.1 Bias.

Bias is described as predisposition or partiality. In qualitative inquiry, it involves influences that can compromise any stage of the research process and produce a distortion of the findings (Polit & Beck, 2017). The researcher was mindful about the possible biases that could affect this study and these were subsequently addressed either from either the participant's or the researcher's side.

To addressing bias from the participants' side, researchers must be aware of the effect of their presence on the participants and their influence on the data (Hammersley & Atkinson, 2007). In this study, the researcher was careful to minimise her influence on the participants. Participants' lack of candour, or what is called the Hawthorn effect, was originally noted as a possible source of bias (Curry, Nembhard & Bradley, 2009; Speziale, 2007). This occurs when the participant alters their normal behaviour due to their awareness of the researcher's presence or of the situation being scrutinised (Curry et al., 2009; Speziale, 2007). To avoid the 'observer effect' and reduce the Hawthorn effect, the researcher's role needed to be non-intrusive for the participants (Holloway & Wheeler, 2010). This was achieved by the prolonged period of engagement in the unit and with participants. The more time the researcher spent in the unit, the more participants became used to her presence. At times, the researcher used the strategy of covert data collection (concealment) by observing while pretending to be engaged in other activities such as reviewing nurses' notes and charts, or by observing participants from the nurses' station. Another strategy was the audit trail. This is a system of collecting materials and documentation (e.g., interview transcripts and analysis, methodological and reflexive notes) that would permit review by an independent auditor (the supervisors) (Polit & Beck, 2017; Rodgers, 2008). The audit trail included the

progress of data collection (O'Leary, 2010; Richards, 2010), which was a vital contributor to the validity and reliability of this study (Bazeley, 2013; Richards, 2010).

In addressing bias from the researcher's side, she generally acknowledged her own subjectivity throughout the research process (Ogden, 2008). The researcher managed her bias by being conscious of her values and assumptions and suspending her internal (e.g., beliefs) and external (e.g., environmental factors) presuppositions, biases, and experiences to describe the essence of caring in this ICU (Firmin, 2008). In addition, the researcher sought negative case data, which offered different interpretations of the data. This was experienced in different scenarios, as follows.

The first scenario occurred when participant P29 was allocated to a patient who was a former nurse. This patient was admitted to ICU following a drug overdose because of her addiction. The researcher observed participant P29 treating the patient as an inferior and relaying the patient's story to her colleagues in an unprofessional manner. As both a researcher and a nurse, the researcher felt so upset about the participant's mannerism. She needed to control herself at that point and chose to ask the participant about her attitude in the interview. When asked about this incident, the participant's explanation was accusatory of the patient being addicted. The researcher found it difficult to not respond, as she wanted to focus on listening to the participant's side of the story [P29: field notebook 1].

The second scenario occurred during a bronchoscopy procedure in ICU. During this procedure, the surgeon and participant P11 discovered that a tiny piece of the bronchoscope was missing and they needed to get another bronchoscope. As an observer with experience in the OR, the researcher suggested use of a three-way stopcock connection to address this problem. The surgeon and the nursing team appreciated this idea at that time and obtained the three-way stopcock, which rectified the problem. Unfortunately, it was later discovered that participant P11 complained about the intervention to the CNM. This incident made the researcher very careful about her

participation, even when it was helpful. She reminded herself to remain in her role as an observer and informed the unit manager that she would not interfere in the future. This incident affected her for several days, and she reflected in the field notes to continuously remind herself to be cautious in her research role while conducting this study.

Given these scenarios and the conflict in relation to her research position, the researcher realised that she needed to develop a greater capability for reflexivity and mindfulness by acknowledging her position and responding appropriately.

In conclusion, to conduct a study with all the hallmarks of rigour and credibility, a number of criteria need to be met. Table 4.4 provides a schedule of those criteria that informed this study.

Table 4.4

Criteria Used to Achieve Rigour in This Study, as Modified from Polit and Beck (2017)

Research stage	Criteria used to achieve rigour					
Strategy	Credibility	Dependability	Confirmability	Transferability	Authenticity	Reflexivity
Throughout the Inquiry						
Reflexive Journal	✓				✓	✓
Careful documentation/audit trail	✓	✓	✓	✓		
Data Collection						
Prolonged engagement	✓				✓	
Persistent observation	✓				✓	
Comprehensive field notes	✓			✓		
Theoretically driven sampling	✓					
Audio recording and verbatim transcription	✓				✓	
Triangulation (data & methods)	✓	✓				
Data saturation	✓			✓		
Data Analysis						
Transcription rigour	✓					
Intercoder checks, development of codebook (NVivo 11®)	✓		✓			
Triangulation (investigator analysis by checking with supervisors)	✓		✓			
Search for confirming evidence (caring cases)	✓		✓	✓		
Search for disconfirming evidence (negative cases non-caring cases)	✓					
Peer review/ debriefing (with supervisors)	✓		✓			
Inquiry audit		✓	✓			
Presentation of Findings						
Documentation of quality-enhancement efforts	✓			✓		
Dense, vivid description	✓			✓	✓	
Effective, evocative writing					✓	
Disclosure of researcher's credentials, background	✓					
Documentation of reflexivity	✓					✓

4.7 Summary

This chapter provided a description of the methods used in undertaking this study. The chapter explained the study setting, the processes used for access and recruitment of potential participants and the criteria for participant involvement. In addition, data collection and data analysis methods were discussed. The ethical considerations and the methods for ensuring rigour throughout the study were also presented. The chapter concluded with some of the researcher's reflective experiences during the study. The next three chapters present the finding of this study.

Chapter 5: Findings, Part 1

5.1 Introduction

The findings of this research are presented over three chapters: 5, 6 and 7. Chapter 5 begins with an overview of the mission, vision and values of the organisation in which the ICU is located. This is a prelude to the presentation of the first three themes: nurses' perceptions of caring in ICU, a culture of inclusive caring practice in ICU, and qualities required of the ICU nurse to provide quality care. Chapter 6 continues the discussion of findings by presenting themes four and five: the unit manager as a culture carrier of caring and patterns of communicating caring. Chapter 7 concludes the presentation of findings with a discussion of the final two themes: enablers, challenges and negative cases of caring in ICU, and nurses' patterns of caring in stressful moments in ICU. This is followed by a presentation of the conceptual model of a culture of caring in the unit. A summary of all seven themes and subthemes is presented in Table 5.1.

Table 5.1
Themes and Subthemes Related to this Study

Theme No	Theme	Subthemes/Categories
1	Nurses' perception of caring in ICU	− Conceptualisations of caring − Caring viewed as a culture − Caring as levels

2	A culture of inclusive caring practice in ICU	− Culture of 'caring-for':
		  - oneself
		  - patients
		  - families
		  - colleagues
		− Caring as ecological consciousness

3	Qualities required of the ICU nurse	− Ability to work in emergency and intense nursing situations − Being an effective communicator − Being professional
4	The unit manager as a culture carrier of caring in ICU	− Being open and approachable − Respecting, listening to and valuing the staff − Knowing what is occurring − Being understanding and supportive
5	Patterns of communicating caring in ICU	− Changing patterns of communication − Types of communication − Factors affecting communicating caring in ICU − What stood out in relation to communication in this unit

6	Enablers, challenges and negative cases of caring in ICU	− Enablers and challenges in relation to the:
		  - Patient.
		  - Family.
		  - Nurse.
		  - ICU environment.
		− Negative cases of caring in ICU

7	Patterns of coping with stressful moments by nurses in ICU	− Expressing one's emotions − Responding to stress through communication/language − Supporting each other − Time reduction in dealing with stress − Choosing and rejecting roles and acquiring competencies − Management strategies − Expecting and accepting the worst scenario
8	The Conceptual Model of the Culture of Caring in the ICU	− Fundamentals of the culture of caring − Patterns of caring in the ICU

5.2 Mission, Vision and Values of the Hospital and ICU

From the discussions and interviews with participants, a review of documentation in the unit and the hospital website, the researcher was able to identify the mission, vision and values of the hospital and the ICU as a precursor to undertaking this study.

Mission. This ICU is located in a private hospital, which is a part of Uniting Care Queensland (UCQ). Tts community services are a vital part of the Uniting Church's mission, which is expressed through numerous organisations in Queensland. The Uniting Church in Australia has a philosophy that the work of healing, growth and liberation is God's work in the lives of people throughout the world.

The staff live the Uniting Church's philosophy, mission and values in service to the communities in which they are located. UCQ holds the belief that they 'express the mission of God by being present in people's lives to offer hope, healing and transformation' (Uniting Care Queensland, 2018, para. 2).

Vision. We exist to improve the health and wellbeing of individuals and their families. We differentiate ourselves by living our values to optimise the patient's care and experience every time.

Values. Five values underpin the UCQ's mission: compassion, respect, justice, working together and leading through learning. Each value is simplified with an example:

Compassion: Through our understanding and empathy for others, and bring holistic care, hope and inspiration.

Respect: We accept and honour diversity, uniqueness and the contribution of others.

Justice: We commit to focus on the needs of the people we serve and to work for a fair, just and sustainable society.

Working together: We value and appreciate the richness of individual contributions, partnerships and teamwork.

Leading through learning: 'Our culture encourages innovation and supports learning' (Wesley Hospital, 2018)

5.3 Theme One: Nurses' Perceptions of Caring in ICU

As a prelude to an exploration of the culture of caring within the ICU, participants were initially asked to share their understanding of what constitutes caring for them. They were informed that they could use words, sentences or symbolic representations that captured for them the essential nature and manifestation of caring as practised within the unit. Three subthemes emerged from the researcher's analysis of interview transcripts and field observations: conceptualisations of caring, views of caring as a culture and levels of caring.

5.3.1 Conceptualisation of caring.

Caring was conceptualised by participants in various ways: 'caring is reflective, mysterious and un-measurable' (P36 & P9); '[about] achieving the best outcomes' (P11, P19 & P20); 'it is beyond words' (P2 & P31); 'an attitude and behaviour' (P1); 'being present' (P16 & P13); 'I am here with you and for you' (P7 & P18); 'being empathic' (P7 & P12); 'being vigilant and methodical' (P36); 'treating others as you would like to be treated' (P1, P12, P25 & P26); 'an amalgam of many things' (P34); 'something within yourself which you can't put in words' (P31); 'you need to be a caring person to provide care' (P11 & P18); 'can't be taught or learnt' (P35); 'is part of a nurse' (P35); 'being the patients' ears, eyes and heart and acting on their behalf' (P7 & P12); 'dotting every *i* and crossing every *t*' (P36); 'exciting, challenging and stressful' (P2, P7 & P29); 'extraordinary and reciprocated caring' (P37), 'extended' (P25). Most participants described caring as 'systemic from head to toe', 'social, emotional, spiritual, physical',

'clinical, ordinary and basic', 'critical' and 'medical' (P16, P18, P20, P27, P17, P15 & P10).

To represent what constitutes caring, a diagram in the form of a Tagxedo word cloud heart is presented in Figure 5.1.

Figure 5.1. Tagxedo heart-shaped word cloud shows what constitutes caring in ICU.

5.3.2 Caring viewed as a culture.
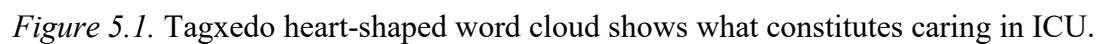
When asked to share what nurses believed to be caring within the unit, the participants' spoke of caring as a culture and the importance of maintaining that culture. Participants were unanimous that staff attitudes towards caring are a core value underpinning all activities that take place in the unit, as articulated by participant P9 in stating that 'a culture of caring can only be established if all members of the healthcare team both individually and collectively value and work towards caring for each other including patients and their families'. Participant P12 shared similar sentiments in suggesting that 'without a culture of caring the ability to provide person-centred care cannot be achieved'. The importance of employing staff who have a disposition of caring, irrespective of their discipline, was raised by participant P25 when discussing the

importance of employment interviews as the gatekeepers to hiring new staff: 'the interview panel who are responsible for employing staff have a significant responsibility to ensure those who actually are employed share the unit values of caring for others'. Participant P1 spoke of the importance of employing staff who demonstrate a strong disposition to care for others in stating: 'we take great pride in the type of person we want to work in this unit. Knowledge and skills are two important considerations when employing staff, but the one that is of paramount importance is the ability and commitment to provide quality care'. Participant P25 held similar views to participant P1 and stated that 'caring for others whether they are patients or families or caring for each other is at the heart of the unit'.

Participants also mentioned moving beyond having an attitude or disposition of caring to demonstrate such an attitude. Participant P7 shared her thoughts in commenting on the importance of communicating:

It is all about respect. If you don't respect others, how can you actually care for others? Respect is at the heart of caring for others, but respect needs to be communicated to others in the way you interact and work alongside other members of the team. [P7: interview]

The centrality of interpersonal communication in conveying that one cares was raised by participant P12 in discussing the need to demonstrate to patients and their families that caring for them is 'what we do … as nurses. It is about being with the person in all their ups and downs of their illness and letting them know you are there for them'. For participant P25, 'it is not only feeling a sense of empathy for the patient and their loved ones but demonstrating that empathy by communicating that you care through words and deeds' [P25: interview]. It is about letting the patients and their family know that you are there to do everything possible to ensure their loved one is safe, and that the

team together has the expertise and commitment to work to restore the person's health where possible'.

For a number of participants, and especially in the context of the ICU, professional behaviour was viewed as 'the ultimate conduit for the demonstration of caring for others' [P11: short interview 2]. At the centre of the nurses' professional behaviour was 'the importance of reflection on practice as a means of meeting the spoken and unspoken needs of patients and their families' [P18: interview 2]. Participants explained that 'it is about working toward the best outcomes for both the patients and their families' [P11: interview 2] and 'being open, receptive and empathic to the needs of patients, their families and fellow colleagues' [P16: interview]. A number of participants spoke of caring within the context of professional behaviours as 'providing continuous care, being vigilant in the assessment of patients' changing needs and being there for them' [P36: interview 1]. Core elements of caring mentioned by most participants—and which underpin the unit's culture of caring for them—were conceptualised as 'holistic, multidimensional' [P14, P4 & P24: interviews], 'person-centred, individualised and collaborative' [P23, P16 & P35: interviews]. When sharing their conceptions of caring in the unit, participants were quick to assure the researcher that the culture of caring was a team effort and that each member of staff contributed to the unit's caring ethos.

5.3.3 Caring as levels.

Caring was also described by participants as having three levels: surface, intermediate and deep. Participants considered the three levels of caring as not rigid or static, but rather dynamic in nature, changing as circumstances of the unit changed in terms of the fluctuating intensity of the work environment, level of personal and collective stress experienced by staff and the needs of staff, patients and families. For

example, the strength of the therapeutic nurse–patient relationship was a determinant of the level of care provided. The stronger the bond, the deeper the caring response by the nurse, as described by participants and observed by the researcher. The three levels of caring, as described by participants and observed by the researcher, are visualised in Figure 5.2.

Surface
'Being vigilant and methodical'

Intermediate
'Effective communicator'

Deep
'Treating others as you would like be treated'
OR
'Being in patient's shoes'
OR
'Caring beyond words'
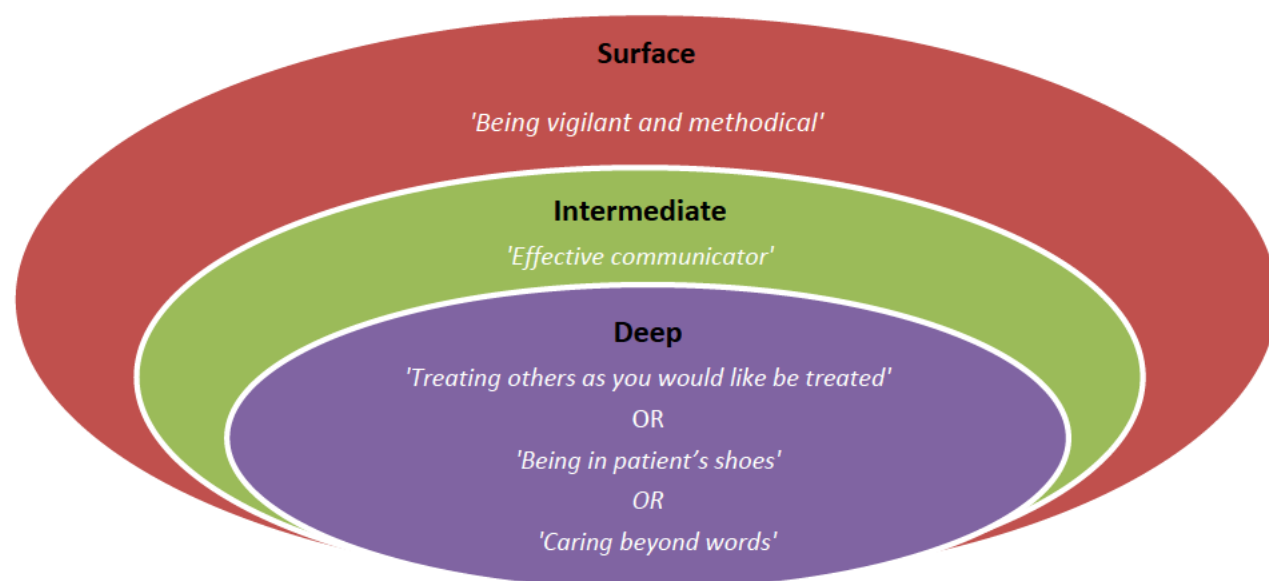
Figure 5.2. Levels of caring in ICU.

The first level of caring is termed 'surface caring' and focused on the ordinary, routine and technical skills including attending to daily activities, monitoring the patient's condition, documenting treatment interventions, reporting to the team any changes in the patients' health and keeping the relatives informed of their family member's condition. At this level of care, the nurse–patient relationship was considered by participants to be superficial in nature, as stated by participant P36: 'nurses who are engaged with a hectic schedule do not have time to communicate with the patients and to attend to their psychological needs. It is essentially about *being vigilant and methodical* in carrying out essential treatments or interventions' [field notebook 1; emphasis mine].

The second level is termed the 'intermediate level', where there is some connection to the patient and relatives and where the family is invited to be involved in the planning and delivery of care. The intermediate level of caring is essentially about '*being an effective communicator* about the health status of the patient with the patient when appropriate and with the family' [P2: interview; emphasis mine].

The third level of caring described by participants and witnessed by the researcher is termed 'deep caring' and involves being empathic, having a deep sense of being with the person during their illness and advocating on their behalf, especially when the patient is unconscious and requires the nurse to anticipate what type of care is required to respond to their fluctuating healthcare needs. The central focus of deep caring is adopting a person-centred approach to care. At this level, the nurse–patient relationship is strong. For example, when changing the position of an unconscious patient, it is necessary to be mindful of the importance of remaining respectful, treating the person with dignity and ensuring privacy. Participants spoke of the need to 'treat the person as you would like to be treated' [P26: interview 1], 'placing yourself in the shoes of the patient' [P3: interview 1] and being 'truly present with the person through their illness experience' [P31: interview].

5.3.4 Summary.

Each of the three subthemes described by participants was observed by the researcher during her extensive period of field observation. What came to the fore was the synergy between what the participants described in articulating their perceptions of caring and what transpired in the work environment. Concepts such as holistic care, a systematic approach to health assessment, the way staff conducted themselves and how they communicated to patients, families and each other was evident throughout the period

of observation. This clearly demonstrated their commitment to providing an environment where caring for others was highly valued and lived as part of professional practice.

5.4 Theme Two: A Culture of Inclusive Caring Practice in ICU

The second theme to emerge was the different dimensions of caring in the unit. The culture of 'caring-for' was described by participants as being ingrained in the ICU as a valued part of the overall culture. The inclusivity of a culture of 'caring-for' was multidimensional and involved: oneself, patients (and their families) and colleagues. In addition, caring as ecological consciousness—'caring-for' the ICU environment and the organisation—also formed part of the theme. Figure 5.3 provides a conceptualisation of the various components.
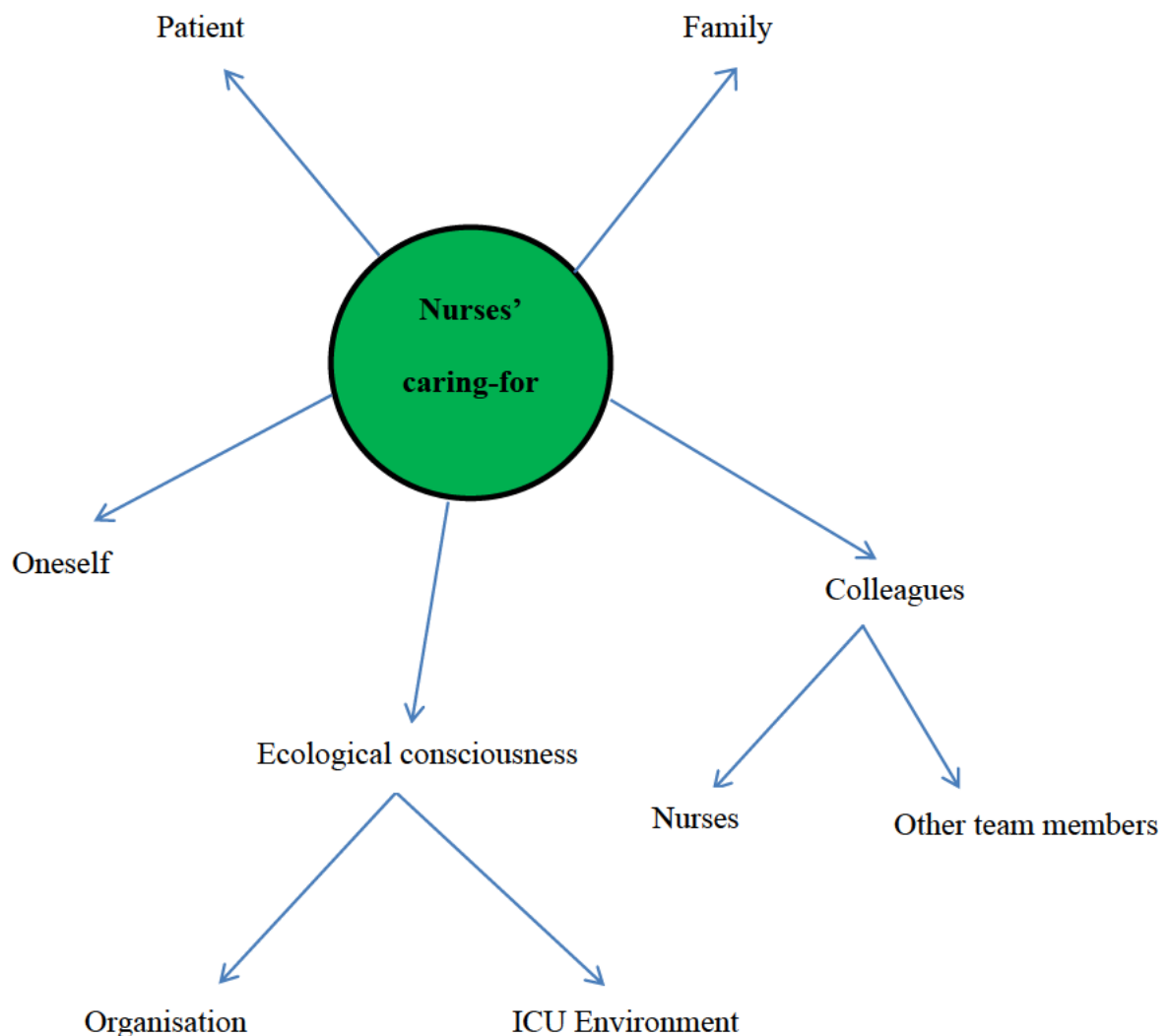
Figure 5.3. Sun model reflecting the multidimensional nature of 'caring-for' in ICU.

In this theme, there are different types of 'caring-for': oneself, patients, families, colleagues (nurses and other team members) and caring as ecological consciousness (ICU environment and organisation).

5.4.1 Caring for oneself.

The first facet of 'caring-for' was caring for oneself. This was identified by most participants as a priority within ICU. Without it, caring for others would be compromised. Participants described a range of activities considered important by the unit staff as means of self-care. These included looking after oneself physically, emotionally and psychologically by ensuring sufficient time during and between rostered shifts to rest and recuperate, taking allocated breaks during the shift and maintaining a work–life balance.

5.4.1.1 Looking after oneself physically, emotionally and psychologically.

In looking after oneself physically, emotionally and psychologically, personal appearance was raised by a number of the staff as an important consideration in being professional and in caring for oneself. Dress and grooming were also mentioned by several participants as a necessary requirement, not only in terms of the unit's profile, but also because of the significance of personal appearance in generating a positive psychology for staff. Observation of staff confirmed the views participants articulated in interviews. The importance of personal appearance as a means of looking after oneself was articulated by participant P1 in stating:

> We need to look after ourselves. We need to care about how we look and how we present ourselves as a member of the team. For example, it is important for me to go to the hairdresser and to put my makeup on every day and to look professional at work, because it means I am caring about myself. It is important to me as a human being, as a woman and as a unit manager. [P1: interview 3]

Most participants spoke of the importance of maintaining emotional and psychological health in light of the demanding nature of their work. Caring for patients and their families during times of significant crisis—a daily occurrence—was described by staff as 'emotionally draining and physically exhausting' [P31: interview 2]. Being cognisant of such stresses and their effect on staff was voiced by the majority of those interviewed, who spoke of the need to monitor oneself for signs of emotional and psychological stress and emerging distress.

Having the ability to monitor oneself was an important consideration in determining staff suitability. A process of referral for support counselling and debriefing was part of the risk management policy and procedures of the unit. The importance of caring for oneself emotionally and psychologically was shared by many of the staff and is captured in the words of participant P36:

> Having a run of patients dying, especially after caring a long time for a particular patient, can affect you deeply. In such situations, you may need to seek professional counselling. The unit makes such provisions for staff. Seeking professional counselling is viewed by unit staff as a normal process of caring for self if the need arises. Members of staff who choose to seek help through this process are not judged as not coping but are seen as responsible professionals. [P36: field notebook 2]

Participants stressed the importance of having sufficient time between and during rostered shifts to rest and recuperate. For instance, taking appropriate allocated breaks between shifts was considered by all the participants as central to their physical, emotional and psychological wellbeing and to the provision of quality patient management. Given the intensity of the workplace, having sufficient time to rest and recuperate between shifts was endorsed by all participants as an important consideration

in staff rostering. One of the participants captured the general sentiments of all those interviewed in stating that 'you cannot serve from an empty vessel, you need to care for yourself first … you need to have enough time and rest between shifts' [P4: interview].

In discussions with participants, there was a pervasive sense of the importance of needing time away from the unit to care for oneself. Taking allocated breaks during the shift was declared by a number of participants, who indicated the need to have time away from the unit, which also extended to having 'time out' during the shift. Taking designated breaks from the unit was strongly reinforced to ensure staff were able to provide appropriate care. As an example, participant P4 spoke of the importance of 'resting as part of caring for self. When you take time to refill your spirit, it allows you to serve others from the overflow'. The general sentiments expressed by most participants are captured in the following quotes by participants P2 and P14:

> Caring in ICU is not only about caring for patients who are acutely ill, it really starts with caring for oneself … One of the values of the unit that drew me to work in such an environment was overt support of the unit culture for staff to self-care. [P2: interview]

> Taking breaks in the shift can be seen as getting out of work. That is not the case in this unit … where having periods of 'time out' are viewed by the unit staff as essential for self-care in order to be able to provide quality safe care. [P14: interview]

5.4.1.2 Maintaining work–life balance.

Work–life balance was viewed by nurses as an important part of the culture of caring in ICU. Participants spoke of the unwritten expectation that all members of the nursing staff needed to have a balance between work and life outside of work to be able to function at the level required by the unit. There was a general sense that staff

informally monitored each other's work commitments and time away from work. This often took the form of informal conversations with colleagues. In situations in which staff appeared to be under stress, colleagues would make it their concern to inquire as to the nature of the apparent stress to help the person address the situation. Participant P9 shared her thoughts, which captured the general feeling of most staff:

> Within the unit there is an expectation that staff will take special care to maintain a work–life balance given the acuity of the unit and the incessant demands placed on staff. Staff are constantly reminded of the importance of having a life outside the unit and to be able to separate what goes on at work from one's home and social life. When staff seem to be increasingly absorbed by work or are seen to take work home, questions are asked of the person about what is going on? [P9: interview 2]

5.4.2 Caring for patients.

The second facet of 'caring-for' was caring for the patient. Although caring for patients is core business irrespective of the healthcare setting, participants expressed the need to talk about the provision of care to highlight its significance within the context of the ICU. The all-important need for patient safety underpins the need to provide a person-centred approach to care. Participants spoke of the attention by staff to ensure that risk assessment was embedded in all nursing activities. The complexity and acuity of the health status of patients, the unpredictability of changes in a patient's health and the time constraints in providing appropriate person-centred care in a timely manner were voiced by all participants as ever-present daily challenges for all staff. Participants noted terms in their PAWIs such as: 'being present with'; [P36: PAWI], 'being in the moment' [P32: PAWI], 'being aware of the non-verbal care needs of patients' [P18: PAWI] and 'being responsive to the subtle changing health status of patients and their personal illness

experience' [P3: PAWI]. Participants unanimously agreed on the importance of 'seeing the person' who happens to be a patient.

As expressed by all participants in their interview transcripts and PAWIs, the primary duty of care was to the patients. Participant P25 confirmed this position in stating: 'I believe my duty firstly is to care for the patient'. Similar sentiments were expressed by participant P36 who stated that 'there's a deep sense of satisfaction knowing that I have dotted every 'i' and crossed every 't' and I've gone the extra mile to give my patients the best care possible and I could not have done any more'. Participant P13 described the importance of meticulous attention to care in stating that 'caring is being sure that every base of providing care is covered if at all possible'.

Almost all participants agreed that they look after their patients as they would look after themselves or a family member. Participant P2 echoed these sentiments in stating that 'in our unit, we have to ensure that patients are well looked after … the way nurses look after their patients is the way we look after ourselves and that is why we always strive to provide the best care possible'. [P2: interview]

Interestingly, a number of participants declared in their interviews that one of the reasons they prefer night shifts is that it permits them to provide quality care because there are less distractions, which gives them more time with their patients. For example, participant P33 described how night shift is a good opportunity to be with their patient in a special way, which is not possible during a busy day shift:

> Some nurses enjoy the night shifts because it can be a little quiet. This enables them to spend more time with their patients as they are not distracted by the physiotherapist and visitors. These people are important but it's nice to have more time, and a one-to-one relationship with the person you are caring for. [P33: interview]

Several participants spoke of the tension between team members about end-of-life (EOL) choices for patients. The question of what constitutes ethical care often arises between staff concerning maintaining a person on life support and prolonging their life to meet family needs and wishes. The cause of this tension is the often-different views held by nurses and medical staff. The nurses interviewed considered prolonging life as an unnecessary trauma to the patient and their family, while the medical staff viewed maintaining a person on life support as sustaining life. For example, participant P10 expressed her view about prolonging life:

At times I get annoyed at what happens in the unit in terms of keeping people on ventilators. I do not like how doctors push the patients to live longer. I feel sometimes we are not doing them any justice to keep them going by prolonging the inevitable. I feel sometimes it is a bit cruel. I can understand why we do it because the family does not want to let their loved one go yet, and it is nice for the family to say good bye. I think it becomes a bit selfish of the family to let the patient suffer. Ultimately, caring is making sure your patient has the opportunity to have the best outcome in their current situation. [P10: interview 4]

In addition to having to make decisions about when to terminate a person's life, participants spoke of the importance of meeting patients' needs at the all-important time of EOL experience. Participant P1 shared a story about caring for a patient at the end of her life:

We had a patient two weeks ago who was dying. She was in isolation room 18. The patient told me that she misses her little dog, and I said to the husband I will speak to the director of nursing if we can organise to have her precious little dog being brought down into ICU. I organised for the husband to have the little dog brought down the next day and she saw her dog for the last time. It is not

something you do every day and I think it is part of holistic care to fulfil patients'

needs. It is compassion. [P1: interview 5]

The importance of communication in caring for a dying patient was shared by

several participants. During her field observations, the researcher noticed how participant

P19 looked after her dying patient. She held the dying patient's hands and spoke to her

softly:

Participant P19: 'It is ok to go, and hopefully you are not in pain. Someone is

with you; you are not alone'.

Researcher: 'You are talking to her'.

Participant P19: 'I found myself privileged to care for dying patients that you

spend the last few moments with. Their family members are not there and

therefore, they had somebody with them'. [P19/Researcher: field notebook 2]

5.4.3 Caring for families.

The third facet of 'caring-for' was caring for the patient's family. Participants

spoke of how essential it is to care for the family, especially in circumstances where their

loved one is unconscious. Participants described a range of ways in which they care for

the families of their patients. These include: keeping them well informed and updated

about their family member's health, involving them in the patient's care, being available

to listen to their concerns and fears and offering them any assistance and support needed.

A number of participants considered caring for families essential, especially in

a foreign and unknown area like ICU. As participants P26, P1 and P11 stated in their

interviews, 'caring often extends to patient's relatives as well. The time in ICU is highly

stressful for them' [P26]; 'the last thing you want is patient's relatives coming in and

collapsing. Unfortunately, they do from time to time because they get completely

overwhelmed with the environment' [P1]. 'It is important to demonstrate that you care

for them as well as keeping them informed, listening to them, and inquiring "what can I do for you?" ' [P26]. Participant P11 said:

> If the patients in ICU are sedated, you're often looking after the relatives more than the actual patient. You get to know the family. You get to know the patient through the stories and the feelings that the family has for them, and that gives a better understanding of that patient. [P11: interview 4]

Participants spoke of the need to involve the family in providing care to their loved one as a means of letting the relatives be close to them. Give them the opportunity to feel that they have been of assistance and helpful is better than leaving them feeling impotent and unable help. Providing an opportunity to be close to their loved one was an important consideration in caring for the family. Participant P12 stated: 'we used to involve the family in the patient's care, because sometimes they just feel so helpless, so if they can do even a tiny little thing it relieves them'.

During the researcher's fieldwork observation period, the following was noted: Participant P15 was observed bringing a chair to the patient's wife and assisting her to take a seat. She [the nurse] lowered the patient's bed to the same level as the seat of the relative. Participant P15 spoke to the wife in a very kind and warm way and asked if she would like a cup of tea, while putting her hand on her shoulder. [P15: field notebook 2]

Although most staff were attentive to the needs of the family, the researcher also observed times at which nursing staff were not attentive to their needs. For example, on one occasion, a patient was lying in an elevated bed and his wife was standing most of the time. The allocated nurse, participant P29, did not lower the bed for the wife to see her husband and did not offer her a chair to sit. Nurse participant P29 did not pay attention to the relative's needs and comfort, which is an indirect discomfort for the ICU patient too. [P29/Researcher: field notebook 2]

Participants P1 and P3 shared their thoughts about caring for relatives. Participant P1 said: 'we need to have very close communication with the family, to keep them in the loop of what's going on', while participant P3 stated that 'sometimes families are just so stressed, and all you can do is to provide the information and to be empathic to them'. Conducting a family conference or meeting with health team members for any clarification and decision-making were considered an essential element of providing care to the family. Participant P37 said: 'usually we arrange for relatives to talk to the doctor and arrange the time for a family conference'.

The researcher witnessed some conversations between participants and patients' families during fieldwork when the nurses offered the assistance of the Chaplain or counsellor and informed them about the availability of different supportive resources such as accommodation and free parking; this was evident with participants P3, P1 and P37. Participant P3 said: 'we can always provide them with support from the nurse counsellor if they're really not coping and if they don't have a good network support, or we can bring the Chaplains into the fold, for their spiritual needs'. Similarly, participant P1 stated: 'we can give the relatives accommodation across the road if they come from out of town. In addition, we can provide free parking tickets for them'. This support was further evidenced by participant P37, who said: 'we let them know about the restaurants and other facilities here and we can get the relative a cup of tea or coffee'.

As reviewed in nurses' documentation, caring for the families also extended to maintaining a record of family visitors and any issues that had arisen. For example, this included who visited the patient, the communication with relatives either by phone or in person and the nurses' experiences and activities with the relatives and their responses (see Figure 5.4).
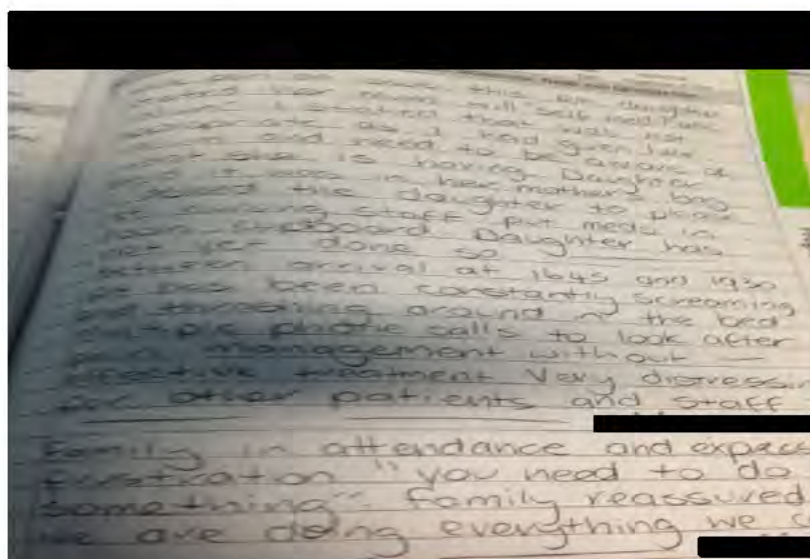
Figure 5.4. Nurse notes about a relative's frustration and the nurse's response to them.

5.4.4 Caring for colleagues.

The fourth facet of caring for colleagues comprised two groups: nurse colleagues and other team members.

5.4.4.1 Caring for nurse colleagues.

A key aspect of nurses' experiences working in this ICU was the support they received, especially from their nurse colleagues and the nurse manager. Nurses knew that they could rely on their colleagues to assist them if they needed help with any aspect of their work. Being helpful and supportive of each other was part of the ICU culture. Nurses acknowledged that they could ask other nurses for help and other nurses could seek them out if they appeared to be having any difficulty or workload issues. There was an underlying atmosphere of assistance and collegiality as well as a general sense that the nurses supported each other both physically and emotionally. This also extended to the visiting nurses (e.g., agency or casual). As participant P29 expressed:

> Most of the time we look after each other when someone's tired, upset, stressed, or needs a bit of help, we can always go and help them. We keep a bit of an ear out if someone's getting a difficult patient. To make sure you go and give them

assistance, to make sure they're not going to get injured, or if they're busy, you go and see if they want a drink or a cup of tea, because sometimes it's a bit hard to get away. [P29: interview]

There was a general sense that staff not only took note of any stresses faced by colleagues while on duty but also stress experienced outside work that had the potential to affect the quality of care. This was articulated by participant P7:

Nurses though can be distracted if they've got a sick kid at home or if something is going on in their lives. Therefore, you make sure as an in-charge nurse that those nurses are properly allocated … somewhere that they are able to care for patients appropriately, and you do not allocate them with a workload which is going to be stressful for them. For instance, if the nurse had a family member pass away, you don't give her a dying patient. Those nurses might go for their breaks earlier or they got longer breaks if they need to. That is where the team part all comes in, and you hope as a float or in-charge that you can pick up and support them through it. This is how we care for our nurses who have got things going on. [P7: interview]

A further example was from fieldwork observation. One of the participants received a phone call from home saying that her husband had suddenly become ill and had gone to the hospital. Directly, the researcher saw the nurse manager (P1) go over and hug the nurse participant (P29) and speak to her as she was crying. She assured her and calmed her down. The manager enquired how she could help and sent her home after ensuring that she was alright [P1/P29: field notebook 2]

Caring for junior nurses was one of the elements of caring for other nurses in the unit. This was not only observed by the researcher but was also explicitly stated by participants during their interviews. Support was provided by senior nurses to junior

nurses who were found to be struggling with meeting the heavy workload requirements of the unit. Being available to assist junior nurses to 'find their feet' and deal with difficult situations was one of the roles of senior nurses in ICU. One participant (P27) spoke about her experience of receiving support during her early days in ICU:

> One of the biggest troubles I have at the moment is prioritising my care to the patient's family, especially when I have got a critically ill patient. I am still junior and I have to learn a lot from the other staff. They are very good at helping me and telling me: 'you need to tell the family "to leave now", so you can do your care'. [P27: interview]

> Agency and casual nursing staff were viewed as part of the unit team and therefore, were cared for like the other staff. Participant P12 said that 'with the agency or casual staff, you just have to double-check with them that they know how things get done in here. If they don't, then you need to orientate them'. Participant P1 stated: 'because you don't know their skill level, attitude or time management, you're constantly checking up on them all the time: paperwork, communication, medications and nursing care to ensure they are safe in their practice'. [P1: interview 4]

5.4.4.2 Caring for other team members.

Throughout the observation period and in the participant descriptions, there was an overarching collegial atmosphere of caring for each other irrespective of the professional discipline. All members of the unit appeared to work in a harmonious manner, being cognisant of each other's contributions to the overall care of the patients and families in the unit. There was a general sense of respecting each other's role and being sensitive to each other's needs. For example, participant P9 articulated: 'we need to look after our co-workers, whoever they are on our shift—doctors, physiotherapists,

cleaners or the people delivering the meals—everybody has a job in ICU. So, we look after our team'. Similarly, participant P35 stated:

> We have a very strong team and we look after each other across the board; it is multidisciplinary in ICU. I do not think it matters whether they are cleaners or doctors. We all work together and what is important is supporting each other; it is a part of our unit culture. [P35: interview 3]

Participant P34 added that 'it is good to help your colleagues because you care about them. You are like a small family in ICU and in case you would need help, they will help you'. Participant P7 confirmed this by stating: 'here, it is more of a family setting where people do care about each other and have closer relationships and you probably share more with them about your personal life, and then you become more connected to each other'. [P7: interview]

The consensus of participants about caring for doctors in ICU was expressed by participant P16 in stating: 'we look after our doctors who work 24-hour hard shifts'. Participant P3 captured how they care about their doctor colleagues when on-call:

> The in-charge looks around and gathers all the information and try to sort things as planned, but if that doesn't work and it needed to be attended, then the in-charge goes around the whole unit and says: 'has anyone got anything for the on-call doctor?' and then [they] cluster it all together and do it at one time, rather than calling him every 45 minutes about something. [P3: interview 2]

5.4.5 Caring as ecological consciousness.

The fifth facet of caring-for was caring as ecological consciousness. This manifested in two ways: caring for the unit environment and caring for the organisation.

5.4.5.1 Caring for the ICU environment.

All participants considered this important but viewed it differently. One group of participants spoke of the importance of caring for equipment and machines in the ICU, while others spoke about workplace safety and reduction of hazards. Participant P12 stated that 'caring in ICU includes caring about the whole unit: caring about the work space, equipment and that everything is nice, clean and restocked and it's not in a mess'. [P12: field discussion/notebook 1]

Participants P2, P37, P1 and P13 agreed as to the importance of caring for the ICU environment. Participant P2 stated: 'usually when nurses start their shifts, they check their patients, bays and ensure all the emergency equipment is ready to use and the entire environment is safe to practice'. Participant P37 added that 'caring for the ICU environment involves caring for the equipment so that it lasts longer'. Participants P1 and P13 spoke in practical terms about the safety of the workplace:

> The fire exits need to be free, not to be cluttered with chairs, tables or pumps, and in a case of a fire or whatever event we might have to evacuate, and it is not allowed to block the existing pathway. [P1: interview 3]

> Environmental-wise we do the best we can for the space we have in ICU. We need all the equipment; the raised-up trolleys, chairs and beds to be located appropriately to have a safe environment to work in. We try to clear the corridors and make things less of a hazard. [P13: field discussion/notebook 2]

One participant echoed the sentiments of the unit concerning repetition in documentation in stating:

> Everybody says: 'why [do] I have to write the same thing three or four times'. This is just literally wasteful of time, ink, papers and the storage. The unit is moving towards a paperless unit; we need to move to a paperless society. Too

many trees die and we need to protect the entire environment, our world and universe. [P11: field discussion/notebook 1]

5.4.5.2 Caring for the organisation.

Interestingly, caring was not limited to the ICU environment but extended to the whole organisation, including caring about documentation (as an organisational requirement) and the organisation's budget.

