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# The role of the patient liaison nurse in the ambulatory care context of a Middle Eastern teaching hospital: a practice model

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# THE ROLE OF THE PATIENT LIAISON NURSE IN THE AMBULATORY CARE CONTEXT OF A MIDDLE EASTERN TEACHING HOSPITAL: A PRACTICE MODEL

# THE ROLE OF THE PATIENT LIAISON NURSE IN THE AMBULATORY CARE CONTEXT OF A MIDDLE EASTERN TEACHING HOSPITAL: A PRACTICE MODEL

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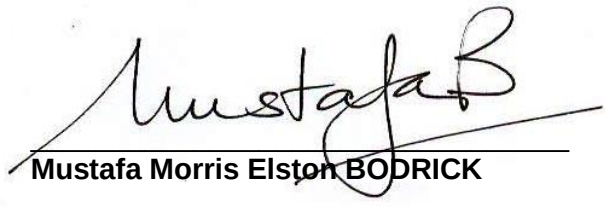
**Degree of Doctor of Philosophy**

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, in fulfillment of the requirements for the degree of Doctor of Philosophy.

**Sept 2011**

# DECLARATION

I, **Mustafa Morris Elston BODRICK,** formerly known as Morris Elston BODRICK from birth until 2007, *hereby declare that this thesis is my own work. It has not been submitted before for any other degree or examination at this or any other university. Minor corrections have been inserted subsequent to examination.*

Signed: 

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Date: 16 SEP 2011

**City of Riyadh, Kingdom of Saudi Arabia**

**Human Research Ethics Committee (Medical) Ref:** R14/49 Bodrick, M03-01-27; M080568.

# DEDICATION

*In loving and evergreen memory of my*

**Mother E. WADE BODRICK**

*and my only sister*

**F. F. BODRICK**

*both who departed unexpectedly from this life during the period of this research project.*

This thesis is dedicated to my only brother

**Ashton S. BODRICK**

for whom my love is infinite.

# ORAL SCIENTIFIC PAPERS ARISING FROM THIS STUDY

**Paper 1:** *A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Teaching Hospital in Saudi Arabia*
**Paper 2:** *The Leadership Context of Practice-Based Nursing Research in Saudi Arabia*
**Conference:** *The Honor Society of Nursing, Sigma Theta Tau International, 41st Biennial Convention*
**Location:** *Grapevine, Texas, USA*
**Dates:** *29 October – 02 November 2011*
Accepted for presentation
**Appendices:** *32 and 33*

**Paper 1:** *A Model for Ambulatory Care Patient Liaison Nursing at a NGHA Hospital*
**Paper 2:** *Real-Life Clinical Scenarios Used as Vignettes in Nursing Research*
**Conference:** *King Faisal Specialist Hospital & Research Center, 5th Nursing Symposium: Excellence in Health Care – A Joint Venture*
**Location:** *Jeddah, Kingdom of Saudi Arabia*
**Dates:** *1 – 2 May 2011*
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**Appendices:** *34 and 35*

**Paper:** *A Practice Model in Ambulatory Care Services for Patient Liaison Nursing in Saudi Arabia*
**Conference:** *The Honor Society of Nursing, Sigma Theta Tau International, 20th International Nursing Research Congress Focusing on Evidence-Based Practice*
**Location:** *Cancun, Mexico*
**Dates:** *13 – 17 July 2009*
**Note:** *Conference cancelled due to outbreak of H1N1 Flu in Mexico.*
**Appendix:** *36*

**Paper:** *Ethical Alarm Bells – Can a Male Nurse Researcher in a Conservative Arab Male-Dominant Culture Collect Data in a Female Nursing Environment?*
**Conference:** *International Council of Nurses, 23rd Quadrennial Congress*
**Location:** *Taipei, Taiwan*
**Dates:** *21 – 27 May 2005*
**Appendix:** *37*

**Paper:** *Deployment Through a Different Lens: The Health Care Context in a Foreign Setting*
**Conference:** *American Academy of Ambulatory Care Nursing (AAACN) – 30th Annual Conference*
**Location:** *San Diego, California, USA*
**Dates:** *7 – 11 April 2005*
**Appendix:** *38*

**Paper 1:** *The Impact of Context as a Methodological Consideration*
**Paper 2:** *Methodological Considerations: Data, Data Everywhere; Where to from Here?*
**Conference:** *International Institute for Qualitative Methodology, 10th Anniversary Qualitative Healthcare Research Conference*
**Location:** *Banff, Alberta, Canada*
**Dates:** *30 April – 4 May 2004*
**Appendices:** *39 and 40*

**Symposium:** *VIGNETTES – What Are They? Who Cares? What Do They Have to Offer to Health Related Research?*
**Chair:** *Professor Julianne Cheek*
**Paper 1 of Symposium:** *VIGNETTES – What's Behind A Name?*
**Paper 3 of Symposium:** *VIGNETTES in Action: A Tale of Two Studies*
**Conference:** *International Institute for Qualitative Methodology, 10th Anniversary Qualitative Healthcare Research Conference*
**Location:** *Banff, Alberta, Canada*
**Dates:** *30 April – 4 May 2004*
**Co-Author:** *Dr. Rhidian Hughes, King's College, London, UK*
**Appendix:** *41*

**Paper 1:** *Championing Change Through a New Functional Role – The Patient Liaison Nurse (PLN) – in the Context of a Middle Eastern Teaching Hospital*
**Paper 2:** *Forging New Frontiers for International Consideration in Ambulatory Care Nursing Research: Reflections on Specific Ethical Issues in a Middle Eastern Contextual Study*
**Conference:** *American Academy of Ambulatory Care Nursing (AAACN) – 29th Annual Conference*
**Location:** *Phoenix, Arizona, USA*
**Dates:** *18 – 22 March 2004*
**Appendices:** *42 and 43*

**Paper 1:** *Ethical Alarm Bells – Can a Male Researcher with Perceived Organizational Authority be Permitted to Collect Data in a Conservative Male-Dominant Middle Eastern Cultural Setting?*
**Paper 2:** *Innovative Use of Vignette Technique Using Real-Life Material from Reflective Journals and the Critical Incident Technique (CIT)*
**Conference:** *International Institute for Qualitative Methodology, The 5th Anniversary International Interdisciplinary Conference, Advances in Qualitative Methods*
**Location:** *Edmonton, Alberta, Canada*
**Dates:** *29 – 31 January 2004*
**Appendices:** *44 and 45*

**Paper:** *Organizational Obstacles in Qualitative Data Collection – Maintaining Scientific Integrity*
**Conference:** *International Institute for Qualitative Methodology, 4th International Interdisciplinary Conference, Advances in Qualitative Methods*
**Location:** *Banff, Alberta, Canada*
**Dates:** *2 – 5 May 2003*
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# ABSTRACT

The commencement of the role of patient liaison nurse (PLN) in the ambulatory care context of a Middle Eastern teaching hospital was an organizational response to patient care concerns during the site absence of physicians and the healthcare team. The PLN consequently evolved as a functional role of the registered nurse (RN) in ambulatory care nursing. The core research question asked was: how can a model be developed to describe the PLN role? The related topics for research included (i) the lived experiences of nurses in the functional role of the RN as PLN, (ii) what the nursing management team in the ambulatory care context considered as the functional role of the RN as PLN, (iii) the core and related concepts of the functional role of the RN as PLN, (iv) a conceptual framework to describe the PLN role, (v) the relational statements of the model that describes the functional role of the RN as PLN, (vi) the evaluation of the model, and (vii) formulation of guidelines for operationalization of the model. A qualitative process of scientific research inquiry followed two phases. The first phase included the research methods on the critical incident technique and reflective journaling to study the lived experiences of the PLN participants, and vignette responses that were used to investigate what nursing management respondents considered to be the functional role of the RN as PLN. The empirical results that emerged from the data analyses of the reflective journals and vignette responses were stated as conclusion statements of the emergent themes, and were used in phase two as the starting point for model development. The process of scientific inquiry concluded with an evaluation of the model, and the generation of guidelines for the operationalization of the model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital.

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# LIST OF ACRONYMS

| | |
|---|---|
| **AA** | Administrative Assistant |
| **AAACN** | American Academy of Ambulatory Care Nursing |
| **ACC** | Ambulatory Care Center |
| **ACC-EXCO** | Ambulatory Care Center – Executive Committee |
| **ACN** | Ambulatory Care Nursing |
| **ACSS** | Ambulatory Care Services and System |
| **CIT** | Critical Incident Technique |
| **CNC** | Clinical Nurse Coordinators |
| **CRN** | Clinical Resource Nurse |
| **ICN** | International Council of Nurses |
| **IIQM** | International Institute for Qualitative Methodology |
| **IOM** | Institute of Medicine |
| **JCAHO** | Joint Commission on Accreditation of Healthcare Organizations |
| **JCI** | Joint Commission International |
| **KAMC-R** | King Abdulaziz Medical City – Riyadh |
| **KSA** | Kingdom of Saudi Arabia |
| **MRP** | Most Responsible Physician |
| **NGHA** | National Guard Health Affairs |
| **NGHS** | National Guard Health System |
| **OPD** | Out-Patients' Department |
| **PDCA** | Plan-Do-Check-Act |
| **PLN** | Patient Liaison Nurse |
| **REIS** | Relevance, effectiveness, impact, sustainability |
| **RJ** | Reflective Journal |
| **RN** | Registered Nurse |
| **VT** | Vignette Technique |

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***'…and if you could count the blessings from Allah;***
***never would you be able to count them.'***

*(Qur'an 14:34)*

# PREFACE

I am a nurse, can I help you?

A simple question, but herein is the complexity of how nurses in the ambulatory care context respond to patient concerns when physicians and healthcare team members are not available. This consideration steered the conceptualization of this study to capture how nursing actions focused on patient-centeredness in practice. The patient liaison nurses were not using clinical pathways, written procedures or practice guidelines, yet they were acclaimed for being effective in their role. It was this phenomenon that served as a precursor to developing a nursing practice model using a qualitative process of scientific inquiry.

At the closure of this scientific journey, it is hoped that patient liaison nurses can revise their introduction to a patient by saying, 'I am a patient liaison nurse who is here to help you; what is your concern?'

**Mustafa M. E. BODRICK**
Riyadh, Kingdom of Saudi Arabia
20 March 2011

# CHAPTER ONE

# ORIENTATION AND APPROACH TO THE RESEARCH STUDY

## 1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Over the past decade, there has been a worldwide shift by healthcare consumers from the use of in-patient services to using ambulatory care services in response to the rising costs of in-patient healthcare services and global economic restraints (Swan 1996:368, Sherman 1997:44, Farrell, Johnson, O'Neal, Mann, Seaver, Piper, Hokans, Sciammaco, Gaw, Schwartz, Emery, Philipps & Larrivee 1998:73, Schim, Thornburg & Kravutske 2001:311, Foege, Daulaire, Black & Pearson 2005:xxi, Sullivan & Decker 2009:23). In relation to this global shift, Laughlin (2006:ix) confirmed that there has been a concurrent challenge in ambulatory care nursing because of its consequent growth in 'volume, magnitude, and complexity'. She expands on this challenge for nurses to advance their knowledge and related understanding of patient care issues, contextual setting of the practice arena, and the developing role complexity in ambulatory care nursing. However, Schim, Thornburg and Kravutske (2001:311), based on their survey findings, contend that while the role of ambulatory care nurses has increased in complexity, there has also been a paucity of role preparation and scanty professional support which is mismatched with the rapid expansion of services. The study found that nurses experienced a sense of 'disconnect' and lack of congruence between time-consuming non-nursing operational tasks and their most frequent job activities, which were dependent on physician prescription. This finding was compared to what nurses regarded as the independent functions of the

professional nurse in the ambulatory care setting. The latter was deemed as an essential role component of ambulatory care nursing that included coordination of care, building relationships with the patients and colleagues, and patient teaching. Schim, et al., (2001) advise on the need to develop nursing practice in ambulatory care by means of 'assessment and critical evaluation' of what is important in contemporary ambulatory care nursing. Furthermore, they suggest that the effectiveness (taking the right action) and efficiency (implementing an action correctly) of nursing interventions was possibly a way of addressing the large gap between 'high frequency and low importance' for operational activities on one hand, and on the other hand the 'very low frequency of knowledge work' and high importance for ambulatory care nurses in the professional nursing aspects that contribute to nursing as a value-based discipline (Schim, et al., 2001:313).

Professional nursing practice in ambulatory care is pinpointed as a key nursing research focus by Swan, McGinley and Lang (2002:83), who identify the universal need for evidence in ambulatory care nursing to support contemporary practice. They regard nursing research evidence as essential for informing ambulatory care nursing practice, particularly in support of best practice guidelines, protocols, procedures, policies, and healthcare planning and delivery approaches. Their perspective supports the contribution of nursing to research activities in addition to the use of available evidence. This dual nursing perspective of using evidence and contributing to research is also promoted by Greenberg and Pyle (2004:8) who examine this potential contribution of ambulatory care nurses in relation to evidence. They indicate that nurses primarily utilize a three-dimensional input in contemporary practice, namely (i) clinical nursing expertise, (ii) patient preference and (iii) research evidence, which all converge in clinical decision-making that is informed by the context and scope of ambulatory care nursing. They offer a secondary potential contribution by the rearrangement of these three dimensions, and emphasize that more evidence is

currently needed in ambulatory care nursing to inform practice, and therefore suggest that clinical nursing expertise combined with patient preference within the context of ambulatory care nursing should be the starting point for the nursing profession's focus on generating more nursing evidence and knowledge, and in turn to inform contemporary ambulatory nursing care practice.

The suggestion that ambulatory care nurses should concentrate their research-related efforts on the generation of evidence in contemporary nursing practice is aligned with the robust reasoning presented by several nursing authors (Rolfe 1998:674, Upton 1999:551, Moseley 2000:41, Wallin, Boström, Wikblad & Ewald 2003:515, Turkel & Ferket 2005:257, Morice & Parry-Billings 2006:231, Windle 2006:64). Rolfe (1998:672) clearly distinguishes between 'research-based practice' and 'practitioner-based research', while he confirms that the former exists as an established research paradigm in the traditional social science and medical professions, whereby mainly generalizable scientific research findings and outcomes are used. However, he argues that a shift in the research paradigm to 'practitioner-based research' is needed, whereby research evidence is used, not necessarily as an end point to inform clinical practice, but rather as a means for clinical practitioners to use practice experience with literature and research evidence in contemporary situations to identify a research purpose and to conduct appropriate research.

DiCenso, Ciliska and Guyatt (2005:4), Turkel and Ferket (2005:254) and Brown (2009:16) advance the focus on practitioner-based research by postulating that excellence in patient care delivery is grounded in evidence-based practice and nursing research. Turkel and Ferket (2005:254) substantiate this stance with corroboration from healthcare facilities that have achieved 'Magnet' status. In reference to these facilities, the authors assert that the nursing practice settings foster an environment for evidence-based practice and nursing research by intentional creation and maintenance

of efforts to ensure that systematic inquiry is employed to guide practice from the bedside to nurse administrators. Rycroft-Malone and Bucknall (2010:23) advocate that it is necessary for organizations to select a theory, model or framework to lay the groundwork for evidenced-based practice which also entails a mechanism for individual practitioners to appraise research utilization. In their perspective, Melnyk and Fineout-Overholt (2011:3) postulate that it is recognized in worldwide healthcare settings that evidence-based practice is essential for the provision of best quality patient care outcomes. To this end, the authors contend that evidenced-based practice has been expanded in scope and is referred to as a 'lifelong problem-solving approach to clinical practice' that integrates the following three (3) dimensions:

i. A systematic search for the best external evidence that embraces critical appraisal and synthesis of the most relevant and best research that answers a clinical question.
ii. The use of clinical expertise by the practitioner as internal evidence that is generated from quality improvement projects, systematic patient assessments and re-assessments, and evaluation of the use of available resources to achieve the desired best possible patient outcomes.
iii. The personal preferences and values of the patient.

(Melnyk & Fineout-Overholt 2011:4).

Hall (2003:18) proposes that the future of nursing as a profession depends on the intellectual capital that comprises nursing knowledge and skills whereby frameworks are used to daily guide nursing practice, and/or accessibility to nursing intellectual capital in an organization. To achieve this environment, the author suggests that rethinking and reformulation of the concept of productivity in nursing through processes of scientific inquiry in the contextual setting of nursing practice could be achieved through nursing knowledge expansion and by understanding the contemporary relationships between concepts in nursing, healthcare delivery and patient safety (Hall

2003:19). It is therefore this larger contextual background of scientific inquiry and nursing intellectual capital that comprises the two interrelated domains, namely nursing practice and nursing research, which underpin the rationale for this proposed study to gain new knowledge through research on patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital.

## 1. 2 RATIONALE FOR THE STUDY

The need for this study evolved from operationalizing the functional role of the registered nurse (RN) as a patient liaison nurse (PLN) subsequent to the perception that the PLN contributes to quality patient care in the ambulatory care context of this Middle Eastern teaching hospital. In essence, a study was required to assess the functional role of the RN as PLN to formulate a nursing practice model aimed at guiding the functions of the PLN.

Therefore, the research setting for the study was the Ambulatory Care Center (ACC) of a Middle Eastern teaching hospital in Riyadh, Saudi Arabia. The five (5)-storey stand-alone, purpose built facility was opened in March 2001 to replace the traditional 'out-patient department' (OPD) that had functioned as four (4) clinics within the in-patient teaching hospital setting. The floor space of the entire OPD was equivalent to the space of one floor in the new ACC. This move into the new facility heralded a trend of rapid expansion of ambulatory services with all floors occupied and utilized by the end of the same year. This accelerated expansion of services resulted in multidisciplinary team members of the Ambulatory Care Center Executive Committee (ACC–EXCO) identifying a trend of multifactor disruption in the treatment of patients in November 2001. It was noted that the expansion of ambulatory care services exceeded the

capacity of the initial ACC organizational structure and its related mechanisms for coordinating the input of various healthcare disciplines to clinical operations and patient care. During discussion of the challenges, it became clear to the ACC–EXCO members that the issues did not relate necessarily to any specific healthcare discipline, but that the related contributory factors nevertheless resulted in an interruption to the continuity of care. The major forces that had contributed to the situation were identified to be the post-commissioning building phase of opening a new facility, and the consequent lack of capacity to cope with the service demands of rapid expansion. The ACC–EXCO further identified the multiple contributory factors as, but not limited to, misplaced laboratory results, misfiled patient records, health professionals being on leave, hospital policy changes on patient eligibility for treatment, alterations in medical specialist clinic schedules, patients with multiple medical record numbers, and/or multiple conflicting appointments or missed appointments, and the unavailability of specific drugs. The ACC–EXCO members confirmed that the identified problems resulted in a disruption to the continuity of patient care, and thereby also contributed to a lack of quality patient care in the ACC.

The nursing services division responded to the identified disruption in the continuity of care and the consequent lack of quality patient care in the ACC by proposing that the registered nurse (RN) role be refocused to address these patient situations that specifically arose from multiple contributory factors. A functional RN role was proposed that was described as the ‘patient liaison nurse’ (PLN) to facilitate problem-solving of the factors that negatively affected quality patient care. This functional RN role as a PLN was suggested as a pilot project by the nursing services division. The PLN was regarded as an extension to the existing RN role of the ambulatory care nurse. At an operational level, it was a rotational role to which registered nurses (ambulatory care nurses) in each of the sixteen (16) specialist clinics would be assigned at the discretion of nursing management to function in the role of a patient liaison nurse (PLN) for two

(2) to six (6) months at a time. The PLN input was therefore referred to as 'the functional role of the RN as PLN' on the basis that it was a rotational aspect of the ambulatory care nurse who was an RN with an approved generic job description. Each RN, when not functioning as a PLN, would return to regular clinical practice, as set out in their job function for ACC, and another RN would assume the functional role of the RN as PLN by assigned rotation.

The functional role as a set of behaviors that is characteristic of the RN in the context as PLN was initially outlined as follows when it was implemented in the ACC:

- receive and interview patients with problems that could potentially interrupt or compromise the treatment regimen
- retrieve the medical record to review the current patient care and treatment regimen
- document concerns from the patient's perspective, and identify possible related causes
- contact the responsible physician and/or health professional(s) and liaise appropriately on alternatives for action to continue treatment
- direct and/or advise patients accordingly
- facilitate a follow-up appointment for the patient with the attending physician, and/or health professional(s), as appropriate
- document the episode and outcome on the patient's medical record.

The PLN was regarded as successful by the ACC-EXCO within three (3) months and was adopted without further analysis of the effectiveness of this functional RN role in the ACC. Furthermore, the registered nurses (ambulatory care nurses) who undertook the functional role of the RN as patient liaison nurses (PLNs) had expressed a greater sense of satisfaction in their practice of ambulatory care nursing, which they attributed

to job enrichment in the functional role of the RN. Therefore the nursing services division permitted the PLN role to continue because of the perceived successful contribution to quality patient care in the ACC.

The monthly ACC patient attendance statistics had showed a steady increase of between 20-30% in patients attending the PLN patient sessions within the initial period. This increasing trend contributed to the perception by the multidisciplinary team, as evidenced by increased referrals, that intervention by the PLN contributed to overall quality patient care. Herein lies the core rationale for this research study, as it was not known, nor could it be readily identified, as to why or how the intervention by the functional role of the RN as PLN was regarded as an effective contribution to quality patient care in the ACC. This perceived success was taken to be an unexplained phenomenon, and therefore became the focus of this research study on the development of a model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital.

## 1.3 IMPORTANCE OF THE STUDY

The functional role of the RN known as the patient liaison nurse (PLN) is embedded in the role of the ambulatory care nurse, and therefore has a potential contribution to nursing as a value-based discipline. The focus of this study was to reveal the dynamics and/or components of the PLN so that an exploratory, descriptive and interpretive study could investigate the functions that contribute to the effectiveness of the PLN role. The results of the study could possibly reveal (i) the operational or relational components in the nursing actions of the PLN that contribute to quality patient care in the ambulatory care setting of a Middle Eastern teaching hospital, and

(ii) the specific aspects of ambulatory care nursing that the PLN uses to perform the role as PLN that contributes to the continuity of care with the site absence of the physician and other members of the healthcare team.

Schim, Thornburg and Kravutske (2001:314) identified a lack of congruence between what ambulatory care nurses actually do and what they believe to be important. In her conceptualization in the delineation of ambulatory care nursing practice, Verran (1981:2) focused on domains of responsibility for the 'performance of categories of tasks and duties' in ambulatory care nursing, and concluded that nursing research was needed to categorize and scale the levels of complexity of nursing activities. She suggested that a nursing care complexity index be determined for each clinic within ambulatory care nursing. To date, such an index has neither been researched nor published. This was initially shown by Mastal (2006:44) who traced the evolution of health concepts since the early 1900s to date, and, concurrent to reviewing trends and models that influenced the evolution of ambulatory care nursing, she concluded that changes in disease patterns and the healthcare environment triggered 'new, expanded, evolving roles for the nurse'.

Therefore, the importance of this study to the profession of nursing is to contribute to the body of knowledge by investigating the lived experience of the PLN in ambulatory care nursing so that the identified concepts that underlie this functional role of the RN can be classified. This should lead to the description of a model for patient liaison nursing in the ambulatory care context, whereupon guidelines for related practice in ambulatory care nursing could be generated. With this outcome, relevant and appropriate guidelines can be generated for the practice of the functional role of the RN as PLN aimed at contributing to quality patient care in a Middle Eastern teaching hospital.

## 1.4 RESEARCH PROBLEM AND QUESTION

There is a lack of literature-based evidence on the defined functional RN role as PLN, either in ambulatory care nursing or similar settings, (Rheaume, Frisch, Smith & Kennedy 1994:30, Conti 1996:97, Schim, Thornburg & Kravutske 2001:311, Stichler 2002:52, Greenberg & Pyle 2004:12, Mastal 2006:29 and Sullivan & Decker 2009:23). The identified research problem indicates the lack of a descriptive model of what constitutes the functional RN role of the PLN and how the PLN role would contribute to quality patient care in the ambulatory care context of a Middle Eastern teaching hospital.

On the basis of this identified problem, the research question was: how can a model be developed that describes the PLN as a functional role of the RN in the ambulatory care context of a Middle Eastern teaching hospital? Based on this core research question, the following related questions were asked:

- What are the lived experiences of the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital?
- What is the functional role of the RN as PLN according to the nursing management team in the ambulatory care context of a Middle Eastern teaching hospital?
- What are the core and related concepts on the functional role of the RN as PLN?
- How can a conceptual framework be described?
- What are the relational statements of the model that describes the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital?
- How can the model be evaluated theoretically?

- How can guidelines be formulated for the implementation of the model of patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital?

Based on these research questions, the research purpose and objectives were formulated.

## 1.5 RESEARCH AIM AND OBJECTIVES

The overall aim of the research was to develop and describe a model for the functional role of the RN as PLN in the ambulatory care context. The functional role of the RN as PLN was studied specifically in relation to its contribution to quality patient care in the ambulatory care context of a Middle Eastern teaching hospital. In order to achieve the overall aim of the study, research objectives were formulated. The research study was conducted in two distinct phases, namely, phase 1: the process of concept identification and description, and phase 2: the process of model development and description that used the empirical results of the study on the functional RN role as PLN in the ambulatory care context in phase 1. The research objectives for the respective phases were as follows:

### 1.5.1 Phase 1 objectives: the process of concept identification and description

(1) To explore, describe, and interpret the lived experience of the functional role of the RN as PLN within in the ambulatory care context of a Middle Eastern teaching hospital

(2) To explore and describe the functional role of the RN as PLN from a nursing management team perspective in the ambulatory care context of a Middle Eastern teaching hospital

(3) To identify, classify, clarify, and describe the core and related concepts from the empirical data on the functional role of the RN as PLN and in relation to the literature.

### 1.5.2 Phase 2 objectives: the process of model development and description

(4) To describe the conceptual framework of the study on the functional role of the RN as PLN

(5) To formulate and describe relational statements in order to describe a model for the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital

(6) To evaluate the described model according to preset theoretical criteria

(7) To formulate guidelines for the implementation of the model on the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.

## 1.6 CENTRAL THEORETICAL STATEMENT

The insight and understanding gained on the lived experiences of the PLN, and the description of the functional role of the RN as PLN from a nursing management team perspective will inform the practice model on the functional role of the RN as PLN in the ambulatory care context in a Middle Eastern teaching hospital.

## 1.7 ASSUMPTIONS OF THE RESEARCHER

The assumptions of the researcher guide the intellectual activity and scientific inquiry in the research process (Kuhn 1996:44, Rodgers 2005:11, Creswell 2007:16). These assumptions are value statements (Chinn & Kramer 2008:293) that express the beliefs of the researcher (Creswell 2007:15) and are not tested empirically. Mouton (1996:174) asserts that it is acceptable in the contemporary philosophy of science to make assumptions that are not necessarily tested specifically within a study. The assumptions stated here by the researcher contribute to shaping research decisions made as the scientific activities advance, and provide a philosophical context that shapes the phases of the research process (Polifroni & Welch 1999:9, Rodgers 2005:11, Klopper 2008:63, Risjord 2010:33).

### 1.7.1 Meta-theoretical assumptions

Mouton (1996:174) asserts that meta-theoretical assumptions are important in a research study as they comprise underlying theories, models or paradigms that contribute to defining the context in which a study is conducted. Walker and Avant (2011:7) express a similar assertion and add that a common thread throughout the meta-theoretical literature is the appraisals on the meaning of nursing, from the perspectives both as a science and a profession, which defines nursing as a 'practice discipline'.

Fawcett (2005:4) defines a metaparadigm as 'the global concepts that identify the phenomena of central interest to a discipline, the global propositions that describe the concepts, and the global propositions that state the relations between the concepts'. The definitions used by Fawcett (2005:3) are as follows:

- a concept is a word or phrase that summarizes the essential characteristics or properties of a phenomenon.
- a proposition is a statement about a concept or a statement of the relation between two or more concepts.
- a non-relational proposition is a description or definition of a concept. A non-relational proposition that states the meaning of a concept is called a constitutive definition. A non-relational proposition that states how a concept is observed or measured is called an operational definition.
- a relational proposition asserts the relation, or linkage between two or more concepts.

The researcher is aligned to the metaparadigm of nursing by Fawcett (2005:6) that has been adapted and is presented in table 1.1. The metaparadigm using aspects of Fawcett's (2005:4) structure of contemporary nursing knowledge will convey the related meta-theoretical assumptions of the researcher. The metaparadigm of nursing by Fawcett (2005:5) is composed of four (4) concepts, four (4) non-relational propositions, and four (4) relational propositions. Included in the last column of table 1.1 are the meta-theoretical assumptions applied to the functional role of the RN as PLN in the ambulatory care context.

**Table 1.1** The metaparadigm of nursing by Fawcett (2005) applied to the PLN role

| Central Concept | Non-relational Propositions | Relational Propositions | Meta-theoretical assumptions applied to patient liaison nursing |
|---|---|---|---|
| 1. Person | The metaparadigm concept person refers to the individuals, families, communities, and other groups who are participants in nursing. In this study, person refers to the patient | The discipline of nursing is concerned with the principles and laws that govern the life-process, well-being, and optimal functioning of human beings, sick or well. In this study, this is ambulatory care nursing. | The PLN uses communication skills in an interaction with the patient, families, or health professionals aimed at preventing disruption in the treatment process and contributes to well-being. |
| 2. Environment | The metaparadigm concept environment refers to the person's significant others and physical surroundings, as well as to the setting in which nursing occurs, which ranges from the person's home to clinical agencies and society as a whole. The metaparadigm concept environment also refers to all the local, regional, national, and worldwide cultural, social, political, and economic conditions that are associated with the person's health. Environment in this study includes the home of the ambulatory patient. | The discipline of nursing is concerned with the patterning of human behavior in interaction with the environment in normal life events and critical life situations. This is the environment in the ambulatory care context in which patient care observations and assessments are undertaken. | An essential aspect of interacting with the patients in the ambulatory care context is assessing the home environment, family input, referral agencies, and other support structures that would contribute to continuity of care on an out-patient basis. Further, the patient is informed as to the necessary action required when emergencies or life-altering situations arise. The PLN educates the ambulatory patient on maintaining a home environment that is oriented to health lifestyle. |
| 3. Health | The metaparadigm concept health refers to the person's state of well-being at the time that nursing occurs, which can range from high-level wellness to terminal illness. Health in this study means that a patient's concerns have received a response from the PLN so that treatment is continued. | The discipline of nursing is concerned with nursing actions or processes by which positive changes in health status are affected. In this study, ambulatory care nurses identify patient concerns and initiate a referral to the PLN. | The PLN responds to the presenting patient's problem, and accordingly intervenes by interacting with appropriate health professionals aimed at maintaining or restoring health. In essence, the PLN is focused on actions with either clinical or operational support staff aimed at resolving the patient's identified concern. |
| 4. Nursing | The metaparadigm concept nursing refers to the definition of nursing, the actions taken by nurses on behalf of or in conjunction with the person, and the goals or outcomes of nursing actions. Nursing actions are typically viewed as a systematic process of assessment, labeling, planning, intervention, and evaluation. Nursing in this study refers to the functional role of the RN as PLN. | The discipline of nursing is concerned with the wholeness or health of human beings, recognizing that they are in continuous interaction with their environments. The combined actions of the ambulatory care nurses and patient liaison nurses are coordinated to ensure quality patient care is the desired outcome from an episodic visit of a patient to the ambulatory care clinic. | The PLN uses the nursing process to assess the patient's problem, explores alternatives, plans the intervention, implements the action, evaluates, and documents in the patient's medical record. The PLN functions within a nursing management structure that includes all ambulatory care nurses who report in the line structure to the clinic nurse coordinators who are responsible for overall functioning of all registered nurses in a specific ambulatory care clinic. |

### 1.7.2 Theoretical assumptions

As the researcher at the outset of this study, I did not use any specific pre-determined theoretical framework to structure the theoretical assumptions in my approach to designing the research activities. However, admittedly using reflexivity that involves self-questioning and self-understanding (Patton 2002:64, Schwandt 2007:260, Holloway & Wheeler 2010:9) of the organizational cultural setting in which this study was conducted, it must be stated that perhaps elements of 'bricolage' (Denzin & Lincoln 2008c:5) were evident in my research activities whereby a 'theoretical … pieced-together set of representations that are fitted to the specifics of a complex situation' were used. Denzin and Lincoln (2008c:5) state that the qualitative researcher, depending on the context as the research process unfolds, becomes a 'bricoleur' in that 'materials tools of his or her craft' are put together innovatively as the researcher advances through the activities of the study. Denzin and Lincoln (2008c) quote Nelson (1992) and agree that the choice occurs pragmatically, self-reflexively, and that the process of selection does not occur in advance, but is dependent on the questions asked while in the context of the research field.

Admittedly, this did occur, which perhaps reveals aspects of post-modern thought in that there was no unified thought or coherent theoretical approach (Cheek 2000:18) used to structure the theoretical assumptions in a conceptual framework, especially during the conceptualization phase of the research project (Burns & Grove 2005:139). The research field was approached without any specific theoretical framework; however, in the development of the data, it will be shown that a diverse source of acknowledged work was used. Furthermore, literature sources are acknowledged in the definitions of terms that follow and thereafter in the methodological assumptions which contain diverse literature-based support for the methods used.

In summary, from a reflexive perspective, the following literature sources related to the theoretical assumptions that were used during the conceptualization and methodological phases of the research process:

- **Quality**

Donabedian (1996:88-103) provides theoretical assumptions of quality from his previous works that were used iteratively during the development of the conceptual and methodological phases. Relevant aspects are summarized below:

- Quality has the distinctive characteristic of emphasizing the health consumer as the final arbiter of quality.
- Quality is ultimately based on the consumers who say whether or not their needs or expectations were met.
- The aim of quality is not only to merit customer satisfaction but, if possible, to exceed expectations.
- Quality in providing care is done in ways that are convenient, congenial, and pleasant to patients.
- Quality is defined in the healthcare delivery model by using a complex set of responsibilities toward individuals and society.
- Quality in healthcare embraces interpersonal complex relationships that are the product of the joint efforts of the practitioners and the patients.
- Quality involves the ability to influence the capacity of patients to participate in acquiring their health gains, albeit a salient attribute.
- Quality has efficiency and effectiveness as centrally important factors and as determinants of achieving quality outcomes.
- Achieving quality includes embracing the entire set of structural units in an organization, process, and persons concerned in the conceptualization,

design, resource use, and consumption of any health service. This encompasses all external and internal participants.

- In healthcare, the conceptual formulations are emphasized to embrace not only the physicians in care delivery, but the contribution of all caregivers, the patients and their families, and not only one episode of care at one site, but all episodes of care at all sites, including successive episodes when the patient returns for continuity of care.
- Quality is not exclusively the domain of clinical caregivers in healthcare, but also includes other professionals, such as operations technical personnel, whose functions are closely related to the care of patients. The attention here in the spectrum of contributors to care is an explicit or implicit set of priorities that focus attention on care delivery guided by consequentiality, relevance, scope of responsibilities, and capacity to influence.
- Quality has the following affinities that underpin service to the consumer; recognition of the worthiness, dignity, devotion, and skill of all the employees, refusal to blame individuals for inherent deficiencies of systems and processes, reliance on education rather than punishment as a correct strategy, belief in leadership rather than dictation, and emphasis on internal self-amelioration rather than external regulations.

  (Donabedian 1980:24, Donabedian 1982:6, Donabedian 1985:164).

McEachern, Makens, Buchanan and Schiff (1995:117) acknowledged the Donabedian paradigm that has been articulated for healthcare for the past two decades, and therefore has an evergreen nature. They attribute Donabedian with having the ability to take caregivers in healthcare to ‘a new level of understanding quality’, and contribute two further theoretical assumptions in Donabedian’s writing on quality as follows:

- Quality in healthcare has system design and performance monitoring as two inseparable yet mutually supportive components of quality.
- Quality in healthcare adds value to service, and therefore increases the meaning of health gain to people who use the services.

  (Donabedian 1980:116, Donabedian 1982:38).

- **Ambulatory Care Nursing**

The American Academy of Ambulatory Care Nursing (AAACN) texts [Robinson 2001 (1st edition) & Laughlin 2006 (2nd edition)] describe ambulatory care nursing whereby:

- In the first (1st) edition (AAACN 2001), the text focused on the context of patient care and content of the nursing role dimensions with three (3) primary sections as follows: (i) the organizational/systems role of the ambulatory care nurse, (ii) the clinical nursing role in ambulatory care, and (iii) the professional nursing role in ambulatory care (Robinson 2001:xi).
- In the second (2nd) edition (AAACN 2006), the text is focused on advancing the art and science of ambulatory care nursing in relation to role preparation for two (2) core rationales: (i) the growth of ambulatory care nursing in volume, magnitude, and complexity concurrent to the shift in healthcare demands to increased use of ambulatory care settings. Linked to this trend is the expanding body of nursing knowledge and its related role competencies; and (ii) ambulatory care nursing has advanced to a complexity level and depth of specialty practice that a written evidenced-based resource is required to support, recognize and value the unique attributes of the ambulatory care nursing role. The role is seen on a continuum of nursing specializations, and the commitment to nursing as a discipline to establish an appropriate credentialing system and a continuing education process, and for the

installment of a related career pathway leading to a specialization in ambulatory care nursing (Laughlin 2006:ix).

It is noted in both editions that the functional role of the RN as PLN is neither described nor implied (Robinson 2001, Laughlin 2006). However, the following theoretical assumptions are generated from the latest edition in relation to scope of the ambulatory care nurse (Hastings 2006:15-25). The theoretical assumptions are:

- The ambulatory nursing care practice domain is defined as the overall scope of nursing practice, and is concerned with the environment in which the RN practices, the patient requirement for care, and specific RN role dimensions.
- The ambulatory patient profile includes simple to complex diverse conditions, patients as informed consumers who may question the dimensions of care, and a patient entity constituted of family members and concerned others who become involved in patient care decisions.
- Patient care in the ambulatory setting is episodic with a focus on patients continuing the treatment regime in their residential settings.
- The spectrum of patient care delivery is the single episodic locus of control requiring the ambulatory care nurse to integrate the clinical and operational components with greater precision in nursing actions in comparison to the in-patient setting where patient care delivery has multiple points of care opportunities.

### 1.7.3 Definition of concepts and terms

Mouton (1996:66) provides a dynamic characteristic to definitions by referring to the researcher for defining concepts and terms used in the investigation. He asserts that in

this process, the references or denotations that pertain to the concepts in a research study are defined and uniquely determined for the specific study. In this manner, Mouton (1996) maintains that the construction of terms serves to connect the research problem to the real world and suggests that it is an integral part of formulating and conceptualizing the research problem specific to the research study. In keeping with this principle in the research process, the definition of terms that follows provides a link to the setting of the research study in the ambulatory care context of a Middle Eastern teaching hospital.

**Patient liaison nurse (role):** A registered nurse who is basically assigned as an ambulatory care nurse, and who assumes the functional role (a set of behaviors that is characteristic of a person in a given context) as an RN to respond to patient concerns in the site absence of a physician or other members of the healthcare team.

**Ambulatory care context:** An outpatient setting in a large Middle Eastern teaching multi-center hospital complex. The outpatient care delivery approach is episodic, often using the patient and/or family as the main informants. The medical specialist care clinics, also referred to as the Ambulatory Care Center (ACC), are provided by medical consultants in the major clinical branches of the medical disciplines, such as Medicine, Surgery, Pediatrics and Obstetrics and Gynecology. Each branch includes highly specialized sub-branches, for instance, a Pediatric Cardiac Surgery clinic, a 'Living-related' Liver Transplant clinic, a Laser Ophthalmology clinic, and a Plastic and Reconstructive Surgery clinic. The outcome of an episodic visit to the ACC is the return of the patient to their residential setting, except for patients with acute problems or an exacerbation of a chronic problem. These latter types of patients are usually admitted as in-patients directly from the ACC.

This is the healthcare service in which the study will be conducted, which houses the sixteen (16) purpose-designed ambulatory care clinics. The ACC facilities include a pharmacy, pathology laboratory, lung function laboratory, medical imaging department, patient and support services, and the medical records department.

**Ambulatory care nursing:** A field of nursing practice by registered nurses characterized by rapid, focused assessment of patients, management of a high volume of patients in a short time period, and care responses to patient issues that are not usually predictable. The patient population ranges from newborns to aged persons. This field of nursing embraces the restoration and promotion of health, prevention of disease, and caring support for the dying patient and family.

**Middle Eastern teaching hospital:** The hospital at which this research study was conducted is situated in Riyadh, Saudi Arabia in the Middle Eastern region. At the international level, the organization is accredited by the American accreditation standards for hospitals that have been set out by the Joint Commission International (JCI). At the local level, the hospital has an affiliated university that is recognized by the Ministry of Higher Education. It has a college of medicine and a full medical residency program in all the major clinical departments. A college of nursing is on site with a deanship that manages the undergraduate nursing curriculum. Members of the clinical nursing staff at the institution are mainly ex-patriot employees (above 90%) from more than forty-two countries worldwide.

At this Middle Eastern teaching hospital in Saudi Arabia, all written communications and software computer programs use American spelling of English. This research study, being contextual, utilizes American spelling of English for purposes of congruency, especially since the participants will also use American spelling of English in their responses.

**Patient Liaison Nurse (PLN) patient sessions:** These are periods of time allocated to each patient for assessment and related nursing action by the PLN in a consultation room in the ACC. The period may range from ten (10) minutes to one hour. During this time, the PLN communicates with the patient to assess the problem, and reviews the patient's medical record for clarity on the factors that could potentially detract from quality patient care. After the appropriate patient liaison nursing assessment and consultation with the appropriate health professionals, the PLN reconsiders the presenting concern(s) of the patient in light of the possibilities for resolution, and then selects the most appropriate course of action aimed at responding effectively to the patient's concern.

**Quality patient care:** In this study, it is intentional that the word 'quality' is placed before 'patient care' (Besterfield, Besterfield-Michna, Besterfield & Besterfield-Sacre 1999:5) as a 'modifier' meaning 'having or showing excellence or superiority' (Collins 2006:976). The description 'quality patient care' is taken to communicate that excellence in the 'structure', 'process' and 'outcome' of healthcare is the central focus in providing care to the patient as adopted from Donabedian's work on the assessment and monitoring of quality in healthcare (Donabedian 1980:79, Donabedian 1982:211). Donabedian's work is embraced by the American Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (McEachern, Makens, Buchanan, & Schiff 1995:117).

### 1.7.4 Methodological assumptions

Mouton (1996:124) states that methodological assumptions inform on the nature of the research process, including the most suitable methods to be used. This includes a description of the methods, quantitative or qualitative, and portrays whether universal

statements on methodological assumptions require interpretation or explanation either in a specific or generalized context.

Botes (2003:176) is specific on what constitutes the nature of the research process and on which methodological assumptions are informative. She states that methodological assumptions have their origins in science philosophy and deal with the purpose, method and criteria for validating a research study. She further qualifies this contribution by stating that the methodological assumptions convey the researcher's view of both the nature and structure of science and research within the professional discipline of the investigator. Kuhn (1996:18) is aligned with Botes and asserts that when examining the nature of science by considering the methodological assumptions, it is essential to consider how the paradigmatic perspective would affect the members of the disciplines who practice within the field. In embracing this, Botes (2003:176) advises the researcher to state the methodological assumptions explicitly, which would facilitate the likelihood of reducing intolerance towards an unfamiliar paradigm and promote the evaluation and justification of the selected paradigm. Methodological assumptions for this study will be described from two perspectives, namely,

- qualitative research
- model description

This approach embraces the comprehensive description of this research study as being qualitative, yet permits methodological assumptions to be stated for each of the two phases in the research study. Phase one commences by studying the meaning and lived experience of the PLN, using self-reporting methods, such as the critical incident technique, reflective journaling, and the vignette technique. The second phase qualifies the first phase by using the empirical data in model description as a research approach.

### 1.7.4.1 Methodological assumptions on qualitative research

In using the qualitative research approach in this study, the assumptions described below are based on Creswell (2007:16) and are integrated with assumptions by Mouton (1996:74) and Denzin and Lincoln (2011:3). The Sage Dictionary of Qualitative Inquiry advanced insight into the terms and definitions used to understand the methodological assumptions and to consolidate my clarity on the terms used (Schwandt 2007). From the perspective of the researcher, the assumptions are as follows:

- Qualitative research holds a belief in real subjects, or real individuals who reside in the real world, and is able to report on his or her lived experiences.
- Qualitative research blends observations with information from individuals (subjects) through various methods such as interviews and other documents that portray lived experiences.
- Qualitative research interest is in meaning, that is, how people make sense of their lives, experiences, and structures in the world.
- Qualitative research involves fieldwork in that the researcher physically goes to the people in a setting to observe, record or obtain information on experience in its natural setting.
- Qualitative research is descriptive in that it pertains to process, meaning and understanding gained through words or pictures.
- The process of qualitative research uses inductive and deductive reasoning to construct abstractions, concepts, hypotheses, and theories from details of experience and/or observation.

The methodological assumptions that are specific to the second phase of the research study, namely model description, are presented and will embrace reference to the qualitative methodology to illustrate consistency in the study on the research methods used.

#### 1.7.4.2 Methodological assumptions on model description

Model description as a research method in this study essentially commences from the first research objective, namely, to explore, describe, and interpret the meaning and lived experience of the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital. While the research study continues using qualitative enquiry, the parallel operant method is model description. The first phase of model development is concept identification and description. In order to achieve this, the results of the analysis of empirical data obtained by the use of the critical incident technique, reflective journal technique and vignette technique provide the basis for concept identification.

From the results of phase one, deductive logic was used to formulate conclusion statements, and thereafter the conclusion statement concepts were identified once again using deductive logic. This approach fits with Klopper's (2010) work on IDLE™. IDLE™ stands for "inductive and deductive logic evidence" and this approach is followed throughout the study to ensure logical argumentation in the process of model development.

The methodological assumptions for model description primarily embrace the perspectives of Chinn and Kramer (2008:22). Their perspectives are enriched by a range of authors who write on model description and the related philosophical

positions. These include Kuhn (1996:177), Mouton (1996:74), Fawcett (2005:31), Meleis (2007:149), Risjord (2010:172) and Walker and Avant (2011:3). Based on this literature, the methodological assumptions that follow are presented as applicable to this research study:

- Concepts are attributes, symbols, dimensions, and/or aspects of reality that represent the empirical world and/or the nature of phenomena for the researcher.
- Concepts evolve from the complexity of human experience, perceptions and cognitive processes, and are representative of a mental image of reality.
- Concepts are conveyed in language, particularly in words, and may represent a timeless and abstract notion of reality, or the universal essence of existence which makes a meaningful and productive contribution to a researcher in the development of knowledge as in a model or theory.
- The development of conceptual models and theory-based nursing practice is linked to the process of innovation and creativity within the dimensions of the discipline of nursing.
- Model description is useful in the practice of nursing when it is informed by practice-based empirical research.
- Inductive and deductive logic are forms of scientific reasoning that are fundamental to model description.
- Model description is a creative and rigorous structuring of ideas that projects a purposeful and systematic view of a phenomenon.
- The process adopted in model description represents congruency within a scientific specialty or discipline, as it represents a degree of agreement by members in that scientific community on the boundaries of the scientific subject being investigated.

- Model description provides a means of identifying and expressing key ideas about the essence of practice within a specific discipline.
- Model description focuses on the construction of the person-environment as it relates to health and nursing as a specific discipline within a specific context.
- Model description aims to facilitate the practitioner's understanding of the dynamics of the discipline on a more complete and insightful level regardless of the extent or limitation of the scope of practice within a specific context.
- Model description commits the practice within a discipline to sound, reliable knowledge, which is a hallmark of a profession and practice discipline.
- Model description serves the discipline by integrating practice and knowledge aimed at narrowing the practice-theory gap, which intrinsically contributes to advanced practice.

The methodological assumptions that have been presented in this research study are intended to guide the direction of the research for the purposes of developing new nursing knowledge. Fawcett (2005:589) asserts that nursing as a professional discipline *'*is mandated by society not only to develop and disseminate nursing knowledge*'*, but to utilize nursing knowledge in the practice setting *'*to improve the well-being of human beings.*'* If this is the intended outcome of this research study, then the researcher accepts that the comprehensive presentation of assumptions is a departure point in the pursuit of new nursing knowledge.

## 1.8 RESEARCH DESIGN

Research design is theory generative, qualitative and uses exploratory, descriptive, contextual, and interpretive approaches to study the functional role of the RN as PLN, and to describe a model for the functional role of the RN as PLN in terms of its contribution to quality patient care in the ambulatory care context of a Middle Eastern teaching hospital.

The theory generative aspect of research design is based on the process of theory development as laid out in the three (3) editions of Chinn and Kramer that were used during the course of this research project. These are the fifth (5th) edition (Chinn & Kramer 1999:49) the sixth (6th) edition (Chinn & Kramer 2004:55) and the seventh (7th) edition (Chinn & Kramer 2008:179). The four processes for generating an empirical theory in this study are therefore taken as:

(1) creating a conceptual meaning

(2) structuring and contextualizing a theory

(3) generating and validating theoretic relationships

(4) evaluating and applying the theory in practice

A range of three editions on the work of Walker and Avant were also used. These included the third (3rd) edition (Walker & Avant 1995:3), the fourth (4th) edition (Walker & Avant 2005:3) and the fifth (5th) edition (Walker & Avant 2011:6). The recurring stance is that nursing is a practice discipline and, therefore, theory development in nursing as a profession is supported as the way forward in advancing the profession. Although they indicate that, as a practice discipline, nursing is complex, but they add that regardless of this complexity, theory development is aimed at facilitating the nurse in gaining an understanding of and deeper insight into practice. They uphold that this

characteristic of being committed to practice based on sound reliable knowledge defines nursing as a practice discipline and profession. Fawcett (2005:32) concurs with this, and describes theory-based practice as a means of viewing practice through an 'intellectual lens' which serves as a purposeful and systematic process for scrutinizing nursing for efficiency and control over practice outcomes.

Polit, Beck and Hungler (2001:17) and Streubert and Carpenter (2011:87) justify the use of qualitative research design to study when not much is known about the phenomenon. In approaching this research study, it was found that there was a lack of empirical studies investigating the scope and functional role of the RN as PLN in the context of ambulatory care nursing, and neither in a Middle Eastern teaching hospital setting. The research design comprised of an approach that included exploratory, descriptive, contextual, and interpretive aspects. Various authors, including Mouton and Marais (1990:43), Polit, Beck and Hungler (2001:19), Mason (2002:31), Ritchie (2003:27), Creswell (2007:249), Denzin & Lincoln (2008c:31), Stake (2010:36), Marshall and Rossman (2011:69) were used to outline the purposes for exploratory, descriptive, contextual and interpretive approaches to research design. In addition to obtaining definitions to these aspects of research design, the consultation extended to the 'Sage Dictionary of Qualitative Inquiry' (Schwandt 2007) to ensure that the lexicographic component was embraced in the definition and purposes generated as follows:

- Exploratory research
    - To discover the various dimensions of a phenomenon through investigation and observation
    - To gain new insight into the meaning and nature of a phenomenon
    - To identify or discover important categories of meaning.

- Descriptive studies
    - To provide an in-depth depiction of the characteristics, occurrence, and importance of a phenomenon
    - To clarify and classify the central concepts related to a phenomenon of interest
    - To give an account of that which is perceived from the facts about the objects and events.
- Contextual research
    - To identify what exists in a social setting and the way it manifests itself
    - To describe the features of beliefs or practices that are bound in culture, language, tradition, influences and the determinants that enhance the form or nature of what exists
    - To gain a sense of the distinctiveness of the different elements in data that reveal meaningful characteristics of real-life cycles, organizational or managerial processes.
- Interpretive research
    - To investigate through observers who define and redefine the meaning of what is seen and heard
    - To study social life by focusing on the meaning of human action by the inquirer unearthing the meaning of human actions
    - To emphasize human values and experiences by capturing what and how lived experiences alter and shape as meaning and understanding of action unfolds.

Therefore, based on the component aspects of the research design as portrayed above, this research study will investigate the phenomenon of the functional role of the RN as PLN in its natural setting of ambulatory care nursing, which may include social,

physical, historical, or professional elements of its intrinsic uniqueness in function. The contextual setting will be studied as the ambulatory care setting in a Middle Eastern teaching hospital to discover characteristics that contribute to empirical findings of how the functional role of the RN as PLN contributes to quality patient care in this unique setting.

## 1.9 ETHICAL CONSIDERATIONS

A range of texts were consulted in relation to the ethical considerations for this study. The topics included ethics in qualitative research from the perspective of fieldwork, participation and research practice (de Laine 2000), ethics in research with human participants (Sales & Folkman 2000), ethics in qualitative research (Mauthner, Birch, Jessop & Miller 2002), ethics in nursing practice (Fry & Johnstone 2002), integrity in scientific research (Institute of Medicine National Research Council 2002), and responsible conduct in research (Shamoo & Resnik 2003).

The spectrum of ethical concerns are far-reaching in qualitative research and are acknowledged by Carpenter (2011:56), who asserts that it is a professional responsibility of nurse researchers to design research methods that protect human rights and uphold universal ethical principles. The summarized ethical issues pertain to:

- informed consent
- participant-researcher relationship
- gaining access
- confidentiality and anonymity
- sample size

- data generation
- data analysis.

In relation to the above areas of ethical concern as a nurse researcher, I was particularly drawn to the guidelines for ethical research conduct (Shamoo & Resnik 2003:20) that guided my professional manner and shaped my approach to the research activities in this study. These include:

- Honesty by ensuring truthfulness in all scientific communications and reports of data, results, methods, and potential conflicts of interest. An alert was to never confabulate, fabricate, misrepresent or falsify the data.
- Objectivity by avoiding subjectivity in data interpretation, data analysis, personal viewpoints, and bias.
- Integrity by ensuring all actions taken in the research process are correct and acceptable in professional conduct.
- Care in avoiding errors and negligence that entails a review of research activities and by maintaining orderliness in records related to research.
- Openness by accepting feedback on research work and by being open to sharing ideas, methods, tools, resources, and data.
- Confidentiality by protecting individuals participating in research, and by taking physical measures to protect data, papers and respecting organizational policy on publications and access to patient records.
- Respect for others which includes colleagues, participants and workers in the research field by avoiding all actions that may harm them or impact their well-being and by treating others in the same manner that one would want others to treat oneself.
- Respect for intellectual property by honoring copyrights, institutional data access, organizational policies and other forms of intellectual property

through acknowledgement and by requesting permission to ensure due credit of work belonging to others.

- Social responsibility by promoting social good in research practice and by preventing social harm through research publication, education of others and advocacy on social concerns that are related to research practice.
- Efficiency and competence by ensuring maintenance and skillful use of human and technological resources with the concurrent acquisition of advanced abilities in scientific capacity.
- Legality by gaining knowledge of relevant policies, laws and rules pertaining to research practice, and thereto to fulfill the expectations of scientific conduct of study investigations.
- Protection of human subjects by conducting research that minimizes physical and mental harm to participants, and maximizes benefits through respect for human dignity, privacy and autonomy with special precautions for vulnerable populations.

The above context for ethical conduct in research embraces the universal ethical principles of non-malfeasance, beneficence, autonomy and justice (Shamoo & Resnik 2003:16, Carpenter 2011:60). Research activities that serve to uphold these ethical principles apply primarily to measures taken at the institutional and individual levels.

Institutional approvals were initially obtained from the nursing services division for permission to conduct the nursing research study at a Middle Eastern teaching hospital (see appendix 1). The imperative to retain the principle of non-malfeasance whereby the participants must not be harmed (Shamoo & Resnik 2003:16) was portrayed in the two (2) presentations that I delivered first to the nursing executive council at the hospital in Saudi Arabia (see appendix 2) and then to the post-graduate committee of

the University of the Witwatersrand in South Africa (see appendix 3). At both presentations, in addition to satisfying the panel members of the worthiness of the proposed research, both had to be satisfied that there was an absence of physical or mental harm to the participants. The outcome of these dual presentations resulted in the granting of institutional approval by the nursing services division in Saudi Arabia (as shown in appendix 2), and by the university as stated in the approval letter as shown in appendix 4.

I took multiple level actions to uphold the principle of autonomy where informed consent was obtained from potential respondents so that participation was voluntary by rational individuals who make their own decisions because they have the capacity of responsible choice (Shamoo & Resnik 2003:16, Carpenter 2011:61). Entwined with the principle of autonomy is the principle of justice that upholds participants being treated equally with dignity and respect (Shamoo & Resnik 2003:16), Carpenter 2011:61). To this end, I took the following measures in relation to the process of data collection:

- A PowerPoint delivery was presented to all ambulatory care nurses which included the clinical nurse coordinators and the nursing management of the Ambulatory Care Center (ACC). The presentation included an overview of the research study, the research objectives, and the methods for data collection. An invitation and information sheet (appendix 9), a handout on guidelines on the critical incident technique and reflective journaling (appendix 7) and the guidelines for responding to the vignette technique by the nursing management positions (appendix 23) was distributed, and an informed consent form for participation in the nursing research study (appendix 10).
- Training sessions were organized for the reflective journal respondents who had returned the signed informed consent. At the training sessions, the

data collection tools were introduced (appendix 8 and 24) and the generation of a personal data coding system was explained using the steps given on appendix 11. The personal data code was written on a form (appendix 12) that was submitted to the clinical nurse educator and administrative assistant for confidential safe-keeping. Therefore, the personal code of each participant was not known to me as the nurse researcher and principal investigator. This action upheld the confidentiality of the respondent. Further to this action, guidelines were given to the clinical resource nurse (CRN) and the administrative assistant (AA) as shown in appendix 13 and 16.

- The CRN and AA recoded each data return sheet from the participants with a research data code that commenced with 'RJ' for reflective journal and 'VT' for vignette technique. Herein was the mechanism to ensure confidentiality and anonymity, because the AA retyped all handwritten responses and recoded each data return sheet prior to me as the nurse researcher or the data analysts reading the responses. The original respondent had therefore been recoded so that confidentiality and anonymity was assured and all participants were therefore treated equally.

My approach as a nurse researcher was at all times respectful, helpful, informative, reassuring and non-threatening to ensure that all potential respondents felt that their participation was uncoerced. The same manner was embraced by the CRN and AA when undertaking the activities within data collection. The identical manner, approach and system were applied to the nursing management participants when they participated in response to the vignettes. In both instances, the participants were verbally reminded of the condition written on the informed consent sheet that withdrawal at any stage during the nursing research study was a right that did not require any explanation to me as the principal investigator. All respondents were

reassured that if any data was used at future scientific meetings, anonymity and confidentiality would be ensured by omitting any identifying information or the original ambulatory care clinic from which an RJ or VT response was received.

Ethics approval from the university was granted unconditionally on the basis of the above considerations. See appendix 5 for the original ethics approval and appendix 6 for the extension of ethics approval. I obtained further institutional approval towards the completion of this thesis (see appendix 30). This institutional approval confirmed that: (i) the nursing research study had been completed, (ii) all ethical considerations were upheld, (iii) organizational achievement reports were used in the description of the model, and (iv) a request made for publication approval, which was granted.

## 1.10 SCIENTIFIC INTEGRITY

Scientific integrity in research is vital for maintaining the trust of the public in scientific enterprise and for achieving and maintaining excellence in research processes of inquiry (Institute of Medicine 2002:4). In this regard, the Institute of Medicine (IOM) 2002:4 states that the highest level of a research scientist is integrity of the individual that embraces commitment to personal responsibility for conduct of the research process, and intellectual honesty in proposing, performing and reporting research activities as well as acknowledgement of sources of literature, evidence and/or ideas.

The research site is the environment and setting in which the researcher practices in a manner to uphold universal principles that guide the responsible conduct of research (Shamoo & Resnik 2003:12), and whereby scientific rigor is achieved by maintaining thoroughness in research methods, approaches and activities (Streubert 2011:47).

I encountered the question of scientific rigor early in the conceptual phase of formulating my research study. I wrestled with what scientific rigor meant to me in the far-away land of Saudi Arabia where I had not had the opportunity of meeting a qualitative researcher, despite working in a healthcare facility for five (5) years and in spite of extensive networking within the region. This sense of unease was channeled into finding out for myself what 'scientific rigor' in qualitative research meant to me at the point of embarking on a journey of qualitative inquiry. My self-searching yielded results when I discovered the work of Clive Seale (1999) entitled 'The Quality of Qualitative Research'. Seale (1999:2) captured my interest by stating in the first line of his work that quality matters in qualitative research. Mason (2002:40) states that she agrees with Seale (1999), and contends that the measures of quality in quantitative research such as validity, generalizability and reliability need not be abandoned in principle. To this notion, Mason (2002:40) subscribes to engaging in self-critical and reflexive practice that is 'active and labor-intensive' (Seale 1999:6). To this end, Seale, Gobo, Gubrium and Silverman (2004:4) best describe my way forward to keep my 'feet firmly planted in the ground' because as a pragmatist, they confirmed that it was 'a matter of practice'. Mason (2002:40) summed it up for me in her work by describing 'quality as a critical practice' in qualitative research.

A series of pragmatic steps followed whereby I immersed myself intentionally into the world of qualitative research. For three (3) years I attended and presented aspects of this research study at conferences hosted by the International Institute for Qualitative Methodology (IIQM) on advanced qualitative methods and qualitative healthcare research. My participation included active oral presentations at intentional engagements (see appendices 37, 39, 40, 41, 44, 45 and 46) as a means of opening scientific dialogue with like-minded participants. Concurrent with these oral presentations, I attended the following pre- and post- conference IIQM workshops and invited lectures aimed at expanding my qualitative research skills:

- 2003 Banff, Canada
    - ‘Strategically planning and advancing as a qualitative researcher: considerations, choices and consequences’ (Invited lecture by Professor Julianne Cheek)
    - ‘Writing for publication’ (Invited lecture by Professor Janice Morse)
    - Workshop on qualitative analysis (Professor Juliet Corbin)
- 2004 Edmonton, Canada
    - Workshop on analyzing qualitatively: finding order in chaos (Professor Sally Thorne)
- 2004 Banff, Canada
    - Workshop on metasynthesis in qualitative research (Dr. Margarete Sandelowski and Professor Sally Thorne)
- 2005 Edmonton, Canada
    - Workshop on analysis of narratives (Dr. Arthur Frank)
    - Workshop on developing theory (Professor Janice Morse).

The initial participation in the IIQM workshops and conferences revealed that more exposure knowledge and skills were necessary in relation to the international context of ambulatory care nursing for the purposes of supplementing my clinical nursing experience in a Middle Eastern teaching hospital. Subsequent membership in the American Academy of Ambulatory Care Nursing (AAACN) followed along with active participation characterized by involvement as evidenced by oral scientific papers presented at the annual conferences of the AAACN in 2004 and 2005 (see appendices 38, 42 & 43) and ongoing membership.

My focused intention as a novice qualitative researcher who was practicing literally in the desert of Saudi Arabia, which was also, figuratively, a desert of qualitative

research, was to gain the required skills and related research competence to ensure scientific rigor within the qualitative research process of inquiry from the commencement of the study. It would have been irresponsible insofar as scientific integrity to enter the field of qualitative research without self-directed effort towards achieving scientific rigor and thereby attaining high-quality qualitative research during the conduct of my study. Given this scientific awareness at the beginning of the study, it would have been disingenuous to ignore my conscience and to simply address these shortcomings in scientific rigor in the final chapter as limitations.

Seale (1999:159) helped me along by the use of vivid descriptive metaphors to highlight that some qualitative researchers should move away from the 'confessional' accounts that became a common genre three decades ago when qualitative researchers discussed extensive methodological issues as limitations at the end of a research project. Similarly, he states that this sense of methodological self-consciousness arose from qualitative researchers wanting to prove their scientific credentials. He asserts that it is a mistake to assume a 'fallibilistic attitude' like a 'Catholic … confession … degrees of repentance' (Seale 1999:160).

As a developing qualitative researcher, I subscribe to this shift that embodies an identity of scientific rigor that reflects the nature of research work in the qualitative process of inquiry. Manning (1997), Seale (1999), Patton (2002) and Denzin and Lincoln (2008a) serve as my literature evidence to support my categorization of the following elements of scientific rigor in my study, in addition to those identified by qualitative researchers to demonstrate trustworthiness (Streubert 2011:47). They are as follows:

(i) Explaining methods with literature support as appropriate (Seale 1999:162), also referred to as auditability by Burns and Grove (2005:162) who regards it as a means of obtaining methodological congruence to illustrate a

rigorous decision trail of methods that were developed as a study progresses.

(ii) Illustrating authenticity in the research activities and field experiences (Seale 1999:161, Manning 1997:97).

(iii) Adopting postscientific critiques (Seale 1999:9) in particular, postmodern reflexivity and member validation, which contribute to the researcher's self-understanding of research accounts.

(iv) Disciplined use of bracketing [Atkinson & Delamont (2008) in Denzin and Lincoln (2008a)] with the use of field notes and memoing (Corbin & Strauss 2008:123).

### 1.10.1 Auditability in explaining methods

The explanation on the use of the critical incident technique, reflective journaling, and the vignette response with particular reference to the decision trail on how they contributed to the reorganization of the thesis layout in this study is justified later in more detail later in section 1.11 on the approach to writing this thesis. The specific referral is to the research methods that were applied to the various methods of the data collection process. The literature on data collection methods is extensive with a range of justifications for their use in research, and are explained in detail in chapter three (3) in relation to the critical incident technique and reflective journaling, and in chapter four (4) concerning the vignette research method. Therefore, for reasons of methodological congruence, contextual flexibility, contextual validity and rigor (Burns & Grove 2005:627, Richards & Morse 2007:34, Saukko 2008:461, Marshall & Rossman 2011:196), the detailed aspects of their use are retained in separate chapters with the related empirical data and findings from analyses of the reflective journals and vignette

responses respectively, while illustrating the auditability of applied research methods in the field during data collection.

### 1.10.2 Authenticity in data collection and data analysis

The aspects of authenticity used in this study are put forward by Manning (1997:93) and Schwandt (2007:13) for use in qualitative inquiry. These include informed consent with an information presentation and later distribution of information sheets explaining the purpose of the research and training sessions on the critical incident technique and reflective journaling. This also involved the use of a CRN as an intermediary and the use of a 'double-coded' identifier in the data return process to protect the anonymity and confidentiality of the respondents (see section 1.9 on ethical considerations). This participant coding system and the ethical rationale are explained in detail in the context of reflective journaling in chapter three (3). The second aspect of authenticity that was embraced was planned 'prolonged engagement' (Manning 1997:102). This involvement was in relation to reflective journaling where about sixteen (16) PLN respondents submitted daily returns over a ten-week period. Although this represented a potential of eight hundred (800) reflective journaling returns, the actual return was just under five hundred and fifty (550), because on some days the PLN respondents did not identify a patient situation that was categorized as 'critical' for reflection. More expansion on this detail in the data collection process is described in chapter three (3).

### 1.10.3 Postscientific critiques

The postscientific critiques discussed by Seale (1999:169) are postmodern reflexivity and member validation. Postmodern reflexivity is supported by Manning (1997:103) and Patton (2002:64) as a 'qualitative lexicon' that gives prominence to the importance

of researcher self-awareness, contextual awareness of political and cultural factors in the research field, and ownership of the researcher's perspective. In applied terms, it is the ongoing self-examination by the researcher who asks 'what I know' and 'how I know it' so that there is ongoing mental conversation that occurs while living the research experience simultaneously. It facilitates the researcher's return to bracketing so that theoretical assumptions, personal values and beliefs are made explicit (Manning 1997:103), and subjected to critical examination (Seale 1999:167). This was an essential mode for me as a researcher because I was employed in the organization of the research site where the study was conducted (further detail is provided later in section 1.10.5 on demonstrating trustworthiness).

Member validation is the research activity whereby the researcher returns to the field to corroborate, revise and confirm the accuracy of the data, themes or descriptions aimed at ensuring that the content is specific, accurate and not contradictory to the original respondent source. In my study, this was conducted at two (2) levels. First, group sessions were conducted weekly in the presence of the intermediary CRN with about sixteen (16) PLNs during the first five (5) weeks. The purpose was to ensure that the emergent theme categories were aligned to the participants, because they determined the formulation of the vignettes that were used as the second level of data collection. The procedure of how this was done is described in the next chapter on reflective journaling (chapter three). Secondly, as the researcher, I used the opportunity to collect field notes from the PLN group sessions that underwent validation by the intermediary CRN. The field notes were essential to contextual descriptions in relation to the formulation of the vignettes and the overall data analysis as discussed in section 1.10.4 on bracketing that follows.

### 1.10.4 Bracketing

Streubert (2011:27) states that bracketing is a cognitive process by the researcher whereby one's beliefs, feelings, thoughts and perceptions are set aside to prevent judgments being made about what one has heard or observed. To achieve this, Carpenter (2011:77) suggests that the researcher has to remain neutral concerning the phenomenon throughout the study process without permitting personal beliefs or disbeliefs to influence the generation of pure description of the phenomenon.

The two techniques that I found valuable to bracketing are memoing and field notes. Corbin and Strauss (2008:123) distinguish field notes as written when the researcher is in the field as described above in section 1.10.3 concerning member validation. Memos, according to Corbin and Strauss (2008:124) are written after leaving the field and are usually lengthier and more in-depth.

My use of field notes and memoing facilitated my self-discipline of bracketing. Particularly because I was also employed in the organization where my research was conducted, it was crucial that I noted my beliefs, feelings, thoughts, or perceptions as they emerged either in the field or after leaving the field. During data analysis, I used memoing for myself as well as the data analysts who noted their own feelings or thoughts in relation to the data on the phenomenon being studied. A serendipitous research discovery triggered by my sense of self-discipline of bracketing combined with the use of field notes and memoing was its contribution to thick description.

Denzin and Lincoln (2008a), in their third (3rd) edition on 'Collecting and Interpreting Qualitative Materials' have added a new chapter on analytic perspectives that feature 'thick description' as a classic principle in qualitative research by Atkinson and

Delamont (2008:299). The authors quote from the original work of Geertz (1973) on 'thick description' whereby multiple perspectives or interpretations are captured to convey detailed descriptions that inform social events and actions. Schwandt (2007:296) also sourced the original work of Clifford Geertz (1973) in the essay on thick description and clarifies that it is not merely a process of accumulating voluminous details. Instead, Schwandt (2007:296) specifies that it is dense descriptions of social action as the starting point of interpretation in relation to 'circumstances, meanings, intentions, strategies, motivations' that characterize particular 'interpretive characteristic of description rather than detail' that defines the conceptual idea of 'thick' in the narrative.

Herein was my serendipitous research discovery, as I found that as I made notes on circumstances, situations, meanings in relation to beliefs or disbeliefs, feelings, or perceptions in my field notes and memos, I was in fact recording crucial information that contributed later to thick descriptions of the data. Admittedly, the aim of making these additional comments on my field notes and memos was part of my self-discipline of bracketing, while later and with a sense of cheer I realized that the comments on field notes contributed to thick descriptions that enhanced the contextual understanding of the empirical data with valuable insights on the meaning and interpretation of the findings.

These four (4) elements discussed above as sections 1.10.1, 1.10.2, 1.10.3 and 1.10.4 converged during my lived experience as a qualitative researcher into the overarching approach of trustworthiness that follows in the discussion.

### 1.10.5 Demonstrating trustworthiness

Demonstrating trustworthiness (as shown in table 1.2 that follows) is widely regarded as a means of establishing quality and soundness in the practice of qualitative research (Krefting 1991:215, Botes 2003:176, Bryman & Bell 2007:411, Schwandt 2007:299, Bloomberg & Volpe 2008:77, Holloway & Wheeler 2010:297, Marshall & Rossman 2011:251, Streubert 2011:47). All authors are aligned to the criteria of trustworthiness as listed below and referred to by Lincoln and Guba (1985:290), which was reaffirmed and regarded as contributing to authenticity by (Guba and Lincoln 1989:233). The criteria are:

(i) credibility (truth-value) whereby the participants' perceptions are matched in resemblance to the portrayal of meaning provided by the researcher. (This is referred to as internal validity in traditional science).

(ii) transferability (applicability) wherein the findings from one context can be useful in another similar setting. (Generalizability is the equivalent term for traditional research findings)

(iii) dependability (consistency) that is focused on the process of inquiry in relation to the researcher's responsibility to ensure accuracy, adequacy and traceableness of decision-making processes in scientific activities. (In traditional positivist research, the parallel term is reliability).

(iv) confirmability (neutrality) whereby the data, interpretations and findings contribute to an audit or decision trail that facilitates others to judge the manner in which research objectives had been achieved so that links to assertions, data, evidence and findings can be discerned easily. (The corresponding term in quantitative research is objectivity).

**Table 1.2** The criteria and strategies used to demonstrate trustworthiness and authenticity in this study

| Criteria | Strategy | Applicability in this study |
|---|---|---|
| 1. Credibility (truth value) | • Member checking<br>• Prolonged engagement and varied field experience | • Reflective journaling responses arising from critical incidents were returned daily by respondents over a period of ten (10) weeks (50 days of journaling). The researcher conducted weekly support groups with the reflective journal respondents and was able to ask respondents if the emerging initial themes were portraying their experiences accurately as member validation on the emerging themes.<br>• The researcher was submerged in qualitative research conferences and workshops presented by qualitative scientists, and became an active member of the American Academy of Ambulatory Care Nursing (AAACN) as further engagement in the clinical practice field of ambulatory care nursing.<br>• In relation to the vignette technique, the researcher initiated engagement with two (2) researchers in Australia and the United Kingdom. First-hand experience was gained by a visit to King's College, London, a meeting of all three (3) researchers in a London café and a subsequent symposium on Vignettes in Canada. This exchange was conducted over two (2) years. |
| | • Reflexivity | • Field notes to record observations from the support groups, methodological notes from qualitative research workshops, theoretical notes to provide insights into model development, and personal notes as bracketing technique were used to enhance reflection on my reflections as a researcher.<br>• Memoing was used by the data analysts (four) including me to note thoughts, ideas or observations in the process of data analysis. These notes were the content of discussion in supervision sessions with supervisors (promoters). |
| | • Peer review and debriefing | • Peer review with data analysts who were all registered nurses at senior levels. Exchange of e-mails between experts on the vignette technique and related data analysis occurred mindful of confidentiality and anonymity. |
| | • Structural coherence | • Discussions of findings were framed either in terms of the literature of the AAACN, JCI or NGHA, and thereafter in relation to published evidence in the literature. |
| | • Referential adequacy | • The referencing style used denotes actual page numbers of work used as well as cluster referencing to several authors. In most instances, original references were sourced and quoted.<br>• In concept identification, concept classification, and the generation of the conceptual framework, extensive reference was made to the literature, field notes and memoing from data analysis. |
| 2. Transferability (applicability) | • Nominated sample | • Purposive sampling was used that constituted registered nurse that had rotated into the functional role of the RN as PLN, were the immediate lines managers of PLN and all participants were ambulatory care nurses with related clinical experience of two (2) or more nurses. |
| | • Defined contextual setting | • The research setting was defined as specific in terms of the healthcare delivery system in Saudi Arabia and the nursing workforce as multinational. These two defining demographic factors would facilitate the use of these findings in other similar contextual settings in transferability. |

| | | |
|---|---|---|
| | • Dense description | • Thick description was used with detailed descriptions captured in the empirical data and enhanced by field notes and memoing balanced with the use of bracketing. In so doing, the reader can identify similar contextual settings for research utilization of useful findings. |
| 3. Dependability (consistency) | • Inquiry / process audit | • Extensive appendices are provided in this study for a vivid portrayal of qualitative research activities, particularly because supervisory promoters were not available for site supervision due to the considerable geographical distance. The supervisors were in South Africa and I was in Saudi Arabia.<br>• Four (4) data analysts were used and co-checking was done to improve rigor and the structured system of memoing by data analysts to the researcher assisted in preventing the blurring in coding of categories and themes. |
| | • Data collection and data analysis training session | • The established practice of reflective journaling in the nursing services division was the foundation of training conducted with potential respondents so that the response to the structured reflective journal was congruent in the group, yet unique by individuality.<br>• Training was conducted for the four (4) data analysts who originated from four (4) different countries. All data analysis was co-checked within the group and color stickers were attached to signify the data analysts (see appendices 15 & 17). |
| | • Dense description | • Saturation of data themes and categories denote that no new concepts or dimensions were identified. In essence, saturation conveys that despite the fact that all data have been analyzed, there was no emergence of new or unique categories. In relation to dense description, therefore, all information input on the vividness of description has been attained when saturation is reached. |
| 4. Confirmability (neutrality) | • Inquiry / Process audit | • In addition to the comprehensive availability of the appendices that illustrate the activities in the research process, there are substantial references made to institutional documents of the NGHA and AAACN, particularly in model development, that show a trail as the researcher progressed. |
| | • Reflexivity | • Reflection on reflection as reflexivity was a necessary process as the model evolved by way of ongoing discussions with clinical nursing experts in the field at the hospital that contributed to refining of the model. |

Initial approaches to demonstrate trustworthiness and authenticity taken from Guba and Lincoln (1989:233-251), Manning (1997:97-112), and Krefting (1999:215-221) were used at the outset of my study. As the literature became available and my qualitative research repertoire expanded, I was able to appreciate how these criteria of trustworthiness and authenticity were applied and operant in my study, as shown in table 1.2 that presents the collective strategies suggested by the authors that I used as relevant and applicable to my study (Botes 2003:179-183, Bloomberg & Volpe 2008:77-78, Holloway & Wheeler 2010:297-311, Marshall & Rossman 2011:251-257, Streubert 2011:47-51).

## 1.11 APPROACH TO WRITING THIS THESIS

The approach to writing this thesis embraced the flow of qualitative inquiry on three (3) considerations. The first consideration was the use of the authorial voice (Wolcott 2001:20, Holloway & Wheeler 2010:316), the second was making convincing arguments with qualitative data and literature (Mason 2002:173, Rossouw 2003:38), and the third consideration was the organization of the thesis as a means of presenting a synthesis of qualitative research findings (Sandelowski & Barroso 2007:235, Holloway & Wheeler 2010:315).

### 1.11.1 Authorial voice

Authorial voice is addressed by several qualitative research authors who are proponents of using the first voice or first person as opposed to using the traditional third voice or third person in research (Wolcott 2001:67, Holloway 2005:280, Bloomberg & Volpe 2008:23, Denzin & Lincoln 2008b:5, Holloway & Wheeler

2010:316). The researcher/writer is regarded as the narrator who presents an account of the life of individuals through the words of the informants (Wolcott 2001:20, Denzin & Lincoln 2008b:7).

Holloway (2005:274) and Holloway and Wheeler (2010:6) advance the notion that the qualitative researcher deals with 'emic' and 'etic' dimensions. The 'emic' dimension focuses on the 'insider' perspective such as the ideas of the participants, while the 'etic' dimension targets the 'outsider' perspective. Holloway and Wheeler (2010:6) and Streubert (2011:172) point out that researchers access the 'emic' view by a range of data collection methods, and that the 'etic' view is an outsider view with interpretation. Denzin and Lincoln (2008a:16) attribute rich descriptions by qualitative researchers as detail that is generated from emic and etic perspectives that have social value for the phenomenon being studied. In this regard, Wolcott (2001:67), Holloway (2005:280), Bloomberg and Volpe (2008:23), and Holloway and Wheeler (2010:316) suggest that the writer therefore would adopt a unique style as narrator, which is an integral aspect of a qualitative research study, and be placed within the narration but without being egocentric. Holloway (2005:280) elaborates on this by advising that researchers give an account of themselves and their decisions without continuous repetition of 'I felt', 'I believe', or 'I think', while maintaining a level of evocative writing so that the voice of the author is heard and attracts the reader's involvement in the study. As advice to writers, Holloway (2005:280) cautions that the first person singular in research must not be overused because it could detract from a work of science if all descriptions and writings are embedded in an egocentric perspective. She suggests that 'I' be used as a literacy device to convey imaginative dimensions, lively portrayals or when credibility and reality are being communicated.

As the writer of this thesis, I have chosen to write in a combination of the first and third voice, and that first or third person perspectives would be selected for use based on

whether I am central or not to a matter under discussion. My stance hereto is supported by Holloway (2005:282) who suggests that the research writer must strive to achieve a balance between 'lively' and 'scholarly' in written work.

### 1.11.2 Making convincing arguments

Making convincing arguments with qualitative data is key to developing a written account in qualitative research that is coherent and persuasive (Rossouw 2003:37, Holloway 2005:272). Evidence from data is therefore used to support arguments by the use of words of the participants and/or from field notes and memos of the researcher (Corbin & Strauss 2008:123).

Mason (2002:182) suggests that making convincing arguments is based on a relational process between an idea and data. To this end, Mason (2002:176) provides four (4) ways of approaching arguments that were adapted by Abu Ghori (2010:15) as follows:

(i) arguing evidentially, whereby what is relevant is presented logically and appropriately to support arguments in relation to the data

(ii) arguing interpretatively or narratively, whereby the argument is linked to the data meaningfully or reasonably, and therefore the evidence is used to support the interpretation and to illustrate that it is valid and appropriate in nuance

(iii) arguing evocatively or illustratively, whereby the argument evokes understanding or empathy towards the data on the phenomenon, and thus facilitates experiential understanding. In this regard, evidence is used to illustrate or convey the meaning that supports the evocative argument

(iv) arguing reflexively or multivocally, whereby the argument illustrates a range of meaningful experiences, understandings or perspectives encountered in

the data, including critique and indications of gaps or omissions in knowledge about the phenomenon under study.

I have used these four (4) ways of arguing to be explicit about the relational process between the phenomenon under study, the data and evidence accessed. These approaches took on essential meaning for me as a researcher when I struggled somewhat to form conclusion statements on the emergent themes of the extensive data and evidence in the results of chapter three (3) on the critical incident technique and reflective journaling and in chapter four (4) on vignette responses. In essence, the conclusion statements of the emergent themes positioned the description of the theme in relation to data and/or evidence. To solve my conceptual impasse using the different ways of arguing by Mason (2002:176), I developed a formula to represent the relational process as a means of summarizing the relational connection between data and evidence concerning the phenomenon under study. The idea of developing a formula with the use of the symbols x, y and z originated from Chinn and Kramer (2008:212-216) who use x and y as well as A, B and C to explain how to design relationship statements when conceptualizing and structuring knowledge development from empirical data by inductive and deductive reasoning. Walker and Avant (2011:180-188) also use symbols and formulae when illustrating simplification in statement analysis and synthesis so that relationships in statements can be classified and logic can be examined. Hereto, I used the symbols x, y and z to facilitate the construction of conclusion statement formula on the emergent themes and concepts for the purpose of clarity in my research action to link the themes and concepts to the empirical data.

The conclusion statement formula that was generated is as follows:

**x + y = z**

- whereby '**x**' is the 'what' that is being described in relation to an emergent theme

- whereby '**y**' is the data or evidence that is argued as (i) evidential, (ii) interpretative or narrative, (iii) evocative or illustrative, and/or (iv) reflexive or multivocal (Mason 2002:176).
- whereby '**z**' links the description of the emergent theme and data or evidence cited to the contextual setting of the phenomenon under study. Holloway (2005:275) maintains that 'qualitative research is always situated in context' and that in 'the write-up this has to be shown'. The formula that was devised assisted me in surpassing the conceptual impasse that had bedeviled my ability to generate conclusion statements on the emergent themes, which was a critical juncture in the research process, and moreover in model development.

Pattern-matching logic as described by Yin (2009:136) is an analytic technique that I used in conjunctive with the descriptive conclusion statement formula with flexibility to gain the credible outcome by use of empirical data on the emergent themes. The formula was therefore used descriptively in four (4) combinations as follows:

(i) **x + y = z**

(ii) **y + x = z**

(iii) **z = x + y**

(iv) **z = y + x**

Yin (2009:137) states that pattern matching is relevant in the descriptive context as long as the pattern is relational. The descriptive formula therefore placed the emergent theme in a pattern that was matched to the data and/or evidence and linked the description to the contextual setting of the phenomenon under study. Yin (2009:136) asserts that when an empirically-based pattern coincides with the rational description that is relevant to the contextual study of the phenomenon, then the internal validity of the study is strengthened. Internal validity, accordingly to Guba and Lincoln (1989:234)

and Koch (2006:92), is the extent of 'truth value' of a given study that establishes how things are in reality and how they relate.

The core essence of making a convincing argument that was illustrated in the conclusion statements of the emergent themes in chapters three (3) and four (4) were crucial to the relational statements between core and related concepts, and the development of a conceptual framework in chapter five (5). Admittedly, this analytical process was time-consuming for me, but also enormously gratifying when the conceptual activity moved on to advance the process of model development.

### 1.11.3 Organization of this thesis

The organization of the thesis presented a writing challenge in itself. This was largely because the traditional thesis structure of an introduction chapter followed by chapters on the literature review, methodology, data analysis, findings and conclusions did not reflect the process of qualitative inquiry used in this study. The outline and plan of the thesis was changed thrice during the writing period. Below is the justification for the final reorganization of the thesis that portrays an unconventional layout, yet in keeping with a qualitative process of inquiry. Additionally, reasons are provided from my lived experience of implementing the research activities during this study.

Richardson and St. Pierre (2008:474), in the third edition of Denzin and Lincoln's 'Collecting and Interpreting Qualitative Materials', challenge the prescriptive manner of presenting qualitative research. They suggest that the process of writing in itself is a method of inquiry that does not necessarily fit into the quantitative structure of writing up a research study. Richardson and St. Pierre (2008) state that qualitative writing is taken often as a means of reporting about a social world, and then assert that 'writing is

not just a mopping-up activity at the end of a research project'. In a refreshing tone they suggest writing to be a way of knowing that comes through in a method of discovery and analysis, and add that the 'form and content are inseparable'. Interestingly, Cheek (2000:93) raises questions concerning each research perspective having its own approach on the management and analysis of material collected in a research project, and suggests that when the given rules are followed prescriptively, there tends to be only one view of what the reality was in the study. She puts forward that in postmodern and poststructural research, it is difficult to rely on a set of rules or guidelines because there is usually more than one approach or method from a postmodern or poststructural perspective. Sandelowski and Barroso (2007:235) maintain that qualitative research synthesis compels the researcher to consider challenges of representation of the component aspects of a study. As a synopsis of their perspective, it suffices to state that they support the organization of a research study to (i) reflect what took place in a study that is conveyed by constructions of data, and (ii) portray a synthesis of analysis of empirical data, contextual settings and evidence. This stance in qualitative research synthesis (Sandelowski & Barroso 2007:240) is based on their earlier work (Sandelowski & Barroso 2002:219, Sandelowski & Barroso 2003:908) where they assert that the content and form of qualitative research cannot be separated and are inevitably entwined to portray the findings of a study rather that conform to prescriptive approaches or methodological orientations. They reiterate that the aim of qualitative inquiry in the practice disciplines such as nursing is to generate knowledge for use in practice, and therefore support a research study being presented in a manner that best portrays its findings.

In this study, therefore, I had to be cognizant that a combination of data collection methods were used as research methods, namely, the critical incident technique, reflective journaling, vignette responses and model development. Therefore, it was pertinent for me to be aware of the innate chronological sequence in the use of the

research methods because reflective journaling could not occur until the participant had isolated and analyzed a critical incident, which itself as a critical process of selection (details are given in chapter three). It was not until midway (5 weeks) through the period of reflective journaling returns which lasted ten (10) weeks that a preliminary content analysis was undertaken that identified five (5) major theme categories. It was these themes and descriptive scenarios from the empirical data of the reflective journals that was essential in enabling the contribution of lived reality to the vignette scenarios and response process to be conducted as a research method.

The data gained from these initial data collection research methods then contributed as empirical data for concept development, which marked the beginning of the second phase of the study, model development and description. Yin (2009:176) suggests that it is possible when evidence is presented in a chronological order that the sequence of chapters may pattern the chronology as an approach. Richards (2009:198) supports this approach and suggests that the chapters reflect the chronological or logical order in sequence 'through stages in the story that is being told', and further suggests that a chapter be given for each dimension, problem or situation that was studied. Richards and Morse (2007:34) refer to this as the 'purposeful nature of qualitative inquiry' termed as methodological congruence, which is the action of matching the research problem and question to the research method, and in turn the match of the research method with handling of the data, whereby the overall aim is the integration of all components of the research activities to 'make the best possible end product'. They articulate their stance on methodological congruence by pointing out that research methods are not necessarily all predetermined, and that flexibility is employed by the qualitative researcher so that the research approach fits the purpose, method and data. Richards and Morse (2007:35) conclude that 'qualitative research is not just a matter of performing techniques on data'; rather, the qualitative process of inquiry is a particular

manner of thinking about techniques and methods aimed at collecting and analyzing data to achieve a research goal.

I adopted this perspective based on the extensive and integrated justification provided by Cheek (2000:93), Richards and Morse (2007:34), Sandelowski and Barroso (2007:235) and Richards (2009:198) as set out above. In this regard, therefore, an overview of the research design and research methods are provided in chapter two (2) as an outline for the reader, while the details of the applied research methods are chronologically positioned in the respective chapters that follow on the critical incident technique and reflective journaling (chapter 3), the vignette technique as a research method (chapter 4), and model development and description (chapter 6).

In their advice on the structure and content of writing up and organizing research reports, White, Woodfield and Ritchie (2003:295) refer to advice from Wolcott (2001), Holloway and Wheeler (1996) and Kvale (1996) in that the research report can be written in the order that it developed. Pope and Mays (2006:145) describe this process of putting such a structure together based on chronological, thematic or theoretical development as narrative synthesis which they acknowledge is rooted in the story–telling approach for the purpose of generating new insights or knowledge by a systematic approach of structuring research findings. Therefore, based on this justified approach to present the chronological sequence that was apparent by the developmental links between the data collection methods, the thesis is organized in the outline given below:

- Chapter One – Orientation and approach to the research study
- Chapter Two – Overview of the research design and methods
- Chapter Three – Critical incident technique and reflective journaling applied as a research method: data collection and analysis, results and literature

- Chapter Four – The vignette technique applied as a research method: data collection and analysis, results and literature
- Chapter Five – Conceptual framework
- Chapter Six – Model description, model evaluation and theory technique
- Chapter Seven – Guidelines for implementation of the model, evaluation of the study, limitations and recommendations.

#### 1.11.3.1 Appendices

Guidance on appendices was sought for what constitutes an appendix in a thesis. This search was steered by a range of questions concerning (i) scientific integrity and the need to provide an audit trail, (ii) ethical considerations to demonstrate respect for universal principles that guide institutional and personal participation, and (iii) to avert plagiarism. In relation to the academic offense of appropriating ideas and the work that contributes to plagiarism, as the researcher and writer of this thesis, I am persistently aware that my span of participation in various conferences and workshop in qualitative research required consideration. Therefore, and with the intention of acknowledging my repertoire of involvement, items were placed as appendices as an act of integrity so that transparency was embraced as to my development as a qualitative researcher who experienced cognitive influence and stimulation from the spectrum of academic and qualitative research-related activities.

A paucity of writing or guidance on what constitutes the appendices was found, particularly as to how one triages what to include or exclude, whether they are placed before or after the references, and whether they are required to be referenced or not. My search focused on a purposive sample of qualitative research authors.

Commencing with early classical work on projective techniques in the social sciences by Anderson and Anderson (1951), I consulted the following listed authors:

- van Manen (1990) on researching lived experiences
- Kvale (1996) on interviewing
- Morse, Swanson and Kuzel (2001) on the nature of qualitative evidence
- Holliday (2002) on doing and writing qualitative research
- Mason (2002) on qualitative researching
- Ritchie and Lewis (2003) on qualitative research practice
- Silverman (2004) on the theory, method and practice of qualitative research
- Denzin and Lincoln (2005) in their handbook on qualitative research
- Morse and Field (2006) on the application of qualitative approaches in qualitative research
- Richards and Morse (2007) who provided the user's guide to qualitative methods
- Sandelowski and Barroso (2007) in their handbook for synthesizing qualitative research
- Bloomberg and Volpe (2008) on how to complete a qualitative dissertation that provides a referenced roadmap from the beginning to the end.
- Corbin and Strauss (2008) on the basics of qualitative research
- Denzin and Lincoln (2008a) on collecting and interpreting qualitative materials
- Denzin and Lincoln (2008b) on strategies on qualitative inquiry
- Denzin and Lincoln (2008c) on the landscape of qualitative research
- Stake (2010) on studying how things work in qualitative research
- Marshall and Rossman (2011) on designing qualitative research.

None of the above listed authors on qualitative research provide guidance on the appendices for a thesis or research report. I regard this as a gap in the literature because guidance on what to append as attachments is essential in qualitative research for the following reasons:

(i) to advise what to place as an appendix so that the narrative within the thesis or report is not overwhelming to the reader, while ensuring accessibility to further information as an appendix if required

(ii) to provide evidence of scientific integrity on conducting the research study in situations when it does not necessarily apply to the purpose of the chapters in a thesis or report, or would detract from methodological congruence

(iii) to provide detail or actual versions of methods and research instruments used to collect and/or analyze data

(iv) to furnish legal and ethical documents or acknowledgements such as institutional approval for the conduct and/or publication of research, and funding or grants received for the protection of the investigators, participants or publishing journal if conflicts of interest become an issue

(v) to append abstracts from related conferences or submissions to journals for publication that occurred during the period of the research study as corroboration of how the researcher contributed to the body of knowledge beyond the thesis as a report of research, or as evidence of research competence

(vi) to supply pictorial evidence such as photographs, illustrations, graphics or sketches that relate to the contextual setting that would otherwise not be available to the reader except when provided in a research thesis or report.

Therefore, in essence, appendices fulfill a mandatory and optional function as integral segments of qualitative research for legal, explanatory, descriptive, integrity and

justifiable purposes. Appendices are included by intentional decisions for illuminatory reasons, and although they are not included in the word count of the thesis, they nevertheless convey essential views on the qualitative research process of inquiry that are not necessarily portrayed in the narrative of a thesis.

Table 1.3 that follows illustrates and justifies my purpose for focusing on the appendices. Guba and Lincoln (1989:181), Wolcott (2001:160), Klopper (2008:71) and Holloway and Wheeler (2010:329) provide some advise of what should be attached as appendices, but also have an absence of purpose or guidance on inclusion. Guba and Lincoln (1989:181) hint that appendices provide evidence as a criteria of quality research. On the other hand, Wolcott (2001:161) suggests that perhaps some qualitative researchers should consider moving from the rigid prescriptive paradigm of listed appendices in quantitative research to a paradigm that is qualitative for future 'research luminaries' to address. In their approach, Holloway and Wheeler (2010:329) confirm that the words in the appendices are not counted in the total words of a study, then state that 'appendices depend on the advice given to researchers and on their own common sense', and refer the qualitative researcher to the rules of the universities.

I am not a qualitative research luminary, I do not believe that common sense answers scientific inquiry, and I am not convinced that university rules are necessarily the best source of guidance on what constitutes the attachments to be appended to a qualitative thesis or dissertation. Based on my seventeen (17) years of exposure to qualitative nursing research on two (2) academic levels, namely (i) in my post-graduate studies towards a Master of Public Health and a Master of Science in Nursing, and (ii) as an honorary lecturer in qualitative nursing research for the Master of Nursing programs for

**Table 1.3** Summary of appendices and related purpose for inclusion in this qualitative research study

| Type of appendix | Requirement is: | | Appendix number(s) in this thesis | Justification of purpose in qualitative inquiry for inclusion in this thesis |
|---|---|---|---|---|
| | Mandatory | Optional | | |
| 1. Institutional approvals | √ | | 1, 2, 4, 5, 6 & 31 | • To meet universal principles of ethics for consented participation of the organization and individual participants<br>• In fulfillment of the university requirements for the post-graduate committee approval and the university ethics approval<br>• To obtain institutional approval for publication of findings |
| 2. Individual participant counseling process | √ | | 5, 6, 9 & 10 | • To meet university ethics committee requirements as a mechanism of safeguarding the integrity of research and research subjects<br>• To uphold universal ethical principles of non-malfeasance, beneficence, autonomy and justice that embraces the rights of self-determination, autonomy and respect |
| 3. Process of data collection | √ | | 7, 8, 11, 12, 13, 16, 22, 23 & 24 | • To demonstrate the research competence of the principal investigator<br>• To provide details on the extent of training the participants that were undertaken and the related rationale for the specific data collection methods used |
| 4. Process of data analysis | | √ | 14, 15 & 17 | • To reveal the approach undertaken by the team of data analysts and the measures taken to ensure co-checking |
| 5. Excerpts of qualitative data | | √ | 18, 19, 20, 21, 25, 26, 27, 28 & 29 | • To provide segments of data from the reflective journals and vignette responses on which data analysis was conducted<br>• To portray the formats used by participants from which empirical data was extracted |
| 6. Evaluation tools | √ | | 30, 52 | • To supply the tools that was designed for the purpose of theoretical evaluation of the model and the entire study |
| 7. Abstracts of oral papers arising from this study | | √ | 32, 33, 34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45 & 46 | • To provide the range of scientific presentations related to the development and competence of the researcher of this study<br>• To illustrate the spectrum of involvement that contributed to prolonged engagement in the field of research, which added value to trustworthiness of qualitative methodology and the substantive in this study. |
| 8. Abstract of symposium on the use of vignettes in qualitative research | | √ | 41 | • To give prominence to the extent of collaboration with qualitative research experts on the use of the vignette technique in eliciting responses from participation<br>• To depict the scientific event of integrating the international experience of using vignettes in qualitative research as evidence of contributing to new knowledge |
| 9. Batches of figures that illustrates model development in this study | | √ | 47, 48, 49 & 50 | • To furnish a convenient set of figures used in model development for convenient reference of the reader in relation to the comparison for evaluation of structural development of the process<br>• For ready reference to the reader concerning contextual considerations in transferability to another similar setting |
| 10. Organizational statement | | √ | 51 | • To provide the mission, vision and core values of the NGHS that guide the leadership of the NGHA |

the immediate past six (6) years for Monash University and the University of New England, Australia that included site co-supervision of qualitative nursing research projects in Saudi Arabia, as well as seven (7) years of living with this research study, it therefore is an obligation to contribute to the body of knowledge on this gap in the literature on the approach to appendices in qualitative research, albeit a minor consideration perhaps to major experts. It is hoped that this input is useful to novice qualitative researchers on the compilation of the appendices by the use of table 1.3.

Lastly, on the matter of placing references before or after the appendices, the following was decided and justified. The references relate directly to the content of the chapters in a thesis and therefore are placed at the end of the final chapter. This decision was aligned to the layout by contemporary nursing and qualitative authors who place references prior to the appendices, including Fawcett (2005:601), Rodgers (2005:209), Bloomberg and Volpe (2008:187) and Peterson and Bredow (2009:363).

## 1.12 SUMMARY

My intention in this first chapter was to provide on orientation and research approach to the contextual setting of ambulatory care nursing, the research problem and research questions that contributed to the qualitative research process of inquiry into the functional role of the registered nurse as patient liaison nurse within a Middle Eastern teaching hospital in Saudi Arabia. The research aim and objectives were provided as the foundation for the research process that was followed by the paradigmatic perspective that I adopted at the outset of this study. A synopsis of the research design was presented prior to in-depth discussions on ethical considerations, scientific

integrity and the approach to writing this thesis and the related structure. In the second chapter, I present an overview of the research design and methods that guided the scientific activities in this study.

# CHAPTER TWO

# OVERVIEW OF THE RESEARCH DESIGN AND METHODS

## 2.1 INTRODUCTION

In this chapter, an overview of the research design and research methods are provided, and justifications are put forward for the qualitative research process of inquiry that was used to meet the research aim and objectives that were described in chapter one. The science philosophy that underpins the process of inquiry is described as well as the use of reasoning strategies and specific ethical aspects that apply to the research methods.

## 2.2 JUSTIFICATION FOR THE RESEARCH DESIGN

The justification for having a research design in a study is to provide an outline of features, elements and arrangements that would guide the process for generating or validating knowledge that in turn contributes or refines the body of knowledge in the discipline of nursing as a health profession (Fawcett 2005:12, Rodgers 2005:8, McKenna & Slevin 2008:84, Holloway & Wheeler 2010:236, Risjord 2010:16, Stake 2010:17, Blais & Hayes 2011:97, George 2011:23, Marshall & Rossman 2011:71).

Chinn and Kramer (2008:270) are aligned to this notion and put forward that the research design must be consistent with the intention whereby they distinguish between theory-generating research and theory-validating research. They contend that the design of theory-generating research aims to clarify and describe relationships

concerning a phenomenon through an inductive approach, and without the use of presupposed ideas on the meaning of the related relationships. On the other hand, Chinn and Kramer (2008:272) assert that the method of theory-validating research is designed for establishing how closely an existing theory portrays the phenomenon and its relationships.

In this study, the research design that is theory-generating aims to describe a practice model for the functional role of the RN as PLN in ambulatory care nursing by the use of a qualitative research process of inquiry that is exploratory, descriptive, interpretive and contextual. The justified research design of theory generation and the research methods will follow to illustrate the link to the practice setting and phenomenon under study.

Figure 2.1 that follows provides an overview of the research design that represents phase one of the research study with three steps, and phase two with four steps that were used to achieve the research aim and objectives that were constructed to answer the research problem and question, and the research aim and objectives as presented respectively in sections 1.4 and 1.5 in chapter one (1).

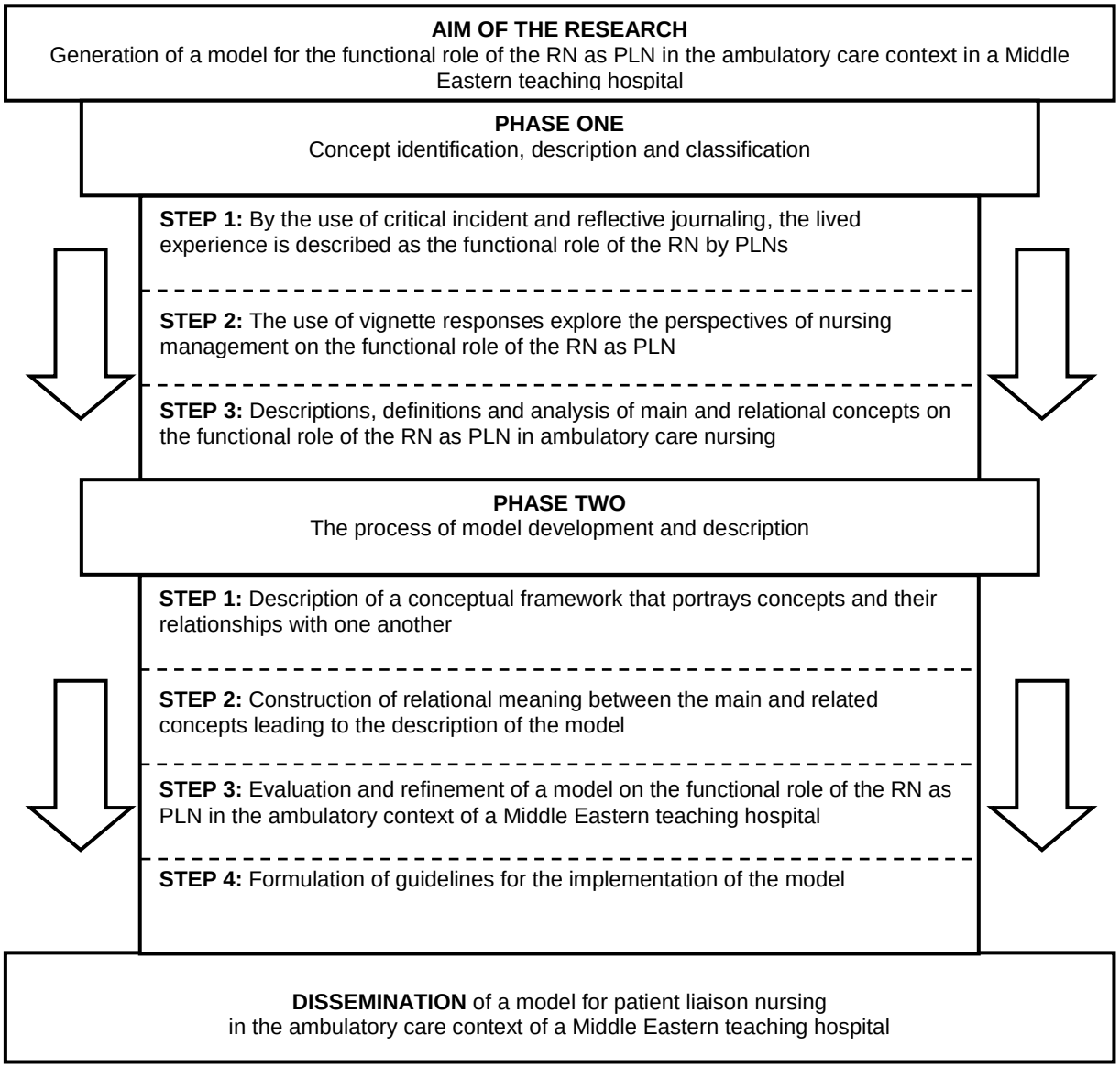



**Figure 2.1** An overview of the research design that was implemented in two (2) phases.

## 2.3 THEORY GENERATIVE RESEARCH

Theory generative research is best positioned within the levels of theory development for justification of a study that aims to describe a model for nursing practice (Dickoff, James & Wiedenbach 1968a:416, Rodgers 2005:12, McKenna & Slevin 2008:29, Risjord 2010:18, George 2011:27). Chinn and Kramer (2008:48) and Walker and Avant (2011:5) consider theory development first as a mandate for the evolution of nursing as an autonomous profession, and second by the intrinsic value of theory for

nursing, as it provides the profession with an organized and distinguished body of specialized knowledge on which the practice component of the profession can be underpinned. However, Chinn and Kramer (2008:183) go further to assert that theory-linked research provides the profession of nursing with the opportunity to refine concepts and theoretic relationships, and thereby provides empirical evidence to support practice. Conversely, they also contend that if empirical evidence does not support concepts and theoretic relationships, the constructs within a theory will not be sustained. This rationale further supports the use of theory-generating research design in this study that seeks to identify, clarify and classify concepts from empirical data on the practice of the patient liaison nurse (PLN), and formulate relational statements from the empirical data of the main and related concepts that resulted in the development and description of a practice model for the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.

Prior to expounding further on theory generative research, it is necessary to define what is meant by 'theory'. Chinn and Kramer (2008:305) define theory as 'an expression of knowledge' that is derived from empirical evidence whereby 'creative and rigorous structuring of ideas' is projected to represent 'a tentative, purposeful, and systematic view of phenomena'. Furthermore, theory is assigned accordingly to different levels, whereby there is general consensus by authors on their classification (Fawcett 2005:19, Rodgers 2005:19, Meleis 2007:43, Chinn & Kramer 2008:48, McKenna & Slevin 2008:29, George 2011:5, Walker & Avant 2011:5). However, for the purpose of articulating the levels of theory, Chinn and Kramer (2008:48) and Walker and Avant (2011:6) have been selected because they best position the development and description of a model for nursing practice in relation to this study.

These levels of theory are:

- **Metatheory:** At this level, Walker and Avant (2011:7) maintain that broad universal issues are debated without producing grand, middle-range, or practice theories. Examples of issues are given as (i) analysis of the kind and purpose of theories in nursing, (ii) review, recommend and critique the sources and methods of theory development in nursing, and (iii) advancing appropriate criteria to evaluate theory in nursing. They contend that a common theme throughout the metatheoretical literature is recurring reviews of the meaning of nursing as a 'practice discipline', namely nursing as both a science and a profession. In their description, Chinn and Kramer (2008:53) regard metatheory as writings that explicate on what the essential and fundamental qualities of a theory should be, and the processes for developing theory.

- **Grand theory:** At this level of theory, Chinn and Kramer (2008:224) and Walker and Avant (2011:12) regard the aim as expounding on a worldview in nursing that gives a global perspective of the goals and structures of nursing practice. Walker and Avant (2011:12) provide an important function of grand theory as contributing to the conceptual distinction between the practice of nursing versus the practice of medicine by illustrating the nursing-defining perspectives of practice in a healthcare setting.

- **Middle-range theories:** Chinn and Kramer (2008:58) put forward that the focus of this level is the development of theory around areas of substantive concerns in practice or concepts of interest and related phenomena. Walker and Avant (2011:16) consider this level of theory as useful and testable in nursing research because it has a limited scope and fewer variables compared to grand theories, yet retains its scientific value in theory development. They maintain that it provides

sufficient specificity for research and practice, and is therefore useful for inquiry between grand theory and practice theory.

- **Practice theory:** Chinn and Kramer (2008:58) and Walker and Avant (2011:18) advise that this level of theory has at its core a particular goal and directions for actions to accomplish the goal, and support the stance of Meleis (1987) that this level of theory focuses on nursing concepts that are grounded in a practice context. Walker and Avant (20011:18) advocate that practice theory is a scion of nursing metatheory that has become distinguished as a particular type of theory for nursing as a practice discipline. It is at this level of practice theory that this study is engaged with the research aim of generating a practice model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital. The specific practice phenomenon under study is the functional role of the registered nurse as a patient liaison nurse. The emergent main and related concepts on the phenomenon and their interrelatedness within the practice setting forms the essence of this study.

Walker and Avant (2011:20) point out that there are linkages between the levels of theory development, as shown in figure 2.2, indicating how they are interrelated.

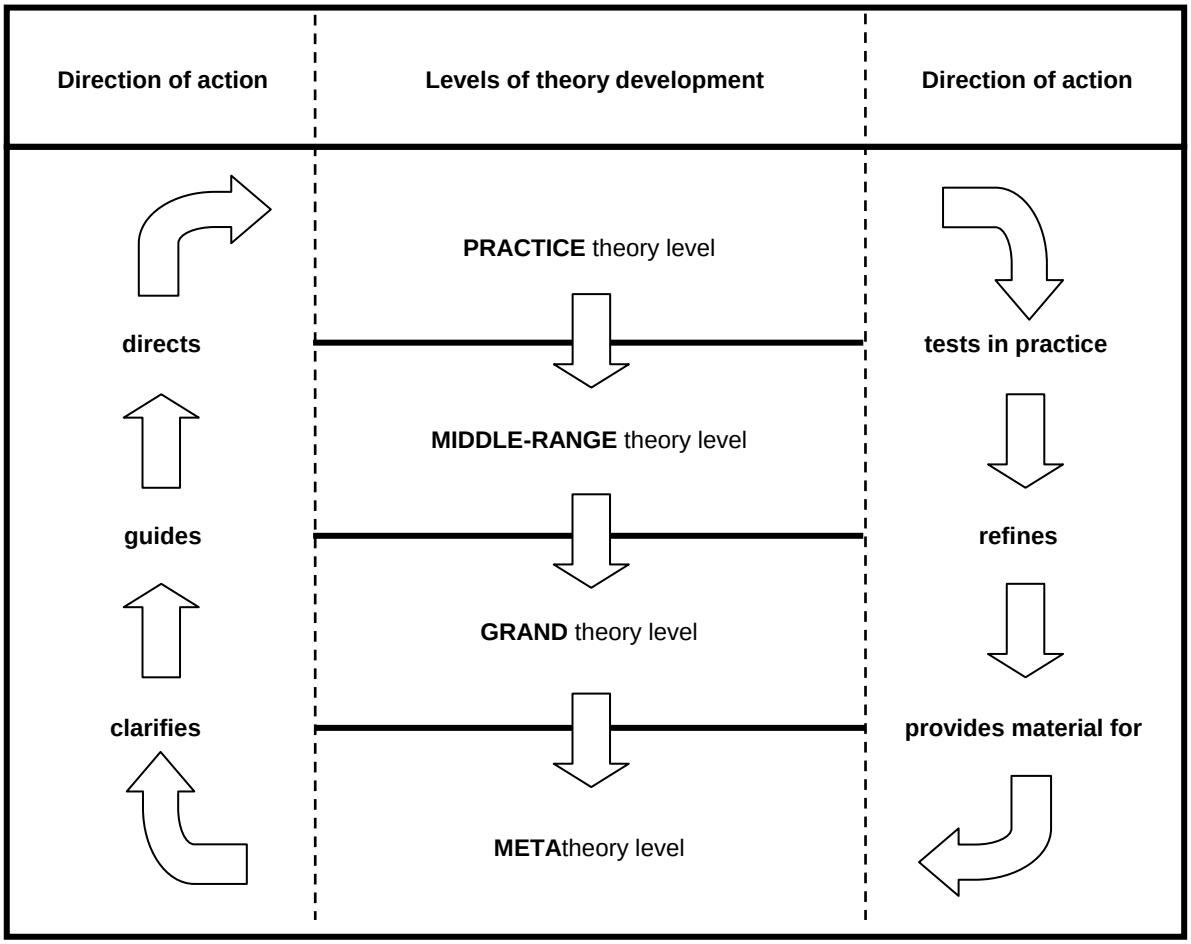



**Figure 2.2** Linkages between levels of theory development (adapted from Walker & Avant 2011:20).

The seminal work of Dickoff, James and Wiedenbach (1968a:415-435, 1968b:545-554) on practice oriented theory is extensively referred to by Walker and Avant (2011:18) when practice theory is discussed. Dickoff, James and Wiedenbach (1968a:420) refer to four (4) levels of theories at the practice level of nursing theory development, which are:

(i) factor-isolating theories

(ii) factor-relating or situation-depicting theories

(iii) situation-relating theories

(iv) situation-producing theories or prescriptive theories.

The last level is pertinent to this study on the functional role of the RN as a PLN because it was the situational context in ambulatory care nursing that contributed to the

development of a practice model. Dickoff, James and Wiedenbach (1968a:421) indicate that three (3) components are essential in a situation-producing theory. These are:

(i) Goal content that is specified as to the aim of the activity. In this study, the goal is quality patient care as an outcome of the functional role of the RN as a PLN.

(ii) Prescriptions for the activity to ensure that the goal content is realized. In this study, the prescriptions are the functions of the RN as a PLN that constitute the phenomenon under study aimed at generating a practice model.

(iii) A survey list that serves to classify the prescriptions aimed at future preparation so that the prescriptions are carried out aimed at attaining the goal content. In this study, the survey list is used in chapter five (5) to facilitate concept classification after concept identification from empirical data is produced.

In table 2.1 that follows, the levels of practice theory by Dickoff, James and Wiedenbach (1968a:420) are presented and the relevant application to model development in this study is outlined.

**Table 2.1** Application of the levels of practice theory by Dickoff, James and Wiedenbach (1968a:420) in relation to model development in this study.

| Levels of practice theory by Dickoff, James & Wiedenbach (1968a:420) | Application to model development in this study |
|---|---|
| i. Factor-isolating | ▪ concept identification<br>▪ concept classification |
| ii. Factor-relating | ▪ conceptual framework<br>▪ relational statements |
| iii. Situation-relating | ▪ description of practice model |
| iv. Situation-producing | ▪ evaluation of practice model<br>▪ guidelines for operationalization of practice model |

Walker and Avant (2011:58) discuss the three fundamental elements of theory development, namely concepts, statements, and theory, which are summarized in the discussion that follows. Concepts are mental images that represent an idea, phenomenon, or a construct about something or an action. It is not the tangible thing or action as such, but a mental representation of it to assist in categorizing or organizing environmental stimuli. It facilitates our identification of how our experiences are similar or dissimilar by equating them against a mental image of related aspects of the stimuli, and in this way contributes to new learning. There are three types of concepts. The first is primitive concepts, such that all persons can identify that trees are either 'green' or 'not green', as this would be a universally shared mental image of 'green'. The second is concrete concepts, which exist in time and space, and although there can be a shared universal mental image such as with primitive concepts, they are observable and definitive in the reality of daily living. The last is abstract concepts, which can be defined similar to primitive and concrete concepts, but are independent of time and space, such as temperature, which is an abstract concept until time and space are added, at which point it becomes a concrete concept such as 'the temperature in Johannesburg on Friday is cold'.

Furthermore, Walker and Avant (2011:59) assert that language is the means by which we express concepts; however, the terminology that we use to communicate the concepts conveys the expression for which a mental image is created, because the terminology itself is not the concept. Concepts, by way of terms or names, permit us to classify the meaning of experiences in a useful and skilful manner. Further to this, the ability to articulate a relationship between two or more concepts has a higher level of usefulness, which is referred to as a statement. Statements are essential prerequisite segments for building a scientific body of knowledge, which must be generated before explanations or predictions can be made. In reference to theory development, statements can be relational or non-relational. Relational statements therefore denote

a relationship or association between two or more concepts, and non-relational statements denote independent existence, or are defined by a concept. The definitional statements can either be theoretical or operational in that the former has abstract defining characteristics and the latter has a degree of measurable characteristics. In theory development, relational and non-relational statements are crucial as they serve as a means of testing and validating theories in real settings. A theory is taken to be a set of coherent relational statements that articulate a new understanding about the phenomena of interest in a systematically constructed manner. Furthermore, theories are dynamic and undergo change through refinement and revision concurrent to the evolutionary process in science. A graphical representation of a theory is referred to as a model. Such a schematic representation is used to illustrate or clarify relationships between concepts for the purpose of facilitating the related theoretical discussions.

To complete the description of the research design that was used in this study, an overview of the qualitative research process of inquiry follows that is exploratory, descriptive, contextual, and interpretive.

## 2.4 QUALITATIVE RESEARCH PROCESS OF INQUIRY

The emergence of a qualitative research process of inquiry is relatively new within the Middle Eastern setting when compared to the traditional practice of quantitative research, and particularly clinical designs linked to pharmaceutical research. Therefore, the research emergence of qualitative inquiry will be briefly outlined historically, defined and discussed as fundamental to the research design in this study. Thereafter, the exploratory, descriptive, interpretive and contextual aspects of the

research design that were used in this qualitative research process of inquiry will be specified.

The earliest emergence of qualitative inquiry is given as the 17th, 18th and 19th centuries in relation to sociology and anthropology by Vidich and Lyman in the second handbook of qualitative research by Denzin and Lincoln (2000:37). The authors provide evidence of ethnographic studies by Western explorers, missionaries, buccaneers, and colonial administrators, which they state are found at historical sites such as churches and museums throughout the world. These historical writings are attributed to contain 'thick descriptions' on the lived experiences of 'natives' within their local settings, which is taken to be human experiences in their natural setting. Chase (2005:652), in the third handbook of Denzin and Lincoln (2005), acknowledges the wealth of history in early development qualitative research, and confirms the foundational contribution of historical developments to the contemporary practice of qualitative research processes of inquiry. Ritchie and Lewis (2003:6) identify the earliest specific association with qualitative inquiry with the emergence of interpretivism, and link it to the writings of Immanuel Kant who published his writings entitled 'Critique of Pure Reason' in 1781. In his writings, Kant argued that there were other ways of knowing about the world through human experience and interpretation in addition to direct observation. He proposed that:

- perception went beyond the human senses to include human interpretations of what our senses tell us
- knowledge gained about the world embraces 'understanding' that arose from thinking about human experiences as they occur, and not simply from having a specific experience
- human knowing and knowledge that is gained surpasses basic empirical enquiry

- distinctions exist between ‘scientific reason’, which was taken to be based on ‘casual determinism’, and ‘practical reason’, which was further taken as based on moral freedom and decision-making which are somewhat less certain than reasoning.

Qualitative inquiry has expanded since these early times, and has retained some of the historical identity, which is evident in contemporary explanations aimed at definition. Patton (2002:39) emphasizes this aspect of ‘naturalistic inquiry’ by stating that qualitative inquiry is conducted in ‘real-world settings’ where the researcher does not attempt to manipulate the subject of interest being studied, such as interactions, events, programs or group interactions. He elaborates that the research study occurs as these real-world situations unfold, and therefore the researcher’s design strategy is ‘non-manipulative and non-controlling’, and embraces an ‘openness to whatever emerges’. Ritchie and Lewis (2003:7) emphasize that qualitative researchers focus on the value of ‘human, interpretative aspects of knowing about the social world and the significance of the investigator’s own interpretations and understanding of the phenomenon being studied.’ Denzin and Lincoln (2005:2) take a step back and debate whether or not ‘qualitative research’ can be defined. They state that as ‘a site of discussion, or discourse, qualitative research is difficult to define clearly. It has no theory or paradigm that is distinctly its own … multiple theoretical paradigms claim use of qualitative research methods and strategies, from constructivist to cultural studies, feminism, Marxism, and ethnic models of study. Qualitative research is used in many separate disciplines … It does not belong to a single discipline. Nor does qualitative research have a distinct set of methods or practices that are entirely its own.’

In summary, Denzin and Lincoln (2005:6) conclude that qualitative research is ‘inherently multi-method’ whereby ‘objective reality can never be captured’ and claim that a phenomenon can only be known by its representations. Denzin and Lincoln

(2005:5) refer to Fick (2002) by synopsis that qualitative research is a 'combination of multiple methodological practices, empirical materials, perspectives, and observations', which are best placed in a single study that portrays the process of inquiry 'as a strategy that adds rigor, breadth, complexity, richness, and depth' to the phenomenon under study.

Other authors of similar views on defining qualitative research include Rice and Ezzy (1999:1) who state that 'qualitative research cannot be described in terms of a set of theories and techniques … qualitative research draws on a variety of theoretical perspectives and practical techniques, including theories such as phenomenology, symbolic interactionism, cultural studies, psychology, and feminism, and techniques such as interviewing, narrative analysis, ethnography, and focus groups.' Snape and Spencer (2003:2), in their opening chapter entitled 'The Foundations of Qualitative Research' in the textbook 'Qualitative Research Practice' edited by Ritchie and Lewis (2003) refer to 'an attempt' to define what is meant by 'qualitative research', and agree that the emergence of a precise definition is not possible. They affirm that 'qualitative research' is an 'overarching category' that includes a 'wide range of approaches and methods found in different research disciplines.'

The challenge of defining qualitative research is apparent by the lexicon absence in two (2) dictionaries commonly used in healthcare. These are Stedman's Medical Dictionary (2006:1616) and Mosby's Dictionary of Medicine, Nursing and Health Professions (2009:1565) in which an absence is observed on defining qualitative research in healthcare. A further reference check in the Oxford Dictionary of Philosophy by Blackburn (2008:301) confirms the omission of defining either qualitative research or a research process of inquiry in the social sciences (Blackburn 2008:186). Schwandt (2007:247) provides a definition of the qualitative process of inquiry in his third edition of a dictionary on qualitative inquiry. He defines 'qualitative inquiry' as a

‘designation of all forms of social inquiry that rely primarily on qualitative data, (that is data in the form of words) including ethnography, case study research, naturalistic inquiry, ethno-methodology, life-history, methodology, and narrative inquiry’. He adds that when research activity is referred to as qualitative inquiry, it broadly means that the aim of the research is focused on understanding the meaning of human action. However, despite his attempt, Schwandt (2007:248) reaches the conclusion that qualitative inquiry is ‘difficult to define precisely’ and links the inherent lexicon challenges to the qualitative social movement in universities in the late 1960s. He states that the movement was associated with ‘rediscovery and legitimation’ in the approach to studying social life and credits this movement with the subsequent intellectual development of different qualitative methodologies and epistemologies concerning the purpose of qualitative inquiry (Schwandt 2007:248).