A number of participants spoke about caring for documentation as a part of the organisation's requirements, which needed to be achieved. This was expressed by participant P36:

> Well, I suppose it's not so much caring for the patient as caring for the needs of the organisation as well. The organisation's requirement is to do documentation at least once in every 24 hours. So, we're taking care that we document thoroughly about everything that we've done to meet that requirement. [P36: interview 4]

Most of the participants, especially those in in-charge positions, articulated their commitment to caring for the organisation by emphasising their concern about the organisation's budget for staff and resources. Participant P7 stated: 'if we are really busy, we require additional staff to be safe, but at the same time we have to consider the budget'. Participant P10 said: 'we are always thinking about how much the staff is going to cost us'. [P7 & P10: field discussion/notebook 2]

As noted previously, participants enumerated several dimensions and entities that need to be cared for. Participant P36 summarised this in stating:

> We are caring for several entities in the ICU setting. In my personal experience, it is a process of maturity where I care for the physical and psychological wellbeing of the patients and their families, care for the integrity of the team, care

for the equipment and environment, and also care for my overall wellbeing. [P36:

interview 4]

In conclusion, the second theme—a culture of 'caring-for'—included five facets

of 'caring-for': oneself, patient, family, colleagues and ecological consciousness. The

third theme to be identified was the qualities required of the ICU nurse to provide quality

care.

5.5 Theme Three: Qualities Required of the ICU Nurse

The third theme to emerge was the participants' beliefs about what qualities are

required of the ICU nurse to provide quality care. Three main qualities were identified

by participants as requirements of nurses for working in the ICU: ability to work in

intense nursing situations, being an effective communicator, and being professional (see

Figure 5.5). These characteristics and quality requirements of ICU nurses are compatible

with the unit, hospital and organisation's mission, vision and values as previously

discussed.

Qualities required of the ICU nurse to provide quality care

Able to work in intense nursing situations	Effective communicator	Professional
- Knowledgeable & skilful - Attentive & vigilant - Capable of critical problem-solving - Flexible & able to multi-task	- Approachable - Empathic - Assertive - Advocate for the patient - Able to develop trusting relationships	- Willing to work with others - Fair & non-judgemental - Respectful - Honest - Reliable

Figure 5.5. Qualities required of the ICU nurse.

5.5.1 Ability to work in intense nursing situations.

ICU is an area where the patients' health status can change at any time and require an immediate response or intervention. Four dimensions of this theme were identified by participants. These include being knowledgeable and skilful, attentive and vigilant, able to engage in critical problem solving and flexible and able to multi-task.

5.5.1.1 Being knowledgeable and skilful.

Knowledge and skill in meeting the fluctuating healthcare needs of patients constituted the first dimension mentioned by participants as a mandatory requirement for working in ICU. When questioned further, participants spoke of the need for high-level competency in both the clinical practice and unit management domains of the ICU. Participant P34 stated that 'there is no exception to the rule that all staff in ICU need to be highly skilled and knowledgeable. It is both expected and required'. [P34: interview 2]

For the participants of this study, having a well-managed unit was considered fundamental to functioning effectively. Establishing a culture in which skilled management was valued was attributed to the leadership team, in particular, to the ICU manager. As stated by participant P13:

> Our manager is an expert; she has amazing knowledge and skills particularly in the area of cardiac care. She knows everything, which is great. We as a unit turn to her for leadership in establishing a culture of high level of knowledge, skills and management. [P13: interview 2]

A number of participants spoke of the importance of time management and prioritising tasks as a fundamental requirement for providing safe care in ICU. Participants identified timely prioritisation of care as the cornerstone of the unit's ethos. Therefore, a key criterion for nurses applying to work in ICU is their ability to manage

time and prioritise care. Participant P33 stated that 'the most important thing for a nurse in ICU is to prioritise [the] patient's care prior to commencing their shift, which involves clearly identifying the patient's health status and needs and to establish a plan of action for the shift'. [P33: interview] Participant P2 reiterated many of the sentiments of the participants in stating: 'underpinning all the various qualities of a nurse in our ICU is the ability to prioritise care and time management to ensure the patient's health status will not be compromised'. [P2: interview]

5.5.1.2 Being attentive and vigilant.

This is particularly important with regards to the ever-changing health status of the patient. Twenty-three participants acknowledged the importance of being attentive, which involved a quiet vigilance in monitoring the health status of the patients for any slight change, whether positive or negative and being ready to intervene as required. The need to be vigilant was not restricted to the patients alone but also to the needs of the patient's family and colleagues. The comments by participants P21 and P25 reflected the general sentiments of all the participants:

> If you are not attentive and vigilant to what is going on with the patient moment-to-moment, the potential to miss an important clue exists. Changes are often subtle at first and then escalate rapidly. It may be as simple as monitoring changes in a patient's pO_2 level which, if unnoticed, can lead to serious complications. Being ever-watchful and attentive to the health needs of patients is [an] essential characteristic in the ICU nurse. [P21: interview]
>
> When a patient's cardiac rhythm is starting to get a little bit irritable, such a pattern could be the beginning of a short run of tachycardia because they have had a valve replacement, and a knowledgeable nurse can anticipate that they may

be going into atrial fibrillation, and the patient needs a little bit of extra magnesium. [P25: interview]

5.5.1.3 Being able to engage in critical problem solving.

This is important in situations requiring a rapid response. As stated by 27 participants, nurses in ICU need to be critical thinkers, trouble shooters and problem-solvers in critical situations where a rapid response is necessary. The need to be a critical problem-solver was reflected in the sentiments of most participants, as expressed by participants P14 and P9:

> Nurses need to be able to engage in critical thinking in order to accurately assess the situation and make appropriate decisions. This involves being able to think through available information and to make informed choices about what needs to be done. [P14: interview 1]

> ICU nurse[s] need to be able to troubleshoot anything that is going wrong. It is about synthesising the information that is available and make decisive and appropriate judgements about what is happening and what needs to be done to eliminate or minimise the risk of complications [P9: interview 2]

5.5.1.4 Being flexible and able to multi-task.

A number of participants indicated that this is an essential requirement for an ICU nurse. The complexity and acuity of the health status of many ICU patients, coupled with the need for technological competency and prioritisation of patients' changing healthcare needs, required nurses to be adaptable and to take on many tasks simultaneously, as described by participants P11 and P26: 'flexibility and being able to multi-task is a necessity of staff working in ICU. There is no place in ICU for nurses who are unable or unwilling to be open and receptive to the needs of the unit'. [P11: interview]

In the ICU environment, every day is different with different demands and responsibilities. Nothing is ever the same. Your responsibilities from one day to the next can change and as a healthcare professional, you need to make appropriate adjustments to the needs of the unit. As well as being flexible, nurses also need to be able to multi-task, given the complexity of care needed for each patient. [P26: interview]

5.5.2 Being an effective communicator.

The second main quality perceived by all participants as an essential requirement of being an ICU nurse was that of effective communication. This directly affects the quality of care in healthcare and has a number of dimensions: being approachable, empathic, assertive and a patient advocate as well as having the ability to develop trusting relationships.

5.5.2.1 Being approachable.

Nurses in the ICU valued the time with patients, irrespective of unit demands and time availability. This was considered integral to the quality of both care and life experiences for the individuals and their families as 15 participants shared their belief that a caring nurse is one who values the time spent with patients and families, supporting them in their illness. This was not only about linear time but also the quality use time in providing excellent care. Two examples of the unit's values about the significance of time in providing quality care were provided by participant P12 in stating that 'the caring nurse doesn't ignore the family or snob them, but rather sits there and holds their hand in moments of great distress … somebody who had the time to explain what she or he's going to do before doing it' [P26]. Participant P11 stated that 'the caring nurse is one who is prepared to take time to listen to both the patient and their families' needs'. It also

involves 'trying to do what they [patients and their families] want, irrespective of the work demands placed by the unit' (participant P9).

5.5.2.2 Being empathic.

Participants agreed that empathy is a significant criterion for an ICU nurse. Being empathic was described by participants as involving being passionate, compassionate, understanding, reassuring, caring, friendly and patient. A number of participants mentioned the importance of being able to view a situation from the perspective of the other person—'be that the patient, the family or colleagues'. Participant P1 stated that 'nurses in ICU are required to be compassionate, empathic and understanding of the needs of others'. Participant P36 contributed her insights into what constitutes an empathic nurse in stating that 'nurses need the skills to put patients and their families at ease, to be open and receptive to their needs and be willing to understand what is happening to others from their perspective'.

Participants P9 put themselves in others' situations and stated that 'being empathic to people occurs with maturity. As you get older you bring to the situation a lot of experience and [the] ability to understand where another person is coming from'. [P9: PAWI]. Similarly, participant P20 stated:

> The nurse is in a unique situation as he/she has considerable experience in caring for people from all walks of life and in difficult situations. Then the nurse tries to put him/herself in that situation and asks the question: 'what would I like someone to do or how would I like someone to be?' [P20: field discussion/notebook 2]

All participants agreed that their clinical manager is a passionate, compassionate and understanding person. For example, participant P36 spoke about her personal experience of having an empathic unit manager:

Our nurse manager has that level of empathy and connection with her staff. As a personal experience, I have that connection with Kerrin that I could comfortably go to her and talk about a lot of stuff, particularly if there was something that really needed to be addressed. This occurs with the whole of our staff. [P36: interview 2]

Most of the participants emphasised that reassurance is an important element of being empathic. Reassurance was described by participants as involving a range of behaviours including: being there for others, communicating verbally and non-verbally and providing support in times of fear and anxiety. For example, in a discussion while working, participants P18, P20 and P37 shared their perceptions of being empathic: 'when a patient is intubated we reassure them that everything is going to be fine and that when they wake up from the procedure they will have a tube in their mouth, and it is going to be uncomfortable' (P18); 'we are always aware of how terrifying such a situation can be for them [patients] and therefore, we are very conscious of the need for reassurance and that we are there for them' (P20); 'being there for them may involve stroking their forehead, and holding their hands to let them know we are here for them' (P37) [P18, P20 & P37: field discussion/notebook 1]

5.5.2.3 Being assertive.

This was raised as a quality of the ICU nurse by several of participants and was described by participants as being able to express one's opinion in a respectful manner with patients, families and colleagues. For the participants, assertiveness implies a sense of directness in communicating one's needs without compromising the integrity of others in the process. It is about being heard without becoming aggressive or acting in a negative manner. The participants spoke of a variety of situations in which being assertive is a necessary quality of being an ICU nurse. For example, during field discussions,

participants P9 and P7 shared their experiences of the use of assertiveness in caring for one of their patients:

> ICU patients are often fearful about what is happening to them, in pain as
> a result of their injuries or surgery and resistant to interventions because of their
> level of confusion and uncertainty. In such situations, the nurse is required to take
> control of the situation in making decisions on behalf of the patients while being
> attentive to their needs. Such situations require of the nurse to be quietly firm in
> informing the patients that certain activities or procedures need to be performed.
> [P9: field discussion/notebook 2]

> At times, it can be difficult for the nurse seeing the patients resist any intervention
> because of their fear and uncertainty about what is happening. What is important
> is to be gently firm in talking to the patients about the necessity of what is
> happening, despite their resistance. [P7: field discussion/notebook 2]

> Participant also identified managerial assertiveness as important, especially in a highly technological area like ICU, where staff have firm opinions about what should constitute a patient's management and how things should be done. Participant P3 shared his perspective of the need for assertiveness skills when he is in a managerial role:

> Sometimes you have to be direct with people, especially in situations when staff
> are not providing appropriate care that is required for a particular patient. At such
> times, you need to bring the situation to their attention but without being negative
> or aggressive. As a leader, being assertive to a certain degree is important by
> saying: 'look [someone] this is what we're supposed to be doing'. You try to do
> things in a polite and democratic way that people will respond to it. [P3:
> interview 3]

5.5.2.4 Being the patient's advocate.

A number of participants identified being a patient advocate as one of the fundamental characteristics of the ICU nurse. As patients in ICU are vulnerable and usually unconscious or sedated, nurses must act on their behalf. As described by participant P2: 'usually ICU patients are critically ill and unconscious … they can't look after themselves … their lives are in our hands, so we are their ears, eyes, hearts and advocate'. [P2: interview] Participant P24 noted in her PAWI how the nurses in the unit advocated on the patients' behalf:

> Our nurses are acting as advocates for their patients in front of the doctors or physiotherapists by saying: 'the patient is complaining of/says/is asking for … could you please review their situation?' Speaking out on behalf of the patient is a very effective way of advocating for them, especially when they cannot advocate on their own behalf. [P24: PAWI]

Another participant described how the nurse advocates for the patient in front of patients' families:

> There are things you can't do in front of the family because it's for the patient's privacy. The nurse finds it really staggering when he/she says: 'I'm just going to put your mum or wife on a bedpan', and they still stand there, and then the nurse needs to say: 'would you mind stepping out, she wants to go to the toilet'. Sometimes nurses need to speak on behalf of their patients for their privacy's rights. [P1: interview 4]

5.5.2.5 Being able to develop trusting relationships.

Fourteen participants emphasised the significance of building trusting relationships with patients, their families and colleagues. Generally, patients in ICU are critically ill and vulnerable, with little control over their health status and health needs;

they are dependent on health professionals in an unfamiliar and often frightening environment. This requires time and different methods to build a trusting nurse–patient relationship. Participants P18, P20 and P3 said that the 'ICU environment is fairly intensive and patients are often frightened. Sometimes patients want to share something but they just keep it bottled up because building a trust relationship is difficult at times' (P18). 'Patients need time to trust nurses' (P20) and 'rapport works when patients have confidence in nurses' ability to look after them properly, which makes them feel more at ease about receiving the best care' (P3). [P18, P20 & P3: interviews]

Participants P4, P18 and P15 added that 'when nurses are explaining and keeping the patients well informed and meeting their spoken and unspoken needs, they are on the right path to building a trusting relationship' [P4, P18 & P15: informal discussion/field notebook 2]. Participant P16 pointed out the importance of talking to patients and their families to build a trusting relationship:

When nurses chat with patients and their families, this makes a nice environment for patients, families and nurses. Families leave their sick relatives with nurses [who] they do not know. Trusting our nurses and feeling confident to leave their relatives with us can help to put people's minds to rest a little bit. [P16: interview]

The importance of developing trusting relationships also extends to colleagues, as expressed by many participants, particularly participant P9:

Occasionally, in-charge nurses in ICU are busy with administration and unit requirements. This necessitates delegation of some jobs to the floating nurses. The need to be able to trust colleagues to complete delegated tasks is essential in such an environment. Thus, trusting your colleagues is another way of caring. [P9: interview 2]

5.5.3 Being professional.

The third main quality that participants identified as a fundamental requirement for being an ICU nurse was being professional. In describing what constitutes professionalism, the participants identified five dimensions: being willing to work with others, fair and non-judgemental, respectful, honest and reliable.

5.5.3.1 Being willing to work with others.

The first dimension to emerge was that of having a cooperative spirit in the multidisciplinary team. Participant P26 provided an example of collegial professionalism in stating:

> On one occasion when I was exceptionally busy, two of my colleagues without having to request assistance, came over and quietly asked whether they could be of any help. The manner in which they offered assistance was extremely professional without any fuss or bother. [P26: field notebook 1]

5.5.3.2 Being fair and non-judgemental.

A number of participants indicated the necessity of being fair and non-judgemental (of patients, their families and colleagues) and investigating, listening to and understanding their points of view. This was articulated by participant P14:

> Sometimes nurses have been told that this patient and his family are hard to deal with. However, this is not the case in our unit. Nurses working in our unit need to be fair and non-judgemental and give everyone a chance. Each person is different. As in every aspect of nursing, it's important to assess the situation yourself before you make any judgement. [P14: interview 3]

Participants P3 and P36 confirmed the significance of being non-judgemental in sharing their experiences about pain assessment: 'the nurse needs to listen to patients and what they've got to say and try not to be judgemental. Especially, with people with certain

ailments, like people [who] come in with certain illness such as chronic alcoholism'. [P3: interview]

> Patients experiencing chronic pain can sometimes be very difficult to assess and manage. This necessitates investigating the extent and all of the factors in relation to pain and providing an appropriate level of care and pain relief, as opposed to someone who judges or minimises the level of pain that the patient has got and says, 'it can't be that bad'. [P36: interview 3]

> Participant P1 shared her experience of moving from what she considered to be a position of being judgemental by being a 'non-listener' to a one of being open and actively receptive to the needs of her staff:

> At one time if I had a staff member make a complaint about another staff member, I found myself only listening to half of the story, only the bit that I wanted to hear so that I could give them my opinion. I did not take the time to listen to the full story and think carefully about how I should respond in fairness. I have taught myself to listen more and not to be judgemental, which I believe is an essential quality of a unit manager in order to be fair to all my staff. [P1: interview 5]

> *5.5.3.3 Being respectful.*

> This was described by most participants in different ways, identifying different facets of respecting the dignity of not only patients, but also their families and professional colleagues. Patients' rights were at the forefront of care. For example, participant P9 stated that 'some patients do not want to talk and we as nurses must respect that; they just have to be able to read the signs and the body language—respect is all-important'.

> In discussing the culture of professionalism in the unit, participants P14, P21 and P4 stated that 'being professional is all about respect for each other as colleagues and

respect for our patients and their families' (P14); 'it is an expectation that respect underpins our daily practice' (P21) and 'being professional in our unit is not just about appearance; it is also concerned with having the respect and correct attitude to providing quality care to both patients and their families'. [P14, P21 & P4: interviews]

Being respectful was not limited to the patient, family and professional colleagues but also included respect for oneself. As articulated by participant P36:

> Nurses need to have respect for themselves first. The degree to which we respect and care for ourselves, is the degree to which we extend that to other human beings … Respecting our patients, colleagues and ourselves is required to expand our caring capacity and knowledge. [P36: interview 4]

Participant P7 considered professionalism from the perspective of not disclosing personal issues within the workplace: 'one of the important aspects of being professional in our unit is that of self-respect by ensuring that personal issues do not intrude into or compromise professional practice'. [P7: interview]

5.5.3.4 Being honest.

A culture of honesty was evident in the participants' interview transcripts and 23 spoke of honesty as a fundamental principle underpinning the provision of quality care in the unit. The expression of honesty within the unit was demonstrated in a number of ways including being honest with patients, their families and with colleagues in the unit. Staff were encouraged to speak up if they felt that they lacked knowledge or expertise. In such situations, the acknowledgement was received in a positive rather than a punitive manner. Staff welcomed opportunities to share their knowledge and expertise with colleagues, especially in situations where a need for assistance was expressed. Honesty with patients and family was also regarded as an important part of being trustworthy. For instance, participants spoke of the importance of not attempting to know everything and

being honest with patients and relatives about what they did and did not know. Participant P36 noted in her PAWI that 'being honest with our patients, colleagues and ourselves is important. Knowing our own capacity and knowledge and being prepared to say, 'I don't know' is an important quality for a nurse working in ICU'. [P36: PAWI] An example of being honest was provided by participant P25:

> I had a patient that had a weird condition about black cancer thing, even when I googled it, I found it complicated, then I just said to the patient, 'I do not really understand your diagnosis'; and then the patient explained it to me. So, if you do not know what is going on, just be honest about it. [P25: interview]

> Two further examples of the importance of honesty were provided by participants P26 and P8. Participant P26 spoke of a situation with a colleague: 'gossiping about you— I'd rather if someone had a problem that they need to be direct and say hey, this is happening, be honest about it. So, I guess acting like children is not good and not accepted as part of being professional' [P26: interview 2]. In her PAWI, participant P8 noted that 'every nurse has his/her own work ethic and honesty is one of the essential common qualities and that is working well within the team in our unit'. [P8: PAWI]

5.5.3.5 *Being reliable.*

Many participants spoke of the importance of being reliable when working in ICU. This was considered central to patient safety in the provision of quality care. Participant P26 discussed reliability as an essential requirement of a professional nurse working in the unit in stating that:

> Nurses are getting satisfaction knowing that they can be relied upon in doing the best they can do for their patients and in working within their team, by not letting their colleagues down, by pulling their weight and [by] being responsible. [P26: interview 3]

Participant P12 described a situation when she needed to take a responsible stance in determining whether an agency nurse employed on the unit was safe to practice:

> There was one time when an agency nurse was allocated to our unit. When questioned whether she felt competent to work in such an environment, she indicated that she was. However, when she was asked to administer medication through an epidural catheter, it became obvious that she had no idea about the procedure. I reported the situation and requested she never be re-employed in our unit. [P12: interview 2]

Finally, a number of additional qualities of the ICU nurse were mentioned by a few participants: being a hard worker, being accurate, being tidy and neat and adhering to the values and mission of the hospital and ICU policies and procedures. Surprisingly, the latter (adhering to the values, the mission, policies and procedures) is an essential requirement of being a nurse in both the hospital and ICU—but was only mentioned by four participants (P1, P9, P22 & P36)!

5.6 Summary

In conclusion, the third theme—characteristics required of the ICU nurse to provide quality care—included three subthemes: being able to work in intense nursing situations, being an effective communicator and being professional. Apart from how staff viewed the qualities of the ICU nurse, one aspect that stood out the most was the unit manager as an exemplar for promoting a culture of caring. In the next theme, the CNM is presented as a case study of a culture carrier in ICU.

Chapter 5 included an overview of the mission, vision and values of the organisation in which the ICU is located as a prelude to the presentation of the first three themes: nurses' perceptions of caring in ICU, a culture of inclusive caring practice in ICU and qualities required of the ICU nurse to provide quality care.

Chapter 6: Findings, Part 2

6.1 Introduction

Chapter 6 includes Part Two of the findings, which includes themes four (the unit manager as a culture carrier of caring) and five (patterns of communicating caring in ICU).

6.2 Theme Four: The Unit Manager as a Culture Carrier of Caring in ICU

This theme discusses the contribution of the CNM to a culture of caring in the ICU. Through field observations, dialogues with participants and reading participants' PAWI entries, several qualities were identified that characterised the unit manager as a culture carrier of caring within the unit. This was underpinned by a commitment to valuing staff, which manifested in different ways: being open and approachable, being respectful, being willing to listen and understand and making every effort to be attuned to the staff needs in the daily activity of the unit (see Figure 6.1).
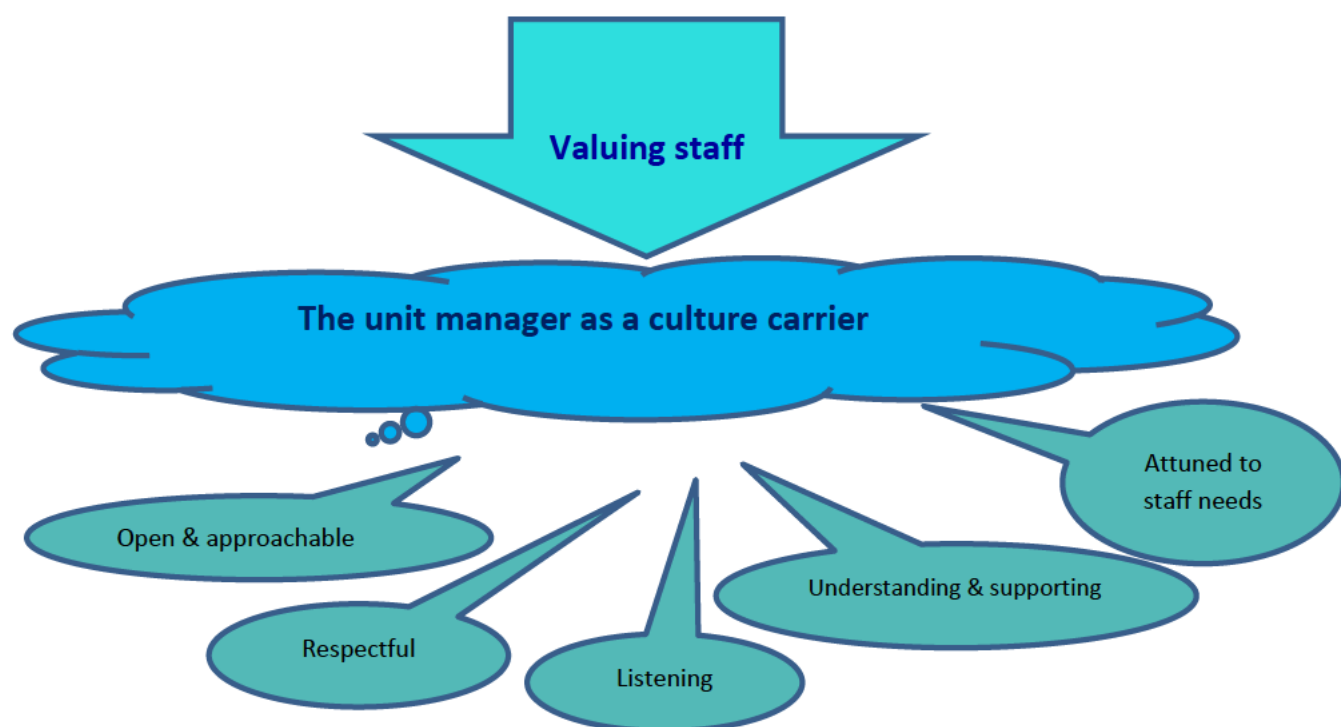
Figure 6.1. The Clinical Unit Manager as a culture carrier of caring in ICU.

6.2.1 Being open and approachable.

This was described by all participants as the CNM willingness to be available to the needs of her staff'. There was general consensus among participants that the manner in which the unit manager was available to them set the tone of the unit. This was evidenced in her approachability to patients, families and staff, as stated by participant P16: 'Kerrin's daily pattern of work is on arrival in the unit to introduce herself to the patients and their family members and to meet with the staff to check how things are for everyone'. Similarly, participant P22 said:

> Kerrin is very approachable, even when she is in the office because her door is always open. If the staff have any issues such as the need to change a shift, she makes every effort to accommodate such a request. Her approachability is one of the key aspects of her ability to set the culture of the unit. [P22: interview]

In their interviews, participants highlighted their unit manager's availability. P24 and P26 said: 'our manager has an open-door policy'; 'our CNM makes time for

everybody if they need to discuss things' (P6); 'if you've got any problems, such as a family concern … Kerrin is always available to you' (P3). The unit manager herself, P1, said: 'I always attempt to make myself available to staff, whenever they need me'.

Another component of valuing staff was the unit manager's obvious respect for her staff, evidenced in her commitment to be available to listen to them as well as being attuned to the needs of each and every staff member irrespective of their role in the unit.

6.2.2 Being respectful of others.

A number of the participants mentioned the unit manager as a role model for the way they should care for others and as a benchmark for their professional practice. Respect was most evident in the ability of the unit manager to listen to the concerns of staff because she valued what they shared. Staff spoke of 'feeling validated' by the unit manager 'listening to their concerns'. As stated by participant P19, 'all of us feel that if we go to her about any problem, we feel like it will be resolved and not just pushed under the carpet. She listens and makes sure that you feel you are valued'. [P19: interview]

Another participant, P17, said:

Ninety percent of the times when I have approached Kerrin with any problem, she has been caring. When I hurt my back, I had so many problems; I used to come and talk to her about them. Even if she couldn't do anything, at least she was listening, being there for me and being sympathetic … that helps so much. [P17: interview]

When asked to share what is important to her about providing a culture of care, the CNM (P1) stated:

I try to treat everybody in a respectful manner. I see myself as one of the team, rather than being on a pedestal. I am very conscious that the way I conduct myself impacts on the entire unit. It is important for the unit manager to set standards.

For me these standards are listening, respecting and valuing each member of staff.

It is one of the ways I care for my staff. [P1: interview 4]

A further component of valuing staff was the ability of the unit manager to be attuned to the needs of her staff members motivated by a need to knowing what is going on in the unit.

6.2.3 Being attuned to the needs of the unit.

This was one of the hallmarks of Kerrin's management style. When asked about why she needed to be fully aware of the unit activities, Kerrin responded that 'in order to be there for staff, it is important to be in touch with what is going on. If you lose that connectedness, you cannot be there for staff, especially in times of need' [P1: interview 4]. The general consensus of staff was that the unit manager makes it her business to know what is occurring to be available if the need arises. According to two of the participants, 'Kerrin always knows what is going on in this place and knows her staff very well' [P22: PAWI] and 'because she knows her staff, she is careful to only delegate responsibilities to staff that fall within their abilities. In this way, you know she cares not only for you as the nurse but for the patient and family'. [P9: field discussion/notebook 2]

Two further characteristics that exemplified the manner in which the unit manager cared for members of the team were those of being understanding and supportive.

6.2.4 Being understanding and supportive.

Given the acuity of the unit and the often-unpredictable nature of the work environment, when situations became difficult or staff were stressed, the unit manager seemed to understand the situation and was there to assist. This was observed by the researcher during the field observation period. On the first occasion, the CNM was

observed working closely with the allocated nurse and the patient, ensuring the nurse was well supported and had the required assistance. On another occasion, the unit manager was observed helping staff to maintain the cleanliness of the unit. [P1: field notebook 1], (see Figure 6.2).
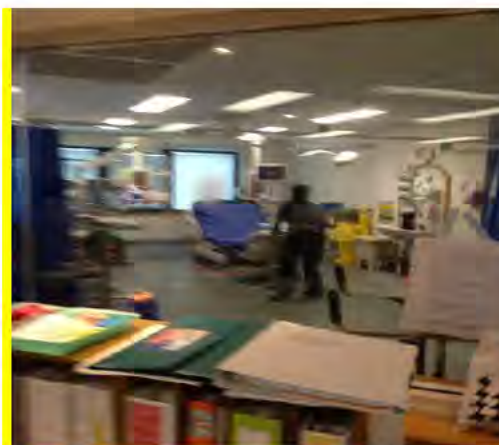
Figure 6.2. The unit manager is clinically leading by acting as an exemplar in maintaining the cleanliness of the unit.

Participant P36 stated:

Having someone like Kerrin as a manager is a big bonus. She is professional and supportive. She just seems to understand the situation and what the staff need. She is very empathic and caring in whatever she does. We all feel that if we had something that needed to be addressed, we could quite comfortably go to her and say: 'I feel this needs to be addressed'. [P36: interview 3]

Being supportive extended to all levels of staff for whom the CNM was responsible. In relation to staff acting as in-charge nurses, participant P14 stated:

The CNM is very supportive. She always asks if there is anything I need for the shift without making me feel inadequate. It is done in a respectful and sensitive manner. You know her intent is to ensure I am okay. Supporting for staff was not limited to the unit but extended to advocating on behalf of the staff and the unit. [P14: interview]

Comments by participants P6, P31, P10 and P7 reflected the general sentiments of all participants about the CNM's support and understanding. According to participant P6, 'the CNM is always prepared to go into battle with other nurse managers to ensure we have adequate resources to provide quality care'. Such sentiments were shared by a number of participants including P31 ('Kerrin is very caring. She fights for her staff. Really, I am so pleased to have her as a manager for our unit'), P10 ('she is good for standing up for her nurses if there have been issues with other staff members from different wards. She will support us in our decisions and actions if it was reasonable to do so') and P7, who stated:

> She supports any decision that you make as long as it is safe. She will always back you in whatever decision you make in terms of staffing or beds or patients, and that helps you to do your job better when she trusts you therefore, you know that she is going to support you. [P7: interview]

Most participants viewed the CNM as a major force in providing a culture of caring within ICU. This was validated by the field observations and interviews with participants. According to participant P7:

> Kerrin has been instrumental in creating a culture of caring within our unit. Her attitude, interactions with staff, her willingness to listen in a respectful manner and to value the individual has been like a ripple effect. It has impacted on staff and influenced how we relate to each other irrespective of our position in the unit. The qualities that Kerrin has can now be seen in the behaviour of the unit staff. She has been a great role model for us. [P7: interview 1]

Participants P6 and P13 added to the words of P7, stating that 'she [Kerrin] has got our best interests at heart' [P6: PAWI] and:

Honestly if we did not have Kerrin as our manager, I would not have stayed. She is amazing … she is the best. She is knowledgeable and she laughs. A good nursing unit needs a good leader like Kerrin. We are a good bunch because we have got a good manager. She is the heart of the unit. [P13: interview 2]

This theme presented the unit manager as a culture carrier of caring in ICU by valuing staff, being open and approachable, respecting, listening, understanding and supporting them and by being attuned to their needs.

6.3 Theme Five: Patterns of Communicating Caring in ICU

The fifth theme that emerged from the data analysis involved the patterns of communicating caring in ICU, which varied. This theme discusses these patterns from a variety of perspectives: changing patterns of communicating caring in ICU, types of communication used in the unit, factors affecting communicating caring in the unit and what stood out in relation to communicating caring from the perceptive of the researcher (see Figure 6.3).
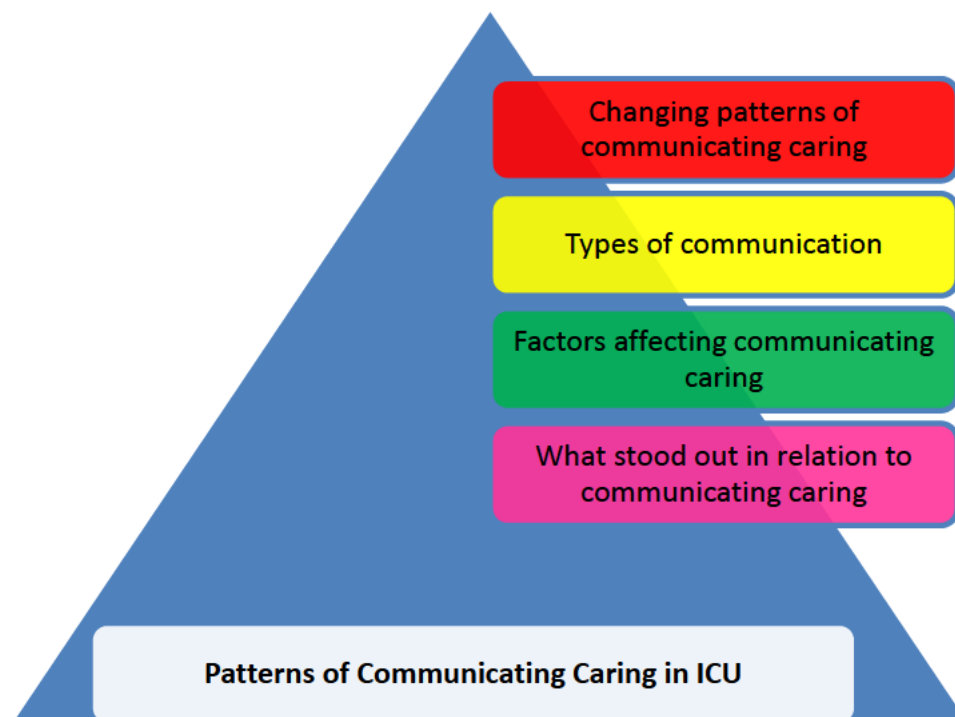
Figure 6.3. Patterns of communicating caring in ICU.

6.3.1 Changing patterns of communicating caring in ICU.

Changing patterns in the way staff in the unit communicated with each other were noticeable to the researcher. From the period of observation in the field and participants' interview transcripts, the ways individuals communicate are found to be varied. First, in communication with patients, participants indicated that changes had occurred in the way patients communicated their healthcare needs to staff, as expressed by participant P9: 'patients are not just receiving instructions or orders like before, patients have the right of partnership to participate and be involved in their treatment and to be informed about the progress of their condition'. [P9: interview 2]

Second, participants stressed the importance of communicating caring with the patient's family by being with them, listening and responding to their needs and involving them in the decision-making process. According to participant P35, 'it is important how you communicate with family … it is about making them feel that their care is your priority … and that they [are] valued in terms of their contribution in family's conferences or meetings'. [P35: interview 3]

Third, when nurses communicated with other health professionals such as doctors, the researcher observed that there appeared to be no hierarchy in the way they related to each other. In essence, there was a sense of collegiality and equality between the doctors and nurses, based on mutual respect for their levels of competency, expertise and knowledge. Participant P29 explained how communication with doctors has changed:

> Intermingling with different staff members, like how people talk to each other now, where you wouldn't 10 years ago. You wouldn't talk to a specialist; you'd wait 'til you got spoken to, but now that's different. Now you can initiate the conversation with doctors … Things have changed. [P29: interview]

On one occasion, the researcher observed a conversation between the CNM and one of the visiting doctors:

Participant P1: 'Excuse me, can I help you? Who are you?'

Visiting doctor: 'Dr X … Why isn't anyone following me on the ward round? On the wards, they follow me with all the pathology'.

Participant P1: 'Well, we're all busy and you don't have a ward round, you come whenever you like … please don't speak to me like that'.

Participant P1 later spoke to the researcher with some annoyance about some visiting doctors' behaviour in the unit:

Visiting doctors who just walk in and don't identify themselves at all and you have the audacity to ask, 'who are they'. They still think nurses are subservient but we're not, we're professional colleagues. You treat people with respect … it's treating people how you like to be treated. [P1/Visiting Dr: field discussion/notebook]

Participants stressed the importance of good communication between nurse colleagues, irrespective of their status and role. According to participant 9:

There is no real hierarchy in the unit in the way staff communicate with each other. All are professional, contributing their own knowledge and skill to the situation. Each of us works together for the common good that is quality person-centred care. For example, the unit manager involves herself as a member of the team, whether she is working at the bedside or as in-charge. Status is no barrier to the way staff communicate.

6.3.2 Types of communication in ICU.

Analysis of the data collected revealed different patterns of communication in the unit, including verbal, non-verbal and documentary communication.

6.3.2.1 *Verbal.*

Verbal communication was the primary means by which staff interacted with each other, patients and their families. Of interest to the researcher were the different ways in which staff communicated in different contexts and how such patterns of communication contributed to the unit's culture of caring. Four key aspects of verbal communication were identified, each with its own pattern of use specific to the situation. These included communicating with patients and their families about the patients' health, clinical handover and communication between staff members.

As observed by the researcher during the fieldwork, when nurses were communicating with both patients and relatives the type of language used was essentially lay in nature—terms commonly used by the public in everyday conversation—to describe their experiences and explain what had happened to them. Staff appeared cognisant of the importance of language when explaining how recovery was progressing to the patient and relatives. This involved the avoidance of complicated technical language or medical terminology. The researcher also noted the sensitive way in which staff communicated, given the vulnerability of the patient in terms of their health and potential future. Time was given for the patient and family to digest the information and ask questions for clarification to enhance their understanding of their illness and prognosis.

Communicating verbally with patients depended on their level of consciousness. For the patient who was cognisant of their surroundings and able to communicate with staff, the length of interactions was significantly longer than with unconscious patients. In such situations, the participants were more engaged with the patient, sharing information and responding to the patient's enquiries. With unconscious patients, the participants were observed to continue talking and explaining what was happening to the

patients they performed procedures. The focus of this interaction was primarily on treatment and management of care. Irrespective of the patients' level of consciousness, staff were aware that the patient still had the capacity to hear.

On many occasions during the fieldwork, the researcher noted that any discussion about the patient and their care focused on treatment, management and intervention outcomes. There was virtually no reference to the care provided by nursing staff in terms of reassuring and listening to the patient and simply being with them in moments of anxiety, uncertainty and confusion or how such activities affected the patient's health. Little consideration was given to subjective nursing care. This will be exemplified and discussed further in the documentation section.

When nurses 'handover' at the bedside, there is patient involvement. Nurses greet the patient and the needs of the patient are considered by giving them the opportunity to speak about how they view themselves and to ask any questions. The use of both lay and professional language was noted in these situations. When talking with the patient, lay terminology was used but as the team continued discussion of the patient's health status, they reverted to medical jargon and technical language, often using acronyms for brevity. The focus of the language was on treatment, interventions, pathology results and management. This was economical language utilised in an intense environment for time management. Noticeably, the researcher observed that the bedside handover used lay, inclusive and expansive language, with more detail of what was happening than was given in handovers at the in-charge level. These were economical, with abbreviations, medical language and use of the patient's bed number or diagnosis, rather than their name. In addition, the researcher noticed that when the handover occurred during night shifts, nurses were conscious about communicating appropriately but handle it in a hurry and did not involve the patient much. [Field notebooks 1 & 2]

Nurses sometimes communicated indirectly in the ICU. This involved sending a messenger (e.g., a float nurse) to deliver a specific message. As observed by the researcher on different occasions, the leaders tended to communicate indirectly and generally to staff in meetings for two reasons. First, this is done 'to let the person involved get the message without embarrassment' [P9: informal conversation]. This avoids confrontation and considers the recipient's feelings. Second, this allows staff to learn vicariously from other people's experiences or mistakes, as seen in one of the unit meetings where the researcher witnessed how the CNM and in-charge nurses send messages indirectly, rather than through direct confrontations with staff. The incident involved the administration of a blood transfusion. Rather than naming the person/s involved, the CNM made a general statement that an incident had occurred as a result of not checking whether the blood type was the correct one for the patient. Such an approach conveyed the importance of such an error to staff present without embarrassing those involved while simultaneously inviting all the staff to reflect on their own practice. On other occasions, the CNM was seen to meet with staff individually to address issues that related to them specifically.

It was evident in the researcher' observations that despite there being some tension between nurses, they were able to communicate verbally in a professional manner. They tended to move beyond differences of opinion and the personalisation to work in a professional manner for the benefit of the patient and unit. [Field notebook 2]

6.3.2.2 *Non-verbal*.

The use of touch in communicating caring. Of the many types of non-verbal communication, what stood out for the researcher was the central role of touch, which was not only described by participants during the interview but was also observed by the researcher during the fieldwork. Central to the use of touch as a means of communicating

caring was the importance of recognising the context of appropriate touch and its subsequent effects.

Recognising the context of appropriate touch. A large number of participants spoke of the importance of touch in communicating caring. In discussing the place of touch in the provision of care, participants were keen to highlight the importance of assessing the context of the use of touch, including informing the patient if touch was indicated. Assessing the context involved ascertaining the patient's level of consciousness, their background, the acuity of their illness, their potential vulnerability (for instance, being naked with only a sheet or gown covering their body) and the level of control and involvement in their care. For example, when undertaking a clinical assessment, touch can be used not only to communicate that you care, but also to provide important information about the person's physical health. In discussing the importance of touch in undertaking a health assessment, participant P7 stated that 'the use of touch can be a sneaky way of assessing the peripheral body temperature of the person, their heart rate and rate of breathing without the person actually being aware of what you are doing'. Participant P34 stated: 'as part of the protocols for our unit, assessment as to the use of touch is extremely important as much of our care revolves around attending to all aspects of care, including the patient's activities of daily living much of which involves touch'. [P34: interview 2]

Similar sentiments were expressed by participant P8:

Prior to engaging in any form of touch with the patient, we need to reflect on the situation, what is involved and how you believe the patient will respond. This can only be achieved if we talk to the person about the procedure if touch is involved. For many people, touch can be viewed as invasive and therefore, we need to take

this into account. We need to prepare them, not just spring it on them. [P8: interview 2]

In discussing the unconscious patient, participant P2 said:

Even when patients are sedated or unconscious, still they can feel when they are being touched. That is why we [nurses] always prepare the patient by explaining to them what we are about to do to keep them informed before touching them as part of carrying out any procedure involving touch. We treat them as any normal person, even though they may be comatose. [P2: interview]

In the process of assessing and preparing the person for touch, the nurses in the unit talked about knowing whom to touch, what/where to touch and when to touch (or not). Whom to touch was an important consideration in the provision of care. The diversity of patients being cared for in the ICU raised many issues for the staff, especially in respect of the patient's cultural/religious background, age, gender, illness severity and life experience. Therefore, participants were very cognisant that every individual responds to touch in different ways depending on their life history. One consideration is the patient's cultural background, as articulated by participant P14: 'in our unit, a person's cultural and religious background needs to be checked to identify if the use of touch is acceptable and if so, by whom'. Participant P28 provided an example of the importance of assessing the appropriate use of touch in respecting the faith, gender and age:

In some faiths, touching another, especially a stranger or a person who is not a member of the family is not acceptable. We are from time to time confronted with such situations, especially when the patient is female. When this occurs, the care and management of that person are entrusted to a female rather than a male staff member …When a patient is a young person, there is a need to be cognisant

of their sensitivities in respect of others viewing and touching their body. We are very conscious of not embarrassing them. This is also the case for elderly people, who often require care which involves touch. It is important to remember touch is meant to be therapeutic not invasive. [P28: interview 2]

When and when not to touch were also raised by participants as important considerations. When to touch was mentioned in discussions of the appropriate use of touch and its intent. Participants considered touch to be appropriate when patients were perceived by staff to be anxious about their situation, wanting to talk about things worrying them and feeling the need for reassurance that things would improve. Participants spoke of the importance of touch at these times as a point of connection that transcended the spoken word and allowed the patient to just be with their own thoughts, as articulated by P8:

> The use of touch can be a source of strength for the person in the bed that does not require conversation. It is about communicating to the patient that you are with them without having to talk. It also can be a point of affirming the person as they speak. [P8: interview]

The use of touch was also mentioned by participants as a means of calming the patient when unsettled. This was expressed by participant P7, who stated that 'if the patient is restless, touch can have a calming effect, especially when they are confined by tubes and monitors. At such times, touch can be extremely therapeutic for the person'. [P7: interview]

For patients at the EOL stage, participants discussed the importance of providing touch as a means of reassurance and comfort. According to participant P21, 'even when a patient is living through their last moments of life, I find that simply holding their hand

can provide a sense of comfort that they are not alone'. Participant P14 expressed similar sentiments:

> We have had the privilege in this unit of being with patients as the person comes to that moment of death. At such times, touch has become the point of connection when words fail to express how one feels. It is in many respects a sacred moment. Being with the patient and their family at such time[s] is considered to be an important part of providing care in the unit. [P14: interview]

In caring for an unconscious patient, the importance of touch was raised by a number of participants, as expressed by participant P22:

> When we are taking care of a patient who is in an unconscious state, it is difficult to know whether the person can hear us or not. Sometimes touch is the only way the person can sense that someone is there for them. In touching the person, you are essentially saying without words that you are there taking care of them … and because of the noise, it is hard to assess if they got the message … It is to get their attention. [P22: interview]

A number of participants pointed to utilising touching to build rapport and trusting relationships with patients: 'when it is busy in the unit, there is a little time left for compassion, which can't be measured easily such as touch … it is communication and building rapport with the patient' [P24]. Participant P17 reiterated this, saying that 'by holding the patient's hand, you are trying to connect with them … you are building a rapport with the patient … and letting him or her feel a bit more closer [*sic*] and extra bit of caring that you are more sympathetic and empathetic nurse rather than just being superficial and only professional nurse'. [P17: interview 2]

For many participants, the effects of touch extended to the patient's physical health, as described by participant P28:

The use of touch has been effective in reducing patients' blood pressure and heart rate. On many occasions, I have witnessed that the simple act of touching the patient on the hand or arm can have an immediate impact in helping them relax. You can often see this in their facial expression. By touching their hands, we immediately drop their high heart rate; they will be comfortable and that can be seen over their faces. [P28: interview]

On one occasion, the researcher observed one of the staff talking to the patient from the end of the bed and requesting that they stop fidgeting with their tubes. Another nurse (P15) who was in the process of assuming care of the patient moved to the side of the bed and gently held the patient's hand and quietly said, 'it is ok … I have just come in … my name is … and …'. Participant P15 spent time talking to the patient. When questioned by the researcher on why she chose to hold his hand, she commented:

I think it is just communicating and showing someone that I am here for you and you have been heard … that you are safe … In such circumstances, the person's physical status can improve just knowing you are there for them then yourself saw how the BP and HR went down. [P15: Field notebook 1]

Touch is often used by staff to provide comfort and reassurance for family members struggling to make sense of what is happening to their loved one. In reflecting on her experiences, participant P34 stated:

Sometimes patients can cope with bad news more than their family members … At such a time[s], they [relatives] need you more than the patient. By simply placing your hand around their shoulder, lets them know you are also there for them. [P34: interview 1]

In one occasion, following the death of his wife, one of the nurses was seen to gently move closer to the husband of the deceased and hold his hand. The researcher,

who was close by, put her hand on the husband's shoulder as a means of consoling him. Later, the allocated nurse (P39) said: 'Hanan [researcher], her husband said that your hand on his shoulder was very kind and helpful at that difficult moment'. [P39/researcher: field discussion/notebook 2]

The use of touch was not limited to patients and relatives but also extended to colleagues. At times when staff were observed by colleagues to be distressed whether because of a work situation or something external, staff were observed to be there for each other. On one occasion, participant P29 received a phone call that her spouse was very sick and had been admitted to hospital. Her colleagues comforted her by hugging her and asking how they could help. There was an immediate response to cover her shift so that she was able to leave work to be with her husband [Field notebook 1]. On another occasion, participant P31 informed the staff that her nephew and his fiancée had been killed in an accident. The staff responded with a gentle embrace followed by an offer to be there for whatever she may have needed. [Field notebook 2]

What/where to touch were important considerations raised by a number of participants. Given the complexity of the unit in terms of patient diversity, participants reiterated to the researcher the importance of touch in communicating that they cared. However, their foremost consideration was to ensure that they did not compromise the person's integrity or self-worth. Participant P9 conveyed the general sentiments of the participants in stating that:

> The appropriateness of where to touch our patients where necessary without violating their integrity is the centre of our assessment procedures. People have their own sensitivities about where they are comfortable at being touched. Within the unit, there are acceptable parts of the human body that touch is generally permitted and accepted. These include the head, which for some is a very

vulnerable part of the body, shoulders, hands, legs and feet. Outside these parameters, we need to be sensitive to how our patients feel about being touched in other aspects of their body. [P9: field discussion/notebook 1]

6.3.2.3 Documentation.

Documentary communication took multiple forms, including nurses' notes, patient charts, the unit communication book, emails between staff and the staff unit notice board. In talking with participants about the way healthcare delivery is documented (coupled with a review of what was actually documented), the nursing staff raised two questions: what did nurses document and why? And what did nurses not document and why?

What nurses include in their documentation and why. An examination of the documentation processes used in the unit was undertaken. Further, participants were questioned about what they documented and why. The consistent message received was that any form of documentation about patient care needed to contain objective, factual and measurable data such as physical assessment outcomes, diagnostic findings, treatment interventions, management strategies, patients' responses to treatment and the needs of the family. The participants were keen to point out that the inclusion of a decision-making trail and treatment plans was important to track the health of the patient, as articulated by participants P18 and P9:

> The main thing in documentation in ICU is recording the results of the patient's physical assessment. The forms we use are set out in a systems approach from head to toe, for instance, neurological, cardiovascular and respiratory systems. It is bit of a unit culture here. [P18: interview 2]

> Documentation of patient care by the nursing staff is all about recording any change in the health status of the patient and any other clinical procedures that

the patient requires. For example, chest drains removed and mouth, eye, pressure area care. It is all about recording objective facts, which is what we are taught to do. [P9: interview 2]

Participant P29 spoke of the importance of psychosocial assessment as part of unit routine:

It is very important to document psychosocial aspects of the patient's care, which is part of holistic practice; for example, the person's response to pain relief, mental status, level of comfort, outcomes of visits by family, doctor-family meetings and requests by family. [P29: interview]

One particular practice noted by the researcher was repetition in documentation, for example, repeating the same information in different charts. Participant P13 spoke of her frustration at this practice: 'you get nurses who will document something eight times. Myself and others, if we have written something somewhere, we are not going to re-document it elsewhere because we hate to write things twice'. In the review of the patient care documentation the researcher also noted that any reference to nursing care was either very brief or stated in general terms, for instance: 'all care attended to or patient nursed as per care plan or protocol' (see Figure 6.4).
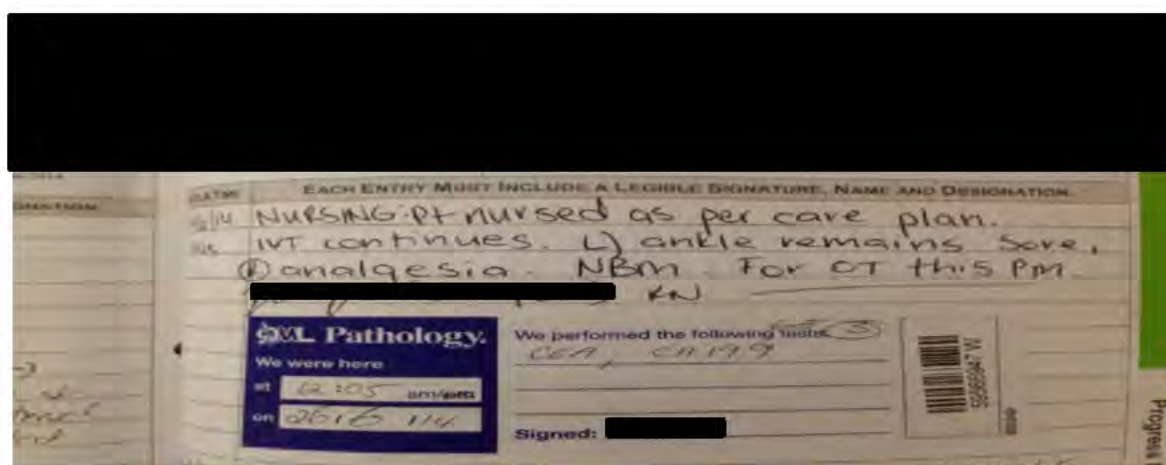
Figure 6.4. Documentation in nurses' notes: 'Patient nursed as per care plan'.

When questioned by the researcher about the reasons for the abbreviated manner of care documentation, participant P5 responded that:

All care attended to means you have given, for example, mouth care and eye care; we've written it down. However, any care involving touching the patient for the purpose of reassurance or to allay their anxiety is normally written as 'psychological support given to allay patient distresses. Therefore, when you use the term psychological support, it is generally understood to mean that you sat down and listened to the patient and assisted the patient to feel comfortable. Such terms remove excessive documentation. [P5: field discussion/notebook 1]

When documentation was between nurses (e.g., in the nursing notes), there was a noticeable change in language and the inclusion of how nurses perceived the needs of the patient. As articulated by participant P17:

As nurses, we also attempt to include the psycho-emotional aspects of the patient's response to their illness experience and treatment. For instance, when a patient is in need of emotional or psychological support, we would include in our documentation 'patient needs a lot of tender loving care (TLC). The use of such a term would indicate to other nursing staff that the person is very fragile, emotional and distressed'. Such language would be used at the verbal handover from one shift to another. [P17: interview 2]

From the researcher's point of view, what participant P17 indicated in the above statement was the importance of documenting subjective data in the provision of care, although these data were not considered important by some nurses in the unit.

The importance of documentation in terms of legal implications was raised by a number of participants and is captured in the words of participant P13:

Nurses are legally obligated to document every shift. Nurses' charts and notes are

legal documents. Subsequently, you've got to be very careful what you document.

You might record 'patient is restless or confused' which are medical terms and

therefore, acceptable. [P13: interview 2]

Apart from the issue of documentation legality, several participants mentioned

the importance of not only being clear in their documentation for patient safety, but also

to protect the nurse from potential litigation. This was articulated by participant P32:

Documentation is important for the patient as a means of providing evidence of

what procedures have been undertaken and the outcome of such interventions.

Clear documentation can also be a protective measure in the case of treatment

error or when the patient or family believe there has been a failure in care and

treatment. [P32: interview]

Although there was considerable resistance to documenting subjective data, some

participants felt it has a place. Participant P14 was of this opinion:

In the Philippines, we were trained to record both objective and subjective data

as part of legal requirements. For example, where there may be

a misinterpretation of communication between patient and nurse, and nurse and

family for instance, leading to complaints being made. Therefore, here in our

ICU, the way documentation works is if you do not write down what you have

done, then you did not do it … 'not written not done'. So, I write everything

down. [P14: interview]

A further example of the content of documentation concerns family visits, (see

Figure 6.5). As participant P2 stated, 'in the unit, we are taught to write in our charts that

family have been updated about the health status of their loved one. It is also evidence

that the member of the family did visit'. [P2: interview]
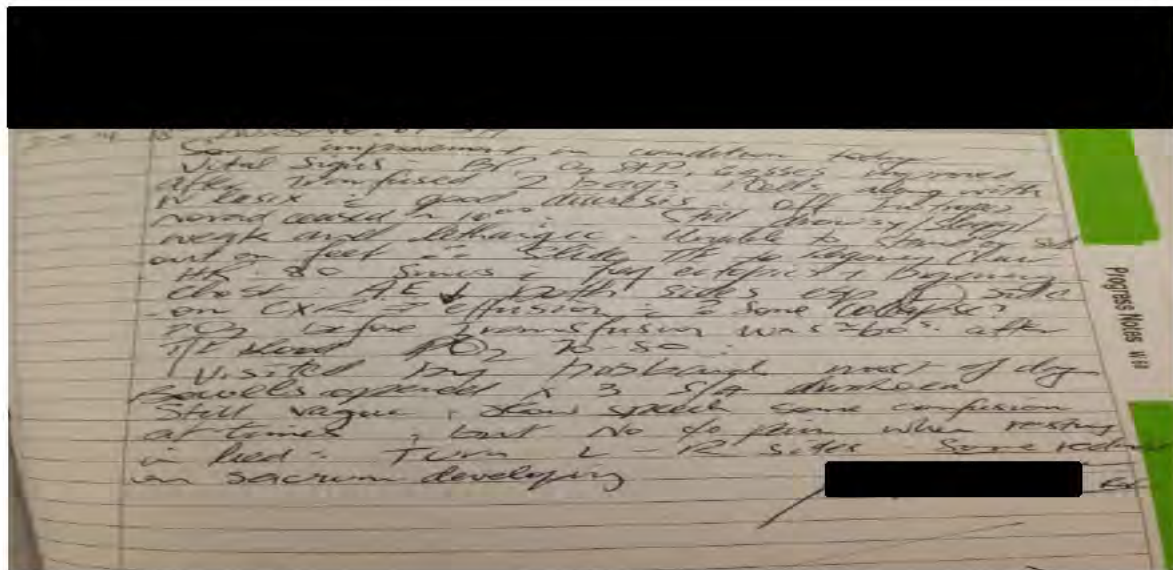
Figure 6.5. Nurses' notes about visitors' attendance.

Participants were informed of the apparent discrepancy between what they described as significant in creating a culture of caring and what was recorded in the official and legal documentation of patient care and treatment. When questioned by the researcher as to why such an anomaly existed, given the importance of care espoused by participants, participants responded with quiet dismissal as if to suggest that nursing care was essentially subjugated to the realm of non-importance in the absence of evidence— that engaging with the patient on a personal level cannot be proven to make a significant contribution to health improvement and quality of life. Although proud of their contribution to providing care, a number of participants were reticent to include such information in their documentation, as it was not considered as valuable as other information. Participant P37 shared her thoughts about this and stated that 'nurses don't write that they listened to the patients, touched them or held their hands. This is taken for granted as part of providing care and people had writing such things' [P37: interview]. As participant P19 added, 'recording that you held a patient's hand or massaged their feet is generally considered to be not important. No-one is going to read it'. This option was

shared by P21—'nobody reads the nurses' notes'—and P34, who stated that 'reassuring the patient is part of providing care, but we do not write it'.

Similar sentiments were expressed by participant P6:

I believe it is important to write down how we cared for our patients from a nursing perspective as such information can be very helpful; however, none of the staff are going to read it, especially if it is lengthy, so we don't write it down. It is very time-consuming, spending too much time documenting the care instead of delivering it. [P6: interview]

Also, participant P22 stated:

You could probably write a whole book when you write in your notes. You have to get straight to the point and also you could be spending half an hour writing one patient's notes. I think you need to write things that are going to be useful for the next person. [P22: field discussion/notebook 1]

In summary, while nurses spoke about the importance of the culture of caring, it was not evident in their notes of the care provided. The manner in which the participants engaged with each patient and their family and the effects of this engagement were noticeably absent in the unit documentation of patient care. The reason given for this discrepancy was that, although highly valued as part of the practice, such activities were viewed by the unit as not significant for documentation of patient care. After completion of analysis and further reflection, one question remained from the researcher's perspective: if caring is considered fundamental to nursing and is a valued practice in the unit, why are caring behaviours undocumented? Nurses do not have a model for documenting caring behaviours in ICU, which needs to be reconsidered.

6.3.3 Factors affecting communicating caring in ICU.

The data analysis revealed a number of factors that appeared to affect the process of communicating caring in the ICU. These factors were divided into facilitators and obstacles (see Figure 6.6).
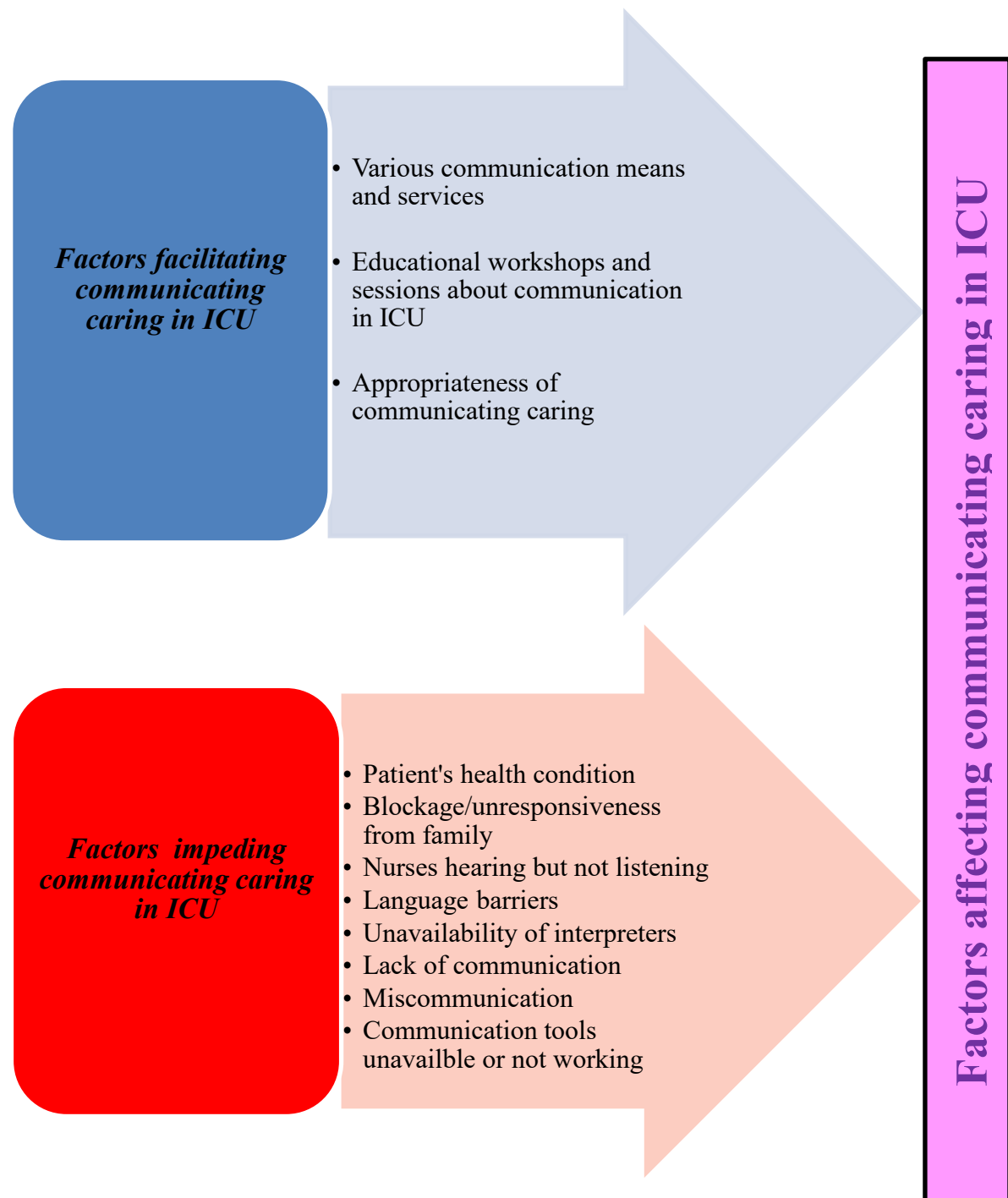
Figure 6.6. Factors affecting communicating caring in ICU.

6.3.3.1 *Factors facilitating communicating caring in the unit.*

As outlined in Figure 6.6, several factors that facilitated communicating caring in the ICU were identified by the researcher. These were contextually based and included using communication means and services, attending unit workshops to enhance effective communication with patients, their families and colleagues, and the appropriateness of communicating caring. The researcher observed that a number of alternative strategies were employed by participants to facilitate effective communication. These included the use of different tools including mobile phones, writing boards, iPads, pictures, lip reading, leaflets and information brochures and using services such as an interpreter when language was an issue. Two examples are presented below: information brochures for family members and the magic board used to communicate with patients (see Figures 6.7 and 6.8, respectively).

Figure 6.7. Visitors' information brochures and book kits.

Figure 6.8. Magic board used for communication with patients in ICU.

Education was a major aspect of developing effective communication skills for staff. Participants informed the researcher that they were required to attend different workshops and educational sessions to enhance effective communication with patients and their families, as well as appropriate etiquette practices especially in sensitive situations. As shared by participant P34, 'we [nurses] need [further] education and training about how to communicate with different relatives … dealing with difficult relatives … on the psychological aspects [of caring] … about how to understand people'. [P34: interview]. Additionally, participants provided some illustration of the way that nurses need to communicate with their patients, as described by participant P9:

> You are communicating continuously with your patients. It is about looking at their body language or eyes when they are not conscious. When they are unconscious, you need to speak clearly, keep it simple, direct to the point and usually a little bit louder because there is so much other noise going on, but not shouting at them. [P9: interview 1]

> Nurses in ICU need good communication skills [which involves] being patience, being a good listener, being … attentive to the patient because all patients have

different needs … also, the way you present yourself [in terms of] eye contact, body language, mannerisms [and] tone of voice. Definitely, there are quite a few aspects to the overall … care for your patient. [P18: interview]

Further, participants pointed to the importance of choosing a suitable time for communicating with their patients and respecting their unwillingness to talk, either because of being preoccupied with their illness or simply not being in the mood to engage in conversation. As explained by participants P9 and P1:

Nurses need to read the patient's non-verbal cues. Some people do not want to talk and you must respect that; they know that you [the nurse] are there for them. Therefore, you just have to be able to read the signs … whether your patient needs or wants to communicate or not. [P9: interview1]

Actually, we [nurses] forget that people need to rest. We need to leave them [patients] alone, for a period of time in the day—where possible—for an hour, to rest … that is really an important part of healing. We often forget that because ICU is so noisy all the time. [P1: interview 4]

Communication between staff was another aspect raised by a number of participants who had experienced situations in which unprofessional communication occurred. As stated by participant P26, 'some float nurses criticise you in front of the patients when they say "hasn't anyone brushed your hair today, or haven't you had a shave?"… they just come and pick on you … that is greatly annoying'. [P26: interview]

Regarding a suitable place for communication, the researcher attended several family conferences/meetings with members of staff (doctors and nurses) responsible for the patient being discussed. The provision of such an important space in which to talk in an environment of respect, privacy and confidentiality was clearly evident [field

notebooks 1 & 2]. Further, the importance of conducting handover in a suitable place—away from the nurses' station to avoid distraction—was shared by participant P5:

> The in-charge and float nurses' handover is in the nurses' station, where there are phones continually ringing and doctors coming in and out all the time. In order to address the situation, we said, 'why don't we give the handover in the manager's office, here … where the nurses' station is close to the office door … this will allow us privacy in which to review each patient's case. [P5: interview 3]

6.3.3.2 Factors impeding communication in the unit.

When questioned about what factors tended to impede the ability of nurses to communicate caring for their patients, a number of examples were raised. These included caring for patients who were experiencing psychosis, were unconscious, had an endotracheal tube (ETT) in situ and had vision or hearing impairments. In such circumstances, the challenge for nurses was to create different ways to communicate caring, as explained by participant P24:

> When patients are confused, communicating caring becomes very difficult. It can be hard to determine what the patient needs. For example, if a patient is trying to climb out of bed and we have to keep pushing the patient back into the bed, the patient can feel that he is not being cared for. Another thing that inhibits my capacity to care is when I am looking after ventilated patients, and these patients cannot communicate effectively because of their tubes. So, it's hard to provide the emotional or physical care that they specifically need. [P24: interview]

Participants also mentioned that sometimes communicating with the patient's family is a challenge because of the barriers imposed by the family. This was articulated by participant P3:

Well, sometimes it is challenging when communicating with family … they come in and you can see that there are walls there between you [nurse] and them, or they put these walls up. Having to get through that to tell them what is going on, or to break down the wall … that is incredibly difficult and frustrating. [P3: interview 3]

On one occasion during field discussions with staff, participant P36 stressed the importance of listening to the patient or relatives, as a means of communicating that they cared:

Some nurses in the unit have a very busy shift and preoccupied with carrying out procedures, which are more often than not highly technical. Turning off from what they are doing. They are great nurses … do not get me wrong but just we are talking about communication. [P36: interview]

One of the significant challenges of communicating while one cares was the language barrier. When the patient does not speak English and there is no interpreter or family member available to act as an interpreter, the situation can become problematic, as stated by participant P2: 'most of the time, language can be a significant barrier in communicating with patients in our ICU' [P2: interview 2]. This was supported by P37: 'we have had Greek people and sometimes it was hard to get an interpreter. Luckily, their family spoke English which is helpful … but their family are not here in the middle of the night and that is just a nightmare'. [P37: interview 2]

The use of medical jargon by members of the healthcare team further challenged effective communication with patients and their families, as explained by participant P28:

The medical staff tell patients that there are some changes in their condition and they speak to patients in medical terms … then you see the patients just nodding their heads; then you ask them 'did you really understand [what the doctor was

saying] … do you have any questions?'. As a nurse, it is your responsibility to make sure that the patient understands what is going on. This is an important part of caring for your patient. [P28: interview]

The issue of language was not confined to patients and their relatives but was also present for members of the healthcare team whose first language was not English. Participant P24 stressed the challenges faced by some nurses who are non-native English speakers in her interview:

> For some nurses, their English is not easy to understand. If their accent is strong/thick or not clear or difficulties can arise. For instance; one time a doctor gave an order for insulin by phone and it was difficult for the doctor to understand the Asian nurse's accent … the nurse had to ask another nurse for assistance in taking the order … This was a big frustration for both the nurse and doctor. [P24: interview]

A number of participants indicated other obstacles in communicating caring:

> Today, an agency staff gave me a reasonable handover, and just she was not certain about different things because she was not familiar with the paperwork and procedures of the unit. Although one of my patients was to be discharged, and I never found out until late … that my patient is going to the ward. [P27: interview]

Further, nurses spoke about difficulties with communication between health professionals in the unit (e.g., doctors), whether it was verbal or written communication. As participant P36 described, 'some surgeons make your job harder; first, because they don't talk to you and second, you can't read their writing … it's illegible. So, how are we meant to know what to do?' [P36: interview 2]

Participants identified miscommunication as another obstacle, as articulated by participant P7:

> There might be a personal clash between the nurse and patient in terms of how the nurse approaches and the different perspectives of the situation by the patient. So, it can be purely down to miscommunication and someone's misunderstanding from either side. [P7: interview]

The researcher observed some confusion in communication when working or dealing with certain cultures and groups of nurses in ICU, such as Filipino (when nodding their heads) and Indian nurses (when shaking their heads). The situation that can arise is difficulty understanding whether they agree or not. In such situations, the nurse often has to ask for verbal clarification. In addition, some groups were sometimes observed conversing in their native language, which was neither appropriate behaviour nor appreciated by both the patient and the staff. [field notebooks 1&2]

One obstacle witnessed by the researcher required the use of communication tools for engaging with patients, which were found to be inoperable as a result of flat batteries. The researcher asked three participants about the situation— none said anything about it. [Field notebook 2]

This section discussed the factors affecting communicating caring in ICU. The next section describes what stood out in relation to communicating caring in this ICU, from the researcher's perspective.

6.3.4 Remarkable aspects of communicating caring in this unit.

In her time in the unit, the researcher had many opportunities to observe the ways in which care and caring were communicated. However, five elements concerning communicating caring within the unit stood out: care of the patient after death, a sense

of humour, communicating care through touch, the contributions to a culture of caring by nurses from different backgrounds and a pervading sense of caring within the unit.

Of particular note was the manner in which the person who had died was cared for posthumously. The staff attending to the final preparation of the patient were extremely respectful of the person before them who, moments ago, had been fighting for their life. During corporal preparation of the deceased, which required dismantling and removal of the technology surrounding them, the nurses continued to honour the body as if the person was still alive. Words of comfort and support were replaced with a respective attention to preparing the body for transportation to the mortuary. On a number of occasions, the transportation of the body was undertaken by the staff.

A sense of humour amid the daily stresses of working in such a unit was evident during the researcher's period of observation. Humour seemed to neutralise the stresses and difficult times faced by the staff. Whether in the form of joking, making what they perceived to be clever comments in the form of retorts or responding to comments of staff that elicited a smile, humour was the antidote for coping with life and death situations. It also assisted staff in maintaining a sense of confidence, whether that be with the patient, family or nursing staff. Participant P37 captured the general feeling of the unit concerning the place of humour:

> Humour and laughing make all of us feel at ease. Whether the patient, family or staff, humour plays an important role in making a dark place more light-filled. It helps us get through the day, which is often filled with difficult events and decisions. Humour often replaces feelings of not being confident with feeling confident. [P37: interview 3]

Amid what initially appeared to the researcher to be a culture of 'standoffishness' (being more cerebral than emotive, more technical than person-centred and with a focus

on task completion rather than holistic care), it is becoming increasingly apparent that this was not the case. In essence, the unit was a place where touch formed the conduit of care and caring, as previously discussed.

The manner in which nurses provided care was perceived by the researcher to be linked to their educational backgrounds. To the present researcher who has worked in this environment for many years, each person brings their own style of caring; some care much and some care little. In this instance, nurses who were trained in England more often than not were observed as providing quality care that superseded that provided by other members of the nursing team. One of the characteristics of this particular group that stood out for the researcher was their ability to connect with patients and their families through what the researcher observed as a 'quiet presence': talking to them in quiet and respectful tones that seemingly invited both patient and family to share their concerns and hopes for recovery.

Apart from each of these elements, there was a pervasive sense experienced by the researcher, which, for her, defied description. It was if each of the elements converged to make an unspoken statement that this was a unit that valued communication as an essential mechanism of creating a culture of caring within the unit.

6.3.5 Summary.

This theme discussed the changing patterns of communication and types of communication used between a diversity of people within the unit, including the importance of touching and pragmatic documentation of caring. In addition, various factors affecting communication in the unit (both facilitators and inhibitors) were discussed as well as aspects of caring communication that were particularly visible to the researcher. Chapter 6 included Part 2 of the findings, which covered themes four (the unit

manager as a culture carrier of caring) and five (patterns of communicating caring in

ICU).

Chapter 7: Findings, Part 3

7.1 Introduction

Chapter 7 includes Part 3 of the findings, which includes themes six (Enablers, challenges and negative cases of caring in ICU) and seven (Nurses' patterns of responses to stressful situations in ICU). In addition, a conceptual model of the culture of caring in ICU is presented at the end of the chapter.

7.2 Theme Six: Enablers, Challenges and Negative Cases of Caring in ICU

The participants identified a variety of factors affecting caring in ICU, which were either enablers that enhanced nurses' ability to care, or challenges that impeded this ability. Enablers, challenges and negative cases of caring originated from various sources: patients, families, nursing staff and the ICU environment (see Figure 7.1 and Table 7.1).
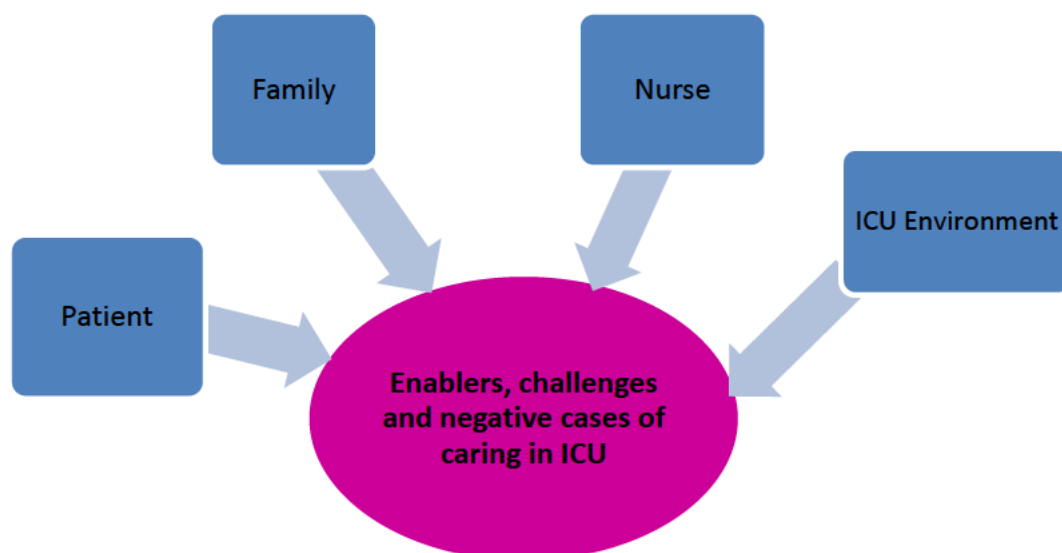
Figure 7.1. Enablers of, and challenges to, caring in ICU, as perceived by ICU nurses.

Table 7.1

Examples of enablers and challenges of caring in ICU

Components	Factors	Caring enablers (+ve effects)	Caring challenges (−ve effects)	Both (+ve/−ve effects)
Patient	Patient health knowledge	✓	✓	✓
	Acuity of illness		✓	
	Level of consciousness and communication	✓	✓	✓
	Length of stay in ICU		✓	
	Age, gender, weight and language	✓	✓	✓
	Patient behaviour	(e.g., cooperative)	(e.g., uncooperative)	
	Prolongation of patient's life		✓	
	Objectification of patients		✓	
Family	Family involvement in nurses' provision of care and vice versa	✓	✓	✓
	Family culture		✓	
	Family conflicts		✓	
Nurse	− Educational background and experience − Employment type − Leadership styles − Relationships − Personal factors	− Teamwork (support) − Camaraderie and collegiality − CNM appreciation − Variety/flexibility of shifts and roles − Involvement in patient's life and family − Personal motivators	− Busyness, tidiness and shortage of time for caring) − Extra workload (staff 'chasing their tails') − Personal problems (detract from caring)	
ICU Environment	Layout/design of ICU environment			✓
	Noises and distractions		− Patient sleep deprivation − Distractions during handover	✓

Components	Factors	Caring enablers (+ve effects)	Caring challenges (–ve effects)	Both (+ve/–ve effects)
	Resource availability	− Availability of staff, equipment and finance	− Shortage of staff, equipment and finance	
		− Having students (assistance and observations)	− Having a student (extra burden, exhausting, time-consuming)	✓
		− Technology (accuracy, life and time saving)	− - Technology (time-consuming, takes attention from patients)	
	Nurse-to-patient ratio	Close and continuous observation		

7.2.1 In relation to patients.

Within the context of the ICU patient, a number of situations were identified by participants as being either enablers or challenges to the provision of care. These were the patients' knowledge of their health status, condition acuity, level of consciousness, length of stay in ICU, age, gender, weight and language as well as patient behaviour, objectification and prolonging of life.

Assessing the patient's level of knowledge and how it might affect them and their illness was an important consideration of the nursing staff. There is always an issue with how much information is going to be beneficial and how much information is going to be distressing. Patients sometimes expressed that knowledge about their health status was a double-edged sword. For those patients with minimal knowledge, the task of providing an appropriate level of knowledge sufficient to be comprehensible and meaningful to the patient is difficult. The nurse must monitor their response and to react accordingly by assessing whether the information provided enhances the patient's sense of control or creates anxiety, fear and uncertainty. Conversely, in the case of well-educated patients,

their knowledge is recognised and they are invited to be part of the decision-making in their treatment. At times, this can be problematic for staff who have to acknowledge and respect the patient's level of knowledge while also carrying out the necessary treatments without their constant input. However, a third group of patients may not want to know about their illness and the nurse needs to be sensitive to these situations. Participant P23 summed the necessity to respect patients' desires about being informed and acknowledged or not given information on their health status:

> Each patient is different. Some patients might have more of a cognitive understanding and want to know everything: what this is doing and why this happened. So, you have to let them know what is going on and that might affect your caring because sometimes, if they know too much, they get really stressed about it. Sometimes, they don't need to know while they're so sick here in ICU, they've got a lot of other things going on. On the other hand, you might have completely a different patient, who is depressed or one of those old population who don't want to know what's going on. Then you have to work on that and you need to respect it. [P23: interview 1]

Regarding the condition acuity, there was general consensus by participants that the criticalness of the patient's illness is an essential consideration when caring in ICU. For some participants, the acuity of illness was viewed as an enabler, while others saw it as a challenge to the provision of care, depending on the situation.

> The patient's illness can be a challenge and we are limited by what we can do for them because of how sick they are. If they [patients] are critically unstable patients or ventilated, then you are really with their physiological needs that have to be addressed first. Nurses are too busy in stabilising and maintaining life support for the patient. It is hard to manage their psychological needs because

you are so busy. In some ways, the patient gets left out a little bit from other caring activities, which is what generally happens. [P7: interview]

Considering the patient's level of consciousness, many of the participants prioritised care irrespective of whether the patient was conscious or unconscious. Participants expressed mixed views about whether the level of patient consciousness is an enabler or a challenge of care. Participant P34 explained why she preferred looking after conscious patients, stating that 'caring for conscious patients is easier, because they can tell you what they feel if something hurts them or not'. In contrast, other participants such as participant P19 preferred caring for unconscious patients: 'when we've got unconscious patients, we have more time to do things for them without much distractions'. [P19: interview 2]

In terms of the patient's length of stay in ICU, participants viewed the period of hospitalisation as having a significant effect on the patient and the provision of care. A group of participants indicated that some patients do not receive sufficient care because of the shortness of their stays and the high turnover in ICU. Participant P5 explained how this makes a difference in caring:

> When a patient comes in today and goes tomorrow your care is different because you do not get a chance to know the patient and therefore, find yourself only providing basic care and the patient goes to the ward, but if the patient stays longer you get to know the history in more depth; you become more close [*sic*] to the patient and you feel for the patient and that is when your care gets more involved. [P5: interview 3]

Other factors related to patients that were identified by nursing staff as affecting caring were age, gender, weight and language. Age and gender were identified as interrelated sensitive factors that the nurse considers when looking after patients in ICU.

The manner in which staff communicated with patients differed in terms of their age. From the period of observation and interviews, the elderly seemed to prefer to be cared for by mature and experienced nurses irrespective of gender, as expressed by participant P20: 'they [elderly] trust us as we are mature in age and experienced nurses'.

However, gender is considered in other situations, as explained by P11, a male: 'if the patient is a young girl, usually I would prefer not to shower or catheterise her, so certainly I would ask one of the female nurses to do that, which is an accepted practice in our ICU' [P11: informal conversation/field notebook 1]. When female patients indicated their preference to be cared for by nurses from the same gender, their request would be respected and a change of patient allocation considered, as participant P37 expressed:

> We had some requests from patients such as: 'can I ask not to have a male nurse to look after me'. The patient's request was honoured. This is a normal practice within the unit to respect the requests of patients, irrespective of whether it is an issue of gender or age or ethnicity. [P37: interview 2]

Interestingly, the patient's weight was a challenge to the provision of care. Some nurses refused to look after bariatric patients because of their back injuries. As witnessed in the fieldwork, nurses with such injuries were allocated to non-bariatric patients or were not required to be involved in any activities associated with lifting or turning these patients; for example, they just held the ETT while the patient was turned.

Language was described by participants as a potentially significant challenge to caring for patients in ICU, whether it was on the patient's or the nurse's side (the latter of which will be discussed in Section 7.2.3). Patients from non-English speaking backgrounds often posed significant challenges for nurses to communicate what they intended to do as part of their care. In such situations, the accepted strategy within the

unit was to engage an interpreter, if possible. When an interpreter was not available, nurses asked a family member who could speak English to interpret. In the event that both avenues were unavailable, body language or communication tools were used (as viewed by the researcher in the observation period; please see Theme 5).

Patient behaviour was viewed by the ICU nurses as significantly influencing the provision of care. As expressed by most participants, the cooperative/compliant patient facilitates the caring process. In contrast, participants agreed confused, aggressive or combative patients can impede quality care. As participant P24 noted in her PAWI:

When patients are cooperative, it is easy to care for them, but most of the ICU patients are confused or aggressive—because of the electrolyte imbalance or waking up post-surgery and sometimes that makes it difficult to care for them. [P24: PAWI]

A similar option was expressed by P11:

'Non-compliant patients were a big challenge because they won't take their medications. That set nurses back 30 or 40 minutes just trying to placate someone and to give them medications, when nurses have other patients to see'. [P3: interview 2]

Irrespective of the situation and patient behaviour, nursing staff agreed that the most important element for providing care was finding appropriate avenues to communicate effectively with patients in the context of their illness experiences, as described by participant P18:

My patient was blind and approximately deaf and was difficult; these are barriers that I had to overcome. I tried being close to the patient as I can, worked out the voice pitch or tone in which he was able to pick up on and respond to me. I tried

to communicate with him and to get a response from him whether it was a verbal or physical response. Eventually I succeeded. [P18: interview]

Prolonging patient's life unnecessarily was raised by a number of the participants as a point of tension between members of the treatment team, family members and ICU staff. At times, nurses perceived doctors to be prolonging the life of a patient at the behest of the family when the prognosis was terminal. Participants spoke of the difficulty they experienced at having to be part of this because the family were not prepared to face the reality that their loved one was about to die. In such situations, participants felt torn between providing quality EOL care. Sentiments were expressed by a number of the participants and are summarised in the words of participant P10:

We [nurses] do not like when a decision is being made by doctors not to do anything for the patient, except for prolonging the inevitable, simply for the sake of the family who is not prepared to let them die. We appreciate that the family has their needs but it should not be at the expense of the patient, especially when you can see the patient no longer has any quality of life. We [nurses] are all on one page in this regard but our hands are tied. It is the decision of [the] medical treating team in consultation with family. Such decisions are not easy when there is a difference of opinion. [P10: interview]

The objectification of patients was raised by a number of participants. Even in a culture of person-centred care, some of the practices in which patients are sometimes objectified were disconcerting. The researcher observed staff behaviours in which the patients were objectified, particularly in reference to handover (see Theme 5). This was articulated by participant P36:

Because ICU is such a technical and high-technology environment, we [are] so concentrated on the technology and test results … we can forget that we are caring

for human beings. This often results in us focusing on the intervention and its outcome … it is an aspect of care that none of us like doing. It just seems to take over from time to time, especially in the handover. [P36: interview]

7.2.2 In relation to families.

The family was identified as the second source of enablers and challenges in the unit. Three key factors were identified: involvement of the family in the provision of care (and vice versa), the family's culture and family conflict. Each of these aspects was a common occurrence in the unit, posing significant challenges for staff.

The presence and involvement of family members in the care of their loved one were valued and generally encouraged by staff in the unit. The staff viewed the family of patients as an important aspect of the healing process, especially in terms of providing comfort and support and reducing feelings of isolation and loneliness. In addition, involvement of the family provided opportunities for them to contribute to their loved one's care. However, this was not always possible as staff were sometimes confronted with challenges of how best to involve family members; some did not wish to be involved while others sought heavy involvement, sometimes to the detriment of the patient. In such situations, the challenge for staff was how to strike a balance concerning family involvement to facilitate rather than interfere with care.

Several participants described some of the tactics used in trying to involve family members in caring for their loved one. A common strategy was updating and involving the family members in the patient's condition and treatments. Another was to invite family members to conference about their loved one. Participant P1 stated that:

Unfortunately, relatives get completely overwhelmed with the ICU environment, especially when the patient is very sick. We need to have a very close communication with the family to keep them in the loop of what's going on …

and we need to have a very structured approach to family conferencing in order to keep them informed. [P1: interview 2]

A third strategy described by staff was to allocate tasks, which family members could perform to feel that they were participating in their beloved relative's care. The presence and involvement of family at the bedside was valued by staff as it provided opportunities for staff to offer support and guidance:

Some families may ask you: 'what can they do?'. In such situations, you can suggest that if they have a nice body cream they can come and sit with their relative and massage their feet or hands. It's so much nicer for the family to get involved in their loved one's care than for me [nurse] to do it because sometimes the family just feel so helpless and if they can do something, even if it's just a tiny little thing, that makes them happy. Sometimes it is enjoyable for the family to get involved in the patient's care, because it's caring about family too. [P19: interview]

Actually, the care provided by the nurse at the bedside is not limited to the patient; it involves the relatives as well, because both go hand-in-hand. If the relatives feel comfortable, then the patient feels comfortable. Helping the family to make sense of what is going on is a fundamental consideration of staff as part of providing comprehensive holistic care. [P1: interview]

In situations where the patient is unconscious or unable to communicate, the family is a significant resource and there is often a great reliance on them to provide information about the patient that can be incorporated into their care and treatment plan. A number of the participants spoke of the importance of obtaining patient information from family, which is part of the unit's admission procedure:

On occasions, the patient is unable to remember their past medical history as a result of their situation. Information from the family can change the whole context of care. It might only be small things that the team does not know about, but it is important to the patient's care. That is why, as a unit, we all value the input of family. [P33: interview]

Participant P7 provided further information about valuing the presence and involvement of family in stating that 'in the absence of the patient being able to provide informed consent, the family plays a pivotal role. They are often the ones that have to take the responsibility for decisions'.

The presence and involvement of family was also described by several participants as being important in settling patients who, as a result of the health status or situation, became anxious or agitated. The presence of family often has a calming effect that staff cannot provide:

It has often been observed in the unit that the presence of family impacts positively on the patient. The very presence of family more often than not, has a calming effect as a result of hearing familiar voices and seeing familiar faces.