Stake (2010:31) regards the essence of qualitative inquiry as characterized by a ‘rich description of personal action and complex environment’ and asserts that qualitative inquiry is distinguished scientifically for ‘the integrity of its thinking’. He purports that there is an absence of thinking along a linear pathway, but that qualitative inquiry represents a collection of thinking that is ‘interpretive, experience based, situational, and personalistic … that understanding them requires a wide sweep of contexts: temporal and spatial, historical, political, economic, cultural, social, personal, … the thing is seen as unique as well as common … such uniqueness is established not particularly by comparing it on a number of variables … but (by) the collection of features and the sequence of happenings … unprecedented, a critical uniqueness’ (Stake 2010:31).

In their perspective of the usefulness of qualitative inquiry in healthcare, Holloway and Wheeler (2010:11) put forward that the appreciation lies in gaining knowledge and insight on human experience whether the human being in focus is the patient, a nurse,

or any other healthcare professional. They project that the value of qualitative inquiry in healthcare is due to the in-depth research data gained on human reality, which embraces the social and cultural context of experience, and whereby critical thinking extends beyond the clinical conditions or academic requirements. Holloway and Wheeler (2010:12) state succinctly that qualitative health inquiry is congruent to the emotions, perceptions and actions of the phenomenon under study, and as such and in reference to Paterson and Zderad (1988), is matched to the core elements of the healthcare professions on the levels of 'commitment and patience, understanding and trust, give and take, flexibility and openness'. It is the last elements of 'flexibility and openness' that Holloway and Wheeler (2010:12) assert are the commonality between qualitative research inquiry and the approach by healthcare professionals toward their patients and colleagues.

Based on the various dimensions of qualitative research, as the researcher, I chose to follow a qualitative process of inquiry. In essence, this meant that I adopted a sustaining questioning approach within the genre of qualitative research whereby strategies of inquiry were used as the starting point of the research design. Denzin and Lincoln (2008c:33) support this approach and advise researchers to remain focused on the research question and follow strategies of inquiry that answer specific research questions (as outlined in chapter one, section 1.4). The qualitative research process of inquiry is described by Denzin and Lincoln (2008c:34) as comprising research skills and practices that connect the researcher to the empirical world, inclusive of specific methods for data collection and analysis of empirical material from the field.

The research design of this study consisted of exploratory, descriptive aspects for the purposes given in chapter one, section 1.8 that orientate the reader to the research design. An outline of how these aspects of the research design contributed to the qualitative research process of inquiry in this study will follow while the application of

the research methods specifically within the research field are discussed in depth in chapter three (critical incident technique and reflective journaling) and in chapter four (vignette method).

### 2.4.1 Exploratory

This study was exploratory in research design because it inquired on unknown aspects of the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital. In the exploratory approach, the discovery or revelation of concepts or new ideas potentially add to the acquisition of knowledge and insight about the phenomenon being studied, without being influenced by predetermined ideas (Mouton & Marais 1990:43, Mouton 1996:103, Marshall & Rossman 2011:68). The exploratory aspect of this qualitative inquiry was therefore congruent to the research purpose because of the unexplained nature of the apparent success of the newly introduced functional role of the RN as PLN within the ambulatory care context of a Middle Eastern teaching hospital.

### 2.4.2 Descriptive

The descriptive aspect of the research design of this study was intended to collect accurate information or data on the phenomena, related and core concepts under investigation (Mouton & Marais 1990:44, Marshall & Rossman 2011:69) to provide an accurate depiction of a particular situation or activities, individuals or groups so that new explanations or sense are discovered for the described phenomena (Schwandt 2007:64, Marshall & Rossman 2011:69). In this study, data collection methods were used to obtain data from the participants who were functioning in the RN role as PLN.

The collected sets of data were analyzed with the aim of describing the following in the first and second phases of this study, respectively:

- the meaning and lived experience of the functional role of the RN as PLN within the ambulatory care context of a Middle Eastern teaching hospital
- a model on the functional role of the RN as PLN in the ambulatory care context of a middle Eastern teaching hospital.

### 2.4.3 Contextual

Ritchie (2003:27) asserts that context in research is 'concerned with identifying what exists in the social world and the way it manifests itself', which needs to be revealed through a process of inquiry to find out 'what lies inside' to find out how 'they are understood by those connected with them'. This aspect of context related to the study on the functional role of the RN as PLN within the ambulatory care setting of a Middle Eastern teaching hospital. Lewis (2003:56) expands contextual aspects to embrace the personal and organizational considerations or circumstances of what is naturally occurring within the research location and how the participants relate to it, and emphasize that if context is fundamental to researching a phenomenon in its natural context, then it would be essential that naturally occurring data is preferred. Patton (2002:40) and Stake (2010:14) are aligned to this perspective as naturalistic inquiry in relation to design strategies of qualitative inquiry that pertain to studying a real-world phenomenon with openness as situations unfold naturally.

### 2.4.4 Interpretive

The study included an interpretive aspect of research design whereby the meaning of human action is taken to be inherent in the action, and that the process of inquiry

uncovers the meaning in a manner that makes sense to the subjective reality of the phenomenon being studied (Schwandt 2007:64, Holloway & Wheeler 2010:25, Stake 2010:36). Yin (2011:207) regards interpreting in qualitative research as the craft of attributing meaning to data and emergent themes as a basis for understanding the phenomenon being studied.

In this study, the RN participants documented their responses in the functional role of the RN as PLN, and as nursing management responses to the PLN role, which constituted the empirical material that was studied within the ambulatory care context of a Middle Eastern teaching hospital. During the process of data analysis, the interpretive aspect entailed uncovering the meaning of the PLN experience that was refined to attach meanings, which gave insight into the lived experience.

## 2.5 RESEARCH METHODS

Research methods comprise data collection techniques and procedures, the research population, and the approaches to sampling and data analysis. An overview follows on the research methods employed in phase one (1) of the study, that is the process of concept identification and description, and in phase two (2), that is the process of model development and description. The details of how the research methods were applied are discussed in detail in chapters three (3), four (4) and five (5) that follow as explained and justified in the approach set out in chapter one (1), section 1.11.3 on the organization of this thesis to pattern the chronological use of research methods. The outline that follows on the research methods are linked to the research objectives as described in chapter one, sections 1.5.1 and 1.5.2.

### 2.5.1 Critical incident technique and reflective journaling

In phase one of the research study, the first data collection method that was used to investigate the meaning and lived experiences of the patient liaison nurses (PLN) was reflective journaling with the integrated use of the critical incident technique (Flanagan 1954:327, Cox, Bergen & Norman 1993:408, Andersson 1995:131, Jasper 1995:446, Grant, Reimer & Bannatyne 1996:469, Cheek 1997:253, Kemppainen 2000:1264, Byrne 2001:536, Keatinge 2002:33, Broström, Strömberg, Dalhström & Fridlund 2003:223, Aveyard & Woolliams 2006:929).

At the organization where the study was conducted, reflective journaling is integrated with the use of critical incident analysis, and is used as part of the daily work program of RN professional development. The respondents participated in reflective journaling after informed consent was obtained for the purpose of data collection in this study to gather data for the first research objective. The detailed steps on how this research method was conducted resulting in concept identification is discussed fully in chapter three (3), sections 3.2 and 3.3.

The core rationale for using reflective journaling was to minimize disruption to the work of the PLN in the ambulatory care context (ACC). The reflective journaling technique is extensively supported for data collection of rich narrative accounts of lived experience (Jasper 1995:446, Croke 2004:125, Plack, Driscoll, Blissett, McKenna and Plack 2005:199, Walker 2006:216, Steven & Cooper 2009:19), while Riley-Doucet and Wilson (1997:964), Johns (2004:20) and Taylor (2006:196) advocate that it provides a safe and private means for nurses to review and examine their experiences freely. The reflective journaling process is discussed fully within the contextual setting of the study with the critical incident analysis in chapter three (3), section 3.3.

### 2.5.2 The vignette technique

The vignette technique was the second research method used in phase one of the research study. The use of vignettes in research is supported widely in the literature (Finch 1987:105, Lanza 1988:347, Stolte 1994:727, Ely, Vinz, Downing & Anzul 1997:70, Hughes 1998:381, Wilson & While 1998:79, Barter & Renold 2000:307, Hughes & Huby 2002:382, Cheek & Jones 2003:40, Davis, Ware, McCann, et al 2010:online). In this study, it was used as a data collection method with the RN participants who are the first line nursing management as well as the immediate supervisors of the PLN participants. The empirical data fulfilled the second research objective in this action by collecting data using vignettes that were created from real-life data that were generated from the reflective journaling on the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.

A host of authors confirm the value and the use of vignettes in various research studies including anthropology, phenomenology, sociology, nursing science, gender studies and psychology (Alexander & Becker 1978:93, Neff 1979:105, Finch 1987:105, Lanza 1988:347, Rahman 1996:35, Denk, Benson, Fletcher & Reigal 1997:95, Lanza, Carifio, Pattison, & Hicks 1997:82, Hughes 1998:381, Barter & Renold 2000:307, and Hughes & Huby 2002:382). The process of vignette formulation and contribution of the empirical results are discussed in depth in chapter four (4) to reflect that it was actioned chronologically five (5) weeks after the reflective journal returns were received. The vivid descriptions from the reflective journals contributed to the process of generating the vignettes that were based on the initial emergent categories of themes from the reflecting journaling returns.

The empirical results of the first and second research objectives are the conclusion statements from chapters three (3) and four (4), respectively (see chapter five (5), table 5.1 which contains a summary of the conclusion statements). The identification and classification of concepts that are discussed in detail in chapter five (5), sections 5.4 and 5.5, signified the achievement of the third research objective.

### 2.5.3 Model development and description

Model development and description followed chronologically as the commencement of the second phase of the study after the data analysis of the reflective journals and vignette responses had been completed. The empirical data gained from phase one (1) was used for meeting the fourth research objective of constructing a conceptual framework that used the concepts and relational statements, and is extensively described and discussed in chapter five (5).

The fifth research objective to describe a model for the functional role of the RN as PLN was commenced by contextualizing the relational statements within the ambulatory care context of the Middle Eastern teaching hospital by a representation of interrelated structures in a schematic diagram that contributed to the model, which is discussed extensively in chapter six (6).

To meet the sixth research objective, the described model was evaluated against the theoretical criteria by Chinn and Kramer (2008:234-249), which is discussed in detail in chapter six (6), section 6.4 both as to the theoretical criteria and evaluation of the model.

The seventh research objective was fulfilled by the formulation of guidelines for the implementation of the model. The method and process for the formulation of the guidelines are discussed in detail in chapter seven (7), section 7.2.

## 2.6 SCIENCE PHILOSOPHY: UNDERPINNINGS OF THE RESEARCH DESIGN AND THE PROCESS OF MODEL DESCRIPTION

Science philosophy pertains to values that focus on scientific development and validation within a professional discipline (Fawcett 2005:12, Meleis 2007:36). However, Fawcett (2005:11) expands on a philosophy as being a statement that embraces ontological claims about the phenomena of central interest to a discipline, epistemic claims about how those phenomena become known, and ethical claims about what is valued by members of a discipline.

The abstraction that conveys the components of science philosophy is referred to as a paradigm (Kuhn 1996:10, Meleis 2007:35, Schwandt 2007:217, Holloway & Wheeler 2010:24). Holloway and Wheeler (2010:23) attribute the paradigm shift in thinking about qualitative research to the ideas of Kuhn (1970) who argued on the rationality of scientific inquiry (Schwandt 2007:217). The authors agree that a paradigm consists of an aggregate of beliefs, values, theoretical ideas, technical procedures, methods, stances, and perspectives that a community of scientists adopt within a professional discipline that has a transforming impact on scientific approaches to research inquiry (Kuhn 1996:18, Meleis 2007:35, Schwandt 2007:217, Holloway & Wheeler 2010:24). Moreover, Kuhn (1996:24) states that the paradigm is reflected in language and terminology that portrays a particular worldview and roots of the scientific stance.

The dimensions in science philosophy that guided this study as the paradigm are provided in table 2.2 that follows, and are evidenced in the social science philosophical stances that are adopted from Mouton and Marais (1990:7), Denzin and Lincoln (2005:25), Fawcett (2005:12), Schwandt (2007:37), Corbin and Strauss (2008:10), Denzin and Lincoln (2008a:31), Denzin and Lincoln (2008b:5), and Guba and Lincoln (2008:255).

Schnelker (2006:42) provides an account of research students as bricoleurs in direct reference to Denzin and Lincoln (2005:4), who use the metaphors of 'bricoleur' and 'quilt maker' to describe the research activities that are fitted together as 'pieces of a quilt' to form constructed representations of different tools, methods, approaches, and techniques that portray the qualitative research process of inquiry that was adopted. By the use of 'bricoleur', Denzin and Lincoln conjure an image of a researcher who is able to extend him/herself in a self-directed manner, which is the essence of the academic journey in a qualitative process of inquiry.

The philosophical underpinnings of the constructivist paradigm guided me as the researcher in my qualitative research process of inquiry. For this core reason, as discussed in chapter one (1), section 1.11.3 on the organization of this thesis, I could not align this thesis to a pre-determined 'recipe approach'. By 'recipe approach', I allude to the cookery metaphor of having all the ingredients listed clearly before the activity of cooking commences. Furthermore, and within the metaphor of a recipe wherein the steps are specified as 1, 2, 3, etc., I was unable to use the traditional thesis layout of chapter one (1) as introduction and background, chapter two (2) providing the literature review, chapter three (3) detailing every activity in the research design, chapter four (4) setting out results, and chapter five (5) providing the discussions and conclusion. For this reason, the layout of this thesis changed thrice.

Denzin and Lincoln (2008b:7) expand on the metaphor of the 'bricoleur' and 'quilt maker' to describe the abilities and characteristics of the qualitative researcher who follows a scientific process of inquiry and includes the following descriptions:

- ability to construct interpretations that build on one another as an inquiry unfolds
- multilogical thinking that is simultaneous, instead of unilateral thinking that is sequential in nature
- alert to different textures of experience such as different voices, different stances, different points of view and different approaches
- dexterity and congruence in the use of combinations when executing activities and strategies such as methodological practices, empirical materials, perspectives and observations that include field notes and bracketing
- mastery in qualitative crafting that adds rigor, richness, depth, complexity, and breadth to the process of inquiry

Appleton and King (1997:13), and Cutcliffe and McKenna (2002:611) point out that insufficient attention has been paid to the science philosophy dimensions (as provided in table 2.2) above in specific relation to qualitative research crafting in constructivism as a naturalistic methodology for nursing inquiry. Furthermore, Cutcliffe and McKenna (2002:611) ask 'when do we know that we know?' Herein lies the rhetorical question as to how a qualitative researcher can use a process of scientific inquiry and be able to provide a fully comprehensive chapter on research design and research methods during the early phases of the research journey. I believe that one cannot, and therefore this thesis narrates two (2) stories, namely (i) the lived experience of the functional role of the RN as PLN, and (ii) the experience of the researcher through a

qualitative process of inquiry that culminates in a practice model for the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.

I am an advanced beginner in qualitative research inquiry and therefore the mode of reflexivity is tuned to being alert to gaining quality of experience in this research journey. The journey continues with reasoning strategies that are the foundations to inquiry.

**Table 2.2** Science philosophy dimensions in the constructivist paradigm that guided this study

| Dimension | Constructivist paradigm applications |
|---|---|
| 1. **Ontological**<br>- focus on a specific aspect of reality<br>- answer 'what is?' | • exploratory, descriptive and interpretive research on the lived experience of the functional role of the RN as PLN in ambulatory care.<br>• descriptive of a model for nursing practice of the functional RN role as PLN in ambulatory care. |
| 2. **Epistemological**<br>- the quest for truth<br>- makes valid and reliable judgments<br>- answers 'what can be learnt?' and the 'where is the researcher in the research setting?' | • the researcher's relationship to the setting is described.<br>• concept identification and concept classification.<br>• conceptual framework on the functional role of the RN as PLN.<br>• model that describes RN practice as PLN in ambulatory care. |
| 3. **Sociological**<br>- involves collaborative activity to reflect the nature of the discipline<br>- considers impact by society on scientific activity<br>- answers 'who is involved?' and 'who is influenced?' | • relational statements that portray links between concepts.<br>• interactions between the patients and the PLN, the PLN and members of the team in collaboration and cooperation for a common purpose.<br>• research participants that included RNs who functioned as PLN and RNs who supervised nursing practice, and thereby fulfilled the inclusion criteria of purposive sampling in this study. |
| 4. **Methodological**<br>- refers to the planning, structure and implementation of procedures and processes<br>- answers 'how can this be done?' | • data collection methods that used the critical incident technique combined with reflective journaling, the vignette technique and the process of model development.<br>• the process of model development that utilized empirical data derived from the participants. |
| 5. **Ethical**<br>- concerns morality, reasoning and human purpose<br>- answers 'who and why' of participation and involvement | • organizational consent for site research.<br>• ethics consent from the university.<br>• informed consent from the research participants.<br>• institutional consent for publication of findings. |
| 6. **Teleological**<br>- focused on intentions and outcomes that are goal-directed<br>- refers to overall purpose and functions that are criteria-driven<br>- answers 'what and why' of the research goals | • model evaluation and theory critique of the practice model developed in this study.<br>• operationalization guidelines for implementation of the model in nursing practice in the ambulatory care context of a Middle Eastern teaching hospital. |

## 2.7 REASONING STRATEGIES

The main reasoning strategies used in theory development and construction according to Walker and Avant (2011:66) are induction and deduction. They expand on this perspective by stating that there is no single reasoning strategy that exceeds the other because the manner in which theory develops in practice is an iterative process between deductive and inductive reasoning strategies (Walker and Avant 2011:67). Chinn and Kramer (2008:212) consider deduction and induction as forms of logic that portray relational statements between concepts that are formulated. Rossouw (2003:39), Schwandt (2007:147) and Chinn and Kramer (2008:214) regard deductive logic as reasoning from the general to the specific, whereby the starting point embodies two or more concepts that are categorized in relation to one another in broad terms or descriptions with a conclusion that contains specific concepts or data on the relationship. In generating deductive arguments, it begins with a general or universal statement and moves by inference to state a specific case of the argument with a statement that contains specific data in the conclusion.

In describing inductive logic, Rossouw (2003:40), Schwandt (2007:146) and Chinn and Kramer (2008:214) consider inductive logic as reasoning in statements with data that is specific to statements that have broader and general conclusions. Therefore, when reasoning from the specific to the general, the data that emerges in the conclusion can be considered in relation to broader events or phenomena in another similar context or system. It would follow then inductive conclusion statements may vary from weak to strong in support of data in arguments.

Schwandt (2007:147) and Chinn and Kramer (2008:215) are aligned that deductive logic and inductive logic are used widely either separately or jointly with the qualitative

research process of inquiry. In this study, deductive logic was used extensively, particularly with the conclusion statements formed as explained in chapter one (1), section 1.11.2 on making convincing arguments and shown in table 5.1 in chapter five (5) that provides a list of empirical data that was generated from the critical incident analysis and reflective journaling, the vignette technique response and the conceptual framework. Inductive logic was used in the study in the process of model development and model description.

The essence of reasoning strategies, therefore, irrespective of whether deductive or inductive logic is used, lies in approaching this activity in the qualitative research process of inquiry in a systematic and consistent manner. In doing so, the qualitative researcher is able to generate plausible relational statements that would show linkages in the data to arrive at logical deductive or inductive conclusions that embrace the empirical reality.

## 2.8 SAMPLING AND POPULATION

Sampling is the useful selection of an element of the whole population for the purposes of gaining knowledge and information on a phenomenon (Holloway & Wheeler 2010:137, Marshall & Rossman 2011:105).

The sampling strategy used throughout this study was purposive sampling. Holloway and Wheeler (2010:138) indicate that purposive sampling is the selection of participants that fit the criteria of the researcher in relation to situation, units of time, settings and experiences. Marshall and Rossman (2011:105) include the site as a consideration of purposive sampling because it embraces considerations of access to

the population and the field. Mason (2002:121) expounds on sampling in qualitative research and states that there are two overarching reasons that support the logic of sampling, which are (i) the practical reason of access to human and material resources that are selected for the function of providing data and information, and (ii) the focus of the research study in relation to specific issues and processes that relate to the phenomena that are under study aimed at depth, nuances, complexity and understanding of how things are and work in reality. Mason (2002:121) indicates that these two (2) reasons for sampling are useful as an approach because:

- the selected sample would facilitate access to data to answer the research questions
- it becomes a means of obtaining thick descriptions from meaningful empirical contexts, perspectives and/or illustrations
- it combines empirical and theoretical considerations for sampling decisions
- it promotes intellectual work that requires the establishment of relationships to gain a wider empirical universe that may involve political, economic, social, cultural, religious, and organizational factors
- greater depth is gained and potential for interpretive aspects in discourses, structures of power distinctive gender elements and attributes are considered.

Sampling and population in this study was purposive in phase one (1) of the study because the participants were selected based on their experience within the context of the ambulatory care setting of a Middle Eastern teaching hospital. The first population group was selected by purposive sampling because all were registered nurses who functioned as patient liaison nurses in ambulatory care clinics. These participants used critical incident analysis and reflective journals for documenting their lived experiences in the functional role of the RN as PLN.

The second group of participants was also selected by purposive sampling because they were working in the direct next line reporting role, either as clinic nurse coordinators or assistant nursing supervisors and therefore all were exposed to the first participant group. The second participant group, based on their experience managing the functional role of the RN as PLN, was best positioned purposively to respond to the vignettes on the PLN in the ambulatory care context.

Purposive sampling continued into phase two (2) whereby the conclusion statements from the reflective journaling and vignette responses were used in phase two (2) in model development in combination with the conclusion statements from the conceptual framework as shown in table 5.1 in chapter five (5).

## 2.9 OVERVIEW OF DATA ANALYSIS

The process of data analysis for reflective journaling is discussed extensively, chronologically and contextually in section 3.4 of chapter three (3), and for vignette responses in section 4.4 of chapter four (4). The core steps of data analysis set out by Tesch (1990:142) were adapted accordingly with reference to the later work of Richards (2009:58) for use in guiding data reduction within the process of data analysis. The details of how Coffey and Atkinson (1996) and Richards (2009) were used with Tesch (1990) are shown in use in section 3.4 in chapter three (3) throughout the process of data analysis.

The approach to data analysis in this study is in keeping with systematic stance put forward by Bernard and Ryan (2010:5) who indicate that the data analysis must have the following features:

(i) methodological reduction of experiences into recordable units

(ii) means of reducing people's thoughts, behaviors, emotions, artifacts, and environments to sound, words, or pictures/diagrams

(iii) ways to chronicle ephemera so as to capture characteristics of the phenomenon of interest before it disappears or is lost

(iv) creative techniques to validate the human component to science and thereby impart meaning to experiences.

In order to move ahead with this scientific journey, it is necessary to consider the ethical aspects and the research methods.

## 2.10 ETHICAL ASPECTS AND RESEARCH METHODS

The ethical aspects that apply here to the research methods are discussed comprehensively in section 1.9 on ethical considerations in chapter one (1) and were embraced throughout the study. A particular focus in relation to the research methods, the anonymity of patients, consent of study participants, and protective storage of research material follows.

### 2.10.1 Anonymity of patients

The medical record or identification by medical record number of the patients were excluded in the study. The PLN excluded any reference that may identify the patients in any manner, be it by name, affiliation, residential address, disease process or social affiliations. The participants in the study were anonymous, as each allocated to themselves a participant code that was not known to me as the researcher and aimed

to protect their identity at source of reflective journaling, and at a second level of protection to the patients as the clinics were not identified at all on any of the data returns.

### 2.10.2 Consent and protection of study participants

Informed written consent was obtained from all participating registered nurses as shown in appendix 10. A presentation of the research study was given by the researcher prior to agreement to participate. The right of participants to withdraw at any stage without providing reasons was specified on the participant information sheet, and was addressed in the presentation prior to obtaining informed consent from potential participants. Further, participants were assured that the returned participant data would be kept safe in a locked cupboard for access only by the researcher, and that all data entered onto the computer would be protected by password.

## 2.11 SUMMARY

The justification for the research design was given at the opening of this chapter followed by the components of the research design used in this qualitative research process of inquiry. The research methods were described in connection to their chronological application in the research study and the science philosophy underpinnings were described. Sampling of the research population and data analysis were outlined prior to the ethical aspects that pertain specifically to the research methods. In chapters three (3) and four (4) that follow, each chapter will detail the application of the research methods used, the analysis of collected data, as well as the results, empirical data and literature used to embed the results in evidence.

# CHAPTER THREE

# CRITICAL INCIDENT TECHNIQUE AND REFLECTIVE JOURNALING APPLIED AS A RESEARCH METHOD: DATA COLLECTION AND ANALYSIS, RESULTS AND LITERATURE

## 3.1 INTRODUCTION

This chapter presents how the critical incident technique and reflective journaling were used in data collection, followed by the process of data analysis that was undertaken, and concludes with the presentation of the emergent themes that are supported by the empirical data and the literature.

## 3.2 CRITICAL INCIDENT TECHNIQUE AND REFLECTIVE JOURNALING AS A RESEARCH METHOD

The use of critical incident analysis was integrated with reflected journaling as a research method for use in this study. The first research objective was to explore, describe and interpret the lived experience of the functional role of the RN as a PLN within the ambulatory care context of a Middle Eastern teaching hospital.

A seven (7)-step process (see appendices 7 and 8) was designed as follows:

Step 1: Selection. The PLN participant selected a critical incident from their daily professional nursing practice situation using six (6) categories that were provided as guidelines. These categories were adapted and outlined based on the critical incident methodology developed by Flanagan (1954:338) and adapted for use in nursing practice by Kemppainen (2000:1265), Taylor (2006:133) and Quinn and Hughes (2007:366). The adapted categories related to anticipated critical incident experiences that were likely to be encountered by the PLN and were given as follows:

(i) Participation as PLN was required because the process of care or communication was faulty, which could affect patient care negatively.

(ii) Identification of a chronic patient situation that impacted negatively on the care or treatment regime.

(iii) Intervention by the PLN made a difference to the outcome of patient care.

(iv) Professional judgment that a particular situation was particularly demanding and stressful.

(v) Input as PLN contributed to events going unusually well or positively for the patient.

(vi) Regard for an outcome that captured the essence of professional nursing care.

Step 2: Description. This step extended the critical incident methodology by guiding the PLN to identify specific components in describing the incident. Four (4) types of components were described to guide the PLN in justifying the selection as follows:

(i) Factors, causes or situations that led to the critical incident that was identified.

(ii) Actions or behaviors of the patient and/or family in the situation.

(iii) Results or outcome of the actions or behaviors by the patient or family in the situation before intervention by the PLN.

(iv) Identification or summary of the situation or problem in nursing terms.

Steps 1 and 2 concluded the critical incident analysis aspect of the research method used in this study. From steps 3 to 7, the reflective practice aspect of the reflective journaling was used.

Step 3: Perception. In this step, the PLN participant considered what they had written down for steps 1 and 2. They were asked to reflect on what they were thinking or feeling at the time of experiencing the situation. This step embraced the Johns 1992 model of guided reflection (Johns 2004:20, Quinn & Hughes 2007:448). It facilitated the PLNs to expand on their descriptions by adding what their perceptions were at the time of the experience. This gave depth to the experience of a phenomenon by focusing them on the 'here and now' of the experience because they considered the causal or contextual nature of the experience, and therefore enhanced the clarity of what they had experienced. This step concluded with the PLN gaining an awareness of the experience by recognizing their feelings as a result of observed behaviors of the patient and/or family in the situation.

Step 4: Exploration. This step utilized Schön's approach of 'reflection-in-action' (Schön 1983:128, Schön 1987:22) that Johns adapted in his model (Johns 2004:14, Quinn & Hughes 2007:448). The PLN was asked to define or explain what was positive, negative or neutral about the experience in the situation. They were invited to express their thoughts and ideas that qualified the situation as a positive, negative or neutral experience.

Step 5: Analysis. They were asked to reflect on what they had written down in step 4. The PLN reviewed what they had written, and identified a separate aspect in the situation for consideration in isolation while making notes. Thereafter, they were to review each separate aspect within the whole experience. New thoughts or ideas that emerged were to be recorded as further considerations or interpretations of what they

were experiencing. They were asked to repeat this for each aspect as a thinking process and to record the thoughts and ideas that arose. The aim of this step was to facilitate expression of internal and external factors that potentially influenced their responsive actions as a result of either choice or consequence within the lived experience (Johns 2004:16).

Step 6: Evaluation. In this step, the PLN reviewed the separate aspects as a synthesis of a whole experience, and asked what else could have been done for the patient and/or family if it were possible. Johns (2004:17) guides that in this step the practitioner evaluates what was 'good' or 'bad' about the experience and 'what else could you have done'. Johns (2004:19) admits that there is a degree of reflexivity occurring in this step because there is current reflection on previous reflection. He cautions on the prescriptive nature of the 'orderly step-by-step progression' of structured reflections, but justifies its value for novice practitioners by the facilitative approach for the individual to grasp the essence of reflection as a process.

Step 7: Renewal. As the researcher, I added this step as the final action so that the PLN could write down what could be committed to doing within the ambulatory care context if they were to encounter a similar situation again in their future PLN experience. My reason for this step described as 'renewal' was to ensure consolidation of the new insights gained so that it reaffirmed part of their revised professional nursing practice.

This step is absent in the work of Johns (2004:44) as he concludes the model of guided reflection on evaluating reflection. Taylor (2006:115), while expanding on different types of reflections that can guide nursing practice, also does not return to the practice arena or renewal in practice after critical thinking about practice has occurred. This omission is evident in the works of several authors who appear to conclude reflective

practice with awareness suggestions or implications on how insights gained can be used in practice. None of these authors return to the actual clinical practice settings as an intentional step to suggest how the practitioner could renew their previous practice informed by the new insights gained from the reflective process (Powell 1989:831, Burnard 1995:1172, Burrows 1995:349, Minghella & Benson 1995:210, Riley-Doucet 1997:967, Teekman 2000:1134, Johns 2004:43, Taylor 2006:202, Stevens & Cooper 2009:33).

The inclusion of step 7 on renewal in practice is unique to this study, and contributed to the guidelines for implementing the model as it assisted in contextualizing the model in nursing practice based on the empirical data from the PLN respondents.

## 3.3 PROCESS OF DATA COLLECTION

A reflective journaling data collection instrument was designed (see appendix 8) to integrate critical incident analysis and reflective journaling as explained above in section 3.2.

Purposive sampling was used to select the participants because of their 'first-hand experience' with the phenomenon of interest (Todres in Holloway 2005:114, Streubert & Carpenter 2007:29) as they were the PLN participants who executed the functional RN role aimed at quality patient care. Burns and Grove (2005:352) and Patton (2002:45) support the use of purposive sampling to select participants who would provide 'information-rich' accounts that are illuminative and 'offer useful manifestations of the phenomenon of interest'. Therefore, all registered nurses who could potentially

function in the PLN role in the sixteen (16) ambulatory care clinics were invited to attend an information session.

At the information session, a presentation was given by the researcher that included a background to the study, a literature-based review of what was understood by reflection in professional practice, and the process of reflective practice that was proposed for use in the research project. A letter of invitation, an information sheet in which the presentation was summarized (see appendix 9) and a copy of the informed consent for (see appendix 10) were distributed. The system of double-coding was explained, as was the role of the CRN as an intermediary in collecting the reflective journals. I explained double-coding in that the trained administrative assistant would access the reflective journal returns from the CRN with the personal codes that would be devised by each participant (see appendix 11 & 12). A list of personal codes and PLN participants was kept by the intermediary for purposes of back-tracing if member checking was needed. The participants were informed that the list was strictly confidential between them and the intermediary. The administrative assistant would then transcribe the handwritten reflective journal returns and allocate a new research code as part of double-coding to further protect the participant's identity. The participants were assured that the reflective journal data sheets were not to be accessed by the researcher and neither was the reflective journal data linked to any particular clinic in the ambulatory care center. All interested participants were invited to a training session conducted by the researcher so that they could become familiar with the reflective journal data return sheets and to practice generating their personal codes.

The actual reflective journal data return sheets (see appendix 8) were used in the training sessions with the self-generating personal code sheet (see appendix 11 & 12). The topic used for practicing the critical incident methodology was 'the most

unforgettable vacation' that each person had planned and experienced. Support for selection of a non-nursing experience was based on Flanagan's (1954:327) definition of a critical incident as first used in aviation psychology. He described a critical incident as any observable human activity in a situation where the purpose or intentions are clear to the observer, and that the incident is sufficiently complete in itself to permit inferences or predictions to be made regarding the persons involved in the act. Kemppainen (2000:1264) confirms that the critical incident analysis had since been used as a technique for a variety of purposes in training programs within business, industry, organizations and other professional groups. The reason for using it as a trigger training scenario in relation to a past 'most unforgettable' vacation with the PLN participants was to ensure a non-threatening environment for practicing the use of the reflective journal instrument because the scenario would not be considered right or wrong to the participant. Furthermore, it would contain a personal lived experience that had an 'unforgettable' meaning for each participant. This approach was successful because as the PLN participants used the reflective journal instrument (appendix 8) so that they felt comfortable sharing their vacation experiences and asked questions for clarity on the steps in the reflective journal instrument. At the end of the training sessions, PLN participants were asked to read the informed consent forms and were invited to ask questions related to the process for participating as respondents. A returned completed informed consent form signified their willingness to participate whereby reflective journal data return sheets were made available with the 'quick-guide' for their ready daily use (as in second part of appendix 8).

The written responses were returned anonymously using personal data codes. The reflective journal data returns were placed in plain envelopes and marked 'reflective journal' and posted in the mailbox of the intermediary, the CRN. The daily reflective journal returns were recoded individually with a research data code commencing with reflective journal and a three-digit number consecutively from 001 to 483. The trained

administrative assistant typed these handwritten responses daily on the day immediately following their return. Member checking was used by the intermediary to determine the accuracy of specific descriptions (Marshall & Rossman 2011:221), and occurred when deciphering of handwriting was needed. The CRN as the intermediary used backward tracing through the personal coding to the individual PLN participant for clarity on handwriting while maintaining the confidentiality of the person. The steps of the data collection procedure for the administrative assistant and intermediary CRN were provided as guidelines (see appendix 13).

The typed reflective journal data sheets with the reflective journal research codes were then made accessible to the researcher in keeping with the ethical principle to maintain confidentiality of the PLN participants at the source, therefore maintaining scientific integrity and rigor. It was confirmed by the intermediary that the typed reflective journal data sheets were an exact typescript of the handwritten script, which included errors and deletions as done by the participant writer. The coded reflective journal typewritten data sheets were taken as ready for data analysis.

### 3.3.1 PLN support group sessions

During the first five weeks of the ten-week reflective journal data collection period, PLN support group sessions were conducted by the researcher with the intermediary CRN who also made field notes (Corbin & Strauss 2008:123) which were used by me as the researcher to add my notes as well. Six (6) support groups were held in total. The introductory session was used as a forum to emphasize the process of reflective journal data collection. Anonymity at the level of the researcher and confidentiality at the level of the intermediary was assured again by explaining the double-coding system, as well as the respective roles of the intermediary clinical educator and

administrative assistant. Questions were invited on any aspect of the data collection process, which gave the PLN participants an opportunity to clarify any aspect that was unclear. It was repeated to all participants that the right to withdraw would be respected at any time without needing to provide a reason.

I informed the PLN group of thirteen (13) attendees at the introductory session that the purpose of the five (5) scheduled sessions was as a forum for asking me, as the researcher, any questions directly on any aspect of the reflective journal data collection process, and to verbalize any comments on the process of the critical incident technique and reflective journaling. I asked them for their assistance particularly in session 5 where I would present the major categories of ACC situations that emerged, and explained how their input would be of value to designing the vignette scenarios for the following activity of data collection from the management level of the clinic nurse coordinators and assistant nursing supervisors, who were their immediate nursing superiors in line of management. A period of free verbalization followed as each PLN attendee expressed their initial impressions of the PLN functional role. The following are some direct quotations from this introductory session:

- **'**My practice is more meaningful. I'm thinking about what I'm doing and saying to the patient'
- **'**Provides continuity for problems to be solved so that what is not solved at first meeting of the patient can be followed-up so the patient experiences a quick solution on the next visit**'**
- **'**I'm no longer bored. By the reflection at the end of the day I realize my job is more interesting**'.**
- **'**It gives me time to focus on the patient's problem when it is complicated and by looking at the different parts of the problem I can help the patient in a better way**'.**

- **‘**I like being the PLN in our clinic because even when the patient arrives angry they sense you are trying to help them and they leave happy**’.**
- **‘**When I first did the PLN session I did it because I felt I had to, but now I am enjoying it because I realize that I am directly making things easier for the patients. I think all nurses need to do reflective practice because the happiness comes when a patient’s problem is solved**’.**
- **‘**In our clinic we all are ready to do PLN sessions because as nurses we can assist when patients have complex problems, and sometimes it’s because they do not understand the systems we use**’.**
- **‘**PLN work is what we all should be doing as nurses**’.**

These responses were kept as field notes and used as contributions for context in designing of the vignettes as described in chapter four (4), and provided as well a contextual perspective in the data analysis when the emergent themes were identified. Other field notes arising from consequent PLN group sessions were used for contextualizing the presentation of the emergent themes in section 3.5 later in this chapter.

At the first session a week later, I discussed two (2) situations that were recurring in the first set of reflective journal data returns. These were:

(i) Patients who had missed appointments

(ii) Patients needing medication refills because they could not secure a physician appointment before their medication was finished.

The fourteen (14) PLN participants verbalized a common patient response of anger. One of the PLN participants stated that patients were sometimes ranting, while others confirmed the intensity of anger and stated that the patients were intolerant of excuses

and expressed this openly, or demanded an immediate solution. Some PLN participants stated that patients raised their voices and were anxious, particularly when told that physicians' appointments were rescheduled. Other patients were insistent on seeing the physician immediately.

We moved to focus to how the PLN participants felt by these experiences. The most common response was that they felt empathy for the patients because in some cases it was not the patients' fault. Some PLN participants stated that it was unfair to the patients because some of them had made many trips to the ACC, and still did not get it right to see their physicians. The PLN participants suggested future use of role-play to learn from one another how to handle the anger of patients.

The sessions always closed with a debriefing focus that emphasized the group contributions of communicating to the patients that the PLN understood their situations, and to inform the patient of what corrective action would be taken. It was insightful to observe the exchange of ideas and approaches between the PLN participants because the importance of empathetic responses was the dominant topic.

The two subsequent sessions were insightful as the PLN participants arrived at the sessions with the expectation to role-play their experiences. The session attendees ranged from thirteen (13) and fifteen (15), respectively, and the focus was on their interactive skills in the PLN sessions. The PLN participants used a flipchart at both sessions to write down the nursing actions identified by them from their actual patient PLN sessions. Leadership emerged in the group resulting in the listing of approaches that included active listening, rapport building, repeating instructions to check understanding, summarizing to ensure that the problem is understood, and education of patients so that they understand the system in the clinics. The PLN participants agreed that the common goal was to demonstrate to the patients that they were being

cared for by the nurses' actions. Some PLN participants agreed that it was about gaining the trust of patients that facilitated the settling of anger.

The general consensus by the end of the fourth session was that the PLN functional role gave them a depth of understanding into patients' problems, and therefore the role contributed to ensuring quality patient care in the ACC because they were able to assist patients with continuation of their care and treatment regimens.

The last session was attended by fourteen (14) PLN participants and was used to confirm the following five (5) major categories of situations that were emerged from the reflective journal data midway through the data collection period of ten (10) weeks (see appendix 14). These were:

- Category 1 – Patient situations related to actual or potential interruptions in the medication and/or treatment regimes, including medication side-effects.
- Category 2 – Patient situations related to ACC systems, support services or operational problems, patients' eligibility or faulty procedures executed by ACC staff.
- Category 3 – Patient situations related to the appointment or referral system. This included missed appointments, incorrect appointments, patients without appointments, incorrect specialist appointments, and appointments defaults (no-show patients).
- Category 4 – Patient situations related to patient-initiated consultations with the PLN, patient circumstances, patient satisfaction and customer service incidents.
- Category 5 – Incomplete or nil responses by the PLN.

There was consensus in the PLN participant group that the above five (5) categories were a representation of the patients situations experienced in the ACC – PLN sessions. This action of returning to the respondents to see whether they recognized the findings in a study to be true to their experiences was referred to us as member checking following Marshall and Rossman (2011:221), while Manning (1997:102) specifically states that it includes checking the drafts of a case study to ensure that the researcher has 'got it right'. This was an important research action because the categories and reflective journal data were targeted for use in designing vignettes, which are discussed in chapter four (4). Seale (1999:61) describes this as member validation wherein the researcher aims to ensure the findings are consistent, appropriate and adequate as a convincing account from the view of the participants.

The PLN support group sessions were concluded by mutual agreement with the understanding that a subsequent PLN support group session could be conducted if required. No further PLN support groups were requested; therefore, subsequent to the return of all reflective journals at the end of ten (10) weeks, the preparation for data analysis was commenced.

## 3.4 PROCESS OF DATA ANALYSIS

The approach selected for data analysis is by Tesch (1990:142). Tesch provides an 'organizing system' with eight (8) steps that can be used for analyzing 'unstructured qualitative data'. Miles and Huberman (1994:11) support Tesch's approach to data reduction or 'condensation' as a form of analysis that 'sharpens, sorts, focuses, discards, and organizes data' so that conclusions on themes can be 'drawn and verified'. Creswell (2003:192) endorses the Tesch (1990) approach as 'detailed

guidance for the coding process' and offers a summary of the facilitative eight (8) step process of analysis. These steps were reviewed in conjunction with Tesch's (1990) original work and adopted for use in analyzing the scripts from both reflective journals and in chapter four (4) for the vignette technique returns as follows:

1. Read the entire script to achieve a sense of the whole.
2. Re-read the script questioningly to ascertain the underlying meaning in the data segments.
3. Generate a list of topics and cluster similar topics accordingly.
4. Review the data again, use abbreviated data as codes and encode the data segments in the text.
5. Refine the analysis further by providing descriptive words for topics to emerge as identified themes.
6. Finalize the identified themes and alphabetize their corresponding codes.
7. Assemble the data according to the identified themes and perform a preliminary analysis of the actual content of each theme. Retain notes on data that are irrelevant for discarding.
8. If necessary, recode the existing data based on the results of the preliminary analysis in step 7. Review themes mindful of the research objectives for their contribution to becoming concepts as part of the research outcomes. The aim was to finalize the process of an organized system to perform analysis on the subsequent sets of data.

To undertake data analysis, three (3) colleagues with previous research experience were trained as 'data analysts' using the adopted Tesch (1990) method described above (see appendix 15). As the researcher, I explained the process and facilitated peer review after the implementation of data analysis steps on five (5) scripts each. The details of the adopted Tesch (1990) method were reconfirmed before data analysis continued. After the analysts confirmed their comfort with the data analysis process,

each team member commenced data analysis and read completely through a script to obtain a sense of the whole as part of step 1. This was undertaken without locating topics within the content of the script because the primary purpose of step 1 was to obtain a sense of the whole critical incident that was selected by the participant for reflective journaling. Thereafter, as part of step 2, the script was re-read questioningly to obtain a sense of the underlying meaning. Questions such as, 'what is the nursing action occurring here?' or 'what is the nurse hoping to achieve by this action?' The answers that were invoked by these questions were written down as comments by the data analysts. These comments were reviewed as part of step 3 to generate a list of topics that were collapsed into a cluster of topics. Tesch (1990:143) advises that the name of the clustered topic may change during step 3 according to the emerging themes and as the underlying meaning is detected. Each analyst, with justification, made these changes as they progressed.

At this point between steps 3 and 4, the four (4) analysts, including the researcher as the team leader, convened a team meeting to discuss progress made and to reaffirm that all analysts remained within the analyzing functions expected in steps 1 to 3. In addition to notes made on the scripts during these initial steps of analysis, the analysts had memorandum templates for the purpose of memoing the researcher on any comments, concern or issues outside the anticipated process of analysis to this stage.
At this team meeting of the analysts, the clustered emergent topics were reviewed and discussed with the aim of generating a comprehensive list for all analysts to use with a common set of abbreviated coding as required in step 4.

For the purpose of enhancing rigor in the process of analysis, the analysts were arranged into two (2) sub-groups of two (2) pairs for co-checking exchanged data scripts on the process of data analysis from steps 1 to 4. Color stickers were used by each analyst as they reviewed the scripts as either the primary analyst or secondary

analyst (see appendix 17). Each analyst, as a secondary analyst, used the facility to memo the researcher for raising areas that perhaps illustrated a difference in the identification of a topic and theme coding or comments were made related to the underlying meaning in the text. These citations were considered later in relation to context in the analysis and were integrated into the description of the emergent themes.

The related memoing notes were made available by the secondary analysts as the scripts were returned to the primary analysts for continuation of step 5 facilitated by the color code of the analyst (see appendix 17). The primary analyst considered the comments of the secondary analyst whereby the different perspectives were discussed and agreement was reached regarding analysis. Thereafter, each analyst reviewed the topics and notes in the margins with the aim of refining the analysis by providing descriptive words and labeled these as emergent themes. This description of themes signified the completion of step 5.

Step 6 commenced with an open discussion in a team meeting of all four (4) analysts, with the researcher as the team leader, aimed at finalizing the identified themes and alphabetizing the corresponding codes. Thereafter, step 7 was implemented by assembling the data into categories according to the identified themes and a preliminary analysis was performed.

Tesch (1990:145) provides detail for performing the preliminary analysis in step 7 to review the content of each category closely for:

a) commonalities

b) uniqueness

c) confusions and contradictions

d) missing information

In this close analysis, Tesch (1990) advises scrutinizing content in relation to the research purpose and research questions, which also is aligned to the research design that is exploratory, descriptive, contextual and interpretive. Included here is to make notes on data that are irrelevant for discarding. These were noted and included in memoing to the researcher with corresponding justification by the primary analysts.

For the final step 8, the researcher as team leader conducted a second team meeting of all analysts. The purpose was to discuss the process of the preliminary analysis of step 7. In step 8, Tesch (1990:145) advises re-coding the existing data based on the results of the analysis performed in step 7. The categorized themes and codes were reviewed questioningly mindful of the research objectives. There was a discussion by the analysts as to whether re-coding was needed. Minor changes to the coding were made related to descriptive words for labeling the themes. This was based on consensus of the team of analysts on the meanings conveyed by the choice of the words describing the themes. Tesch (1990) depicts this process of refining the data codes as a means of the categories being 'crystallized' into concepts that would be representative of the research outcomes of data analysis. The conclusion of the data analysis process in step 8 represented the end point of the development of a process of an organized system to be used as a method for data analysis of the remaining scripts (Tesch 1990:145).

The remaining scripts were analyzed using steps 1 to 8. While the generation of topics, themes and categories were not necessary repeated for each script being analyzed because the developed system was being used as the method for data analysis, nevertheless, the system itself remained under close scrutiny and was subject to interval team discussion by the analysts to ensure rigor. Furthermore, the analysts continued memoing by making comments on two (2) levels, namely on the script being

analyzed, and on the system for data analysis being used, thereby maintaining and enhancing rigor throughout the process.

Tesch (1990:145) cautions on the 'strict adherence' to a developed organizing system for data analysis and suggests flexibility in application to safeguard the 'intellectual importance' of the findings so that attention is given to the congruence between the technicality of data reduction in the process of data analysis and the actual research findings.

Richards (2009:58) advises on the timing of this aspect of data reduction and states that the 'crucial question' is not whether the data is reduced, 'but when'. The indicator given by Richards (2009) is the point when the 'complexity and context' is still contained for understanding of the text and its meaning, and that if any further data reduction is done, the meaning and understanding may be lost. Richards pinpoints this as an 'exquisite sense of timing of data reduction'.

The total data record sets received originated from n=30 registered nurses who had functioned in the PLN role over the ten (10) weeks in the sixteen (16) clinics. All of the participants had attended the information and training sessions, and had provided informed consent. The total number of data scripts was 483. A systematic process of data reduction was implemented aimed at organizing the large volume of data.

All 483 scripts of data received were analyzed and represented 30 data sets. Further convenient sampling of the purposeful sample was undertaken to ensure that the reflective journal data for analysis were improved for representatives (Corbin & Strauss 2008:154, Saldaña 2009:150) of all the steps in the critical incident and reflective journaling research methods. The following initial criteria were used to reduce the number of reflective journal scripts:

(i) exclude all reflective journal data sheets that were incomplete

(ii) exclude reflective journal data sheets where steps were left blank by the respondent

(iii) select reflective journal scripts where respondents submitted daily returns for the purpose of gaining a sense of continuity by ongoing participation.

The initial exclusion using criteria (i) above resulted in fourteen (14) sets of data, and after applying criteria (ii) and (iii) above, the final number of reflective journal data sets was eight (8), i.e. respondents who had completed all steps in the critical incident and reflective journaling process. The actual number of scripts was 240. This process of data reduction, which was adapted from Richards (2009:56), was used to decrease the quantity of scripts to narrow the choice of the type of data records using criteria which maximized the quality of the data sets and improved the access to the data as needed. The researcher reviewed all the excluded reflective journal sheets to ensure that there was an absence of unique themes and confirmed that the 240 reflective journal scripts (eight (8) sets of data) represented all the emergent themes, which also confirmed saturation of the themes (Saldaña 2009:161) as there were no new or unique themes contained on the excluded reflective journal data scripts. The intermediary CRN who had access to the personal data codes and research codes given to each script undertook the process of confirming the sets of data. Therefore, an audit trail was confirmed, representing eight (8) of the PLN participants who had most functioned in the PLN role evidenced by the completed series of submissions within the ten weeks of data collection from the sixteen (16) clinics.

The first level of the data analysis undertaken by the four (4) data analysts resulted in identifying emerging themes on all 483 scripts that constituted the initial n=30 sets of data records. Subsequent to the data reduction process, eight (8) sets of data records, i.e. 240 scripts, were reviewed again for accuracy to ensure that the interpretations

were accurate and corresponded to the first set of sixteen (16) emerging themes as shown in the arbitrary list in table 3.1 below:

**Table 3.1** Arbitrary listing of initial emerging themes

| | | | |
|---|---|---|---|
| advocating helpfulness | sensitivity to client needs | beneficial communication | patient problem-solving |
| customer-service | nurse autonomy in actions | teamwork for improvement | liaising actions |
| empathetic responses of support | focused patient education | health promotion | operational responses |
| system correction | system information-giving | patient-focused orientation | collaborative networking |

The major topic themes and emergent themes were finalized using the work of Coffey and Atkinson (1996:26) and Richards (2009:171) whereby the emerging themes were questioned and interrogated to confirm related meanings in the sets of data and codes. Linkages between themes were reconfirmed where ideas were recurrent or similar using logical reasoning. The outcome of this final process of data analysis is shown in section 3.5 that follows in this chapter. The PLN sessions conducted were a source of field notes that were valuable as were memos that follow in the discussion as to how they were used in this study.

### 3.4.1 Field notes and memoing in data analysis

Field notes were made at two contact points in the research field. First, field notes were made arising from the weekly support groups with the PLN participants. These were kept for use with the emergent themes to ensure that the best possible context was reflected (Mason 2002:165, Lewis 2003:56, Corbin & Strauss 2008:123). Second, field notes were kept from informal updating meetings held every week to two (2) weeks, as necessary, with the intermediary CRN and administrative assistant who transcribed the handwritten data to typewritten on the computer. They reported any observation or comments related to the data collection process, which were also

retained as field notes for consideration during data analysis as a means of adding contextual detail (Silverman & Marvasti 2008:216).

The memoing undertaken by the data analysts was reviewed by the researcher for accuracy and context-related considerations also in relation to the interpretation and emergent themes. Memoing consists of records arising from analysis that contribute conceptually in density, clarity and accuracy in the research analysis progress, and are considered important, 'regardless of how pressed the analysts might be for time' because it adds distinction to the interpretation and grounds the analysis in the empirical reality of the data (Corbin & Strauss 2008:124, Silverman & Marvasti 2008:198). The memos were also retained for use in contextualizing the empirical data with the emergence of the themes (Coffey & Atkinson 1996:46, Richards 2009:66, Saldaña 2009:149).

## 3.5 CRITICAL INCIDENTS TECHNIQUE AND REFLECTIVE JOURNALING: TOPIC THEMES AND EMERGENT THEMES

The emergent themes from the data analysis arising from the critical incidents and reflective journaling were interpreted within the research context of nursing practice in the Ambulatory Care Center (ACC) for the purpose of contextualizing the emergent themes as part of interpretation (Richards 2009:66). This led to re-organizing the emergent themes into a structure for explaining their contextual meaning by the use of topic themes that were assigned by me as the researcher (Richards 2009:100) based on the contextual information from the empirical data, field notes and memoing.

The three (3) topic themes included (i) nurse-centered actions, (ii) patient-centered actions, and (iii) system-related actions. The emergent themes were grouped according to the core thrust of the PLN action that was explicit in the essence of the theme as to whether it respectively encapsulated, first, the nurse executing the action related to her professional nursing skills, or second, that the action was directed uniquely towards the patient, and last, that the action was related to the system of care delivery in the ACC.

Table 3.2 below provides a synopsis of the three (3) topic themes and the nine (9) emergent themes that were derived from the critical incidents and reflective journals.

**Table 3.2** Topic themes and emergent themes from critical incidents and reflective journaling

| Topic theme | Emergent themes |
|---|---|
| Nurse-centered actions | Prompt advocacy<br>Collaborative communication<br>Supportive empathy<br>Contact liaising<br>Operational facilitation |
| Patient-centered actions | Responsive customer service<br>Tailored patient education |
| System-related actions | System orientation<br>System improvement input |

In the presentation of the topic themes and the related emergent themes (as shown in table 3.2 above) that follow, each topic theme is defined in this study and supported by the literature, then followed by the corresponding emergent themes that are described with support from empirical evidence in the reflective journals and literature. In the written presentation of the emergent themes, ellipsis (…) are frequently used to indicate omissions from the original transcriptions of the reflective journal data

segments, while it aimed to maintain the logic and original meaning of the respondents. The excerpts from the respondents' reflective journals are taken from the seven (7) step template reflective journal that was given as a template to all participants (appendix 8). Examples of reflective journal scripts are shown in appendices 18 to 21.

The reflective journal excerpts were selected specifically as empirical data evidence to support the emergent themes. In the presentation of the excerpts, parentheses with *italicized (word)* insertion(s) are used to (i) explain local abbreviations or expressions that are used by the respondents in their original data transcripts, (ii) add a word to correct grammar for purposes of clarity or understanding, or (iii) insert an obviously missed word given that for some participants, English is their second language. In all three (3) such situations, the insertions are used mindful of retaining the original meaning by the respondents. Where parentheses exist in the text without italicized *(word)* insertions, it is taken that the contents of the parentheses are taken exactly from the original text of the respondent.

Incorporated into the description of the topic and emergent themes are extracts from field notes and memoing that are interwoven into the respective descriptions aimed at enriching the contextual meaning of the themes (Coffey & Atkinson 1996:31). The discussion opens on the first topic theme on 'nurse-centered actions' and the related emergent themes of 'prompt advocacy, collaborative communication, supportive empathy, contact liaising, and operational facilitation' follow. Thereafter, conclusion statements are provided which summarize the essence of the concepts that emanated from the topic and emergent themes. This pattern of presentation will be used for the discussion on all topics and emergent themes.

### 3.5.1 Topic theme: nurse-centered actions

This topic theme of 'nurse-centered actions' that was assigned by the researcher (Richards 2009:100) was influenced by field notes that reflected the discussions in the PLN support group sessions. The PLN participants often referred to the 'actions that we as nurses take'. This topic theme therefore refers to a set of nursing actions that portray professional nursing practice that characterize the care delivery role of the nurse. Nursing actions are part of professional role preparation, which the nurse gains in his/her basic training, and therefore can be expected within the role of a registered nurse as autonomy in practice. This means that before the needs of the patients are identified, these potential nursing actions pre-exist before the registered nurse assumes the PLN role. These autonomous nursing actions are used irrespective of the specificity of the presenting unmet needs of the patients. The unmet needs of the patients revealed health related problems that could potentially interrupt treatment if left unattended in ambulatory care services. The PLN responded with her autonomy as a registered nurse from a composite range of professional nursing actions aimed at the continuity of patient care by ensuring that treatment regimens were followed, and therefore contributed to quality patient care.

Nurse-centered actions are depicted in ambulatory care nursing by the PLN setting up the nurse consultation room and, as stated in the field notes from the PLN group support sessions, the PLN participants stated that they 'get themselves ready' at the beginning of the day according to the day of the week and the type of medical specialty clinics that are scheduled. This setting up process by the PLN heralded a paradigm shift from the previous OPD (Out-Patient Department in the hospital) to the ambulatory care nursing**.** Mastal (2006:44) refers to changes in the healthcare delivery environment as triggers that lead to the scope of the registered nurse evolving and

expanding that reflect new dimensions to this role autonomy of the registered nurse. A PLN participant in the group sessions echoed this shift by qualifying the readiness when she said, 'everyday is a new day, everyday has new problems, therefore sometimes you have to be ready with new ways of doing things because the old way sometimes doesn't (does not) work.' Another PLN participant became specific and stated that for the clinics with chronic manageable conditions, they would inevitably expect 'angry patients' because they always seemed to have problems either with the sufficiency of the medication supply until the next physician appointment, or they mixed up their appointments between the Gregorian calendar used in the computerized appointment system and the Arabic Hegira calendar that is used commonly in the community.

This readiness for action that is epitomized in the topic theme of 'nurse-centered actions' is described by Chitty and Black (2011:204) who state that the nurse listens to the patient and uses a range of abilities in an autonomous manner, for instance by using the nursing process, clinical skills, genuine compassion and a broad knowledge base to deliver patient care by using specific nursing skills from his/her professional nursing education, as will be shown in the empirical data related to the emergent themes of prompt advocacy, collaborative communication, and supportive empathy. Finkelman and Kenner (2010:293) extend the scope of professional nursing skills to include patient-centered physical activities by nurses in the process of care delivery, whereby these aspects of coordination are an essential integration to facilitate the treatment regimen, for instance as will be portrayed by the emergent theme actions of contact liaising and operational facilitation in that nurses contribute to either access to care or promoted continuity of care for the patient. Blais, Hayes, Kozier and Erb (2006:218) support these nursing actions that extend to coordination with other specialized services according to the health needs of the patient, and state that nursing actions are modified by the setting in which the care is delivered, while the goal

remains quality patient care. These actions that are initiated by the PLN characterize the nature of ambulatory care nursing as a unique contextual practice setting when compared to nursing practice in the acute hospital in-patient setting. In the latter context, the registered nurse is dependent mainly on the physician treatment plan and fits nursing practice into the pre-determined routine of the unit, including regular physician treatment rounds. In the former setting of ambulatory care, the PLN functions independently in response to patient needs using self-initiated coordination of care within a health environment of interprofessional relationships (Hammick, Freeth, Copperman & Goodsman 2009:38, Garman 2010:43). Moreover, PLN exposure to the patient in ambulatory care constitutes a brief episodic visit of less than an hour, which usually demands precision and accuracy in the absence of physicians. The team of an acute in-patient unit usually has the patient for eight (8) to twelve (12) hours of continuous exposure in addition to regular availability of physicians and other members of the health team.

The PLN function in ambulatory care is therefore unique as was revealed by the nurse-centered actions because the outcome of PLN action is aimed at gaining quality patient care either by facilitating access to care or by ensuring continuity of care. In the context of an acute in-patient care setting, the same set of nursing actions may be used as part of therapeutic care but not necessarily with the focused outcome intended by the PLN.

Emergent themes that characterized these ‘nurse-centered actions’ within the PLN role emerged from empirical data, and are described as prompt advocacy, collaborative communication, supportive empathy, contact liaising, and operational facilitation, which will be illustrated with reflective journaling excerpts that portray evidence of these actions. The selected data segments from the reflective journaling of the participants

illustrate the range of these nurse-centered actions from the lived experience of the PLN within the functional RN role in the ambulatory care context.

#### 3.5.1.1 Emergent theme: prompt advocacy

The first nurse-centered emergent theme of 'prompt advocacy' refers to autonomous nursing actions taken in response to a rapid assessment of the most pressing care need by the PLN on behalf of the patient to facilitate access to care. The prompt advocacy responses by the PLN were useful to patients as the volume of attendees increased rapidly, and therefore the input by the PLN on behalf of the patients ensured attention to priority needs from rapid assessment, so that continuity of treatment was ensured to prevent default in the care of patients. The reflective journal excerpt that follows illustrates the rapid assessment by the PLN and the swiftness of nurse-centered action to advocate promptly on the patient's behalf to ensure that the patient left with sufficient medication until the follow-up appointment in three (3) months time:

> *'patient claims that medication prescribed … is not enough to last for three months and beside she is living outside (the city) of Riyadh … coordinate with patient, doctor and pharmacy so that patient will be given enough medication … patient should be given right doses to (so) that her condition will improve … remind doctors to prescribe medication enough for patient's next appointment (RJ 031).*

Bateman (2000:6) and Sheldon (2009:164) regard the advocacy role as arguing positively on behalf of another and by pleading for the best possible case by presenting the facts in the most effective manner. This impression of the PLN role was expressed in a memo from an analyst who noted being 'amazed at the extent of nursing input' to

take up issues promptly on behalf of the patients to ensure quality patient care. This emergent theme of prompt advocacy in ambulatory care is evidenced by the extent of PLNs accessing other healthcare professionals or services on behalf of the patient without delay. In most instances where this theme emerged, it was evident that the patients could not access the healthcare provider directly, and therefore by the advocacy action of the PLN either to facilitate access to care or ensure the continuity of care, quality patient care was gained by the patient. This aspect of PLN advocacy action in the ambulatory care context underscores the uniqueness of the PLN role when compared with in-patient nursing practice, because the physician and other healthcare providers undertake regular rounds that are an established means of access to care and the nature of in-patient admission is continuity of care.

Davis, Konishi and Tashiro (2003:404) assert that advocacy is a core professional value that it is central to nursing based on nurses knowing the 'patients better and in a different, more intimate way than other health professionals'. They expand on this, which illustrates the specific nature of advocacy by stating that patients and their families are in 'vulnerable positions within the healthcare power structure' and need nurses to speak on their behalf when they cannot speak for themselves or 'when others do not hear their voice so that continuity of care is provided'. This nature of advocacy is portrayed by the PLN in the examples that follow where a father is assisted promptly with his son to the extent of accessing medical care from another physician to ensure continuity of treatment:

> *'father complain(t)s patient don't have medication … he is on continuous intermittent catheterization 3 – 4 x a day … frustration because the MD (medical doctor) responsible for the pt (patient) has no clinic … pt will not receive his right dose and will jeopardize his condition … doctor's can't be contacted easily coz (because), his OR (operating room) schedule today … ask other physician*

*if he can help me and prescribe medication for the patient … explained to patient … not to miss the appt (appointment) so that this problem will not occur again (RJ 190)*

To accomplish prompt advocacy actions in ambulatory care, a PLN participant stated in a support group session that contact was sometimes initiated with many healthcare professionals to have a single patient need attended, and that it was not uncommon that, on behalf of a single patient, contact was made with the physician, clinical pharmacist, or social worker to ensure continuity of care. The PLN participant elaborated that, especially with chronically ill patients, perhaps their most pressing needs were not taken seriously. To this, another PLN participant in the group session stated that sometimes it felt as if 'we functioned as a second brain for the doctors' so that the patients' needs were anticipated in order to avoid interruption of treatment. On the contrary, in the exemplar that follows, the PLN uses advocacy promptly to explore the possibility of the patient to be seen, despite the apparent demanding approach of the patient without an appointment:

*'patient walk-in to the clinic demanding … female doctor on triaging the patient problem is non-urgent … she thinks (the patient) that she will be seen if she just walk-in … I guess it will also educate the patient on the clinic protocol in booking patients … discuss with MD (medical doctor) problem of the patient and ask opinion of the doctor – if she will accept non-urgent walk-in (patient) in slot as over booking' (RJ 253)*

However, this emergent theme of prompt advocacy did not operate in isolation as a nurse-centered action within the ambulatory care system, and therefore the next emergent theme of 'collaborative communication' continued this portrayal of nursing actions as a means of gaining quality patient care.

#### 3.5.1.2 Emergent theme: collaborative communication

'Collaborative communication' as an emergent theme is distinguished from the emergent theme of 'prompt advocacy', in that the PLN moves beyond taking up an issue on the behalf of a patient. In collaborative communication, the PLN uses the contact in established interprofessional relationships where mutual respect exists based on a sense of working together cooperatively for the best interest of the patient (Muller 2002:225). Blais and Hayes (2011:218) distinguish that in collaborating, mutual respect denotes a sense of honor for each other's role, while trust in collaborating evolves as confidence in the actions of other health professionals. The trust element in collaborating is achieved over time when working mutually within situations, which provide many opportunities for persons to develop informed judgments about the abilities of one another (Blais & Hayes 2011:218). Metaphorically, trust is akin to a lubricant that facilitates people working together in an efficient and effective manner.

In the context of ambulatory care, the nature of inter-professional relationships is dynamic, characterized by changeability. Two factors that contribute to this are the rotational patterns of physicians and health team members in a teaching hospital and the daily changes within the weekly specialist clinics. In reality, a physician that only has a specialist clinic once or twice a week for a half-day is not necessarily exposed to the PLN at the same frequency and intensity as the RN on an in-patient unit where physician contact could be once or twice a day.

In collaborative communication in the context of ambulatory care, therefore, mutual respect is a foundational attribute with trust on a continuum dependent on the period of the relationship and the level of mutual confidence in professional abilities.

Arnold and Boggs (2003:549) nevertheless regard 'new relationships' in the 'work setting' as 'collaborative in nature' due to the interactive process whereby through communication the various new team members cooperate for the purpose of sharing responsibility to deliver 'holistic, safe, effective, and compassionate care for the clients.' Arnold and Boggs (2011:548) expand their perspective on communication in professional nursing by stating that the ability of the nurse to collaborate in this manner within new relationships originates in the professional nursing education process. A participant in the PLN support groups emphasized this emergent theme when asked about the success factors for the PLN role in ambulatory care. The response was, from ambulatory care experience in the new ACC with physicians and other team members, it was about 'communicate, communicate, communicate, because eventually they will listen!' The emergent theme of 'collaborative communication' is illustrated in the journal excerpt below whereby despite one physician refusing to collaborate to see a patient, the PLN does not give up and continues her focused communication with another physician who accepts the PLN's communication in the best interest of the patient, and collaborates to see the patient:

> *'Pt (patient) and her son came asking to be seen … pt is old lady on wheelchair … (a) case booked wrong to … clinic … unfair for the pt. to be rebooked as it is not her mistake … Pt should be seen. I should speak to her Dr. (doctor) to see her as (an) exception … I deal(t) with the problem quickly, I didn't let the pt wait at all … her consultant refuse(d) to see her … I asked another Dr … he accepted' (RJ 293)*

This determination by the PLN in communicating to elicit collaborative responses is seen as a nurse-centered action and unique to ambulatory care as a vital contribution of the PLN role by ensuring that treatment of a patient is not disrupted. The PLN's determination was driven by her brief yet critical time exposure to the patient, because

a missed opportunity of a two-minute PLN intervention may result in health complications from treatment interruption. Arnold and Boggs (2003:553) make the link between communication by the nurse who conveys to 'the other party involved' that the goal or reason for initiating contact is based on the 'goal of maximizing' the client's well-being, and therefore gaining quality patient care.

The same PLN respondent who previously emphasized 'communicate, communicate, communicate' in the PLN support group session went to say that once the physicians understand the information received and realize that the PLN is insistent for the sake of a patients, then they usually respond. The exemplar given below epitomizes this nurse-centered emergent theme of collaborative communication as the PLN vividly illustrates mutual respect in the best interest of the patient by the phrase 'effective transmission of information by the nurse (PLN) to the physician and vice versa in the management and care of the patient that is contained in the following journal extract:

> *'A follow-up patient who is leaving (living) outside Riyadh, came to the clinic very early (08H00) for his appointment … physician has no clinic … patient upset and uncontented (discontent) … I felt that immediate and proper action (had to be taken) to solve the existing problem… at the same time we are helping the patient … recover from … emotional reaction through effective communication, we could manage the incident … so that Doctor would find (a) way to help the pt … Effective transmission of information by the nurse to the physician and vice versa in the management and care of the pt (patient) is achieved through good communication' (RJ 313)*

Arnold and Boggs (2011:83) point out that nurses see patients at their most needy level in healthcare situations, and Bateman (2000:114) states that there is, in a sense, a negotiation component in the communication that is not concerned with finding a

compromise, but rather at 'obtaining the best possible result for the client'. This notion of action by the nurse of not settling for a compromise entrenches the contribution of the PLN to quality patient care in ambulatory care because deferring the patient for another day is not usually an option. This persistence is illustrated in the evidence below where the PLN initiated communication with her peer PLN and used 'collaborative communication' aimed at ultimately obtaining a positive response from the physician so that the patient could be seen. The physician response can be taken to occur due to mutual respect because he perhaps did not know the competencies and abilities of the PLN from another clinic, but as a result of effective communication about the patient's case situation, a collaborative physician response followed:

> *'New pt. (patient) … found out that she has been booked wrongly. Discussed the matter to (with) the patient and I assure her that I'll do all my effort to help her. I phoned my colleague – PLN of another unit and presented the case of the patient. (She) Discussed with the relevant doctor and eventually accepted the patient to be seen in his clinic … Patient went home happily and satisfied' (RJ 376)*

One of the analysts summed up this emergent theme of 'collaborative communication' in a memo by commenting that the 'doctors were having a hard time' with the new PLN role because their 'communication had an insistence to it until results for the patients were obtained'. This drive that underpins PLN communication to gain collaborative cooperation from the physicians was illuminated in a PLN group session. A PLN participant, while gesticulating with open hands, asked a rhetorical question and said, "How can I go back to the patient and say '*mafee* doctor, *mafee* treatment'?" *('Mafee' is a common colloquial Arabic expression that has a meaning of negation, and is widely used in Saudi Arabia).*

In some ambulatory care situations, nurse-centered actions involve communication with the patient in a specific manner to demonstrate that the patient's need is understood. It is this element of understanding in the communication that distinguished the next emergent theme of 'supportive empathy' as part of nurse-centered actions.

#### 3.5.1.3 Emergent theme: supportive empathy

'Supportive empathy' as an emergent theme refers to PLN responses that display sensitivity and understanding of the healthcare situation of the patient. Arnold and Boggs (2011:106) emphasize that nurses need to have empathic skills to convey a sense of validation for the feelings of the patient about their healthcare situation, and expanded further that a lack of empathy in nursing responses could lead to failure in understanding the needs of the patients, and consequently may lead to failure in providing quality patient care. In ambulatory care nursing where patients encounter new procedures or systems compared to their previous visit, which may have been three to six (3 – 6) months earlier, or encounter delays in care delivery, the emergent theme of 'supportive empathy' was an essential PLN response to convey a reassuring approach to patients who may become frustrated at gaining access to healthcare. The journal extract below depicts how the PLN used supportive empathy related to an unavailable medical record:

> *'Old chart not available … for procedure … temporary chart available… procedure cannot be started … I feel that the patient will be upset and anxious of (for) the delay of his procedure and it may add more to his anxiety … Explain and reassure the patient to alleviate his discomfort and worries … inconvenience … he is experiencing' (RJ 024)*

In the ambulatory care context, the immediate solution perhaps to a frustrating patient situation may not be apparent instantly; however, by the use of nurse-centered action, in this instance, 'supportive empathy', the patient would retain a sense of hope that access to care remained possible. This theme of supportive empathy emerged boldly in the last PLN support group session when I asked how the PLN participants cope with their own sense of frustrations or perceptions of service inadequacies that arise while in their PLN roles. A chorused response from some of the PLN participants was '*Insha'Allah*, it will improve!' In Saudi Arabia, it is common to respond with the Arabic word '*Insha'Allah*' to any matter for hope in the future. Literally translated, it means *'if God wills it so'*. Some PLN participants qualified this by explaining that when one lets a patient know that you understand their situation, and that you are trying to assist them or make a difference, then 'they still see this as caring'. This caring value was conveyed by the PLN in supportive empathetic responses that are depicted in the exemplar that follows:

> *Patient had seizure while waiting ... paged the doctor but he can't come … page(d) another doctor but no reply and no one (doctors) in the clinic at this time … so frustrating … can't give medication … except comforting the family and give emotional support, and closely watched the patient … parents anxiousness will be lessened … (by) supportive care … transport them to ER (Emergency Room) (RJ 104)*

Arnold and Boggs (2003:161) qualify the supportive dimensions of empathic responses to include 'offering of time and attention, showing interest' in the patient's issues, while End-of-Life (2007:19) vividly characterizes the supportive element of empathetic responses by stating that it 'lets the patient voice his concerns and needs. Lets him or her feel heard… shows that the nurse is concerned about the patient and not only about finishing a task'. Hood and Leddy (2003:473) encapsulate these supportive

perspectives in summarizing that empathetic responses by nurses communicate helpfulness, respect and genuineness for the situation of the patient. An analyst wrote in a memo to the researcher that a sense of protecting patients' rights came through in the PLN responses when they used empathy to support the patients in various situations, despite not being able to resolve a situation instantly. The data segment below depicted the supportive extent to which the PLN valued empathy in that annoyance is expressed at overbooking and how it affected the patients, and immediately discloses the empathetic intention to convey support to the patient in the situation, including the genuineness in the phrase, *'don't forget them'*:

> *'Three patient(s) given same appointment … today with the same time … I feel mad with this situation because it deprive(s) each patient of their precious time to be examine(d) thoroughly because clinic is overbook(ed) … adding to their anxiety (and an) upsetting (with a) situation prolong(ed) waiting period … (I) Communicate to patient everytime and (am) letting them know that we don't forget them and that clinic is really busy.' (RJ 283)*

Adding to the range of emergent themes that are grouped as nurse-centered actions is the next emergent theme 'of contact liaising' which is manifested as a combination of the emergent themes of 'collaborative communication' and 'prompt advocacy' in a sense, but where a resourceful network is accessed outside the regular internal communication structure of ambulatory care.

#### 3.5.1.4 Emergent theme: contact liaising

The emergent theme of 'contact liaising' refers to action taken by the PLN to develop and maintain a resourceful network outside the immediate ambulatory care delivery

system. This network is beyond the established communication structure, and serves as a external resource for the PLN in ambulatory care. The Oxford Dictionary (2007:209, 597) defines 'contact' as 'the state of communicating or meeting … a relationship or communication established with someone', and 'liaise' as 'cooperate on a matter of shared concern.' Contact liaising as an emergent theme was therefore taken to be the PLN action of establishing a relationship with an external department for the purpose of cooperation on shared concerns arising from patients' needs in ambulatory care. This contact liaising action was triggered by the PLN in response to an identified need with an external department or service based on recognition by the PLN that, for purposes of access to care or continuity of care, contact with the external department would resolve the patient's health need. This action is triggered by an identified need within the ambulatory care context when the PLN realizes that, for purposes of access to care or continuity of care, contact needs to be initiated outside the scope of the ACC clinic boundaries. Liaising as a modified form of 'liaise' in Collins Dictionary (2006:686) is 'to maintain contact … between groups and units'. My field notes had an entry from an exchange that the clinical educator intermediary had with some PLNs reportedly during reflective journal data collection. He said that some of the PLNs had commented that part of their PLN role was to bring healthcare to the patients in the Ambulatory Care Center instead of sending them 'all over the hospital to get it!' The journal evidence that follows portrayed this emergent theme of 'contact liaising' by the prompt PLN access with an external department, and therefore managed a situation to gain quality patient care by minimizing the delay for the patient:

> *'The referring doctor did not specify properly in the referral … field of specialty … contacted the concerned dept. (department) … necessary arrangement has been done … explaining to the patients … delay and interruption avoided' (RJ 291)*

Schulz and Johnson (1990:111) associates ‘contact’ to the liaising role in healthcare management through interpersonal relationships with people ‘outside of an immediate area of work’ where a ‘network of high-status contacts’ has been established in which ‘information and favors are traded for mutual benefit’ of the patient. In a PLN support group session, a participant produced a pocket notebook and fanned through the pages while stating, ‘in this book are all my special contacts in the different departments’, and proceeded to tell the other PLNs that initially one gets to know the person in the other department, then one offers helpful assistance at anytime from ambulatory care, and lastly ensures that one extracted their precise contact details before ending the call. This contact liaising action by a PLN is described graphically in the following excerpt:

> *New pt. (patient) … found out that she has been booked wrongly … I phoned my colleague … of another unit … Discussed … eventually accepted the patient … Teamwork among colleagues really plays an important role in providing service’ (RJ 376)*

Sullivan and Decker (2009:57) portray liaising from the classical work by Mintzberg (1973) as ‘expanding … information sources and networks outside the organization’ that are of value as contacts when working efficiently to gain quality patient care. In using interpersonal networks in liaison, Daft (2010:18) conveys that having contact links outside the organization’s immediate internal structure, for instance by telephone, sustains information resources. In the two above extracts of journal evidence (RJ 291, RJ 376), the PLNs illustrated the value of liaising with contacts with external departments aimed at ensuring access to care so that patients are not turned away. In both situations, the patients could have been requested to return at a future date while the arrangements in the referral system were resolved. In both exemplars, the

successful liaison of the PLN portrayed the value of contact liaising in the episodic nature of ambulatory care nursing.

Although there was no evidence of the preceding emergent theme of supportive empathy by the PLN in the extract below, towards the fourteen (14) patients who were potentially affected, the PLN used her contact liaising action instead to reach the supervisor of medical records directly to prevent unnecessary delays for the patients. The usual procedure would have been to complete an internal official reconciliation form for the missing files, then enter all the medical records numbers and send it through the internal mail system. In this way, through contact liaising, there was a greater chance that the problem would be addressed speedily, and most importantly, that the ambulatory care outcome would be aimed at access or continuity of care, and ultimately at quality patient care.

> *'14 files were noted missing … Patients were upset and unhappy. Immediately, I paged the M.R. (Medical Records) supervisor to discuss the matter … Unnecessary waste of time and delay in work system … every effort should me (presumed error – possibly intended as 'be' instead of 'me') made to retrieve their files and have it available' (RJ 417)*

In the context of ambulatory care, sometimes nurse-centered actions need to coordinate with operational support departments that play a role in the daily facilitation of access to care or continuity of care. The emergent theme of 'operational facilitation' that follows shows the extent of PLN action with operational support departments to gain quality care for patients in ambulatory care.

### 3.5.1.5 Emergent theme: operational facilitation

'Operational facilitation' as an emergent theme portrayed nurse-centered action in the ability of a Patient Liaison Nurse to expedite care delivery when an operational support problem in ambulatory care was identified. This description of the emergent theme is somewhat affable, whereas one of the PLN participants disclosed disdainfully in a PLN group session that 'I drive them mad at the registration desk, and I will continue until they get it right!' The fellow PLNs understood this sentiment, but immediately suggested that the approach of the colleague be modified, as all PLN participants emphasized consistently that working in harmony with the operational support departments were an essential part of the success of the PLN in ambulatory care. This situation is addressed by Sullivan and Decker (2009:113) who indicate the need for operational input by nursing to raise awareness of the deficiencies between the realities of the presenting patient situation versus what the desired expectations should be in healthcare delivery. Rossi (2003:74) embraces the importance of operational facilitation in healthcare management by outlining related support responsibilities to include the adequacy of health information systems, patient registration services, account enquiries, eligibility for benefits within a system, policy notification to patients and avenues for formal complaints. She separated out these services in a healthcare system from those provided by healthcare professionals, and emphasized nursing's input to operational support as essential so that the respective departments could 'ensure smooth operation' in the delivery of healthcare. In the exemplar below, the PLN identified the need of a private paying patient for attention by the Business Center Administration regarding operational support, and swiftly took action as operational facilitation, which is illustrated in the evidence excerpt below:

*'Pay patient … for Business Center (private paying patient) … wants to be seen immediately in spite of explaining … that doctor is still engaged with the booked appt (regular appointment) patients and there's no available room … to perform the procedure … Pt was unhappy and claimed that he should be first since he is a pay pt (private paying patient) … booked appointment cases are being interrupted which causes them likewise to complain … discuss with the Business Center … immediately to take the necessary step to help the patient.' (RJ 450)*

In their approach to operational facilitation, Slack, Chambers and Johnston (2001:39) state that an organization should regard it as the implementation of a business strategy by supporting it, and driving it aimed at customer satisfaction. They note that factors in the global, social, political, and business environment are to be considered in operational support so that output is harmonized for the benefit of consumers. In turn, they place an emphasis on feedback from the end-users within a system, which in the context of ambulatory care are patients, nurses and other healthcare professionals. Feedback is regarded as central to improvement by way of expanding the capabilities of operational systems so that customer service is assured (Slack, Chambers & Johnston 2001:65), which in the ambulatory care context is continuity of care. It is this regard, the PLN in the ambulatory care role identifies the need for operational facilitation as a feedback mechanism on the impact of patient care, which detracts from quality patient care. In the illustration below related to medical imaging, the PLN pinpoints the level of operational support that is needed to ensure quality patient care:

*'Patient had his Radiological studies done last month … came ... for follow-up, … films were not available. Every effort … to retrieve his films but to not avail … to re-schedule him again next week. Patient was upset and unhappy about the situation … Unavailability of x-ray films creates unnecessary delay … we*

*don't have a proper system in tracking / filing such films … problem must be sorted out … In this way unnecessary delay … could be avoided ... (and) x-ray reports … needed by the doctor is available before patients' consultation.' (RJ 390)*

Fitzsimmons and Fitzsimmons (2004:429) add a service management component to operational facilitation and include an inventory of 'waiting lines', 'queues' and delivery of services 'just-in-time'. They raise the importance of facilitating operational support to move customer culture towards appreciating the value of an appointment system rather than a 'walk-in' approach. In the ambulatory care context in Saudi Arabia, the use of an appointment management system in the context of growing customer needs and the use of two calendar systems are considered essential. In the data evidence below, the PLN displays knowledge of a key problem between the Islamic Hegira calendar and the Gregorian calendar, and expressed the need for operational support to facilitate confirmation of appointments with patients aimed at patients as the end-users of the appointment system, gaining maximum benefit from ambulatory care services. In the journal data evidence, the PLN offered a suggestion on handling the patient issue as a contribution to operational facilitation, while ensuring that the patient still had immediate access to care:

*Missed appointment … came for follow-up … wasn't able to be seen by his treating doctor since the date and day in the (Islamic) Hegira calendar doesn't (does not) correlate with the Gregorian calendar … would have been better for the appointment desk to double check the date / day of appointment printed in the slip before handing over to the patient … so as to avoid conflict … Re-scheduling the patient the soonest possible time is the best way to help and comfort the patient … could … also … go to the ER … To sort out immediately and do every effort to help the pt. (patient)' (RJ 369)*

The PLN gave end-user feedback to various operational support departments aimed at overcoming or minimizing the obstacles that prevent patient access to care or continuity of care.

The combined impact therefore of nurse-centered actions by the PLN contributed either singularly or collectively to ensuring quality patient care. The summary of the conclusion statements on the topic theme of nurse-centered actions and the related emergent themes now follow.

#### 3.5.1.6 Conclusion statements on the topic theme: nurse-centered actions and the related emergent themes

- Nurse-centered actions of the PLN in ambulatory care nursing characterize the autonomy of the registered nurse in care responses to the needs of the patient so that access to care and/or continuity of care are achieved.
- The PLN undertakes rapid assessment and responds autonomously in ambulatory nursing by using prompt care advocacy on behalf of the patient to gain access to care for the most pressing healthcare need and to ensure continuity of care.
- The PLN engages autonomously in collaborative communication with team members in ambulatory care based on mutual respect in the best interest of the patient aimed at gaining professional cooperation ultimately to ensure quality patient care.
- The PLN displays supportive empathy towards the patient's situation in ambulatory care though nursing actions that demonstrate understanding, respect, helpfulness and genuineness so that patients appreciate that their expectations on continuity of care are respected.

- Contact liaising depicts autonomy in the ambulatory care nursing action of the PLN by establishing a resource network outside the immediate department to access cooperation for continuity of care in meeting the needs of the patient to ensure quality care.
- Autonomy of input to operational support departments by the PLN portrays by operational facilitation in ambulatory care through end-user feedback that aims at gaining maximum benefits for patients from the care delivery system so that quality patient care is the potential outcome.

While the first topic theme related to nurse-centered actions demonstrated PLN efforts to ensure quality patient care in the ambulatory care setting, there are 'patient-centered actions' that are regarded as the second topic theme and related emergent themes. In these themes, the PLN participated with an individual focus on the patient so that access to care and continuity of care was assured, and therefore further embraced the goal of quality patient care.

### 3.5.2 Topic theme: patient-centered actions

The topic theme of 'patient-centered action' embraces PLN actions that focus on the individual satisfaction level of the individual patients in response to their unique and specific needs. Zalon (2007:437) focuses on patient-centered action by nurses through the lens of the nurse-consumer relationship using the healthcare provider-consumer economic-based dynamic. She purports that patient-centered nursing actions should embrace a consumer focus whereby the nurse's response has a service orientation to the needs of the patient as a consumer. She characterizes the service orientation that drives patient-centered action to consist of a customer-friendly approach that responds to the patient comprehensively within his family and/or community setting. This

comprehensive nursing response regards the patient as a "whole," and therefore the nurse, the PLN in this study, mobilizes nursing care and other appropriate healthcare services to deliver unique patient-centered care that is satisfying and meaningful to the individual patients. The outcome of patient-centered actions by the nurse is an individual patient that has experienced care and respect for their health needs. In gaining this patient outcome, Zalon (2007:441) puts forward that the 'ultimate success' of nursing action is achieved, namely quality patient care. She considers this ultimate patient gain to be the essence of care by nursing. Furthermore, she identifies that critical thinking and decision-making by the nurse to take the appropriate patient-centered action in a timely manner is part of both the therapeutic process of care and patient satisfaction. In summary, she outlines seven (7) primary dimensions of patient-centered care from Gerteis, Edgman-Levitan, Daley and Delbano (2002) who have done extensive research on evaluative care from a patient's perspective. The dimensions are:

1. Respect for patient's values, preferences, and expressed needs.
2. Coordination and integration of care.
3. Information, communication, and education.
4. Physical comfort.
5. Emotional support and alleviation of fear and anxiety.
6. Involvement of family and friends.
7. Transition and continuity.

In the ambulatory care context of the PLN, there were two (2) emergent themes that reflected patient-centered actions by focusing on the individuality of patient needs, namely, 'responsive customer service' and 'tailored patient education." A discussion in the weekly PLN group sessions confirmed this patient-centered focus. The PLN members conveyed a sense of 'depersonalization' as one PLN participant explained, and stated that the patients had experienced this due to the large facility expansion and

the corresponding new ambulatory care services. Members in the group session concurred and stated that patients appreciated the individual attention afforded by the PLN sessions. The PLN participants identified the key action of the PLN that characterized patient-centered actions in ambulatory care as minimizing multiple referrals of patients to different departments to meet their related identified needs. An open discussion in the PLN support group revealed that their efforts were focused on an integrative and efficient use of services aimed at satisfying unique, individual patient health needs, and therefore contributed to quality patient care. The following discussions on the two (2) related emergent themes of 'responsive customer service' and 'tailored patient education' illustrates this focus on patient-centered actions.

#### 3.5.2.1 Emergent theme: responsive customer service

'Responsive customer service' as an emergent theme that illustrates patient-centered action is portrayed in PLN actions that go beyond general clinical ability to focus on the individuality of a specific patient need. Baird (2000:30) qualifies healthcare responsiveness in customer service as the consistent willingness to meet the needs of patients on a personal level with respect and dignity for the uniqueness of their presenting healthcare situation. Fitzsimmons and Fitzsimmons (2004:107) point out that the emphasis of customer service is on enthusiasm in personalized care delivery, active evidence of efforts being made to satisfy the customer in a manner that is 'courteous and competent', and where positive work attitudes are observable by the customer through 'superior service' in executing practices and procedures, improved productivity and more person-focused services. Hersey, Blanchard and Johnson (2001:366) state that serving the customer 'boils down to consistent, conscientious dedication to customer needs' and provide descriptions of 'serving characteristics' to include listening to the perspective of the customer, clear identification of patient

needs, and responsiveness in a timely manner. Peters (1999:36) qualifies the last serving characteristic as an 'obsession with responsiveness to customers'. In her perspective of responsiveness, Baird (2000:33) incorporated being able to handle confrontation and conflict with the customer and yet remaining consistent and responsive, irrespective of the presenting situation, and still introduce oneself to the patient and provide clear information about the process of care. Barwise (1999:437) summarized this as focused effort that creates a sense of unique value for the customer.

The portrayal of responsiveness to customer service by Zalon (2007:442) is extended to the service recovery element of healthcare quality improvement that was derived from Bendall-Lyon and Powers (2001). Service recovery is a component in customer complaint management that focuses on indentifying individual complaints and rectifying deviations or failures to retain or "recover" dissatisfied consumers. The six (6) steps in effective service recovery given by Zalon (2007:443) are modified as follows for alignment to responsive customer service by the PLN as follows:

1. Be receptive to complaints and embrace them as opportunities to provide individualized improvement to care responses.
2. Utilize various services for a coordinated response to address complaints.
3. Resolve consumer issues promptly and effectively.
4. Monitor trends that arise and refer these to management for further action.
5. Identify recurring features of failure in the system and report these as an end-user.
6. Use documented information to monitor improvement in services.

In using service recovery in customer service individual patients, Zalon (2007) recommends that the response consist of an apology and details of the efforts being made to rectify or adjust the service.

‘Responsive customer service’ as an emergent theme is depicted in the journal evidence below showing how the PLN made focused and responsive efforts to go beyond obstacles in care delivery and a staffing situation in the clinic to serve the patient, and ensured that the patient received medication for continuation of treatment.

> *‘Medication refill … Patient husband … with an old prescription … pharmacy refuse to give him the medicine. The patient thought as long (as) she has some (of her) medicine (at) home (she) should use it (all) first and then to get the new prescription (with added new medication) … her app (appointment) (is) still 3/52 (in three weeks) time … it is good that pt (husband) follow us (meant to be ‘followed-up’) earlier (and) not wait until her app. As we are short of staff in the clinic the float out (should be ‘float-in’) nurses should be oriented ... to direct pt (patient) properly to get their prescription in (on) the same day … should be oriented (to) pt properly ... Nothing more (as long) as pt get(s) her new prescription at (on) the same day and went home.’ (RJ 093)*

In the evidence from a journal that follows, while it may not illustrate a specific care-related action, but it portrays the patient-centered regard of the PLN, notwithstanding that the patient may have misunderstood or been uneducated on the care delivery process. Despite the discontented reaction of the patient, the PLN demonstrated a readiness to be responsive in customer service as shown below:

> *‘blood test (on) same day of his appt (appointment). that’s why the result had been delayed. Patient is screaming and very demanding, he wants to be seen by the doctor even without blood test result … result finished after 2 ½ hours but the patient was still angry … to lessen pt’s. anger … because … the best way to comfort the pt (patient). is to keep on talking to them … patience comes (first) on this situation as it will help in … quickest time possible. Patience*

*involves … understanding on patient's point of view … patient's berserk action could be calmed down by nurse through effective communication, patience, and listening to the patient's problem … to apply all the necessary techniques in responding pt's (patient's). problem' (RJ 143)*

In the next extract from a journal, the PLN reveals how she processes her mental thoughts in responsiveness to a patient situation to achieve patient satisfaction so that the outcome of service rendered contributed to quality patient care. This extract portrays the essence of responsive customer service evidenced by meeting the unique health need of the patient in this scenario:

*'advised by the doctor (to) have therapeutic phlebotomy today but the file is missing. The procedure couldn't be performed without the file. The patient was observed to be unsatisfied for what is happening … an immediate response … involves the ability of the nurse to trace successfully where is the file … good communication … to the pt (patient) … to be relaxed and feel that they are being helped as a special person … pt. feel … satisfied on the services given for their existing problem is the positive aspect … (of) nurses … effort to lessen pt's sadness, anger, and unsatisfaction … a nurse must (act) by way of listening to their complaints and feelings and to be followed by reassurance … focus on … the pt … have full concentration to (on) the problem to create appropriate response in a very professional way.' (RJ 447)*

In the second emergent theme, the nursing actions remain patient-centered but converge on educating the patient within their individual self-care context in relation to their health issues. By so doing, the PLN ensures either access to care or continuity of care, and therefore quality patient care is gained.

### 3.5.2.2 Emergent theme: tailored patient education

The emergent theme of 'tailored patient education' refers to patient-centered actions by the PLN that facilitate or influence patient learning in relation to their individual health situation. 'Tailored' is used explicitly to modify the regular activity of programmed patient education. The Oxford Dictionary and Thesaurus (2007:1052) defines the present tense of the verb 'tailor' as 'make … to fit individual customers, … make or adapt for a particular purpose or person', and provides the synonyms 'customize, adapt, modify, attune, and shape'. McMurray (2003:25, 172) maintains that the outcome of patient education is tailored for self-care actions by the patient to preserve or improve their health status and insists that patient self-care is targeted at gaining or improving individual health by adherence to medication regimes, regular and proper use of healthcare services and improved lifestyle behaviors, which amplifies the role of the PLN in tailoring health education in response to unique and individual patient needs.

Taken from a health consumer perspective, Zalon (2007:448) affirms that this is a patient right because tailored patient education empowers the consumer to exercise self-determination. She further states that patients have either health concerns or health needs that are unique to individual situations and preferences, and therefore health information is modified to fit the particular situation of the patient. Furthermore, she expands the usefulness of tailored patient education to positioning the patient best within their living circumstances for decision-making in different healthcare situations aimed at self-care. In this regard, Zalon (2007:438) supports her perspective with the Institute of Medicine and the input by Nielson-Bohlman, Panzer and Kindig (2004), who attest to health literacy whereby health consumers rely on information to make decisions about their health. However, they argue that health literacy extends beyond

the traditional literacy of reading and writing, and contend that an individual consumer's health literacy stems from the convergence of patient expectations, preferences, level of self-care skills, availability of related health services and considerations of the individual's social and cultural context. The outcome of tailoring patient education to the unique health needs of the individual makes a direct contribution to patient adherence and self-care, and therefore continuity of care.

The two (2) excerpts of reflexive journal evidence given below are instances related to patient education on medication use and storage where the necessity for a tailored focus is identified by the PLN to take the patients beyond a general approach:

> *'Medication inquiry about heparin self injection … Patient was seen here … but nobody instructed her … she was lost doesn't know what to do … educated about heparin self injection as our routine' (RJ 061)*

> *'prescription of heparin + aspirin for his wife … they forget all the vials of heparin in the car in the hot weather … spoiled because of heat … take care and pay attention to their medicine and put immediately in the fridge' (RJ 153)*

In another excerpt of reflective journal evidence, the PLN raised appointment issues that required a tailored patient education aimed at self-care by focusing on the consequences of missed appointments. While the approach contains the elements of emphasizing compliance with appointments, the PLN portrays the individual focus by educating the patient on possible outcomes if treatment adherence is neglected. In this manner, quality patient care for this specific patient in their daily living is illustrated specifically as a potential outcome by individually tailored patient education.

*'missed appt for more than six months, he wanted a refill of medication and wants to see a doctor … Proper education to the patient on how important to kept their appt. (appointment) in the continuity of their follow-up with the doctor … Patients needs to be educated or given proper instruction regarding missed appt. so that they will know the consequences they'll gonna (going to) suffer if problem like this will arise (RJ 386)*

#### 3.5.2.3 Conclusion statements on the topic theme: patient-centered actions and the related emergent themes

- Patient-centered actions of the PLN portray the autonomy of the registered nurse in ambulatory care nursing by individualized care responses to satisfy the unique needs of a patient and gain individual quality patient care.
- Responsive customer service in ambulatory care nursing by the PLN embodies autonomy as a registered nurse in the delivery of individualized care for the uniqueness of the presenting healthcare situation of the patient so that specific needs or complaints of the patient are addressed by targeting a quality patient outcome.
- In tailored patient education, the PLN uses autonomy in ambulatory care nursing practice by focusing health information individually to match the unique needs of the patient for self-care benefits so that continuity of care is gained.

The final topic theme of 'system-related actions' in the ambulatory care context embraces a range of PLN input that safeguards the standards concerning access of care and continuity of care in relation to the various components of the healthcare delivery system so that quality patient care is assured as the outcome of care.

### 3.5.3 Topic theme: system-related actions

'System-related actions' as a topic theme pertains to nursing actions that contribute to changes in components of the healthcare delivery system aimed at providing improved continuity of care or access to care for the patient. Lindberg, Hunter and Kruszewski (1998:195) maintain that the healthcare delivery system includes the arrangement of components that mutually interact and function as a whole to support care delivery by health professionals like nurses, while Daft (2000:691) considers delivery systems to be comprehensive with outcomes such as accuracy, timeliness and reliability. For the newly opened ACC building, the PLN contributed to refining the system of care delivery so that services responded effectively and efficiently to the needs of the patients. In the PLN group sessions, the participants disclosed that the previous OPD (out-patient department) care delivery system had been dismantled and the promptness and usefulness of a newly functioning system within the newly commissioned ACC building was fundamental to ensuring care delivery for the patients.

Schulz and Johnson (1990:212) assert that the elements in healthcare systems include personnel productivity, resource and space utilization, reporting systems that integrate direct and indirect care aspects with work flow and methods in related departments, scheduling systems, operational planning plus improvement initiatives, and quality outcomes. These elements, although perhaps not readily experienced or known to the patient within the new ACC system, were essential for access to care and continuity of care that ultimately would result in a positive experience for the patient and resultant quality patient care. However, it is the PLN, as will be shown by the emergent themes of 'system orientation' and 'system improvement input', who interfaced with the essential elements of the newly introduced system so that efficiency was achieved in

use, which therefore led to an effectively functioning system that was able to make a positive contribution to quality healthcare for the patient.

Hood and Leddy (2003:184) and Blais and Hayes (2011:317) are aligned in their opinion that nurses make an extensive input to the functioning of healthcare systems because they focus their contributions through the lens of patient. In this regard, Swansburg and Swansburg (2002:25) expand on the dynamics between nursing input and a delivery system. They regard the nurse's participation to be based on awareness and a consciousness of the patient's perspective, and therefore through nursing knowledge and skills they interface with the components of a care delivery system aimed at producing specific patient-focused results. In this regard, Swansburg and Swansburg (2002:26) refer to nursing as the 'head, heart and hands' discipline and ascribe to nursing the ability to 'tie the parts of the healthcare system together'. Representative of this topic theme of 'system-related actions' are two (2) emergent themes of 'system orientation' and 'system improvement input' that originated from the empirical evidence in the reflective journals.

#### 3.5.3.1 Emergent theme: system orientation

'System orientation' emerged as a theme in the PLN journal data, particularly in relation to the patients experiencing the new extensive facilities of the ACC building. Lindberg, Hunter and Kruszewski (1998:195) confirm that patients who enter large health facilities find themselves in an environment that is 'unfamiliar and unsystematic', and 'feel overwhelmed by the system' that is often characterized by the multiple specialist clinic consultations and diagnostic procedures, long waiting queues and experience 'difficulty finding their way' around the system. They suggest that contributory factors are 'poor coordination' and 'inadequate collaboration among providers of services', and

suggest that nurses are pivotal in responding by orienting patients to the system so that professional resources are used effectively. It is at this juncture between patient and system that the PLN intervenes to provide an orientation to the newly established system in the ambulatory care context. This intervention by the PLN, as will be shown by the journal empirical evidence that follows, is regarded as supportive to the patient to facilitate coping with adjustments or expansions in the system. In the journal excerpt, the PLN expressed the sentiment of how nurses should respond to patients concerning orientation to the system:

> *'Patient walk in … asking for another lab (laboratory) request as she lost her lab request and her app (appointment) to the Dr is tomorrow she needs to do her blood work today, she came fasting … nurses … should … explain very well … pt was instructed properly to do her lab work before Dr. app … every nurse in the clinic should do liaison nursing and direct pt (patient) properly and instruct them' (RJ 083)*

This component of PLN input in the context of a newly commissioned purpose-built ACC facility was considered essential so that patients could become oriented to the new systems which were sometimes different to the previous systems in the hospital-based OPD premises. Daft (2010:50) confirms that system orientation occurs in response to identified needs so that problems are solved, whereas Zerwekh and Claborn (2000:116) qualify that once individuals possess an orientation to a system, they become empowered to function effectively within that system. In the two (2) data illustrations below, the PLN deals with patient situations at hand, but pinpoints the inadequacy of patients having not been properly oriented to the system:

> *'Pt (patient) … brought by … private care (spelling error, meant to be car) for follow-up with her treating doctor … they informed me that they need an*

*ambulance to bring the patient back home after consultation … explained … hospital policy that 24 hours prior notice is needed for ambulance booking … pt. is bedridden, I tried my very best to arrange for the ambulance … Proper instruction / education to patient and families could help indessiminating (meant to be in disseminating) information concerning hospital policies' (RJ 402)*

*Pt had an appt today at 1630H but showed up to the clinic 10 minutes later. Since his treating doctor had already left the clinic, the nurse paged him and the doctor advised the nurse to re-schedule the pt. next week. I explained to the pt what the doctor has recommended however, he was so upset … demands to talk and the doctor … Patient must come on time or earlier than his scheduled appointment … patient should be kept informed regarding hospital policy as well … concerning OPD (out-patient department) follow-up so as to avoid any problem in future (RJ 427)*

In the PLN group sessions, the participants reported that from their PLN experiences they are able to make meaningful contributions at the nursing staff meetings in the clinics. They explained that they conveyed specific examples to their nurse colleagues at their meetings to emphasize the value of orienting patients to the system so that at subsequent visits, patients are familiar with the system, and can use it to their advantage to avoid frustration, delays or disappointment.

In the next emergent theme of 'system improvement input', the empirical data on PLN action descriptions portrayed their contribution to improvement of the ACC care delivery system as a mode of providing quality patient care by improvement to either access to care or continuity of care.

### 3.5.3.2 Emergent theme: system improvement input

The emergent theme of 'system improvement input' encapsulated specific PLN action with the various departments or persons so that a nursing contribution to improvement of the healthcare delivery system in the new ACC facility was made. The PLN has a range of possibilities for input into the various components of a healthcare delivery system. Schulz and Johnson (1990:215) provide a review of hospital sub-systems using an approach by Gillette, Rathbun and Wolfe (1970), and list the following five (5) components for attention when improving a care delivery system. They are given as (i) a patient diagnosis and treatment system, which includes clinical pathology laboratories, electrocardiography, diagnostic radiology, pharmacy, and other associated healthcare professionals, (ii) a patient record system that embraces the medical record department, and the patient services (admission) department, (iii) patient scheduling and order systems that rely on support departments such as the informatics and computer department in collaboration with the appointment system in a patient services department, and (iv) a patient accounting and classification system, which includes the patient eligibility system and access permissibility for care.

The empirical journal data depict how the PLN contributes to system improvement by awareness of how the system should be improved to facilitate care from a patient perspective. The excerpt below demonstrates a PLN action in anticipation of a patient's double appointment so that the medical record (file) is not returned to source, but forwarded to the next clinic as the site of the second appointment. Although not stated here, the PLN has raised the need for such appointments to be flagged in the ACC appointment system to ensure that the medical record follows the patient. In this manner, continuity of care is ensured, and access to care is attainable; otherwise,

without a medical record, a potential disruption in patient care is possible. The empirical data below graphically portrays the PLN action:

> *(Two) 2 different appointments today (for the same patient), one appt was in the morning in another clinic and the second appt. is with us @ pm (at the afternoon) session. Immediately, in the morning we gave the "double appt. slip" to that particular clinic … Delay in pt's consultation due to staff negligence is not at all acceptable. Staff should be more responsible in carrying out their task … Communication among depts. … in carrying out certain duties … Remind the clinic to keep the files for … double appointment … to avoid unnecessary delay in the work system … (RJ 437)*

It was the encounter by the PLN with system-related issues that raised the awareness level of the PLN that patient needs were at risk of being unmet. The PLN conveyed this by either offering information or raising questions so that specific departments could respond by rectifying those components in the system that could potentially interrupt continuity of care or prevent access of care. In so doing, the PLN contributed to 'system quality' which Daft (2000:691) states is the degree to which the system performs the tasks according to its specific purpose, and therefore the PLN's input to system improvement can be taken as 'user penetration'. He explains that this penetration by the user, in this case the PLN, triggers system changes that are intended at 'longevity' in that the improvement gained in the system serves all parties for a prolonged period. In his later edition, Daft (2010:589) goes further to suggest system improvement contributes to efficiency.

Evidence of how the PLN provides input to system improvement is sketched in the two (2) journal excerpts below.

*'… radiological studies done last month and came … for follow-up, however his x-ray films were not available. Every effort has been made to retrieve his films but to not avail … It only shows that we don't have a proper system in tracking / filing such films … This problem must be sorted out and implement a good system wherein … available at once when needed. In this way unnecessary delay in the work system / patient could be avoided' (RJ 390)*

In the second excerpt, the PLN discerningly refers to an existing hospital policy as is shown:

*Patients … not meant for tertiary care should not be given further follow-up in the hospital, instead, they should be referred to their respective PHC's or in a place where they are eligible … Discuss with the concerned doctor and let the pt. understand the hospital policy concerning eligibility (RJ 453)*

Although the PLN may not improve the components of the care delivery system directly, it is the input to system improvement that makes a vital contribution to overall improvement that is underpinned by the common goal of quality patient care.

#### 3.5.3.3 Conclusion statements on the topic theme: system-related actions and the related emergent themes

- System-related actions by the PLN are nursing actions autonomously aimed at ambulatory care delivery components so that resourceful, efficient and effective outcomes were achieved to ensure quality patient care.
- Ambulatory care system orientation by the PLN consists of autonomous nursing actions targeted at familiarizing the patients to the range of care services, related

adjustments and expansions for maximum benefit of patients to gain access and/or continuity of care.

- System improvement input by the PLN in ambulatory care encapsulates autonomy in nursing contributions from an end-user perspective that aims at raising awareness of system quality elements that are conducive to achieving quality patient care.

The three (3) topic themes and their emergent themes discussed above have been portrayed using empirical journal evidence and supported by the related literature. Additionally, excerpts from field notes and memoing were used in re-contextualizing the emergent themes to provide insight into the meaning and lived experience of the professional nursing scope of the PLN in the context of ambulatory care.

## 3.6 SUMMARY

This chapter presented the critical incident technique integrated with reflective journaling as a research method that included how it was used in this study in a manner congruent to the workplace setting. In-depth discussions followed on the process of data collection and analysis that were presented with related empirical findings and literature. The next chapter focuses on the use of the vignette technique as a research method, as well as the related data collection and analysis processes with the empirical data of the results and the literature.

# CHAPTER FOUR

# THE VIGNETTE TECHNIQUE APPLIED AS A RESEARCH METHOD: DATA COLLECTION AND ANALYSIS, RESULTS AND LITERATURE

## 4.1 INTRODUCTION

This chapter presents the vignette technique applied as a research method in data collection, the adapted data collection process and how the data was analyzed. The results are given with literature to support the topic and emergent themes.

## 4.2 HISTORICAL DEVELOPMENT AND USE OF THE VIGNETTE TECHNIQUE AS A DATA COLLECTION METHOD

The second research objective was to explore and describe the functional role of the RN as a PLN from the nursing management perspective in the ambulatory care context of a Middle Eastern teaching hospital. The vignette method was selected as an appropriate data collection method for this research objective. Hughes and Huby (2002:382) state that the use of vignettes in nursing research is 'less developed' although widely used throughout the social sciences. Therefore, a brief historical overview of the use of vignettes will be presented to contextualize their use and detail that I found necessary as a nurse researcher who dared to use the vignette method for data collection.

The earliest indication of vignettes being used in the social sciences was in the 1950s. In Anderson and Anderson's (1951:517) classical work entitled 'An Introduction to Projective Techniques and other Devices for Understanding the Dynamics of Human Behavior', the use of vignettes was supported in Psychology as 'creative story-telling' as a means of obtaining data that was believed to be of 'clinical utility'. They elaborate that responses are triggered to reveal information that would not necessarily emerge from direct questioning because of a naturalistic element that is imparted by the story-telling nature by using topics in the content that function as stimuli to elicit an information response. Thereafter, vignettes were used during the 1960s, 1970s, and 1980s, but mainly in attitudinal and survey research in applied psychology and in anthropology (Alexander & Becker 1978:94, Faia 1979:951, Lanza 1988:348, Thurman, Lam & Rossi 1988:567, Levkoff & Wetle 1989:85, Hughes & Huby 2002:382). In the late 1990s, noteworthy nursing research using vignettes emerged from Lanza, Carifio, Pattison and Hicks (1997:151) where a study was undertaken using vignette simulations of assaults on nurses by patients in a neuropsychiatric hospital. Vignettes were designed by experienced psychiatric nurses to portray the real-life situation of nurses being assaulted. The results included a classification of aggression levels by patients that could be used to plan preventive interventions. Thereafter, there was a steady emergence of research studies using vignettes, particularly in the clinical setting, social sciences and education (Clark & Gioro 1998:85, Hughes 1998:381, Chuk 1999:859, Ludwick 1999:65, Barter & Renold 2000:307, McKinstry 2000:867, Bindschadler 2002:10, Oestman 2002:11, Whittaker 2002:631, Cheek & Jones 2003:40).

Over the past two decades and concurrent to the emergence of research studies using vignettes, research texts have appeared that focus on defining the vignettes and addressing the methodological considerations of their use. Ely, Vinz, Downing and Anzul (1997:70) define the use of vignettes in qualitative research as a 'narrative

investigation' or 'snapshot' that contains 'an interpretation of the person, experience, or situation that the writer describes'. They expand on this by stating that 'a vignette restructures the complex dimensions of its subject for the purpose of capturing, in a brief portrayal, what has been learned over a period of time…vignettes are compact sketches that can be used to…highlight particulars findings, or summarize a particular theme or issues in analysis or interpretation'. In essence, they regard vignettes as 'composites that encapsulate what the researcher finds'. Patton (2002:451) motivates his use of the vignettes to illuminate experiences and states the value of vignettes by how multiple sources of data 'can be brought together to offer a comprehensive picture of a person's experience' whereby data from all the sources were 'integrated to produce a highly readable narrative that could be used by decision makers' on a program. Ritchie and Lewis (2003:129) confirm vignettes as 'short descriptions of a particular circumstance, person or event, which might be described verbally or a written down version'.

### 4.2.1 The vignette technique as a contemporary research method

Hughes and Huby (2002:383), after reviewing research studies that used the vignette method, assert that the use of vignettes is 'ultimately determined by the requirements of individual research studies'. They expand on this by cautioning on practical pitfalls and offer advice on practical methods for generating vignettes. They advocate strongly for the use of real-life experience, contexts and content so that reality is closely simulated. They contend that the use of fictitious content in vignettes may result in a disjuncture between real experiences and fantasy. Their second major suggestion is to use short sentences aimed at brevity and conciseness and to avoid information overload, provided the intended stimuli are integrated into the narrative scenario. Hughes (1998:383) also suggests that vignettes should be designed as a 'snapshot' of

a given situation in a manner that provides the participants with real-life experiences in a situated context to which they can respond and make a useful contributions to a research method. Cheek and Jones (2003:42) cite Patton (2002) extensively and offer the following advice on the construction of vignettes:

- Select information-rich cases that contain depth on the issues of central importance.
- Use a strategy of maximum variation from information-rich respondents.
- Identify patterns of themes that are of particular interest and value in capturing the core experiences.
- Incorporate high quality vividness of descriptions that portray scenarios and themes across the data sources.
- Use inductive reasoning to construct the vignettes with concepts and related broad shared themes from the data source.

The literature-based guidelines discussed above facilitated the use of the vignettes as a research method for data collection. In this study, empirical data from reflective journal returns were used midway during reflective journaling data collection to construct the vignettes to ensure they contained real-life experience within the actual context of ambulatory care.

Bases on the five (5) categories that were identified by the content analysis of the reflective journal data, and further to the PLN participants confirming their authenticity in the last PLN support group session, the reflective journal data scripts were categorized from one (1) to five (5) to correspond with the category descriptions of real-life situations that were identified (see appendix 14).

The reflective journal scripts were read on multiple instances to identify information-rich scenarios. During this process, it was realized that there was a possibility of collapsing two of the categories as they were closely related. By collapsing the categories, it potentially added depth to issues of central importance; namely, patient situations in category 2 related to patient eligibility and faulty procedures by staff and category 3 related to the appointment/referral systems. The resulting vignette categories were finalized as follows (see appendix 22):

- Vignette no. 1 – medication refill and potential interruption to medication/treatment regime.
- Vignette no. 2 – faulty referral and appointment systems related to faulty procedures by members of the staff and ACC system problems.
- Vignette no. 3 – patient situation related to patient social circumstances, patient satisfaction and customer service issues.
- Vignette no. 4 – PLN situations related to the absence of the functional role where registered nurses submitted incomplete RJ returns or used the RJ return to indicate that a PLN was not assigned. The last vignette was retained to explore and verify the perspective from the nursing supervisory level.

An essential characteristic of designing vignettes is to be methodical and systematic in the process of constructing the vignette from actual empirical data. To ensure integrity of the process, a literature-based checklist was designed so that each vignette could be subject to the same criteria aimed at achieving consistency and scientific rigor in the approach irrespective of the vignette content. The following checklist in table 4.1 with three (3) major components was created to facilitate the formation of the vignettes.

**Table 4.1** The three (3) major components as a checklist used to create the formation of vignettes (Wolcott 2001:109, Mason 2002:52, Creswell 2003:58, Burns & Grove 2007:628)

| **(A)** Representative of context | **(B)** Descriptive Vividness | **(C)** Coherence |
|---|---|---|
| Components that represent potential empirical data sources [adapted from Mason (2002:52)] | The inverse of threats on descriptive vividness when using empirical findings [adapted from Burns & Grove (2007:628)] | Readability and connectedness in ideas when forming narratives to include a sequence in using empirical data aimed at achieving a coherent whole [adapted from Wolcott (2001:109, Creswell (2003:58)] |
| • People as individuals or groups<br>• Contextual setting<br>• Textual descriptions of content<br>• Objects or materials that are relevant to the scenario<br>• Events or happenings that provide insight to the scenario<br>• Emic view to portray an insider perspective. | • Includes essential descriptive information<br>• The description has clarity or depth, or both<br>• Contains factual accuracy in the description of the subjects and setting<br>• Descriptions are reviewed for authenticity, credibility and trustworthiness. | • Reviewing for content and style to ensure capturing of descriptive substance<br>• Revising versus editing, whereby the former refers to changes in the content to gain accuracy of description, and the latter refers to rearranging the pattern of how words, phrases and sentences are expressed and connected. |

The three (3) components of scientific rigor as shown above in table 4.1 were used in a three-stage process for the construction of the actual vignettes using empirical reflective journal data. The description of the detailed construction follows.

### 4.2.2 Process of vignette construction

The first stage of construction involved selection of the representative components. This involved selecting the people as depicted in the empirical reflective journal data evidence, which was the PLN, patient and/or family members, other nurses, team members or physicians who would feature as real-life representations from the reflective journal data in the vignette. The contextual setting was selected thereafter into which the people were situated to represent the situation. There were three (3) sources of empirical evidence that informed the construction of the vignettes in relation to the contextual settings in the vignettes. These were (i) reflective journal empirical

data segments, (ii) field notes from the PLN support group sessions and intermediary clinical nurse educator, and (iii) memoing content from the analysts to the researcher during reflective journal data analysis. A further confirmation of rigor was the member validation of the vignette categories by the PLN participants. The four (4) categories (see appendix 22) which became the contextual setting for each vignette, as confirmed by the PLN participants in their final group support session, served to embed the vignette context firmly within the real-life ACC contextual setting. Furthermore, the researcher discovered the serendipitous value of the field notes generated during the PLN group sessions. These added vivid descriptive context to both the design of the vignette data collection instrument and was meaningful during the data analysis process.

Specific textual descriptions from the reflective journal scripts were selected with a focus on content, objects and materials to reflect the real-life situation. These were taken from the reflective journal scripts as categorized from 1 to 5 (see appendix 14), but with categories 2 and 3 collapsed into one category. The scripts were read and re-read to select segments of data that provided insight into events and happenings in a scenario. These segments were crafted into a narrative from an emic perspective.

The second stage involved the review of the first draft of the vignettes for components of descriptive vividness aimed at ensuring essential descriptiveness while removing redundant segments. The draft was reviewed again for clarity and depth. This part of the process included returning to the reflective journal scripts, memoing data and field notes to review the context and content whereby adjustments were made. The third review and adjustment of the draft considered the factual accuracy of the subjects in the setting. The final review was checked for authenticity, credibility and trustworthiness, and changes were made according to the original data in the reflective journal scripts.

In the final phase that occurred after a time lapse of two days, the focus was on components of coherence so that the readability of the vignette illustrated the connectedness of ideas and the logical flow and sequence of events. Content and style were adjusted or changed to maintain the descriptiveness of the vignette's substance. For the final review, the vignette was revised and 'tightened up' (Wolcott 2001:109) to ensure that the narrative was understandable to the potential participants. Finally, editing was done to refine and arrange the pattern of words, phrases and sentences as a connected whole that integrated the representative components with descriptive vividness and coherence to portray a real-life situation. The intermediary CRN checked the final vignette for the naturalistic sense of portraying an actual ACC situation in which the PLN functions.

The vignettes were considered ready for use (as shown by the completed vignettes in appendix 22) when they met the requirements as discussed previously and outlined by Cheek and Jones (2003:42), namely:

- Central issues were embedded in an information-rich vignette scenario
- Elements of variation were integrated as sourced from segments of reflective journal respondent information-rich text.
- Core experiences of the PLN participants with focused patterns of themes were interwoven to capture the real situation.
- Portrayal of high quality vividness in description from multiple data sources.
- The concepts and broad themes were confirmed from data sources and constructed into the vignette using inductive reasoning.

The total time taken to construct the vignettes was five (5) weeks and the vignette technique was administered to the participants in the tenth week of reflective journal

data collection. Thereafter, I exited the field as a researcher to prepare the data for analysis.

### 4.2.3 Design of the vignette method as a data collection instrument

The vignette method data collection instrument (see appendix 24) was designed aimed at contributing to meeting the second research objective to explore and verify the scope of professional nursing care within the functional RN role as a PLN. The research population was the nursing supervisory positions to which the PLN reported in the organizational structure.

The three (3) domains of Bloom's taxonomy (1956) of educational objectives (as cited in Quinn and Hughes 2007:114) were adapted for use because it was widely used in the organization in relation to clinical teaching by the nursing education department in the nursing services division of the hospital. The three (3) domains of cognitive, affective and psychomotor taxonomies were adapted and described as follows:

(1) cognitive: knowledge-in-action

(2) psychomotor: helping skills

(3) affective: attitude and approach

Two further aspects were added for congruence to the research purpose, namely:

(4) quality care contribution

(5) professional suggestions

The six (6) step process was designed as follows:

Step 1: synopsis. The respondent was asked to read the vignette and provide a brief summary to demonstrate their understanding of the patient situation.

Step 2: attitude and approach. A comment from their professional nursing perspective was required on the how the PLN would handle the patient situation and what attitude was portrayed.

Step 3: helping skills. The respondent assessed the actions undertaken by the PLN that constituted helpfulness towards the client both verbally and non-verbally. Justification was requested for their assessment.

Step 4: knowledge-in-action. Either clinical nursing and/or operational knowledge demonstrated by the PLN in assisting the patient was assessed and motivated.

Step 5: contribution to quality care. The vignette was reviewed for identification of structural, process or outcome components of care delivery. These components were part of the existing nursing management framework used in the ACC. The respondents were required to identify evidence in the vignette that contributed positively to support their responses.

Step 6: professional suggestions. The respondents were invited to offer suggestions from their professional nursing backgrounds on how the PLN in the vignette scenario could either improve the care delivered or advance the PLN role aimed at providing improved patient care.

An open-ended invitation was offered for unstructured comments on the nursing supervisory experience of the functional RN role as PLN in the clinical setting of ACC. The vignette data collection instrument was formatted in a self-report style in which the responses were written directly. The same instrument was used to respond to all the vignettes (see appendix 24).

## 4.3 PROCESS OF DATA COLLECTION

Purposive sampling was used in data collection to select the participants because of their first-hand experience with the PLN functional role as the phenomenon of interest (Mason 2002:138, Holloway & Wheeler 2010:137) to provide illuminative information-rich accounts (Burns & Grove 2005:352). The research population, therefore, was all the nursing supervisory positions to which the PLN participants reported. The total number of participants were eighteen (18) that were made up of sixteen (16) clinic nurse coordinators and two (2) assistant nursing supervisors who were responsible for clinical nursing management of two floors each, that is eight (8) clinics each. Their participation matched the inclusion criteria of (i) direct daily contact with the clinical nurse coordinators, (ii) regular contact with PLN participants during the daily clinical supervision of nursing practice on the floors, and therefore they were regarded as having first-hand experience of the functional RN role as PLN in the ACC.

At the morning information session for the vignette method, a summary of the research project was given because the research population members had attended the first original information session with the PLN participants. An update was given on the progress of the reflective journal data collection and an explanation on how the vignettes were constructed. The steps in the process of response to the vignette scenarios were given and a handout was distributed comprised of an information sheet in which guidelines for the vignette responses were summarized (see appendix 23). The informed consent forms (see appendix 10) were distributed and it was emphasized that participation was voluntary. Those members that wanted to participate were asked to complete the consent forms and to return for the afternoon session for the vignette data collection.

All members signed the consent forms and returned in the afternoon to a conference room. The same method of double-coding as with reflective journal data collection with a personal data code and research code was explained (see appendix 11 & 12). The intermediary clinical educator was present throughout the session and was responsible for administering the vignette scenarios and the related data collection instrument. The process of using the same instrument for all four (4) vignettes was explained, and the respondents were required to indicate the vignette number (1 to 4) to which they were responding. The researcher left the conference room at this point when the intermediary clinical nurse educator commenced the distribution of the prepared packages. It consisted of the four (4) vignettes and a response sheet for each. The intermediary clinical nurse educator remained in the room to assist the respondents if they had any questions for clarity on the data collection process. Specifically marked boxes labeled as 'vignette 1' to 'vignette 4' were available for the respondents to post their completed vignette technique responses. The entire session lasted just under three (3) hours from 13:00 to about 15:45 when the last respondent completed the vignette response.

The intermediary CRN collaborated directly with the administrative assistant within the guidelines as shown in appendix 16. The boxes were opened for the commencement of the typewritten data with allocated VT research data codes. The original vignette data returns were locked away with the original reflective journal data scripts by the administrative assistant who retained the key to the locked cupboard.