On the contrary, there are other times when the presence of family upsets the patient, as participant P33 articulated: 'in some situations when the presence of family causes anxiety or agitation, we ask them to leave for a while'. At other times, the family is asked to leave for staff to follow routine patient care, as observed by the researcher.

A further aspect relating to family is the frequent and repetitive questioning that occurs, especially when family are anxious about their relative's condition and preoccupied with the potential outcome. Such situations occur from time to time and the unit as a whole is prepared to accommodate them because they appreciate that this is part

of responding to the family's needs for information and a sense of certainty. Participant P17 captured the sentiments of staff in this regard in stating that:

> The importance of communicating with relatives cannot be overestimated; however, it can become repetitious not only because family members are anxious and upset about their family member and forget what they have been told, but also in situations where there are many family members. Each member wants to hear what is happening, which involves quite often repeating yourself, which at times can be irritating. Despite this, it is a unit expectation that we need to keep all members of the family up-to-date with what is going on. [P17: interview 2]

The need for privacy and respect was highlighted by all participants as a fundamental principle of care. Protecting the dignity of the patient extended to family members, especially at times of treatment procedures or care interventions:

> Depending on the procedures, there is a given protocol to follow. With simple procedures that are not of an invasive nature or do not lead to the exposure of the patient, family are encouraged to stay. However, when this is not the case and the patient may be compromised by the family's presence, they are generally asked to wait in the waiting room until the procedures have been completed. It is so important to protect our patients; we are their advocates at all times. [P37: interview]

Conversely, nursing staff valued being allowed by family to be privy to personal stories and experiences. The nurses felt honoured that families felt safe to share their hopes, aspirations, fears and doubts with the staff. As articulated by participant P19, 'nurses are in a privileged position as they are often invited into the personal world of family members, especially when we are virtual strangers … such times are very special and precious because people let you into their lives'. [P19: interview]

The needs of the family in relation to its culture were conveyed by many of the participants as fundamental to the provision of quality care. According to participant P1, 'there is an expectation of the unit that everybody is to be treated with dignity and respect, irrespective of where the patients and relatives come from - their cultural heritage'. In addition, meeting the spiritual and religious needs of patients and their families is a core value of the unit. The importance of meeting such needs was raised by many participants and was observed on many occasions by the researcher. For example, participant P29 said:

> If the relatives are very religious and they want whoever to come and see their family member; for instance, if they were Catholic, a priest would be called, and if of the Jewish faith, a Rabbi would be called, if requested. This is a normal part of daily practice in our unit. [P29: Field discussion/notebook 2]

> Nurses need to take into account each family's cultural and spiritual needs. At times, this can be difficult, especially when people who come from cultural backgrounds where all the family want to be with their family member all at once. We as a unit often have to go into 'crowd control' but the unit has in place processes and protocols for dealing with such situations. [P18: interview]

For many of the participants, one of the challenges faced was family conflict. Within the unit, this primarily involved issues around family arguments and disagreements about decision-making in such matters as discontinuing life support or organ donation. These situations require a position of non-involvement by staff beyond professional involvement. The usual procedure is to deescalate the situation by seeking intervention by the unit manager. If unresolved, then a family conference is convened at which issues can be aired, discussed and resolved, if possible. Participant P37 spoke about what occurs in the unit:

When issues of conflict arise between family members in the unit, we quietly and expediently remove them from the situation, which is followed by an opportunity for them to debrief with a staff member. The situation is then documented in the case notes and discussed at patient review sessions … If conflicts continue, the unit manager would be asked to intervene to ascertain what the issue is and assist in resolution of the situation … If all fails, then a family conference is convened, attended by senior unit staff caring for the patient. [P37: interview 3]

Many nurses spoke of the difficulty in dealing with family issues and indicated that they do not like to participate, but usually found themselves involved in one way or another. Attending to the complex needs of families was an area in which the nurses found themselves ill-equipped, especially when there was family dissent or conflict, as observed by the researcher upon attending a number of family conferences. According to participant P7, 'there is a complexity of some of the issues families face when their family member is in a critical condition. I know we are meant to care for both patient and family but in situations where there is family disharmony or conflict, we do not like to be involved'. Participant P37 continued the discussion:

Dealing with family conflict is one area in which I try not to become involved. Being caught in the middle between family and the patient is not a nice place to be. This is not our area of expertise and therefore, referral to a counselling service is the best option, which is the correct protocol followed on the unit. However, every now and again, you cannot avoid being involved. [P7 & P37: field discussion/notebook 2]

Although there are set protocols for working with families who are having conflict, for many of the participants, dealing with family conflict comes down to individual approaches. The initial point of intervention is heavily reliant on the expertise

of the nurse to work through the issues with family without talking sides or becoming too involved. It was generally accepted within the unit that the staff have their own ways of working through issues with family to reduce the stresses and conflicts. As voiced by participant P18:

> Most of the nurses have their own ways and strategies to deal with family conflict concerns, which they have developed over years of experience. The unit as a whole supports such an approach to working with family conflict. First, it starts at the informal level simply by talking with family to identify what the issue is, then teasing out with them the possible solutions. In many instances, this works but when there is no resolution and the patient's situation is compromised a formal process of family intervention is generally set in place. What is ultimately important is to be the advocate for the patient irrespective of family issues. [P18: field discussion/notebook 2]

7.2.3 In relation to nurses.

As professional nurses, participants identified a number of situations, which acted as either enablers or challengers of the provision of care. These were their educational backgrounds and professional experience, employment working factors, leadership styles, relationships and personal factors.

As the nursing staff came from different educational systems both within Australia and overseas, their range of skills and level of knowledge differed considerably. To develop consistency in the provision of care and ensure professional standards were maintained, the unit offered a range of in-service and professional development programs. Part of the orientation program for new staff included ongoing opportunities for professional development, which involved having a sound working knowledge of the unit's policies and procedures (a mandatory requirement). According to participant P2:

Every year, all staff are required to undertake refresher courses as a means of ensuring that staff are competent to provide the required care to patients. This in itself is a basic requirement for working in the unit. The primary foci are on knowledge acquisition, technical skill development and patient management, all of which underpin what the unit requires for quality care. [P2: interview]

Nurses' employment working factors include the different types of employment for nurses, including shift work and work allocations. Permanent staff were viewed as the backbone of the unit, especially in maintaining consistency and continuity of care, which allowed staff to get to know their patients and to monitor their health status over time. Casual and agency staff were viewed by the more permanent members of staff as 'a necessary evil' for the simple reason that they were only in the unit for short periods of time. For some participants, casual or agency staff were 'carried' by the full-time staff, because they were viewed as needing supervision. As a result, casual or agency staff were sometimes considered more of a hindrance than a help by full-time staff. The following descriptions from participants highlight the range of views in the unit:

Simply, we don't trust agency or casual nurses. Therefore, they are allocated the least acute patients because we don't know them. However, the longer they've been here, the more likely they are to be allocated more difficult patients. We have some agency nurses who are very good and are in many respects better than some of our own ICU nurses. [P11: interview]

We had agency nurses who had never worked in ICU before and therefore, [were] considered unsafe by the unit staff. Sometimes agency nurses seemed to not care about providing the required care. They just sit at the end of the bed and play with their mobile rather than offering to help others when needed. Even the simplest of tasks such as brushing the patient's teeth was avoided. [P12: interview]

My experience over the years has been that agency nurses work under significant difficulties. They do the very best they can in an unfamiliar environment and provide the best care they can. What impedes their ability to give good care is the permanent staff who are resistant to the presence of agency nurses in the unit. [P36: interview 2]

With regard to the shift types, there were mixed feeling about working a 12-hour shift. For a number of participants, these shifts were considered too long given the intensity of the unit, especially on day shifts. According to participant P11:

Some nurses find a day shift hard. Working 8-hour shifts is considered enough hours of work. I refuse to work 12-hour shifts because I personally think they are too long and extremely tiring, especially toward the end of the shift. I have been watching the girls do 12-hour shifts for more than 10 years and between three and seven o'clock in the evening, it is pretty hard to get some work done … Everything slows right down. [P11: interview 4]

However, several staff members spoke positively about working the 12-hour shift, especially when it was night duty, as stated by participant P29:

A 12-hour night shift allows you to plan your care in a timely manner. You don't have to rush procedures and it allows you to spend more time with the patient and their family. It is a good time to work with the family in being involved in their loved ones' care, which is virtually impossible on a day shift. The 12-hour shift allows for consistency and continuity of care, which is more difficult to achieve on the rotating eight-hour shifts. [P29: interview]

Conversely, the eight-hour shift was the preferred shift for a number of our staff because of the acuity of patients' health status and the need to be vigilant for subtle yet critical changes that could occur at any time. According to participant P12, 'the eight-

hour shift allows you to maximise your care without draining you emotionally and physically. You have to keep your wits about you at all times and this can be best achieved on an eight-hour shift'.

Nurses were allocated different roles including patient allocation, floating, in-charge and managerial roles, dependent on the unit's needs and staff competency. Nursing staff may be allocated any of these roles. Today a nurse can be in-change; tomorrow, they could be the float nurse and the day after, they may be assigned a patient load. While possible, role changes can create tension between staff, as described by participant P35:

> Nurses need to work well together, but it is really difficult to be in charge of a shift when your float nurse keeps interfering with what you are doing. This sometimes happens when there is a nurse who is usually in-charge is allocated to be the float nurse. What seems to happen is that the float nurse continues to act as if in-charge rather than performing the task of the float nurse. Even though it is not her role today, she forgets and doesn't seem to care about her colleague. [P35: interview]

Additional allocation factor that impedes the provision of care are having to care for difficult patients or family members, which adds to the already heavy workload of staff and may require reallocation:

> Some patients are difficult to deal with. So, the nurses can say: 'look, I've been here six hours, it is someone else's turn now', or if you're seeing the nurse from next door is struggling with a patient, you go and say: 'I think you need to change the allocation, because this patient is very difficult'. [P29: interview]

> Sometimes there is a clash between the nurse and patient as a result of misunderstanding. For example, they [patients] feeling that they had not received

adequate pain relief, or they felt like the nurse was not paying enough attention to them. In such situations, both the patient and their family become upset and request a changing of staff. [P7: interview]

Participant P30 stated that 'there are some nurses who always have two patients like me. It always happens with me … I am going to request now to have only one patient'. [P30: field discussion/notebook 1]

Nurses displayed different leadership styles in ICU and stressed that the adoption of a particular style depended on what was happening at the time. Further, depending on the leadership style operationalised at a certain time, the quality of care could either be enhanced or diminished. According to participant P11, 'the leadership style can certainly affect the way in which nurses provide care for their patients or others'.

A transactional leadership style was primarily used with junior and agency nurses who were new to the unit and required close supervision and guidance. For example, participant P4 clarified this:

> As in-charges, we have to know our staff's idiosyncrasies by knowing their little ways of doing things, skills and motivations. With some nurses such as juniors, casual and agency staff, who are new to the unit, we are very conscious of the need to be there to support them and to gauge their level of competency in providing safe care. [P4: interview]

Four sub-styles of transformational leadership were observed by the researcher in the course of her observation period. These were also described by participants in their interviews: *autocratic, democratic, affiliative and coaching.* First, the autocratic leader makes decisions without considering input or feedback from staff, especially in emergencies where there is no time for discussion. This was witnessed by the researcher in cardiac arrest situations. Participant P10 shared her experiences in such a situation:

At times of an emergency such as a cardiac arrest the whole unit swings into crisis mode while the team lead goes into autocratic mode giving directions. We all fall in behind waiting for instructions. This is a normal process at times of an emergency or a crisis situation where a patient's life is at stake. [P10: interview 4]

The most dominant style of leadership in the unit was democratic in nature, and there was open consultation between staff members. This primarily happened in daily unit rounds. The leaders communicated effectively with their staff and encouraged them to participate in decision-making. For example, senior managers of the unit regularly consult with staff about current practice, policies and procedures. Each person's input is valued, and a consensus approach to decision-making is the usual mode of resolving issues. This was voiced by participant P3, who stated that 'it is important to involve staff in important decisions regarding the running of the unit. Allowing people to share their ideas helps to build an environment of mutual respect and collegiality where everyone feels valued'. [P3: interview 3]

Coupled with the democratic style of leadership was that of affiliative leadership, which involves forming emotional bonds and attachments to create a sense of belonging and harmony. Given the stressful nature of the unit and the propensity for conflict to arise, there were always members of the unit who would step forward in subtle ways to give praise and encouragement to those members of staff having a difficult day:

There are members of the team who take a leadership role to ensure that we all remain connected. They make it their duty to check that all is well. Just giving people positive comments and using comments such as 'what a group' goes a long way to make you feel connected. [P7: interview]

Another form of leadership observed in the unit was that of coaching, which is concerned with practice development and professional enhancement. The CNM and in-charge nurses encouraged staff to engage in ongoing educational opportunities by attending workshops and in-service education sessions both within and outside of the ICU environment. This is exemplified by participant P10:

I applied for a level 2 and in-charge position. I was encouraged by the unit manager and was supported by a level 2 nurses. In the beginning, they taught me what to do and I was buddied with a level 2 staff member until I was competent to work independently. [P10: interview 3]

Servant leadership is underpinned by the philosophy of 'servant as a leader' and is directed towards meeting the needs of others. The researcher observed this leadership in all roles within the unit. Needs were addressed in simple ways such as ensuring that staff took their required breaks and when needed, were given additional assistance to meet the demands of the unit. Laissez-faire leadership was also present within the unit, allowing staff to carry out their duties with minimal interference. The in-charge nurse provided minimal direction or supervision, especially in relation to those staff considered to be experts in their field of practice. During the period of observation, the in-charge nurses were observed to leave the expert float nurses to divide the work between them because they were considered to know exactly what to do. [Field notebooks 1 & 2]

Changing circumstances within the unit gave rise to different leadership forms and no particular leadership style was suitable for all situations. Observational data was validated in discussions with participants about leadership styles. Participants spoke about the need to be flexible and use different styles to fit varying circumstances to ensure that the operations of the unit were not compromised.

There was complete agreement by ICU nurses in appreciating the leadership of their CNM (Kerrin), as evidence by data from observations and field notes, reviewing documentation, interviews, round discussions and PAWIs. There is no doubt that the unit manager—who was viewed by staff as a role model—was influential in creating a caring culture. Her ability to be flexible and work with a range of leadership models depending on the circumstances allowed the unit to run smoothly irrespective of what was taking place. Participant P6 expressed: 'I have known Kerrin for many years and we are lucky here to have her. She is amazing. She is really unique. She knows very well how to treat and manage her staff at all times through providing sound leadership'. [P6: interview]

The camaraderie and collaborative collegiality between nurses were not only valued in ICU but expected as part of professional practice. Overall, the unit atmosphere between nursing staff was supportive and collegial with an overarching expectation of caring for colleagues. Nurses valued working in this particular ICU because there was a sense of friendship and togetherness as well as a general feeling of being a family. They viewed this unit not just as a working place, but as a second home. Most nurses spent significant time together in this unit both providing patient care and sharing social moments, such as having coffee and food together. On many occasions, participants expressed to the researcher that their unit was often a better place to be than home because of a deep sense of collegiality and collaboration, as shown in Figure 7.2.

Figure 7.2. Staff gathering on one occasion.

As participant P8 stated, 'I wear my uniform more than I wear my home clothes. I spend half the time in the unit and half the time at home, so ICU is my second home … we are like a family here'. In addition, nurses spoke of their collegial relationships in this unit:

> We are here as healthcare professionals who value each other and work as a team to achieve our goals. Being supportive and respective of each other is one of the essential values in our unit culture. It has been my experience that staff are generally there for each other. We just seem to watch out for each other, especially in times of significant stress. I genuinely believe that I have the back of my colleagues who really care about my wellbeing. [P14: interview]

However, tensions and collegial conflict occasionally arise between colleagues, resulting in disharmony and disruption of the flow of patient care. A number of participants mentioned situations where they were seeking support or assistance from colleagues and was viewed negatively, as voiced by participants P16 and P26:

> When working with the majority of nurses in the unit, you feel at ease. You know that they are going to help you when you are busy. However, there are some staff who are just difficult to work with [and] who make you feel you are not doing your job well, always picking faults. There is not much you can do about it except

ignoring their behaviour or avoiding them. You may even need to confront them about how you perceive their behaviour. What is important though is to remain professional and avoid personalising the situation. [P16: interview]

Some of my colleagues, rather than talking in a positive manner in front of patients, engage in personal criticism. Such behaviour, although is not a common occurrence, nevertheless it is more frequent than it should be. Such behaviour is against all the principles of providing a positive caring environment. [P26: interview 2]

The ethos of teamwork within the unit was considered of paramount importance and participants stressed the significance of working as a multidisciplinary team:

Our intensive care has a strong team atmosphere. We help our colleagues as we appreciate their help too when we are busy … working as a team allows us to manage any situation whether predicted or unpredicted. In situations that requires a quick decisive decision, it is all to the helm. [P33: interview 2]

We've got our multidisciplinary team on board; that's really important to make sure that the patients' healthcare needs are met. It is about bringing everyone's expertise into the equation; it is like pooling resources to meet the changing healthcare needs of our patients and relatives. Working as a team is like working as a family irrespective of your role. [P23: interview]

The acceptance and rejection of the nurse by the patient/family (and vice versa) is a sensitive issue that nurses in ICU face from time to time. As witnessed by the researcher in the observation period, when nurses are accepted by the patients and their families, it facilitates the provision of care. At other times there were situations when nurses refused to look after some patients and families. Reasons for refusal to care for particular patients and families have been previously discussed (see sections 7.2.1 and

7.2.2). In such situations, strategies used by nurses included being patient, being polite, attempting to understand the situation from the perspective of the patient or family, providing explanations in response to their concerns and providing reassurance, when required. When these all failed, the nurses requested reallocation to other patients.

Participants identified language as a potentially significant barrier to caring for patients in ICU as the language barrier is not limited to patients and extends to nurses. From the perspective of non-Australian nurses for whom English is a second language, difficulties often arose in communicating with patients even though they were relatively competent in English, (see Theme 5, Chapter 6). Many participants who work as in-charge or float nurses indicated that patients occasionally complained of not understanding nursing staff with strong accents:

> We have a few requests from time to time from patients requesting 'can I have a [non-Asian] nurse to look after me'. It is usually just a preference. All of our foreign nurses speak very good English, so maybe it is just the accent that the patients cannot understand. Then the solution is just to change the nurse's allocation. [P12: interviews]

The last component of enablers and challenges in the provision of care in relation to the nurse is 'personal factors', which is presented in two parts: first, attractions and deterrents for nurses working in ICU and second, nurses' personal dispositions.

Through the processes of observation and interviews with staff, a number of factors that attracted nurses to work in this ICU were identified. These included the challenge and variety of the job (every day is different and unexpected), acquisition of specialised knowledge and skills, the rewarding nature of the job, flexibility of shifts and roles and the sense of autonomy, freedom and power. These motivators were the reasons put forward by participants for working in this ICU. In contrast, deterrents included

caring for the deteriorating patient**,** a lack of control in some situations, the extra workload and other displeasures or dislikes.

For many of the participants, the challenge of the job was one of the main attractions for working in this ICU. During individual interviews and roundtable discussions, participants frequently spoke with palpable excitement about the intensity and hectic nature of the ICU environment, as well as the complexity of work, which they found challenging. As participant P10 stated, 'I like the complexity and intensity of ICU; it is a challenging job'. Similarly, participant P12 responded: 'I like to care for very sick patients because it's more exciting; there is always something interesting going on'. In contrast, several participants expressed their unhappiness when caring for deteriorating patients in situations where the nurse feels unable to provide the required care:

> What frustrates us as nurses in the unit is when we cannot do more for our patients who are gradually deteriorating … it is an awful feeling having to witness a patient's condition deteriorate and not being able to change the course of events. [P7: interviews]

> In our unit, we as nurses empathise with patients and their families, knowing they are going through [an] extremely difficult time and trying to understand what is going on and what might be the outcome. It breaks your heart to see your patient's condition deteriorating. Sometimes that affects us … it is never far from your mind, you even think about it at home, which is normal once in a while but not all the time. [P34: interview 2]

There was a consensus between participants that every day is different; no two days are the same. Every day is full of surprises with the admission of new patients, bringing associated challenges for the staff. As stated by participant P18, 'I like the fact that I do not know who I am going to look after. I do not dread coming to work because

it is always a surprise, exciting and interesting'. This option is shared by participant P20, who stated that 'each day our roles change, opening up new challenges. We like to come to work because of the unknown and every day is a surprise'. [P20: informal conversation]

During the fieldwork period, the researcher noticed that all nurses were keen to take every opportunity to enhance their knowledge and skills by having different experiences, as expressed by participant P12: 'When I'm looking after patients, there is always something new to learn each day. Patients are admitted with different histories and conditions'. Similarly, participant P25 stated: 'even though I have been working in ICU since 2006, I continue to learn. The experience I have gained enables me to take better care of my patients'.

Other participants verbalised their satisfaction and view of nursing in ICU as a rewarding job. According to participant P36, 'there's really a deep sense of satisfaction … and you smile on the inside knowing that you've done your best and you could not possibly have done any more'. Similarly, participant P11 stated: 'I like looking after an individual person to the best of my ability. Many times, patients or relatives show their gratitude and say 'thank you', or include our names on a card, or whatever, it's a real reward' (see Figure 7.3 7.3). From the manager's perspective, participant P1 added:

> I care about my staff. I care about who they are and how they're feeling and what's happening to them in their lives. I care about helping my staff in times of need. Really, it's very important to show compassion and understanding. I get a lot of reward and joy out of helping people. [P1: interview 4]

Figure 7.3. 'Thank you' letter from a patient to the nursing staff and students.

A further incentive of working in this ICU was the variety and flexibility of shifts and roles. According to participant P33, 'there is flexibility in our roster, we can swap our shifts if there is a real need … of course, with the manager's permission'. Participant P6 stated that 'you can choose your shift work according to your preferences, whether long or short shifts, day or night shifts'. Similarly, participant P1 said:

> Even I, as the unit manager, do some in-charge shifts and I like to have hands-on patient care. I like working closely with my nurses and the medical staff; this is how I know what's going on. Having such flexibility of shifts and roles allows me to engage with all aspects of the unit. [P1: interview 2]

Nevertheless, a number of the nursing staff expressed their dislike for the float nurse role. Reasons given included lack of continuity of care, being a patient-minder (rather than providing holistic care) and being at the whim of staff. Comments included: 'I do not like floating. Sometimes it is very tiring' (P14); 'when you are floating, you have to have your wits about you and be on the ball all the time' (P4) and 'when I have been in the role of float nurse, I found that staff can be quite demanding of you' (P25).

This was further explained by participant P7:

There are people who do not like the role of float nurse because it takes you away from the actual bedside [and] providing continuous and holistic care to the patient. They do not want the stress that comes with being a float. [P7: interview]

Many participants underlined the importance of having a sense of autonomy, freedom and power, which comes with working in ICU. Participant P29 reiterated many of the sentiments of the participants:

Nurses in our ICU have a lot of autonomy, authority and freedom to make decisions about patient care such as adjusting ventilator settings and extubating patients if required, which they wouldn't be able to make in other situations. People trust and listen to us here. [P29: interview]

Conversely, other participants complained and expressed their dissatisfaction with a lack of control in some situations. Politics that had power, control and an effect on the unit included the budget, staff shortages, delays in getting (general ward) beds to discharge patients from ICU and certain decisions made by doctors because they had the power (e.g., prolonging a patient's life, as discussed earlier). In one of the field discussions, participant P38 stated:

Certainly, there are occasions where we have issues with doctors, nurse managers and hospital coordinators and the bookings people, where somebody wants to bring a patient into the unit and there's no bed or nurse. As in-charges, we adopted the approach that we just say 'yes, we'll accept the patient as soon as we can'… If there is a bed and no nurse, which is more often, I'll just simply say 'yes, we can accept the patient, but we haven't got a nurse yet'. So, I can't accept them until we get a nurse, so then I'll organise a nurse and get back to them. Just we need to be flexible with the bookings people and the coordinators because we can't control things sometimes … Just take it easy. You are going to get that

patient whether you like it or not, so you just need to organise the best you can whether you have to use your float nurse or you have to double somebody up with a second patient. [P38: field discussion/field note 1]

Contending with extra workloads was another major challenge identified by the participants. When staff are under pressure as a result of work overload, these situations affect the use of time, quality of care provided and reactions of staff. As participants P9, P14 and P6 explained:

When the day is as busy as today, it only takes one stressful moment or somebody to lose their temper and the day begins to deteriorate. On days like this, we [nurses] worry for our patients and co-workers, especially the team leader. Mistakes are made in these conditions. The pace and pressure are exhausting to maintain quality care in the unit. [P9: field discussion/notebook 2]

When it is very busy in the unit, it has the potential to impact on nurses' capacity to care … things are overlooked and therefore, don't get attended to. This is not to suggest [that] nurses do not care, but rather a matter of work overload. Everything ends up being done in a rushed manner. We've been too busy to do all the little bits and pieces that are nice to have done, which sometimes makes it hard to talk to patients as there is a pressure to attend to other tasks. [P14: interview]

The unit staff have to deal with many things at once: admissions, discharges, Blue Codes, for example … in such situations, it is difficult to complete all your duties. You are continually on the go and at times, it feels like I am chasing my own tail. Like, what is going on? [P6: interview]

During the field observation period, the researcher noticed that several tasks performed by nurses were essentially outside their normal practice capacity. This was

because the ICU received patients who would normally be admitted to the general wards but were admitted to ICU because of a shortage of beds. Also, cardioversions cases were performed as an additional task for the unit. Another facet of the extra workload was that unit staff are periodically required to respond to MERTs and Blue Codes, which require them to leave ICU for a period of time. This increases the workload and subsequent stress on staff in the unit. In addition, when there is shortage of staff, the workload is elevated, which affects the staff's ability to care for each other. Further, supervising students, having to work with inexperienced staff and caring for patients outside the unit (e.g., when nurses went to general wards for tracheostomy care or cannulation) and the expansion of the nurses' traditional roles all contributed to the workload. On one occasion, the researcher and participant P2 discussed the float position:

> **Participant P2**: We have to respond to the MERTs calls or Blue Codes. Sometimes it can be really busy and such situations are unpredictable. When an emergency is called, it puts pressure on everyone to assume the workload of those who are in the emergency team.

> **Researcher**: I heard that sometimes you attend MERTs and Blue Codes for two to three hours.

> **Participant P2**: Yeah, sometimes that happens and it can be so busy in the unit. ICU nurses are more competent than ward nurses in these situations, and they need our support. [Field discussion/notebook 1]

Participant P3 said that 'sometimes the students chew up a lot of time … creating opportunities for their learning. Supervision of students is in addition to our normal workload, which more often than not puts additional pressure on staff'. Thus, another matter that nurses generally dislike in ICU is working with inexperienced staff. For example, junior, casual or agency staff who are new or unfamiliar with the work of the

unit were sometimes considered by participants to be more of a hindrance than a help, as time had to be allocated to explaining, guiding and double-checking their work:

> Agency staff make it harder because they do not know where anything is and you do not know what their skill levels is [*sic*]. As well, junior staff make it harder too because they are still learning. It is good to have an orderly who knows where everything is and physiotherapists who know what they are doing and being able to get the agency or casual staff who know what to do in relation to completing the paperwork. [P7: interview]

Consequently, there is a cultural dynamic of expanding nurses' traditional roles in ICU. There is a strong commitment and ethos to patient-centred care and nurses were strong enough to expand their traditional role because they valued growth beyond this role. Nurses like challenges and want to be involved and valued through three current streams, which currently distract them from patient-centred care: medicalisation of care, technolisation and willingness to change their role, as concluded by the researcher, *(*Figure).

First, medicalisation of nurses involves being more closely aligned with the medical staff and doctors' work to enhance their self-esteem, self-image and role. Another reason for nurses to accept some medical tasks is that they can undertake these tasks and adapt them to suit their nursing schedules. It is interesting to note that nurses in ICU take the expanding role and define it in the situation of work overload and busyness. The result is that they aim to cope with work overload instead of relinquishing the extra work and expanding role, which is a major contributor to overload and stress. During the period of observation, the researcher noted instances of nurses extubating patients and removing their chest drains, which led her to ask a number of participants: 'Don't you think that when nurses extubate the patients, [it] is an extra job or extra

workload for ICU nurses?' Interestingly, all participants responded in the same manner as participant P1:

> No. It's not an extra workload. ICU nurses are very technical people and they like the challenge and they don't want just to be washing people's backs … that's not what they're here for. Extubating and taking lines and drains, that's part of their job and skills and it's never ever been an issue. [P1: field discussion/notebook 2]

For technolisation, several ICU nurses move into the realm of high technology and a more medical role (e.g., adjusting ventilator parameters according to ABG analysis). This enhances their third expansion goal by demonstrating their willingness to change their roles and daily nursing practices. They believe that some tasks should be assigned to a lower level of health carer, as participant P26 suggested:

> Caring in ICU will continue to be get harder and busier; it will be more technologised and we're [nurses] expected to perform a more medical-type role and nurses will be expected to take on more work in a short time, where caring starts to go by the wayside. Then those little things that our patients love, we may not be able to do for them anymore. Nursing might end up with getting lower levels of health carers and their job will be to do that type of caring. [P26: interview 2]

Participants described a culture shift towards increasing emphasis on the technological aspects of care, which seemed to be prized above basic nursing:

> With the increasing complexity of ICU and the need for high-level competency in the use of medical technology, the role of nurses is changing. The medicalisation of the role of nurses in the unit has changed in the way nurses provide care. Patient acuity, increasing complexity of treatments and time

constraints means that person-centred care is in danger of going by the wayside.

[P26: field discussion/notebook 2]
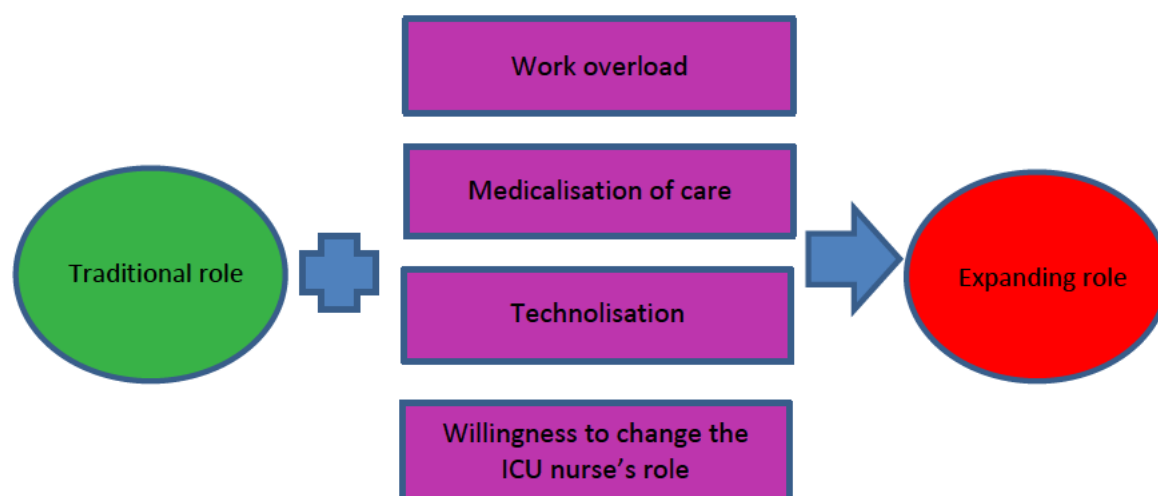
Figure 7.4. The cultural dynamics of expanding the nurse's role in ICU.

Other dislikes mentioned by the participants were attending to the patient at times of bodily discharge, having to wake a patient from sleep, having insufficient time to be with patients and their relatives and not being able to take scheduled breaks because of work commitments.

Two of the main areas in which participants expressed their aversion to attend to the needs of patients were cleaning up after faecal discharge or the suctioning and disposal of sputum. Such situations were observed by the researcher on more than one occasion. However, despite their dislike for these tasks, staff did not allow their personal aversions to interfere with the quality of care provided. During one period of observation, three staff were attending to one patient, who was experiencing some faecal discharge and required a complete linen change. Between ensuring that the ETT and monitor leads remained in place, the staff were able to carefully negotiate cleaning up the patient and changing the bed linen. Although the nurses seemed to be experiencing some discomfort at the odour, they did not let the patient become aware of how they felt.

Participant P22 was overheard speaking to a patient who had been rolled onto one side, away from view of the nurse's facial expressions. Participant P22 spoke to the patient in a sensitive manner, asking him, 'do you want to defecate?' The patient replied 'yes' and P22 responded, 'ok. One moment; I will get you the bed pan'. However, the nurse's facial expression indicated that this was not a likeable task. [P22: field notebook 1]

Another participant acknowledged the displeasure of sucking secretions and sputum from patients. Participant P37 said: 'I really don't like patient's sputum'.

Discharging patients from ICU was another procedure that participants disliked:

In intensive care, you do a lot of moving and transferring of patients. It is a complex process, having to arrange and move someone to the ward. It involves collating all essential paper work et cetera … and then [you] spend a lot of time cleaning up when you come back to the unit … and then you need to prepare for admission of the next patient. [P25: interview]

Most nurses in the unit expressed concern about what they sometimes perceived as a lack of continuity in patient care because of high patient turnover:

At times, there is a lack of continuity of care in ICU, the nurse has a patient for today and probably might have him again next week or might not. We need to have continuity of care, although it can be a double-edge[d] sword. For instance, when you have your patient for like three 12-hour shifts in a row; on one hand, you might like the continuity of care and watching someone improve and be discharged from the unit. On the other hand, if the patient's condition deteriorated and you were assigned to that patient for three long days, you are entirely exhausted. [P27: interview]

Several participants expressed their dissatisfaction that nurses from time to time miss out on scheduled breaks or are required to work beyond their shift because of the busyness of the unit. Participant P16 said: 'every so often when I am in the float role I may not get to lunch until three o'clock, and not being able to leave work [after night duty] until 8:30 am, especially on Fridays …when I am only paid 'til 7:30 am'. Similarly, P7 explained that:

> Being in-charge or floating is stressful because you are busy all the time and you do not get an opportunity to go to lunch until everyone has been … but that is just the job. Sometimes I have my lunch at 3:00 pm … I do not like the politics of being in-charge. [P7: interview]

Waking up the patient from sleep just to attend to pressure care or washing patients at five am was another activity that the participants disliked. This was articulated by participants P4 and P15 who said that 'what is annoying is having patients who are sleeping and resting comfortably and you have to perform pressure area care which requires you to disturb their sleep' (P4) and 'what I dislike in general, is washing patients in the morning … especially at five am. I do not think that is nice' (P15).

The second part of nurses' personal factors relates to their personal dispositions affecting their willingness or ability to provide care. This includes exercising personal spirituality, being pedantic, not 'pulling their weight', being selfish and allowing their personal lives to intrude in the workplace.

A number of participants spoke of the importance of having faith or belief in a higher power, which was a source of strength for some in dealing with daily crises in the unit. Participant P36 stated: 'I believe that if people have a strong belief system, it can be a buffer to the daily trauma in the unit and be a sustaining force in providing quality care despite of [sic] the situation. However, that doesn't mean that atheists can't

also provide quality care'. Participant P5 echoed similar sentiments in stating: 'I am very spiritual and that helps me if I have a problem at work with a patient, family or colleague'.

The importance of being pedantic was raised by a small number of the in-charge nurses as essential to reduce the possibility of error in the unit; however, being pedantic was also viewed as impeding the process of caring by participant P3:

I delegate things to the floats and they know what they have to do. However, I like to make sure things are done well. Even though I trust them, I still need to check on what they are doing, which sometimes interferes with the nurses' ability to care. I sometimes blame myself for being too pedantic. [P3: interview 2]

A number of participants were derogatory about some of their colleagues who they considered to be lazy in the workplace. Participant P7 stated that 'some nurses ask the float nurses to do things which they could do themselves because that is their expectation of the floaters, that they will do anything'. Participant P35 that 'some people don't consider anybody else …they are not a team player and they are the same people every time, so it is laziness'. Participants spoke of the need to confront these people, as stated by participant P1:

If we have nurses who are not really pulling their weight while others are working really hard, as a manager, I will speak to them: 'you need to help on the other side, you need to be more attentive and your time management wasn't as good as it could have been'. [P1: interview 4]

Selfishness was another concern that was raised by the CNM and other in-charge nurses:

There is a group of nurses who always make demands because it is all about them and they don't care about their colleagues. They expect to have everything they want such as the shifts they want. They are very selfish. Selfishness is not good

for us as a team who [are] supporting each other in the unit. I need to be fair with everybody here. [P1: interview 1]

There was general consensus by participants that the nurse's social life can affect patient care and safety, especially when the patients' notice the body language of a nurse who is having personal life issues. On such occasions, the patient is often reluctant to seek assistance and thus, these situations are discouraged in the unit. To avoid them, staff are encouraged not to bring personal issues into the workplace. As expressed by many participants, P6 stated that:

A person's private life definitely affects us and our ability care at work … we should try and put all personal issues aside … We [nurses] cannot always do that because we are human and we are not programmed to separate our social life from our work life completely. It is quite difficult when nurses come to work so upset. It is better to call in sick rather than compromise patient care and safety. It is important to be prepared to work. [P6: interview]

Another participant, P34, echoed this sentiment in stating that:

If our nurses have significant family issues, they simply shouldn't be at work. They should call in and take family or sick leave because it is not safe. They could make mistakes. It could affect their care ability to provide safe care. [P34: interview]

As observed in the field, nurses cared for each other. In situations in which staff were unable to work or required leave from the unit for personal or family issues, staff supported them by reducing their workload, keeping a close eye on them and where appropriate, assisted them to seek professional help:

Unfortunately, some nurses come to work and they are distracted with their family problems, and they might miss things at work, then that is where the team

all come together, where the float or in-charge nurses can pick up and support them through it. [P7: interview]

7.2.4 In relation to the ICU environment.

The fourth source of enablers and challenges to caring in the unit was the ICU environment itself and several factors therein were identified by participants. The main sources were the nature of the ICU layout, noise and distractions, resource availability and the nurse–patient ratio. These were significant challenges, which the participants faced on a regular basis within the unit.

7.2.1.1 ICU layout.

A number of participants expressed their dissatisfaction with the design/layout of the unit and, in particular, the size of the rooms. These are viewed as getting smaller and more restrictive, especially when extra machines (e.g., haemodialysis equipment) are required. Coupled with no access to windows or balconies, this increased the perceived restrictive nature of the unit:

> Sometimes when a patient requires to be put on haemodialysis, we struggle to find space. Everything is so cramped with little space to move. The layout of the bay itself can be annoying when we are carrying out procedures. [P18: interview 2]

> I don't like the setup here in the unit … no windows for the patient. Sometimes when you are caring for someone who has been in the unit for over 20 days, they get bored … looking at the ceiling … if they only had a window to look out, it would make a world of difference to them. [P17: interview 2]

7.2.1.2 Noises and distractions.

Participants viewed noises and distractions as another impediment to the provision of care as staff were often distracted by alarms, smells, lights and phones

constantly ringing, coupled with incessant activity in the unit. During the period of observation, many of these distractions were witnessed. For instance, the noise level of the unit at handover between shifts appear to disrupt the flow of communication, resulting in important information about the health status of patients and families not being conveyed. This led some nurses to suggest having their handover in a quiet place (the CNM's office) or asking the receptionist or float nurses to respond to distractions like phone calls, families, doctor's inquiries or unattended alarms. As stated by participant P36:

> Ironically, we dislike unattended alarms … going off all the time. However, there is no dispute about their importance. What we have to do is to make sure the alarms are set appropriately, so that when the patient lifts his arm to have a drink, the alarm does not go off. Otherwise, you will end up with alarm fatigue. [P36: interview 2]

> Participant P37 explained how nurses respond to (and cope with) the distracting

noises in ICU:

> Nurses in our ICU try to minimise all noise as much as possible by controlling the environment, by having a rest time for patients and families from 2–4 pm and by attending to phone calls, buzzers and beeps. Also, at night if patients are complaining about the lights, we try to have minimum lights … and use a flashlight when necessary … we try not to disturb patients; we close the curtains and minimise the staff chatter. [P37: interview 3]

7.2.1.3 Resource availability.

High resource availability in ICU boosts the ability of staff to provide the necessary care to the patients and their families. Conversely, the absence or shortage of resources—which, within the context of the unit, are human, material and financial in

nature—makes caring in ICU difficult. Human resources include health professionals, counsellors, ministers of religion, receptionists, students and volunteers. For example, participants appreciated the continuous accessibility of medical staff, especially doctors who could be contacted for emergencies, writing of treatment orders or clarification about patient management. Participant P34 said that 'one of the reasons that our nurses like our unit is because doctors are around; they are here 24/7 for any emergency or in case of any concerns or problem'. Further to this, when the original ICU nurses are available, the rhythm and routine of the work run smoothly and easily because they are familiar with their own ICU environment and system. However, at times of staff absenteeism (due to sickness or leave backfilling) problems may arise, necessitating the employment of agency nurses. They are generally unfamiliar with this unit and therefore, require orientation and follow-up to ensure appropriate care is being given. In such situations, care can easily be compromised and behaviours to this effect were observed by the researcher in her period of observation.

Another example was having access to an interpreter when language was an issue. This enabled nurses to gain information from the patient and their family and to be able to communicate what was happening to them. However, interpreters are unavailable, communication is impeded and care can be compromised. Counsellors play an important role in providing support for both patients and their families throughout the period of hospitalisation. Counselling is highly valued, especially in relation to the acuity of the patient's illness and the life and death situations, which are a regular occurrence in the unit. Counselling is also available to staff if needed for debriefing and support.

Students could be a resource. For example, some participants found students useful, especially when the nurses were busy caring for two patients, as expressed by participant P35:

Sometimes you have a good student, which is a great help when they are confident to document OBs [observations and vital signs] and can provide basic nursing care. It helps a lot when you have two patients. Their contribution to the care of patients can be substantial. [P35: interview]

Conversely, other participants considered students another burden. Overall, the complex culture of care in ICU does not benefit students, because they cannot really get involved in patient care because their role is primarily observational. At times, tension can surface when staff are reluctant to assume a supervisory role (especially for undergraduate students) because of the complexity of the ICU, which sometimes takes nurses away from patients when they try to educate their students.

Further reasons for not wanting to supervise students were that nurses sometimes felt overwhelmed or exhausted because of their workload or were simply disinclined to mentor students. During her fieldwork, the researcher observed this behaviour on four occasions. In further discussions with participants, the patient was emphasised as the first priority. Participant P25 stated that 'firstly, our duty in ICU is to care for the patient. It's hard having a sick patient, family and a student. Sometimes nurses feel the student is like another patient that needs a lot of time!'. According to P7:

Students are an extra load in ICU and we have to slow our pace down to teach them, which interferes with the caring process. Intensive care is not a setting that students should be in full-time because they are not going to learn the basic skills that they need. It is time-consuming for nurses who have students because they [nurses] are having to be with them all day and that exhausts them. [P7: interview]

Technology is considered an essential enabler of caring in ICU. Nurses were aware of the need for balance in looking after both patients and technology, as maintaining machines is part of caring for patients. Participants view the approach to the

use of technology to provide care as balanced. They use technology to enhance rather than obstruct patient care:

> You cannot have intensive care without monitoring and technology. You walk into the unit and see ventilators, drips, monitors and it is all a bit overwhelming. Many junior nurses get caught up in the technology and they actually forget the patient in the bed. We have to put it into perspective that we need to do both; looking after the technology is essentially looking after the patient. [P1: interview 2]

> The use of technology is central to providing optimal care, given the acuity of the patient's health status. The complexity of the technology can, however, detract from the person-centred approach to care (the human element to care). We are always mindful that technology is pivotal to what we do in ICU, which without it patients would die; however, it does not take the place of the health professional but rather complements what nurses do well by providing person-centred care. [P33: interview 2]

Participant P19 stressed the importance of prioritising maintenance of machines and equipment for the safety of the patients at certain times:

> Yes, ICU patients are sick and need psychological support during their illness experience. However, in the acute stages of a patient's illness, priority needs to be given to what can be called technological care such as the use of machines and drips. In many respects, the rest has to be put on hold until the patient is stabilised. [P19: interview]

Participants presented a wide range of reasons for wanting to work in this highly technological environment. Some participants believed that it is better for patient recovery and that the work is easier, quicker and more accurate. In addition, technology

provides the opportunity to spend time with patients and their families. Further, it gives nurses a sense of personal satisfaction and professional importance because they are highly respected and acknowledged for their expertise:

> I am a technical person and I love new technology because it works better for everybody. It gets the patients better and out of here faster. I spend a lot of time learning about how it all works and making sure everybody is familiar with it. [P11: interview 3]

This satisfaction was articulated by a number of participants, who stated that 'using technology enables nurses to provide a better level of care in some aspects because most of those patients would not be alive without it. Technology saves lives and time' (P25). P29 discussed how 'technology makes life much easier for us when you have monitors such as IV infusion pumps which are easy to set up and can accurately record the health status of the patient. Without technology, you'd be a lot busier' (P29). This opinion was shared by P33 and P19, who stated that 'technology helps us [nurses]. We have more time to spend with the patient rather than standing there and counting the IV drops or measuring vital signs' (P33) and 'when we [nurses] use technology it makes us feel important. It is the feeling of accomplishment when you have battled all the day to keep your patients alive by using all the surrounding machines'. [P19: interview]

The budget as a resource that can affect patient care in both positive and negative ways. For example, when ICU is appropriately budgeted, the CNM and the in-charge nurses can request agency nurses, if required. However, when the budget is restricted, it is difficult to employ extra staff from the casual pool or the agency. In such situations, staff shortages because of budget constraints can lead to patient care being compromised. Therefore, with each shift, consideration is given to what should constitute the required number of staff in relation to the changing healthcare needs or requirements of the

patients and the unit budget. Participant P1 stated that 'our in-charge nurses need to take in[to] account the budget concerns when they request casual or agent staff in case of shortage or absence of the staff'. During her period of observation, the researcher witnessed many occasions where the in-charge nurses had to contact administration to seek permission to hire additional replacement staff.