## 4.4 PROCESS OF DATA ANALYSIS

The same group of data analysts was used to analyze the vignettes. This approach ensured consistency of analysis using the same data analysis method developed by Tesch (1990:142) and adapted by Coffey and Atkinson (1996:26) and Richards (2009:171). The process of vignette data analysis was conducted on seventy two (72) scripts. A common data analysis approach for the reflective journals and vignette response data was implemented as indicated in the following summary:

- The scripts were equally divided among the data analysts
- Each data analyst attached a color-coded sticky label to indicate primary data analysis at the top right page (see appendix 17)
- Scripts were exchanged with secondary data analysts who attached a color-coded sticky label to the top left page
- The secondary data analysts would read the script and make separate notes in the margins either indicating agreement with the data coding or noting a question
- The researcher as team leader facilitated discussions aimed at coding reliability (adapted principle from Richards 2009:108) so that differences were discussed and the original text context was rediscussed. Once agreement was reached, the final coding was confirmed and indicated on the script in the margin.

Although memoing was used in the reflective journal data analysis, it was not necessary with the smaller volume of scripts in vignette data analysis because the team discussions served to clarify points of difference or agreement on notes related to context. This input served to review the vignette text again and resulted in either confirming an interpretation and sub-theme, or discussion sometimes continued

eventually resulting in agreement with the interpretation based on the closer scrutiny of the vignette text by all four (4) analysts.

## 4.5 THE VIGNETTE RESEARCH METHOD: TOPIC THEMES AND EMERGENT THEMES

In the design of the vignette data collection instrument above in section 4.2.1, it was acknowledged that the topic themes (Richards 2009:100) where assigned in the design of the instrument. This action was based on the organizational educational culture in Bloom's taxonomy (1956 as cited in Quinn & Hughes 2007:114) that was embedded in the clinical teaching approach of the organization. In practice, professional nursing development used Bloom's taxonomy of cognitive, affective and psychomotor domains as a framework in clinical practice. However, it was realized that the wide usage of Bloom's taxonomy was not necessarily literature-based, and therefore as part of empirical evidence, the topic themes were supported by the literature in addition to the sub-themes that were also supported by the evidence from vignette data segments. Examples of vignette data scripts are provided in appendices 25 to 29. Furthermore, the two added topic themes of 'quality care contribution' and 'professional suggestions' were also subjected to the literature control for completeness. Table 4.2 that follows provides a synopsis of the topic themes used in the vignette data respondent instrument, and lists the corresponding emergent themes.

**Table 4.2** Themes from the vignette research method

| Topic theme | Emergent themes |
|---|---|
| A. Attitude and approach | 1. Attending behaviors |
| B. Helping skills | 2. Supportive action |
| C. Knowledge-in-action | 3. Rapid problem assessment |
| D. Quality care contribution | 4. Tailored patient education |
| E. Professional suggestions | 5. Support network |

In the written presentation that follows below on the themes, the uses of three punctuation full-stops (…) are inserted to indicate missing words in the original text of the vignette data segments. In each instance, care is taken not to alter the intended meaning, while maintaining the original response by the participants. The excerpts from the respondents' vignette responses are taken from the six (6) step vignette data template that were given as a response form to all participants (appendix 24). The excerpts are selected to support the emergent themes. Also in the presentation, (sic) in parenthesis is inserted to denote that despite a questionable sentence, it is in fact accurately taken from the respondent's original text. Further, parentheses with *italicized (word) insertion(s)* are used to (i) explain local abbreviations, (ii) add a word to complete grammar for understanding, or (iii) insert an obviously missed word given that for some participants, English is their second language. In all three (3) such situations, the insertions in parenthesis are used to safeguard the original expressions of the respondents to maintain authenticity. The conclusion statements to the topic themes and emergent themes are given at the end of the each topic theme for completeness.

Incorporated into the description of the topic and emergent themes that arose from the vignettes are extracts from field notes from the PLN support group sessions that are interwoven into the respective descriptions aimed at enriching the contextual meaning

of the themes. The first topic theme on ‘attitude and approach’ is discussed, followed by a discussion on the related emergent theme of ‘attending behaviors’. Thereafter, conclusion statements are provided which summarize the essence of the concepts that emanated from the topic and emergent themes. This pattern will be used for the discussion on all the themes.

### 4.5.1 Topic theme: attitude and approach

Quinn and Hughes (2007:118) regard ‘attitude’ as that which prompts an individual to act in a particular manner towards stimuli and considers it to be a ‘powerful influence’ on behavior. Yoder-Wise (2007:180) embraces this definition but further states that it is in the ‘attitude’ of a nurse that the professionalism of the role is portrayed in the manner of interaction with the patients, families and members of the team. ‘Approach’ encompasses the mode, procedure, technique and style of how an action is executed (Collins 2006:57). Therefore as a topic theme, ‘attitude and approach’ represents the way in which actions are taken for the patient that characterized the specific nursing role behaviors associated with processes or procedures by which the ‘how’ of practice was carried. In the newly commissioned ACC, there was a prevalence of rhetoric on the manner in which patients were handled when dissatisfaction was identified. This contextual consideration had been recorded in the researcher’s field notes during the PLN group sessions. The PLN group members had disclosed their concern about the sense of disregard they had observed by some of their fellow RNs in the clinics towards patients who were experiencing problems with the new care delivery systems of the ACC. They labeled their manner in which patients were disregarded as ‘unhelpful and uncaring’ whereby one of the PLN participants stated ‘some of them care less about the patients than making the new system work’. The topic theme of 'attitude and approach' therefore was an interesting point of view with the vignette

participants because ‘attending behaviors’ emerged as a theme that reflected how the nursing leadership of the clinics had regarded the PLN role. This topic theme in a sense contextualized the ‘how’ of practice in the ACC care delivery system because it qualified the PLN’s contribution to the patient gaining ‘access of care’, or it ensured ‘continuity of care’, and thereby determined quality patient care. Empirical data evidence from the vignette data is provided to support this by the emergent theme of ‘attending behavior’ that follows.

#### 4.5.1.1 Emergent theme: attending behaviors

Arnold and Boggs (2011:115) describe the emergent theme of ‘attending behaviors’ as those that ‘let the client know that you are focused on understanding their situation’, and a manner of checking to ensure that whatever has been observed or heard is correct. This includes being attentive, supportive, understanding, and empathetic. In their descriptive of these attending behaviors, Blais and Hayes (2011:243) point out that all interaction is patient-focused. The emergence of this theme corresponded with the rationale for introducing the PLN role in the newly commissioned ACC. It had been observed that there was an interruption in the continuity of care as a consequence of rapidly expanding services in the new ACC care delivery system. A return to being patient-focused was identified by the ACC Executive Committee, but no single healthcare discipline accepted the challenge to respond meaningfully. This topic theme perhaps illustrated a reason for the perceived success of the PLN role as it emerged from the vignette empirical data that the PLN was patient-focused evidence by the identification of ‘attending behavior’ as an emergent theme. Bateman (2000:17) integrates supportive and attending behaviors as part of advocacy, which he clarifies as the underlying purpose to serve the patient and to ultimately gain quality patient care. However, Baird (2000:138) recognizes that attending behaviors are an essential

part of customer service that influences patient perceptions of a service. The excepts that follow illustrate the nursing leadership participants' viewpoint of the PLN action that constitutes the emergent theme of 'attending behaviors':

*'… was helpful and positive, she explained the situation … very well' (VT 013)*

*'… active listening and asked … handled … with proper explanations … understanding and support' (VD 133)*

*'… made the patient settled … she (PLN) let the patient talk, she listened to him, she clarified the problem … and finally apologize (sic) for all the misunderstanding' (VD 061)*

#### 4.5.1.2 Conclusion statements on topic theme: attitude and approach and the related emergent theme

- Attitude and approach by the patient liaison nurse reflect the professional role behaviors in ambulatory care nursing that encompass mode, procedure, technique or style of how the action is executed autonomously, aimed at either access of care or continuity of care.
- The patient liaison nurse uses attending behaviors in ambulatory care nursing that convey a supportive, understanding and empathetic manner that is patient-focused on individual needs for the ultimate purpose of quality patient care.

The second topic theme of 'helping skills' illustrated that the PLN was expected to go beyond 'attending behaviors' in their nursing actions with 'supportive action' emerging as a theme evidenced by the vignette data that illustrate the PLN action.

### 4.5.2 Topic theme: helping skills

'Helping skills' is taken by Lindberg, Hunter and Kruszewski (1998:295) to be when the nurse acts in the role on one or a combination of four (4) levels by (i) direct administration of physical care, (ii) advocacy on behalf of the clients, (iii) psychosocial support, and/or (iv) health education and counseling. This refers to the specific ability of the nurse acquired through training, and either manual or verbal proficiency acquired by learning a set of procedures. On one hand, this could be a psychomotor skill evidenced by the capacity to execute a task, while on the other hand, it can be acquired responsiveness to provide support and cooperate with a situation. Often, the psychomotor skill and responsiveness are employed jointly as set of deliberate actions in a coordinated response to the identified concerns or needs of the patient. This topic theme of 'helping skills' was reinforced by the PLN members in the PLN support group sessions. My field notes had an entry from a group session that the PLN participants confirmed that often patients settled when they saw that a PLN was making an attempt to assist them with a problem. The extended discussion with the PLN participants revealed that the patient's displeasure or anger became noticeable if the patient perceived that nurses were not attentive to their needs. Moreover, they recounted that even if the nurse's efforts were not fruitful, the patients nevertheless expressed appreciation for their helpfulness. They expressed this as an essential approach to patients in the new ACC, which they believed was a vital part of the 'adjustment' period to the new systems of care delivery in a recently commissioned facility. The theme of 'supportive action' that emerged from the nursing leadership participants in the vignette data indicates their regard for the helping skills of the PLN.

#### 4.5.2.1 Emergent theme: supportive action

'Supportive action' as an emergent theme illustrated the sense of helpfulness by the PLN for the patient. The responses that convey supportiveness, according to Lindberg et al (1998:292) and Arnold and Boggs (2011:184) are listening, clarifying, explaining, and reassuring even when it is clear that the patient will be referred to another appropriate agency for assistance. The period of transition between the former out-patient department clinics in the hospital and the move into the newly commissioned building happened almost immediately after the building contractors endorsed the new ACC facility to the hospital management. One of the PLN participants in the support group sessions stated that, at the time of the move into the new ACC facility, 'we were all happy because we were so short of space in the hospital', and other members of the group chorused their affirmation of this perspective as the participant continued, that 'we were not really prepared for the problems we and the patients will face in the new Faisalliah' *(The 'Faisalliah' was the newest building in the city of Riyadh that reflected modern architecture. The glass and chrome interiors of the new ACC facility were likened to the Faisalliah during colloquial discussions).* As a result, there had not been a sufficient period of notification to patients and related advertisements, or education on the new system of services in ACC. Therefore, it was often left to nurses to redirect or educate patients on the new system of services in the ACC. The PLN group sessions members referred to, this as a 'readiness to help' even when a patient was not targeted for the clinic in which the PLN was based. According to Hood and Leddy (2003:452), these interactions are the essence of helping and supporting patients with their concerns and needs so that they utilize healthcare resources to gain self-care, and thereby gain continuity of their care. This emergent theme of 'supportive action' is depicted in the vivid descriptive excerpts given below that portray the perception of the nursing leadership participants in their vignette responses of what they regard as

supportive action by the PLN in practice. The detail of the excerpts reveal the participants' respective observations of 'helping skills' that detail the contribution to the emergent theme of 'supportive action' in the four (4) extracts from the vignette data:

> *'calm pt (patient) down by giving him good support … call pharmacy to clarify the dose … get chart and see doctor … for his advice … pt (patient) talk to MD (doctor) … more secure' (VT 011)*

> *'explained the problem and reassured patients … understanding of the exact problem and getting good results that satisfied the patient' (VT 043)*

> *'tried to listen, clarify … action, feedback…patient happy, satisfied and not anxious anymore' (VT 063)*

> *'listened and expressed her understanding … gave assurance … use active listening skills … demonstrate genuine concern and assistance … keep pt (patient) involved and tell him of your planned action' (VT 131)*

#### 4.5.2.2 Conclusion statements on topic theme: helping skills and the related emergent theme

- Helping skills are used autonomously by the patient liaison nurse in ambulatory care and constitute either psychomotor skills and/or verbal responsiveness aimed at facilitating care delivery to gain access of care or maintain continuity of care.
- The patient liaison nurse demonstrates supportive action autonomously in ambulatory nursing care by a helpful professional manner and/or by gaining

professional team cooperation aimed at responding to patient needs to ensure access of care or maintain continuity of care.

The next topic theme of 'knowledge-in-action' follows from the discussion on related vignette data evidence that supports the emerging theme of 'rapid response assessment'.

### 4.5.3 Topic theme: knowledge-in-action

'Knowledge-in-action' is defined by Quinn and Hughes (2007:444) as practical professional knowledge that is inherent in the action itself. Mastal (2006:38) regards nursing knowledge as the foundation and source of continued expansion of professional nursing practice that has a theoretical base. The topic theme therefore characterizes a level of awareness and perception based on acquired facts. It reflects a comprehensive judgment based on learnt recognition of facts on a subject by a nurse, and may project a sense of knowing certain details or specific features related to the patient situation. The PLN members revealed in their support group in the ACC that there was a core group of nursing staff to whom they often referred for information because of their long-standing knowledge of hospital systems, physician practice approaches, and who knew the patients with chronic conditions. These core nursing staff members apparently had continuous service of seven (7) to fifteen (15) years in ambulatory care nursing. The PLN group members supported their colleague by affirmative head nodding that their 'knowledge base' expanded with input from the long service nursing members in addition to their self-directed knowledge pursuits concerning a current patient situation. The PLN participants went onto say that this knowledge base helped them when reviewing situations that required clinical decision-making. The approach of using 'knowledge-in-action' encompasses a sense of belief

that action taken should match the situation of the patient, and further that the action has logical steps that are focused, relevant and appropriate based on the judgment of the PLN. The PLN action that followed would either target access to care for a patient, or ensure continuity of care. Empirical vignette evidence from the vignette respondents illustrated this topic theme of 'knowledge-in-action' in the portrayal of the emergent theme of 'rapid problem assessment' that follows.

#### 4.5.3.1 Emergent theme: rapid problem assessment

The emergent theme of ‘rapid problem assessment’ is regarded by Haas (2006:3) as a core characteristic of nursing practice in ambulatory care, which she links to being skilful in execution. As a researcher in the field, I was struck by the rapidity of assessment in each of the new ACC clinics. Each clinic had one (1) or two (2) nursing assessment rooms that served about ten (10) to fifteen (15) physician consultation rooms. My researcher field notes reflect a note to explore this type of expedited assessment that results in an overview of the patient's vital signs, essential details on the main complaint, and a comment on the level of adherence to the existing treatment regime. It became apparent that a PLN needed to be an experienced ambulatory care nurse who was adept with rapid problem assessment. This aspect was corroborated from the field notes from the PLN group sessions. It was stated, and agreed by members present, that sometimes patient problems could have been identified and re-directed during the initial nursing assessment instead of being referred to the PLN. All seemed to agree that it was probably a less experienced ambulatory care nurse who referred some patients to see the PLN because it was apparent that sometimes a second nursing assessment of the problem was required. In problem assessment, Hood and Leddy (2003:238) maintain that good clinical judgment and decision-making that are patient-focused are essential for assessing patients swiftly. In their

development of rapid assessment methodology, Yasin et al (1999:46) assert that efficient rapid assessment at the outset is the first step to achieving quality care, while Redfern and Norman (1990:1263) suggest that focusing on a problem and acting promptly to solve it contributes to either access to care or continuity of care. In the vignette empirical data given below, it is noted that the nursing leadership vignette respondents affirmed the clinical judgment of the PLN level of 'rapid problem assessment' in response to the vignette that were reviewed:

> *'handle the situation … by calming the patient, sharing understanding … resolving the situation … had applied good clinical judgment … ascertained facts and dealt with in a professional manner' (VT 171)*

> *'patient is upset … understood, … kept explaining, apologize … clinical nursing knowledge ... of the nurse … patient was calmed by the PLN, problem solved, everybody feel win-win' (VT 191)*

An expectation surfaced from the empirical vignette data that the assessment skills of the PLN should perhaps extend beyond the immediate response to the presentation of patient problems. In the excerpt that follows, a vignette respondent pointed out that after a patient situation is sorted out, the PLN could make a contribution from the initial assessment to system components that perhaps needed correction:

> *'system which appears faulty … aggravate the situation … provide patient with immediate assistance … reporting last … after the patient's problem has been sorted out … rectify' (VT 162)*

#### 4.5.3.2 Conclusion statements on topic theme: knowledge-in-action and the related emergent theme

- Knowledge-in-action is portrayed by the patient liaison nurse in ambulatory nursing care as a sense of knowing that is reflected in autonomous judgment of a presenting situation for which the action outcome contributes to quality patient care**.**
- Rapid problem assessment reflects the core of autonomy in ambulatory care nursing practice whereby the patient liaison nurse undertakes nursing action based on good clinical judgment and patient-focused decision-making aimed at quality patient care outcomes.

'Quality care contribution' is the next topic theme for discussion with its corresponding emergent theme of 'tailored patient education' with supporting evidence from the vignette responses.

### 4.5.4 Topic theme: quality care contribution

'Quality care contribution' as a topic theme refers to an act that provides ideas or facts that would add value to the basic nature or character of patient care. Shindul-Rothschild et al (1997:36) asserts that upholding standards in patient care delivery contributes to quality in care processes, while Luker et al (2000:776) suggest that a reasoned or purposeful usefulness in patient interaction adds value to care and contributes directly to better standards, which is the cornerstone of access to care and continuity of care. In the new ACC building, upholding quality by aiming to maintain or exceed previous ambulatory care standards were important to the ACC Executive Committee, for which the trigger arose originally for the introduction of the PLN role.

The executive committee members had expressed their concern about compromised standards of care observed subsequent to moving into the new ACC facility, but there were no assessment data on the extent of the problem, and therefore exploring appropriate plans for solutions had not been feasible. In this regard, the PLN appeared to assess the nature and extent of the problem, then based on knowledge of the care delivery system and previous standards of care, was able to respond and/or initiate meaningful and appropriate action to add value to the patient's current experience, and in so doing made a contribution to quality care in the ACC. It is an action component that results in care of a higher standard than was previously experienced by the patient, and therefore represents gain in quality care for the patient. In this regard, it was the PLN's ability to position the patient on a pathway to self-care so that the patient could utilize the new services in ACC appropriately and in a way relevant to their health problems. In this manner, because ambulatory care is episodic in nature and unlike the continuous delivery of nursing care in an in-patient unit, the PLN's role was to influence the patients' journey to self-care assisted by the services and resources in the ACC. The essence of this influence is depicted in the emergent theme of 'tailored patient education' that is supported by the empirical vignette response data.

#### 4.5.4.1 Emergent theme: tailored patient education

'Tailored patient education' as an emergent theme moves beyond the traditional giving of information to the patient on their health situation as so-called 'packaged' health education. It integrates elements of customer service with health education by first listening to the patient, then clarifying to ensure that the patient is understood, followed by explaining health matters and response possibilities that are aimed at specific self-care of the patient (Hood and Leddy 2003:464), which has a direct impact on attaining continuity of care. In this regard, a PLN participant stated that their role often

embraced patient education because a 'one size fits all' approach to patient education may not necessarily be effective for patients who have unique needs. It therefore required that the PLN closely assessed what the presenting situation was for the patient, and as part of responding strategy, tailored the content of patient education specifically for the unique situation of a particular patient. The vignette respondents recorded this observation of 'tailored patient education' from the vignette scenarios. The empirical data from two (2) excerpts vividly showed that this with emphasized when the PLN listened to the patient so that the tailored patient education fit the presenting unique circumstances of the patient always aimed at self-care, as is shown below:

> *'understanding and non-judgmental … she (PLN) also was listening to what patient was telling (sic) … make sure patient are checking his prescriptions in the future to make sure he understands how to take his medication and why' (VT 021)*

> *'confusion … asking for explanation … (the PLN) willing to listen, digest, consult Dr (doctor) and then gave unscrambled feedback to pt (patient) … when pt (patient and relative understood situation, pt. (patient) become a "willing" participant in the healthcare (sic)' (VT 123)*

#### 4.5.4.2 Conclusion statements on topic theme: quality care contributions and the related emergent theme

- Quality care contributions by the patient liaison nurse in ambulatory care nursing add useful value to basic patient care that result in higher standards of quality patient care.

- The patient liaison nurse in ambulatory nursing care provides tailored patient education in an autonomous professional manner by responsiveness to the unique needs of an individual patient situation aimed at self-care so that continuity of care is achieved.

The final topic theme was ‘professional suggestions’ and its related emergent theme of ‘support network’ are discussed with relevant excerpts from the vignette data as supporting evidence.

### 4.5.5 Topic theme: professional suggestions

The nature of the topic theme of 'professional suggestions' evokes a sense of openness to alternative ways of accomplishing functional tasks by the PLN. McPherson, Headrick and Moss (2001:47) link ‘professional suggestions’ to alternative choices of how procedures can be accomplished or implementing varied functions in professional execution of what needs to be done to achieve a favorable outcome. For the PLN, it embraced the adjustment and transitional aspects of occupying a new building and the implementation of a new system of care delivery to ensure quality patient care. This echoed a poignant moment, when after a cathartic phase in a PLN group session on multiple issues that still needed attention, I asked the participants what keeps them in the PLN role or in the ACC. After a notable silence, one of the participants said that 'everyday in the ACC you learn something new'. Idiosyncratic nodding by all participants affirmed the spoken response. This component of learning new or different ways of accomplishing tasks endorses the topic theme of 'professional suggestions'. The related theme of ‘support network’ emerged with supporting evidence as an indication of vignette respondent concurrence with the topic theme of ‘professional suggestions’.

#### 4.5.5.1 Emergent theme: support network

'Support network' as an emergent theme is concerned with an organized arrangement of appropriate inter-professional referrals (Caelli, Downie & Caelli 2003:172). This type of professional access by the PLN with other professionals echoes self-awareness whereby a second professional opinion or input of another colleague is obtained. Redfern and Norman (1990:1269) regard this professional action as affirmation that the nurse has listened to the patient, and has gained an understanding and knowledge of care processes that are best suited for the patient, and then opts to source assistance from within a network of professionals. By the PLN using a 'support network' in this manner, the patient ultimately benefits because a new formal appointment is not necessary, and therefore treatment for the patient is not delayed until a follow-up visit. This system of prompt access to another healthcare professional by collegial support results in prompt access to appropriate care, and therefore reaffirms the focus of quality patient care by the PLN role. Exemplars that illustrate the view of the respondents, who are the nursing leadership in the ACC, is apparent in the emergent theme of 'support network' as depicted in the empirical vignette data:

> *'find someone to help this pt (patient) … even if we are busy … explain … pt (patient) situation but we will help' (VT 014)*

> *'PLN should have (someone for) talked (talking) … and asked for help, made suggestions … to allow PLN to help (him/her) with pt. problems which would also help … them with this assignment' (VT 054)*

*'delaying a patient's urgent consultation … acquire assistance … use other team members … to solve / or try to solve issues … by using the correct persons to aid me' (VT 122)*

The emergent theme of 'support network' represented the dynamism of the evolution of the PLN role and the openness of the nursing supervisor for further development of the PLN role aimed at the overall goal of achieving quality patient care ultimately by collective improvement efforts in the ACC.

#### 4.5.5.2 Conclusion statements on topic theme: professional suggestion and the related emergent theme

- Professional suggestions reflect an openness to autonomy in practice by the patient liaison nurse in ambulatory nursing care to alternative professional executions within the patient liaison nurse role aimed at achieving favorable quality patient care outcomes.
- A support network is an organized arrangement of resources used autonomously by the patient liaison nurse in ambulatory care nursing for professional cooperation to facilitate prompt access to care or to maintain continuity of care, and therefore reaffirms the focus on quality patient care**.**

## 4.6 SUMMARY

This chapter presented the vignette technique as a research method, as well as the data collection and data analysis processes, which embraced the empirical findings and literature. This chapter also marks the end of phase one (1) in the research study.

Phase two (2) of the research study begins in chapter five (5) which follows that embraces the conclusion statements from the empirical data included in chapters three (3) and four (4) as shown in chapter five (5), table 5.1.

# CHAPTER FIVE

# CONCEPTUAL FRAMEWORK

## 5.1 INTRODUCTION

The conceptual framework of the study is presented in this chapter subsequent to the identification of the concepts from the empirical data, concept classification and the approach to literature searching and review. This chapter also denotes the beginning of the second phase of this research study.

## 5.2 THE SCIENTIFIC CONTEXT OF KNOWLEDGE FOR A CONCEPTUAL FRAMEWORK

The scientific context of knowledge for an intended conceptual framework should be harmonized with the world of nursing practice (Chinn & Kramer 2008:48). Boykin and Schoenhofer (2001:1) link science and knowledge by indicating that science deals with valid ways of knowing and the means of validating what is known. In this regard, Walker and Avant (2011:18) agree that, ahead of constructing a practice model, the context of discovery of knowledge is given initially as a conceptual framework. The usefulness therefore of the conceptual framework is not necessarily known at the outset, while Chinn and Kramer (2008:51) indicate that the broad context of concepts are known and are aimed at being congruent to nursing practice.

The seminal work of Mouton (1996:8) provides an arrangement of the kinds of knowledge according to three worlds within a social context that are applicable to the world of nursing knowledge. The three worlds are explained as follows:

### 5.2.1 World one: the world of everyday life and the pragmatic use of knowledge

At this level, a person produces actions based on what to do and how to do it. It embraces pragmatic and useful actions that involve 'objects' or 'entities' to include human beings and social practices as a collective of actions occurring in society, organizations, institutions and groups that pertain to the physical world. It is within this physical world that acquired knowledge is applied to gaining understanding or agreement within the world of everyday living. Mouton (1996:8) refers to Turner (1990) who describes this use of knowledge in coping with daily living as 'ontological security', and then endorses this notion of knowledge application in everyday living as a 'pragmatic interest' by human individuals that strive for gaining knowledge so that problem-solving and/or decision-making happens for the ultimate goal of enabling human beings to cope with and live a human life, which he terms as 'existential interest'.

It is at this level of world one that the empirical data were collected in relation to the experience of the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.

### 5.2.2 World two: the world of science and epistemic production of knowledge

The phenomenon of inquiry in world one is linked to world two as the focus of an investigation through a systematic and rigorous process. In my study, the patient liaison nurse who practiced in the contextual setting of ambulatory care services was the phenomenological focus of research using a qualitative process of inquiry.

Mouton (1996:9) refers to world two as the world of science or 'epistemic interest'. At this level, research methodology is used for an investigation into the study of what happens in world one and why it happens to gain understanding of the nature of the phenomenon. This search for truth using various approaches such as research questions, hypotheses, research paradigms, theories and models has become the main goal of scientific inquiry. Moreover, Mouton (1996) positions this practice of science within a discipline, which in this study is nursing science. He expands on the practice of science as having the fundamental aim of generating truthful models or theories at the level of world two to explain the human actions occurring in world one. He concludes that 'epistemic interest' of knowledge production in world two is the driving force for the world of scientific research. Further, he amplifies the knowledge production process by asserting that the world of science is not homogenous within one discipline only, and that it extends to the heterogeneous and multifaceted realm of the different science disciplines, including natural sciences, physical sciences, social sciences and humanities that are targeted in the pursuit of understanding world one actions at the level of world two.

It is at this level of world two that the empirical data in this study derived from the practice setting of the patient liaison nurse in world one of ambulatory care nursing

were analyzed and used to gain an understanding of nursing actions in the functional RN role as PLN. The latter involved a process of concept identification and classification using existing knowledge and theory in the literature aimed at formulating a conceptual framework to describe the main and related concepts and their relationships. A pertinent theory that underpins the ambulatory care delivery system is systems theory that will be outlined prior to concept identification and concept classification.

### 5.2.3 World three: the world of metascience and critical inquiry on knowledge

According to Mouton (1996:9), world two is connected by critical inquiry and reflection to world three. The 'critical interest' at the level of world three may include the aim to criticize, deconstruct, dissect, de-contextualize, or analyze within a scientific activity targeted at the improvement in the practice of science. It is at the level of world three that conceptual and relational clarity is gained through either the philosophy, history or ethics of science that informs the methodology of scientific research when methods and techniques are used logically by scientists. It is at this level of critically reviewing interrelationships that an ongoing quest for the generation of knowledge is driven that impacts all three worlds of knowledge.

It is at the level of world three that the practice model was generated in this study from the data as empirical evidence from world one, grounded scientifically in literature evidence at the level of world two, and critically positioned at the metascience level in world three for the overall purpose of improving the science of nursing practice.

An outline on systems theory follows, as a means of positioning the practice model that evolved in this study.

## 5.3 SYSTEMS THEORY AS A PHILOSOPHICAL UNDERPINNING TO A CARE DELIVERY SYSTEM

The concepts derived from empirical data portrayed relatedness in function to elements of a system because aspects of input, throughput, output and feedback became evident in the conclusion statements on critical incidents and reflective journaling in chapter three (3), and the vignette responses in chapter four (4). From this observation emanated the philosophical underpinning to systems theory. It must be stated here that the relatedness to systems theory was a deductive logical conclusion and was not a component of predetermined research design since this link was made after review of the conclusion statements from chapters three (3), four (4), and five (5), respectively. Therefore, prior to concept identification and concept classification, a review of the characteristic elements of systems theory are necessary to set aside the concepts in systems theory aimed at advancing clarity in the process of concept identification and classification.

French and Bell, Jr. (1999:82) and McKenna and Slevin (2008:114) attribute the articulation of systems theory to Ludwig von Bertalanffy in 1950, and Katz and Kahn in 1966 to applying the theory of open systems to organizations, and thereafter assert that systems theory is one of the most dominant tools for comprehending the dynamics of organizations. They summarize a system to denote an arrangement of interrelated elements that are interdependent and interconnected to form an identifiable whole entity that is referred to as a system.

It is accepted generally that the nature, dynamics and characteristics of open systems have been studied extensively and are well-known (French & Bell, Jr. 1999:82, Gibson, Ivancevich, Donnelly & Konopaske 2006:22, Senior & Fleming 2006:7, van Tonder & Roodt 2008:44, Daft 2010:47, Sullivan & Garland 2010:39). The following statements depict the fundamental characteristic elements of an open system:

- Input – throughput - output mechanisms
- Input from the environment that can be in the form of energy or information from material and/or human resources
- Throughput that is input being acted on by conversion or transformation processes
- The changed input is returned to the environment as the product of a system as output
- Each system is demarcated by a boundary to distinguish the system itself within the boundary, and the environment that is outside the boundary
- All open systems have purposes and goals that represent their reasons for existence
- Each system has feedback information related to the performance of the system.

These tenets of systems theory provided the underpinning to the development of the model in this study. It is therefore intentional at this point not to provide a figure to depict the characteristics of a classic system. Instead, the cognitive journey begins here for the reader as the model is constructed incrementally in this chapter resulting in the practice model that is described in chapter six (6) that follows.

## 5.4 PROCESS FOR IDENTIFICATION OF CONCEPTS

The forerunner in understanding the process for identification of concepts commenced by gaining an understanding of the three worlds by Mouton (1996), as discussed above in section 5.2. This scientific understanding permitted clarity and rigor in the concept identification process when reviewing the conclusion statements that were generated from the themes that emerged from the reflective journal and vignette responses in chapters three (3) and four (4), respectively. Furthermore, the philosophical review of systems theory enabled the identification of concepts related to the elements of a system, which facilitated the process of concept identification so that concepts that were connected to the ambulatory care delivery system were linked accordingly as main and related concepts. A method was devised and justified with literature primarily from Mouton and Marias (1990) and Chinn and Kramer (2008) for systematically reviewing the conclusion statements to ensure consistency and congruency in the process of identifying concepts:

- Read the conclusion statement to identify at the level of world one what has emerged in summary of the theme, and how related action is described therein (Mouton 1996:7). Mouton and Marais (1990:58) support this approach by stating that the process begins by identifying the concepts that are 'linguistic constructions by means of which people order and categorize reality'. Chinn and Kramer (2008:223) advise that concepts are identified by 'searching out words or groups of words' that represent the phenomena and their related actions.
- Generate a list that tentatively identifies key concepts and other concepts that appear to be interrelated (Chinn & Kramer 2008:224). Mouton and Marais (1990:58) refer to this step as sorting out 'the chaos and unsystematized content' of experiences that are occurring in world one, and

propose that words or groups of words are identified that are regarded as 'symbols of meaning', which become the concepts that are considered to be 'the primary instruments' of language that expressed the sense of 'coming to grips with' the lived experiences.

- The list of tentative key and other concepts is reviewed by asking questions about the nature of the concepts and their interrelated organization (Chinn & Kramer 2008:226). Mouton and Marais (1990:126) put forward that the 'meaning' of the concept needs to 'explicated' by referring to two dimensions in the meaning. These are 'connotation' so that the 'sense' of meaning is grasped, and 'denotation' so that the related 'reference' to the meaning of the concept is embraced.
- The list of tentative key and other concepts is reorganized by color-coded highlighting of concepts that surface as apparent main concepts, and with a different color, the related concepts are highlighted as the identified concepts that are related to the main concept. Chinn and Kramer (2008:208) refer to this step as identifying 'major concepts' with 'subconcepts', and further as to whether the major and subconcepts constitute a single related entity by their relationships and interrelationships.
- A revised list of 'main' and 'related' concepts is generated and put through a further review to ensure rigor in the finalization of the concepts to confirm the identification of the main and related concepts. This transaction follows Mouton and Marais (1990:126) by reviewing each of the main concepts for 'connotation' by checking out what sense of meaning or intention is being conveyed by use of the main concept. In some instances, either the use of the Oxford Dictionary or Thesaurus (2007) is used so that the meanings of concepts were confirmed. A similar transaction is used to review the

'denotation' in reference to the concepts, which Mouton and Marais (1990:59) state to be characteristics, actions, behaviors or processes that are linked to the phenomenon under study, and offer the following two guidelines as primary requirements in concept identification:

(i) Connotations of concepts should be clearly articulated and unambiguous

(ii) Denotations of concepts should be related and accurate references of the connotations

- In finalization of the list of main and related concepts that are identified, Chinn and Kramer (2008:209) advise not to become anchored on the number of main and related concepts, but rather to reconsider the qualitative features of the concepts to ensure that the central idea that links the identified concepts is congruent.

Table 5.1 that follows represents the outcome of the above method of concept identification with the listed empirical concepts. The detail of the formulae used to construct the conclusion statements are discussed in chapter one (1), section 1.11.2 on making convincing arguments.

**Table 5.1** Concept identification from the empirical data

| **Conclusion Statements** *from Critical Incidents and Reflective Journals* | **Conclusion Statements** *from Vignettes* | **CONCEPT IDENTIFIED** |
|---|---|---|
| 1. Nurse centered actions of the patient liaison nurse in ambulatory care nursing characterize the autonomy of the registered nurse in care responses to the needs of the patient so that access to care and/or continuity of care are achieved.<br><br>2. The patient liaison nurse undertakes rapid assessment and responds autonomously in ambulatory nursing by using prompt care advocacy on behalf of the patient to gain access to care for the most pressing healthcare need to ensure continuity of care.<br><br>3. The patient liaison nurse engages autonomously in collaborative communication with team members in ambulatory care based on mutual respect in the best interest of the patient aimed at gaining professional cooperation ultimately to ensure quality patient care.<br><br>4. The patient liaison nurse displays supportive empathy towards the patient's situation in ambulatory care though nursing actions that demonstrate understanding, respect, helpfulness and genuineness; patients appreciate that their expectations on continuity of care are respected.<br><br>5. Contact liaising depicts autonomy in the ambulatory care nursing action of the patient liaison nurse by establishing a resource network outside the immediate department to access cooperation for continuity of care in meeting the needs of the patient to ensure quality care.<br><br>6. Autonomy of input to operational support departments by the patient liaison nurse portrays operational facilitation in ambulatory care through end-user feedback that aims at gaining maximum benefits for patients from the care delivery system so that quality patient care is the potential outcome.<br><br>7. Patient-centered actions of the patient liaison nurse portray autonomy of the registered nurse in ambulatory care nursing by individualized care responses to satisfy the unique needs of a patient and gain individual quality | 13. Attitude and approach by the patient liaison nurse reflects the professional role behaviors in ambulatory care nursing that encompass the mode, procedure, technique or style of how the action was executed autonomously aimed either at access to care or continuity of care.<br><br>14. The patient liaison nurse used attending behaviors in ambulatory care nursing that convey a supportive, understanding and empathetic manner that is patient-focused on individual needs for the ultimate purpose of quality patient care.<br><br>15. Helping skills are used autonomously by the patient liaison nurse in ambulatory care and constitute either psychomotor skills and/or verbal responsiveness aimed at facilitating care delivery to gain access of care or maintain continuity of care.<br><br>16. The patient liaison nurse demonstrates supportive action autonomously in ambulatory nursing care by helpfulness in professional manner and/or by gaining professional team cooperation aimed at responding to patient needs to ensure access to care or maintain continuity of care.<br><br>17. Knowledge-in-action is portrayed by the patient liaison nurse in ambulatory nursing care by a sense of knowing that is reflected in autonomous judgment of a presenting situation for which the action outcome contributes to quality patient care.<br><br>18. Rapid problem assessment reflects the core of autonomy in ambulatory care nursing practice whereby the patient liaison nurse undertakes nursing action based on good clinical judgment and patient-focused decision-making aimed at quality patient care outcomes. | **PATIENT LIAISON NURSE**<br>- Responsive customer attention<br>- Nursing actions<br>(Statements 1 to 22)<br><br>**NURSING PRACTICE AUTONOMY**<br>- Rapid problem assessment<br>- Clinical decision-making<br>(Statements 1 to 22)<br><br>**THE PATIENT**<br>- Unique care needs<br>(Statements 1 to 22)<br><br>**COLLABORATION**<br>- Facilitative liaison<br>- Mutual cooperation<br>- Helpful coordination<br>(Statements 1,2,3,4,5,6,12,14,15,16,22) |

| | | |
|---|---|---|
| patient care.<br><br>8. Responsive customer service in ambulatory care nursing by the patient liaison nurse embodies autonomy as a registered nurse in the delivery of individualized care for the uniqueness of the presenting healthcare situation of the patient so that the specific needs or complaints of the patient are addressed by targeting a quality patient outcome.<br><br>9. In tailored patient education, the patient liaison nurse uses autonomy in ambulatory care nursing practice by focusing health information individually to match the unique needs of the patient for self-care benefit so that continuity of care is gained.<br><br>10. System-related actions by the patient liaison nurse are nursing actions autonomously aimed at ambulatory care delivery components so that resourceful, efficient and effective outcomes are achieved to ensure quality patient care.<br><br>11. Ambulatory care system orientation by the patient liaison nurse includes autonomous nursing actions targeted at familiarizing the patients to the range of care services, related adjustments and expansions for maximum benefit of patients to gain access and/or continuity of care.<br><br>12. System improvement input by the patient liaison nurse in ambulatory care encapsulates autonomy in nursing contributions from an end-user perspective aimed at raising awareness of system quality elements that are conducive to achieving quality patient care. | 19. Quality care contributions by the patient liaison nurse in ambulatory care nursing added useful value to basic patient care that result in higher standards of quality patient care.<br><br>20. The patient liaison nurse in ambulatory nursing care provides tailored patient education in an autonomous professional manner by responsiveness to the unique needs of an individual patient situation aimed at self-care so that continuity of care is achieved.<br><br>21. Professional suggestions reflect an openness to autonomy in practice by the patient liaison nurse in ambulatory nursing care to alternative professional executions within the patient liaison nurse role aimed at achieving favorable quality patient care outcomes.<br><br>22. A support network is an organized arrangement of resources used autonomously by the patient liaison nurse in ambulatory care nursing for professional cooperation to facilitate prompt access of care or to maintain continuity of care, and therefore reaffirms the focus on quality patient care. | **QUALITY PATIENT CARE**<br>- Access to care<br>- Continuity of care<br>(Statements 1 to 22)<br><br>**AMBULATORY CARE SERVICES**<br>- Operational networking<br>- Service recommendations<br>(Statements 2,3,4,5,6,11,12,14,15,16,20,22)<br><br>**CARE DELIVERY SYSTEM**<br>- System orientation<br>- System function<br>- System improvements<br>(Statements 6,10,11,12 ) |

## 5.5 THE PROCESS OF CONCEPT CLASSIFICATION

The process of concept classification utilized the work of Dickoff, James and Wiedenbach (1968), which Hickman in George (2002:9) acknowledges as classical work that guides theoretical thinking in theory development, specifically in nursing. The relevance of Dickoff, James and Wiedenbach's work was acclaimed by Craig (1980:350) who acknowledged their influential contribution to scientific knowledge and theory construction as well as being 'staunch proponents' of practice theory based on their assertion that 'all theory exists finally for the sake of practice'. My use of Dickoff, James and Wiedenbach's (1968) work is based on their clarity in isolating concepts within the practice arena, and the emphasis that a practicing nurse must have knowledge to support decisions in practice that contribute to an educated, caring, competent and committed nurse practitioner.

This study aimed to produce a practice model aligned to the level of theory development that Dickoff, James and Wiedenbach (1968a:421) designate as 'situation-producing' theory. The discussion on the use of Dickoff, James and Wiedenbach's work is provided in chapter two (2), section 2.3 on theory generative research. They refer to three (3) essential components on the nature of a situation-producing theory that are:

- Goal content specified as the aim of the activity: in this study, the goal of the situation that triggered the creation of the functional RN role of the patient liaison nurse was to prevent interruption in the treatment of patients attending ambulatory care services.
- Prescriptions for activity to realize the goal content: at the outset of activities by the patient liaison nurse, they were instructed by nursing administration to receive and interview patients with problems that could potentially interrupt or

compromise treatment, and to take relevant and appropriate actions aimed at facilitating the continuation of treatment.

- A survey list to classify the activities or elements aimed at achieving the goal content: in this study, these activities and elements are represented by and have been identified as concepts arising from empirical data related to the practice of the patient liaison nurse, and therefore the survey list is justified as appropriate and relevant for use in classifying the emerging concepts.

Dickoff, James and Wiedenbach (1968a:421) further state that the use of the survey list 'calls attention' to two further actions that support the process of concept classification, and these are:

- Use of the survey list to cluster 'factors, facets, and aspects of activity judged relevant to achieve situations' in practice that are simple or complex in nature, but that are still at the conceptual level without relational statements.
- Use of knowledge in the literature in appraising the concepts at whatever level deemed is necessary or as a possibility for achieving the overall aim of producing a practice model.

They elaborate further that the purpose of using a survey list is to articulate a conceptual awareness that in situation-producing theory, the goal content that triggered the initial activity, and the prescriptions of activity to realize the goal content are not necessarily determinants of the practice model that emerges. Therefore, it is necessary that the survey list be utilized to classify concepts so that all related and salient characteristics are studied as to how activities and features adjust idiosyncratically within a particular situation to realize the goal content.

The survey list of Dickoff, James and Wiedenbach (1968a:422) uses the following six (6) modified questions for concept classification in relation to activities and their features:

1) AGENT: Who or what performs the activity?
2) RECIPIENT: Who or what benefits from the activity?
3) CONTEXT: In what context is the activity performed?
4) TARGET: What is the targeted outcome of the activity?
5) PROCEDURE: What is the guiding procedure, protocol or technique of the activity?
6) DYNAMIC: What is the energy source for the activity?

Figure 5.1 that follows illustrates the coherent generation by use of deductive logic from concept identification to concept classification using the modified survey list of Dickoff, James and Wiedenbach (1968). A related outline follows to articulate how this was applied to concept classification in this study.

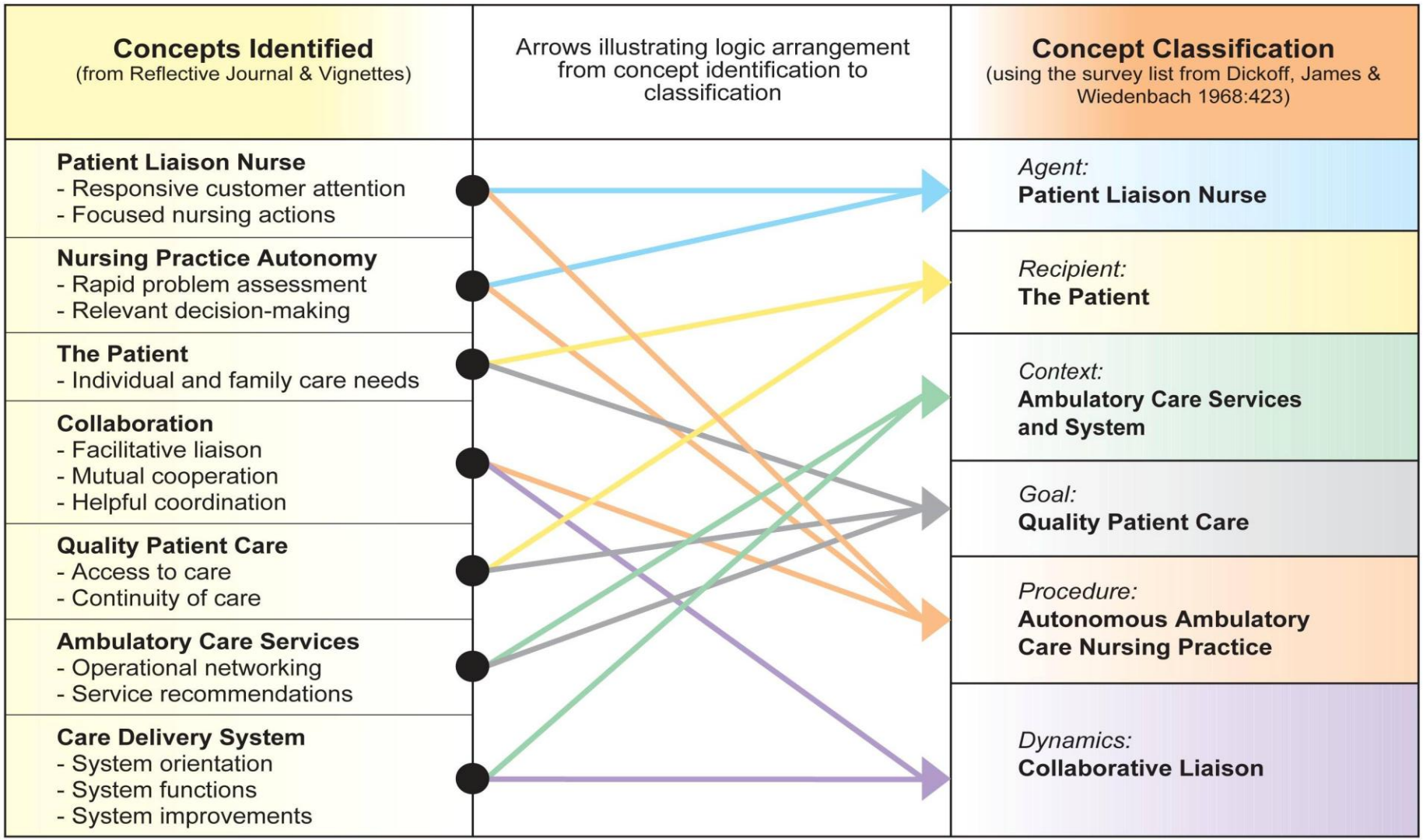



**Figure 5.1** Illustration of Concept Identification and Concept Classification using the Survey List (modified) from Dickoff, James and Wiedenbach (1968:423). *Figure adapted from Bruce (2003)*

### 5.5.1 Agent: patient liaison nurse

Dickoff, James and Wiedenbach (1968a:425) indicates that the ‘agent’ can be a person or point of service that carries out activities within an organization. The nature of the ‘agent’ stimulates activities that are ‘creative, constructive’ and significant within performance that is aimed at ‘goal’ achievement. The ‘agent’ in this study is the ‘patient liaison nurse’ who is an RN (registered nurse). S/he assumes a particular functional role to contribute specifically in attendance to patients without physician-initiated actions for the goal of quality patient care.

### 5.5.2 Recipient: the patient

The ‘recipient’ according to Dickoff, James and Wiedenbach (1968a:427) can be any person or an unspecified object that is the receiver of the activity by the ‘agent’. Interestingly, it is noted that the 'recipient' is not passive necessarily in receiving the agent’s activity because there always is a reaction, although perhaps not perceived by the ‘agent’ (sic). ‘The patient’ is the ‘recipient’ in this study and includes idiosyncratic characteristics of ‘the patient’ that are contributory in defining ‘the patient’ as the ‘recipient.’ In this study, ‘the patient’ encompasses the individual and the family as recipients.

### 5.5.3 Context: ambulatory care services and system

Dickoff, James and Wiedenbach (1968a:428) refer to the ‘context’ as including the ‘setting, location, the physical structure of ward, hospital, or medical center’ … ‘time, space, or structure’ that constitute different elements of the situation in which the activity occurs. They note that the physical elements are arranged in a manner to

support a ‘patient-centered’ approach that unifies all activities in which the ‘agent’ is functioning towards the ‘goal’ for the benefit of the ‘recipient.’ The ‘Ambulatory Care Services and System’ is the ‘context’ in this study where the activities are happening.

### 5.5.4 Goal: quality patient care

The goal is referred to as the ‘terminus’ by Dickoff, James and Wiedenbach (1968a:428). The root of the word ‘terminus’ is Latin and means ‘the last or final point’, ‘a goal aimed for’, ‘end’ point, ‘limit’ or ‘boundary’ (Collins English Dictionary, 2006:1248, Oxford Dictionary & Thesaurus 2007:1066). In essence, Dickoff, James and Wiedenbach (1968a:428) regard it as the goal that represents the point of ‘accomplishment of the activity’ whereby the activity is ‘characterized in terms of its end point’. The authors (p 429) expand on the characteristics of the goal as unifying all activities as achievable through organization and structure so that the ‘agent’ acts by ‘visualizing the end product’. They elaborate on ‘visualizing’ the goal whereby it ‘facilitates’ the ‘performance’ of the ‘agent’ to ‘consider how best to describe an activity’s end point’ (Dickoff, James & Wiedenbach 1968a:430). The patient-centered nature of the ‘goal’ is given by its ‘acceptability’ to the ‘recipient’ (ibid). The ‘goal’ in my study is ‘quality patient care’.

### 5.5.5 Procedure: autonomous ambulatory care nursing practice

In Dickoff, James and Wiedenbach (1968a:430) they view the ‘procedure’ as ‘features’ along a ‘path’ and/or emphasis of ‘steps’, instructions or patterns on how the activity is to be performed. They enlarge on the ‘procedure’ by stating that its facets include principles, sets of rules, routine or particular features that contribute a series of actions aimed at the ‘goal’ that is to the advantage of the ‘recipient.’ It is agreed that the

‘procedure’ does not determine the ‘activities’ in detail but offers to ‘guide’ or ‘safeguard’ such as ‘policies and procedures’ within an organization or a professional health discipline. The ‘procedure’ of this study is ‘autonomous ambulatory care nursing practice’.

### 5.5.6 Dynamic: collaborative liaison

The ‘dynamics’ are taken by Dickoff, James and Wiedenbach (1968a:431) to comprise the vivacity of influence as an energy origin and an attribute associated with capacity to execute activities. The possible origin of functioning could be physical, physiological or psychological and ‘is relevant’ only to ‘persons functioning’ as ‘agent’, ‘recipient’ or within the ‘context’. In relation to merely ‘functioning’, the authors specify that it must be ‘purposeful’, ‘goal-directed’, have ‘drive’, ‘impetus’ or ‘direction’ (ibid). The ‘dynamics’ in the study is the ‘collaborative liaison’ essential for propelling the activity to goal attainment.

Prior to an in-depth discussion of each classified concept in relation to the reviewed literature, the approach will be described for conducting the literature search in support of the conceptual framework. Dickoff, James and Wiedenbach (1968b:546) confirm this approach and refer to it as embracing an openness to relevant empirical reality as it exists in the literature and/or evidence.

## 5.6 CONDUCTING A LITERATURE REVIEW TO SUPPORT THE CONCEPTUAL FRAMEWORK

The approach to conducting a literature review to support the conceptual framework on the discussion of the concepts that were classified required a search strategy. Polit and Beck (2008:109) support this notion that is based on rapid technological and electronic advances, whereby the focus is not on finding information but how the access to information is accessed logically. They highlight four (4) approaches to searching that are put forward by Cooper (1998), namely:

(i) Searching for references using bibliographic databases

(ii) The ancestry approach that follows footnotes that cite relevant studies

(iii) The descendancy approach that locates a pivotal early study and tracks recent studies that cite the original key study

(iv) Grey literature tracking that involves devised methods to track limited distributions, conference papers and posters, unpublished reports, dissertations, and institutional reports.

The above four (4) approaches were used integrated with the following modified three (3) principles by Silverman and Marvasti (2008:368) for application when undertaking a literature review:

(i) Broad-mindedness in pursuit of literature that embraces earlier work whereby a connection is shown in transmitting old knowledge and classical work aimed at creating new knowledge that embraces our scholarship heritage within a professional discipline.

(ii) Being focused and critical while exploring the literature with a sense of scholarship to advance knowledge by employing a critical perspective.

(iii) Avoiding mere description in the use of literature by keeping the purpose of the literature review as balancing topics that are central to the research focus with the aim of critique and support instead of reporting.

The process of literature review was therefore informed by the above approaches and principles, and was set out in the following steps that embrace combinations of work by Creswell (2003:33), Silverman and Marvasti (2008:365), Holloway and Wheeler (2010:35), and Marshall and Rossman (2011:77).

**Table 5.2** Steps used in the process of literature searching and review

| Step | Activities for engagement for each step |
|---|---|
| 1. | Identify key words that pertain to the search topic. |
| 2. | From initial scanning, identify further recurring concepts or words that are common in the literature abstracts. |
| 3. | Define the key words and concepts using dictionaries or the glossaries of textbooks. |
| 4. | Finalize the search profile including the scope of the search and parameters. |
| 5. | Use search engines of electronic literature sources, select publications that have supportive and non-supportive contributions on the search topics, key words and concepts. |
| 6. | Review the selected literature specifically for perspectives that (i) discuss key concepts, (ii) define the research approaches used, (iii) describe theoretical components, and (iv) include expert opinion. |
| 7. | Consider the analysis of the selected literature within the specified and related context of the research study. |
| 8. | While analyzing literature be aware of (i) areas that would require further clarification or more research, (ii) gaps in knowledge or unanswered questions, (iii) controversy or inconsistency in the literature, (iv) aspects from past experience or logic that are possibly relevant to the phenomenon under study, and (v) perspectives that are common or uncommon in occurrence. |
| 9. | Make a judgment on the component parts that are analyzed, then utilize these to generate justifications and arguments using deductive and inductive reasoning in relation to the points of focus. |
| 10. | Synthesize the ideas by combining points, themes, opinions and arguments into a logical complex whole that integrates judgment and theory into a single flow of reasoning in response to the dimensions of the search topics that are comprised of the key words and concepts. |

The specialized electronic search engines that were used included Blackwell synergy, CINAHL, MEDLINE, Medscape nursing, Ovid, Pubmed, Sage and Science direct. Multiple Boolean operators of the AND, OR and NOT functions were used that included key words and concepts in a recognizable arrangement for an advanced level of searching (Bryman & Bell 2007:662, Sandelowski & Barroso 2007:48). Concurrent to the review of published literature, I noted the experts who were repeatedly quoted by authors. This led to the activity of purchasing a vast and wide range of textbooks on qualitative research, theory development in nursing and other relevant topics associated with the practice of nursing and research. Parallel acquisitions of dictionaries of the English language (and thesauri), and for philosophy and qualitative inquiry were attained, which were helpful in the analysis of the literature and the synthesis of arguments.

The literature search strategy was not exclusive to the conceptual framework, but was iterative in the early design and conceptual stage of this study, during data collection and data analysis, and in the results phase which included the conceptual framework and model development and description. This approach in model development is aligned with Chinn and Kramer (2008:267) who assert that in theory-generating research, the literature search and review extends beyond the background and justification for a study, and therefore is continuous and comprehensive. Chinn and Kramer (2008:267) advise that as concepts and ideas emerge from the data, the researcher uses the data to guide further explorations in the literature, which contributes to the model development process of refining and delineating central concepts and the relations between them.

Walker and Avant (2011:110) state that a ‘careful examination of the literature’ is required and term it as a ‘literary synthesis’ aimed at acquiring ‘new insights about the

phenomena of interest'. They offer two (2) techniques within literary methods for statement synthesis in theory construction (Walker and Avant 2011:131). These are:

- making the meaning of the concepts included in a statement more general
- expanding the scope of the phenomena of interest to include a wider variety of related situations.

The above approaches to literature searching and review converged on the requirements of a conceptual framework of the classified concepts that were derived from the empirical data in this study. Mouton (1996:195) refers to a conceptual framework as functional for the classification of characteristics of the phenomenon being studied. The three (3) major characteristics in table 5.3 that follows were used to guide the activity of generating a conceptual framework.

**Table 5.3** Defining characteristics of a conceptual framework and related activities

| Major characteristics | Activities of engagement |
|---|---|
| 1. **Description of the 'ideal type'** as a basic unit of typology | • exclusion of inconsequential or incidental characteristics.<br>• retention of the most common and outstanding characteristics by abstraction from the most concrete levels of experience to the most abstract.<br>• identification of the most common characteristics and emphasize above the specific. |
| 2. **Consequence of abstraction** in that no single type of characteristic of the phenomenon can be exactly reproduced | • endorsement of the process of selection by uniqueness of abstraction.<br>• involvement of references of abstraction and the relationship that combines the concept and the typified phenomenon. |
| 3. **Criteria for good classification,** which are exhaustiveness and mutual exclusiveness | • inclusion of all the conceivable and relevant characteristics associated with the phenomenon.<br>• distinction of differences between characteristics by mutual exclusiveness.<br>• where overlap is noted, a further process of refinement occurs for distinctiveness. |

Mouton (1996:198) states that the identification of the above major characteristics contribute to a conceptual framework in which phenomena are classified in terms of their concepts. Mouton and Marais (1990:137) and Polit and Beck (2008:141) echo this definition of a conceptual framework, while the latter authors expand that the concepts are arranged by 'virtue of their relevance to a common theme'. However, Mouton (1996:199) goes further to elaborate on three (3) tendencies or nature that the theoretical model ultimately assumes in terms of functionality. They are:

i. The universalistic tendency that explains empirical science of nature, such as Newton's law of gravitation
ii. The formalistic tendency that explains scientific propositions in the mature sciences deductively using universal laws
iii. The logicist tendency that describes what has been formulated to describe phenomena.

This study aimed to generate a model in nursing practice, and therefore is aligned to the logicist tendency to describe the identified and classified concepts that contribute to describing a phenomenon, and therein lies the purpose of the conceptual framework and related literature review. Congruent to the timeline of this thesis, multiple editions of texts were used. In most instances the references were updated to match the latest editions, however, in some cases the earlier editions have been retained either because passages of text or chapters are absence or changed in the most recent edition. In this regard therefore, all editions are listed as references. The sections that follow will provide an in-depth literature based description on each of the classified concepts according to their order on the previous survey list as shown in figure 5.1 and discussed in section 5.5 on concept classification.

## 5.7 AGENT: PATIENT LIAISON NURSE

To pinpoint the patient liaison nurse as an agent in the ambulatory care context, it is necessary to determine the professional foundations of this role. In so doing, it necessitates a review on what is not in the role description.

### 5.7.1 Foundations of the PLN role

The PLN role is founded on the core credentialed functional role as a registered nurse (RN) that embodies the listing of the person's name and general nursing qualifications on an official legal record at a governmental agency and/or regulatory authority for nurses (Blais, Hayes, Kozier & Erb 2006:76, Guido 2007:60). In nursing practice universally, an RN is allowed to engage in professional practice within a legal scope of practice that governs the acts and omissions of the licensed nursing practitioner (Blais & Hayes 2011:77). Creasia and Parker (2007:57) postulate that the foundations of the RN in clinical practice constitute defined standards of professional performance that are regarded as the areas of responsibility in the RN role. In an organization, this is the basis for a job description that outlines the obligations and functions of the RN role so that standards are grounded in role expectations (Roussel and Swansburg 2006:444, Blais, Hayes, Kozier & Erb 2006:78).

It is widely agreed that RN role responsibility has corresponding accountability for execution of the job role with delegated authority within an organization. The RN role therefore has matching self-directedness for accomplishing RN responsibilities in an autonomous manner (Muller 2002:57, Danna 2006:116, Killeen & Saewert 2007:60, Yoder-Wise 2007:485).

The fundamental RN role of the PLN is the ambulatory care nurse (ACN) with the PLN role as a specific functional RN role. The PLN role is therefore not a specialized or advanced practice nurse because post RN qualifications are not required for the PLN role such as post-graduate qualifications that are required universally for the nurse specialist and advanced nurse practitioner or consultant roles (Gilliss 2000:38, Hickey 2000:4, Hixon 2000:54, Lewis & Smolenski 2000:67, Daly & Carnwell 2003:162).

Daly and Carnwell 2003:158 provide a framework for distinguishing between RN nursing roles and levels of practice, and emphasize that as clinical nursing practice expands and diversifies, it is imperative that role differentiation be clarified. The purpose is overcoming role confusion in relation to the scope of practice, the nature of the role, preparation and expectations of the various roles. Table 5.4 below is modified from Daly and Carnwell (2003:162) as a framework for the levels of nursing practice.