7.2.1.4 Nurse-to-patient ratio.

The nurse-to-patient ratio was another important factor for caring in ICU and depended on the patient's condition. The ratio is usually one-to-one, which allows for continuous monitoring of the patient and a quick response from health professionals when deterioration of the patient is detected. Participant P38 said that:

> Being able to provide one-to-one care is consider[ed] by the unit to be appropriate, as it allows for continuity of care and ongoing observation and management. It allows the staff to be able to monitor any subtle changes in the patient's condition and respond quickly. Having one patient in ICU allows the nurses to develop a close relationship with their patients through being able to spend more time with them and their families. [P38: interview]

Nevertheless, at times it was observed by the researcher that nurses were required to care for two patients if they were not intubated and stabilised— and there were times that staff struggled to provide the required care. Participant P23 experienced such a situation:

> When the ICU nurse gets two patients, it is quite hard, especially if one patient's health status deteriorated. Sometimes the outcome of such situations was for the nurse to focus on the more critical patient and therefore, not spend the same amount of time with the other patient. [P23: interview]

On some occasions, nurses were required to care for three to four patients as a result of ward patients being transferred to the ICU when ward beds were unavailable. According to participant P7, 'usually we get ward patients when there are no beds available in the general wards, and then the nurse in our unit is expected to get three to four ward patients'.

7.3 Negative Cases of Caring in ICU

In exploring what constitutes a culture of caring within an ICU, the researcher also considered the presence of non-caring behaviours or negative cases in the unit. The process of confirming and disconfirming cases pertaining to a particular aspect of a culture—in this case, caring—is an important consideration when undertaking ethnographic studies (Katz, 2001; Polit & Beck, 2017). Negative cases can be displayed in people or places or events (Brodsky, 2008). The process of identifying negative cases was primarily done through both observation and interviews rather than simply relying on what views participants shared with the researcher (Boswell & Cannon, 2011; Holloway & Wheeler, 2010). Here, the researcher searched for 'non-caring' behaviours (Brodsky, 2008; Saumure & Given, 2008), which assisted in refining the data analysis of this study (Mays & Pope, 2000). The researcher identified cases in which participants exhibited non-caring behaviours with patients, families, colleagues, themselves (oneself) and the ICU environment. Examples of each of these follow.

7.3.1 Towards patients.

In one of the field conversations, participant P13 stated that 'not to care is not paying attention to the patient's needs', as illustrated by participants P9, P26 and P16:

> Some nurses do not engage with the patients … they [nurses] might just be sitting there reading a magazine and not paying attention to what is happening with their patients and they are paying more attention to their mobile phone … that sort of

thing. You do not have to be chatting to them [the patients] all the time … but if somebody wants to say something or get your attention, you need to be aware of that, such as [for] pain relief. [P9: field notebook 2]

Occasionally, you see people from the start of their shift sitting in front of their desk, reading something or looking at their mobiles. I always think, 'where do these nurses get all this time to sit at the desk?' It is like the same people doing it, so I just think that they probably do not do those extra things, they probably go in, do their OBS, do their medications, do the minimum of what is expected of them to do and then they leave their patient and do their own things. [P26: interview 2]

The way some nurses act is quite offensive when they are not communicating with their patient. These nurses prefer to sit tapping on their phones at the nurses' station and even at the bedside where there is a patient. That might be appropriate at night, when everyone is asleep but not during the day … this still happens. [P16: interview]

Similar sentiments were expressed by participant P36 in stating:

Sometimes you just seem to focus on patients' physical wellbeing; if they have pain or [are] uncomfortable … but it is that emotional connection that is sometimes missed. Sometimes I lose that connection with myself. When that happens, I cannot have it with someone else and that is what gets left out of the equation when you are having a bad day. [P36: interview 2]

During the observation period, the researcher noticed that what participants P26, P16 and P36 articulated in their interviews was evident in the practices of colleagues; some nurses used their mobile phones at the bedside and the nurses' station and certain staff did not communicate with their patients. [Field notebook 1&2]

Participant P31 once viewed an uncaring nurse performing a rough cleaning on her patient:

> People do not think a lot when they do simple things like when they wipe a patient's bottom, some nurses are really rough. Would you wipe your own bottom that hard? They should consider what it is like being in the patient's position. [P31: interview]

Participant P2 shared her thoughts about having to remind some colleagues to attend to procedures in a timely manner:

> For example, the chest drains should be removed in the morning or prior to returning the patient to the ward. At times, nurses don't follow through with what is required but rather just sits there and they [nurses] do not withdraw the drains … So, if I am on a round, I will always push them saying 'this one need to be done before lunch. Can you please go and do it?' These nurses are not bad nurses but [are] not as diligent as others and can be careless at times. [P2: field notebook 2]

Occasionally, some staff 'take the easy road' and do the bare minimum. As articulated by participant P37, 'there are some lazy nurses out there. It is so annoying to take over from one of them and to wonder if the poor patient received any care … by how the patient looked'. Similar sentiments were expressed by participant P35:

> There is no excuse really … you have got a job to do. It might be that you are tired or something else is going on … but if it keeps happening, the same persons are not doing their job. Some people are just not team players and they do not consider anybody else but themselves. [P35: interview 2]

In one of the conversations at the nurses' station, participants P15 and P9 agreed that patients sometimes complained:

Occasionally I have been in the position that a patient has clearly indicated that the care they have been receiving is not good enough. I have sometimes heard the patient say, 'I told the nurse I was feeling this way and they did not do anything about it' (P15)

'Yes, that can happen with me too' (P9). [P15 & P9: field notebook 1]

In a discussion with participant P1 about lack of care for patients, her response was that 'some junior nurses get caught up in the technology and actually forget that there is a patient in the bed, which I always drum into new nurses'. [P1: interview 2]

In the observation period, the researcher witnessed some incidents that she considered examples of a lack of care for patients: needles covers and empty medication ampoules/vials were left around the patient, not disposed of and ECG lead patches that were not in use were not removed from the patient. [Field notebooks 1 & 2]

Participants also spoke of handovers as an indication of whether the staff actually cared about their patients:

At times in the handover, you can see whether nurses care for their patients or not. The very language they use, the way they speak about the patient and their focus on tasks rather than the person, having no eye contact with the patient and giving a half-hearted handover … obviously, that means she doesn't care. [P8: interview]

7.3.2 Towards families.

The researcher witnessed three cases of uncaring behaviours by nurses towards families. The first case occurred when one patient was laying in an elevated bed and his wife was standing most of the time. The allocated nurse, P29, spoke nicely to the patient and his wife but she did not lower the bed for the wife to see her husband and did not offer her a chair to sit. The second case was when participant P31 kept relatives waiting

outside at visiting time for no reason; she was not busy with the patient at all and she asked the relatives to wait outside for half an hour, which surprised the researcher. The last case was when one of the patient's relatives was experiencing significant distress about her husband's health. The assigned nurse, P32, did not take any action to support her in this situation: participant P32 did not communicate with the relative, kept herself busy and then withdrew to the nurses' station to avoid the relative. [Field notebooks 1 & 2]

7.3.3 Towards colleagues.

The researcher observed that sometimes when the unit was very busy with admissions, those who were not involved did not offer to assist but rather continued to either sit by their patient or sat in the front desk, despite having little to do. [Field notebooks 1 & 2]. Participant P36 shared her thoughts about how she sometimes becomes annoyed and hurt by a colleague:

> We're just a bundle of human personalities working together and sometimes we barb up against each other … sometimes we just need step back from those people and go and find someone else to help … For example, one colleague in particular, when she floats, she always addresses the patient and tells the patient what needs to be done without speaking to me very much. [P36: interview 2]

In one of the informal conversations, participant P1 mentioned another situation where some nurses were uncaring about their colleagues:

> There is a group of nurses who always make demands because it is all about them and they do not care about their colleagues. They expect to have everything they want such as the shifts they want. They are very selfish. [P1: field notebook 2]

The researcher observed another case when a number of participants took long tea or lunch breaks, which affected other staff member's allocated break times. This

behaviour was described by participant P9 as unacceptable in stating that 'some of the staff take more than the allocated time for lunch breaks. They have got to do meal relief … you can't take 45 minutes for lunch, where everyone else is only getting half an hour' [P9: field notebooks 1].

Participant P2 described another aspect of an uncaring attitude: 'there is one group of nurses from overseas who always talk to each other in their own language despite other nurses being present. This is very disrespectful of others and most unprofessional' [P2: interview 2].

7.3.4 Towards oneself.

There was a small number of participants who exhibited a lack self-care and two examples are presented. Participant P3 was observed as being thorough in his care of his allotted patients, while also acting as the in-charge nurse. At times, he was required to multi-task, attending to the complex needs of both his patients and staff. Throughout the period of observation, it became apparent to the researcher that participant P3 was, for the most part, operating by himself without assistance from colleagues. His meticulous attention to detail to ensure quality care required time when he was actually time-poor. At times, he designated tasks to other members of the healthcare team but continued to assume the majority of the care activities for his patients. At times, this resulted in him not taking allotted breaks. As explained by participant P3 in one of informal field conversations:

> I delegate some stuff and most floats know what they have to do … if they are sitting around and you are busy right now, you say, 'look guys I cannot get around there, can you go and write this one up for me' or 'you can do such and such' because I need to do something else. Sometimes, you just go to the beside and there is problem … which takes all your time working things through, when you

could just delegate these jobs to others, but I like to make sure things are done well. Therefore, sometimes I blame myself for being too pedantic about things. [P3: field notebook 2]

Similarly, the researcher observed participant P31 continuing to work alone, even when some tasks needed assistance from other colleagues. When questioned as to why, her response was that she preferred to do things on her own rather than asking for assistance, despite at times feeling exhausted and overwhelmed:

Researcher: I saw you more than one occasion washing your patients' long hair by yourself. What about asking for extra hands from the floats to help you?

Participant P31: Normally I don't ask for help … this is me and people know that. I prepare and organise everything … I do not normally ask for help.

Researcher: What about when you need to turn your patient?

Participant P31: Yes, for sure when I need their help. Only, I ask if it is part of their job or what they are supposed to do, but I do not ask for extra things. I do not normally ask for help.

Researcher: In taking such an approach, aren't you making your job a little bit hard? Doing things by yourself isn't a big burden? What about if somebody can give you extra hands, wouldn't it be better?

Participant P31: I am happy to do my own things from A to Z. It is not that I do not trust people to do it, but I feel more happy [*sic*] if I do it by myself … if I cannot do it, yes, for sure, I'll ask for help. [P31: field notebook 1]

7.3.5 Towards the ICU environment.

Throughout the observation period, a failure to care for the environment was observed by the researcher on a number of occasions. This was also articulated by a number of participants who said that 'there are some nurses who are very messy, which

is a constant source of annoyance. Sometimes I do not know what people do in the eight hours or 12 hours they are here'. [P37: interview 2]. Likewise, participant P25 said: 'you get to know people because you work with them for long enough and sometimes it does not matter what workload they are allocated, they will always be in a shamble … no matter what kind of patient they have'. [P25: interview]. Equally, participant P33 shared her thoughts:

> In the ICU environment, you look at the room and you can say 'okay, if the patient is very sick and very needy, you cannot blame the nurses who leave the room in a mess'; but if the patient is stable and only in need of basic care and still the bay is left in a mess—things are just thrown everywhere … the bay is not clean … and the nurse has not done her job. [P33: interview]

Similar sentiments were expressed by participant P1 who, on a number of occasions, found herself having to clean up after staff, see Figures 7.5 and 7.6):

> Oh, I am a neat freak (laughter) … I like things in place and in order … if I'm walking in the front door in the morning and I see linen trolleys overflowing in the corridor, chairs up against the wall, the restocked trolleys in the middle of the corridor on an angle and blocking peoples' path. When I see beds shoved against the wall, not stripped and all the dirty linen on top of it and there [are] 17 empty half bottles of water and 16 coffee cups and the rubbish bins are overflowing … that is not good and not safe too. Then, you can see everyone is sitting around the nurses' station. So, I have to lead by example … I'll go out and my staff know now 'oh God, Kerrin is cleaning', and they all start to clean and I get this thing, 'alright I'm doing a tidy round' … I will push the restocked trolley up against the wall out of the way; I will move the linen trolley, empty a trolley or rubbish bin … I know there are times when you can't tidy things … it's just a mess and that's

just the way it is … But I like to have my environment presented as the best I can

to the organisation and the public and I expect the same of staff. [P1: interview

2]
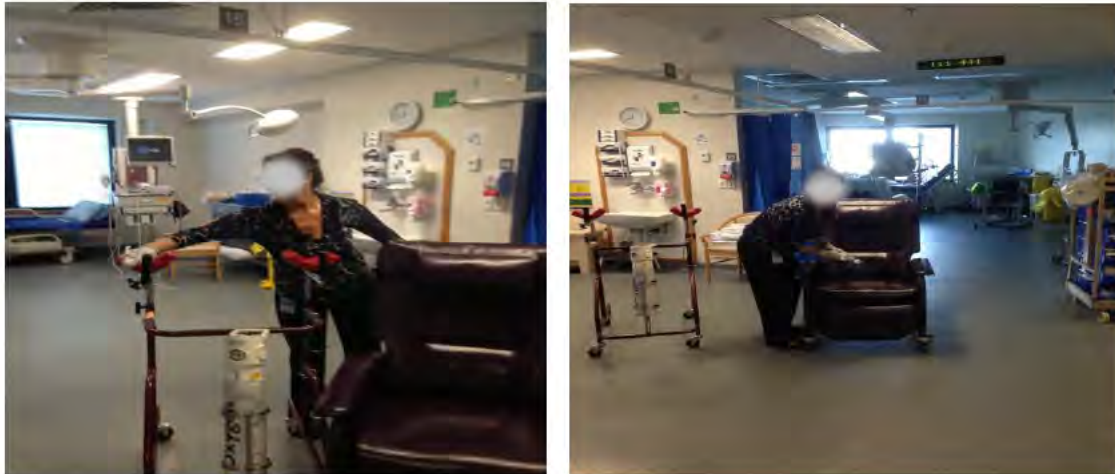
Figure 7.5. The unit manager in a tidy and cleaning up round.

Figure 7.6. Food and water bottles left on the bench for days.

A further case in which there was a lack of caring for the environment was

described by participant P35, who explained:

'On one occasion, it was hard to communicate with a patient, so I got one of the

communication instruments [see Figure 7.7] to assist in communicating with him.

Unfortunately, it did not work; it was not charged and they could not find the

charger. After a few days, I checked the instrument, which was still not working.

I checked with other nurses who seemed not to care about fixing this issue'.

From the researcher's point view, this was an example in which a lack of caring

for the environment in ICU was evident. [field notebook 1]

Figure 7.7. A communication instrument used with ICU patients.

In this section of the findings, the negative cases of the absence of caring were

discussed in relation to patients, families, colleagues, oneself and the ICU environment.

The next theme to be discussed is nurses' patterns of caring in stressful situations.

7.4 Theme Seven: Patterns of Coping with Stressful Moments by Nurses in ICU

7.4.1 Introduction.

Stressful moments are a regular occurrence in ICU as a result of the acuity and complexity of patients' health, the need for rapid responses to critical events, working with complex technology and having to contend with demanding workloads. The staff coped with stressful situations on both an individual and a unit level. On an individual level, staff appeared to cope with stress by taking time out, being selective in what roles and tasks they undertook, taking a pragmatic stance in expecting and accepting the worst scenario and maintaining a sense of light-heartedness. From a unit perspective, strategies for coping with stress were an open-door policy, task delegation and a collaborative and supportive manner (see Figure 7.7).
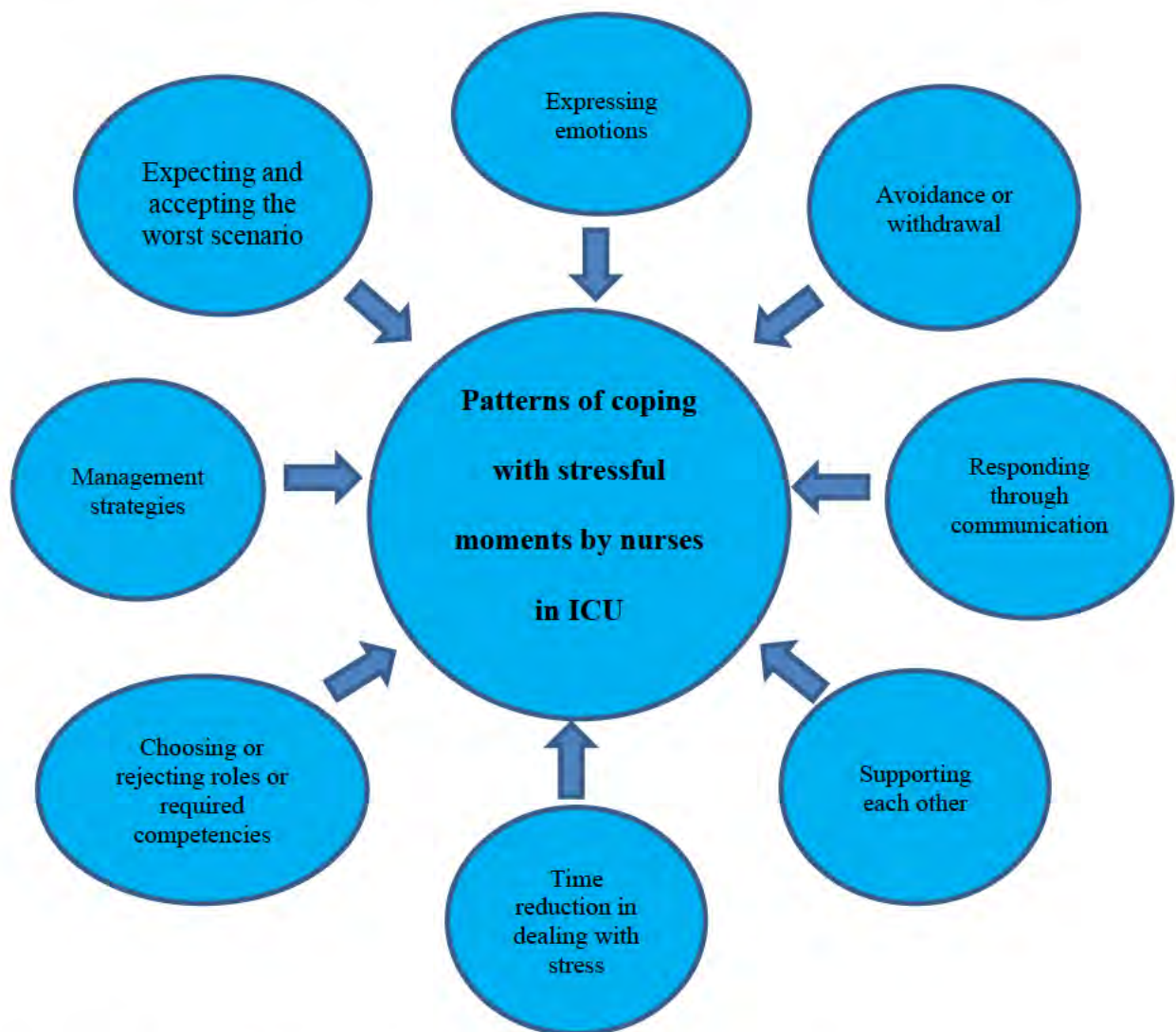
Figure 7.7. Patterns of coping with stressful moments by nurses in ICU.

7.4.2 Emotional responses to stress.

During stressful moments in which participants felt overwhelmed by what was occurring in the unit, they highlighted a need to express their emotions, which primarily took the form of being tearful. On several occasions during the observation period, the researcher witnessed members of the unit needing to step aside and take time out to regain their composure after becoming tearful. When questioned about how they felt about expressing their emotions in stressful moments, the general consensus among participants was that colleagues considered crying a natural response and an accepted form of expression, as articulated by participants P3 and P5:

I do not think there is anything wrong with crying if we become stressed, as long as it is not over the top. It is a natural way of letting go. It happens to all of us at some time. The types of things we have to face can be very distressing at times. [P3: interview 2]

Sometimes you get emotional; you cannot help it … There was a young patient dying from cancer. She had three small kids—6, 8 and 10 years [old]—and their dad brought them in … My back was turned to those kids because I could not face them … I was crying. I was actually drawing an antibiotic injection and all I could hear is the dad saying, 'this is mummy … She does not normally look like that; this is because she is sick and you come to say bye to her'… it was very sad. I had to ask another nurse to come to the bed so I could have a brief timeout to gather my emotions. My colleague was also crying … there are certain things that stay with you, which you can never forget. [P5: interview 3]

Venting emotions was tempered with the need to maintain some sense of control over the way they were expressed. Most nurses spoke of the importance of maintaining a sense of self-control during stressful times. Taking stock of the situation and trying to contain emotionally themselves was one of the strategies participants used to deal with the situation, as described by participant P16:

At times, you do feel like crying at what you are witnessing. You cannot help becoming emotionally drawn into the situation. Yes, at times it can be so overwhelming and distressing that your first response is to cry—a natural response to stress—but you quickly pull yourself up and take a deep breath. [P16: interview]

Participant P8 captured this succinctly by saying that 'you just have to suck it up, for it is not going to last'. In sharing their thoughts, participants P3 and P34 conveyed the pragmatic sentiments of many participants:

At times, I find it quite overwhelming when I am in-charge in really a busy shift … I struggle with stress; yes, I do. Sometimes you just try to take a deep breath and tell yourself: 'look, I can only do what I can do' and if I do not get everything done then the next shift will understand and work it out. [P3: interview 2]

Our priority is the patient … we need to be professional … we have to get along with each other for the sake of the patients and their families, for they are our core business. [P34: interview]

During stressful times, a small number of participants found themselves displacing/projecting their feelings on to others and affecting unit staff:

Some in-charge nurses get a bit narky when stressed and that is their usual response when they get stressed … they scream at you and tell you to do things that you had not done; that [was] just miscommunication and you said:

'I haven't do[ne] that because blah … blah'. [P37: interview 2]

As witnessed during the period of observation, there are a very small number of nurses who act out their stress by swearing, as one of the in-charge nurses, participant P9, commented: 'she [P1] swears a lot. I was doing her job one day … then I swore, then one of the girls said: "now, I know why P1 swears all the time".

The emotional detachment was another strategy used by participants who spoke of it as a means of self-protection and self-care. Participant P11 noted in his PAWI:

When I was new to the unit … I found myself crying about a patient who was dying and being generally very upset about the demise of this particular patient.

I felt very connected to him. However, over time and considerably more experience, I have developed a thick skin, which I needed to protect myself from disasters that occur for somebody nearly every day. It is not that the ICU nurses do not care, but if they fall off their perch and were greatly affected every time something bad happened, nobody would be able to continue to work in the unit. It might sound strange but it is one way of being able to care for others. [P11: PAWI]

7.4.3 Avoidance and withdrawal from stressful situations.

Several participants spoke of physically withdrawing or, where possible, attempting to avoid confrontational or extremely distressing situations. Participant P5 shared one of her most distressing experiences:

I was assigned to care for a young woman who was terminal and only had a short time to live. Her husband brought their children into the unit for the last time. I was ok until the father spoke to each of the children, asking them to say goodbye to their mother. At that moment, I could not stay there. I just had to get away before I started to break down. I called one of my colleagues to take my place so I could have time to regain my composure. [P5: interview 3]

On a number of occasions over the observation period, the researcher witnessed staff having to withdraw from situations that they perceived as stressful. However, when these situations arose, those affected first ensured that their patients were not left unattended by asking other staff to cover in their absence. When questioned further about how the unit viewed such behaviour, participants responded that staff are encouraged to step away for a brief time to regain their composure rather than escalating to the situation. [Field notebook 1]

Avoidance behaviours were not limited to stressful times and occurred when staff felt exhausted when caring for patients requiring complex care over extended periods of time. When these situations arose, participants expressed the need to have time out, as described by participant P20:

> I am a very empathic person; however, there are times when you reach a point where you feel your ability to care for the person is slipping. When this occurs, you know you are open to making mistakes. You need to step away and ask a colleague to take over, such as a float nurse. [P20: interview]

Engaging in avoidance and ignoring behaviours was not limited to patients and their families but also included fellow colleagues, especially those who participants perceived as stressed:

> The environment in which we work is stressful enough without having to contend with staff who are stressed. Sometimes I find myself trying to avoid them. I know this is not the right thing to do but sometimes you just have to do it to keep your own sanity. [P16: interview]

Similar sentiments were expressed by participant P19 in discussing working with staff who are negative or judgemental:

> When I need help, I avoid asking staff members who come across as being negative or not wanting to be there. They only compound the situation by dragging their feet or making unhelpful comments about what you are doing as if to suggest what you are doing is wrong or stupid. These people are not going to change; that is who they are … I would just rather be ignoring and avoiding [*sic*] them than dealing with them and the extra stress they cause; there are plenty of good people that I can ask for assistance. [P19: interview]

7.4.4 Responding to stress through communication.

From time to time nurses needed to speak up by debriefing with their colleagues or talking to their unit manager when there was stress or an important concern. As was both observed by the researcher and disposed by participants:

> If you are a level 2 nurse and there is a problem in the unit, sometimes you have a quiet chat to the nurses on the bedside or you communicate with other level 2s. We have level 2 meetings and staff [are] saying: 'have you had an issue with such and such' … then some people say: 'yeah, I have had that too' … and then if it is like a big issue it needs to be addressed to [CNM] Kerrin who usually say: 'ok … I will have a chat with them'. [P3: interview2]

In relation to informal talks as a means of debriefing, participant P35 conveyed their feelings of how nurses in the unit use informal talk to vent their stress in times of sadness and grief:

> We had a patient who was 30 years old and just had delivered her first baby who was stillborn. Nurses who were looking after this patient were distraught and actually, the whole unit had this feeling; it was such a sad experience. We just talked about it and people were supportive of each other because it was brutally painful for all of us. [P35: interview]

At the unit level, there is an open-door policy where staff are encouraged to talk with colleagues when feeling stressed. This was most evident with the CNM, whose door was always open to staff who needed to debrief or just have an informal chat about their concerns. According to participant P24, 'Kerrin has an open-door policy. She will listen to you and be sympathetic if you are in trouble. She will bend over backwards to help you with your work if you need it'. Participant P30 echoed similar sentiments:

The manager knows everything; always, her door is open … she ensures that the in-charge nurses make sure that there is no shortage of staff, and if there is an issue, she will go and talk to the nursing manager in administration to get additional staff. [P30: interview 1]

On some occasions, the in-charge nurse needs to be assertive and ask the nursing staff to do their work. Being assertive is praiseworthy in managing certain conflicts between staff, as described by participant P9:

Most of our staff gets on really well. It is unusual to have conflict and if they are reluctant to ask for help then … they may ask one of their mates but they are just putting more workload on to one of their mates. One day I asked somebody if they could relieve each other for their breaks—actually they were two agency girls—and one of them said 'no. We do not get on and I am not going to ask her'. Well, then it looks like you would not get a break because that is your choice. So, they had to suck it up and do it. [P9: interview]

Occasionally, the CNM and in-charges use the blanket effect by talking in general in the unit meetings without mentioning specific events or names. According to participant P10:

A lot of the times, we do a blanket effect when we find [that] one or two nurses keep on doing something [that] is not in a proper way; we might have a ward meeting and say: 'right from now and moving on, the policy is to do this …', so everyone gets the information, no-one is targeted, so hopefully it gets picked up and they get the idea indirectly. [P10: interview 3]

The experience of working in a stressful environment also gave rise to negative talk where staff engaged in talking behind each other's backs. Participant P36 said: 'I don't like backstabbing, I don't like gossip about people, but it happens in the unit

irrespective of gender'. In conversation with the unit manager P1, this practice was placed in context:

Nurses from time to time engage in a little backstabbing. They will whinge about things: 'well … I took over from that patient, and the TPR chart was not done … the way the patient was left was a mess, no shelves [were] restocked … blah, blah'. Then, they are happy to say things behind each other's backs but they do not like bringing the issues up face-to-face as that may result in conflict. They seem to find it difficult to simply say 'well, can you help me; we'll both restock before you go home'. Many nurses do not like engaging in conflict, so they keep quiet. It is easier for them to whinge about something after the person has gone home than to deal with it at the time. [P1: interview 4]

Indeed, a number of participants preferred to remain silent:

Sometimes when I have been acting in-charge nurse, staff have attempted to push their weight around and try to take over by telling you what should be done. At such times, it is difficult to say anything as you know, it would only inflame the situation. Inside, you feel you want to say 'back off, this is my shift', but common sense says 'say nothing and just keep quiet'. That is not easy to do but more often than not [it is] the best thing to do. [P14: interview]

Maintaining an atmosphere of light-heartedness was a more common way of dealing with stress in the unit; both it and joviality were evident in stress reduction. Telling jokes and engaging in banter and laughter with patients, families and other staff members was an accepted way of dealing with stressful moments, as observed by the researcher. [Field notebooks 1 & 2]

There is one particular nurse, P8, who always jokes with everybody in the unit: patients, families and other colleagues. Although at times the jokes become a little risqué,

the unit staff generally accept them. Participant P3 captured the general sentiments of staff concerning the place of humour in combatting stress in the unit:

> The unit gets busy and heavy with lots of things, so it is nice to have a bit of a joke and most of the staff have a good sense of humour. Most of them like a little bit of a giggle every now and then. So, it is good to keep it light because there is plenty of sadness where we work … otherwise, you'll be going home and drinking a bottle of wine every night just to cope if you don't try and keep it light to a certain degree. [P3: interview 2]

Nursing staff identified the CNM as an important model who uses humour to balance the stresses experienced by staff. Participant P13 commented that 'our manager is fun … she jokes and laughs. She is the heart of the unit; she is our model … She is a good leader that has a positive impact on her staff'. [P13: informal conversation] Figure 7.8 shows the CNM in a happy frame of mind, whether she is in her office or when she assists her staff in the unit.

Figure 7.8. The CNM is happy working in her office (left) and when assisting staff (right).

Participant P7 contributed her appraisal of the need for humour in the unit:

A sense of humour is a useful tool in caring for people by alleviating the tension of the situation. If you are able to joke with the patient and/or their family, you can make a difference in how they see themselves within the unit … it makes them feel more normal to have a bit of a joke. Families as well, we can joke with them even if their patient is critically ill, which can alleviate some of their stress and anxiety … but you're got to use humour appropriately and you have to gauge the situation before you use it appropriately … it may cause the person to feel worse than if you had not used it. So, humour is very useful in our unit. [P7: interview]

Participants P20, P19 and P18 also confirmed the importance of evaluating the appropriate use of humour when caring for their patients:

Joking and laughing with patients can make a difference when caring. It makes it less stressful for the patient. However, it would depend on who the patient is. We do not engage in humour with everybody. We need to judge with whom to do that sort of stuff. [P20: interview]

Humour does not work all the time and we need to be receptive to who your patient is … not all patients are receptive to a joke and a bit of humour, especially given their situation such as being in pain or sleep-deprived. [P19: interview]

Having [a] sense of humour with patients is important, especially when the patient has a sense of humour. It is a good feeling for both of us. It helps the nurse to get through the day and it makes the patient's day more enjoyable too. Being a little bit light-hearted with patients helps them to relax. [P18: interview 2]

7.4.5 Supporting each other.

Participants highlighted how supporting each other as a unit helped reduce stress. Through working as a team, looking out for each other and having an open-door policy

(of the CNM), the unit created an atmosphere in which staff felt supported and cared for. Participant P7 stated that 'we work as a team within the unit. Support from our team is always helpful … that is probably the number one thing in our unit … I am really happy about it'. These sentiments were echoed by participants P34 and P35:

> Our staff care about each other. If there is someone who is busy and others are not busy, they generally ask if they can be of assistance. So, it is a big help and relief because sometimes it gets stressful here. We have good teamwork. [P34: interview 1]

> If we see colleagues are experiencing difficulty with their patients, we swap patients … I have done that before. I just tell the coordinator. The coordinators do not mind if you are swapping patients for a good reason. Sometimes the patients just clash with a nurse for no good reason. [P35: interview]

> Working as a team extended well beyond just helping out; it also involved being able to call upon various forms of expertise when required. Participants spoke of situations in which they felt out of their depth. They knew that they could seek assistance and support from other staff members with the necessary skills and expertise. As shared by participant P2:

> If a patient has any questions about their treatment or prognosis and I can answer, I will. However, if I cannot and it is beyond my capability or scope of practice, I know I can seek the appropriate help. There are times when the best person to be with the patient is their doctor or counsellor, especially at times of pending death of a patient. You know at such times you can call on such members of the team for assistance and support. [P2: interview]

The float nurse is also a conduit for stress relief because their role is to assist other nurses, who are under significant stress because of workload issues, and to 'break the tension'. Participant P16 stated:

> You see [that] someone is busy and struggling with the work and so, you offer your assistance; that is the idea of having float nurses around. Basically, we are there to help the staff with their workload … We need to support them workload-wise, and emotionally as well … helping them in that regard if they're upset … you can listen to them and allowing them to vent if they want to. [P16: interview]

Seeking assistance in stressful moments was not limited to talking with staff but also extended to the inclusion of spirituality. Participants spoke of having faith in God and seeking his help and guidance in difficult times, as voiced by participant P30, who said: 'I just pray that I can carry on with my work and God will guide me to carry on with the task at hand. Knowing that I can call on Him is a great source of strength at such times'. Another participant P24 stated: 'I simply say, 'Oh Lord, help me to get through this day, amen'. Participant P5 shared her thoughts on seeking God's help during difficult times in the unit:

> When there is a stressful time at work, especially when I am in-charge or floating, I manage the stress and calm myself down by talking to God … I know it may sound stupid or weird but I only talk to God; that's all I do. I get my strength and patience from God and no-one else. [P5: interview]

7.4.6 Time reduction in dealing with stress.

A reduction in work hours was a further stress-reduction strategy used by nurses in the unit. A number chose to either reduce their working hours from a 12- to an eight-hour shift or reduce the number of working days. Participants stated: 'I have stopped working [the] 12-hour shift because it is too much to do and too much stress. I am only

working eight hours now' (P20) and 'now, I work in ICU and I do a couple of permanent days in the preadmission clinic to have some change and to work in [an] unstressful area' (P9). Participant P24 provided elaborated further:

> When you work [a] 12-hour day shift, you get rid of one patient and then you have to take another two patients for the remaining 4 hours. This means [you have] to do more charting and physical assessments … Two extra people to feed and to get them back into their beds, and get them cleaned before the handover … I found that really hard and stressful … and that's why I only do eight-hour day shifts, but I don't mind to work [the] 12-hour night shift … I am so grateful because I now work in two areas … It is awesome not to work all the time in such a stressful area as ICU. [P24: interview]

Further action taken by the participants to reduce stress includes requesting a change of shift to allow additional time between shifts. As shared by participant P11:

> We have some nurses who request a change of shift for personal reasons, especially if they have no accrued leave pending. The unit is very sympathetic to facilitating such changes, particularly if there are personal issues involved. Caring for staff in this manner is very important for the stability of the unit and the quality of the care provided. [P11: interview 3]

Encouraging staff to take time off from the unit was an endorsed practice, which allowed staff to distance themselves from the unit, particularly when highly stressed. On two occasions, the researcher observed a nurse who was emotionally distressed. On the first occasion, the nurse P36 was given an opportunity to debrief with the in-charge nurse P11, who advised her to leave the unit for a while saying, 'have some time for yourself'. On the second occasion, the nurse P14 was encouraged by P9 to leave the unit and to 'go and have a cup of coffee'. [P36, P11, P14 & P9: field notebook 2]

For many of the participants, an alternative solution for stress reduction was spending time with colleagues outside the work environment, where they were able to enjoy each other's company. As voiced by participant P16:

> Spending time with colleagues outside work, having a meal and a drink brings reality into focus. Work is one thing but is not our whole life. Having time to be together without the stress of work allows us to get to know each other in a more personal way. When we first started to meet outside work, we were six in number. Then more staff started to join us, now we are14 and we have been doing it since last year. [P16: interview]

7.4.7 Choosing or rejecting nursing roles and acquired competencies.

Being selective in the role as a means of stress reduction was an interesting behaviour observed by the researcher, given the technical skills of staff working in the unit. Of particular note was the avoidance of the in-charge role, which was a daunting task for many of the participants who only wanted to look after their one or two patients. According to participant P12:

> Some nurses simply cannot cope with the stress of taking a leadership or management role. They just cannot lead and delegate work. Managing the whole unit, for them, is viewed as a very stressful position, which requires looking at the bigger picture of what is occurring in the unit at any given time. All they want to do is to care for their allocated patient load. [P12: interview 2]

Some participants were happy to declare that they were not competent in certain procedures to avoid being sent to work in unfamiliar wards. As stated by participant P35:

> When ward staff are not proficient in cannulation, either they call the cannulation nurse or they call ICU staff. Some nurses in the unit have never been certified to

cannulate nor do they wish to be, because they may be continually sent to the

wards to undertake such procedures. [P35: interview]

7.4.8 Management strategies.

The researcher noted that ICU leaders used various leadership strategies in

problem solving, such as delegation instead of doing all the work themselves. Similarly,

nurses delegated some tasks to other staff when they were so busy that they ran of time.

This strategy is well-known between staff and was obvious to the researcher:

> If we [in-charges] do not get enough time to write the handover sheet or do certain
>
> things, we just delegate one of the float nurses or you might get the people at the
>
> bedside to do it. All the in-charges use that tactic if they could not get around.
>
> [P3: field discussion/field note 1]

In other circumstances, some nurses, especially in-charge and float nurses,

preferred to do the work themselves, because it was easier and quicker than delegating,

guiding and giving instructions or asking for assistance. According to participant P7:

> It depends on what you want the bedside nurses to do. If it is something that can
>
> be done later in their own time, then it is okay to be done later, but if it is
>
> something that needs to be done now you are instilling [in] them the importance
>
> of getting it done sooner, or you can do it yourself … and sometimes this is better
>
> from our experience as in-charge nurses. We [in-charges] do things because
>
> sometimes, people are just too busy to do it themselves. [P7: interview]

Concerning staff management, the researcher observed a few nurses sitting in

front of their patients and not helping their colleagues when they were busy. This attitude

is not acceptable to other staff; however, those particular nurses were still able to get

other staff to assist when they were busy. The unit is characterised by the ethos of

teamwork. The consensus of in-charge nurses was to give those particular nurses some extra work to do. Participant P35 stated:

> I dislike working alongside … somebody who does not help. Some persons are not giving a hand to their colleagues, and the in-charges knew that and allocated those nurses with two patients to be sure that they will take care of at least these two patients, which reduces the unit workload. However, if you will give them one patient they will not help other staff. [P35: interview]

Participants stressed the importance of time management in reducing stress for themselves and others in the unit. As participant P16 said, 'if the nurse can manage the time properly, that helps to alleviate the stress because she will not be running around trying to do things'. [P16: interview] This was corroborated by P25:

> With my time management, flexibility, efficiency and communication as well, I need to be able to deliver good care to the patient … to set the time for every task for the patient; those tests that need to be done. I make sure that all drugs are administered [at] the right time and of course the patient's turns and the whole care to the patient … because I just do not want to be rushing and still doing things when I want to give handover … every task should be done at the right time. [P25: interview 2]

The on-call roster was used to manage nurses' stress from staff shortages and hosting casual or agency staff. Sometimes, there is a need to call nurses to cover the shortage because colleagues are sick, on family leave or require assistance with the extra workload of the unit. Another benefit derived from this roster is that the unit has its own staff who are familiar with their environment and routine. These nurses can be called before casual or agency staff who might be new or unfamiliar with the unit. The unit

manager, P1, wrote a recommendation in her PAWI that will be applied in the unit in the near future: 'we are going to establish an on-call roster for nursing staff in our ICU'.

7.4.9 Expecting and accepting the worst scenario

The last strategy used by some staff was to expect and accept the worst scenario on any given day. They trained themselves to expect the worst. According to participant P13: 'our work environment is not easy. What is important is to think of the worst and be grateful for the least. This way, one protects and cares for [them]self and is ready to care for others' [P13: interview]. Similarly, participant P30 stated:

> As a means of coping with the stress of the unit, I try to prepare myself for the worst that could happen. By doing so, I try to cover myself for what could occur. I have been working in the unit for some time and have some knowledge of what can happen. [P30: interview 2]

7.5 The Conceptual Model of the Culture of Caring in the ICU

A conceptual model was developed from the findings of this study and represents two major concepts in ICU: fundamentals of the culture of caring and patterns of caring. Both the fundamentals and the patterns of caring in ICU are underpinned by four dimensions, all of which were conceptualised in a dynamic and interrelated process.

7.5.1 Fundamentals of the culture of caring in ICU.

As previously mentioned, four dimensions underpin the fundamentals of the culture of caring in ICU. The first dimension includes the mission, vision and values espoused by the hospital and the unit, which formed and informed the structure and processes around providing care in this ICU. Coupled with the notion of living out the mission, vision and values of the unit, were participants' perceptions of what constitutes the culture of caring. Based on these perceptions, participants formulated what they believed to be qualities required of the ICU nurse to provide quality holistic care. In

maintaining a culture of caring, the unit manager was perceived by staff as a model who epitomised living out the mission, vision and values of the unit (see Figure 7.9).

Modelling by the unit manager as a culture carrier/Modelling

Qualities required of the ICU nurse to provide quality care

Nurses' perceptions of caring in ICU

Ligitmacy of caring's Mission, Vision & Values

Fundamentals of the culture of caring in ICU

Figure 7.9. Fundamentals of the culture of caring in ICU.

7.5.2 Patterns of caring in ICU.

The second major concept in this model is patterns of caring in ICU, which is underpinned by four dimensions: a culture of inclusive caring practice, patterns of communicating caring, the contextual nature of caring (which incorporates influencers of care provision: enablers, challenges and negative cases) and patterns of coping with stressful moments by nurses in ICU (see Figure 7.10).
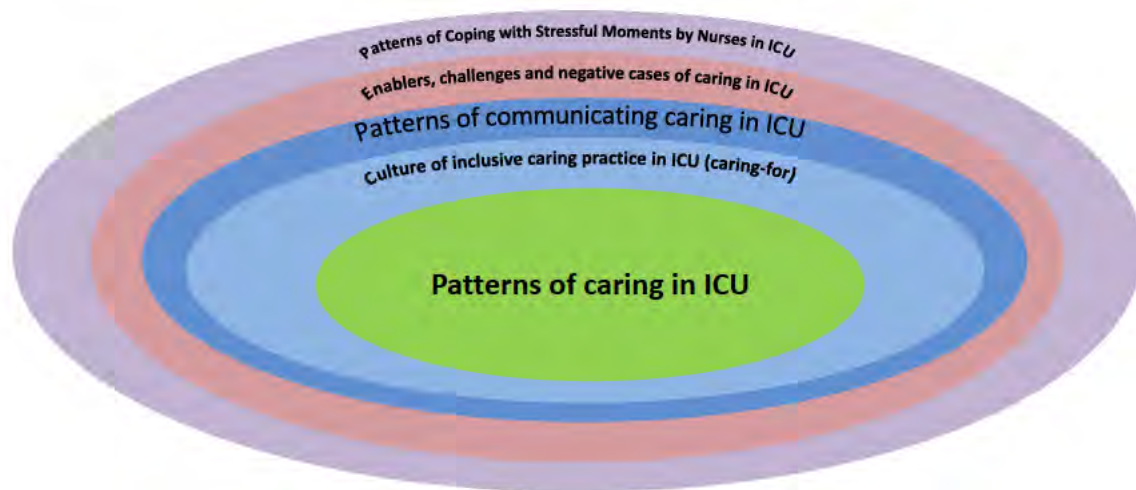
Figure 7.10. Patterns of caring in ICU.

The final conceptual model (see Figure 7.11) is presented in three parts (1, 2 and 3) and is a synergy of interrelated forces that affect each other. In its current form, it is a representation of the dynamic forces that are constantly interacting with each other, which creates a living culture of caring. Both positive and negative forces (in the form of facilitators and barriers) are represented with connecting arrows between the fundamental elements and patterns of caring that give rise to the unit's everyday culture.
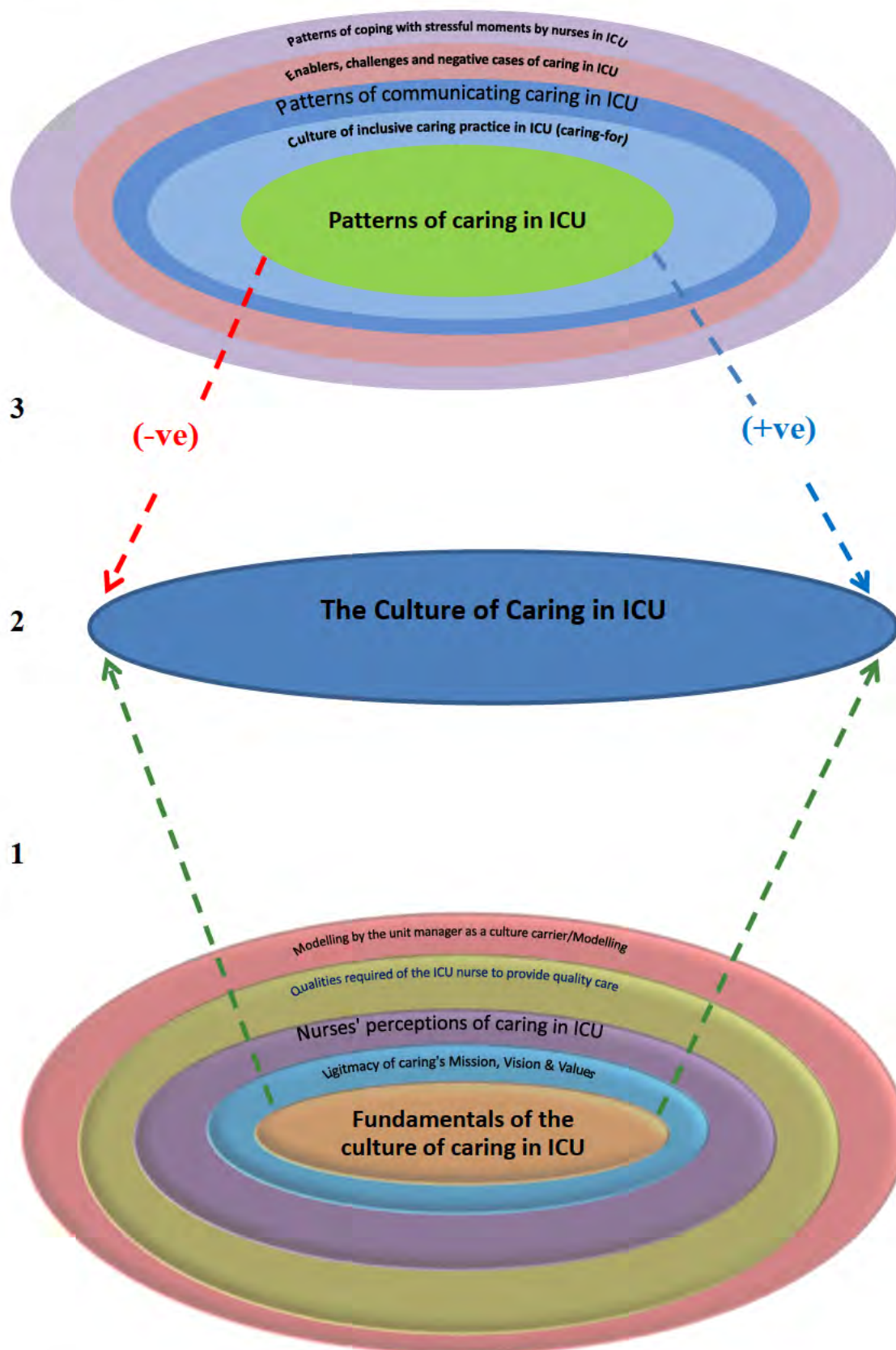
Figure 7.11. The conceptual model of the culture of caring in ICU.

7.6 Summary

The findings of this research were presented in three chapters: 5, 6 and 7. Chapter 5 began with an overview of the mission, vision and values of the organisation in which the ICU is located, as a prelude to the presentation of the first three themes: nurses' perceptions of caring in ICU, a culture of 'caring-for' and qualities required of the ICU nurse to provide quality care. Chapter 6 discussed the findings presented in themes four and five: the unit manager as a culture carrier of caring and patterns of communicating caring. Chapter 7 presented the findings of the final two themes: enablers, challenges and negative cases of caring in ICU and patterns of coping with stressful moments by nurses in ICU. The chapter concluded by presenting and discussing the conceptual model of a culture of caring in the ICU, which unites all themes identified throughout the work. The next chapter discusses the findings in relation to existing literature.

Chapter 8: Discussion of Findings in Relation to Existing Literature, Part 1

8.1 Introduction

The discussion of this research is presented in Chapters 8 and 9. Chapter 8 presents the discussion of the first four themes: nurses' perceptions of caring in ICU; a culture of inclusive caring practice in ICU; qualities required of the ICU nurse to provide quality care; and the unit manager as a culture carrier of caring. Chapter 9 concludes the presentation of findings with a discussion of the final three themes: patterns of communicating caring; enablers, challenges and negative cases of caring in ICU; and patterns of caring in stressful moments in ICU.

This chapter presents a discussion of the findings of this study in relation to contemporary literature. This chapter includes a synopsis of the study findings, overall literature search strategy, a summation of findings of each theme, and a description of the strategies and processes by which the literature review for each theme was undertaken. This is followed by a critical analysis of the literature relating to each theme to identify what is already known and what this thesis contributes to the development of new knowledge. The chapter concludes with a summary of this contribution to expanding existing understandings of what constitutes a culture of caring in an ICU.

8.2 Synopsis of Study Findings

Key findings of this study (as discussed in Chapters 4–6) were explicated under seven central themes and associated subthemes. The seven themes were discussing ICU nurses' perceptions of caring in intensive care; dimensions of caring in the ICU; qualities required of the ICU nurse to provide person-centred and holistic care in intensive care;

the unit manager as an exemplar of a culture carrier of caring; patterns of communicating caring and the processes of documentation of caring in ICU; enablers, barriers/challenges and negative cases affecting a culture of caring; patterns of dealing and coping with stresses in the ICU.

8.3 Overall Literature Search Strategy

A literature review was undertaken for each theme. The initial search was limited to 2007–2017, but was extended to include 2000–2017 because of the scarcity of literature. An example of the process by which each of the searches was undertaken, is presented in Table 8.1. Electronic bibliographic databases CINAHL, Medline, PubMed and Google Scholar were used for the various searches. The search terms were generated from the titles of themes and subthemes, producing a large amount of data. The terms were subsequently refined using inclusion criteria, which were: a full text of the article, English language and peer-reviewed articles published from 2000–2017. The abstracts for each citation were assessed to refine the review and focus on caring for humans rather than objects of caring, such as diagnoses. All duplicates were removed. The reference list of the articles selected was reviewed for any further literature that could form part of the literature review. The first theme to be discussed is *nurses' perceptions of caring in ICU*.

8.4 Theme 1: Nurses' Perceptions of Caring in ICU

8.4.1 Summation of the theme.

The first theme to be explicated in this study was nurses' perceptions of caring in ICU. Three subthemes that underpin the theme were: conceptualisation of caring, caring viewed as a culture and caring as levels.

8.4.2 Search terms for the theme and subthemes process.

Search strategies in the review of literature were key words with quotation marks included: 'Nurse* perception*', 'Nurse* description*', 'Nurse* view*', caring,

'intensive care', 'critical care', 'ICU', to ensure a search for this specific word combination. The asterisk was added to terms to ensure that the search included other ending possibilities: level*, classification*, pattern*, categories. Boolean operators such as 'AND', 'OR' and 'NOT' were used. Terms as child*, neonat*, pediatric* were excluded from the search (see Table 8.1). A gradual elimination of studies according to PRISMA is presented in Figure 8.1.

Table 8.1

Literature Review Search Strategy for Theme 1: Nurses' Perceptions of Caring in ICU

Search terms for theme and subthemes process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No. of papers	No. of papers	No. of papers	No. of papers
'Nurse* perception*' AND Caring AND ('intensive care' OR 'critical care' OR 'ICU') NOT ('child*' OR neonat* OR pediatric*)	16	25	59	449	13
'Nurse* description*' AND Caring AND ('intensive care' OR 'Critical care' OR 'ICU') NOT ('child*' OR neonat* OR pediatric*)	4	2	20	115	3
'Nurse* view*' AND Caring AND ('intensive care' OR 'Critical care' OR 'ICU') NOT ('child*' OR neonat* OR pediatric*)	3	2	24	197	8
Caring AND (level* OR classification* OR pattern* OR categories) AND ('intensive care' OR 'critical care' OR 'ICU')	6	64	106	123	12
Duplicates removed					15
Final number of articles for review after removal of duplicates					21

Identification

Records identified through database searching (n = 1225)

Additional records identified through other resources (n = 12)

Records after duplicates removed (n =1222)

Screening

Records screened (n =1222)

Records excluded (n = 1108)

Eligibility

Full-text articles assessed for eligibility (n = 114)

Full-text articles excluded, with reasons (n = 93)

Included

Studies included in quantitative synthesis (n = 4)

Studies included in qualitative synthesis (n = 12)

Studies included in other synthesis (n =5)

Figure 8.1. PRISMA flow diagram of literature identification process for Theme 1.

8.4.3 Discussion of Theme 1 in relation to the literature.

Careful analysis of the literature indicated that there were few studies directly related to ICU nurses' perceptions of what constitutes the act of caring. Of the 1,215 articles initially located, only 13 referenced nurses' perceptions of caring within the ICU. The review of literature focused on each of the subthemes underpinning the theme. The first sub-theme to be discussed is conceptualisation and expressions of caring.

Conceptualisation and expressions of caring. Study participants' perceptions of caring were described as doing and achieving the best outcomes for their patients. Similar findings were explicated in a qualitative descriptive study by Fridh, Forsberg and Bergbom's (2009) of how ICU nurses care for their dying patients. Nurses perceived caring as '*Doing one's utmost',* which involved nurses using various caring approaches to ensure the dignity and comfort of patients, irrespective of whether their relatives were present. Doing one's best to provide the ultimate care to critically ill patients was found in several studies, pointing to the need to safeguard the rights of individuals and act as intermediaries between the patient and health professionals, and *'standing by'*, especially when patients are sedated or unconscious (Andersson, Willman, Sjostrom-Strand & Borglin, 2015; Wilkin & Slevin, 2004).

Wilkin (2003) considered caring a complex concept, which is consistent with the current study in which participants described caring as having social, emotional, spiritual and physical elements. Several other studies also referred to the different dimensions of caring within the context of their everyday practice: The participants in Price's (2004) study spoke of the importance of attending to physical needs for ICU patients, while participants in other studies identified providing psychological and spiritual support to patients, families and staff as central to their practice (Andersson et al., 2015; Borhani, Hosseini & Abbaszadeh, 2014; Celik, Ugras, Durdu, Kubas & Aksoy, 2008; McCallum

& McConigley, 2013; Price, 2004; Turan & Yavuz Karamanoglu, 2013; Wilkin & Slevin, 2004). Beeby's (2000) phenomenological study about what constitutes caring for ICU nurses found that participants perceived caring in a number of ways: physical, emotional (Beeby, 2000) and technical (Beeby, 2000; Sadala & Mendes, 2000). Beeby's (2000) findings are consistent with other studies, in which participants perceived caring to be '*holistic care*' through attending to physical, psychological, social, spiritual and cultural needs of patients and their families (Andersson et al., 2015; Beeby, 2000; Wilkin, 2003; Wilkin & Slevin, 2004). Similarly, a phenomenographical study conducted by Andersson et al. (2015) explored nurses' perceptions of caring and found caring was viewed as person-centredness with the '*person behind the patient*'. In the current study, nurse participants viewed their patients as people; this was evident, especially with patients in the EOL stage and after death.

An exploratory, descriptive qualitative study by Da Silva, Campos and Pereira (2011) classified the caring provided by ICU nurses in the process of dying in four categories. One category was '*uniform care*', in which nurses provide ordinary care; nothing special is provided for dying patients. The care does not treat the dying patients as humans; it is directed to the technological apparatus. This is consistent with what nurse participants in the current study described as 'clinical, ordinary and basic'.

An ethnographic study by Mclean, Coombs and Gobbi (2016) examined the ways that critical care nurses think and talk (i.e., the language used) about patients. Nurses then described their patterns of practice. Mclean et al. (2016) found that nurses sometimes treated patients as medical cases needing medical care, which is similar to what nurse participants articulated in the current study.

Caring viewed as a culture and disposition to care. Participants in the current study discussed moving beyond a disposition of caring to an attitude or disposition in

clinical practice, through acting as the ears and eyes of the patient and acting on their behalf, particularly in the EOL stage. Similar findings were explicated in a descriptive qualitative study by Borhani et al. (2014) about EOL care within an Islamic context, where the culture of caring articulated by nurses spoke of the importance of communicating to patients and their families that staff were there for them throughout the patient's illness.

The review of literature identified several studies in which participants spoke of the importance of having a caring disposition to provide quality care with particular reference to attitudes (Wilkin, 2003) and behaviours (Andersson et al., 2015; Wilkin, 2003). These were similar to the findings of this study, in which a person's attitudes or disposition, along with caring behaviours, were identified as central to the provision of quality care. Acting in a professional manner as a component of caring has received considerable attention in the literature (Beeby, 2000; O'Connell & Landers, 2008; Omari, Abualrub & Ayasreh, 2013; Pryzby, 2005; Snyder, Brandt & Tseng, 2000; Wilkin & Slevin, 2004). Similarly, participants in the current study viewed acting in a professional manner as an essential component of caring in ICU, and spoke of the importance of reflection on practice, being open and receptive to the needs of others and working towards the best outcomes for patients and their families.

Several authors discussed the importance of acting in a caring manner in attending to the needs of critically ill patients in the ICU. A caring manner meant that nurses consider numerous aspects to achieve the ability to care. For example, Wilkin and Slevin (2004) found that participants perceived caring as preserving patients' dignity, privacy, comfort, freedom from pain and technology of care. In addition, nurses described caring behaviours as empathy and tactility (the use of touch). Nurses consider themselves an ethical tool of care, through listening, respecting and being attentive (Wilkin & Slevin,

2004). Similar findings were explicated in the current study, in which participants described the need to be with their patients through all the 'ups and downs' of their illness. Equally, these findings are consistent with Beeby's (2000) phenomenological study of ICU nurses' experiences of caring, in which '*being involved*' and '*being present*' with patients and their families were of central concern, along with having the knowledge and skills to provide competent safe care. Snyder et al. (2000) emphasised that when CCNs used the intervention of *presence*, they can identify patients' problems and concerns earlier. By '*being present*', nurses can transform a technical impersonal setting into a humane and healing place. Being present was more than a nurse being physically present. It refers to 'nurses who are present with their whole beings and are attuned to patients' needs and concerns' (Snyder et al., 2000, p. 27). The findings of the current study concur with those of Beeby (2000), Snyder et al. (2000) and Wilkin and Slevin (2004).

Further, an Irish study by O'Connell and Landers (2008) in a critical care setting compared nurses' and relatives' perceptions of the importance of caring behaviours of CCNs. The findings revealed similarities between CCNs' and relatives' perceptions of the importance of nurses' caring behaviours, which demonstrate technical competence, and altruistic and emotional aspects of caring. Similarly, nurses in the current study emphasised the importance of caring behaviours, and individualised and person-centred care for patients, families and staff. Additionally, Pryzby (2005) found that there were positive effects of nurse caring behaviours on the stress response of families, and pointed out that the nurses' caring behaviours involved the family in the circle of care; considered the family as partners in care; reduced families' stress; and adopted a family-centred approach to care, which is similar to Beeby (2000) and the current study. Omari et al. (2013) found that nurses perceived cognitive aspects as the most important caring

behaviours, especially teaching behaviours. The consistent caring behaviours from these four studies and the current study are: the importance of knowledge, skills and technical competence and emotional aspects of caring; involving the family in patient's care and the caring partnership of their patient; reducing relatives' stress; adopting a family-centred approach to care, especially in the patient's EOL stage; and providing continuity of care.

Regarding caring levels in ICU. In the current research findings, caring was categorised according to the nurse–patient/family/staff, the nature of work and the quality of relationships. For instance, the strength of the therapeutic nurse–patient relationship was a determinant in terms of the level of care provided—the stronger the bond, the deeper the caring response by the nurse towards the patient. In other words, the caring relationship is divided into three levels or degrees: superficial, intermediate and deep.

Two studies analysed identified different levels of caring. First, Bench, Crowe, Day, Jones and Wilebore (2003) classified caring according to the needs of the patient. The nurses' level of care was informed by the competency framework, not the grade of delivering nursing care. Level one is a baseline, which is the foundation of building the two dimensions of professional competence (scope and quality). Level two is the scope of roles, tasks and situations in which competence is established, while level three is the quality according to the judgements about qualitative facets of working on the continuum from novice to expert.

Second, Beeby's (2000) study pointed to caring classification according to types of caring: professional, physical and technical, and emotional caring. Professional caring is equated with *'being there'* physically with the patient and family, at their bedside anticipating their needs and providing physical care. This is similar to the first degree of caring in the current study, in which participants expressed that they are vigilant and

methodical when carrying out essential treatments or interventions (e.g., when there is insufficient time for communicating psychological needs). The second caring level/degree in Beeby (2000) is routine caring or technical caring, which is equated with *'doing to',* when caring is task-oriented and involves an emotional step back, especially when the nurse is frustrated by either the patient or family, or team or organisation. Conversely, the current study's participants articulated that in this level, they are effective communicators with the patient (beyond the first level). The third is the emotional caring level, which is equated with *'being close'* by having a closer relationship with the patient and caring for the 'person', not the 'patient'. At this level, nurses observe the person behind the patient, not just a body. In the current study, participants always cared for the patient as a 'person', 'individual' or 'human being' and adopted a patient-centred approach, regardless of the degree of their nursing practice. In the three levels nurse' participants in the current research being 'doing', the only difference is the degree and extent of their relationships-closeness was that foster the degree of caring provided (e.g., caring for a patient during and after death). The classification of caring in these levels constitutes the first notion towards evaluating and measuring caring in critical care settings.

Overall, there is common ground between the current study's findings and the literature in terms of nurses' perceptions. For examples, ICU nurses in this study and the literature refer to caring as acting in the '*best interest'* of the patient, providing '*meticulous attention*' to the quality of care provided to patients, families and staff, '*being present*', and caring as demonstrated in 'attitudes and behaviours'. Conversely, there were different categorisations of caring common in the ICU, such as physical, social, spiritual, emotional, holistic, technical and clinical. Caring terms can be used in different

contexts and meanings, which results in the absence of a standard definition of caring in the ICU (Hanson, 2004; Roland, 2014; Schofield, 2013; Wilkin, 2003).

8.4.4 Contribution to new knowledge.

Contributions to new knowledge from this study include:

- Caring is a sense that either exists or does not. Caring is accompanied by feelings, attitudes and behaviours.

- Caring is classified in three levels (surface, intermediate and deep) according to the nature of work provided by nurses, accompanied with the degree of closeness of nurse–patient/family/staff relationships. The greater attachment between any two parties (e.g., nurse and patient), the greater quality of care is provided (e.g., from the nurse to the patient).

- The notion of measuring caring has emerged from this research; consequently, there is an opportunity to develop an instrument to measure caring in the ICU.

8.5 Theme 2: A Culture of Inclusive Practice of Caring in ICU

8.5.1 Summation of the theme.

The theme 'inclusive practice of caring' was underpinned by six subthemes: 'caring-for' oneself, the patient, the patient's family, nursing colleagues, other health team members, and the ICU environment and organisation.

8.5.2 Search terms for the theme and subthemes were as follows.

As a search strategy for this theme, keywords with quotation marks and parenthesis included: ('caring for' OR 'caring-for' OR 'looking after'), ('oneself' OR 'one-self' OR 'self care' OR 'self-care'), patient*, (family* OR relative*), (team OR professionals OR colleague* OR staff*), (ecological, hospital, organization), and ('intensive care' OR 'critical care' OR 'ICU'). Boolean operators such as 'AND' and

'OR' were used. An asterisk was added at the end of terms to ensure that the search included other possible endings (see Table 8.2). In addition, a gradual elimination of studies according to PRISMA is presented in Figure 8.2.

Table 8.2

Literature Review Search Strategy for Theme 1—Dimensions Of 'Caring-For' Several Identities in the ICU Universe

Search terms for theme and subthemes/process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No. of Papers	No. of papers	No. of papers	No. of papers
('caring for' OR 'caring-for' OR 'looking after') AND ('oneself' OR 'one-self' OR 'self care' OR 'self-care') AND ('intensive care' OR 'critical care' OR 'ICU')	1	1	116	5, 743	5
('caring for' OR 'caring-for' OR 'looking after') AND patient* AND ('intensive care' OR 'critical care' OR 'ICU')	33	71	297	17,234	32
('caring for' OR 'caring-for' OR 'looking after') AND (family* OR relative*) AND ('intensive care' OR 'critical care' OR 'ICU')	16	15	35	11,902	30
('caring for' OR 'caring-for' OR 'looking after') AND (team OR professionals OR colleague* OR staff*) AND ('intensive care' OR 'critical care' OR 'ICU')	28	25	43	23,175	17
('caring for' OR 'caring-for' OR 'looking after') AND (ecological OR hospital OR organization) AND ('intensive care' OR 'critical care' OR 'ICU')	16	39	10	9,100	10
Duplicates removed					37
Total after removal of duplicates					57
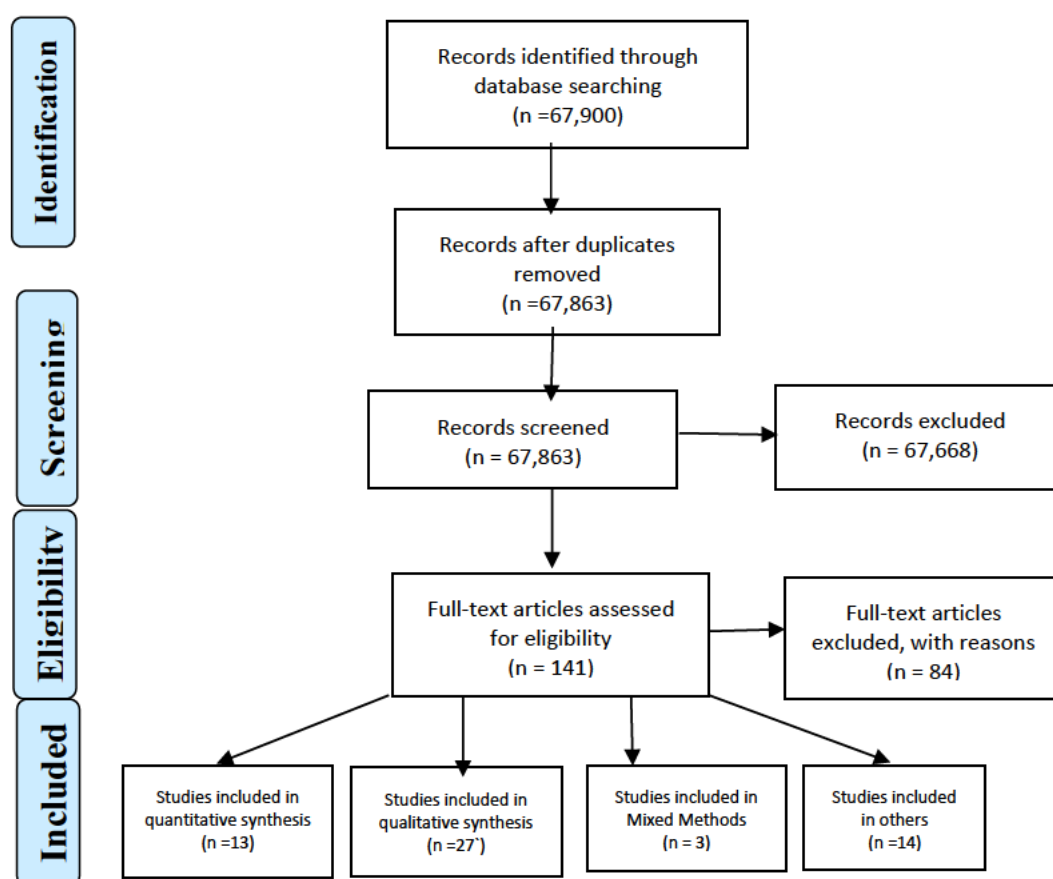
Figure 8.2. PRISMA flow diagram of literature identification process for Theme 2.

8.5.3 Discussion of Theme 2 in relation to the literature.

For 'caring-for' oneself, the importance of self-care was raised by most participants in the current study. The acuity of the clinical setting, the complexity of care and the ever-changing health status of patients require nurses to engage in self-care.

Some self-care strategies employed by participants in this study included maintaining a balanced and healthy lifestyle. A review of the literature on maintaining lifestyle balance uncovered two studies (Mealer, Jones & Moss, 2012; Royal College of Nursing, 2005). Mealer et al (2012) discussed physical health, including sleeping habits, exercise and nutrition. Similarly, the Royal College of Nursing (2005) recommended that nurses maintain a healthy lifestyle to combat the stress of the work environment, including taking holidays, ensuring sufficient rest, eating a balanced diet, taking regular breaks during the working day, delegating tasks when appropriate, saying 'no' as

necessary, and not working overtime when they cannot or do not want to. Similar findings were explicated in this study. Of particular importance to the participants in this study was lifestyle balance, time away from the workplace, such as holidays, and rest between shifts.

Another aspect that CCNs identified as important for self-care was monitoring their psychological wellbeing by accepting opportunities to debrief when necessary, whether that be through professional counselling, peer support or pastoral care. Also, participants reported that attending to their spiritual and religious practices assisted them to maintain a personal sense of wellbeing. These findings were compatible with Mealer et al. (2012), who found that nurses seek solace and spiritual energy in difficult times through religious practices such as praying. Moreover, Mason et al. (2014), in their pilot study of trauma, asked surgical ICU nurses about the effects of compassion satisfaction and fatigue, and moral distress. They found that nurses used different strategies in respect to spiritual self-care, such as reiki and pastoral care. Such findings are synonymous with the current study.

A further element to self-care reported by participants in the current study was looking after themselves *emotionally* through leaving work stress at the workplace and debriefing when required. The findings in the current study align with those of Mealer et al. (2012), Mitchell (2011) and Siffleet et al. (2015). For example, Mealer et al. (2012) found that participants were able to separate work from their personal life as a counterbalance to work stress and self-care. Mitchell (2011) discovered that emotionally distancing oneself from stressful situations provided the necessary barrier for self-preservation. Siffleet et al. (2015) found that participants were able to maintain their *emotional* wellbeing through avoidance and psychosocial processes referred to as '*protecting from stress*'.

Regarding 'caring-for' the patient. The central concern for participants of the current study was the need to focus on providing person-centred care—being with the person in their illness. In other words, acknowledging the person behind 'the patient' and advocating on their behalf. Similar findings were described in other studies (Benner, 2002; Carvalho & Lunardi, 2009; de Lima Guimarães et al., 2017; Hasse, 2013), in which the importance of providing a patient-centred approach to care was stressed. Also, a central concern for participants of the current study was the need to ensure patient safety, especially for the unconscious patient and those on mechanic ventilation. Similar findings were explicated in Gimenes et al.'s (2016) and Karlsson and Bergbom's (2015) research, in which patient safety was of utmost concern, especially in situations in which the patient was unconscious or being mechanically ventilated.

Participants in the current study encountered difficulty attending to the psycho-emotional and spiritual needs of patients at the EOL stage. Of particular note was the difficulty of nurses responding to their patients' spiritual needs. Similar findings were identified in several studies focusing on EOL experiences for patients, and nurses' ability to respond appropriately. These studies found that nurses pay more attention to patients' physical needs than they do to their psychological and spiritual needs, especially in the EOL stage (Canfield et al., 2016; McCallum & McConigley, 2013; Tyler, 2017).

Difficulty attending to the psycho-emotional and spiritual needs of patients at the EOL stage was further confounded by what participants perceived as ethical dilemmas concerning decisions to withhold treatment or prolong life to ameliorate family distress, while maintaining the quality of life for the patient. Similar findings were identified in several previous studies (Campbell, 2015; Carvalho & Lunardi, 2009). For the participants of the current study, amid such ethical dilemmas, participants discussed their role of the advocate in ensuring that the patients' needs at this pivotal moment are met

and preserving the dignity of the person. Similar findings were explicated in King and Thomas (2013), which highlighted the importance of being truthful, being an advocate, remaining connected with the patient, and making the death as comfortable, peaceful and dignified as possible, despite the ICU environment. Beckstrand, Callister and Kirchhoff (2006) reported that CCNs suggested that EOL care can be improved by providing a 'Good death' by facilitating dying with dignity, not allowing patients to be alone when dying, managing patients' pain and comfort, attending to patients' wishes, promoting earlier cessation of treatment, and not initiating aggressive treatment.

For 'caring-for' family, participants in the current study reported a range of ways they care for families in ICU, such as keeping them well informed and updated about their family member's health; involving the family in their loved one's care; responding to the needs of the family; and providing assistance and support as required. These findings were present in previous studies that discussed the importance of providing and updating families with information about their loved one (Attia, Abd-Elaziz & Kandeel, 2013; Cannon, 2011; Carlson, Spain, Muhtadie, McDade-Montez & Macia, 2015).

Involving the family in their love one's care was observed by the researcher during her field observation and described by participants. Areas of care in which the family were involved included feeding, family conferences/meetings to discuss the person's condition and participating in decision-making about their relative's care and treatment. Through being informed of their love one's condition and being educated about the treatment involved, the family could take a more active role in advocating on the patient's behalf. Ågård and Maindal (2009) and Davidson (2009) also identified the need to involve the family in care and treatment decision and to promote the involvement of the family in the daily care of their love one. Further, *respecting, listening and adhering* to the family's views and concerns was evident in previous studies (Cannon,

2011; Carlson et al., 2015; Davidson, 2009; Khalaila, 2014), in which attentive listening by nurses to relatives' needs was instrumental in alleviating the anxiety and distress of families in ICU.

Regarding providing assistance and support to the family as required, was an important consideration expressed by participants of the current study, in which the level of support required by each family was at the centre of identifying family needs and expectations in the care of their loved ones. Consideration of the closeness of the relatives to the patient was an important aspect in determining the types of support and assistance needed. Åsa and Siv (2007), Blanchard and Alavi (2008) and Buckley and Andrews (2011) identified the closeness of the family members to the critically ill patient as an important factor in the provision of care within the unit, in addition to providing psychological support to families (Celik et al., 2008; Nordgren & Olsson, 2004). Participants in the current study explicated that families of ICU patients rely heavily on open communication between themselves and the treating team, which was considered core to building a trusting relationship. Having such a relationship was considered by participants of the current study imperative in working with the patient and family and facilitating understanding of the patient's condition and prognosis, especially at the EOL stage. Similar findings were reported in several other studies (Attia et al., 2013; Ranse, Yates & Coyer, 2012; Rushton, Reina & Reina, 2007), in which the importance of communication with patients' families was identified. A further consideration in the development of a trusting, supportive relationship with family was in the area of family conflict. In the current study, a difficult challenge faced by participants was working with family members in situations of family conflict or disagreement about the health status of the patient, and individual family members' roles in caring for and being part of the

decision-making process (Attia et al., 2013; Esmaeili, Cheraghi & Salsali, 2014; Tracy & Ceronsky, 2001).

For the participants of this study, the provision of care and support was not limited to the point at which the patient died; it continued beyond the death of the patient through to follow-up contact with the family to provide support, send flowers on behalf of the unit, and if appropriate and possible, attend the patient's funeral. Such findings were also identified in other studies, in which staff believed part of their role was to continue to provide support and advocate on behalf of the family if necessary (Bloomer & O'Connor, 2012; Fridh, Forsberg & Bergbom, 2007; Virginio et al., 2014).

'Caring-for' nurse colleagues. There is a plethora of research that has explored caring for nurses as colleagues. The consensus within the literature is that unit managers play a pivotal role in providing psychological, emotional and spiritual support for staff who are confronted daily with high levels of work stress (Efstathiou & Walker, 2014; Tirgari, Khandani & Forouzi, 2013; Walker & Deacon, 2016). Such was the case in the current study, in which nurses spoke of the daily pressures of dealing with life and death situations, having to be a support for grieving families while also being present for each other in stressful moments. Compassionate leadership has been purported by Todaro-Franceschi (2013) to advocate on behalf of nurse colleagues. Todaro-Franceschi's (2013) findings are consistent with those of the current study, in which there was an underlying atmosphere in the unit of collegial support irrespective of staff title or position.

Formal and informal debriefing by staff or professional counselling and pastoral care were available to staff in times of stress and crisis. The findings of this study align with those of Jordan, Clifford and Williams (2014), which identified immediate debriefing, promoting communication among multidisciplinary team members, and accessing counselling or pastoral care as important considerations in stressful

environments such as ICUs. Equally, Beumer (2008) and Halcomb, Daly, Jackson and Davidson (2004) identified the need for professional workshops and education about grief, loss and how to cope in situations in which loss and grief are ever present. France, Byers, Kearney, and Myatt (2011) suggested certain attributes are necessary for creating a healing and supportive environment: trust, mutual respect, mentoring, collegiality and camaraderie. Such findings are consistent with those of the current study, in which participants spoke of and were observed to live the values of support for each other, assist colleagues having difficulty with workloads, experiencing stressful moments or simply feeling overwhelmed with a work situation, and work alongside new staff to ensure appropriate orientation to the unit.

Allocation of workloads was a further aspect of caring for colleagues, as articulated by participants and observed by the researcher. Different combinations of shifts existed within the unit, ranging from 8–12-hours. The unit manager paid particular attention to staff rostered on the 12-hour shifts because of the length of shift and associated workload. The usual pattern of 12-hour shifts was three 12-hour shifts on day duty and four 12-hour shifts on night duty, followed by a 24-hour period between the next sequences of shifts. To ensure staff were not exposed to unnecessary workloads, attention was paid to patient allocation, nurse-to-patient ratios, patient acuity, patient response, resource allocation and patient safety. Each 12-hour shift was reviewed in relation to the previous shift to ensure staff were not overloaded. Of particular import was when nurses on the unit expressed concern about their respective workloads and concern about patient safety. In such situations, a workload review and resource allocation were undertaken to minimise staff concerns. Similar findings were explicated in Richardson, Turnock, Harris, Finley and Carson's (2007) study, which found that the maximum number of consecutive 12-hour day shifts that nurses should safely work is

three. The maximum number of consecutive 12-hour night shifts that nurses should safely work is four. Further, the in-charge nurse must consider nurses who work with complex or demanding patients when allocating the workload for those nurses.

Patients in the current study who were agitated because of their health status but unable to be sedated because of the unit protocol of 'no sedation' posed additional challenges, including the need to view patient care as an interdisciplinary responsibility (Laerknera, Egerodc & Hansen, 2015). At times, some ICU nurses complained about their heavy workload as a result of the complex care needs of patients and associated stresses in meeting their patients' healthcare needs. In such situations, participants were quick to take over some caring responsibilities to ensure their colleagues were not exposed to unsafe practices.

'Caring-for' other health team colleagues. In the current study, participants emphasised their care for nurse colleagues and other health team members in terms of mutual respect, communication and collaboration, especially in critical times. A Canadian qualitative study (Piquette, Reeves & Leblanc, 2009) investigated the perceptions of ICU healthcare professionals including nurses, physicians and respiratory therapists, regarding how medical crises affect their team interactions during the three stages: pre-crisis, during crisis and post-crisis. The study findings demonstrated that during the 'pre-crisis' period, team interactions were based on mutual respect of expertise. However, during the crisis, there was a lack of civility. In the 'post-crisis' period, divergent perceptions among health professionals and team dispersion left nurses with inquiries that could partially be addressed by discussion and feedback (Piquette et al., 2009).

The findings of this study are congruent with those of the current study, in which there is a mutual respect between all health providers, and different styles of

communication for different situations, especially in crises and critical times such as patient resuscitation. Similarly, Rose (2011) highlighted the importance of interprofessional communication and collaboration in the ICU through shared goals, values and partnerships, including explicit, complementary and interdependent roles, mutual respect and power sharing. These findings are congruent with the current study in terms of the existence of collaboration, mutual respect and professional communication between health professionals. In addition, Rushton (2006) noted that CCN leaders are instrumental in creating an environment conducive to ethical practice, such as engaging interdisciplinary colleagues in creating a shared commitment for transforming the critical care environment, exploring moral distress symptoms, and finding solutions and coping strategies for moral distress issues. This was evident in the current study, in which participants pointed out that the health team members always tried to find solutions and coping strategies during moral distress.

For 'caring-for' the **environment and organisation.** Ten of the 67,900 data resources were used for this topic discussion. Regarding the *ICU environment*, participants in the current study undertook a variety of ways to create a healthy environment in the ICU. Issues, including noise, light, colour, temperature and comfort, were improved through creative design, family and pet visitation, and sleep promotion. These findings were comparable with those of Fontaine, Briggs, and Pope-Smith (2001), who suggested designing a humanistic critical care environment. Further, participants stressed the importance of ensuring a safe environment with adequate supplies, equipment, services, technology, and sufficient and competent nursing staff that provide high-quality care and a healthy work environment. These findings were consistent with those of Tremper (2004); maintaining a safe environment through the availability of sufficient supplements, services and competent staff, improves efficacy and work life and

reduces stress for nurses in critical care settings. Moreover, the American Association of Critical Care Nurses (AACN) (2005) identified six standards for establishing and sustaining a healthy critical care work environment: nurses need to be skilled communicators; engage in true collaboration with members of multidisciplinary teams; ensure appropriate levels of staffing, effective decision-making and authentic leadership. In addition, two standards emerged from nurse leaders and direct care nurses, who defined a healthy work environment as involving physical safety for the patient, family and staff, and psychological safety, where staff are empowered to have a voice without fearing retaliation or job loss (Huddleston & Gray, 2016). Similarly, Tracy and Ceronsky (2001) indicated that a collegial, collaborative, healthy work environment results in patient, family and staff satisfaction. A healthy ICU environment not only enables nurses to attain personal satisfaction in their work, but it also helps them meet organisational goals (Schmalenberg & Kramer, 2007). As witnessed by the researcher and expressed by participants in the current study, all nurses and health team members strove to work towards providing a healthy ICU environment through different strategies and standards, such as having skilful communicator nurses, collaborating with multidisciplinary team members, ensuring appropriate levels of staffing, effective decision-making and authentic leadership, and maintaining physical and psychological safety for patients, families and staff. The provision of a healthy environment was cited as a priority in several studies (Huddleston & Gray, 2016; Tracy & Ceronsky, 2001; Tremper, 2004).

In the current study, health team members utilised digital technology as part of patient care. For example; technology provides medical management, electronic health records, patient information, tools to detect vital signs and unstable physiologic patient status. Technology enhanced patient safety by making treatment more secure. In the literature, the importance of technology was emphasised as an important part of critical

care settings. ICU care such as medical treatment and electronic health records would be beneficial in saving time, reducing nursing workloads, enhancing nurses' work by increasing access to patient information and efficacy (Kleinpell, Barden, Rincon, McCarthy & Rufo, 2016; Kossman & Scheidenhelm, 2008; Wikström, Cederborg & Johanson, 2007).

In the current study, ICU nurses were mindful of the wasteful stocking practices and made considerable effort to establish and maintain infection control and waste management. This was evident through the researcher's observations and nurse participants' views about waste management. For example, nurses were cautious about the minimum stock levels in isolation rooms, where there are infectious cases. This was consistent with Morrow et al.'s (2013), who found that reducing waste was one of critical care nurses' concerns.

8.5.4 Contribution to new knowledge.

Contributions to new knowledge from this study include:

- In ICU, nurses care for several entities in the unit (oneself, patients, families, nurses and different colleagues, and the ICU environment and organisation).

- There is a necessity to find consensus and strategies among health professionals in regard to the ethical considerations of patient rights and treatments in critical care settings, especially in the EOL stage.

- Communicating with patients in the EOL stage is a significant element of care that is not limited to the time before and during patients' death, but also after their death.

- It considers caring for the family as 'an extension of caring for the patient'.

- Nurses are reluctant to engage with families because of their perceived subordinate role to medical and other aligned health professionals.

- ICU nurses have a heightened sense of ecological consciousness, which has contributed to the unit culture of waste minimisation and environmental protection.

8.6 Theme 3: Qualities Required of ICU Nurses to Provide Quality Care

8.6.1 Summation of the theme.

This theme includes findings on the qualities required of nurses to provide quality care in intensive care settings. Three subthemes emerged: *ability to work in intense nursing situations* (knowledgeable and skilful, attentive and vigilant, engagement in critical problem solving, skilful in time management, and flexible and multitasking), *being an effective communicator* (being approachable, empathic, assertive, a patient advocate and able to develop trusting relationships), and *being professional* (willing to work with others, being fair and non-judgemental, respectful, honest and reliable).

8.6.2 Search terms for the theme and sub-theme process.

For this theme, the strategy was searching for limited keywords with quotation marks and asterisks, parenthesis and Boolean operators such as 'OR' and 'AND' (Qualities OR abilities OR capacities OR capabilities OR skills OR talents) AND Nurse* AND ('intensive care' OR 'critical care' OR 'ICU') (see Table 8.3). In addition, a gradual elimination of studies according to PRISMA is presented in Figure 8.3.

Table 8.3

Literature Review Search Strategy for Theme Three

Search terms for theme and subthemes/process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No. of papers	No. of papers	No. of papers	No. of papers
Nurse* AND (Qualities OR abilities OR capacities OR capabilities OR skills OR talents) AND ('intensive care' OR 'critical care' OR ICU')	94	128	400	47	46
Nurse* AND (description OR definition) AND ('intensive care' OR 'critical care' OR 'ICU')	24	6	41	3	1
Duplicates removed					12
Total after removal of duplicates					35
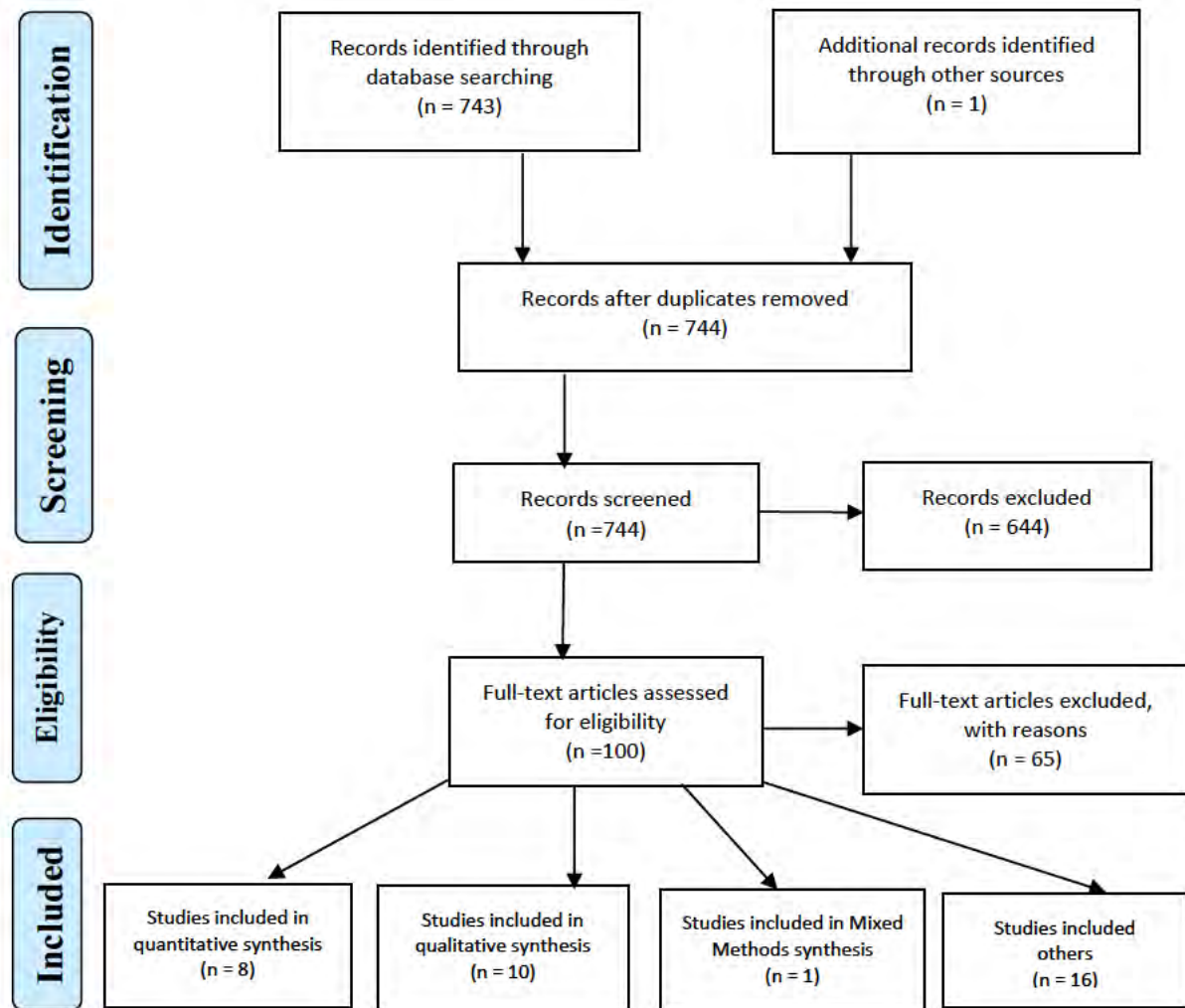
Figure 8.3. PRISMA flow diagram of literature identification process for Theme 3.