**Table 5.4** A framework of RN role differentiation and levels of RN clinical practice (modified from Daly & Carnwell 2003:162).

| RN Role Title | Nature of RN Practice | Educational Preparation for the Role | Type of Position & Time Post RN |
|---|---|---|---|
| 1. Elementary RN practitioner | General clinical nursing care that is elementary and may extend or develop within general nursing services and professional self development. | RN – Diploma in General Nursing or Bachelor of Nursing in General Nursing | Unit RN – immediate to RN registration; usually in a full-time direct care giver role. |
| 2. Clinical Nurse Specialist | Role expansion of core RN role with in-depth clinical focus on specific areas of practice | RN plus a Bachelor or Masters degree involving specialist nursing education | Peripatetic RN role across several nursing units – Usually 3-5 years RN experience to include 6-12 months consolidation of elementary practitioner role and education with practice in area of specialty |

| | | | |
|---|---|---|---|
| 3. Advanced Nurse Practitioner or Nurse Consultant | Role development that embraces higher clinical autonomy usually in response to new service demands or perceived deficits in quality of patient care and/or health resources | Masters or Doctoral Degree and regulatory or statutory provisions for higher level of clinical practice | Usually requires 5-10 years of post registration and specialist practice. Includes preparation for advanced practice and relation consolidation in practice. |

In essence, the functional RN role is an elementary RN practitioner role for the following core reasons:

- Only the basic qualification as a general nurse RN is needed as a nursing credentialing requirement.
- Minimum post-RN registration experience of 12-18 months in ambulatory care nursing is required for the PLN functional RN role.
- The segment of patient care that was selected for functional focus in the RN role was patient care concerns that may lead to interruption in continuity and/or access of patient care.

The functional focus of the RN role will be discussed for the purpose of illustrating the context of role development in relation to the ambulatory care nurse (ACN) and patient liaison nurse (PLN).

### 5.7.2 The functional RN aspect of the PLN

The functional RN aspect of the PLN embodies the functional method that operationalizes nursing care delivery by ambulatory care nurses in the clinical contextual setting of the research site of this study.

Functional nursing is widely regarded as the oldest nursing practice method for delivery of nursing care on a unit (Roussel 2006:16). Authors attribute the popular use of

functional nursing to worldwide nursing shortages experienced in 1940s during World War II from 1939 to 1945 (Hood & Leddy 2003:79, Yoder-Wise 2007:243, Marquis & Huston 2009:317). However, Blais, Hayes, Kozier and Erb (2006:174) assert that functional nursing developed from management science concepts in business administration and were primarily adopted because the focus was on the completion of tasks that constituted nursing care delivery to patients. Irrespective of the impetus on how functional nursing evolved, all authors are aligned that the core purpose is the task-oriented approach aimed at economy, productivity and efficiency in nursing care delivery of the component parts of patient care (Hood & Leddy 2003:79, Blais, Hayes, Kozier & Erb 2006:174, Roussel 2006:16, Yoder-Wise 2007:244, Marquis & Huston 2009:317). The use of functional nursing in practice is operationalized by each RN being assigned specific tasks such as medication administration, checking vital signs, wound care dressings, drawing blood specimens and follow-up of laboratory results and patient education.

The disadvantages of functional nursing are listed as fragmentation of patient care and correspondingly can result in the unique needs of patients being overlooked if a particular aspect of a patient, such as an emotional need, is not assigned to a caregiver role (Blais, Hayes, Kozier & Erb 2006:174, Roussel 2006:16).

Functional nursing is beneficial when large volumes of patients are handled and the component parts of care delivery need prompt and fast attention (Roussel 2006:16). Nursing areas include the operating room, emergency room, long-term care and ambulatory care services where there is a reception or triage area where the patient is subjected to initial assessments and screening activities. Thereafter, the patient moves through various points of care delivery until the exit component. Yoder-Wise (2007:244) compares this approach to industry and throughput in an assembly line, but admits that the RN becomes an expert at their point of care delivery. The common

value of functional nursing shared by authors is that it is the most efficient and best system of dealing with the large numbers of patients that move through healthcare services in a limited period of time (Hood & Leddy 2003:79, Roussel 2006:16, Yoder-Wise 2007:244).

Marquis and Huston (2009:319) contend that contemporary nurse administrators may not readily agree that functional nursing is used in modern healthcare facilities. They argue that irrespective of whether only specific aspects of care delivery are assigned as tasks to an RN, or whether sub-professional categories of nursing assistants are assigned to one RN in a clinical area, it remains functional nursing by definition. In this regard Blais, Hayes, Kozier and Erb (2006:174) accept the overall benefits of functional nursing while stipulating that clearly defined lines of communication, policies and procedures, and specific job descriptions are required with a method of central control and direction for all members of the nursing team. They caution that the non-defined tasks such as psychosocial care would need specific attention to ensure that it is not neglected. Yoder-Wise (2007:245) advises nurses to be alert to quality aspects of patient care when functional nursing is used vis-á-vis the achievement of favorable patient outcomes that become the overall intentional focus of nursing care delivery.

### 5.7.3 Liaison nursing

Liaison nursing is not defined in the core curriculum of the American Academy of Ambulatory Care Nursing that was edited by Laughlin (2006). A brief mention is made in this text by Mastal (2006:40) on the liaison role of parish nursing in religious/faith-based communities whereby the liaison role is limited to referral only.

In the wider panorama of nursing practice areas, liaison nursing has the recurrent emphasis of development arising from either prevention of interruptions in patient care treatment plans or facilitation of continuity of care (Taylor, Readman, Hague, Boulter, et al 1994:122, Arts, Francke & Hutten 2000:293, Calvin & Kolar 2000:308, McBride 2003:46, Chaboyer, Foster, Foster & Kendall 2004:79, Chaboyer, Foster, Kendall & James 2004:28, Green & Edmonds 2004:135, Carlson, Reilly & Hitchens 2005:359, Foster, Gantley, Feder & Griffiths 2005:157, Hoxsie 2006:211, Moroz & Ward 2006:E85, Pettis 2006:E55, Alfonzo, Simpson, Deighan, Campbell, et al 2007:18, Clunie & Stephenson 2008:160, Holtrop, Dosh, Torres & Thum 2008:S369). These various authors however, do not specify whether the liaison nurse positions were created specifically as part of forecasting or strategic plans, yet all commonly appear to identify a service or system gap to which the generation of a liaison RN nurse was assigned. The nature of the RN duties in each context constitutes functional nursing.

Table 5.5 that follows illustrates the functional nursing focus in the summary of fifteen (15) published articles whereby the RN role was developed into a functional extension of the core RN role within the service area of nursing practice. The table indicates the key functions of the RN role, and the related skills and abilities required by the role. The countries in which these liaison nursing roles were found are represented as follows:

- United States of America = 6 (40%)
- United Kingdom = 4 (26.6%)
- Australia = 3 (20%)
- Ireland = 1 (6.67%)
- The Netherlands = 1 (6.67%).

The authors in three (20%) of the articles added ‘specialist’ to the description of the liaison nurse; however, on closer review, it was concluded that the use of ‘specialist’ signifies clinical service focused involvement of the RN and was not a reference to a post-graduate RN credentialing requirement for the role (Taylor, Readman, Hague, Boulter, et al 1994:121, Foster, Gantley, Feder & Griffiths 2005:154, Clunie & Stephenson 2008:160). Furthermore, the three (20%) Australian-based articles revealed that the concept of the ICU liaison nurse had evolved from the idea of the critical care outreach nursing model in the UK. However, the distinct difference was that outreach teams in the UK model focused on improving care for acutely ill patients in the ward environment, whereas the Australian approach included the development of rapport and acceptance of the liaison nursing role as the fundamental basis for networking with nursing peers at the ward level. This approach fostered interpersonal referral levels and mutual comfort with valuing of the of the respective roles (Chaboyer, Foster, Kendall & James 2004:28, Chaboyer, Foster, Foster & Kendall 2004:82, Green & Edmonds 2004:137).

The exclusion of the related literature on the British critical care outreach model and critical care rapid response teams was intentional since these nursing models of care delivery are designed for immediate and direct nurse-physician collaboration in relation to the emergent/urgent care of acutely ill patients. The critical care rapid response approach to acutely ill patients who are further deteriorating is dissimilar to the concept of the patient liaison nurse in this study, because the UK focus is on developing the ICU nurse consultant, which would be regarded as explicit role clarity to include post-graduate qualifications and a minimum of five (5) years of critical care experience (Chaboyer, Foster, Foster & Kendall 2004:78, Green & Edmonds 2004:135).

**Table 5.5** Summary of liaison nursing roles in various areas of practice

| Date | Author(s) | Country | Nursing Practice Area(s)/Service | Key Functions in RN Role | Related Skills & Abilities |
|---|---|---|---|---|---|
| 1994 | Taylor, Readman, Hague, Boulter, et al | United Kingdom | Epilepsy community-based service | • Advice and support to patients and families<br>• Link between hospital & GP<br>• Foster links with governmental services<br>• Training for community caregivers | • Patient education<br>• Counseling skills<br>• Collaboration in team<br>• Critical thinking |
| 2000 | Arts, Francke & Hutten | The Netherlands | Stroke care – home health service | • Link between hospital & home care services<br>• Improve quality of care<br>• Prevent hospital readmission & reduce length of hospital stay | • Organization & coordination<br>• Assessment & evaluation<br>• Counseling & communication<br>• Information management<br>• Patient education |
| 2000 | Calvin & Kolar | USA | Cardiac pediatric surgery<br>- Intensive care<br>- Operating room | • Patient and family-centered care and support through surgical experience<br>• Liaise with social work & bereavement services | • Patient education<br>• Communication skills<br>• Time management<br>• Collaboration |
| 2003 | McBride | Ireland | Accident & Emergency Units and community GP practice | • Front line quality of service<br>• Clinical nursing leadership<br>• Improving links and communication in healthcare system | • Planning & organizing<br>• Team leadership<br>• Information management<br>• Staff education |
| 2004 | Chaboyer, Foster, Foster & Kendall | Australia | Intensive care units and general wards | • Facilitate patient transition from ICU to ward<br>• Provide staff & family support & education<br>• Develop liaison between ICU & ward | • System knowledge<br>• Resource management<br>• Interpersonal skills<br>• Problem-solving<br>• Assessment monitoring |
| 2004 | Chaboyer, Foster, Kendall & James | Australia | Intensive care units and general wards | • Effective discharge of ICU patients<br>• Prevention of re-admission to ICU<br>• Supportive role to ward nurses | • Discharge planning education<br>• Follow-up liaison and coordination<br>• Assessment<br>• Coordination |
| 2004 | Green & Edmonds | Australia | Intensive care units and general wards | • Provide clinical nursing leadership on ICU patients to ward nurses<br>• Decrease length of ICU stay & prevent ICU readmission | • Clinical ICU knowledge<br>• Information management<br>• Problem-solving<br>• Team leadership |
| 2005 | Carlson, Reilly & Hitchens | USA | Research clinical trials & therapeutics nursing | • Ensure safe therapeutic research practice in drug trials through patient advocacy<br>• Maximize quality of care by minimizing patient dissatisfaction | • Multidisciplinary liaison and coordination<br>• Counseling skills<br>• Staff teaching<br>• Patient education |

| | | | | | |
|---|---|---|---|---|---|
| 2005 | Foster, Gantley, Feder & Griffiths | United Kingdom | Primary care for chronic asthma management | • Clinical nursing leadership in referral process<br>• Maintain productive liaison practices with team | • Clinical knowledge and decision-making<br>• Problem-solving<br>• Team collaboration<br>• Information management<br>• Patient education<br>• Negotiation & interpersonal skills |
| 2006 | Hoxsie | USA | Home health service | • Ensure safe & appropriate homecare program<br>• Generate referrals for access to care<br>• Generate marketing action plans for increased agency use and referrals | • Assessment and evaluation skills<br>• Team liaison and collaboration<br>• Coordination and planning skills<br>• Communication skills<br>• Marketing skills<br>• Follow-up & feedback skills |
| 2006 | Moroz & Ward | USA | Infection control | • Front line infection prevent and control practices<br>• Effective liaison with clinicians | • Facilitation & communication skills<br>• Staff education |
| 2006 | Pettis | USA | Infection control | • Advance bedside nurses in infection prevention & control<br>• Standardize related practice | • Networking skills<br>• Presentation skills<br>• Problem-solving skills |
| 2007 | Alfonzo, Simpson, Deighan, Campbell, et al | United Kingdom | Renal nursing in cardiopulmonary resuscitation | • Provide vascular access<br>• Instant source of patient history on reversible symptoms<br>• Contribute to decision to stop CPR | • Vascular access clinical skills<br>• Team collaboration<br>• Communication & coordination skills<br>• Decision-making skills |
| 2008 | Holtrop, Dosh, Torres & Thum | USA | Health education in community services | • Establish clinical working relations with primary care core practitioners<br>• Patient support & counseling<br>• Maintain database of referrals and community resources | • Lifestyle patient education<br>• Networking skills<br>• Counseling skills<br>• Information management |
| 2008 | Clunie & Stephenson | United Kingdom | Orthopedic fracture service | • Service liaison for all fracture referrals<br>• Managing patient protocols of treatment | • Planning & coordination<br>• Information management<br>• Communication & collaboration |

### 5.7.4 Conclusion statements on the agent: patient liaison nurse

The following deductive conclusion statements relate to the agent concept of the patient liaison nurse:

- Patient liaison nursing is a specific functional RN role that is characterized by a focused response to patient concerns arising from potential interruption in the continuity of care.
- Functional nursing is the method of care delivery used by ambulatory care nurses and the patient liaison nurse that aims at specific tasks in response to unique patient concerns aimed at favorable patient outcomes.
- Key functions of liaison nursing in the RN role encompass advice and support to patients, functioning as a link between services, effective liaising with primary health providers, and improving quality patient care.
- The skills and abilities of a liaison nurse in the specific functional role include counseling skills, effective communication, team collaboration, networking and coordination, patient teaching, problem-solving and decision-making aimed at the overall purpose of ensuring quality patient care.

## 5.8 RECIPIENT: THE PATIENT

The recipient of the activity given by the agent is the patient. The meaning of the concept 'the patient' in this study will be viewed from global and local contextual perspectives.

### 5.8.1 Global perspective of 'the patient'

The global perspective of the concept 'patient' has been inextricably linked to financing healthcare organizations over the past four (4) decades (Satinsky 2000:190). As the models of financing healthcare changed or were reshaped and modified, such as the health maintenance organizations (HMO) in the 1970s to Medicaid and Medicare vis-à-vis managed care, so did the ‘patient’ title. In this regard, the concept of 'patient' underwent corresponding renaming as 'consumer', 'purchasers', 'client', 'customer', 'recipients' and 'participants' (Goeppinger & Hammond 2000:175, Satinsky 2000:199, Rossi 2003:479, Haas 2006:9).

However, concurrent to the evolution of 'patient' terminology that originated mainly in the USA, the terminology of health professionals and organizations also underwent a parallel metamorphosis to be described as healthcare 'providers,' 'third-party administrators,' 'preferred provider organizations,' and 'fee-for-service' (Satinsky 2000:192, Rossi 2003:62, Danna 2006:297).

As this scenario unfolded, another transformation was occurring at the level of policymakers, governmental and non-governmental agencies. Goeppinger and Hammond (2000:175) refer to this era as the 'renaissance of primary care' because primary stakeholders became increasingly aware in the mid-1970s of their responsibility for 'public health' or 'community health' (McMurray 2003:16). A flurry of new terminology entered the healthcare lexicon to include 'primary care', 'primary healthcare', 'sustainable health' and a global emphasis on health promotion and health education (Green 1990:447, Green & Kreuter 1991:5, Green 1994:43, Walt 1994:122, Goeppinger & Hammond 2000:176, McMurray 2003:17). Despite this minefield, concepts from large business organizations began to influence healthcare

organizations to focus on the patient and service. The nomenclature included 'consumer relations,' 'consumer focus,' 'service quality indicators,' 'customer service,' 'customer satisfaction,' 'client choice,' and 'healthcare performance improvement' (Joint Commission 2000:37, Foster 2003:737, Fitzsimmons & Fitzsimmons 2004:144, Zalon 2007:437) which raise the question in this study as to who exactly the patient is.

Haas (2006:9), in the textbook of the American Academy of Ambulatory Care Nursing (AAACN), defines the patient as an 'individual who requests or receives nursing services' and indicates that the terms 'client, consumer, member or customer' are used in various settings. Smeltzer, Bare, Hinkle and Cheever (2008:5) indicate that nurse practitioners have the responsibility to comply with the International Council of Nurses' code of nurses and the terminology as 'the patient/client: consumer of nursing and healthcare.' They declare that their choice is to use the term 'patient' in their 'Textbook of Medical-Surgical Nursing,' eleventh ($11^{th}$) edition of 2,629 pages (ibid). Marquis and Huston (2009:77) are aligned to this stance, and who point out that the Congress of Nursing Practice and Economics in the American Nurses Association (ANA) voted to return to the term 'patient' rather than 'client.' This preference in the vote was also to be reflected in the ANA Code of Ethics with the concept of the 'patient' defined as 'individuals with health problems.' Furthermore, 'the patient' is detailed unequivocally in the code as 'an individual, family, group, or community' (ibid).

My preference, as the researcher in the context of this study, is best aligned with the 'patient' definition given by the American Academy of Ambulatory Care Nursing (AAACN) in their 'Telehealth Nursing Practice: Administration and Practice Standards' (AAACN 2004:19). They define the 'patient' as a 'recipient of nursing practice', and use the term '*patient* to provide consistency and brevity, bearing in mind that other such terms such as *client, individual, resident, family, groups, communities,* or *populations*

might be better choices in some instances.' They qualify the foci according to their above definition as follows:

- Patient as an individual – the focus is on the health state, problems or needs of the individual,
- Patient as a family or group – the focus is on the health state of the unit as a whole, or the reciprocal effects on the health state of the other members,
- Patient as a community or population – the focus is on personal and environmental health and related health risks in the community (ibid).

Haas (2006:4) accepts the notion of the patient as an individual, group or community, but provides further distinguishing clinical dimensions to define the ambulatory patient. She uses a health status continuum of descriptions to include the following:

- healthy
- acutely ill
- chronically ill
- terminally ill

Thereto, Haas (2006:5) provides the accepted American Academy of Ambulatory Care Nursing definition of six (6) characteristics of the ambulatory care patient population. These are modified and summarized as:

(i) The patient initiates the episodic visit

(ii) The patient is a member of a defined community

(iii) The patient collaborates with the health team on treatment regimes

(iv) The patient controls healthcare decisions within a span of choices

(v) The patient provides and coordinates healthcare between episodic visits

(vi) The patient has an established relationship with caregivers in Ambulatory Care

### 5.8.2 Local context of the 'the patient'

The local context of what constitutes 'the patient' is self-regulating as to who enters the healthcare system and self-perpetuating because the individual(s) remains in the healthcare system by virtue of life employment. In figure 5.2 that follows, the pathway of a Saudi Arabian citizen in the local context is illustrated in conjunction with a description that clarifies the concept of the patient as a recipient of nursing care. Citizens in the Kingdom of Saudi Arabia are able to make applications to the Saudi Arabian National Guard (SANG) for lifelong employment as a career soldier, and after acceptance, they are eligible for life as SANG personnel and their dependents to receive complete and free healthcare services (NGHA 2009:16). SANG members and eligible dependents are registered immediately within the National Guard Health Affairs (NGHA) healthcare system. Mufti (2000:9) confirmed that health services are regarded as a right of Saudi citizens. He further states that all health services are entirely government-funded, and that citizens hold the expectation that the government is to provide the highest level of healthcare without charging. The National Guard Health Affairs has corroborated this expectation repeatedly in relation to the SANG patient population in published NGHA achievement reports, and has demonstrated their commitment to healthcare services by the progress milestones that have been achieved (NGHA 2001:19, NGHA 2003:18, NGHA 2007:59, NGHA 2009:19). The levels of health services include primary, secondary, tertiary and quaternary levels of care. Encompassed in the quaternary level of care are the provisions of university academic education, multinational and multicenter health science research and serves as a regional and international center for infection prevention and control, and evidenced-based healthcare (NGHA 2009:18).

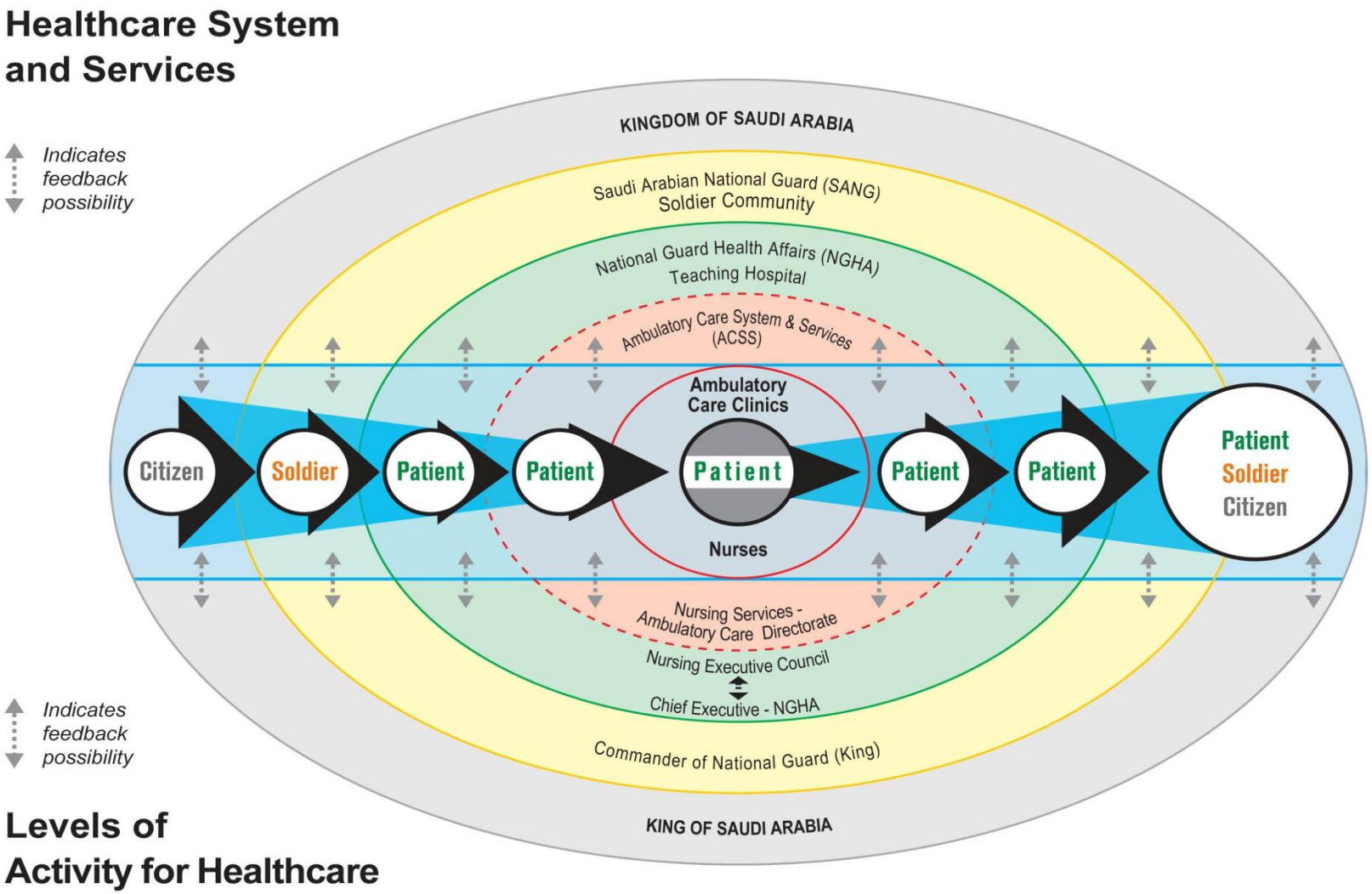



**Figure 5.2** The context showing the patient in the Saudi Arabian National Guard community and how the patient moves through the healthcare system and services.

Figure 5.2 depicts the patient's journey through the NGHA healthcare system back to the community in which a tripartite existence continues as (i) patient, (ii) soldier/soldier dependent, and (iii) citizen. It indeed is this "triple identity" that entrenches the patient as a recipient in this study because whether or not a patient has an in-patient episode of healthcare, all SANG personnel could utilize ambulatory care services within a family as members encounter growth milestones from birth to old age and death.

The vertically placed dashed lines with arrows at both ends [ ◄- - ► ] that are inserted in figure 5.2 to represent feedback at all levels. This is a portrayal of the 'open door' (Roussel & Swansburg 2006:93) approach or 'open communication' (Gibson, Ivancevich, Donnelly & Konopaske 2006:494) in organizations where members of the public can provide feedback with their views on issues, concerns or problems known at any level of leadership and management. In my experience of more than a decade as a nurse administrator in Saudi Arabia, and particularly at an NGHA hospital, it is well-known that patients do not hesitate to access the King if they wish to raise the attention of The Custodian of the Two Holy Mosques to their healthcare plight. It also is not uncommon to receive the written feedback of a patient from the Office of The Custodian of the Two Holy Mosques, the King with a request endorsed by the Office of the Chief Executive Officer, NGHA to investigate a situation and provide written feedback promptly.

### 5.8.3 International context of 'the patient at local level'

All hospitals in the National Guard Health Affairs (NGHA) group are accredited triennially by the Joint Commission International (JCI), Chicago, USA, (NGHA 2009:19) with the most recent re-accreditation in December 2009. In this regard, JCI uses only the term 'patient' in all 260 pages of its 3rd edition healthcare accreditation manual (JCI

2008). The words 'client,' 'consumer' or related terms do not appear in the table of contents, chapters nor in the index.

The six (6) international patient safety goals outlined by JCI (2008:31) that require adherence include the following patient-related measurable requirements that are obligatory for the organization to achieve:

(i) Correct patient identification

(ii) Effective communication by the healthcare team

(iii) Safety of high-alert medications

(iv) Correct-site, correct-procedure, correct-patient surgery

(v) Reduction of healthcare-associated infection

(vi) Reduction of risk and harm resulting from patient falls

The above patient safety goals are known to patients through Arabic and English information banners that are widely posted throughout the facilities, and are reiterated by patient education; for example, patients are advised to ask healthcare professionals whether they had washed their hands prior to entering the patient room. The cornerstone chapters of JCI accreditation (ibid) are self-explanatory by the seven (7) chapters on the patient standards that include:

1) Access to care and continuity of care

2) Patient and family rights

3) Assessment of patients

4) Care of patients

5) Anesthesia and surgical care

6) Medication management and use

7) Patient and family education

In conclusion, the patient as the recipient of the activity by the ‘patient liaison nurse’ agent in Saudi Arabia has a level of 'administrative literacy' based on a free healthcare delivery system and the national expectation to obtain the highest possible level of healthcare.

### 5.8.4 Conclusion statements on the recipient: the patient

The conclusion statements that follow were generated from global and local contextual deductions in relation to the patient as the recipient:

- The patient is an individual or group residing at a location away from the hospital who is entitled to receive healthcare in response to identified needs, problems, concerns or request aimed at gaining quality healthcare.
- Healthcare is a right of the patient to whom the organization is obliged to provide treatment that includes patient teaching on identified problems and related prevention.
- The patient maintains the right to provide feedback on the components of care that may require improvement wherein feedback is valued by the organization as a contribution to attain quality patient care.

## 5.9 CONTEXT: AMBULATORY CARE SERVICES

The context of ‘ambulatory care services and system’ refers to the setting in which the agent interacts with the recipient for the activity to occur. The rhetoric abounds, particularly around the concepts of healthcare ‘services’ and healthcare ‘system’ (Green 1994:38, Walt 1994:16, Attree 1996:44, Henson, Robinson & Schmele 1996:8, Slack, Chambers & Johnston 2001:118, Fitzsimmons & Fitzsimmons 2004:21, Taft

2006:33, Zalon 2007:440). However, whether 'services' are considered as a 'product' or not of a system, when there is a lack of service delivery to the consumers or clients, Slack, Chambers and Johnston (2001:637) point out that it is referred to as 'system failure.' They advocate that it is the opportunity event of system failure to deliver on expectations that trigger a closer examination of the performance behind failure (ibid). It is therefore necessary to pinpoint what is meant by 'service' and 'system'. 'Service' is defined as the actions that are taken in helping, assisting or advising customers (Oxford Dictionary & Thesaurus 2007:945), whereas a 'system' is an organized scheme or 'set of things' working together, that may include a 'group' of 'programs', by which 'something is done' (Oxford Dictionary & Thesaurus 2007:1049).

Henson, Robinson and Schmele (1996:8) quote Robinson (1993) as defining the context of healthcare delivery from a systems-theory perspective who postulates that healthcare delivery is driven by the patients as consumers. The healthcare system is seen as a pattern of arrangements that has input coming from patients according to their eligibility, and throughput as the actual delivery of healthcare by staff members using their abilities, skills and available material resources. The output of a healthcare system is regarded as the level of health and wellness that patients as consumers have obtained by the episodic courses of action through the system, which contributes to a sense of satisfaction with the services received (ibid).

Zalon (2007:436) acknowledges that when healthcare delivery is scrutinized, the field of meaning vis-à-vis the spectrum of healthcare services and healthcare system representatives become a conglomeration of contextual 'multitude of encounters' between consumers, clients, customers and organizations. This context becomes more complex when questions are asked as to whom the customer is when the panorama of healthcare-related components are examined from the levels of healthcare providers and healthcare financing organizations. Arising from the intricate

layers and levels of what may constitute either the healthcare 'service' or 'system', Zalon (2007:436) shifts the focus away from healthcare providers to 'consumer relationships' which embraces the paradigm whereby all healthcare delivery must be service-oriented with the primacy of focus to meet the needs of the customer. She qualifies that, in essence, the customer is the patient and family at which all levels healthcare services converge to meet the "whole" concept of care (Zalon 2007:440 – quotation marks by author). In clarifying this notion, she maintains that, in the context of healthcare delivery, 'a service involves interaction between a consumer and the healthcare system' and concludes that healthcare service organizations should target meeting or exceeding patient expectations. Taft (2006:33) moves further in this regard and summarizes the service orientation for healthcare leadership as 'anticipating, recognizing, and meeting customers' needs, and the motivation to do so.

In this contextual study, the ambulatory care services and system will be reviewed to comprehend the setting in which the activity occurs.

### 5.9.1 The ambulatory care services and system in the local context

The review of the ambulatory care services and system (ACSS) is facilitated by figure 5.3 that follows. There are three (3) rectangles in the figure that are depicted as three (3) parallelograms (or rectangles) with a common center. Between the outer and middle parallelogram is an equidistant space on all sides that portray the Saudi Arabian National Guard (SANG) population. Thereafter, between the middle and inner parallelograms is another aligned space of matching equidistance that shows the National Guard Health Affairs (NGHA). All the inner space of the smallest parallelogram illustrates the ambulatory care services and system (ACSS) in which the agent (patient liaison nurse) and recipient (patient) interact.

The patient pathway through the healthcare system of ACSS is shown as collateral horizontal lines that illustrates the patient as 'P' entering from SANG, moving to meet patient registration requirements of NGHA and thereafter gains eligibility to enter ACSS for services required. The bold line that traverses all three (3) parallelograms shows the direction of the patient through the system towards G that is the goal of the activity whereby the patient returns to the Saudi Arabian community at large.

The achievement reports of NGHA over the last decade confirms that NGHA had implied that a healthcare delivery system is operant, but was not described particularly until the last achievement report wherein the National Guard Health Affairs (NGHA) was referred for the first time as National Guard Health **System** (NGH**S**) (underline & bold – my emphasis, NGHA 2001:18, NGHA 2003:16, NGHA 2009:16). The latter reference to NGHS is congruent to the NGHA publication of health significant indicators (NGHA 2007:59) and publication of the mission, vision and values (NGHA 2009:16) that insert the reference to National Guard Health Systems (NGHS) consistently.

Closer reviews of all these publications as cited above reveal that the terminology of healthcare services are described in a uniform manner as 'National Guard Healthcare Services' vis-á-vis Clinical Services, Medical Services, Dental Services, Ambulatory Care Services, Laboratory Services, Nursing Services, Pharmaceutical Services, and so forth (NGHA 2001:19, NGHA 2003:28, NGHA 2009:26).

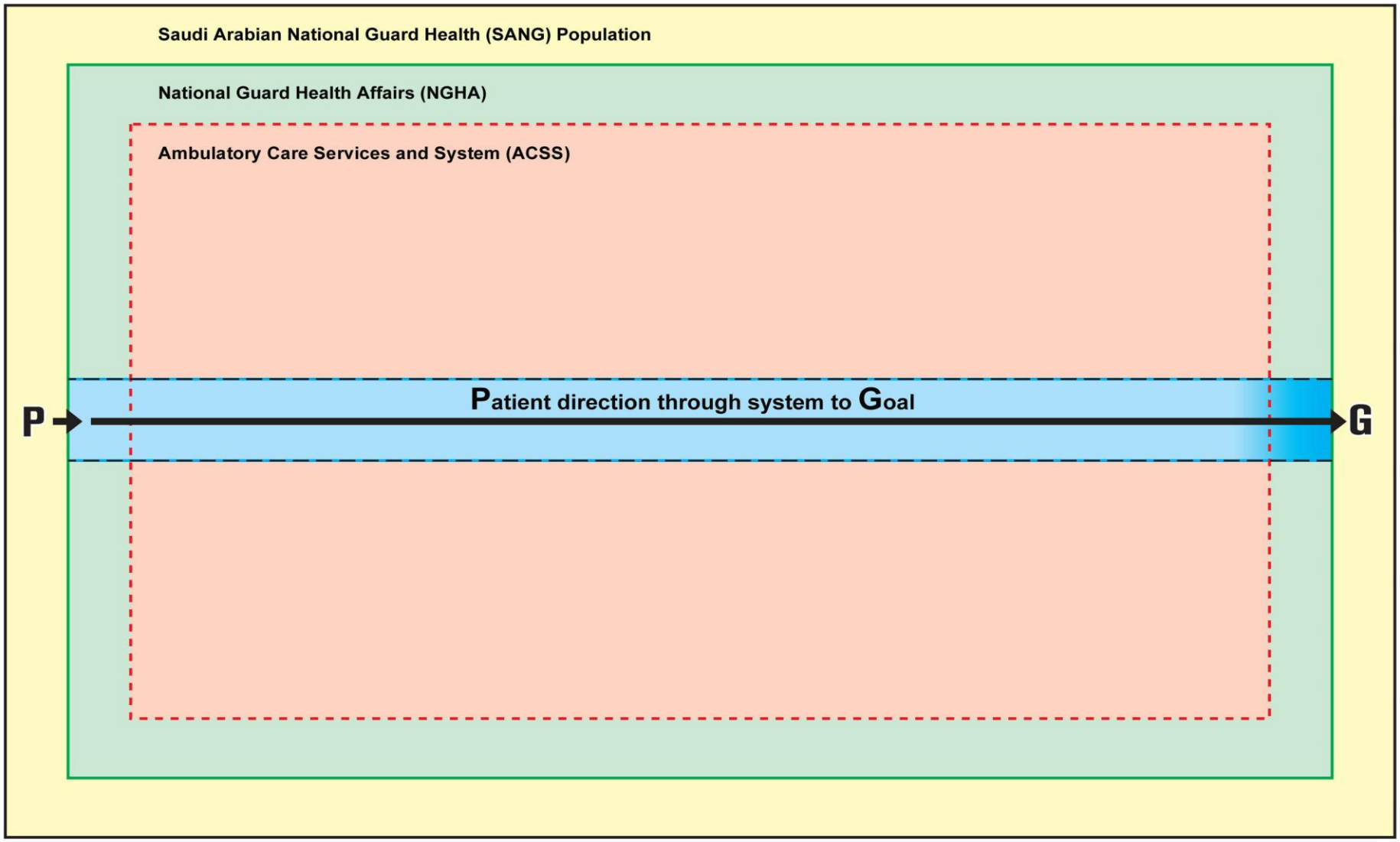



**Figure 5.3** The ambulatory care context of a Middle Eastern teaching hospital with the patient focus centered in the healthcare delivery system.

Mufti (2000:3) provides a succinct overview of the origins of the contemporary healthcare system in Saudi Arabia and outlines the five (5) origins of major health providers which characterize the context. These are (i) the Ministry of Health (MOH), which is the main governmental department for healthcare to the entire population; (ii) the Saudi Red Crescent Society that focuses on emergency and civil services and is linked to the International Red Cross Society; (iii) Medical Services of the Department of the Ministry of Defense and Aviation (MODA), which is the second largest governmental department for healthcare; (iv) Medical Services for the Department of the Ministry of Interior (MOI), which provides healthcare services for MOI staff and internal security forces; and (V) National Guard Health Affairs (NGHA), which provides healthcare for its personnel and dependents. In turn, each governmental department provides a range of services for the defined population group and resident affiliates that include Saudi nationals and the expatriate public sector workforce. Healthcare services are either free or highly subsidized despite rapid advancement in medical science and healthcare technology (Mufti 2000:9). Healthcare, which has remained free of charge or highly subsidized for several decades, has positioned Saudi Arabia as somewhat unique due to an active private sector and governmental involvement to address escalating healthcare costs alongside quality (Al-Ahmadi & Roland 2005:331, Walston, Al-Harbi & Al Omar 2008:243, Al-Tuwaijri 2008:171).

Mufti (2000:21) indicates that, prior to the millennium, a visiting World Health Organization (WHO) consultant observed that the Saudi health system as described with five (5) major healthcare providers, did not fit in to the health profile of a developing country. This conclusion was based on health indicator evidence that the Saudi health system had surpassed the targets that were set in the WHO campaign 'Health for All by the Year 2000'. Three (3) noted factors included the following:

- a system of free or highly subsidized healthcare
- generous healthcare resources and services

- evident improvement in health status of the population corresponding to the increased socioeconomic status of the population.

Thereon from the explanatory account of healthcare services, the notion of ambulatory care services and system (ACSS) is a conjuncture for healthcare delivery in the ambulatory care setting, which in this study is specific to National Guard Health Affairs (NGHA). Notwithstanding this conjuncture that is contextual to Saudi Arabia, similarities were found in the United States of America (USA) and Germany.

The local descriptions of 'service' and 'system' are akin to those of the USA Veterans Affairs (VA) medical system whereby Veterans Affairs medical centers (VAMC) are referred to as the overall healthcare organizations, the VA medical system is referred to as the established arrangements for healthcare delivery that veteran patients access and VA care is the equivalent of healthcare services delivered to the specific population of war veterans in the USA (Phibbs, Bhandari, Yu & Barnett 2003:55S, Ross, Keyhani, Keenan, Bernheim, et al 2008:309, Cone, Brown & Stambaugh 2008:631).

Weil and Brenner (1997:77) compare healthcare delivery by physicians and other significant healthcare data between the USA, Britain and some European countries following the impact of the unification of East and West Germany. The basis for comparison is the 1993 German Health Reform Act. Terminology in reference to the German Health 'System', Ambulatory Care 'Services', Physician 'Services' and 'access to services' is consistent with the descriptions used by NGHA and VA above (ibid).

The review and ranking of the healthcare systems of 191 countries by the WHO (World Health Organization) by public health experts triggered Blendon, Kim and Benson (2001:10) to ask the salient question as to 'Who is better qualified to judge healthcare systems: public health experts or the people who use healthcare?' Their paper

compares the WHO rankings of the healthcare systems of seventeen (17) developed countries with the perceptions of their citizens and showed results with minimal correlation in the WHO rankings versus patient rankings. It is based on this in-depth article that the following scope and nature of 'system' and 'services' were deduced because such extensive comparisons are made on relative homogenous characteristics (ibid).

A healthcare 'system' within industrialized developed countries is taken as a formalized structure and complexity of arrangements that are part of an extensive entity that has an overall function for healthcare access, provision and continuity by its defined users. Healthcare 'services' is the manifestation of delivery of healthcare that reveals performance related to human and material resources and accounts for the patient's experience of the healthcare system.

Based on the aforementioned explanations that were aimed at clarifying the context of the ambulatory care services and system, it is expedient that the nursing services be defined and postured as the context for the activity by the patient liaison nurse.

### 5.9.2 Nursing services in the context of ambulatory care services and system (ACSS)

The context of nursing services within the ambulatory care services and system (ACSS) is identified as being in harmony with the definition of nursing services described by the American Academy of Ambulatory Care Nursing (AAACN) as given by AAACN (2004:19), Haas (2006:11) and AAACN (2010:8). Nursing services in ambulatory care nursing are organized services delivered to groups of patients by nursing staff who are either registered nurses or are supervised by a registered nurse.

Ambulatory care nursing services include direct patient care as well as services to facilitate or support direct care that includes referral actions and care coordination (ibid). Figure 5.4 is a depiction of the ACSS.

Figure 5.4 illustrates the context of Ambulatory Care Services that is an expansion of the previous figure 5.3. In figure 5.4, Nursing Services are inserted as a series of overlapping circles representing the scope of care by the registered nurse (RN). The RN circles of two types. The single circle is labeled as an ambulatory care nurse (ACN) who is the first point of contact with the patient after the patient registration process and appointment or eligibility confirmation has occurred at the entrance desks of Patient Services.

Particularly in the patient situation that is identified by the ACN as necessary for referral to a patient liaison nurse (PLN), there is an overlap with two (2) concentric circles that denotes the PLN (details of the two (2) concentric circles depicting the PLN are explained further in figure 5.6 as representative of autonomous ambulatory care nursing practice). A series of three (3) sets of duplex concentric circles overlap to illustrate the dynamic nature of the PLN while the patient focus concurrently moves towards the exit of an ambulatory episodic visit of the patient. The three sets of duplex concentric circles will be shown later in figures 5.5 and 5.7 an opportunity for collaborative liaison by the PLN.

The patient exits the ACSS at the desks of Patient Services where the necessary follow-up appointments are made and/or is directed to relevant services such as Pharmaceutical Care Services for medication before leaving the ACSS facilities of the NGHA organization.

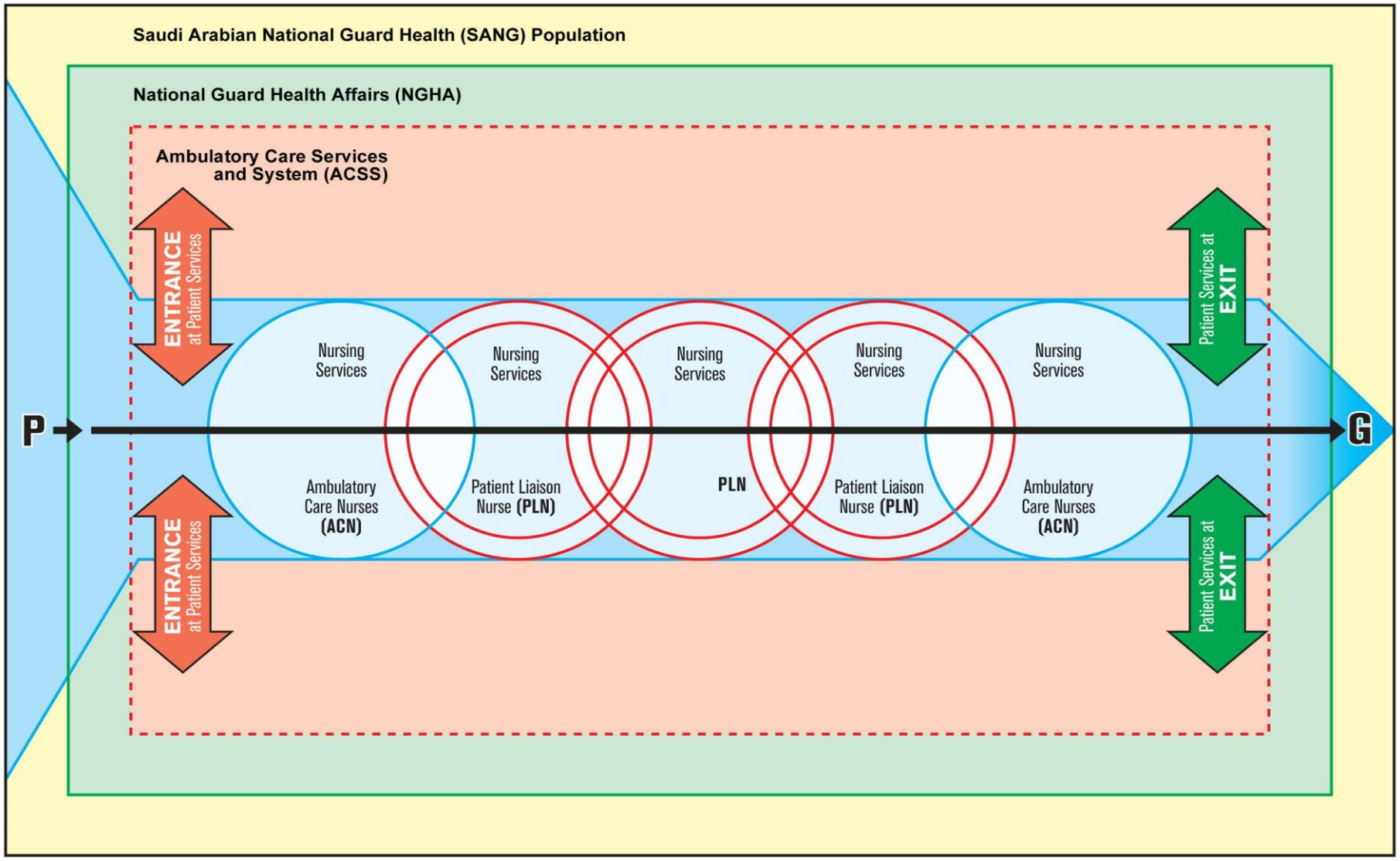



**Figure 5.4** Nursing Services situated in the ambulatory care context of a Middle Eastern teaching hospital.

### 5.9.3 Conclusion statements on the context: ambulatory care services and system

The context in which the agent and recipient engage for the activity to occur is the ambulatory care services and system (ACSS). The conclusion statements that follow are a synopsis of the conceptualization of the ACSS. These are:

- The ambulatory care services and system is the setting in which focused outpatient healthcare delivery occurs in response to patient needs, problems or concerns
- The system component of ambulatory care services and system relates to the structure of arrangements that facilitates the 'service' component that is characterized by performance in the use of human and material resources.
- Operationalization of the ambulatory care services and system have the overall purpose of healthcare provision that includes access and continuity of care
- Nursing Services is a functional component of the ambulatory care services and system in which registered nurses, i.e. ambulatory care nurses (ACN) and patient liaison nurses (PLN), execute nursing care delivery activities which include support functions such as referral and coordination of care.

## 5.10 GOAL: QUALITY PATIENT CARE

Quality patient care is the goal of the activity, i.e. patient liaison nursing. An antecedent to conceptualizing quality patient care is a scrutiny of what is meant by 'quality patient care' versus 'quality of patient care'.

### 5.10.1 Quality patient care versus quality of patient care

Bull (1996:147) has chronicled the historical perspective of quality in healthcare and reveals that 'quality' became a trendy concept of health professionals in the 1970s. She records that in 1974 the Quality Patient Care Scale, also referred to as QUALPACS was published by Wandelt and Ager. The focus was on the level of care to the individual patient as a recipient of care and not on the health provider as had been the previous focus of healthcare surveys (ibid). Furthermore, the Joint Commission on Accreditation of Hospitals (JCAH), which was formed in 1952, revised their approach beyond structural standards and criteria, and launched the retrospective process and outcome auditing method. In this regard, Patterson (1996:300) outlined the five (5) definitive terms that had been introduced by the newly renamed Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to define patient health outcomes. These were given as:

(i) prevention of illness or disability

(ii) restoration of function

(iii) cured as in curable diseases

(iv) maintenance of function

(v) comfort that is physical and psychological.

In reference to the contextual setting of this study, all National Guard Health Affairs' hospitals were accredited in 2006 and reaccredited in 2009 by the Joint Commission International (JCI), the international sector of the Joint Commission (USA) as referenced in the accreditation manual (JCI 2008:1). JCI states that all accreditation programs, which include Ambulatory Care, are based on the underlying philosophy of quality management and continuous quality management (ibid). 'Quality of care', according to JCI (2008:237), is the degree to which health services for individuals and

populations increase the possibility of aspirant health outcomes, and whereby the dimensions of performance include patient perspective concerns, safety of the patient and care environment, and the accessibility, appropriateness, continuity, effectiveness, efficacy, efficiency, as well as timeliness of care.

Therefore, 'quality of patient care' is deductively taken to imply the extent by which structural, process and outcome healthcare standards of an organization are realized. The conception of 'quality' therein is a noun in the English language that means 'distinguishing characteristic or attribute degree or standard of excellence' (Collins Dictionary & Thesaurus 2006:976) and as 'the standard of how good something is as measured against other similar things' (Oxford Dictionary & Thesaurus 2007:837).

In follow-through with 'quality patient care', then 'quality' is an adjective that modifies the concept 'patient care.' The adjective 'quality' is defined as 'excellent or superior' (Oxford Dictionary & Thesaurus 2007:659) and as a modifier as 'having or showing excellence or superiority (Collins Dictionary & Thesaurus 2006:976). Therefore, it is apt that the goal of the activity is indeed 'quality patient care' whereas 'quality of patient care' as described above is relative to organizational performance inasmuch as it portrays the extent of excellence in healthcare delivery.

### 5.10.2 Theoretical perspectives of quality patient care

A major impetus to theoretical discussions on quality patient care was the Institute of Medicine (IOM) report published in 2000 as a book entitled 'To Err is Human: Building a Safer Health System'. The authors, Kohn, Corrigan and Donaldson (2000:17) postulate that in order to address errors in healthcare delivery, a critical component of 'quality', i.e. patient safety, has to be addressed comprehensively within care delivery

systems and processes. The tenet that pervades the patient safety movement in healthcare goes beyond mere correction or remedial actions when an error is discovered or revealed. The underpinning philosophy includes the following:

- 'First do no harm' as proclaimed in the universal healthcare Hippocratic oath
- Achievement of the vision of the right care for every person at every time
- Unsafe patient care is the price paid for the lack of organized systems that should delineate accountability
- Recognition and rewards as incentives for healthcare organizations that strive to improve safety and quality patient care (ibid).

In a report to the USA Congress, Leavitt (2006:3), as Secretary of Health and Human Services, responded to the Institute of Medicine (IOM) report with the prospect of safety through quality improvement programs. In putting his perspective to Congress, he advocated the need for 'fundamental changes in healthcare processes and systems to deliver consistent high-quality care' in keeping with the subsequent IOM report to Congress entitled 'Crossing the Quality Chasm' (ibid).

Noteworthy excerpts from the extensive Congress Leavitt (2006) report which details the responses to the IOM recommendations are provided as a synopsis in the following statements that elucidate quality healthcare as a goal (ibid):

a) driving the creation and use of evidence … to bring effective innovations to patients more rapidly

b) emphasize hands-on … aimed at building provider capacity … for the direct role of providers … as an integral component of improved care, better patient experiences, and patient self-management

c) collaborative quality initiatives in … hospital settings, with a focus on … provider performance on quality measures

d) assistance to practitioners in improving quality local and regional quality initiatives that seek to improve quality … in identified areas of high opportunity and impact

e) improving quality of care for multiple chronic illnesses

f) consistent quality measures for all patients … to achieve meaningful performance improvements

g) promote public understanding of … performance results on quality … and the use of this information to improve care and self-care

h) offer assistance to providers in the redesign of care processes so that they improve patient experience and better meet the needs and preferences of patients … through development of … best practices, and participation of patients and families in quality improvement

i) support improvements in the coordination and management of care across settings and transitions from one healthcare setting to another

j) support … local collaborations between patient, care-giver, … and other agencies to promote person-centered healthcare.

k) revise accountability for performance on several key metrics: timeliness of response, (patient) satisfaction, and the initiation of quality improvement activities … (as) appropriate to an identified quality concern

l) assure that the resources directed to … activities are achieving their intended purpose: higher quality care …

m) evaluation of … methods … to promote learning about how to achieve excellence in care delivery

n) evaluation of its impact on quality and efficiency of care.

In the above selected excerpts related to the goal of ‘quality patient care’ it is deduced on review that there is a cardinal topic that recurs with two subtopics that pinpoint the essence of quality patient care as the goal of the activity. These are:

- healthcare quality improvement as the fundamental purpose of activity, and the two related subtopics that are:
    (i) accessibility to healthcare
    (ii) continuity of care

The above topics will be discussed as contributions in conceptualizing quality patient care as the goal of the activity in this study.

### 5.10.3 Healthcare quality improvement

The root purpose of all activities in healthcare is taken as healthcare quality improvement which is supported extensively in various clinical sub-specialties and healthcare subdivisions with shared central elements in the notion of quality improvement. The date, country, area of practice or departmental section is given with accompanying authors and the essence of quality improvement focus in the respective areas. Table 5.6 that follows provides the summarized information.

The focus on quality improvement in healthcare in the absence of access to care is the next concept to be discussed as a factor in quality patient care as a goal.

**Table 5.6** Conceptualization of healthcare quality improvement activities in selected relevant publications.

| Date | Author(s) | Country | Health Care Practice Area or Department | Summary of Essence of related to Quality Improvement Focus |
|---|---|---|---|---|
| 2000 | Luker, Austin, Caress & Hallet | United Kingdom | Community Nursing in Palliative Care | • study of district nursing team to explore factors that contributed or detracted from high quality care in palliative care<br>• finding that centrality of knowing the patient and family emerged as vital antecedent for high quality care<br>• successful strategies included early patient contact, ensuring continuity of care and patient-centeredness that recognized unique patient needs within the nurse-patient relationship that became a therapeutic vehicle for quality care<br>• it was concluded that establishing early contact was essential for getting to know the patient and family that fostered a positive relationship with patients, limited the number of nurses involved and therefore maximized continuity of care |
| 2001 | Campbell, Hann, Hacker, Burns, et al | United Kingdom | General Practitioners | • stratified random sample (n=60) of general practices areas of six (6) areas in England<br>• management of chronic diseases and preventive care<br>• access to care, continuity of care and interpersonal care<br>• healthcare questionnaire results showed wide variations of patient satisfaction from 17% to 67%<br>• recommendations were longer consultation times with doctors and team support in the general practices to target high quality care outcomes |
| 2006 | Solberg, Engebretson, Sperl-Hillen, O'Connor, et al | USA | Ambulatory Care – Chronicity | • based on IOM Report (2001) entitled 'Crossing the Quality Chasm'<br>• safety, efficiency, timeliness, equity, patient-centeredness<br>• effectiveness of process and outcome |
| 2007 | Mangione-Smith, DeCristofaro, Setodji, Keesey, et al | USA | Pediatric Ambulatory Care | • comprehensive studies lacking on magnitude of deficits in quality of care delivery to children<br>• parents of children (n=1,536) selected randomly for consent to access medical records<br>• quality indicators developed for study focused on care delivery to children with acute health problems, chronic illnesses and preventive conditions.<br>• results showed similar magnitude of deficits to overall adherence rates at 46.5% shown previously at 54.9% for adults<br>• deficits in quality of care in children were regarded as avoidable adverse health outcomes if continuity of care were possible<br>• recommended expansion of access to care as a national health focus for children so that identified deficits in the quality of care be eliminated |
| 2007 | Volpp | USA | Veterans Affairs Health Care | • editorial on Veterans Health Administration in designing a model healthcare system<br>• incentives for quality healthcare are critiqued<br>• postulates that in the US healthcare system there is a misalignment of financial incentives with providers concerning quality of care<br>• poignant situation that healthcare providers are paid more when patients are sick and therefore investing in disease prevention is financially unrewarding<br>• incentives in Veteran Affairs (VA) are presented that are aligned to quality healthcare whereby eligible patients remain with VA usually for life<br>• investment in health of patient and quality of life include electronic tracking of patients on electronic medical record, longer patient appointments, personal health coaches, same or next day responses to patient questions and efforts to transition active military personnel to veteran status to benefit from quality patient care |
| 2008 | Gilje, Soderlund & Malterud | Norway | Patient Group for Chronic Fatigue Syndrome | • patients assumed to have awareness of quality care<br>• findings illustrated patient perceptions of obstructions for quality care<br>• physicians had trivialized symptoms based on lack of knowledge, skepticism and/or ignorance on CFS<br>• study outcome called for improved physician knowledge on the complex nature of disease, patient empowerment through shared treatment decision-making |

| | | | | |
|---|---|---|---|---|
| 2008 | Kruk & Freedman | Costa Rica, Dhaka, Malaysia, Maori in New Zealand, Mexico, Nigeria, Pakistan, Peru, Tanzania, Vietnam, Zambia | Health Systems in Developing Countries | • IOM definitions were used for the scope of the literature review of health performance in developing countries<br>• research population was literature publications using online databases<br>• key performance indicators included effectiveness, equity & efficiency<br>• effectiveness measures were found to be improvement of health status, access to care, quality of care & patient satisfaction<br>• equity measures were identified as accessibility and quality of care for disadvantaged groups, fairness in financing, risk protection & accountability<br>• efficiency measures in results included appropriateness of funding levels, cost-effectiveness of interventions and effective administration<br>• conclusion supported using framework of indicators that depicted key factors that impact quality care<br>• mindful of important limitations associated with this analysis, it nevertheless was shown to reveal the gist of healthcare performance in quality improvement of care. |
| 2008 | McLachlan, Forster, Yelland, Rayner, et al | Australia | Obstetrics Postnatal | • diversity in care provision of hospital postnatal units (n=71)<br>• findings that continuity of care was difficult to provide in postnatal care units<br>• barriers in organization and structure of care were identified as standardized postnatal documentation using clinical pathways and the fixed length of stay<br>• implications for practice included greater flexibility in applying fixed structures of care to enhance individual considerations of patients and provide choice on length of stay after birth with individual patient focus greater than emphasis on organizational structure of care requirements |
| 2009 | Parker, Kirchner, Bonner, Fickel, et al | USA | Veteran Affairs Health Care | • qualitative evaluation study conducted within Veterans Health Administration (VHA) primary care clinics<br>• study was contextualized on managing patients with depression and the quality of treatment for depression<br>• quality-improvement dialogue within a hybrid approach of using local quality staff participants as well as experts in quality staff participants as well as experts in quality improvement was evaluated<br>• findings supported the hybrid approach as possibility the best formula for improving quality of care<br>• a distinct benefit was using frontline staff to customize patient care programs, provide feedback on what works and does not at the patient level<br>• experts in quality improvement concluded that they could focus on program improvement but proposed establishing regular dialogue with frontline staff<br>• face-to-face meetings between frontline staff, managers and experts were recommended for every quarter or semiannually<br>• conclusions of the study recognized that quality improvement activities required protected time within professional duties so that dialogue on quality healthcare is afforded predominant focus in the quality of patient care |

#### 5.10.3.1 Access to care

Access to care is taken as the point of first screening contact with a patient, and thereafter acceptance into an organization for a regimen of healthcare services (JCI 2008:41), and is the topic of chapter one in the 2010 online publication by the two co-lead agencies in the US health system. The chapter entitled 'Access to Quality Health Services' was generated by the Agency for Healthcare Research and Quality (AHRQ) and Health Resources and Services Administration (HRSA) (Healthy People 2010 Information Access Project online). Both agencies, that is AHRQ and HRSA, conceptualize the meaning of 'access' to care according to the Institute of Medicine (IOM) definition as 'the timely use of personal health services to achieve the best possible outcomes' (IOM 1998), and expand the definition to include 'both the use and effectiveness of health services' that 'encompasses physical accessibility of services (ibid).

Definitions are given on 'ambulatory care' and on 'ambulatory-care-sensitive conditions' that contribute to greater clarity on access of care in the particular situation of this study and the goal of quality patient care (Healthy People 2010 Information Access project online). The definitions are as follows:

- ambulatory care: healthcare that does not require the patient to stay in a hospital or other facility, such as care provided on an outpatient basis
- ambulatory-care-sensitive conditions: conditions resulting in hospitalization that could potentially have been prevented if the person had improved access to high-quality primary care services outside the hospital setting (ibid).

In the local context of patients at the National Guard Health Affairs (NGHA) facilities, access to care does not present as a challenge for personnel and dependents of the Saudi Arabian National Guard (SANG); however, the concept of 'access to care' is retained. This is due to the conceptualization of quality patient care since there are highly specialized clinical subspecialties with the ambulatory care services and system (ACSS) that may require input from the patient liaison nurse (PLN) for referral or coordination.

By virtue of lifelong eligibility as NGHA patients, the focus on conceptualization continuity of care in quality patient care would add a beneficial dimension for consideration.

#### 5.10.3.2 Continuity of care

At the outset of conceptualizing 'continuity of care', it would add clarity to distinguish between 'continuum of care' and continuity of care'. JCI (2008:232) defines the concepts as follows:

- 'continuum of care' as matching the individual's ongoing needs with the appropriate level and type of care, treatment, and service within an organization or across multiple organizations
- 'continuity of care' as the degree to which the care of individuals is coordinated among practitioners, among organizations, and over time.

Therefore, it can be deduced from the above definitions that a patient may access the 'continuum of care' within an organization, but may not necessarily experience 'continuity of care' if there is a deficit in coordination of care delivery over a period of time. However, a patient can experience 'quality patient care' if the organization has

ensured ‘continuity of care’ because it would follow that a healthcare team member has indeed coordinated the delivery of care according to appropriateness and relevance within the ‘continuum of care’. In essence, knowledge of the ‘continuum of care’ would be a necessary requirement to ensure ‘continuity of care’.

Wei, Barnsley, Zakus, Cockerill, et al (2008:933) used a questionnaire in a group of patients with diabetes in China to assess continuity of care in relation to improved quality patient care for chronic disease management. They defined ‘continuity of care’ as information exchange and goal alignment between physicians and patients (ibid). The findings of the study showed improved patient outcomes that were measurable such as weight loss, blood glucose control and fructosamine reduction. Based on a control group used in the methodology of the study, the findings affirmed an association between improved quality patient care. The study was concluded with the recommendation that the instrument could be tested in other chronic conditions aimed at potential improvement in quality patient care by improving continuity of care.

The importance of the physician-patient relations in the above study was also found to be an essential ingredient in continuity of care in an in-depth study conducted on the quality of health services and the entitlement of senior citizens in long-term care facilities in Ontario, Canada. Research methods included unobtrusive observations that were recorded as field notes and one-on-one semi-structured interviews that generated qualitative data for analysis using a grounded theory approach (Coughlan & Ward 2007:49). The findings showed that improvements to the physical facilities and program development were less important to the patients, whereas patient-staff relations and patient-staff ratios that afforded directed care were of primary importance in the quality of the care received. Staff relations and adequate staffing were revealed as essential factors in continuity of care. The emergent theme that consolidated this finding was described as ‘relationships are foundations of quality care’ (ibid).

In a similar case study in the USA, Wendel and Durso (2006:602) found that the lack of coordination between ambulatory, acute and long-term care services resulted in a lack of continuity of care, and thereto deficits in the overall quality of care. The strategies to facilitate the transition of patient care between the various services were recommended to include:

- Identify patient and caregiver goals of patient care
- Individualize the plan of patient care in collaboration with the primary physician
- Active planning for continuity and coordination of care (ibid).

A retrospective review of the literature on the concept of continuity of care spans three decades and portrays a questioning approach by healthcare professionals, particularly as linked to quality patient care. Despite finding the absence of a causal relationship between continuity of care and quality of care, Roos, Roos, Gilbert and Nicol (1980:174) nevertheless raised an important question as to whether continuity of care is defined by healthcare practitioners or a group within a health service. The key element that was overlooked was the coordination of care.

In the Netherlands, Temmink, Hutten, Francke, Abu-Saad, et al (2000:92) found that patients with rheumatic diseases in five healthcare locations were positive about the quality and continuity of care that was studied as joint concepts using a questionnaire. Subsequent semi-structured interviews confirmed that information exchange between health professionals was essential in continuity of care.

The importance of positive relations between staff and patients is a recurring finding in further studies on continuity of care in the UK and USA, and concerning adult and pediatric patient groups (Christakis, Wright, Zimmerman, Bassett, et al 2002:109,

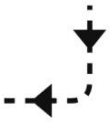
Arthur & Clifford 2004:329, Heller & Solomon 2005:339) that reinforces continuity of care as a concept of quality patient care that has not dissipated in three decades.

In an editorial of the Annals of Family Medicine, Stange (2003:130) called for greater dialogue on the effects of 'forced discontinuity of care' within health system changes and raises questions as to whether healthcare professionals grasp the important dimension of continuity of care on quality patient care. He asks astutely if continuity of care is merely a part of the process of care, or whether the health professionals know enough to pay attention to the 'crisis in continuity' and the lack of…support for healing relationships' (ibid).

Figure 5.5 that follows (see table 5.4 for definitions of the legends) is a diagrammatic representation of the patient pathway of experience through the Ambulatory Care Services and System. The diagram illustrates a merge of figure 5.2 (patient context coming from the community), figure 5.3 (the ambulatory care context within the healthcare delivery system), and figure 5.4 (nursing services situated in the ambulatory care context). To the left of the diagram, there is an arbitrary number of five (5) patients that represent the patients' origin in the Saudi Arabian National Guard (SANG) population. The legend is an oblong shape that is half-shaded to symbolize the ambulatory patient of concern. This symbolic concern is any matter related to the health needs, problems or status of the patient.

Diagrammatically, the patient legend is shown to follow the direction of the patient pathway as illustrated in figure 5.2. Subsequent to the registration requirements at the point of entry to NGHA and ACSS, the patient has the first encounter with an ambulatory care nurse (ACN). At this point, it can be considered that access to care is affirmed because the ACN would be able to access the patient's electronic health

**Table 5.7** Legends for figures 5.5 and 5.7

| | |
|---|---|
|  | Patient concern for attention |
|  | Patient concern being attended by PLN |
|  | Patient concern attended |
|  | Direction and exchange of communication and collaborative liaison |
|  | |
|  | Feedback flow on quality patient care |
| P | Patient |
| G | Goal: quality patient care |
| ACN | Ambulatory care nurses |
| PLN | Patient liaison nurse |

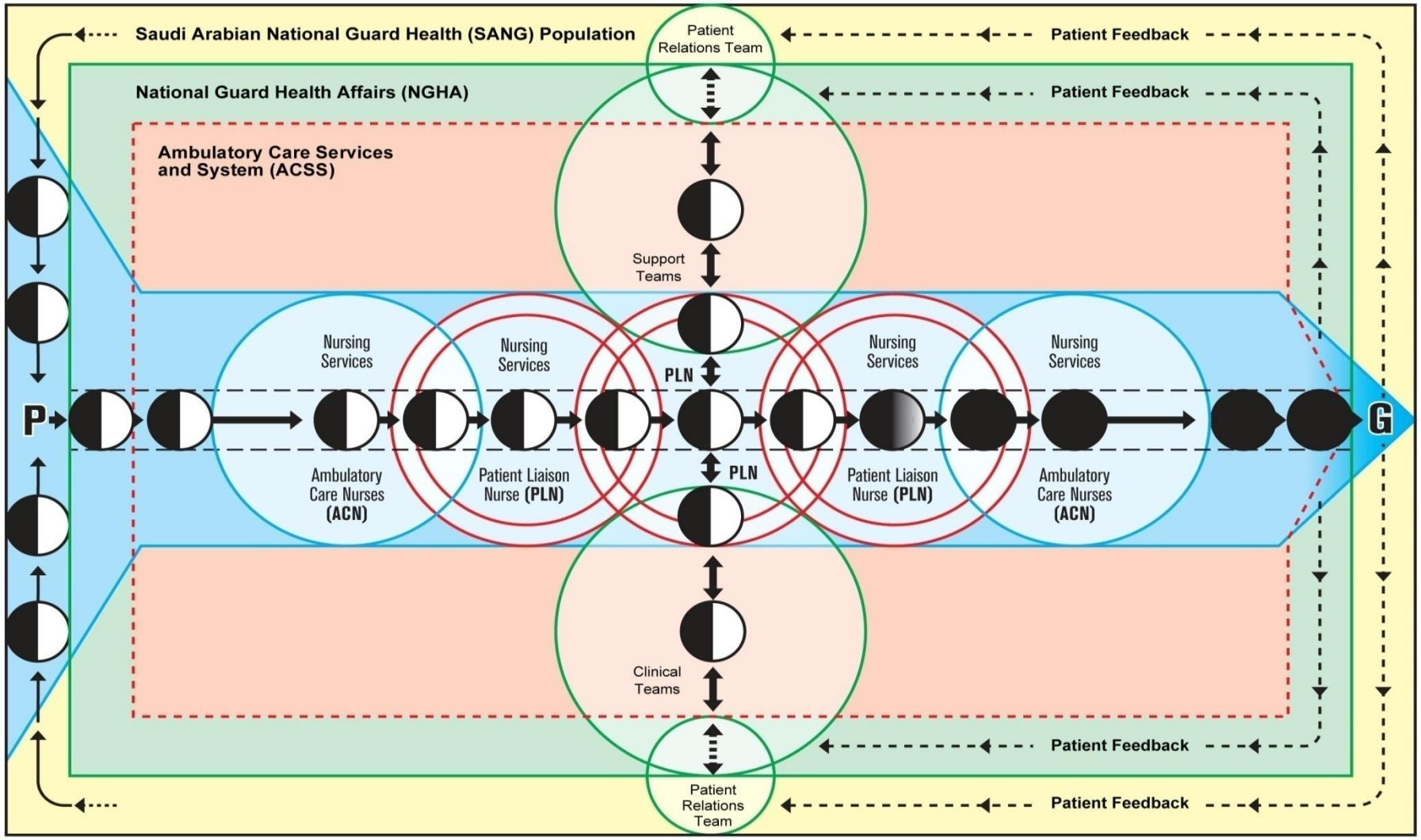



**Figure 5.5** The context of the patient pathway towards the goal of quality patient care that shows the point of access to care and the patient experience for continuity care aimed at quality patient care.

record in the system. In a situation where the patient is assessed by the ACN to have a potential interruption in the treatment regime, the ACN refers the patient to patient liaison nursing for review and intervention.

At the center of the diagram, the circles representing various scopes of care provided by clinical and support teams, the symbolic patient concern can be moved in either direction by the PLN to address the patient's concern aimed at continuity of care. The consequent action by the PLN is illustrated by the changed shading with horizontal parallel lines to portray that the PLN has concluded internal liaison and has refocused on the patient to fulfill continuity of care. The next contact with the PLN shows complete shading of the patient's legend. This full shading represents that resolution by the PLN on the patient concern has been successful. Successive patient legends that are fully shaded to the right of the diagram denotes that the factor which potentially may have caused an interruption of care has been overcome, resulting in continuity of care. Feedback loops are inserted to embody the right of the patient to communicate on any further healthcare concern that may arise after exiting the ACSS.

### 5.10.4 Conclusion statements on the goal: quality patient care

The use of deduction facilitated the following conclusion statements in conceptualizing quality patient care as the goal:

- Quality patient care is indicative of structural, process and outcome standards for healthcare delivery performance review and evaluation for access and continuity of care.
- Consistency in quality patient care is maintained by the role of direct caregivers who intervene in a collaborative capacity with measures to use an improvement opportunity for a better patient experience in healthcare delivery.

- Person-centered healthcare that utilizes positive patient-staff relations is fundamental in personalizing patient care aimed at the best possible healthcare outcomes
- Access to care combined with continuity of care adds value to quality patient care through coordination, collaboration and information exchanges in the healthcare team.

## 5.11 PROCEDURE: AUTONOMOUS AMBULATORY CARE NURSING PRACTICE

The procedure of the activity is autonomous ambulatory care nursing practice. Autonomy will be conceptualized within the context of ambulatory nursing practice so the procedure can be comprehended in terms of the activity in this study. However, it is necessary to conceptualize ambulatory nursing practice prior to the review of autonomy for fundamental procedural relevance.

### 5.11.1 Ambulatory care nursing practice

The International Council of Nurses (ICN 2004) position statement articulated the scope of nursing practice as not limited to specific tasks, functions or responsibilities, and moved to acknowledge that the world of nursing practice is complex. ICN pointed out that 'knowledge, skills and attitudes' underpin the dynamic complexity of nursing practice. Evans and Donnelley (2006:151) endorse the ICN position but point out that nurses often regard themselves only in terms of skill performance because it is most visible, yet the knowledge and attitude component may well drive the execution of those skills. Quinn and Hughes (2007:114) use Bloom's taxonomy (1956) to

conceptualize the practice domains of the registered nurse (RN). The domains are cognitive, affective and psychomotor with which Evans and Donnelly (2006:150) concur but use the terms 'knowledge, skills and judgment'. The latter authors describe that there is a relationship between knowledge, skills and judgment that it is integrated and manifested as the nurse functioning in practice. Figure 5.4 shows the domains of RN practice marked A, B and C to conceptualize Bloom's taxonomy. In figure 5.4, there are three concentric circles with the inner core circle representing the ambulatory patient concern that would be the focus of attention for the RN ambulatory care nurse. The outer circle depicts the scope of the RN ambulatory care nurse (PLN) that constitutes the A, B and C domains of practice as shown in figure 5.4. The middle circle represents the patient liaison nurse (PLN) that is symbolically focused closer to the specific ambulatory patient of concern. This duplex of concentric circles serves to illustrate that all RN ambulatory care nurses can function at the inner focused RN functional role as the patient liaison nurse (PLN) that is an assigned role by rotation in the context of this study. This discretionary use of the RN role permits innovative functional RN roles in Saudi Arabia where the RN role does not have a regulatory approval and recognition framework as of yet for advanced practice or specialist nursing, although the academic options for post-graduate nursing studies have existed since 1987 (Al-Osimy 1994:71). RN post-graduate nurses in Saudi Arabia are usually employed in nursing leadership positions in nursing administration or education (ibid). In nursing practice, therefore, the RN assigned to the RN functional role as PLN is excluded from regular ambulatory care nursing duties for exclusive focus on the patient's concern that may potentially interrupt the treatment regime. Accordingly, and on assignment changes by the in-charge clinic nurse coordinator, the RN rotates back to the ambulatory care nursing role and another RN is assigned the patient liaison nurse (PLN) responsibility for a set period that best fits the scope of service of the clinic and the total number of registered nurses in the approved staffing structure.

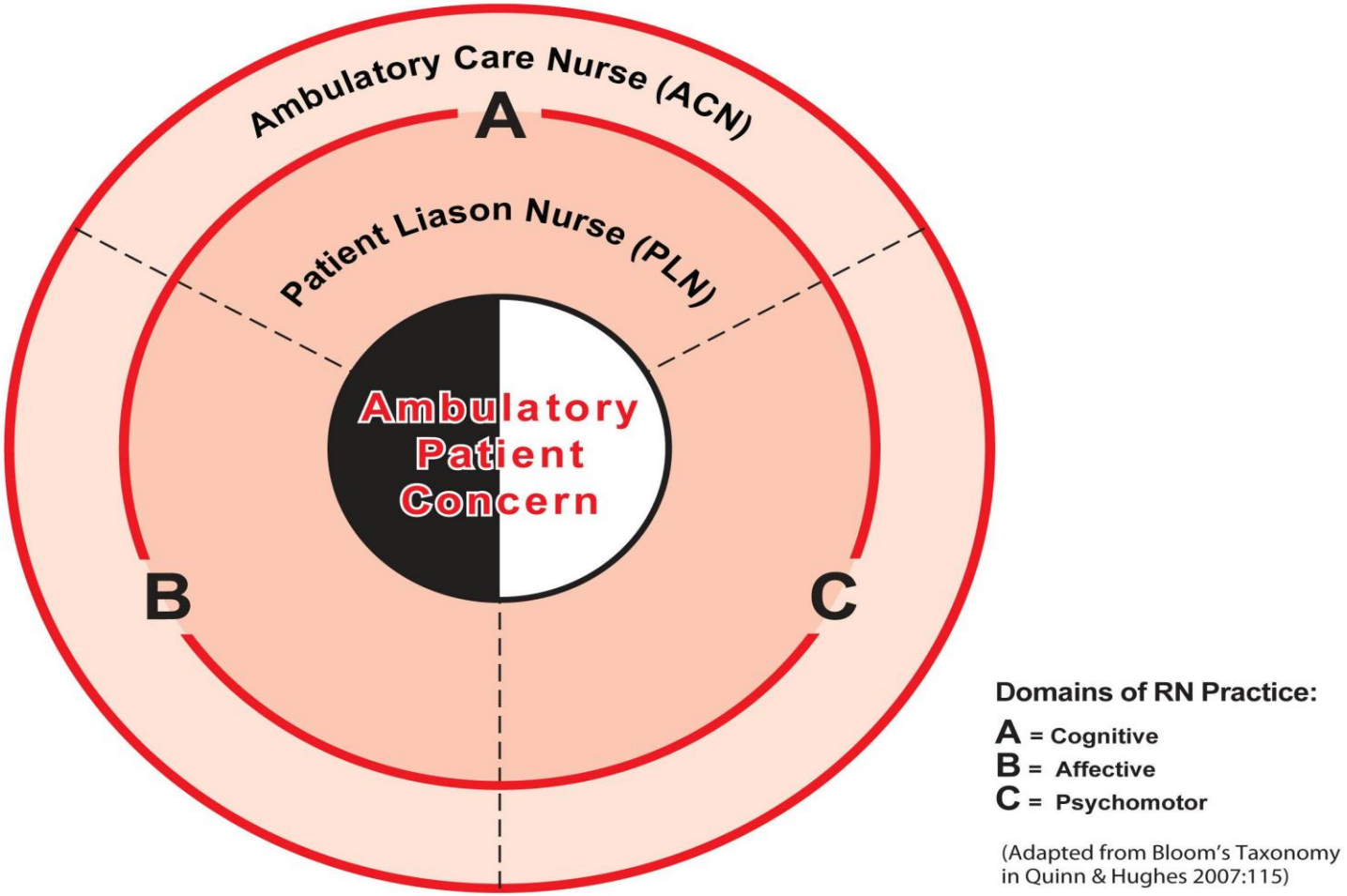



**Figure 5.6** The domains of RN practice illustrated in relation to the ambulatory care nurse (ACN) as the outer circle and the patient liaison nursing (PLN) functional RN role focus in the context as the middle circle. The inner circle represents the ambulatory care concern that is the center of nursing action.

Notwithstanding this limited RN scope within the legal framework of Saudi Arabia, Muller (2002:18) maintains that the qualified RN practitioner possesses the theoretical knowledge, skills and values to function in nursing practice. She qualifies that the knowledge is fundamentally gained in basic RN training and thereafter it is the professional responsibility of a mature RN to gain new insights and to keep abreast of scientific developments and knowledge in the area of nursing practice (ibid). In the context of this study in Saudi Arabia, the RN job description requires the employee to have an RN general nursing qualification from their country of origin, proven primary source verification of qualifications, a valid RN license to practice, and a minimum of two (2) years post-RN qualification clinical experience in the area of practice choice for employment, which in this setting is ambulatory care nursing.

Haas (2006:3) points out that ambulatory care nursing has the unique characteristics in that incorrect assumptions are made that it is similar to in-patient unit nursing approaches and practice structures. She explains that contrary to in-patient nurses caring for an assigned number of patients, ambulatory care nursing has features of rapid, focused assessments that often involve the patient, family and significant others simultaneously, high volumes of patients in a limited time span, and an episodic care spectrum that includes wellness, prevention, chronicity and end-of-life patient profiles. Hastings (2006:24) reports that this diversity in ambulatory care practice assignments has led to 'shock' by nurses transitioning from a single specialty in-patient unit due to the episodic nature of care, assignments in multiple locations, the broader range of nursing skills for the diverse patient profile that Burns (2005:10) attributes to the relatively structured in-patient unit environment and the less structured environment of ambulatory care clinics. In focus groups conducted in 1998 by Haas with experienced ambulatory care nurses, it was found that the following characteristics of nursing practice were common:

- nursing autonomy

- patient advocacy
- skilful rapid assessment
- client teaching
- coordination and continuity of care
- collaboration with other healthcare providers (Haas 2006:3).

Lanzetta (2006:215) advocates that the nursing process (assess, plan, implement, evaluate and record/report) be used in ambulatory care nursing practice to support the RN in the use of a systematic framework in seeking information from the patient or family and for the adequacy of responses to concerns that affect the patient's health. She justifies the use of the nursing process by the RN in ambulatory care practice for the following reasons:

- disciplined and guided thinking that is succinct
- thorough data collection if used methodically
- widely used framework for organized delivery of nursing care
- adaptable if non-sequenced process to identify the missing aspect
- flexibility in use for problem-solving (ibid).

In applying the above, Lanzetta (2006) indicates that the nursing process relies on cognitive, interpersonal and psychomotor skills within the framework of set professional standards and a code of ethics.

An essential component of ambulatory care nursing practice promoted by White (2006:238) is being able to function in a multicultural care setting and therefore cultural awareness, cultural knowledge, and cultural sensitivity in interpersonal encounters are important. In the cultural context of Saudi Arabia, the patient population is homogenous as the Saudi Arabian National Guard personnel and dependents, and

therefore, except on occasional exceptions of expatriate staff as patients, the patients are of Saudi Arab culture and Muslim. This is unique given that the nursing staff is heterogeneous with the number of expatriate nationalities above forty (40). The emphasis therefore is not multicultural considerations in the patient profile but the ability of nurses to function effectively and efficiently in a culturally diverse team that extends to other health team members in clinical and support roles. The latter is crucial to the RN functional role as patient liaison nurse (PLN) because the interpersonal communication aspects of active networking required, trouble-shooting and collaboration will involve expatriate healthcare staff of diverse nationalities that may require goodwill in team relations. This aspect is discussed more fully in section 5.12 as a component of the dynamics of collaborative liaison.

The other aspect of conceptualizing the procedure is a discussion on autonomy in ambulatory care nursing practice.

### 5.11.2 Autonomy

The concept of 'autonomy' is prefaced in front of the concept of 'ambulatory nursing care practice' to contribute to conceptualizing the procedure of the activity described in this study as autonomous ambulatory care nursing practice. In essence, this means that the RN, who is an ambulatory care nurse, and who is assigned specifically as the patient liaison nurse (PLN) for a preset time period, undertakes nursing functions using self-directedness and therefore does not require a credentialed physician order or that of another allied health licensed practitioner for undertaking the PLN functional RN role related direct patient care actions. However, while functioning as an ACN, the RN may require written orders or directives by a physician or another professional team member with related approved clinical privileges for executing the patient care regimen.

Ironically, as the PLN, it indeed would be on the verbal request of the PLN and within the framework of policy that a physician or health team member is requisitioned by the autonomy of the PLN to respond to an ambulatory patient concern as appropriate for resolution on the particular episodic visit.

Joel (2003:355) states aptly that it is the public that entrusts healthcare a 'generous amount of freedom' as they execute their respective roles within society. It is this 'freedom' that is 'better called *autonomy'* and provides a qualifier to the notion of freedom as taking personal liberties by describing autonomy as given to professionals on the assumption that they 'are the stewards, not the owners, of their areas of service' (ibid). Creasia and Parker (2007:61) define autonomy as 'independence or freedom to act' and states that it connotes control over practice that manifests in the execution of a scope of responsibilities. In their perspective, Hood and Leddy (2003:382) state that autonomy refers to the 'independence of functioning', expand that it means that 'one can perform one's total professional function on the basis of one's own knowledge and judgment', and indicate that observers would regard this as a professional right. For the autonomy exercised, Hood and Leddy (2003:382), and Creasia and Parker (2007:61) agree that the nurse practitioner is required to take accountability for the risks, actions and behaviors arising from being an autonomous practitioner. Joel (2006:295) encapsulates the crucial components by using 'professional' as a modifier to preface the concept as 'professional autonomy' and defines it as 'the right of self-determination and governance without external control. Her use of 'professional' as a preface is bolstered by stipulating that autonomy is controlled by the profession's 'education, legal recognition (licensure), and a code of ethics' that she puts forward as a conjecture that 'persuades the public to grant autonomy' (ibid).

Sullivan and Decker (2005:68) embrace autonomy as 'the right of individuals to take action for themselves', but contend that it is not an absolute right particularly, in

situations where exercising the rights of nurses in practice may impact on the rights of patients. They expand, therefore, that this right includes respect for others and respect for decisions that others make, whether or not the decisions are aligned to the practice goals of the nurse (ibid). Sullivan and Decker (2005:68) also point out that 'respect for autonomy is to respect others' by accepting the uniqueness of others, which is gained by understanding and listening to the person and by imagining being in the other person's situation. They culminate their position by presenting some prerequisites for autonomous nursing practice as stated below, and not found in the 7th edition of Sullivan and Decker (2009):

- have the capability of self-governance
- have the capacity to implement their decisions
- operate from a stable and internalized set of professional principles and values (ibid).

In a study on the understanding of the RN on accountability, Bodrick (2001:38) defined autonomy as 'the degree of self-directedness that represents the extent by which an individual uses judgment, decision-making and discretion of authority' for the accomplishment of responsibilities. Furthermore, Bodrick used the work of Batey and Lewis (1982), Bowman (1995) and Duff (1995) to distinguish two types of autonomy, namely:

- structural autonomy that occurs when an RN acts according to an approved job description in an organization and within the scope of practice of the professional institution that regulates the scope of nursing practice.
- attitudinal autonomy in which an RN exercises freedom to use their judgment in a situation that requires decision-making or problem-solving approaches (ibid).

Joel (2006:296) concurs with two types of autonomy and differentiates these in the following adaptation to a patient care scenario:

- job content autonomy as the freedom to determine the methods and procedures to be used to address a given patient's problem or concern
- job context autonomy as the freedom to identify and define the boundaries of a patient problem or concern, indicate the nurse role's relationships with other healthcare team members, and the value, cost or input of consequent action(s) and/or use of services.

She encapsulates and concludes on the nature of nursing autonomy as the 'keys of autonomy as applied to nursing are that no other profession or administrative force can control nursing practice, and that the nurse has the freedom of action in making judgments in patient care within the scope of nursing practice as defined by the profession' (ibid).

In approaching autonomous ambulatory care nursing practice, Burns (2005:10) advocates that an RN mentoring pathway is required specifically in the ambulatory environment. She outlines that the evolving role of nursing in ambulatory care stems from the traditional practice model concerning the education of nurses in acute care hospitals that are disease-focused, primarily based on the biopsychosocial model. Furthermore, most health-restoring interventions in acute care are "doctor's orders" (original quotation marks by author) that nurses follow and with rare further contact with the patient after discharge (ibid). She recommends that the paradigm shift encountered by the RN who transitions to work in ambulatory care nursing be supported by structured professional mentoring with the goal of advancing autonomy in the ambulatory RN role. Burns (2005) acknowledges and uses the work from Brown and Draye (2003) who published a phenomenological study in the Journal of Nursing Scholarship entitled 'Experiences of pioneer nurse practitioners in establishing

advanced practice roles'. In a detailed application, Burns (2005) adopts the defined six (6) themes of Brown and Draye (2003) as modified stages applied to a mentoring relationship towards advancing autonomy for the new or transitioning RN into ambulatory care nursing practice. These thematic stages (ibid) are adapted below, and explained with vivid clinical nursing practice descriptions.

1. *Breaking free*

   This refers to the process of moving into ambulatory care nursing in an outpatient care setting and leaving behind the inpatient care setting, whereby the RN should let go of the inpatient unit's routine structure such as scheduled medication administration, fixed times for vital signs and submission of shift patient reports to a nursing administration office. The awaited ambulatory care RN role involves activities such as organizing the ambulatory care environment to match the scheduled clinics, handling patients without clinic appointments, dealing with unscheduled events or answering a range of non-clinical inquiries. Burns (2005:10) identifies that such a situation in ambulatory care nursing can be daunting for an RN who is transitioning from an inpatient unit, and suggests that an RN mentor can offer guidance, advice and support.

2. *Molding the clay*

   Here, an RN who is relatively new to ambulatory care nursing begins to blend both of her worldviews of nursing in the inpatient unit and outpatient setting, builds new collegial and working relations, and undergoes a degree of stretching personal capacity. Activities include expanded clinical decision-making as part of telephone triage or referral in relation to the collaborative team, being introduced by the RN mentor to other ambulatory care colleagues, and the exploration of the local and national professional activities concerning ambulatory care professional organization activities. The RN mentor discreetly

guides the RN based on understanding the adjustment component, and guides the RN tactfully with discernment in embracing the new ambulatory RN role.

3. *Encountering obstacles*

This relates to the adjustment exposure as the new RN portrays her style of becoming engaged in the ambulatory care RN role. The immediacy of a wide range of professional relations that evolve with highly specialized physicians to the front desk receptionist amidst the rapid volume of ambulant patients can be unsettling. This may result from a sense of being undermined because of the flurry of activities around the new RN as she tries to engage in the momentum of activity. A resultant degree of feeling somewhat invisible or undervalued may impact the RN level of self-directedness particularly at the peak of clinic activities. The RN mentor role becomes meaningful in advancing autonomy at such a juncture by encouraging free verbalization about the obstacles that are encountered. Thereafter, the RN mentor focuses the new RN on appraising the hidden work and recognizing small measures of success that nevertheless equate to progress.

4. *Surviving the proving ground*

Here, the new RN acts to prove his/her professional abilities by employing survival strategies that include establishing credibility, selecting issues for struggle and knowing what to ignore, explain to others without a defensive or condescending approach, drive for acceptance and recognition as an equal RN member of the ambulatory care nursing team, and constructing networks. The RN mentor steps back into a shadowing role as the new RN steps forward in being accepted into the clinic working environment with paranursing members of the staff. The new RN and RN mentor remain connected discreetly for

ongoing support and advice as situations transpire so that the new RN balances courage with caution to act appropriately and when relevant.

5. *Staying committed*

The RN mentor facilitates the newer RN to reflect and recognize role input that contributes to aggregate changes for patient care improvement alongside patient preference for the new RN by name specifically. The latter is taken as reinforcement that patients recognize the effort of new team members in the broader relations that underpin continuity of care. Furthermore, in terms of commitment, the RN mentor engages in active listening for cues linked to perceived salary or benefit package drawbacks associated with the transition from an inpatient to an ambulatory care staff position. In so doing, the RN mentor is best positioned to reiterate favorable factors affiliated with regular duty hours in the clinic without shift work or night duty, and perhaps the insidious loss in quality of personal life that is linked to inpatient shift working, or offer related insight that is unique with role transition to autonomy in ambulatory care nursing.

6. *Building the eldership*

At this time, the newer RN is settled and integrated into the team and role transition to ambulatory care nursing has been completed. In turn the newer RN is positioned with lived experience on the transition, and therefore embraces the role as RN mentor for other newer RN staff who are undertaking a career change and role transition to ambulatory care nursing. In the experienced role as an assimilated team member, the RN identifies and elevates quality healthcare concerns and encourages others to do likewise. At this level, the RN ambulatory care nurse interacts and leads when appropriate as a role model for ensuring that professional nursing standards are attained

autonomously, and that as ambulatory care nurses, the accountability component is linked to the RN role within the framework of policy and legal aspects that govern clinical nursing care practice.

Burns (2005:12) recommends that an RN mentorship tool for these stages needs to be developed so that the approach is shared and advanced autonomy is gained by the RN to practice clinical nursing autonomously in ambulatory care.

### 5.11.3 Conclusions statements on the procedure: autonomous ambulatory care nursing practice

The procedure of autonomous ambulatory care nursing practice for patient liaison nursing is summarized by deduction in the conclusion statements that follow:

- Ambulatory care nursing practice is executed with autonomy using the framework of the nursing process, and includes the three RN domains of nursing practice that are knowledge, affective and psychomotor skills
- The nursing process of assess, plan, implement, evaluate and record/report is a systematic and methodical way for autonomous ambulatory care nurses to carry out the functional RN role in patient liaison nursing to facilitate continuity of care
- The ambulatory nurse functions as a member in a culturally diverse team in meaningful relationships with staff and patients, and uses autonomy within a framework of policies that regulate ongoing nursing practice
- Mentoring is an essential component of an RN within the transition process into nursing in an ambulatory care nursing setting which leads to related activities and corresponding accountability for the nursing input on patient outcomes.

## 5.12 DYNAMICS: COLLABORATIVE LIAISON

Collaborative liaison is the dynamics of patient liaison nursing occurring in the context of ambulatory care nursing practice. The approach to conceptualizing 'collaborative liaison' would be to establish the meaning of the words separately, and then conceptualize what is meant by the 'liaison' that is modified by 'collaborative' in the context of this study.

### 5.12.1 Synthesizing 'collaborative' and 'liaison'

'Collaborative liaison' is a concept that arises by deduction from the combination of meanings to convey the dynamics by the agent, that is the patient liaison nurse, in interaction with relevant others to attain the goal of the activity. The meanings will be reviewed and synthesized by means of setting parameters (Sandelowski & Barroso 2007:35) for discussing the theoretical perspectives in the context of this study.

The Collins Dictionary and Thesaurus (2006:223) indicates the origin of the word 'collaborate' from Latin words; '*com-*' meaning 'together' added with '*laborare'* that means 'to work', and defines collaborate as 'to work with another or others on a joint project, to cooperate'. The synonyms that are provided include 'work together, team up, join forces, cooperate, participate'. The definition of 'collaborate' in the Oxford Dictionary and Thesaurus (2007:185) is given as 'work jointly on an activity or project', and presents synonyms that include 'cooperate, join forces, work together, combine, pool resources'.

'Liaison' comes from the Latin word '*ligare'* meaning 'to bind' and gives the definition respectively of 'liaise' and 'liaison' as 'to communicate and maintain contact' and

‘communication and contact between groups or units … the relationship between military units necessary to ensure unity of purpose’ (Collins Dictionary & Thesaurus 2006:686). The synonyms are provided as ‘communicate, link up, connect … mediate, interchange, hook up, keep contact’ (ibid). The Oxford Dictionary and Thesaurus (2007:597) defines liaise as ‘cooperate on a matter of shared concern … act as a link to assist communication between people’, and gives the definition of ‘liaison’ as ‘communication or cooperation between people or organizations. The synonyms are listed as ‘cooperate … network, interface, link up … contact, association, connection … alliance, partnership … representative, agent’ (ibid).

Liaison has been discussed earlier in section 5.7.3 as part of the concept of liaison nursing that is applicable here. However, the concept of collaboration requires discussion so that the synthesis of meaning as collaborative liaison can be summarized as the dynamics that drive the activity in this study.

The American Academy of Ambulatory Care Nursing (AAACN) defines collaboration as working together toward a common goal; to pursue a common purpose and a sharing of knowledge to resolve problems, decide issues, and set goals within a structure of collegiality (Laughlin 2006:419). Paschke (2006:53) identifies networking as a ‘key behavior’ that is essential in enhancing collaboration in ambulatory care nursing. She defines networking in ambulatory care nursing as collaborative actions that constitute ‘exchange of information or services among individuals, groups or institutions, drawing from the experiences of others as resources and support’ (ibid). The nurse is regarded as a collaborator in relation with colleagues and health team members by Blais, Hayes, Kozier and Erb (2006:219) inasmuch as they consider collaboration as crucial in professional nursing practice as a means to gaining improved patient outcomes. They expand on this notion of collaborator whereby they outline that a nurse takes accountability of getting to know the members of the health team, and more specifically

the extent of their collaborative roles and specific contributions as important in working together so that components of the healthcare delivery system are always utilized in the direction of satisfying the patient's healthcare needs. This aim is opposite to each health discipline separately taking care of their component of patient care that may lead to healthcare fragmentation and, therefore, the nurse collaborates to ensure that the patient does not become the victim of an omission in care while indeed becoming the center of focus of all care activities. It is this characteristic of collaboration as a quality of the professional nurse that Kowalski (2007:355) identifies 'is more than cooperation'. She indicates that the professional nurse brings collaboration to a project that 'adds value to the team and supports the creation of synergy' (ibid).

Arnold and Boggs (2007:155) identify collaboration with referral to a 'component of client advocacy' and assert that, due to the nature of patient problems being multidimensional, it therefore follows that services from more than one healthcare discipline are needed to best respond to the concerns of the patient. They suggest that collaboration is intertwined with coordination by the nurse in readiness to respond after careful assessment of the patient's healthcare concern. Thereto they distinguish that the nurse uses coordination when two or more members of the health team act separately and feedback to the nurse for the patient-focused action required, whereas collaboration would involve joint interaction with a client so that the scope of practice of the different healthcare professionals are synergized by the nurse into a single direction resulting in resolution of the patient's identified care or concern (ibid).

Lindeke and Sieckert (2005:online) outline the contemporary work setting of the nurse-physician relationship to be within a 'rapid, relentless evolution of the healthcare system'. They describe a convergence in the working climate of interprofessional collaboration between nurses and physicians that have gone beyond long-term to include 'fleeting encounters' on patient care matters. Regarding the latter, they indicate

that the focus is interaction-centered and that the volume of these fleeting professional nurse-physician encounters are on the increase concurrent to patient outcomes being the highest priority in interprofessional collaboration. Driven by the primacy of best patient outcomes, Lindeke and Sieckert (2005) describe the nature of collaboration as 'multidimensional' and state that it may include face-to-face encounters, electronic encounters in relation to e-mails or electronic patient records. In this regard, they state that collaboration can therefore take place anywhere or in any form provided that an opportunity is taken to 'exchange views and ideas' and that collaboration is mutually rewarding for nurses and physicians when the well-being of the patient is the shared goal (ibid).

In an exploratory qualitative study of health professionals using in-depth interviews of participants that included nursing, medicine and allied health professional therapists, Herbert, Bainbridge, Bickford, Baptiste, et al (2007:1321) identified professional qualities that were considered as the elements of collaboration the participants associated with 'successful engagement' in collaborative practice. Table 5.8 that follows shows the key qualities from the study findings that are grouped as attitudes, skills and personal qualities.

**Table 5.8** Summary of the elements of collaboration, namely attitudes, skills and personal qualities as found by Herbert, Bainbridge, Bickford, Baptiste, et al (2007:1321)

| Attitudes | Skills | Personal qualities |
|---|---|---|
| • Maintaining an open mind<br>• Valuing other professions<br>• Awareness of power differentials<br>• Enjoying working with people<br>• Being patient-centered<br>• Believing in lifelong learning | • Listening<br>• Learning from one another<br>• Team decision-making<br>• Communication<br>• Establishing trust<br>• Acting with respect towards one another | • Introspection and self-reflection<br>• Humility<br>• Confidence |

Fewster-Thuente and Velsor-Friedrich (2008:40) indicate that interdisciplinary collaboration for healthcare professionals is a vital phenomenon for healthcare providers and patients. The authors quote the Joint Commission (2006) from healthcare organizations' statistics which revealed that almost 70% of patient-related adverse events cited lack of collaboration and communication between healthcare team members as the main cause of error. Patient safety as an indicator of positive patient outcomes is taken to be the priority target of the healthcare system at which healthcare professional collaboration becomes the best position for team members to adopt (Nicklin, Mass, O'Connor, Ferguson-Pare, et al, 2004:32).

A synthesis of conceptual discussions on the patient liaison nurse as discussed in section 5.7 that focused on liaison nursing in section 5.7.3 is combined with the above definitions of the term liaison in this section, and by deduction, a description of collaborative liaison will be affirmed with collaborative as an antecedent to qualify liaison. Therefore, in summary, the meaning of the concept 'collaborative liaison' is a

focused communication interchange between two or more individuals for a shared purpose.

### 5.12.2 Communication interchange directions in collaborative liaison

The communication interchange directions in collaborative liaison that occur in the context of the ambulatory care services and system in this study are portrayed in figure 5.7. Sullivan and Garland (2010:99) are proponents of the directions in communication interchange specified in clinical nursing practice for the purpose of being practical in leadership and management. They expand on the notion of practicality as being facilitative in influencing decision-making and problem-solving. Sullivan and Garland (2010:103) emphasize that having directions in interchange between clinical and non-clinical staff promotes collaboration, liaison, cooperation, active listening and best positions teams within organizations for fulfilling the key purpose of patient care delivery. This figure is a synergy of figures 5.3, 5.4 and 5.5, respectively, that showed the levels of organization with the context of Saudi Arabian National Guard population, Nursing Services displayed in the ambulatory care context and the patient experience pathway with points of access to care and continuity of care.

Figure 5.7 continues with the diagrammatic use of circles to represent the scope of input by respective healthcare team disciplines and departments in relation to the central patient experience pathway that transverses the diagram from point P for patient to point G for goal. In this centrally positioned pathway are the circular depictions of the ambulatory care nurses (ACN) and patient liaison nurses (PLN) that show an overlap proposed as a collaborative liaison focused on a patient care concern whereby the communication interchange occurs in both directions. The result of the interchange is the PLN moving forward to the right of the diagram to the next position

for collaborative liaison that is outside the scope of the Nursing Services regular communication structure. Therefore, at the core of the diagram is the PLN with communication directions shown at the top and bottom indicating collaborative liaisons respectively with support teams and clinical teams. These representations are not fixed as such because this diagram does not represent a reporting structure or established liaisons. The circular representations are only for illustration purposes to show the points of interchange with the PLN. These teams in turn are depicted as having further communication interchanges with the teams that have indirect involvement with the PLN. As appropriate and relevant, the PLN receives communication from the first level of communication interchange aimed at resolving the patient care concern. Accordingly, the PLN considers the content of the communication that was received from collaborating healthcare team members and selects the necessary action that would settle the patient care concern at hand. The outcome is always input to continuity of care whereby the PLN communicates in the direction of the ACN who reaffirms the patient in the continuation of the experience pathway in the direction of the exit.

The diagrammatic circular representations depicted here will facilitate illustration later in the model in figure 6.1 whereby the situation as shown is apt for obtaining feedback directions from the patient population so that healthcare team members are provided with feedback on the quality patient care that is the goal of the model in this study.

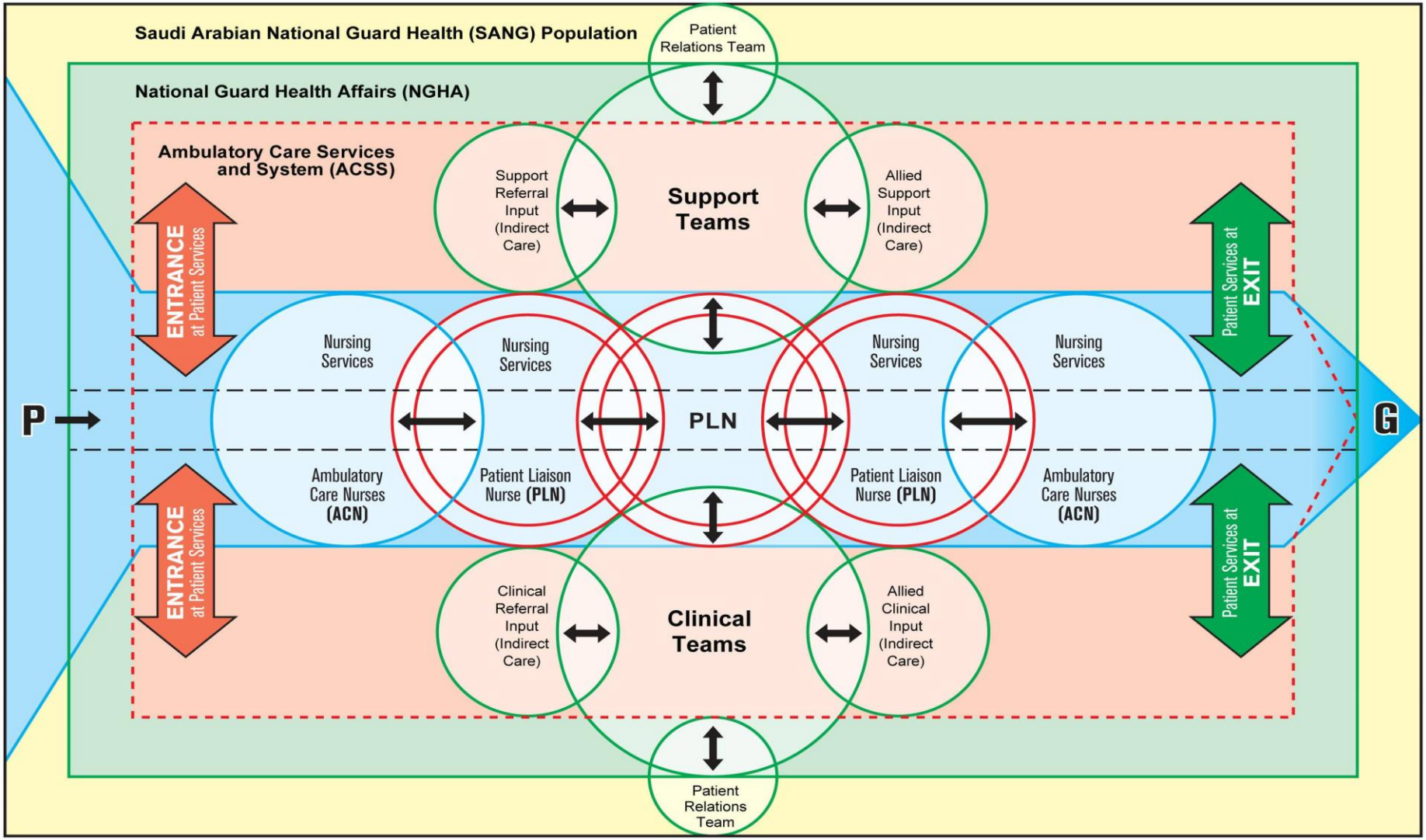



**Figure 5.7** Patient liaison nursing situated in the ambulatory care contextual structure showing the exchange of collaborative liaison as a communication interchange.

### 5.12.3 Conclusion statements on the dynamics: collaborative liaison

The conclusion statements on the dynamics of collaborative liaison were generated using deduction as follows:

- Collaborative liaison involves the exchange of information or services among persons to resolve patient care concerns aimed at satisfying patient healthcare needs
- A range of nursing actions that constitute collaborative liaison include assessment, communication, networking, cooperation, coordination, advocacy and interchange that become synergizing forces in momentum towards the target of a particular situation to elicit the input of the healthcare team in the direction of the best patient outcome.
- The nature of collaborative liaison is multidimensional as a means of communication interchange, exchange of information and attainment of quality patient care.

## 5.13 SUMMARY

In this chapter, the approach to generating a conceptual framework was positioned in the scientific context of the existence of knowledge. The identification of concepts was described from critical incidents and empirical data from reflective journaling in chapter three (3) and vignette responses in chapter four (4). Thereafter, the concepts were classified and a comprehensive literature review was presented to support arguments on the concepts and relationships on the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital. Chapter six (6) that follows includes the process of model description, evaluation and theory critique.

# CHAPTER SIX

# MODEL DESCRIPTION, MODEL EVALUATION AND THEORY CRITIQUE

## 6.1 INTRODUCTION

Chapter six (6) commences with the assumptions of the model followed by a comprehensive discussion and presentation on the description of the model. Thereafter, the model is critiqued using preset evaluation criteria by nursing theory experts.

## 6.2 ASSUMPTIONS OF THE MODEL

Assumptions are essential statements of truth that are given or accepted as the basis for theoretical reasoning (Chinn & Kramer 2008:231), and are to be disclosed in a study so that the reader is informed of what the writer takes as an accepted truth. Moreover, Chinn and Kramer (2008) indicate that the assumptions can be stated explicitly after the purpose of a model is determined whereby the concepts have been structured by the relational statements, and the definitions have been described (ibid). In this regard, the authors advise that assumptions may be expressed in the (i) form of actual assertions, or (ii) may echo value positions. For the former (i), these factual assumptions are known or become known during the experience in the study, whereas in the latter (ii), the value assumptions uphold or connote what is taken as 'right, good or ought to be' (Chinn and Kramer 2008:232).

The assumptions of the model, as discussed in chapter two (2), section 2.9 on the science philosophy that guided this study, are best aligned with the constructivist paradigm (Guba & Lincoln 2008:257) whereby the ontology of scientific inquiry was relativism in the local and specific construction and reconstruction of realities and the epistemology was transactional in the portrayal of findings. Also, the inquiry aim of the study was focused on understanding and reconstruction that therefore contributes to identification in the constructivist paradigm (ibid). Thereto, the departure point of this study was not based on any specific theoretical framework, while the model was indeed generated in a qualitative process of scientific inquiry that used the constructivist approach of eclectic aspects of professional nursing and healthcare practice. The methodology used in the study gave a voice to the various human experiences in an exploratory, descriptive and interpretive context of how the patient liaison nurse (PLN) practices in the setting of ambulatory nursing care in the healthcare delivery system of a Middle Eastern teaching hospital. The following assumptions are therefore postulated in reference to the model:

- The patient liaison nurse is an ambulatory care RN with a functional role that is used uniquely for focus on ambulatory patient care concerns that have the potential to interrupt the patient treatment regime.
- The functional RN patient liaison role is driven by a collaborative intention to restore an identified interruption in the patient treatment plan so that quality patient care remains the targeted outcome.
- The context of liaison occurs outside formal organizational structures so that the healthcare services and system does not become the iatrogenic cause for lack in continuity in care.
- Nursing is depicted as the constant force within the ambulatory care setting as opposed to the physicians and allied health professions that are

transient from a day-to-day basis due to a wider remit and commitment across the healthcare delivery system.

- The model is a synergistic and integrative systems-theory based representation of collective human interactions and experiences that are lived out within an environment that has internal and external influences. The mosaic of views therefore that are gained are valued as having a unique meaning that is central to the exploration and development of a nursing practice model.
- The model aims to construct ways of acquiring knowledge on nursing practice within a spectrum of multifaceted ways of knowing that is inextricably linked to pragmatic use of knowledge in nursing as a discipline.
- Although the purpose of the model was targeted at understanding the functional role of RN as PLN, it would have been meaningless unless, as happened in the formulation of this practice model, the patient journey of experience in the healthcare system was a concurrent focus.

Table 6.1 that follows is a summary of statements concluded from the conceptual framework in chapter five that lead onto the model depicted as figure 6.1. The legends that are used in the model are given and described in table 6.2 that also follows. Thereafter, the model in relation to the diagram will be described.

**Table 6.1** Summary of statements concluded from the conceptual framework.

| **Patient Liaison Nurse** *(Agent)* | **The Patient** *(Recipient)* | **Ambulatory Care Services & System** *(Context)* | **Quality Patient Care** *(Goal)* | **Autonomous Ambulatory Care Nursing Practice** *(Procedure)* | **Collaborative Liaison** *(Dynamics)* |
|---|---|---|---|---|---|
| 1. Patient liaising nursing is a specific functional RN role that is characterized by a focused response to patient concerns arising from potential interruption in continuity of care.<br>2. Functional RN nursing is the method of care delivery used by ambulatory care nurses and the patient liaison nurse that aims at specific tasks in response to unique patient concerns aimed at favorable patient outcomes.<br>3. Key functions of liaison nursing in the RN role encompass advice and support to patients, functioning as a link between services, effective liaison with primary health providers, and improving quality patient care.<br>4. The skills and abilities of a liaison nurse in the specific functional role include counseling skills, effective communication, team collaboration, networking and coordination, patient teaching, problem-solving and decision-making aimed at the overall purpose to ensure quality patient care. | 5. The patient is an individual or group entitled to receive healthcare in response to identified needs, problems, concerns or requests aimed at gaining quality healthcare.<br>6. Healthcare is a right of the patient to whom the organization is obliged to respond by providing treatment which includes patient teaching on identified problems and related prevention.<br>7. The patient maintains the right to provide feedback on components of care that may require improvement wherein the feedback is valued by organization as a contribution to attain quality patient care. | 8. The Ambulatory Care Services and System is the setting in which healthcare delivery occurs in response to patient needs, problems or concerns<br>9. The system component of Ambulatory Care Services and System relates to the structure of arrangements that facilitates the 'service' component characterized by performance in the use of human and material resources.<br>10. Operationalization of the Ambulatory Care Services and System have the overall purpose for healthcare provision that includes access and continuity of care<br>11. Nursing Services is a functional component of Ambulatory Care Services and System in which registered nurses, that is ambulatory care nurses (ACN) and (PLN), execute nursing care delivery activities that include support functions such as referral and coordination of care. | 12. Quality patient care is indicative of structural, process and outcome standards for healthcare delivery performance review and evaluation for access and continuity of care.<br>13. Consistency in quality patient care is maintained by the role of direct caregivers who intervene in a collaborative capacity with measures to use an improvement opportunity for a better patient experience in healthcare delivery.<br>14. Person-centered healthcare that utilizes positive patient-staff relations is fundamental in personalizing patient care aimed at best possible healthcare outcomes<br>15. Access to care combined with continuity of care adds value to quality patient care through coordination, collaboration and information exchanges in the healthcare team. | 16. Ambulatory care nursing practice is executed with autonomy using the framework of the nursing process, and includes the three RN domains of nursing practice that are knowledge, affective and psychomotor skills<br>17. The nursing process of assess, plan, implement, evaluate and record/report is a systematic and methodical way for autonomous ambulatory care nurses to carry out the functional RN role in patient liaison nursing to facilitate continuity of care.<br>18. The ambulatory nurse functions as a member in a culturally diverse team in meaningful relationships with staff and patients, and uses autonomy within a framework of policies that regulate ongoing nursing practice.<br>19. Mentoring is an essential component of an RN within the transition process into nursing in an ambulatory care nursing setting that leads to related activities and corresponding accountability for the nursing input on patient outcomes. | 20. Collaborative liaison involves exchange of information or services among persons to resolve patient care concerns aimed at satisfying patient healthcare needs<br>21. A range of nursing actions that constitute collaborative liaison include assessment, communication, networking, cooperation, coordination, advocacy and interchange that become synergizing forces in momentum towards the target of a particular situation to elicit the input of the healthcare team in the direction of best patient outcome.<br>22. The nature of collaborative liaison is multidimensional as a means to communication interchange, exchange of information and attainment of quality patient care. |

**Table 6.2** Legends for figure 6.1

| | |
|---|---|
|  | Patient concern for attention |
|  | Patient concern being attended by PLN |
|  | Patient concern attended |
|  | Direction and exchange of communication and collaborative liaison |
|  | |
|  | Feedback flow on quality patient care |
| P | Patient |
| G | Goal: quality patient care |
| ACN | Ambulatory care nurses |
| PLN | Patient liaison nurse |

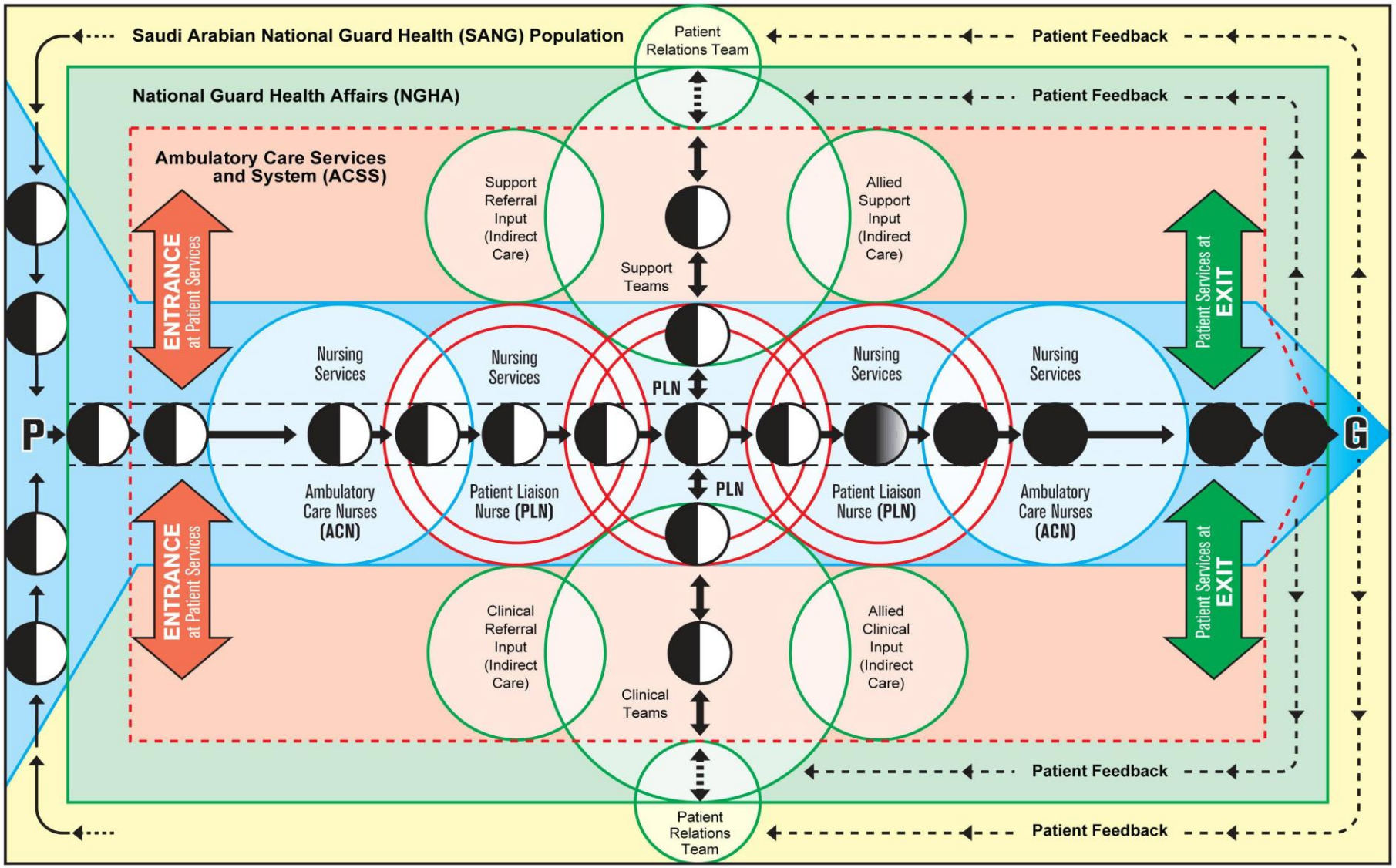



**Figure 6.1** A model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital.

## 6.3 DESCRIPTION OF THE MODEL

The description of the model is set out using the components as given by Chinn and Kramer (2008:220) to include the purpose, context, overview, structure and process of the model. Furthermore, the description of the model (as shown in figure 6.1 above) and relational statements are in fulfillment of the research objectives of this study as stated in section 1.6.2, research objectives four (4) and five (5), respectively. In objective four (4), it was articulated that relational statements would be formulated and described based on the conclusion statements arising from the empirical data. In objective five (5), the intent was to describe a model for the scope of professional nursing care specific to the functional RN role as PLN insomuch as it contributed to quality patient care in the ambulatory care context.

### 6.3.1 Purpose of the model

The purpose for the development of this nursing practice model is to provide a schematic outline that represents the scope of professional nursing care for the functional RN role of the PLN. In so doing, the contribution of this important functional RN role would be determined within the larger context of nursing practice in ambulatory care nursing as a value-based sub-discipline of greater discipline of general nursing practice. In alignment to Chinn and Kramer (2008:222), the purpose and concepts of a model are the key elements in describing the scope of the model, which refers to the range of phenomena or breadth to which the model applies in practice.

### 6.3.2 Context of the model

Chinn & Kramer (2004:92) and Chinn & Kramer (2008:212) explain that the context of the model imparts insight into the background of sociopolitical circumstances that triggered and influenced the creation of the model, which includes the researcher's experience, the setting in which the model was formulated, community or societal trends and underpinning philosophical ideas that gave form to the purpose as to why the model was developed.

In the context of Saudi Arabia as a gulf country on the Arab peninsula, there has been a rapid development of the healthcare delivery systems, particularly services within the National Guard Health Affairs (NGHA) during the past decade with multiple building expansions and expedited completions for expansion of services (NGHA 2001:14, NGHA 2003:9, NGHA 2007:57, NGHA 2009:11). This rate of development means that ongoing review on the delivery of services is needed so that quality patient care is assured as systems and services are adapted, revised or installed according to the rate of expansion. The ambulatory care center was purpose-built as a five-storey with nineteen (19) ambulatory care clinics and opened at the beginning of the decade of growth. This was a greatly welcomed center as opposed to the previous facility of one floor for outpatient services that had space for only four (4) clinics. The patient liaison nurse resulted from these early experiences in the new center when a trend was observed whereby there were a host of patient concerns as a consequence of the move. I functioned at that time as a nurse administrator and was responsible for the input by nursing services to commission and transfer all services into the new facility, and therefore was part of the process in adopting the suggestion that focused attention was required at the RN level of nursing to assess the patient concerns as they arose and to act immediately aimed at resolving essential matters in order that patient

treatment regimens were uninterrupted. It was decided that the patient liaison nurse would be a functional RN role that was not necessarily seen as an expansion of the RN role with an approved job description and scope of nursing, but the RN would be relieved from regular ambulatory care nursing duties for the sole purpose of focusing on immediately identified patient concerns. Personnel of the Saudi Arabian National Guard (SANG) and their eligible dependents therefore held lofty expectations when the ambulatory care center opened, and were therefore justified for wanting instant gratification and immediate attention as patients for their healthcare needs since it also was part of the employment benefit package as a member of SANG. The patient liaison nurse therefore had a crucial role in responding to meet the patient expectations on the key term that their treatment should not be interrupted, but in fact rather it should be enhanced in the new purpose-built facility.

### 6.3.3 Overview of the model

The overview of the model is intended for descriptive purposes to capture a snapshot view (Ely, Vinz, Anzul & Downing 1997:74) of model in the practice setting. Therefore, the overview is a brief portrayal of the main attributes that assists gaining greater perspective ahead of the detailed attributes that follow in the structural and process descriptions of the model.

The core attribute of the practice model is the patient liaison nurse who is centrally positioned to respond to a patient care concerns as part of an overall organizational endeavor to provide quality patient care during an episode visit to the ambulatory care center. The patient liaison nurse (PLN) overlaps with a co-equal RN colleague that is an ambulatory care nurse and who has determined that another level of closer focus at the autonomous nursing practice level is required to best respond to the identified

patient care concern. The multiple actions that occur are shown by the various overlapping circles that are initiated by the PLN with a range of healthcare team members in pursuit of the goal of quality patient care. The patient exits the ambulatory care center after an episodic visit and returns to the SANG community and remains within the healthcare system as an outpatient (see figure 6.1).

### 6.3.4 Structure of the model

Chinn and Kramer (2008:228) states the structure of the model gives overall form to the conceptual relationship of which it is comprised, and therein emerges the structure that illustrates the relationships within the model. They expound on relationships and indicate that there is an identifiable relationship between individuals and the setting that is portrayed as the environment of the model, and therefore all structural elements of the model are to be depicted aimed at determining the strength, direction and quality of the model (ibid), which includes the concepts (inclusive of related concepts) and the relational statements.

#### 6.3.4.1 Definition of concepts

The definition of the concepts as described below is based on concept identification from the empirical data and concept classification as shown in table 5.1 that was undertaken by using the survey list of Dickoff, James and Wiedenbach (1968:423).

- **Patient Liaison Nurse (PLN):** A registered nurse (RN) working in an ambulatory care setting who is assigned for a period of time in a functional RN role with a specific focus to respond to individual patient care concerns arising from the potential interruption in continuity of care, and thereby contribute to

quality patient care. The range of skill sets include counseling skills, effective communication, team collaboration, networking and coordination, patient teaching, problem-solving, and decision-making.

- **Ambulatory Care Nurse (ACN):** A registered nurse (RN) working in an ambulatory care setting that is characterized by episodic patient care to a high patient volume using skilful, rapid nursing assessment based on prior and ongoing knowledge, skills and abilities that are targeted to specific outpatient clinic profiles, and aimed at contributing to quality patient care within the context of the episode of a patient care experience. The ACN rotates through the functional RN role as a patient liaison nurse (PLN) according to internal assignment for a time-specific period as determined by the nursing management of a clinic.