8.6.3 Discussion of Theme 3 in relation to the literature.

The review of literature revealed a plethora of research on the qualities required of ICU nurses. Although reference was made to adhering to the standards of practice in critical care settings, descriptions of the specific qualities needed of ICU nurses were not forthcoming in this study. Reference to the notion of qualities as a determinant of professional practice in the ICU was noticeably absent in the literature, but seemed to have been subsumed under the rubrics of *constructs* (Gill, Leslie, Grech & Latour, 2012), *framework* (Bench et al., 2003; Deacon et al., 2017; Price, 2013); *clinical guidelines and care protocols* (Department of Health, 2001); and *competency standards* (AACN, 2005). Fisher, Marshall and Kendrick (2005) described the Australian specialist level for critical care nurses (ACCCN) as three-tiered: *elements* (related aspects of performance that afford evidence for certain competency), *competencies* (attributes of a specialist nurse who works at a high-performance level) and *domains* (enabling, clinical problem-solving, professional practice, reflective practice, teamwork and leadership).

Wysong and Driver's (2009) descriptive qualitative study of perceptions of patients of nurses' skills found that interpersonal and critical-thinking skills were considered more important than technical skills were. Wyong and Driver's (2009) findings were consistent with those of this study, in which participants were observed by this researcher to be critical thinkers in determining the most appropriate care for patients, and effective communicators in responding to the needs of patients, their families and interacting with colleagues.

The standards of Critical Care Network National Nurse Leads (CC3N) (2012) described competence as 'the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective critical care nursing care and interventions' (p. 14). This description is compatible with the findings of the current

study, in which nurses were found to be skilful, knowledgeable and patient-centred in their provision of professional practice. The AACN (2005) identified six standards for establishing and sustaining a healthy work environment in critical care settings for optimal patient outcomes. These included the need for nurses to be skilled communicators, able to engage collaboratively with other members of the healthcare team, able to make appropriate decisions about the care and management of patients, and provide competent authentic leadership. These standards are consistent with the findings of the current study.

Participants in the current study expressed the importance of being able to advocate on behalf of their patients and their patients' families. Numerous studies identified patient advocacy as an important quality of nurses working in ICU (Andersson et al., 2015; McCallum & McConigley, 2013; Pattison, Carr, Turnock & Dolan, 2013; Wilkin, 2003). An ethnographic study (Sorensen & Iedema, 2007) explored the role of intensive care nurses as advocates for patients at the EOL stage. It revealed that such a role is not restricted to nurses, but requires a multidisciplinary team approach. These findings are consistent with those of this study, in which participants spoke of the importance of being able to advocate on behalf of patients and their families within the context of the multidisciplinary team.

Other essential ICU nurse qualities identified in the literature were compassion and empathy (Kongsuwan & Locsin, 2011; Wilkin, 2003), and fostering the time to care (Kongsuwan & Locsin, 2011; Stayt, 2009). Thornby (2006), The findings of Reader, Flin and Cuthbertson (2007) and Muldowney and McKee (2011) were consistent with the current study in emphasising the importance of effective communication and interpersonal relationships, protecting patient safety and establishing a healthy work environment.

Gill et al. (2012) compared the differences and similarities in critical care nursing practice standards in the United States, Canada, UK, New Zealand and Australia. They discovered similarities between the ICU nurse qualities identified: the need for specialist knowledge and advanced skills in assessment, planning and management of care, risk management, patient/family advocacy, ethical decision-making and resource use. These qualities were also explicated in the current study. The standards for critical care nursing in Ontario are organised into five categories: clinical skills, knowledge, integration and critical thinking; professional behaviours/ethics; continuing competence and research; patient and nurse safety/risk prevention; and therapeutic and professional relationships/caring (Bennett et al., 2005). The findings of Gill et al. (2012) and Bennett et al. (2005) are comparable with those of the current study, in which specialist knowledge and advanced skills, risk management, promoting patient comfort and wellbeing, safety and patient/family advocacy, communication, collaboration, professional relationship, critical thinking, and providing support to colleagues were qualities identified by participants.

Several studies identified essential competencies requirements of critical care nurses (Dunn et al., 2000; Lakanmaa, Suominenb, Perttilä, Puukkae & Leino-Kilpi, 2012; Lindberg, 2006). For instance, Dunn et al. (2000) sought to categorise competency standards for critical care nurses. Six domains were identified: professional practice, reflective practice, enabling, clinical problem-solving, teamwork and leadership. These findings were consistent with the descriptions of the requisite qualities of ICU nurses.

Lindberg's (2006) phenomenological study explored ICU nursing staff's perspective of competence and its development. The author found that personal maturity and attitude are the most significant foundations for a competent nurse in a critical care setting. Further, CCNs require five attributes of competence: the ability to cooperate, the

ability to perceive the situation correctly, awareness of one's own abilities and limitations, the ability to act, and the ability to disregard technology if it interferes with quality patient care. This was similarly described in the findings of this study.

The importance of qualities or competencies required of nurses working in the ICU were classified in various ways by Lakanmaa, Suominen, Ritmala-Castrén, Vahlberg and Leino-Kilpi (2015), O'Leary (2012), and Salonen, Marja, Meretoja and Tarkka (2007). In these studies, clinical competence was deemed to be underpinned by knowledge and skills identified as fundamental qualities required of ICU nurses. Similar findings were explicated in the current study, in which participants discussed the importance of ICU nurses being skilled and knowledgeable in their field of practice.

A study conducted by Mollerup and Mortensen (2004) investigated intensive care nurses' perceptions of their own levels of competence. The researchers assigned the participants, according to Benner's (1984) work, from novice to expert ICU nurses; they described their level of competency in relation to decision-making skills, knowledge base, and possession of a broad, holistic picture of the unit (Mollerup & Mortensen, 2004). The findings indicated that experienced ICU nurses were assumed to be competent based on length of employment rather than the evaluation of their abilities. However, in the current study, participants viewed their own personal level of competency as being generally appropriate for working in the unit.

A quantitative study by Kuokkanen, Leino-Kilpi and Katajisto (2002) investigated how critical care nurses assess their qualities. The findings revealed that nurses assessed their qualities in line with: moral principles (e.g., *respect for individuals, honesty, justness and fairness*), personal integrity (e.g., *assertive, able to work under pressure, broad-minded and flexible*), expertise (e.g., *competent*), future orientedness (e.g., *forward thinking*) and sociability (*respected by others*). Each of these qualities was

explicated in the current study. Similarly, Messmer, Jones and Taylor (2004) indicated that critical thinking, knowledge, self-confidence and self-esteem were characteristics needed by nurses in intensive care settings. Elmers (2010) suggested that competent critical care nurses require critical-thinking skills for safe practice. Swinny (2010) stressed the importance of critical care nurses being critical thinkers by having the ability to rapidly define and change priorities, work in stressful situations, be effective communicators and be willing to collaborate with other healthcare team members. All these findings were evidenced in this study.

A descriptive study in Turkey by Batmaz, Enc & Pektekin, 2001 investigated the self-esteem, assertiveness and decision-making skills of critical care nurses. It found a significant relationship between assertiveness and self-esteem. The study recommended that nurses develop assertiveness skills to undertake independent practice-based decision-making in critical care settings. This was reflected in the findings of the current study.

Hardcastle (2008) suggested that advanced knowledge and technical skills require the development of critical thinking and problem-solving methods in clinical practice, which can be nurtured by education and experience in improving the delivery of care for critically ill patients and their families.

Interestingly, there is a noticeable paucity of literature that has explored the qualities required of a nurse working in an ICU setting.

8.6.4 Contribution to new knowledge.

The current study identified some qualities as adhering to the values and mission of the hospital, and personal characteristics for the ICU nurse, such as being a multitasker, hard worker, accurate, tidy and neat; these qualities are not located anywhere in the literature, which contributes a new area of knowledge.

8.7 Theme 4: The Unit Manager as a Culture Carrier of Caring in ICU

8.7.1 Summation of the theme.

The fourth theme to be explicated was the unit manager as a culture carrier of caring in ICU. Several qualities were identified that characterised the unit manager as a culture carrier of caring within the unit, underpinned by a commitment to valuing staff. Valuing staff was manifested in different ways: being open and approachable, respectful and valuing of others, willing to listen and understand others' concerns, being supportive, and making every effort to be attuned to the daily needs of the staff in the unit.

8.7.2 Search terms for the theme and subthemes process.

The search strategy used in the review of literature was searching for keywords, with or without quotation marks with Boolean operators: ('nurse manager' OR 'manager' OR 'NUM' OR 'in charge' OR leader OR mentor) AND (exemplar OR model OR 'carrier of caring') AND ('intensive care' OR 'critical care' OR 'ICU') (see Table 8.4). In addition, a gradual elimination of studies according to PRISMA is presented in Figure 8.4.

Table 8.4

Literature Review Search Strategy for Theme 4

Search terms for themes and subthemes/process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No. of papers	No. of papers	No. of papers	No. of papers
('nurse manager' OR 'manager' OR 'NUM' OR leader OR 'in charge' OR mentor) AND (exemplar OR model OR 'carrier of caring') AND ('intensive care' OR 'critical care' OR 'ICU')	18	254	39	17,300	142
Duplicates removed					134
Total after removal of duplicates					8
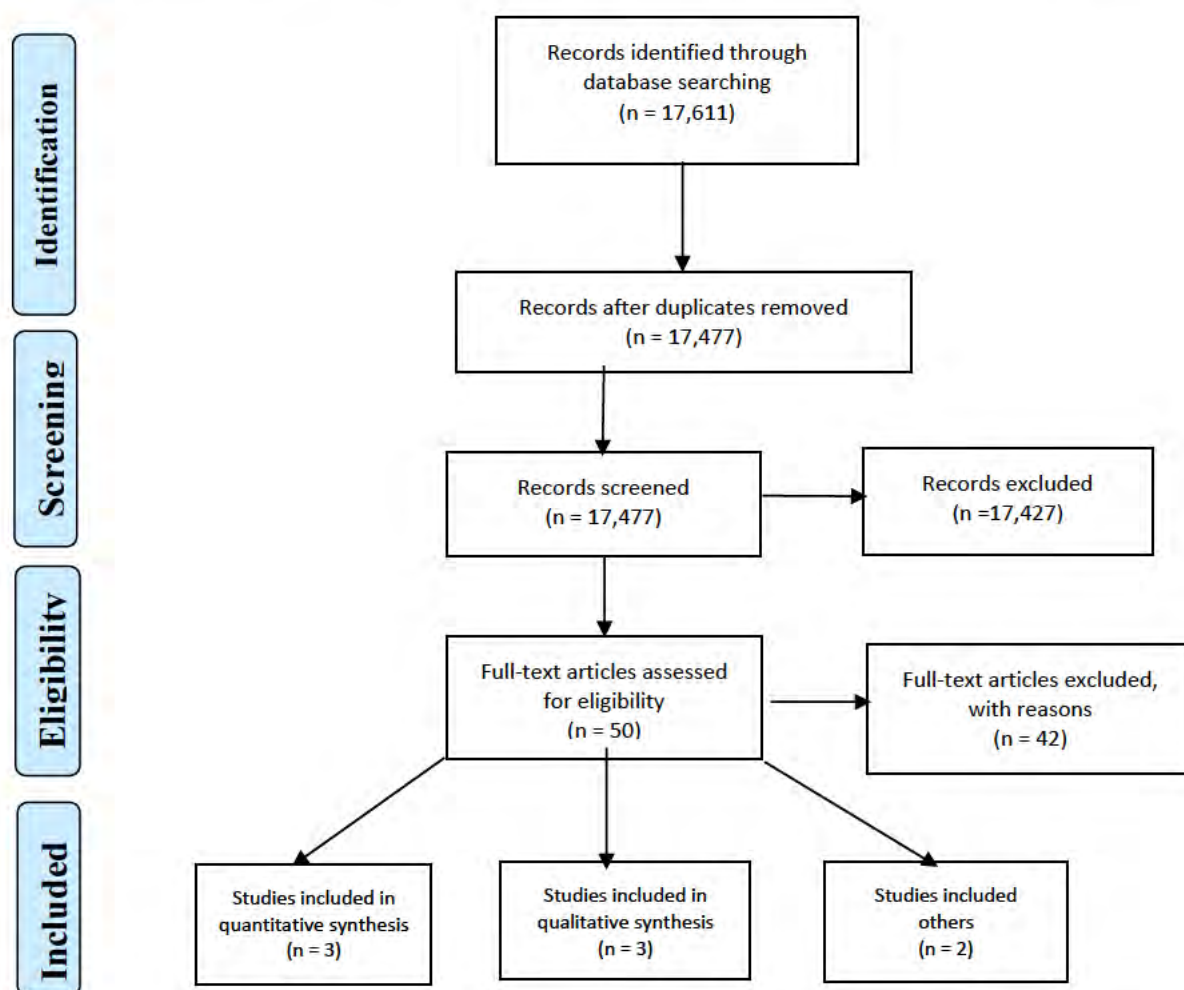
Figure 8.4. PRISMA flow diagram of literature identification process for Theme 4.

8.7.3 Discussion of Theme 4 in relation to the literature.

The review of literature revealed a limited number of published research on nursing leadership in an adult ICU. Much of the discussion was generic to health care (Linton & Farrell, 2009; van Schijndel & Burchardi, 2007). References to positions of leadership included: unit/ward nurse manager, head nurse, team/nurse leader, in-charge/charge nurse, ward coordinator/sister, clinical nurse supervisor, and first-line manager (Bondas, 2006, 2010; Connelly, Yoder & Miner-Williams, 2003; Mejia, Vasquez & Sanchez, 2006; Rosengren, Athlin & Segesten, 2007; Rosengren & Bondas, 2010).

The importance of the unit manager as a culture carrier of caring, in this study, was identified as having a key number of elements. One was the ability of the unit manager to negotiate pathways through staff conflict, leading to resolution using open communication and respectful listening. Similar findings were explicated in previous studies in which conflict management of staff was examined. The findings of these studies indicated that conflict was successfully managed through the effective use of open communication and by listening to others in a respectful manner (Gomes, Noguez, Thofhern & Amestoy, 2012; Linton & Farrell, 2009; Oyeleye, Hanson, O'Connor & Dunn, 2013). In addition to the use of open communication and listening in a respectful manner, empowering and instilling a sense of confidence in staff were also employed by the CNM to address issues of conflict within the unit. These findings were congruent with van Schijndel and Burchardi's (2007) study of leadership and conflict management in the ICU, in which providing emotional support, motivating and empowering team members to resolve potential conflict situations, and creating a sense of self-confidence in staff were identified.

The CNM and other in-charge leaders in the current study, who not only managed the unit but led by example, were prepared to provide clinical support at the bedside when required to alleviate pressure on staff. Similar findings were explicated in a study by Linton and Farrel (2009), in which the CNM was found to be available not only at times of unit crisis, but on a daily basis. However, in contradiction to the findings of this study and that of Kerfoot (2002) and Rosengren et al. (2007), it found that the unit manager did not engage in hands-on bedisde care to focus on financial and administrative responsibilities.

Rosengren et al.'s (2007, p. 522) phenomenographical study of staff conceptions of nursing leadership in ICU revealed that nursing leadership was described as 'being

present and available in daily work', 'supporting everyday practice', 'facilitating professional acknowledgement', and 'improving the individual and team care'. Each of these elements of leadership was described by participants in the current study, in which openness and availability were epitomised by the open-door policy of the CNM.

Leading by example was a further finding of this study; the CNM was described by participants as a model of open communication, with all staff creating an atmosphere of collegiality, trust, respect and feeling valued that led to job satisfaction, commitment to the unit and productivity. Similar findings were identified in other studies (Chiok, 2001; Linton & Farrell, 2009; Manthous, Nembhard & Hollingshead, 2011; Moneke & Umeh, 2013), which revealed that leading through modelling can lead to improved job satisfaction, productivity and organisational commitment.

8.7.4 Contribution to new knowledge.

Contribution to new knowledge included:

- Role modelling by the unit manager is pivotal in creating a culture of caring in the critical care setting.

- Four levels of role modelling caring were exemplified by the CNM in this ICU: 'Close to Far'.

- The unit manager was approachable on different levels, as from ***Close-to-Far*** approachability.

- The unit manager was willing to be a bedside nurse when required to assist in nursing care.

- The unit manager was a team leader, coordinating care from the nursing station and overseeing the delivery of quality care.

- The unit manager assumed a managerial role in coordinating nursing staff from her office.

- The unit manager was available to staff during off-duty times for consultation and advice.

Close   Far

1	2	3	4
Bedside Nurse	Leader/Unit coordinator	Manager in the office	Manager off-duty
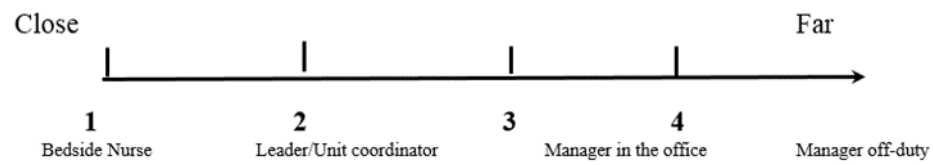
Chapter 9: Discussion of Findings in Relation to Existing Literature, Part 2

9.1 Introduction

Chapter 9 includes Part 2 of the discussion of three themes in relation to existing literature. Theme 5 is patterns of communicating caring in ICU, Theme 6 is enablers, challenges and negative cases for caring in ICU, and Theme 7 is patterns of caring for nurses in stressful moments in the ICU. In addition, the synthesis of the findings in relation to the review of literature is presented at the end of the chapter.

9.2 Theme 5: Patterns of Communicating Caring in the ICU

9.2.1 Summation of the theme.

The fifth theme—patterns of communicating caring in the ICU—is underpinned by several subthemes: the changing patterns of communicating caring; forms of communicating caring used in the ICU (including documentation of care by nurses); facilitators in communicating caring; and factors impeding communicating caring in ICU.

9.2.2 Search terms used in relation to the theme and subthemes.

Search strategies for this theme involved searching for keywords using quotation marks, parentheses and Boolean operators such as 'AND' and 'OR'. An asterisk (*) at the end of keywords ensured that the search included words with alternative endings (see Table 9.1). In addition, a gradual elimination of studies according to PRISMA is presented in Figure 9.1.

Table 9.1

Literature Review Search Strategy for Theme 5, Patterns of Communicating Caring In

ICU

Search terms for theme and subthemes process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No. of papers	No. of papers	No. of papers	No. of papers
Communication AND ('intensive care' OR 'critical care' OR 'ICU')	37	179	1,228	18,800	70
(nurse*' documentation OR recording* OR charting) AND ('intensive care' OR 'critical care' OR 'ICU')	116	91	345	18,700	31
Duplicates removed					66
Total after removal of duplicates					35
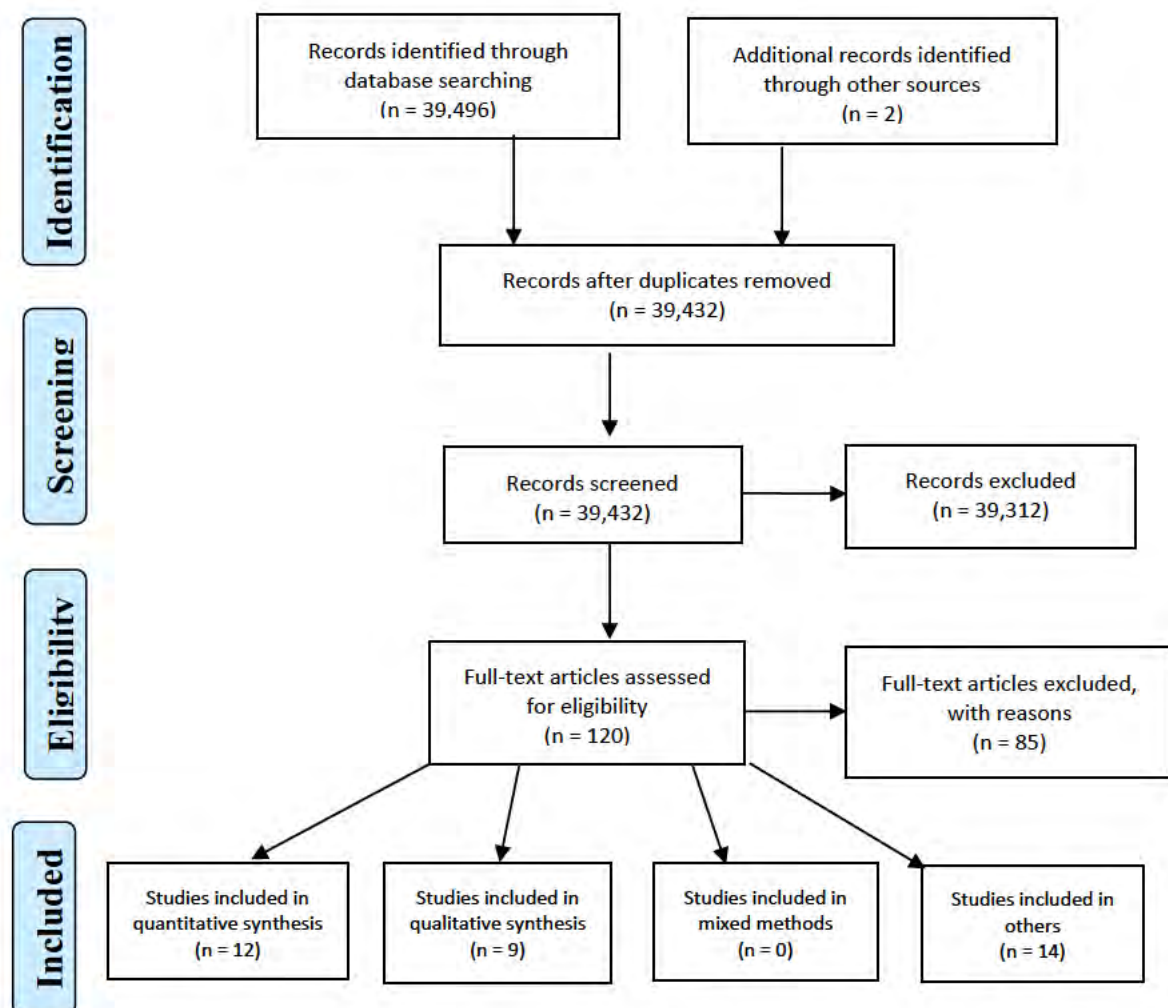
Figure 9.1. PRISMA flow diagram of literature identification process for Theme 5.

9.2.3 Discussion of Theme 5 in relation to the literature.

Regarding different patterns of communicating caring in ICU. In the current study, different patterns of communicating caring were identified between nurses, nurse-patients and families, nurse-unit managers, and nurse colleagues. A hermeneutic observational study by Karlsson, Forsberg and Bergbom (2012) explore the ways nurses communicate with mechanically ventilated patients in the ICU and whether such communication is considered caring. The findings of the study revealed several ways nurses communicate that they care for their patients, including being attentive and watchful, taking note of the patient's non-verbal communication (such as body language); being inclusive (involving the patient in their care); using humour to introduce moments of light-heartedness in stressful times; and creating a sense of security for the patient by the quality of care provided.

The findings of the current ethnographic study showed nursing staff employed a range of strategies to communicate with patients receiving mechanical ventilation who were unable to communicate verbally. In such situations, several devices were made available to the patient (e.g., pen and paper, ABC board. iPad, and texting on smartphones). As partial or complete tube cuff deflation with digital occlusion, plugging or capping of the tube, a one-way speaking valve, and tracheostomy button were used. These measures to assist patients in communicating were found in several studies (Dithole, Sibanda, Moleki & Thupayagale-Tshweneagae, 2016; Flinterud & Andershed, 2015; Morris, Bedon, McIntosh & Whitmer, 2015; Shiber, Thomas & Northcutt, 2016). However, the use of such devices is predicated on the ability of the patient to be able to use them. For instance, in the current study, patients being mechanically ventilated and who also had other injuries (such as injured or oedematous hands) were unable to use handheld devices. In such situations, nursing staff were required to use non-verbal

communication. At such times, direct eye contact, the use of nodding to convey understanding and lip reading were used by nurses (Karlsson et al., 2012). Irrespective of the health status and communication limitations of the patient, nursing staff spoke of the importance of being able to simply 'be there' for their patient, working with the patient to find the most convenient and appropriate way to communicate and anticipate patients' needs. Saldaña, Pinilla Alarcón and Alvarado Romero's (2015) quantitative descriptive study surveyed ICU nurses, and discovered that communication between nurses and patients highlighted the importance of intra/inter/transpersonal communication, in which communication is made with comprehension, empathy, acceptance, authenticity and respect to establish a therapeutic relationship that identifies, comprehends and satisfies patients and their families' psychosocial needs. This is achieved through teamwork and concordance between the nurse and patient. These findings align with those found during the current study, in which participants shared a cultural view of the importance of being empathic, respectful and authentic in all communications with patients and their families.

In terms of staff communicating with each other on the unit, the most common devices used (apart from documentation, which will be discussed later in this chapter) to enable rapid updates of patient information and distribution to all members of staff, day or night, were smartphones and pagers. Staff were frequently observed checking their emails (blogging), smartphones and pagers for information updates, showing a new emerging culture of communication. Similar findings were evident in studies by Curry (2012) and Al-Qadheeb et al. (2013).

In the current study, the findings revealed various **obstacles and facilitators** to the different ways of communicating in the ICU. Obstacles to communication related to the patients' health status, level of consciousness, mechanical ventilation, lack of access

to communication aids and either being too weak or depressed to attempt to communicate. In such situations, nurse participants spoke of the difficulties facing both the patient and themselves in providing the right care in a timely and respectful manner. This is consistent with the findings of previous studies (Happ et al., 2011; Magnus & Turkington, 2006; Nilsen, Sereika & Happ, 2013). In terms of challenges communicating with ventilated patients, several studies were located. Alasad and Ahmad (2005) in Jordan used a phenomenological hermeneutic design to investigate critical care nurses' verbal communication with critically ill patients. Data were gathered through interviews and participant observations. The findings revealed that nurses tended to use less verbal communication when caring for unconscious patients than they did with verbally responsive patients. Also, Alasad and Ahmad (2005) found that nurses communicated less with unconscious patients than they did with conscious patients, which contrasts to the findings of the current study, in which participants stressed the importance of verbally communicating with the unconscious patient when carrying out nursing procedures as a point of respect for the person. This was witnessed by the researcher in the ethnographic observational period. The variances of the findings between the current study and Alasad and Ahmad's (2005) study could be due to the age of the latter study, or it could be merely a cultural issue or the latter's reliance on participants' observations. In the current study, the researcher observed and compared participants' statements, which were compatible with their deeds.

A quantitative, descriptive, observational study undertaken by Happ et al. (2011) described communication interactions, methods and assistive techniques between nurses and nonspeaking critically ill patients in an ICU. They used video recordings and patient self-rated ease of communication questionnaires. Some findings of this study are

consistent with those of the current study; for example, communication difficulty was the greatest stress for mechanically ventilated patients and nurses.

A further barrier to communication in this study was staff handovers, in which the frequent use of jargon and acronyms resulted in some members of staff, especially new or agency staff, finding it difficult to comprehend the terminology. As a subculture (ICU) within a larger hospital culture, which in itself sits within a broader cultural group of nursing, it is not surprising that nuances of language exist, yet it highlights the importance of a shared professional language across all areas of nursing. Difficulty in understanding handover notes between nurses and others has been previously identified in a multicentre pilot study by Magnus and Turkington (2006). This study investigated patients' and ICU staff's (doctors, nurses and allied health professionals) perceptions and experiences of communication interactions in ICU. Barriers to communication included staff being unable to understand handover notes written in medical jargon, which was also described by participants in the current study as a major impediment to receiving a comprehensive handover of the patient's health status and treatment regime.

Participants in the current study identified language as a significant barrier to communication between patients/families and health professionals. Numerous studies also identified language as a major barrier to communication. A phenomenological exploratory study undertaken by Coleman and Angosta (2017) related to CCNs caring for patients and families with limited English proficiency (LEP). In such situations, the use of interpreters, either in person or by telephone, was considered preferable to struggling to understand the need of patients to provide appropriate care. Coleman and Angosta's findings are consistent with those of the current study, in which interpreters were used when and where available. However, when interpreters were not available, the staff had to rely on family or friends to interpret the patient's needs.

Although most staff valued the use of alternative modes of communication when verbal communication was not available, some conveyed to the researcher that such assistive devices were time-consuming and impractical with nonresponsive, sedated or cognitively impaired older adult patients. The identification of the need for communication training programs for ICU staff, especially for communicating with non-verbal patients, is consistent with the findings of other studies (Magnus & Turkington, 2006; Shiber et al., 2016).

Further, Schubart et al. (2015) undertook a qualitative analysis of healthcare professionals' (HCPs) perspectives on communicating with patients' families in ICUs. Analysis of participants' interview transcripts identified a number of potential barriers to facilitating caring, including: person factors—culture, class, education, personality and level of aggression by patients and family; structural factors—role constraints (e.g., limited time); information management—lack of clarity of information; and comprehension—what was communicated by healthcare practitioners and understood by patients and their families. The findings of Schubart et al.'s (2015) study are consistent with those of the current study, in which miscommunication between members of the treating team and patients, limited time, work overload and language were viewed by participants as impeding the provision of quality care.

Interruptive communication is a significant cause of mistakes and can have consequences that affect the provision of patient care in ICUs (Alvarez & Coiera, 2005, 2006; Manojlovich & DeCicco, 2007). For example, the findings of two Australian studies by Alvarez and Coiera (2005, 2006) revealed that communication interruptions could affect retention of important information about patient health and treatment, placing patients at risk (e.g., in drug administration). Alvarez and Coiera (2005) analysed observations and conversations with ICU nurses and doctors. The data indicated that

distractions during handover were likely to lead to miscommunications. Similarly, in the current study, participants spoke of the disruptive nature of handover and how such disruptions interfered with receiving an accurate report about the health status and management of patients.

Loghmani, Borhani and Abbaszadeh (2014) explored the facilitators and barriers that influence communication between nurses and families in the ICU. The study identified barriers to nurse–patient family communication, including misunderstandings about treatment needs, and conflicts between patients' family members about treatment options. These findings are consistent with those of the current study, in which participants struggled to work with families.

Conversely, participants in the current study identified numerous ***communication facilitators.*** For example, the importance of open communication and speaking up among ICU staff was explicated in the findings of the current study. In their quantitative cross-sectional survey of ICU nurses and doctors, Reader, Flin, Mearns and Cuthbertson (2007) found that communication openness was associated with the degree to which staff understood patients' care goals. Therefore, feeling safe among ICU team members was an important consideration to speak openly between staff without fear of reprisal or embarrassment. Open communication among the team was a predictor of the degree to which members reported understanding patient care.

Reid, McDowell and Hoskins (2011) investigated communicating the news of a patient's deaths to relatives. They stressed the importance of the presence of a nurse at that time to support the families and doctors. Nurses were perceived as more available than doctors were in critical care settings; thus, they were in many respects a conduit between the doctor and the patient's family when clarification of information was required and to provide support at such a critical time. Nurses were also well-positioned

to facilitate the family in saying their farewells by encouraging relatives to touch, hold or kiss their deceased loved one. Similar findings were explicated in the current study, in which several participants shared their experiences of providing family support prior to and after their loved one had died, even to the point of attending the patient's funeral.

      ICU nurses need documentation for what? In the current study, the researcher found nurses documented participants' vital signs, haemodynamic parameters, diagnostic tests and procedures by physicians, nursing activities and interventions. This is consistent with Bloomer and O'Connor's (2012) findings that ICU nurses document haemodynamic parameters and clinical interventions. However, the absence of documentation of nursing care (separate from treatment) was noticeable to the researcher. Similar findings were described in other studies. Weyant, Clukey, Roberts and Henderson (2017) and Inan and Dinç (2013) found that nurses rarely document their actual nursing care of patients (e.g., the use of touch and its impact on patient health outcomes). When reference is made to the care nurses provide, it is more often described in general terms such as 'provided psychosocial support'. The importance of documenting care can be summed up in two aphorisms: 'If it's not written down, it didn't happen' (Andrews & St Aubyn, 2015, p. 22) and 'If it wasn't documented, it wasn't done' (Frank-Stromborg, Christensen & Do, 2001, p. 842).

      Carelock and Innerarity (2001) suggest that complete, clear, accurate and concise records of nursing care are a powerful tool in assuring quality patient care in the ICU, which is consistent with the articulations of participants in the current study, but not evident in their documentation of patient care. Further, in the current study, non-standard abbreviations were used, documentation was not in a logical order, and there was repetitious information. Similar findings were described by Paans, Sermeus, Nieweg and Van Der Schans (2010), who used a cross-sectional retrospective patient record review

to measure the accuracy of nursing documentation in 35 wards from seven different specialty areas (e.g., two ICUs) of hospitals in the Netherlands. The findings showed more than 50 per cent of evaluations contained unnecessary wording and non-standard abbreviations that could be misinterpreted. Paans et al. (2010) recommended that nursing documentation should be understandable and presented in a logical order. Reports involving extended-stay situations were repetitious, contained redundant content and were time-consuming to read.

The current study revealed a lack of documentation from participants, which was the case in a number of studies. For example, Inan and Dinç (2013) evaluated nursing documentation of patient hygienic care. They analysed the consistency between the actual care given by nurses and what was documented in nursing records. Critical care nurses were observed and their nursing records audited. The findings revealed that the consistency between the actual hygienic care and its documentation was 77.6 per cent, and documentation was poor and incomplete (Inan & Dinç, 2013). These findings are congruent with those of the current study, in which nurses abbreviated sentences, such as 'patient nursed as per care plan'. Generally, using abbreviations and acronyms in documentation is problematic and might lead to misinterpretation and mistakes within medical records (Beach & Oates, 2014; Blair & Smith, 2012; Dimond, 2005; Kuhn, 2007).

A quantitative descriptive study was carried out by Borsato, Rossaneis, Haddad, Vannuchi and Vituri (2011) based on secondary data of nursing quality assurance at an institution from 2002–2009. The findings showed that ICU nurses' notes were used to record information on care delivery, generate communication among the health professional team, allow the continuity of their work process, guarantee security to patients and support from legal and ethical viewpoints (Borsato et al., 2011). Yet, it was

inadequate or incomplete in that it did not satisfactorily achieve the ICUs' nursing documentation criteria. These findings are consistent with those of the current study in terms of a lack of detailed information in nursing records.

Similarly, a retrospective record review by Goss, Coty and Myers (2011) of documented oral care practices in an ICU identified a lack of detailed oral care documentation in patients' medical records. Further, comprehensive documentation of EOL care was found to be lacking in Kirchhoff, Anumandla, Foth, Lues and Gilbertson-White's (2004) study, which reviewed charts of adult ICU patients. The findings of the previous two studies, in terms of a lack of documentation of care, are consistent with those of the current study, which necessities the development of standard documentation charts for nurses in ICUs.

Participants in the current study stressed the importance of documentation for different reasons. One was to avoid claims of negligence by recording important data that needed to be communicated to other health professionals. As Carelock and Innerarity (2001) noted, documentation is essential for nurses as advocates of their patients. Failure to document effectively could result in unsafe practice and litigation.

Reasons nurses do not document caring activities in patient care records were rationalised by participants in the current study. They suggested that subjective information about the way they care for patients is not valued by the healthcare team; therefore, providing care was prioritised over documentation of care. These findings are similar to those of Gugerty et al. (2007), who found that nurses prioritised patient care over documentation of subjective data that they considered unnecessary. Additionally, participants in the current study cited workload, and shortage of staff and time as reasons for not documenting all aspects of care. Similar findings were reported by Petkovsek-Gregorin and Skela-Savic (2015) in their quantitative non-experimental study conducted

in Slovenian hospitals. A number of barriers were identified that prevented nurses from recording all relevant activities and services, including work overload, and staff and time shortages that required nurses to sometimes stay at work beyond their scheduled work hours to finalise their documentation.

9.2.4 Contribution to new knowledge.

Contributions to new knowledge included:

- There is a lack of documentation of patients' psychological and emotional aspects, in addition to the nurses' behaviours towards patients and families.

- There is a growing culture of communication by technology, both from nurse-to-patient and nurse-to-nurse.

9.3 Theme 6: Enablers, Challenges to Caring and Negative Cases of Caring in the ICU

9.3.1 Summation of the theme.

The findings of this theme revealed enablers and challenges for the participants in the ways they were able to care for their patients, patients' families, their colleagues and the ICU environment. In addition, negative cases of caring were identified by the researcher during her period of field observation. A discussion of the theme in relation to the literature follows.

9.3.2 Search terms used in relation to the theme and subthemes.

Search strategies for this theme involved a search of keywords, using quotation marks, parentheses and Boolean operators such as 'AND' and 'OR'. An asterisk at the end of keywords ensured that the search included words with alternative endings (see Table 9.2). In addition, a gradual elimination of studies according to PRISMA is presented in Figure 9.2.

Table 9.2

Literature Review Search Strategy tor Theme 6, Enablers, Challenges and Negative (Non-Caring) Cases for Caring in ICU

Search terms for theme and subthemes/process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No of papers	No of papers	No. of papers	No. of papers
Caring AND (Enablers OR facilitators OR expediters factors) AND (Barriers OR challenges OR obstacles OR hindrances) AND ('intensive care' OR 'critical care' OR 'ICU')	168	138	22	10,100	8888
(Attractions OR motivators OR reasons) AND Nurse* AND ('intensive care' OR 'critical care' OR 'ICU')	7	339	87	17,900	16
Nurse* AND (satisfaction OR dissatisfaction) AND ('intensive care' OR 'critical care' OR 'ICU')	29	126	438	17,100	14
Nurse* AND (Like OR dislike) AND (Work* OR job) AND ('intensive care' OR 'critical care' OR 'ICU')	3	1	33	17,400	12
'Nurs*' AND ('Non-caring' OR 'uncaring' OR 'not caring' OR negligence) AND ('intensive care' OR 'critical care' OR 'ICU')	25	12	31	3,110	10
Duplicates removed					95
Total after removal of duplicates					45

A flow diagram with four stages labelled on the left: Identification, Screening, Eligibility, Included.

Identification:
Records identified through database searching (n = 67,069)
Additional records identified through other sources (n = 0)

Screening:
Records after duplicates removed (n = 66,974)
Records screened (n = 66,974) → Records excluded (n = 66, 700)

Eligibility:
Full-text articles assessed for eligibility (n = 274) → Full-text articles excluded, with reasons (n = 229)

Included:
Studies included in quantitative synthesis (n = 13)
Studies included in qualitative synthesis (n = 16)
Studies included in mixed methods synthesis (n = 3)
Studies included in others (n = 13)

Figure 9.2. PRISMA flow diagram of literature identification process for Theme 6.

9.3.3 Discussion of Theme 6 in relation to the literature.

9.3.3.1 Enablers to caring in ICU.

In relation to patients, caring for the safety of patients was an issue reported by many participants in the current study. To ensure the safety of patients, collaboration with other members of the unit and working in a spirit of cooperation and support was considered key to enable participants to provide quality and safe patient care. Similar findings were identified in a qualitative conducted study by Berland, Natvig and Gundersen (2008).

In relation to family, some enablers that assist nurses in caring for the family were being informative and supportive, providing explanations and reassurance, listening, and

being present and professional (Warren, 2002; Weyant et al., 2017). These findings are consistent with those of the current study, in which nurses were attentive to the needs of family members in a sensitive and professional manner as relatives struggled with their own feelings of shock, fear, uncertainty and sense of powerlessness to change the situation. Involvement of family in the care of their loved one was considered by participants as important for both patients and their families in providing a counterbalance to feelings of powerlessness and uncertainty. Leon and Knapp (2008) pointed out that families of critically ill loved ones experience a gamut of emotions, including shock, fear, anger, sadness, vulnerability and powerlessness as they struggle to reconcile with what has happened. In such situations, nurses worked with the families in providing information about the health status of the family member, being supportive and available to answer any questions or concerns, and involving family members in the daily care of their family member. Similar findings were identified in a study by Karlsson and Forsber (2008), in which family presence and involvement was considered an important element in caring for the family while simultaneously enhancing the quality of care provided by staff.

In relation to nurses, nurses in the current study considered full involvement in both the care of their patients and patients' families as imperative to providing quality care. To achieve this, nurses attended family conferences, discussed patients' conditions with members of their family and other members of the treating team to avoid situations of conflict and moral distress in the decision-making process of the patient's treatment and prognosis These findings align with those of Pavlish, Hellyer, Brown-Saltzman, Miers and Squire (2015), who found that the early assessment and screening of situations for the risk of ethical conflicts and effective team communication played a pivotal role in mitigating conflict, distrust and moral distress.

Further, participants in the current study indicated that their knowledge and skills had an impact on their ability to care. Similarly, Wilkin and Slevin (2004) found that nurses' knowledge and level of competency were important considerations for the provision of quality care.

In the current study, participants discussed the importance of respecting the spiritual and religious beliefs of patients and facilitating opportunities for them to talk about such matters, including praying with the patient and family if requested. These findings are consistent with those of Tracy et al. (2003) and Cooke, Mitchell, Tiralongo and Murfield (2012), who found critical care nurses considered prayer as a form of therapy that patients sometimes used to cope. However, Bagherian, Sabzevari, Mirzaei and Ravary (2017) and Cooke et al. (2012) suggested that 'spiritual therapies' provide negligible benefit to patients in critical care settings. Such was not the case in the current study.

Collegiality, respect and camaraderie were described by participants in this current study as contributors to a healthy work environment. France, Byers, Kearney and Myatt (2011) used a mixed-method design to explore the empowerment of nurses to create a healing environment. When the nurses were asked what constitutes a healing environment in a critical care setting, they responded with: respect, mentoring, collegiality and camaraderie (nurse-to-nurse caring). These findings are in line with those of the current study. Further, these qualities were cited as valuable in ensuring staff retention. Similar findings were identified in several studies in which staff satisfaction was linked to employee retention (Breau & Réaume, 2014; Manthous, Nembhard & Hollingshead, 2011; Oyeleye, Hanson, O'Connor & Dunn, 2013). Additionally, Shimizu, Couto and Merchan-Hamann (2011) conducted a quantitative, cross-sectional, descriptive study with nursing staff, which identified feelings of satisfaction and

professional achievement in working in ICU, such as caring for vulnerable patients, and feelings of pride in working in a complex, high-technology setting. These findings are consistent with this current study, in which participants indicated satisfaction with professional achievements, possession of autonomy and feelings of pride associated with working in a highly complex unit. Moreover, participants in the current study identified similar reasons for remaining in critical care nursing as those reported by Atefi et al. (2014), Liu, While, Li and Ye (2015), Miracle and Miracle (2004) and Valencia and Raingruber (2010), which included a desire to care for critically ill patients, the reward of seeing critically ill patients go home, flexibility in shifts and team cohesion and camaraderie.

In relation to the ICU environment, participants in the current study pointed to the importance of having an environment that assists nurses to care for patients physically. In the literature, one of the important structural elements of ICUs linked to a healthy practice environment was a physical layout that allowed constant observation and immediate access to patients (Alt-White, Charns & Strayer, 1983).

9.3.3.2 Challenges to caring in ICU.

First, in relation to patients, a lack of patient cooperation significantly affected the ability of nurses to provide quality care as reported by participants in the current study. This was also noted by Verdon, Merlani, Perneger and Ricou (2008). *Second,* in relation to family, the current study indicated that family dynamics concerning grief and loss, family discord in decision-making about treatment options, family vulnerability and level of family involvement in the care of their loved one were impediments to the provision of quality care. McConnell and Moroney (2015), and Minton and Batten (2016) examined critical care nurses' experiences of family involvement in ICU patient care that affect the ability to care. The fragility and vulnerability of family trying to come to terms

with their loved one's health status and uncertain future was a major challenge for participants, which at times left them feeling insecure and reticent to perform tasks in the presence of relatives. Being fragile and feeling vulnerable as a result of the family's response to their relative's health status and uncertainty of what may lie ahead could restrict relatives in assisting in the provision of care.

Third, in relation to nurses, other challenges to caring in the ICU reported in previous studies included high workloads, inadequate staffing levels and nurses being outside of their comfort zone in the provision of care in dealing with the unknown (Aiken et al., 2011; Aldridge, 2012; Francis, 2013; Myhren, Ekeberg & Stokland, 2013; Taverner, Baumbusch & Taipale, 2016). These findings are compatible with those of the current study, which identified work overload, shortage of staff, and participants working outside their comfort zone. Similar findings were explicated in Stechmiller (2002), in which nursing shortages, workload, and nurses taking on additional responsibilities were identified as impeding the delivery of care. Similarly, a South African qualitative, exploratory and descriptive study (Matlakala, Bezuidenhout & Botha, 2014) interviewed CCNs to explore the challenges encountered by ICU managers in the workforce. It found that staff shortages and nurses taking on non-nursing responsibilities compromised patient care.

In the current study, one of the main challenges encountered by nurses was limited autonomy in decisions to withdraw or withhold treatment in patients at the EOL stage, resulting in moral distress impeding patient care. The findings of Rostami, Esmaeali, Jafari and Cherati (2017), who explored ICU nurses' perception of futile care and the caring behaviours of ICU nurses, revealed that moral distress could have a negative impact on nurses' caring behaviours and quality of care, which was also reported in other studies (Choe, Kang & Park, 2015; MacKusick & Minick, 2010;

McClendon & Buckner, 2007; Rostami et al., 2017), in which the self-care ability of nurses in difficult situations was identified. Having to attend to the emotional needs of relatives after the death of a loved one posed significant challenges for the participants, who in many respects were ill-prepared educationally, socially and emotionally to respond to such situations, resulting in compassion fatigue and moral distress.

Participants in the current study reported that language was a major challenge to ICU nurses for whom English was not their first language. These nurses encountered difficulties at times when dealing with patients, families and doctors. Similar findings were asserted in Medin, Alshehri and Alasiry (2012), which identified the challenge of language between nurses and patients and families in Saudi Arabia. Therefore, language can be a significant challenge when the nurses speak a different language from patients and their family.

Finally, a factor that is simultaneously an enabler and a challenge for nurses' caring is having a student in the unit. In the current study, participants indicated that there were advantages and disadvantages of having students in the ICU. Similarly, Swinny and Brady (2010) reported that nurses obtained benefits when supervising students. For example, nurses can update their knowledge through students and nursing faculty resources with the latest evidence-based practice and can be assisted by students. Conversely, having students presented several challenges, such as increased responsibility and teaching requirements, which subsequently divert attention from patient safety.

Fourth, in relation to the ICU environment, participants in the current study identified several challenges in caring for patients. These included having to contend with the physical layout of the unit, which was very constricting with little room to move, the close proximity of patients, continuous noise created by staff as they went about their

business, technological noise of machines such as ventilators and cardiac monitors, and the unrelenting yet essential presence of light 24 hours a day, all of which had the potential to affect patients' ability to rest and heal. In addressing these challenges, disposable blue curtains were used to induce a calming effect on the unit, and dimming of lights from 2–4 pm was as a part of the daily pattern of care to allow patients to rest without the distraction of staff and family. Staff took extra precautions to minimise contact with their patients at this time, without compromising care and treatment. Little could be done in respect to mechanical noise on the unit.

Several studies were located that identified similar findings to those of this study. Coles (2010), Samuelson (2011) and Yava, Tosun, Unver and Cicek (2011) referred to the challenges of the presence of advanced and complex technology required for monitoring and managing the health status of patients and the accompanying noise of machines, the presence of lights throughout the unit, the ongoing buzz of staff carrying out their responsibilities and, at times, the chaotic atmosphere on the unit when patients required immediate emergency interventions such as resuscitation. Redden and Evans (2014) found that in meeting such challenges, nurses attempted to make the environment as comfortable as possible by reducing the number of times patients were disturbed, removing restraining devices where possible and appropriate, and ensuring that periods of the day were devoted to creating a quiet time for patients to rest. Wilkin and Slevin's (2004) study also identified that the presence of high technology essential for patient care was a major challenge for nurses and other members of the treating team, in an environment where much of the care of patients is technology-driven.

9.3.3.3 The negative cases of caring in ICU.

Although a strong culture of caring was evident throughout the unit, there were six negative cases where participants were observed to exhibit no caring behaviours in the six months of observation in the current study.

The first negative case was that of nurses being observed to provide a mechanical approach to attending to the physical needs of their patients without consideration of their psycho-emotional needs. The perceived mechanical nature of care from an observation perspective seemed to be devoid of human connection, as the nurses seemed to place emotional and psychological distance between their patient, treating them as an object of care rather than a person needing care.

Another negative example of patient care involved the objectification of patients by calling them by their bed numbers, cases or diagnosis, rather than referring to them as a person, despite advocating a person-centred approach to care within the unit. This was evident in other studies, in which patients were considered at risk of not being viewed as individuals, marking them as no more than an object of care. For example, Shimizu, Couto, and Merchan-Hamann's (2011) cross-sectional descriptive study analysed the causal factors of pleasure and suffering in ICU nursing staff and compared the occurrence of these factors at the beginning and end of their career.

A hermeneutic observational study by Karlsson et al. (2012) of nurses' communication with conscious, mechanically ventilated ICU patients examined if such communication could be interpreted as caring. Karlsson et al. (2012) found that to protect themselves emotionally, nurses' self-created distance from their patients resulted in potential patient neglect. Although not attending to the psycho-emotional needs of their patients, there was no evidence that such a disposition placed the patient at risk. In the current study, only a few participants were observed to lack communication skills in their

response to patient needs. This is consistent with Nussbaum's (2003) assertions on spirituality in critical care patients' comfort and satisfaction. Nussbaum (2003) discovered that nurses caring for the unconscious or unresponsive patient appear to neglect the need to connect with them, through verbal or non-verbal communication, such as touch. Similar findings were explicated in a hermeneutic phenomenological study by Bagherian et al. (2017), in which lack of attunement to the psychological, emotional and spiritual aspects of patients in the provision of care can result in unsafe practice.

A further negative case observed by the researcher involved one of the nurses responding in a negative manner to a patient diagnosed as drug dependent, who was complaining of pain and requesting analgesic medication. The response of this participant to the request of the patient was negative, evidenced in her derogatory comments about the person, despite knowing that the patient was an ex-nursing colleague. Similar findings were explicated in other studies. Zalon, Constantino and Andrews (2008) described a case study of a critically ill patient in an ICU who complained of 'unbearable pain'. The ICU nurse referred the patient's complaint to the physician, who told the nurse to give the patient a low dose of pain medication besides a placebo, informing the nurse that the patient had a history of drug addiction and was 'pretending' to need medication for her pain. The physician refused to administer further pain relief as he believed that because of her addiction, she should be able to tolerate more pain.

In addition to the negative case studies mentioned above, in the current study, one participant mentioned that she could not understand how some nurses in the unit treated their patients in a rough manner, posing the question that if they were in their position, would they like to be treated in such a manner? A qualitative study by Samuelson (2011) investigated stress-inducing factors, and found that at times, nurses handled patients in an unnecessarily rough and hurried manner.

Another negative case of caring was witnessed by the researcher and articulated by the participants in the current study was the unnecessary interruptions to patients' sleep, specifically at night. Similar findings were reported by Weyant et al.'s (2017) phenomenological study, which explored perceptions of nurses' caring behaviours among intubated patients and their family members.

In the current study, an adverse event incident occurred when a patient was given an incorrect blood transfusion, despite the existence of explicit and stringent protocols. Schulz et al. (2016) emphasised that awareness of errors in critical care is important to patient safety. A review of the literature identified various approaches that have been identified to avoid and prevent adverse events in critical care settings. For instance, Fernandes et al. (2011) suggested that nurses can make changes in the healthcare system to improve patient safety by gaining professional insights from their own experiences, having continuous education and training, and establishing a healthy, safe and non-punitive environment, all of which were evident in the current study. Similarly, Henneman et al. (2010) reported that critical care nurses play a vital role in medical error recovery and preventing adverse events by using several strategies, such as knowing the patient, reviewing or confirming the plan of care, policy and procedures, surveillance, double-checking, using systemic processes and questioning, offering assistance, clarifying, being physically present, referencing standards or experts, or involving another nurse or physician, all of which were explicated in this study.

9.3.4 Contributions to new knowledge.

Contributions to new knowledge included:

- Nurses experience moral distress and disempowerment when not involved in the decision-making process regarding the quality of life for EOL patients.

- The experience of nurses being removed from patient care at the request of the patient and family has not been discussed in the literature.

- The expanding role of nurses in the ICU into the realms of medicine and technology has the potential to compromise person-centred care.

- The critical care layout of the ICU needs to be updated to provide sufficient space and privacy for patients and their families to be present with their loved ones and be able to play a role in their care and management.

9.4 Theme 7: Patterns of Coping with Stressful Moments by Nurses in ICU

9.4.1 Summation of the theme.

Relevant to this theme, nurses used a range of strategies to cope with moments of stress in the ICU, on both an individual and unit level. On an individual level, there are many useful techniques to vent emotions, remain professional and in control, be assertive, and seek assistance and support. However, notable strategies used that will require future research included: avoiding situations of stress; emotionally distancing oneself from the situation; not allowing stressful moments to affect them; displacing their feelings onto others; reducing working hours; and expecting and accepting the worst. On a unit level, strategies included: maintaining an atmosphere of light-heartedness; being there for each other and working as a team; being able to negotiate time away from the unit and changing shifts when required; time and staff management, delegation and creating an on-call roster.

9.4.2 Search terms used in relation to the theme and subthemes.

Search strategies for the review of literature used keywords, Nurse* AND Stress AND (Cop* OR strateg*) AND ('intensive care' AND 'critical care' AND 'ICU'), using quotation marks, parentheses and Boolean operators such as 'AND' and 'OR'. An

asterisk was added to the end of keywords to ensure that the search included words with

alternative endings (see Table 9.3). In addition, a gradual elimination of studies according

to PRISMA is presented in Figure 9.3.

Table 9.3

Literature Review Search Terms and Number of Results in Various Databases For

Theme 7, Patterns of Coping with Stressful Moments by Nurses in ICU.

Search terms used for theme and subthemes/process	Database				
	CINAHL Complete	Medline	PubMed	Google Scholar	Relevant to the searched topic
	No. of papers	No. of papers	No. of papers	No. of papers	No. of papers
Nurse* AND Stress AND (Cop* OR strateg*) AND ('intensive care' AND 'critical care' AND 'ICU')	6	22	9	22,400	34
Duplicates removed					15
Total after removal of duplicates					19

Identification

Records identified through database searching
(n = 22,437)

Additional records identified through other sources
(n = 1)

Records after duplicates removed
(n = 22,423)

Screening

Records screened
(n =22,423)

Records excluded
(n = 22,321)

Eligibility

Full-text articles assessed for eligibility
(n = 102)

Full-text articles excluded, with reasons
(n = 83)

Included

Studies included in quantitative synthesis
(n = 8)

Studies included in qualitative synthesis
(n = 5)

Studies included in mixed methods
(n = 2)

Studies included in others
(n =4)

Figure 9.3. PRISMA flow diagram of literature identification process for Theme 7.

9.4.3 Discussion of Theme 7 in relation to the literature.

As a result of the acuity of the work environment, the complexity of patients' health status, the intensity of the work environment and the potential for compassion fatigue, ICU nurses working in such an environment are confronted daily with stressful situations that have the potential to negatively affect their personal and professional lives. To cope in such a work-intensive environment, participants of the current study used a range of strategies on both an individual and unit level. Nurses adopt elective coping strategies to prevent their withdrawal from workforce (Goetz, Beutel, Mueller, Trierweiler-Hauke & Mahler, 2012) and to avoid other potential negative consequences

for staff and patients wellbeing (Thomas W. Reader, Cuthbertson & Decruyenaere, 2008).

In the current study, a number of participants were observed to revert to tears at various times when under stress. Participants shared with the researcher that to cry at such times was for them a tension-release behaviour, which allowed them to vent pent-up feelings. In the main, crying was not perceived in a negative light; it was a momentary respite from a stressful situation. Hammonds and Cadge's (2014) qualitative study of strategies used by ICU nurses in stressful situations found that crying was a tension release used to cope with negative or overwhelming emotions.

Attempting to remain professional was another strategy used by participants in the current study. Remaining professional was viewed by several participants as a means of remaining in control of themselves and the situation. Two studies identified remaining professional and maintaining a sense of self-control despite feeling stressed (Hays, All, Mannahan, Cuaderes & Wallace, 2006; Li & Lambert, 2008b). A further study by Bloomer and O'Connor (2012) concerning dealing with deceased patients and their relatives found that to cope in such situations, participants felt the need to remain professional, stoic and in control, which was similar to the findings of the current study.

Participants in the current study spoke of the need to emotionally detach themselves from some stressful situations by attempting to disengage with patients and families. This was in line with the study findings of Hammonds and Cadge (2014), who suggested that to cope with patients and family in highly charged emotional situations such as grief, loss or dealing with an unknown and uncertain future, nurses need to take an objective stance and remain professional, which at times requires them to remain detached and emotionally removed without compromising care. Yoder (2010) suggested that to avoid compassion fatigue, healthcare professionals need to sometimes emotionally

disengage from the situation. Tactics such as *avoidance* and distancing oneself from stressful situations and people in the unit was evident in the current study, as described by participants and observed by the researcher. The strategies of distancing oneself and avoiding stressful situations were found in a number of studies from an ICU perspective (Gutierrez, 2005; Hays et al., 2006; Li & Lambert, 2008b); for example, asking not to be the primary nurse for patients with moral distress issues (Gutierrez, 2005). Another strategy to cope with stresses in the ICU was *withdrawal,* which was noted in Gutierrez's (2005) and Martins and Robazzi's (2009) studies as withdrawing from the patient and their relatives by distancing themselves emotionally.

Other participants in the current study chose simply to ignore the stress of the situation by not allowing themselves to be affected, viewing stress as a necessary evil in such a stressful environment. This was noted in by Yoder (2010), who investigated compassion fatigue among ICU nurses. The study asked, 'What strategies do nurses use to deal with stressful situations, and how did they get through it?'. One of the major findings of the study was that to cope in stressful environments, nurses ignore the stress of the situation.

In the current study, participants used their assertiveness to speak out and took the opportunity to debrief with colleagues. For example, nurses used critical incident stress debriefing with nurses, managers or physicians in their units to reduce their stress. Several studies also found that debriefing was an important practice for stress reduction (Bloomer & O'Connor, 2012; Li & Lambert, 2008b; Soreny, 2009; Yoder, 2010) and reducing the impact of stressful events (Caine & Ter-Bagdasarian, 2003; Mealer et al., 2012). Moreover, assertiveness was used by participants in the current study to overcome stressful moments; this was reported in other studies (Alameddine, Dainty, Deber & Sibbald, 2009; Poncet et al., 2007; Reader et al., 2008). Conversely, some participants in

the current study chose to withdraw and remain silent, not wanting to escalate the situation or increase their stress levels. This was also identified in other studies (Bloomer & O'Connor, 2012; Soreny, 2009).

Maintaining an atmosphere of light-heartedness was a strategy that participants used in the current study. This strategy was reported in several studies as 'having a sense of *humour'* (Caine & Ter-Bagdasarian, 2003; Mealer et al., 2012; Yoder, 2010). For example, Caine and Ter-Bagdasarian (2003) explored the early identification and management of critical incident stresses for nurses in CCUs, and described humour as being therapeutic in reducing stress and contributing to the physical and emotional healing of ICU nurses after a critical incident.

Being there for each other was another strategy used at the unit level in stressful moments, which was manifested in participants supporting each other in a spirit of collegiality and collaboration. This was also evident in other studies under the rubric of teamwork (Bakker, Le Blanc & Schaufeli, 2005; Caine & Ter-Bagdasarian, 2003). Seeking assistance and support from colleagues was identified in other studies under the rubric of seeking peer support (Bloomer & O'Connor, 2012; Soreny, 2009) and as instrumental support (e.g., seeking advice, information and assistance) (Li & Lambert, 2008b). Epp (2012), Hays et al. (2006) and McClendon and Buckner (2007) stressed the importance of supportive managers, supporting each other, interacting socially with colleagues at work or outside work, and seeking counselling. Cronqvist, Lutzen and Nyström's (2006) hermeneutical, exploratory, interpretive study of nurses' lived experiences of support in critical care situations and moral distress in the ICU found that nurses need to have both structural and existential support that provides a professional climate of support and access to caring supervisors. Another facet of seeking assistance

was through religious and spiritual support. This was evident in other studies (Hammonds & Cadge, 2014; Li & Lambert, 2008b; Yoder, 2010).

In the current study, participants chose *reducing their work hours* as a response to stresses in ICU. The first facet was reducing the length of shifts from 12 to 8 hours. Scott, Rogers, Hwang and Zhang's (2006) descriptive and exploratory study recommended minimising 12-hour shifts, or limiting nurses' work hours to no more than 12 consecutive hours during a 24-hour work period to reduce stress.

Another facet of reduction of stress time was having '*time off the unit*' by limiting the number of days worked, and changing from full-time to part-time hours. This was recommended by Epp (2012) and McClendon and Buckner (2007) in taking holidays and changing from full-time to part-time work. These types of strategies have workforce implications.

Participants in the current study used different management strategies, such as *delegation* of tasks, to respond to high workload stress in the ICU. These findings were mirrored in studies by Epp (2012) and McClendon and Buckner (2007), in which delegation of tasks was a means of reducing stress in tense moments. Another strategy was *time management*, which similarly reflected the findings of a Chinese quantitative study by Li and Lambert (2008a) that discussed ICU environment stressors, coping strategies, demographics and job satisfaction. This study identified planning as the number one strategy used by ICU nurses to cope with stress.

Other strategies to used and reported by participants to cope with stress in the current study and found in the literature included nurses modifying their attitudes by adopting a positive stance, keeping up their spirits (Yoder, 2010), getting intoxicated at home to lower anxiety (Bloomer & O'Connor, 2012), living a well-rounded and balanced life, which included sufficient rest, a balanced diet, and physical activities such as

walking and attending health clubs (Martins & Robazzi, 2009; McClendon & Buckner, 2007; Yoder, 2010). Nurses also reported that they focused on their activities and relationships outside work, such as family, hobbies, church and social activities. Some of them emphasised the separation of their personal and professional lives (Yoder, 2010).

Finally, other strategies described by participants to cope with stress were not found in the literature: nurses displacing their feelings onto others, choosing or rejecting certain nursing roles and acquired competencies, preparing oneself by expecting and accepting the worst-case scenario, and creating a nursing on-call roster.

9.4.4 Contributions to new knowledge.

Contributions to new knowledge included:

- projecting one feelings onto another as a means of reducing stress

- nurses choosing and rejecting some roles

- nurses expecting and accepting the worst-case scenario

- creating a nursing on-call roster to assist the staff in the stress of employee shortages.

9.5 Synthesis of Contributions to the Knowledge

This section includes a synthesis of contributions to the knowledge of the findings of this current thesis (see Table 9.4).

Table 9.4

Synthesis of the Contributions to the New Knowledge of Findings of the Current Study

No.	Theme	Contributions to new knowledge
1	Nurses' perceptions of caring in ICU	• Caring is a sense that either exists or not. • Caring was classified in three levels (surface, intermediate and deep) according to the nature of work provided by nurses companied with the degree of closeness of nurse–patient/family/staff relationships. The more attached the therapeutic bond between any two parties (e.g., nurse and patient), the greater quality of care is provided (e.g., from the nurse's side towards the patient). • The notion of measuring caring has emerged from this research, and consequently, there is an opportunity to develop an instrument to measure caring in ICUs.
2	A culture of inclusive practice of caring in ICU	• In ICUs, nurses care for several entities in the unit (oneself, patient, family, nurses, different colleagues, and the ICU environment and organisation). • There is a necessity to find consensus and strategies among the health professionals in regard to the ethical considerations to the patient's rights and treatments in critical care settings, especially in the EOL stage.

		• The significance of communicating with patients in the EOL stage, which it is not limited to the time before and during patients' death, but also after their death. • Re-considering caring for the family as 'an extension of caring for the patient'. • Nurses are reluctant to engage with families because of their perceived subordinate role to medical and other aligned health professionals. • ICU nurses have a heightened sense of ecological consciousness, which has contributed to the unit culture of minimising waste and protecting the environment.
3	Qualities required of the ICU nurse to provide quality care	The current study identified some qualities as adhering to the values and mission of the hospital, and personal characteristics for the ICU nurse, such as being a multitasker, hard worker, accurate, tidy and neat; these qualities are not located anywhere in the literature, which contributes a new knowledge.
4	The unit manager as a culture carrier of caring	• Role modelling by the unit manager is pivotal in creating a culture of caring in the critical care setting. • Four levels of role modelling caring and approachability were exemplified by the unit manager in this ICU, 'Close to Far' as:

			• being a bedside nurse when required to assist in nursing care • being a team leader, coordinating care from the nursing station and overseeing the delivery of quality care • assuming a managerial role in coordinating the nursing staff of the unit from her office • being available to staff during off-duty times for consultation and advice.
5		Patterns of communicating caring in the ICU	There is a lack of documentation of patients' psychological and emotional aspects, in addition to the nurses' behaviours towards patients and families. There is a growing culture of communication by technology, both from nurse-to-patient and nurse-to-nurse.
6		Enablers, challenges to caring and negative cases of caring in the ICU	• Nurses experience moral distress and disempowerment when not involved in the decision-making processes regarding the quality of life at EOL decisions for patients. • The experience of nurses being removed from patient care at the request of the patient and family has not been discussed in the literature.

			• The expanding role of nurses in the ICU into the realms of medicine and technology has the potential to compromise person-centred care. • The critical care layout of the ICU needs to be updated to provide sufficient space and privacy for patients and their families to be present with their loved ones and be able to play a role in their care and management.
7		Patterns of coping with stressful moments by nurses in ICU	Nurses project their feelings onto one another as a means of reducing stress. Nurses choose and reject some roles. Nurses expect and accept the worst-case scenario. Nurses create a nursing on-call roster to assist the staff in the stress of employee shortages.
8		The conceptual model for the culture of caring in the ICU	Positive and negative forces in the form of facilitators and barriers are represented to both fundamental elements and patterns of caring that give rise to the ICU's everyday culture.

9.6 Summary

This chapter included Part 2 of the discussion. It consisted of the last three themes in relation to the existing literature: Theme 5, patterns of communicating caring in ICU; Theme 6, enablers, challenges to caring and negative cases of caring in ICU; and Theme 7, patterns of coping with stressful moments by nurses in ICU. It also outlined the contributions of this thesis to existing knowledge. The next, and final, chapter consists of concluding statements of the study and implications, and recommendations for future education, practice and research.

Chapter 10: Concluding Statements of the Study

10.1 Introduction

This chapter presents a discussion of the strengths and limitations of this study. The implications of the findings are outlined, along with the recommendations for future practice, education and research. The chapter concludes with a final statement about the study.

10.2 Strengths

This is the first study in Australia to apply a focused ethnographic approach to explore the nature of caring by nurses in ICUs. There is a dearth of research on the topic within an Australian context. The strength of the study lies in its use of triangulation of data sources, the substantial number of participants across the stratum of nursing roles, an extensive period of researcher observation in the field and a rigorous approach to data gathering and analysis. The findings from each part of the study contributed to providing an accurate and in-depth exploration of the nature of caring by nurses in ICUs. The 'thick descriptions' provided the context for this FE (Denzin, 2002), facilitating transferability of the methodology and method to other similar settings for further research (Lincoln & Guba, 2002).

10.3 Limitations

The only limitation for this study is that the findings could not be considered generalisable to the broader population because of the cultural differences in organisations and critical care settings. However; this was the expectation of the study design; therefore, it is considered a study limitation instead of a weakness.

10.4 Implications and Recommendations

This study delivers multiple implications and recommendations. These implications and recommendations can be applied to nursing practice, education and research as outlined in Table 10.1.

Table 10.1

Implications and Recommendations of/for Study

Theme no.	Findings	Implications	Recommendations	
1	The importance of staff adhering to the mission, vision and values of the institution/organisation in establishing a culture of caring.	For any organisation to be successful in living out its mission, vision and values, all employees need not only to be familiar with the philosophical underpinnings, but live these values in their professional practice.	Education	Orientation programs for new staff need to include content concerning the organisation's philosophy, mission, vision and values Regular revisiting of the organisation's philosophy, mission, vision and values need to form part of ongoing in-service education for staff.
			Research	Evaluation of quality service delivery needs to include auditing of how such values are evident in the professional practice of staff. Further research is required to investigate the caring culture in different ICUs. Nurse researchers can develop instruments to measure caring in ICU, and potentially a comprehensive theory regarding the nature of nurses' caring in specific areas such as ICUs.

	Caring is classified in levels.	This could assist nurses in measuring their caring extent/degree for their patients in ICU to reach the utmost provision of care.	Research	There is a possibility to develop an instrument to measure nursing caring in ICUs.
2	A culture of inclusive caring practice in ICU	Establishing a culture of inclusive caring practice is imperative for the provision of quality health care delivery, which is not only focuses on the health care needs of the patient and family, but also extends to all members of the multidisciplinary team including caring for self and the ICU environment. Nurses' consciousness of caring about the ICU environment, organization is increased. For example, this consciousness assists in obtaining a healthy environment.	Practice	Nurses need to be encouraged to participate in family meetings in their patients' treatment and decision-making. Through their personality attributes, confidence, experiences and relationships with the health team members. Caring for the ICU environment needs to underpin daily practices in ICU. This can be achieved by staff being mindful of the appropriate and carful of use of resources.
			Education	Educational activities in ICU need to focus on the importance of inclusion in caring for not only for the patient and the family, but all members of the healthcare team. Educating nurses how to be present with patients, families and colleagues. Nurses' ecological consciousness needs to be enhanced through various tactics.

4	Leaders can have a strong positive influence on the culture of care within the ICU.	The qualities of the leader can have either a positive or negative influence in establishing a culture of caring in ICUs.	Research	Further research needs to be conducted into the effectiveness of inclusive caring practices within the ICU. Further research is required to investigate and enhance nurses' strategies to care for oneself/themselves.
			Practice	Careful consideration should be given to the appointment of staff in leadership positions to ensure a positive unit culture is enhanced and maintained.
5	ICU nurses prioritise focusing on monitors and technology at the expense of providing person-centred care	Quality person-centred care can be easily compromised when priority is given by the nurse without consideration to the personal needs of the patient.	Education	Nurses need to be educated about the appropriate use of technology that complements rather than compromises quality person-centred care.
			Research	Further research needs to be undertaken into the place of technology in the provision of quality healthcare delivery.
	ICU nurses lack education and training about communicating with patients and relatives in the EOL stage	Lack of clinical competence to communicate with patients and relative in the EOL stage can lead to negative impacts on the patient and family at this critical time.	Education	Education in communicating with patients and families at the EOL stage needs to be included in both undergraduate and postgraduate programs.

	ICU nurses' documentation rarely contains data of psychological, emotional and spiritual care for patients and their relatives.	The absence of detailed documentation of nursing care and patient's response to care reduces a comprehensive assessment of the health status of the patient and the family.	Practice	A review of the process documentation of patient care and management needs to be undertaken to explore reasons for the absence of documentation of nursing care.
6	There is an emerging trend for ICU nurses to expand their domain of practice with an ever-increasing focus on technology and medicalization.	These expanded roles and responsibilities add: increased workload and stress potential of burnout and staff turnover taking the nurse away from direct patient-centred care.	Practice	1-A A review of emerging trends of nursing practice change in ICU, and the implications of such change on staffing and unit budget. 1-B A review of current nursing practice within the ICU in relation to current approved scope of standards of practice. 2. A review of stress factors within ICU and their impact on staff burnout and turnover needs to be undertaken. 3. An additional level of staffing needed to backfill nurses who moved to expanded practice to attend to direct patient-centred care.
	ICU layout	The lack of appropriate space for the provision of care, noise level, and privacy can have a significant negative	Practice	A review of the layout of the unit needs to be undertaken with special

7	ICU is a highly stressful environment in which to work	impact on the patients' illness experience, well-being and the process of recovery. The ICU work environment is highly stressful impacting negatively on the well-being of staff and the delivery of patient-centred care.			consideration to patients' privacy, unit noise, space, and safety.
			Practice		Stress reduction measures need to set in place to reduce the impact of stress on staff.
			Education		Stress management educational program need to be available for staff to access as a preventative measure, and at times of crises.
			Research		Further research needs to be undertaken to identify effective measures for stress reduction within the unit and building staff resilience to combat stress
	The most problematic issue faced by nurses in ICU is that of moral distress regarding conflicts between the medical staff, nurses and patient's family in the decision-making process concerning EOL of the patient.	Unresolved issues involving moral dilemma impacts negatively on life quality of the patient, family and staff The passive nature of nurses involved in clinical decision-making regarding EOL does not allow them to be an active participant in determining the patient's outcomes.	Practice		A review of the decision-making process and protocol in respect of EOL situations for patients needs to be undertaken to identify the best practice from a multidisciplinary team perspective. 2. ICU nurses need to enhance their autonomy and empower skills to deal with these dilemmas and participate with other health professionals in making decisions.
			Education		Education of staff is required about

| | | | EOL issues and effective decision-making processes concerning the patient quality of life and staff moral dilemmas. |
| | | Research | Further research needs to be undertaken concerning best practice for patients' EOL decision-making processes. |

10.5 Conclusion

This chapter presented the strengths and limitations of this study. Also, the implications and recommendations for clinical practice, education and research were outlined.

This thesis was presented in 10 chapters. Chapter 1 provided a description of the context of the study. Chapter 2 presented a critical review of the literature to ascertain what is known and not known on the topic to justify undertaking this study. Chapter 3 provided a description of the methodology underpinning this study—FE. Chapter 4 presented a description of the methods used for data collection, analysis, and considerations pertaining to ethics and rigour in this study. Chapters 5, 6 and 7 presented the findings of the study, while Chapters 8 and 9 provided a discussion of the findings in relation to extant literature on the topic. Chapter 10 concluded the study by presenting implications of the findings and recommendations for practice, education and research.

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Appendices

Appendix A. Human Research Ethics Committee Approval from CQU Australia University

Office of Research

CQUniversity
AUSTRALIA

Secretary, Human Research Ethics Committee
Ph: 07 4923 2603
Fax: 07 4923 2600
Email: ethics@cqu.edu.au

A/Prof Anthony Welch
Ms Hanan Al-Shamaly
School of Nursing and Midwifery

14 March 2014

Dear A/Prof Welch and Ms Al-Shamaly

HUMAN RESEARCH ETHICS COMMITTEE OUTCOME PROJECT: H13/10-178, *THE NATURE OF CARING BY NURSES IN AN INTENSIVE CARE UNIT (ICU): A FOCUSED ETHNOGRAPHY*

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Universities Australia and NHMRC *Australian Code for the Responsible Conduct of Research*. This is available at http://www.nhmrc.gov.au/publications/synopses/_files/r39.pdf.

On 14 March 2014, the Chair of the Human Research Ethics Committee of CQUniversity considered this project, under the provisions of chapter 5.3 of the National Statement (minimising duplication of ethical review). The project has received prior approval from the Uniting Care Health Human Research Ethics Committee (2014.15.121), for you to conduct the project at the XXXXXX Hospital.

It is advised that CQUniversity HREC accepts this determination, and hereby extends full clearance as a CQUniversity project **(Project Number H13/10-178)** please quote this number in all dealings with the Committee. The period of ethics approval will be from 14 March 2014 to 10 March 2017.

The standard conditions of approval for this research project are that:

(a) you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;

(b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. *(A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)*

(c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

(d)   you provide the Human Research Ethics Committee with a written "Annual Report" on each anniversary date of approval (for projects of greater than 12 months) and "Final Report" by no later than one (1) month after the approval expiry date; *(A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)*

(e)   you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project

(f)   if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

(g)   A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Human Research* may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing within five (5) working days if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee is committed to supporting researchers in achieving positive research outcomes through sound ethical research projects. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Ethics and Compliance Officer or myself.

Yours sincerely,

Professor Phillip Ebrall
Chair, Human Research Ethics Committee

Cc: *Prof Ysanne Chapman (co-supervisor) Project file*

APPROVED

Appendix B. Human Research Ethics Committee Approval from the Hospital

UnitingCare Health
ABN: 87 842 457 440

Human Research Ethics Committee

Phone: xxxxxxxx   Facsimile: xxxxxxxx
Email: ethics@uchealth.com.au

Document Submission and Approval Form

Our reference	**2014.15.121**

12 March 2014

Correspondence:	from Hanan Al-Shamaly dated 21 February 2014
Study Title:	*The Nature of Caring by Nurses in an Intensive Care Unit (ICU): A Focused Ethnography*
Investigators:	Ms Hanan Al-Shamaly

Details of documents reviewed and approved:

- Application to conduct the above named research at The XXXX Hospital.

The document/s listed above were received, reviewed and approved.

XXXXX XXXX MBBS
FRACP Executive Officer

The UnitingCare Health Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's Statement on Human Experimentation and Supplementary Notes

The Uniting Care Health Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's Statement on Human Experimentation and Supplementary Notes

Appendix C. Advertising Flyer

Advertising Flyer

Are you interested in a research project about the nature of caring in an Intensive Care Unit (ICU)?

I am looking to recruit participants from Registered Nurses (RNs) in ICU, who have experience in caring for patients in ICU, to become participants in a research project.

Project Title: The Nature of Caring by Nurses in an ICU: A Focused Ethnography.

Purpose of the study: To explore and understand the nature of caring by nurses in ICU.

Researcher: Hanan Subhi Al-Shamaly, PhD candidate, School of Nursing and Midwifery, Central Queensland University Australia.

I am looking for Registered Nurses who meet the following criteria:

Full-time registered nurses (RNs) employed in the ICU with a minimum of one year experience and who have not been on extended leave during the previous twelve months. I am looking for male and female nurses who work a variety of shifts in ICU. In addition, one Nurse Unit Manager (NUM) of ICU with a minimum experience of one year is required.

If you are interested and think you may be eligible for this study or know someone else who may be interested, please contact me:

Hanan Subhi Al-Shamaly

Phone no: 0449060261 OR E-mail: hanan.al-shamaly@cqumail.com

Thank you for your assistance.

Appendix D. Information Sheet

INFORMATION SHEET

Research Overview

Caring is an everyday activity and a professional attitude within the discipline of nursing. It has been described as a complex and nebulous concept. What constitutes caring is an ongoing debate within the discipline of nursing. Over the years there have been considerable changes to the nature of caring within Intensive Care Units (ICUs) brought about by the ever-increasing complexity of technology which has impacted on the nurse-patient relationships and patterns of communication. The changing nature of caring practices within ICU is worthy of investigation especially in relation to the culture of caring.

Participation Procedure

If you agree to participate, I will spend time with you in ICU during your work/duty and may ask questions when it is convenient to do so. I will be observing the provision of caring process, however, I will be observing but not participating in your interactions with patients and I do not require you to discuss the care provided to individual patients when they present. I will not be making any judgments about the care you provide or your caring decisions in any way; I am interested in professional relationships. In addition to the observation component, I would like to conduct an interview with you about the nature of caring by nurses in ICU. Furthermore, subject to approval from the hospital, I will be examining documents such as policy, procedures and the charts in which you record your care provision. Additionally, I will ask you to write your journal about how you are caring in the ICU.

Time commitment:

- Predicted time for observation to the field, participants, is one-to- two months. It is one to two shifts/observations per participant in a two-month period. The duration of

observation can be for a full / half shift each observation according to participant's choice.

- Predicted time for interviewing is one hour.

Benefits

While you may not benefit directly from this study, future patients may have access to improved care in ICU, health professional such as health sector in general, Queensland Health, the university/educational sector, industry and health professionals, and future students will be better informed about caring in ICU, and the clinical guidelines regarding the best practice for caring will be developed to improve caring service delivery.

Risks

A small physical risk that may occur during the interview process is that you become fatigued or develop physical discomfort. To prevent this from occurring, the interview will last no more than one hour. If you develop fatigue or physical discomfort please inform the interviewer that you wish to halt or discontinue the interview. The interview, if desired, can be rescheduled to a more convenient time. A small psychological risk that may occur during the interview process is some questions asked may evoke heightened emotions, please inform the interviewer that you wish to halt or discontinue the interview.

Confidentiality and Anonymity

All information will be kept confidential and all identifying information will be anonymised (via pseudonyms) in any and all publications that may arise from the study.

Findings & Publication of findings

The findings will be disseminated in the form of a written journal article submission.

Consent

Participants will be asked to provide individual signed copies of the consent form prior to the commencement of the interviews and participation. In addition, the project Information Sheet will also be provided at that time.

Right to withdraw

Participants have the right to withdraw without any penalty at any time.

Feedback

Participants can nominate to receive a plain English statement of results from the study

on the consent form.

Questions/further information

If you have any questions or require further information about the project please contact:

Researcher/PhD Candidature :   Hanan   Al-Shamaly

                        School Of Nursing and Midwifery

                        Central Queensland University Australia

                        Telephone: 0449060261

                        E-Mail: hanan.al-shamaly@cqumail.com

Concerns/Complaints

Please contact CQUniversity's Office of Research (Tel: 07 4923 2603;

E-mail: ethics@cqu.edu.au; Mailing address: Building 32, CQUniversity,

Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this

research.

Appendix E. Consent Form

CONSENT FORM

Researcher / PhD Candidature: Hanan   Al-Shamaly

            School Of Nursing and Midwifery

            Central Queensland University Australia

            Telephone: 0449060261

            E-Mail: hanan.al-shamaly@cqumail.com

If you are willing to participate, please sign and date this form and return it to the researcher, thanks.

1- I agree to take part in the Central Queensland University research specified above/ in Information Sheet

2- I have been provided with information at my level of comprehension about the purpose, methods, demands, risks, inconveniences and possible outcomes of this research, including any likelihood and form of publication of findings.

3- I agree to be observed, interviewed, my documentation and journaling to be checked by the researcher.

4- I agree to allow the interview to be audio-taped.

5- I understand that my participation is voluntary.

6- I understand that I can choose not to participate in part or all of this research at any time without negative consequence to me.

7- I understand that any information that may identify me will be de-identified after the analysis of data is completed. Therefore, I, or any information I have provided, cannot be linked to my person/company

8- I understand that all information gathered in this research is confidential. It is kept securely and confidentially for five years from publication at the University.

9- I am aware that I can contact the researcher at any time with any queries.

10- I understand that the ethical aspects of this research have been approved by the CQU Human Research
   Ethics Committee (HREC).

11- If I have concerns about the ethical conduct of this research, I understand that I can
    contact the CQU Ethics Officer. All inquiries are confidential and should be in writing,
    in the first instance, to the following:

Ethics Officer, CQUniversity
Rockhampton QLD 4702
Tel: 07 4923 2603
Email: ethics@cqu.edu.au

Participant's name: Researcher name:

    ---------------------------------   --------------------------

Participant's signature: Researcher signature:
        -----------------------------   --------------------------

Date:

☐   Please tick this box and provide your email address below if you wish to receive
    a summary of the findings.

Email:

Appendix F. Demographic Data Sheet

Demographic Data Sheet

Name: _____ **Date**: _____

Participant ID Number:_____ **Experience years in ICU**: _____

1-   **Gender**:

    a) Male ____   b) Female ____   c) Other

2-   **Age** (in years) _____

3-   Marital Status

  a) Married b) Single c) Separated d) Divorced e) Widowed

  f) Other (please describe) _____

4-   **Ethnic/Racial Identity**

  a) Australian citizen   b) Aboriginal   c) Torres Strait Islanders

  d) Aboriginal Torres Strait Islanders   e) Other (please describe)_____

5- **What is your primary Language?**

  a) English   b) Other _____

6-   **Religion**

  a) Catholic   b) Protestant   c)   Orthodox

  c) Jewish   e) None   f) Other_____

7-   **Educational Level** (please circle highest degree)

  a) Baccalaureate (BsC, BA, etc.)

  b) Master's (MsC, MA, MPH, etc.)

  c) Academic Doctorate (PhD, DSc. Etc.)

  d) Professional Doctorate (ND, etc.)

  e) Other (please describe)_____

Appendix G. A Field Notes Recording Form

A field notes recording form (Schensul, Schensul, & LeCompte, 1999).

Event:..………………………………………………………………………….	
Date:..……………………………………………………………………………..	
Observer: ………………………………………………………………………	

Notes	Field Researchers' Comments

Appendix H. Counsellor Letter

Counsellor Referral Letter

…./…./ 2014

Dr. XXXXX XXXXX
Good Health Medical Centre XXXXXX
XXXXX XXXXXX XXX
P.O. Box: XXXX
XXXX, Qld XXXX
Phone: 07 XXXX XXXX
Fax: 07 XXXX XXXX

Dear XXXXX;

Re: ……………………………………………………

Thank you for seeing …………………………………… aged ………..years,

for assessment and management as you feel appropriate.

Presenting problem:

……………………………………………………………………………………………

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……………………………………………………………………………………………

……………………………………………………………………………………………

Kind regards

Hanan Al-Shamaly

Appendix I. Nurses' Interview Guide

Name of ICU: _____

Day: _____

Nurse Code Number: _____

Time of interview: Beginning:_____ End:_____

Total duration of interview: _____

Interviewer Initials: HS

Introduction

As a Doctoral of Philosophy (PhD) Candidature: Hanan Al- Shamaly, my

research at Central Queensland University (CQU) Australia granted the Human

Research Ethics Committee (HREC) Approvals from CQU and Wesley

Hospital. This research is to study the Nature of Caring by Nurses in an

Intensive Care Unit (ICU).

You are being invited for this study because you are a Registered Nurse in ICU

and I am interested in your work activities. Participation in this study is

voluntary. You may change your mind at any time and discontinue your

participation in this study. [Hand out the Information Sheet to the Nurse].

There is a minimal risk associated with this interview. No identifying

information will be collected. Only researchers associated with this project will

have access to the data gathered.

Is it okay to audiotape the interview?

Do you have any questions about the study?

Appendix J. Interview Questions

INTERVIEWS QUESTIONS

1- What do you believe that constitutes caring in ICU?

2- How would you describe caring practices/behaviours/attitudes in ICU?

3- How would you describe your own caring practices in ICU?

4- How do you communicate that you care to your conscious patients?

5- How do you communicate that you care to your unconscious patients?

6- How do you show your patient/patients' relatives that you care about them?

7- Tell me about touching the patient, what do you communicate with patient when you are touching the patient?

8- How do you communicate that you care to patient with pain or fears and anxiety for example?

9- When you did (ex: touch the patient), what did mean in term of caring?

10- What was your feeling when you were calming/assuring your patient?

11- From your experience: when do you think patients feel that they have been cared for? Please give an example .

12- I saw you doing this…., how is this related to caring, what you were thinking/feeling when you were doing that…please tell me about it.

13- Is there any factors that have an impact on caring on ICU?

14- a- Obstacles/barriers/challenges in providing caring in ICU:

15- b- What are the things that can enhance/foster caring in ICU:

16- What are you trying to achieve at the end of your day in ICU?

17- When you are documenting the care you have provided, what are the most important things that you write about?

18- How do you as the Clinical Nurse Manager/Manager evaluate the quality of caring delivery in ICU?

19- ICU has its own pressures, how have you as a CNM/manager maintained a culture of caring within this pressure environment? what kind of strategies have you used in such circumstances? what/why/how/where…

20- We are getting close to the end. I have some wrap up questions:

    a- What is it about your job as an ICU nurse that you like?

    b- What is it about your job as an ICU nurse that you dislike?

    c- Would you like to add anything else to our discussion?

Thank you for your participation.

Appendix K. Participant's Additional Written Information Form (PAWIF)

Participant's Additional Written Information Form (PAWIF)

- **Participant's Name: ……………………………………………………**

- **Date: ………………………………………………………...……..**

Please write any further information or comments you would like to add to the interview conversation about caring in ICU.