- **Functional nursing:** Functional nursing is a method of care delivery that is focused on the completion of activities in a task-oriented approach aimed at economy, productivity and efficiency, and is beneficial particularly in ambulatory care settings that handle component parts of care delivery needing fast and prompt attention. It is used by ambulatory care nurses and patient liaison nurses due to care delivery points of an episodic nature as the ambulatory patient moves through the system and services.

- **The patient**: The patient in the ambulatory care setting is an individual or group that is eligible to receive a defined range of healthcare responses in fulfillment of identified needs, problems, and concerns or requests so that quality healthcare is obtained and maintained.

- **Patient care concern:** A patient care concern arises from identified healthcare needs, problems or unmet care requests or expectations that could become an inherent factor leading to interruption in the treatment regimen with a resultant impact on continuity of care.

- **Ambulatory Care Services and System**: The Ambulatory Care Services and System is a setting in which arrangements are structured for the delivery of patient care characterized by the performance of human and material resources targeted at the overall purpose of permitting access of care and ensuring continuity of care, which is the essence of quality patient care.

- **Quality patient care:** Quality patient care is manifested by healthcare performance delivery that permits access to care and continuity thereof, characterized by consistent collective caregiver input through collaborative approaches that are patient-centered with added value of ongoing information exchange at all levels of interaction.

- **Access to care:** Access to care is the first point of contact with an organization that is usually initiated in a health screening process and thereafter, based on the screening results, the patient is accepted and assigned to a regimen within the appropriate spectrum of healthcare services.

- **Continuity of Care:** Continuity of care is taken as the degree to which care of individuals is coordinated among healthcare practitioners and healthcare services over time with the least possibility of inherent factors that could potentially interrupt the delivery of care or the patient experience.

- **Autonomous ambulatory care nursing practice:** Autonomous ambulatory care nursing practice is exhibited by registered nurse (RN) autonomy in the use of the nursing process in a self-directed mode of practice using the domains of RN practice, i.e. knowledge, affective and psychomotor skills, in a methodical approach and with reference to the healthcare team for the aim of ensuring continuity of patient care as a contribution to overall positive patient outcomes.

- **Nursing autonomy:** Nursing autonomy is manifested by self-directedness in the function of a registered nurse (RN) based on nursing knowledge, affective and psychomotor skills, and who does not require a credentialed physician directive or that of another allied health licensed practitioner for undertaking actions in direct patient care delivery.

- **Collaborative liaison:** Collaborative liaison is a synergizing force that involves multidimensional exchange of information or services among persons using actions that embrace assessment, networking, cooperation, coordination and advocacy within the communication interchange aimed at the attainment of quality patient care.

- **Healthcare team:** The healthcare team is a group of professionals that are certified within a range of health science or related disciplines as direct clinical caregivers, or as indirect or support caregivers whereby all contribute in varying degrees to the attainment of overall patient care outcomes.

### 6.3.4.2 Structural form of the model

Chinn and Kramer (2008:101) describe the structural forms of models as 'powerful devices for shaping our perceptions of reality', and mention that description of a model may not necessarily fit onto one structure as theory could be expressed in several 'competing structures that cannot be reconciled' into a 'single discernible structure'. Therefore, all concepts may not inevitably fit into a coherent structure to represent all concepts and the relational components. In this regard, figure 6.1 above depicts patient liaison nursing diagrammatically in the context of the ambulatory care services and system because the interchanges within the various healthcare team member and/or units of service are fundamental to dynamics of collaborative liaison used by the patient liaison nurse (PLN). Figure 6.1 is a synergy of three (3) basic types of structural forms within the model that evidences the complexity of services and systems that confront patients when accessing healthcare delivery. The structural forms are as follows:

- Linear graphics: (i) represented as parallelograms/rectangles to illustrate a classic system of input, throughput and output (ii) illustrated by horizontal lines that represent a parallel continuum as a pathway with two points marked 'P' for patient and 'G' for goal, and simultaneously indicate the entry and exit points respectively, and (iii) horizontal and vertical interrupted lines with unidirectional and bidirectional arrowheads to indicate the patient flow direction and/or the exchange directions of healthcare team members that are patient-centered in their response to an identified patient concern.
    - The crux of patient liaison nursing action is illustrated at the central interchange between the horizontal pathway of the patient experience concurrent to nursing services, and the vertical unidirectional arrowheads illustrating collaborative liaison with the respective clinical

and support teams on the symbolic half-moon shaded patient care concern, which denotes the indication for PLN action.

- Spherical graphics: (i) overlapping circles depicting a shared purpose or focus in relation to response to an identified patient care concern, and (ii) an oblong and circular sphere (Chinn & Kramer 2008:229) that is represented as a half-shaded graphic as a metaphorical half-moon to indicate an unmet or unresolved patient care concern, a partially-shaded half-moon that indicates the focus of attention and a completely shaded sphere to show that the patient care concern has been resolved for the current episode.
- Hollow graphic arrowheads with text: the text-filled arrowheads are designated patient service desks for registration and follow-up appointments, respectively, at the entrance and exit including the function as a patient information counter for inquiries and/or directions.

For each use of the three types of graphical forms, a structural orientation will be outlined to facilitate deciphering of the respective models.

Orientation to linear graphics with positioning of the patient spherical graphic: The model in figure 6.1 can be understood by considering the linear graphics of the largest outer rectangular perimeter first, then inwardly in the direction towards the inner rectangle. These three (3) sets of rectangles are aligned to the classic system linear diagram of input at the left, throughput in the center of the rectangle and output shown on the right as shown in figure 5.3. The layered rectangles from the outer perimeter represent the origin of the patient in the SANG (Saudi Arabian National Guard) population, the next level rectangle depicts the national corporate authority of the NGHA (National Guard Health Affairs) that constitutes the executive leadership of the healthcare organizations within the group of NGHA facilities, and the inner rectangle denotes the unspecified healthcare team of ACSS (Ambulatory Care Services and

System). Unspecified refers to the conglomerate composition of the direct and indirect caregivers that will be explained with the circular linear representations below.

The horizontal tunnel of parallel linear graphics through the center of all three rectangular representations portrays the patient experience pathway as shown in figure 5.2. The representative patient pathway traverses the SANG, NGHA and ACSS that are illustrative of access to care and continuity of care. The patient journey is shown symbolically with a half-moon shaded sphere to indicate the patient care concern that requires attention. The horizontal arrowheads show the direction of movement through the nursing services into the scope of the ambulatory care nurse (ACN). Nursing services are depicted as a parallelogram that is a transverse pathway flanking the patient experience journey from entrance to exit. The overlapping of circles throughout the center will be explained below within the focus on spherical graphics, while it suffices to indicate at this stage that the patient care concern moves horizontally only in the direction of the exit until the fully shaded sphere that indicates that the patient care concern has been resolved. Thereafter, the patient is shown at the exit point from the ACSS and NGHA subsequent to the episodic experience and returns to the community residential compounds of SANG.

Orientation to spherical graphics with positioning of the patient graphic: The central horizontal overlapping circles are indicative of the registered nurses (RN) who are staff in the reporting line to the nursing services. The single circle represents the RN ambulatory care nurse and the duplex circles depict the RN patient liaison nurse (PLN) whose RN functional role is focused graphically inwards towards the patient care concern for attention. The overlapping circles between the registered nurses indicate a similar scope of practice, whereas the PLN has a functional RN role assignment on patient care concerns that falls outside the scope of services relating to ambulatory clinics on a given day. The ACN hands over a patient care concern to the PLN whose

RN assignment is beyond the ambulatory care clinic routine to focus on an individual patient. The vertical overlapping circles suggest that the PLN interchanges with clinical and support teams as required during closer assessment of the patient care concern.

The vertical overlapping circles contain the spherical graphic of the patient that is indicative that the PLN seeks possibilities for a plan to assist the patient in a specific unique situation, and functions either for access to care at different levels based on the screening assessment or actions in the direction towards G in figure 6.1 to ensure continuity of care. In a situation where the immediate contact with a healthcare team member is unable to assist immediately, the PLN endorses the patient care concern to a member of the support team or clinical team in keeping with content, who in turn overlaps with the other team members for further specific assistance before responding definitively to the PLN. The PLN returns to the ACN and provides feedback on resolution to the patient care concern as shown by the overlapping circles and the fully shaded patient spherical graphic. The ACN facilitates the exit of the patient or redirects the patient to the exit desk of patient services for a follow-up appointment and/or directions to the final point of services such as pharmaceutical care to collect prescription medications.

Orientation to the hollow graphic arrowheads with text: The hollow graphic arrowheads are situated at the entrance point to the ambulatory care services and system (ACSS) and at the exit point. The graphic arrowheads overlap into nursing services which illustrates their gatekeeper position as the registration desk and overall control of the appointment system which signifies the electronic aspects of access to care based on eligibility. Similar arrowheads are positioned at the exit point as sites for follow-up appointments and further assistance and direction to pharmacy, medical imaging, laboratories, pharmaceutical care and so forth within the larger context of continuity of care. Notably, there are two (2) patient spherical graphics after the exit point at patient

services, the first within the rectangular linear graphic of NGHA and the second in the outer rectangular graphic denoting SANG. These specific spherical graphics imply that the patient could exercise feedback rights regarding the quality of care. The directions of the feedback pathways are so illustrated by interrupted linear graphics into the scope of the patient relations teams that have firm positional status at the level of SANG and NGHA for the sole purpose of handling patient feedback and follow-up, and reports directly into the office of the Chief Executive Officer of NGHA.

Graphic complexity (see appendix 47) to graphic simplicity is revealed on review of the simplified figure 6.2 that follows as a portrayal of how the nursing actions are carried out in the RN functional role as PLN. Linear graphics are used to portray a classic system on input, throughput and output with an interrupted linear graphic to show the feedback pathways that are unidirectional and bidirectional as required. The input and output vertical rectangles and the left and right, respectively, of the figure represent the respective referral to the PLN by the ACN at the left, and the return by the PLN to the ACN for or after implementation of the PLN patient plan. The throughput is illustrated by a differentiation of hollow arrowheads and linear squares that are positioned to illustrate arrangements of services in relation to the action of the PLN. Vertical and horizontal lines show the direction of the interchanges and exchanges that occur in concert aimed at resolving the patient care concern. The patient care concern is not shown graphically in figure 6.2 because the entire diagram shows the existence of direct caregiver services in arrangement for the purpose of the patient without showing the indirect caregivers. The interrupted feedback pathways indicate that patient feedback can be received directly at any level, although with varying emphasis, according to the nature or urgency of the feedback content.

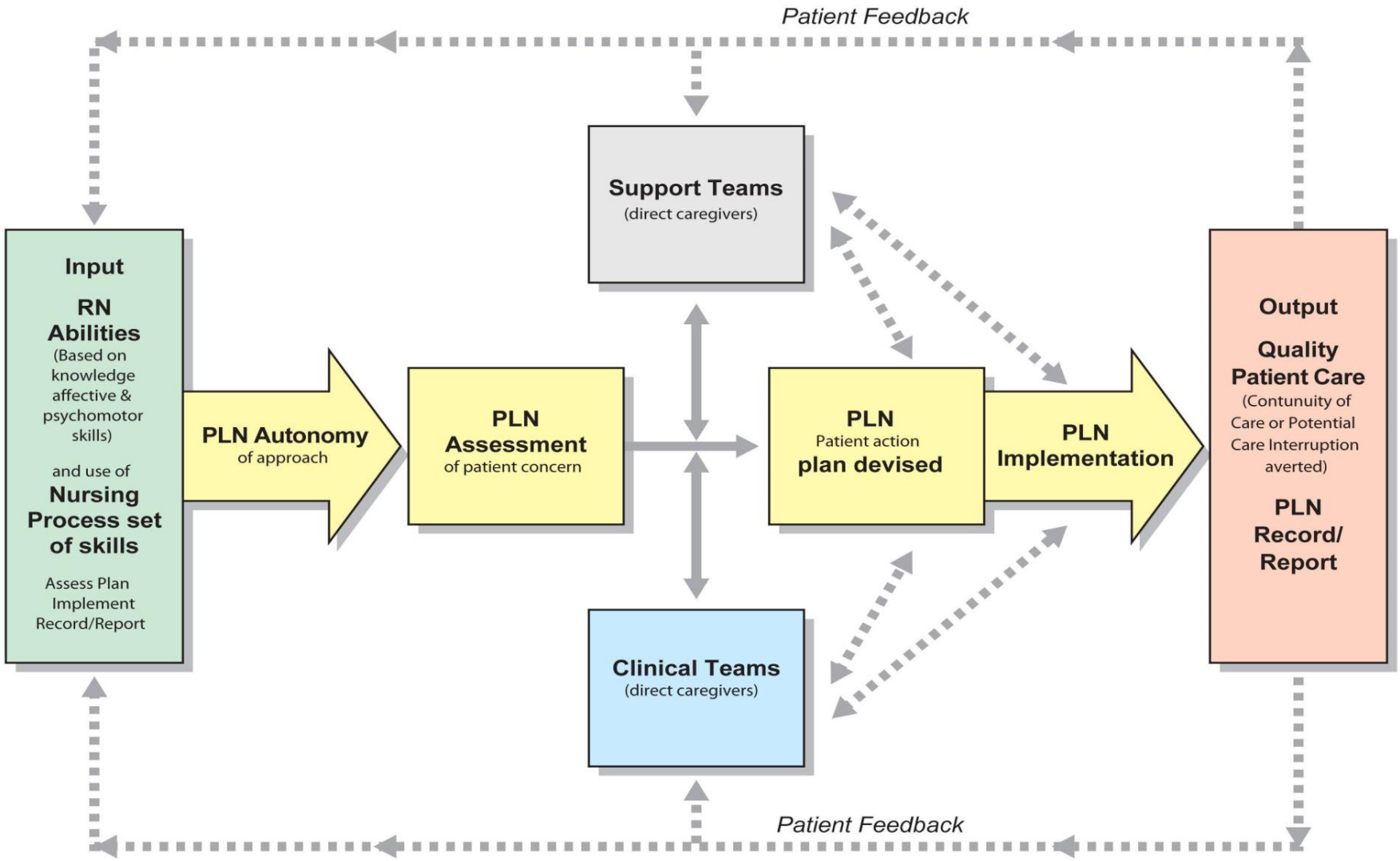



**Figure 6.2** Functional RN role illustrated in context of patient liaison nursing as the functional RN role.

### 6.3.4.3 Relational statements

Relational statements are essential from the perspective of model development because they are ingredients that assert an association between two or more concepts in the process of constructing a scientific body of knowledge (Walker & Avant 2011:59). Furthermore, Walker and Avant (2011:197) advise that the process of construction occurs subsequent to major concepts being identified and examined by commencing with explicit relational statements, then examining the concepts closely to determine further relational linkages by the use of deduction. In so doing, Walker and Avant (2011:198) advise that the empirical support for the relational statements be assessed and indicated.

Therefore, the relational statements that follow are derived explicitly from the definition of concepts and by deduction from the empirical conclusion statements aimed at the portrayal of associations between the major concepts. Each relational statement will be supported in parentheses commencing with the abbreviation 'v:' indicating 'vide' in reference (Collins Dictionary & Thesaurus 2006:1346) to the conclusion statement number(s) indicated by cross-referencing table 6.1 wherein the empirical statements are given. The relational statements are as follows:

- Patient liaison nursing is characterized by the unique autonomous output of a registered nurse (RN) who generally functions as an ambulatory care nurse, but with a time-limited and distinctive focus solely on responding to immediate individual patient care concerns within the ambulatory care setting, which arise due to there being a real or perceived threat of interruption in the treatment regimen of the patient for the sake of achieving continuity of care (v: 1, 2, 3, 5, 6, 8, 10, 12, 13, 15, 18 and 20).

- The input of the patient liaison nurse in response to identified patient care concerns is through the RN abilities of knowledge, affective and psychomotor skills within the framework of the nursing process, that is to assess, plan, implement and record/report, and thereby embraces a range of skilful activities including counseling and communication interchange skills, referral and coordination, collaboration and cooperation, provision of advice and support, information exchange and acceptance of feedback, patient teaching and advocacy, and problem-solving and decision-making that are collectively aimed at the accomplishment of quality patient care (v: 2, 3, 4, 5, 6, 7, 8, 11, 15, 16, 17, 20, 21 and 22).

- The ambulatory care context is a complex setting in which a blend of ambulatory care services and ambulatory care systems are arranged to facilitate access to and continuity of patient care delivery by the healthcare team ultimately targeted at the overall purpose of achieving positive patient outcomes (v: 1, 2, 8, 9, 10, 11, 12, 14, 15, 17, 20 and 21).

- Autonomy in ambulatory care nursing practice is characterized by the self-directness of the patient liaison nurse (PLN) who uses collaborative liaison as an approach in networking with a range of healthcare team members to elicit multidimensional individual responses that are coordinated and synergized into assisting and/or facilitating a patient experience episode for an overall gain in quality patient care (v: 1, 3, 4, 5, 6, 7, 11, 12, 13, 15, 16, 18, 20, 21 and 22)

- Quality patient care is an indication of consistency and the degree by which collaborative improvement efforts by the healthcare team are delivered in a

meaningful staff-patient relationship that includes direct and indirect care, and whereby the organizational performance of the entire healthcare delivery system and services are affirmed as making a positive contribution to overall favorable patient healthcare outcomes (v: 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14 and 21).

- Access to care and continuity of care are linked abstractions pertaining to patient care that are not mutually exclusive because continuity of care is unattainable without access to care, and only when access to care is permitted can continuity of care be assured. Therefore, the notions of quality patient care components are manifested by uninterrupted patient care, timely responses to patient care concerns, patient-centered care input by healthcare members, improved patient care experiences and patient teaching, efficiency in operationalization of services, accountability for healthcare delivery performance and patient-centered health information exchanges (v: 1, 2, 4, 6, 7, 8, 9, 10, 12, 14, 15, 17, 19, 20 and 22).

- A patient care concern is a healthcare need, health problem or health related request that propels an eligible individual or groups to pursue affiliated access to care and thereafter continuity of care within an organization that provides a range of healthcare services in fulfillment of the care concern for gaining and maintaining quality healthcare, inclusive of distinct supportive measures to avoid unwarranted interruption of the patient treatment regime (v: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 20, 21 and 22).

- Collaborative liaison is an autonomous mode of nursing practice used by the ambulatory care nurse (ACN) when engaged in the functional registered nurse (RN) assignment as the patient liaison nurse (PLN) that requires self-direction to initiate appropriate and relevant interchanges with members of the healthcare team for multidimensional purposes aimed at ensuring continuity of patient care and/or preventing interruption of the patient care treatment regimen (v: 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 15, 16, 17, 18, 20, 21 and 22).

### 6.3.5 Process description

Process description in model development is a means of articulating broad frameworks for practice to reflect the core values of nursing as a profession, and has extrinsic value inasmuch as it conveys the science of nursing, which is a core attribute to the development of nursing as a profession (Walker & Avant 2011:4). The processes for developing nursing knowledge therefore lie in transmitting patterns of knowing that are interrelated and emerge from the experience of nursing that Chinn and Kramer (2008:9) asserts as nursing knowledge acquiring 'its richness, depth, and meaning'. This process of description is taken by Chinn and Kramer (2008:3) to be grounded in the empirical knowledge in nursing as a science expressed in the form of practice models with accompanying statements of fact, descriptions and/or interpretations of phenomena. Further attributes of process description in nursing knowledge development include conscious problem-solving, logical reasoning within a contextual background so that the application of knowledge reflects awareness of the reasoning process, as well as pinpointing the experience of nursing as a practice discipline (ibid). Thereto, Chinn and Kramer (2008:270) purport that one of the features of nursing research is that it is theory-generating, as opposed to theory-validating scientific

inquiry. Moreover, they define theory-generating research as designed to 'clarify and describe relationships' and the inherent processes 'without imposing preconceived notions of what the relationships mean', which is the core attribute of inductive logic and reasoning (ibid).

To this extent, Janesick (2000:391) and Chinn & Kramer (2008:61) concur that the emphasis should be on knowledge development processes as the overarching aim for achieving research objectives, or scientific problem-solving, and indicate that adherence to strict methodological obligations with an ultimate aim towards method and focus is 'methodolotry'. Janesick (2000:390) coined the term 'methodolotry' as a combination of 'method' and 'idolatry' to describe a 'preoccupation with selecting and defending research methods to the exclusion of the actual substance' that gives meaning to the experience being conveyed, and cautions that 'methodolotry' as the 'idolatry of method' has shown often to overtake the dialogue in the disciplines of education and human sciences. The way forward, as articulated by Janesick (2000:390) and Chinn & Kramer (2008:61) is the focus on process description arising from research by ways of converging on the substance of the research findings so that sound descriptive data steers the reader to a profound understanding of the meaning of the experience that is being researched.

The process description is therefore a series of events or development that reveals a course of actions in the practice model on patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital as shown in figures 6.1 and 6.2.

The patient originates from a defined community, which is the Saudi Arabian National Guard, and gains access to care in a facility of the National Guard Health Affairs (NGHA) by military employment with lifelong eligibility. The patient undergoes registration upon identification at the patient services entrance desks of the ambulatory

care services and system (ACSS). In situations whereby a problem arises due to either a system failure, faulty patient understanding of services or a lack of specific services in healthcare delivery on a given day, then the patient is referred from the front-of-service desks to the ambulatory care nurse (ACN), who is a registered nurse (RN), and who undertakes a rapid assessment of the patient care concern. Due to the regular broader scope of the ACN insomuch as the clinic-related responsibilities in managing a high volume of patients and accompanying duties, the patient concern is endorsed to another ambulatory care nurse (ACN) who is specifically assigned for a preset period of time as a patient liaison nurse, and has no other general ambulatory care clinic responsibilities.

The complexity of services and systems are such that the patient remains with the PLN so as to avoid further inconvenience for the patient. In essence, the PLN operates using collaborative liaison to bring the healthcare services or virtual team members to the patient in response to the identified care concern, instead of the patient "shopping" for assistance within the five-storey facility of ambulatory care clinics. This series of actions by the PLN may involve a few or several successive exercises in collaborative liaison before the end achievement is attained to resolve or settle the care concern of the patient. Communication interchanges by the PLN may include electronic methods such as sourcing the electronic medical record, beeping the most responsible physician (MRP) in relation to medication repeat prescriptions, arranging for medical supplies that have been exhausted or replacing dysfunctional medical equipment, investigating incomplete tests, renewing eligibility arrangements of SANG dependents, updating changes to marital status, number of dependents and/or dependence subsequent to marriage, issuing medical reports or sick leave certificates, arranging ambulance transportation for attending clinics, replacing misplaced requisitions or informed consent for specialized procedures, facilitating rebooking of appointments that were either missed, incorrect or for multiple bookings for various clinic specialties on the

same day, facilitating medical attention on a recall due to test results or findings, and so forth.

At all times, the PLN retains the ultimate intention of resolving or settling the immediate patient care concern. Consequent to a series of actions that may have been necessary, the PLN is able to inform the patient of the outcome of further access to care or confirm ongoing continuity of care. The end goal of the PLN is to prevent any likeliness of interruption in the patient's treatment regimen. Thereafter, the PLN endorses the patient to the ACN who functions within the regular scope of educating or reminding patients of their self-care actions needed to affirm subsequent episodic visits. At the exit point at the desk of patient services, the patient is either assisted further with directions for services required before the conclusion of the episodic visit such as pharmaceutical care services to collect medications, medical records to obtain medical reports or certificates, the laboratory or medical imaging services for further tests or investigations as may be required, and so forth. If none of the preceding actions are necessary, then the patient is able to secure a follow-up appointment at the exit point of patient services. This interaction is crucial as a further level of prevention of potential interruption of treatment plans or pathways, and therefore the patient is offered the best available follow-up appointment that is convenient to the patient community schedule and in alignment to both the Hegira and Gregorian calendar dates, availability of the most responsible physician (MRP), treatment facilities in the event of day procedure being required, and so forth.

As I observed, there are notices in Arabic and English at multiple points throughout the ACSS that inform the patients and families of their rights in terms of healthcare services, and contact numbers are given for patients to convey feedback directly to the patient relations department. The patient relations department reports directly into the

office of the NGHA Chief Executive Officer and therefore functions in a contributory role as the gatekeeper of the rights of the patients.

The components not shown in figure 6.1, but implied in figure 6.2, are the internal nursing regulatory process of credentialing. Prior to a registered nurse being hired into the organization at NGHA facility, there is an extensive rigorous process of primary source verification on all nursing or related certificates and qualifications, medical screening clearance, police clearance in the country of origin and verified nursing references. On arrival at an NGHA site, a detailed orientation to the healthcare organization, a general nursing orientation and thereafter a specific nursing unit orientation are provided. Throughout these nursing credentialing validation processes, the onus is on the registered nurse to provide proof in practice of professional abilities in relation to knowledge and practice skills. Various assessment methods and techniques are employed by the unit-based clinic nurse manager who is accountable for the staff to provide safe, quality care. These assessments include competencies by demonstration of skills, workshops, presentations, English literacy and fluency testing, observation of clinical nursing activities such as attitude and approach by the primary RN preceptor during the orientation pathway, nursing care and medical record audits and nursing documentation reviews. A system of recertification is also prescribed and preset for registered nurses as a requirement for the renewal of employment contracts applicable to every RN, irrespective of whether the nurse is an international expatriate or a national Saudi nurse. The practice of registered nurses within the NGHA is also subject to a robust system of nursing practice panel reviews as may be necessary or appropriate on the decision of the chief of nursing or the chief executive officer. However, such a nursing practice review is the end point in situations where the documented evidence raises a question on the abilities of a registered nurse from either an individual or system perspective. Thereto, a range of nursing education offerings are offered on an clinical academic calendar to which registered nurses can

volunteer attendance or be mandated by policy according to the maintenance of nursing credentials. All nursing exits from the NGHA are voluntary unless there is proven negligence in nursing practice for which there are extensive legal and human resource processes that must be fulfilled before the decision of termination is confirmed.

## 6.4 EVALUATION OF THE MODEL

Fawcett (2005:53) maintains that the 'evaluation of a nursing model is accomplished by comparing its content with certain criteria', and indicates that the ultimate aim of credibility of a nursing model is to determine whether the content is appropriate for use in clinical situations and relevant to the clinical population. Meleis (2007:242) concurs with the perspective of Fawcett (2005) that criteria are required for comparing the content of a nursing model, and moves to endorse the entirety of chapter four (4) in the sixth ($6^{th}$) edition of Chinn and Kramer (2004:91-119) that sets out questions for critical reflection on a nursing model. Meleis (2007:242) affirms that the set of questions provided by Chinn and Kramer (2004), corresponding to chapter eight (8) of the seventh ($7^{th}$) edition of Chinn and Kramer (2008:219 to 249), would 'guide the evaluation of integrated knowledge', and confirms that the questions are driven by the approach to the definition of a model as theory that contains 'a creative and rigorous structure of ideas that projects a tentative, purposeful and systematic view of phenomena'.

Notwithstanding these definitions by nursing theory experts (Fawcett 2005, Meleis 2007, Chinn & Kramer 2008), the approach to evaluation of the model in this study has four (4) parts that are outlined below:

(i) an initial appraisal that would be termed as 'face validity' in survey research by requested feedback as evidence of acceptable content by three (3) possible sources, namely (i) the literature, (ii) representatives of the relevant populations, and (iii) content experts (Burns & Grove 2005:377). However, as will be discussed later in section 6.4.1, aspects of trustworthiness were used for this initial appraisal and are described accordingly.

(ii) the guide provided by Chinn and Kramer (2008:246) that was adapted for use in this study is discussed later in section 6.4.2.

(iii) the adapted steps of the evaluation framework of a nursing model by Fawcett (2005:53), which were modified for use in this study by omitting criteria that were included by Chinn and Kramer (2008) or irrelevant in a practice model, as presented below in section 6.4.3.

(iv) the critique of theory aspects in the work of Meleis (2007:257), adapted with the exclusion of criteria that were represented respectively in Chinn and Kramer (2008) and Fawcett (2005), discussed later in section 6.4.4.

The rationale for using an approach to evaluation of the model that has four (4) parts are:

- the use of the components of trustworthiness aligns my activities as the researcher to the elements of scientific integrity that are discussed in chapter one (1), section 1.10
- Chinn and Kramer (2008) criteria for evaluation were used for congruency to the approach for model description by Chinn and Kramer (2008:220) that is the content of section 6.3 in this chapter
- Fawcett (2005) and Meleis (2007) were selected for their expertise on nursing theory and nursing knowledge, which are characterized by mutual

reciprocity and collegial critique of each other's stances on nursing theory and nursing knowledge (Fawcett 2005:10, Meleis 2007:242). The benefit of using their respective work on evaluation criteria lies in the refinement over the years gained by ongoing peer critique between two (2) equivalent international nursing theory doyens.

- Meleis (2007) was used also because of her endorsement of the evaluation criteria of Chinn and Kramer (2004), which are strengthened in Chinn and Kramer (2008:234), and because the evaluation criteria include specific scrutiny of the relationship between structure and function, the diagrams and the impact or influence potential, exploration of usefulness in practice, education and administration, and external components of theory.

The evaluation tool is provided in appendix 30 with four (4) parts that illustrate the array of questions denoting the criteria used to conduct the evaluation of the model in this study. The reviews from these evaluations of the model are given in this chapter in sections 6.4.2.1, 6.4.3.1, and 6.4.4.1. Each of the above four (4) parts for evaluation of the model will be discussed.

### 6.4.1 An initial appraisal on demonstrating trustworthiness

The initial appraisal was guided by the components of trustworthiness that are discussed in chapter one (1), section 1.10.5.

At the outset of generating the conceptual framework in chapter five (5), it became apparent to me that the content of the conclusion statements from the critical incident technique combined with reflective journaling in chapter three (3), and the vignette responses in chapter four (4) had elements of input and throughout that were aligned to

classic systems theory (as discussed in chapter five (5), section 5.3). Thereafter, the conceptual framework was crafted and rudimentary figures were sketched to graphically illustrate what was emerging from the empirical data.

An initial set of figures that portrayed the fundamental concepts were produced. These were the elementary and early sketches that now are figures 5.2, 5.3, 5.5 and 6.1. The sketches were circulated to eight (8) nursing colleagues. The nursing colleagues were self-selected as a purposive sample as (i) members of the nursing executive and organizational leadership (ii) credentialed with a postgraduate qualification, and (iii) clinical nursing experience in the organization in Riyadh of two (2) or more years as an indication of being familiar with the systems and processes in the organization. Each colleague received an electronic distribution of the rudimentary graphics and was asked to provide feedback.

Feedback was received from seven (7) of the nine (9) persons either by e-mail or by verbal discussions. The content of the feedback on this initial peer appraisal showed similar trends as follows:

- color was highly recommended to facilitate the comprehension of content in figures that were described as being ‘busy’ and having ‘much to take in’ when reviewed
- for easier understanding in readers who are not familiar with the organizational abbreviations, it was suggested that a full description was to be written with abbreviations in parentheses
- labels were recommended for all circles even where there was repetition in the illustrations without necessitating the reader to refer back to a previous diagram

- in the flow of the first set of figures for initial appraisal, that is figures 5.3, 5.5 and 6.1, it was pointed out that there were large “jumps” and that a few more figures were needed to graduate the reader in conceptualizing the final version of the model
- a subsequent second set of figures was reviewed that included figures 5.4 and 5.7 and were regarded as a more fitting representation of the functional role of the RN as PLN within the internal structure of systems and processes of the ambulatory care center of the hospital
- additionally, figures 5.6 and 6.2 were added for specific focus on the PLN and to facilitate understanding of the model with particular reference to the PLN.

The components of trustworthiness were realized as follows by submitting rudimentary and subsequent sets of figures to a purposive sample of peers to critique:

(i) credibility (truth-value) whereby the figures were adjusted for alignment to the understanding of the sample population of reviewers

(ii) transferability (applicability) wherein the respondents were colleagues with clinical nursing leadership experience in both inpatient and ambulatory care settings, which portrayed that the figure representations of the nursing units were nevertheless understood in relation to collaborative structures in the diagrams

(iii) dependability (consistency) in relation to the scientific inquiry by initiating the appraisal aligned to my responsibility as the researcher to ensure that the sketched content was representative of the concepts in the study and congruent to the organizational structure setting

(iv) confirmability (neutrality) hereto that the sets of figures, that is the initial and the subsequent figures, contribute to a decision trail that respects the

feedback of colleagues so that the final diagrams were a closer representation and were readily discernible to others when reviewed.

This initial appraisal was invaluable because it proved to be essential in the process of model development in that the model evolved based on scientific rigor that circumvented the misrepresentations of the systems and processes. Given the complexity of the final figure 6.1 in chapter six (6) illustrating the model, minor inaccuracies could have been amplified, which is the ex post facto benefit of subjecting the initial appraisal to the components of trustworthiness.

### 6.4.2. The evaluation guide and criteria by Chinn and Kramer (2008)

Chinn and Kramer (2008:234-248) propose five (5) components for use when evaluating a model. These are (i) clarity, which includes semantic and structural clarity, and semantic and structural consistency, (ii) simplicity (iii) generality, (iv) accessibility, and (v) importance.

Clarity of the Model:

Clarity of the model refers to how well the theoretical components and related figures can be understood, and the consistency of the concepts in relation to semantic clarity, semantic consistency, structural clarity and structural consistency (Chinn & Kramer 2008:238).

a. Semantic clarity

Semantic clarity refers to how understandable and coherent the definitions are of concepts in articulating the established empirical meanings within the theory (Chinn & Kramer 2008:238). In essence, semantic clarity would convey the

essence of meaning so that the reader would envisage a similar empirical reality when the definitions of the concepts are read because they would portray comprehension of both the specific and general features of the described concepts that include the contextual sense of meaning (ibid).

b. Semantic consistency

Semantic consistency is a feature of theory wherein the concepts in the theory are used with congruency and harmony with the definitions of the concepts, the purpose of the theory and in accordance to the stated relationships between the concepts (Chinn & Kramer 2008:239).

c. Structural clarity

Chinn and Kramer (2008:241) indicate that structural clarity is closely associated with semantic clarity in that it refers to how understandable and coherent the connections and logical reasoning are in relation to the descriptive elements of a theory.

d. Structural consistency

Structural consistency pertains to the various structural forms that are used to illustrate the general profile of the descriptive elements of the theory for the purpose of providing a conceptual map to enhance clarity and comprehension (Chinn & Kramer 2008:242). In effect, structural consistency can be used as a guide for discussions on structural clarity and consistency and semantic consistency aimed at overall clarity to avoid ambiguity in understanding the model and be useful in stimulating new ideas or discussions in relation to nursing experiences on the basis of the theory.

Simplicity of the Model:

The simplicity of the model refers to the number of elements in terms of descriptive aspects in relation to the concepts and interrelationships that should be kept to the lowest level of complexity without loss of core meaning (Chinn & Kramer 2008:242). The desirability of simplicity or complexity is relative to the contextual situation being portrayed wherein the value of the simplicity or complexity of the theory is embraced by the level of understanding of the various concepts and their interrelatedness within the theory (ibid).

Generality of the Model:

The generality of the model refers to its breadth of scope and purpose that appraise the broad range of empirical experiences to a range of concepts and interrelated applications in healthcare practice (Chinn & Kramer 2008:243). The theory is therefore taken to have ideas that are arranged to facilitate general application to pertinent healthcare professional team members, but has sufficient application to nursing as a discipline while it addresses broad general concepts of individuals, health, environment and society (ibid).

Accessibility of the Model:

The accessibility criterion expounds on the extent of identifying empirical indicators for the concepts in relation to the extent for which the purpose of the theory can be achieved through explanation of an aspect of nursing practice (Chinn & Kramer 2008:243). Empirical indicators are defined as perceptually accessible experiences that can be used in nursing practice to assess the phenomena that the theory describes and that can be used to determine whether the purposes of the theory are

realized in a manner expounded in the theory (ibid). The authors assert that increasing the complexity within theories leads to increasing empirical accessibility, and that as subconceptual categories are clarified, the empirical indicators become more precise. However, they qualify this assertion by stating that empirically accessible theories that provide a conceptual perspective on clinical practice may not need an emphasis on empirical accessibility. However, in specific reference to the latter, Chinn and Kramer (2008:244) point to the purpose of the theory in that if it were to be used to guide research, then empirical accessibility would be essential, whereas if the theory is to shape clinical nursing practice, then the concepts need to be empirically accessible within the clinical setting for which they create conceptual meanings.

Importance of the Model:

The criterion on importance of the model is closely linked to the clinical value or practical significance within the targeted area of nursing practice, which is not limited to current applicability but has a futuristic and pragmatic value for contributing towards a desired vision of where the theory is able to lead practice (Chinn & Kramer 2008:245). The central question that is asked is whether the theory creates understanding that is important to nursing and is valued on one or more of the following levels as important to nursing as a discipline:

- guides research and practice in the discipline of nursing
- generates radically new ideas of nursing, health, and caring
- differentiates the focus or nature of nursing from other service professions.

Innate in the evaluation process on the importance of the model are the professional and personal values in relation to the central question, and the argument of

discernment as to whether a theory had achieved its intended professional purposes (ibid).

#### 6.4.2.1 Evaluation synopsis using the criteria of Chinn and Kramer (2008)

The evaluation is provided as a synopsis using the criteria of Chinn and Kramer (2008:246) that are provided in appendix 30, part B. The criteria are congruent to the Chinn and Kramer approach to model description that was used in this study. It was realized that the evaluation of the model was an iterative process with section 6.3 on model description as a process of refinement. The aspects that were addressed in the model description in section 6.3 are indicated in table 6.3 that follows in this section. The revisions and changes were effected iteratively and directly with the text on model description aimed at the outcome of having a model in this study that would be operationalized as will be discussed in chapter seven (7), section 7.2 that provides guidelines for implementation of the model.

Table 6.3 provides a synopsis of the evaluation review with comments on what was addressed and refined in the description of the model.

**Table 6.3** Synopsis of the evaluation of the model using the criteria of Chinn and Kramer (2008)

| Criteria for evaluation and comments from review |
|---|
| **1. Clarity**<br>- element of clarity and consistency were reviewed simultaneously<br>- all main concepts required greater depth of text to portray a descriptive vividness<br>- additional figures were added to illustrate progressive development of concepts, connectedness in relationships and congruency<br>- appendices 48 and 49 show the figures that were clustered into batches to provide concurrent and incremental diagrams on the description of the model<br>- changes were made to the text subsequent to professional editing of this thesis, which enhanced the clarity |
| **2. Simplicity**<br>- appendix 47 shows the figures from a simple diagram in figure 5.3 with progressive and incremental concepts and their relationships in figures 5.4, 5.5, 5.7, including the final and complete version of the model in figure 6.1<br>- the description of the model and related figure 6.1 is complex, which is necessary for the purpose of explaining the main concepts, their interrelatedness and contextual setting, for which effort is made by the figures in chapter five(5) to show the simple to complex progression |
| **3. Generality**<br>- appendix 50 provides a batch of figures 5.6, 5.7 and 6.2 that relates to the breadth of nursing and the specificity of the functional role of the RN as PLN<br>- appendix 49 shows the 'onion-layered' figure 5.2 in contrast to the model in figure 6.1, which depicts concepts related to the individual, health, environment, nursing and the society that determine the context of nursing practice in the ambulatory care setting of a Middle Eastern teaching hospital<br>- the text describing the main concepts and relationships were refined in an iterative process as figures and tables were added incrementally for clarity |
| **4. Accessibility**<br>- the concepts in this model can be used as empirical indicators for nursing practice of the PLN in the functional role as RN based on the descriptions of the model that are based on empirical evidence in this nursing study and the literature<br>- the definitions and meanings of the concepts, although contextualized in nursing practice, are specified for ambulatory care nursing<br>- the figures as explained above in appendices 47, 48, 49 and 50 provide a means of creating a conceptual understanding of the clinical practice setting of ambulatory care nursing, whether required at a level of simplicity or complexity |
| **5. Importance**<br>- the benefits of this model were reviewed and strengthened by use of the NGHA achievement reports and the NGHA mission, vision, and values statement, which shows the value of this model in the NGHA ambulatory care services and system<br>- at various levels of nursing practice, administration, education and research, this nursing model has the potential for further research especially when implemented in the practice setting<br>- the pragmatic value of the nursing model is that it can be used to operationalize the functional role of the RN as PLN, or be the forerunner to advanced nursing practiced in the Kingdom of Saudi Arabia |
| **Summary comment**<br>- although players may change, for instance, at the time that, this nursing model was being developed, the King of Saudi Arabia announced transfer of authority to his son for the commander leadership of SANG<br>- unless there are major changes to systems, this nursing model would be applicable and related while minor revisions to the description could be embraced on the proviso that the entire nursing model must always be checked for comprehensiveness using the evaluation criteria as set out in appendix 30 |

### 6.4.3 The modified steps in the evaluation framework by Fawcett (2005)

The modified steps from the Fawcett (2005:53) evaluation framework were selected mindful of the evaluation criteria on clarity that are found extensively in Chinn and Kramer (2008), and congruent to a clinical nursing practice setting. The criteria selected include (i) explication of origins, (ii) comprehensiveness of content, (iii) logical congruence, (iv) credibility of the nursing model, and (v) contributions to the discipline of nursing.

Explications of origins:

The evaluation for this criterion includes explicit identification of the author's beliefs and values aimed at obtaining information on the philosophical foundations of the model and any particular focus on any aspect of nursing practice that is emphasized in the nursing model. The scholarly expectation here is that the work of scholars has been cited (Fawcett 2005:53).

Comprehensiveness of content:

In this evaluation criterion, the emphasis is placed on the breadth and depth of content. This includes concepts of a nursing metaparadigm to include human beings, the environment, health and nursing, as well as the existence of relationships between concepts. Furthermore, the criterion includes whether the guidance given for practice situations is adequate and broad enough to span a range of activities that are pertinent to the focus area of nursing practice for which the nursing model has been developed (Fawcett 2005:54).

Logical congruence:

The criterion on logical congruence evaluates the internal structure of the nursing model. This action occurs using the cognitive ability of judging the congruence between the content of the model and the stated philosophical stance of the researcher. Integrated in judging the model on this criterion is congruence on nursing knowledge or world views and how consistently this is handled and whether or not different schools of thought have been translated into one congruent frame of reference for use in nursing as a discipline (Fawcett 2005:54).

Credibility of the nursing model:

The penultimate criterion for the evaluation of a nursing model here relates to determining its credibility and acceptance within the practice setting and within the clinical population. Credibility of a nursing model is implied by way of appropriate and relevant empirical substance from the literature so that the guidance of nursing activities in practice is based on empirical evidence related to nursing knowledge in the disciplines. Three (3) subclasses of this evaluation are specified by Fawcett (2005:55). These are (i) social utility of the nursing model that is linked to how the nursing model can be applied in nursing practice, which may include specialized education or upskilling on interpersonal and psychomotor elements of nursing actions; (ii) social congruence of the nursing model is appraised by determining whether the nursing activities described in the nursing model are harmonized to the nursing practice setting of the healthcare environment and the healthcare team, which means that the goals and outcomes of nursing interventions are consistent with the realities of the socioeconomic factors that impact healthcare; and (iii) social significance of the nursing model relates to the social value of the nursing model with attention on the health impact on the particular population who are the recipients of nursing activities

described in the nursing model, which also value the input of nurses in the related practice setting.

Contributions to the discipline of nursing:

This final criterion of Fawcett (2005:57) pertains to judgments made following a comprehensive review of the literature regarding the concepts and content of the nursing model. Fawcett (ibid) cautions judgments made by the comparison of different nursing models, and advises that a nursing model is best critiqued on its individual worthiness and value by use of its philosophical stance, and by the expectation that the understanding of the phenomenon of interest to nursing will be amplified and expanded by the nursing model.

#### 6.4.3.1 Evaluation synopsis using the modified steps in the framework of Fawcett (2005)

The evaluation synopsis is presented using the evaluation steps that were modified from the framework of Fawcett (2005:53) and given in part C of appendix 30. The use of the evaluation tool as given in appendix 30 continued iteratively by guiding me as the researcher and writer in the activity of rereading and rechecking original texts and articles that steered the editing and rescripting activities until clarity was gained and/or ambiguity was overcome. The impact of applying the modified evaluation framework by Fawcett (2005) is presented in table 6.4 that follows.

**Table 6.4** Synopsis of the evaluation of the model using the modified framework of Fawcett (2005)

| Criteria for evaluation and comments from review |
|---|
| **Step 1: Explication of Origins**<br>- the philosophical stances underpinning this model and the research process were initially unclear, but after revision and more description, it was explicit that system theory was operant in model development, and constructivism in the research process of inquiry that included model development<br>- the scholarly works of nursing theorists and nursing theory experts are extensively cited and referenced throughout this work |
| **Step 2: Comprehensiveness of content**<br>- the nursing model provides comprehensive descriptions on the patient and PLN, the environment as the contextual setting of ambulatory care, health as an outcome and goal of quality care and nursing is described with specificity on the liaising actions taken in the functional role of the RN as PLN<br>- the PLN program was described extensively in terms of how the patient enters the system and a concern is identified, which is the commencement of PLN action as set out in appendix 50 that comprises figures 5.6, 5.7 and 6.2, which depict the detail of the PLN interactions |
| **Step 3: Logical Congruence**<br>- congruence was attained after initial review that showed further refinement was required for logical flow<br>- the perspectives of three (3) main nursing theory experts were used, i.e Dickoff, James and Wiedenbach (1968), Chinn and Kramer (2008) and Walker and Avant (2011), and these perspectives were reformulated and transformed to reflect the single perspective for the PLN program of the functional role of the RN |
| **Step 4: Credibility of the nursing model: social utility, social congruence, social significance**<br>- although the initial operationalization of the PLN program appeared successful, it would require a nursing education program for application to practice to avoid possible divergence in interpretation being rolled-out to the 1st, 2nd, 3rd and 4th generations perhaps of functional role as PLN if the average rotation in the role annually were to be quarterly<br>- each segment of the PLN series of nursing actions, as shown in appendix 50, can be developed separately and more specifically for the various clinics with the ambulatory care setting<br>- the nursing model on the PLN is able to guide nursing research into both efficacy and efficiency, as well as from a patient satisfaction perspective<br>- the value of the PLN program, as explicated in the nursing model lies in the continuity of patient care, and virtually at zero extra cost because the functional role of the RN as PLN can be planned around clinic schedules to utilize downtime advantageously where there are gaps in the schedule and/or physicians' planned absences<br>- the core benefit to the patient is that the episodic visit may never be invalid because in each instance when a concern arises, referral to a PLN can be made for intervention |
| **Step 5: Contributions to the discipline of Nursing**<br>- the value of this nursing model is local and international because the functional role of the RN as PLN has not been described in Saudi Arabia, nor by AAACN or the ICN |
| **Summary comment**<br>- the traditional methods for data collection in qualitative inquiry are interviews, either individual or by focus groups, which possibly means that the use of the critical incident technique with reflective journaling and the vignette technique could be considered as unique to this study, which was used for the generation of model development using empirical data |

### 6.4.4 Adapted critique of theory criteria by Meleis (2007)

Meleis (2007:257-264) provides criteria for critiquing theory that are adapted for use in evaluating the nursing model. The criteria are (i) the relationship between structure and function, (ii) diagram of theory, (iii) circle of contagiousness, (iv) usefulness and (v) external components. For each criterion, Meleis (2007) specifies units of analysis to guide the evaluation of the model. The aspect of social significance is omitted here in the critique by Meleis (2007) because it is included in Fawcett (2005) in section 6.4.3 above.

Relationship between structure and function:

The critiquing of theory is accomplished by making a critical assessment and judgment between the different components of the theory that include concepts, assumptions, relational statements and propositions. The units of analysis with criteria are given as clarity, consistency, simplicity/complexity, and tautology/teleology.

Diagram of theory:

The visual presentation of a theory is reviewed in terms of representation of aspects of the theory that are presented graphically. Moreover, Meleis (2007:259) includes questioning whether the graphic presentation reinforced or enhanced different aspects of the theory, and whether the graphics were an authentic and explicit visual presentation of the major concepts and linkages that were logically and clearly set out.

Circle of contagiousness:

This evaluation criterion refers to the extent and potential for use of a nursing model within a geographical location and institutional setting. The nursing model must indicate its geographical and institutional origin, the purpose related to clinical nursing practice, and the influence of the theorist on the implementation of the nursing model.

Usefulness:

The critique of usefulness relates to the potential for use in clinical practice and nursing administration. For usefulness in clinical practice, the practitioner must be guided to assess the nursing model in terms of its function with regard to goals, consequences and benefits in practice. Questions are asked as to whether there is a framework to guide practice, whether the model applies to current practice, and whether the model fits into the nursing process. In nursing administration, the model is reviewed in terms of structure and organization of care. Meleis (2007:262) states that nursing models are expected to guide the care of patients and not to guide the manner or style of administration or leadership. However, Meleis (2007) indicates that nursing models should be congruent to professional standards that guide the practice of registered nurses such as credentialing requirements that govern the practice of professional nursing of the country in which nursing is practiced.

External components:

The criteria for critique in the external components of the nursing model include personal and professional values, as well as congruence with social values. The values of the theorist must be disclosed and stated as assumptions for the purpose of eliminating bias in the nursing model that is formulated from empirical data. The

assessment for congruence with other professional values are reviewed for opportunities in the nursing model to facilitate collaboration and complementarity of professional value systems that are focused on actions by the nurse and others to enhance patient care delivery for a common purpose. The last aspect of this criterion questions whether the nursing actions and patient care outcomes are congruent with the expectations of nursing by the patient population that represents society.

#### 6.4.4.1 Evaluation synopsis using the adapted critique of theory criteria by Meleis (2007)

The adapted critique of theory criteria by Meleis (2007:257) that was used for evaluation of the model are provided as part D in appendix 30. The Meleis (2007) criteria were well-placed as the fourth ($4^{th}$) part D of the evaluation tool because the items have provided the additional criteria of reviewing external components that are not stated in the criteria of either Chinn and Kramer (2008), or Fawcett (2005). Table 6.5 that follows provides a synopsis on the evaluation of the model using the Meleis (2007) criteria.

**Table 6.5** Synopsis of the evaluation of the model using the adapted criteria of the Meleis (2007) critique of theory

| Criteria for evaluation and comments from review |
|---|
| **Criterion 1: Relationship between structure and function**<br>- clarity, consistency, simplicity and complexity are addressed above in table 6.3 using the evaluation criteria of Chinn and Kramer (2008)<br>- aspects that were repeated unnecessarily in the various elements of the model description were edited out aimed at improving clarity and conciseness in the theory |
| **Criterion 2: Diagram of theory**<br>- the visual and logical presentation of the graphics have been addressed comprehensively above in tables 6.3 and 6.4 in the evaluation reviews using Chinn and Kramer (2008) and Fawcett (2005) respectively<br>- to enhance the clarity and visual vividness of the graphics, it was decided later to use color, which enhanced the understanding of the diagrams on the concepts and relationships |
| **Criterion 3: Circle of contagiousness**<br>- the nursing model has its origins in the NGHA, which is a leading healthcare organization within Saudi Arabia and in the Gulf region<br>- the international overlaps are possible with JCI surveys and the published reports, international and national presentations aimed at highlighting that the PLN program is a pioneering study with the potential of transferability within the Middle Eastern region where the contextual settings and elements of the model are possibly comparable<br>- evidence is provided that denotes the influence of me as the researcher on implementation of the model, which is shown by appendices 32 to 45 as a testimony of fifteen(15) abstracts for oral presentations arising from this study |
| **Criterion 4: Usefulness in clinical practice**<br>- the procedure for care delivery by the PLN is central to the model with a patient-centeredness focus<br>- figures 5.6, 5.7, and 6.2 provide guidelines to the PLN as shown in appendix 50, which focuses the role within the practice setting<br>- guidelines are provided for implementation of the PLN role aimed at usefulness in nursing practice |
| **Criterion 5: Usefulness in nursing administration**<br>- the use of the nursing model in nursing administration is expected to guide the nurse administrator in using the model for the structure of care and the organization of care in the ambulatory care nursing setting specifically<br>- specific operational guidelines are provided to steer the implementation of the nursing model for the PLN in the ambulatory care setting of a Middle Eastern teaching hospital |
| **Criterion 6: External components**<br>***Criterion 6.1 Personal and professional values***<br>- the assumptions are provided in the opening chapter of the thesis in relation to the elements in the research design<br>- bracketing, field notes and memoing was used throughout the qualitative process of inquiring for the purpose of awareness of personal and professional values |
| ***Criterion 6.2 Congruence with other professional values***<br>- the link to other professional values is evident in the assumptions of the model (section 6.2) that are given as being synergistic and integrative while using systems theory to represent the collective interdisciplinary interactions portrayed in the nursing model on the functional role of the RN as PLN<br>- collaboration is innate in the PLN activities evidenced by the establishment of communication directions for liaison beyond the regular nursing chain of communication |
| ***Criterion 6.3 congruence with social values***<br>- this criterion is fully addressed in table 6.4 above in response to step four(4) of Fawcett's criteria for evaluation that include the credibility of the nursing model in relation to social utility, social congruence and social significance |
| **Summary comment**<br>- albeit that there are overlaps in the evaluation criteria between Meleis (2007), Chinn and Kramer (2008) and Fawcett (2005), the use of these three (3) selected authors who each are nursing theory experts in their own right, adds value to the entire model evaluation process in that the specificity by one expert may have another perspective on the same area of review, and therefore ensures that the evaluation of the model is comprehensive, thorough and rigorous |

### 6.4.5 Theory testing

Theory testing is regarded by Meleis (2007:264) as the continuous development and advancement of a theory for the purpose of gathering further empirical data as evidence of the theory being tested in practice, as well as the replication of testing in other settings of similar context. McKenna and Slevin (2008:168) specify that theory testing research is designed to determine how accurately the depiction of the real-world phenomena is portrayed in theory. Theory testing is outside the scope of this study and often belongs to the post-doctoral level of nursing studies.

## 6.5 SUMMARY

In this chapter, the nursing model was presented in a description that was enhanced by graphics. The evaluation of the model was conducted using key elements of trustworthiness that were linked to scientific integrity, and reviewed using selected evaluation criteria by nursing theory experts. The approach to operationalization for implementation of the nursing model in the ambulatory care context of a Middle Eastern teaching hospital follows in the final chapter seven (7) of this study.

# CHAPTER SEVEN

# GUIDELINES FOR IMPLEMENTATION OF THE MODEL, EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS

## 7.1 INTRODUCTION

The guidelines for implementation of the model are presented and situated in the context of operationalizing activities in a nursing service. The evaluation of the study, the limitations, recommendations and transferability of the study are presented prior to the penultimate final reflexivity that leads to the conclusion of this thesis.

## 7.2 GUIDELINES FOR IMPLEMENTATION OF THE MODEL IN AMBULATORY CARE NURSING

The approach to providing guidelines for the implementation of the model in ambulatory care nursing requires consideration of the greater context of nursing services in the hospital including a nursing executive council, which is the highest professional nursing authority that governs the clinical practice of nursing across all nursing sections. As described in chapter five (5), section 5.8.3 on the international context of being a JCI accredited hospital, it would therefore be necessary that the operationalization occurs in a manner that is synchronized to hospital-wide activities that are designed within the framework of the JCI accreditation standards (JCI 2008).

### 7.2.1 Operationalization approach for the implementation of the model

The operationalization approach for implementing the model is based on Kelly (2007:73) who puts forward that a systems perspective is required when considering the introduction of mechanisms that may have an impact on established activities in an organization. Daft (2010:47) considers that any input into the system of an organization are destined to be transformational in nature throughout with a resultant output and feedback that would be informative and contribute to gauging efficacy and results. Feedback is regarded by Daft (2010:47) as 'knowledge of the results that influence' the subsequent cycles in the system when a new mechanism is being used. Daft (2010:48) expands on the notion of impact on an established system especially in open systems that would have to consider external environmental factors, but more particularly on subsystems of the larger systems. His rationale for this consideration is that changes in one part of the system or subsystem inevitably cause changes in other elements of the system or subsystems that are sometimes not readily recognized. Daft (2010) therefore advocates that guideline changes must be coordinated as a whole at a level higher than the floor or unit manager or supervisor.

This operationalization stance by Daft (2010) is supported by authors of organizational development and behavior from the perspective that changes in organizational systems and subsystems must be reviewed for effectiveness, whereby change in individual, group and/or organizational behavior is the key to determining the effectiveness of implementing a new mechanism that may impact work design so as to guide activities that are especially goal-focused (French & Bell 1999:83, Hersey, Blanchard & Johnson 2001:126, Robbins 2003:105, Gibson, Ivancevich, Donnelly & Konopaske 2006:21, Senior & Fleming 2006:5, Kelly 2007:87, van Tonder & Dietrichsen 2008:173).

However, underlying effective operationalization in a nursing service is nursing leadership that influences activities in nursing practice in the direction of goal attainment towards meeting the overall purpose of the organization (Koestenbaum 2002:41, Roussel 2006:171, Yoder-Wise 2007:123, Marquiz & Huston 2009:51, Sullivan & Decker 2009:45). In this regard, Benner, Tanner and Chesla (2009:233) go further than just influencing nursing activities towards goal attainment by pointing out that clinical practice is embedded socially in nursing in tandem with clinical reasoning, but stipulate the nursing leadership ingredients of scientific knowledge, and focus on clinical outcomes and personal and social support as necessary to embed clinical and caring knowledge in nursing practice with 'accuracy and fidelity'. Grossman and Valiga (2009:120) draw attention to the complexity in contemporary healthcare systems and caution that the clinical nursing setting must be adequately prepared before the implementation of changes by remaining informed about the situations in which nurses are practicing, being mindful of professional and personal values and action changes with flexibility and taking into account the wealth and diversity of abilities in nursing teams.

Shaw (2007:77) provides the International Council of Nurses (ICN) perspective of nursing leadership that is adopted from Grossman and Valiga (2000) to include the following:

- study and create new ideas
- make designs
- assign responsibilities
- create an environment of trust
- reliability
- loyalty to followers
- self-confidence

- leadership.

Thereafter Shaw (2007:81) provides the four key areas that the ICN indicate as essential to the successful implementation of programs by nursing leadership. These key areas and associated criteria are provided in table 7.1 with the related applied guidelines for the implementation of the nursing model.

**Table 7.1** The ICN four (4) key areas for successful implementation of programs, the associated criteria and applied guidelines for the implementation of the model (adapted from Shaw 2007:82)

| Key area(s) and associated criteria | Related guidelines for implementation of the model |
|---|---|
| **1. Relevance**<br>• establish linkages between the program and the targeted site and setting<br>• provide policy to guide program use<br>• maintain ongoing interaction with key players<br>• continually monitor and evaluate and adapt for relevance as needed | - systems theory and the model are used to link the practice of the PLN to the nursing services within the larger context of NGHS<br>- the dynamics of interdisciplinary activity and the feedback directions elevate the importance of the program<br>- the PDCA cycle that is selected for implementation of the model promotes continuity of surveillance within the organizational culture of JCI standards |
| **2. Effectiveness**<br>• select appropriate people who are interested in the program content<br>• conduct a presentation to market the program to the staff in the area<br>• focus dually on individual and group development while identifying potential leaders to sustain program<br>• effective teamwork promoted as part of the program<br>• place emphasis on networking, alliances, partnership and key stakeholders<br>• adopt mentorship as an integral part of the program | - the key stakeholders are given in the description of the model to include nursing, medicine, indirect patient care services and various aspects of internal administration<br>- there is a dual focus on the PLN and ambulatory care nurses, and the link made to the nursing services administration<br>- inherent in the communication directions of the model is the explicit value of teamwork<br>- the entire model is based on the premise of liaison that includes active collaboration and cooperation<br>- the PLN role should not be assumed without a degree of preceptorship as well as mentoring by the senior nurses in unit leadership roles and experienced PLNs as time elapses |
| **3. Impact**<br>• focus on ownership and buy-in by key stakeholders<br>• expand network to education providers aimed at ongoing training as needed<br>• establish a systematic review, monitoring and feedback process within the program roll-out so that is still integrated from the beginning<br>• deliver the program from a perspective that is meaningful and relevant to the team at the site of implementation<br>• link implementation of the program to successful outcomes in the work setting | - to a degree the ownership embraces the physician partnership who determined the initial success of the PLN role as a professional response without actual data<br>- the program would be implemented in the nursing services with input from the internal department of nursing education for program delivery of workshops and education sessions<br>- presenting concerns of the patients are categorized for capturing the attention of the PLN who would be able to identify the recurring categories of problems<br>- the successful execution of the PLN role would be linked to the annual performance evaluation as evidence of nursing actions that go beyond regular duties, and therefore be awarded higher scores where relevant and appropriate |

| | |
|---|---|
| **4. Sustainability**<br>• obtain commitment from people of influence with an interest in the success of the program<br>• ensure support of all nurse leaders in the organization<br>• mount a campaign for visual marketing of the goals and benefits of the program<br>• establish open communication channels to receive feedback readily<br>• ensure that adequate resources are available for implementation of the program<br>• integrate plans into the program for ongoing development and mentoring with staff turnover<br>• project for accomplishment of success in the program and for transfer of program leadership to people at site<br>• ensure that success of the program and benefits gained are reported within the organization and to key stakeholders | - commitment for PLN program would be secured at the executive nursing and operations level<br>- in keeping with the campaign culture at NGHA, the PLN program can be rolled out with advertising and marketing of the benefits of the PLN role to the patients and nurses<br>- specific links with the patient relations department can be established for expedited feedback when received from the SANG community<br>- future budgetary projections to ensure adequate numbers of registered nurses can be submitted with evidence of this study to install the PLN program within the nursing infrastructure and functioning in the nursing services<br>- after the PLN program has been campaigned for focus across the hospital, the leadership would be entrenched with the clinic nurse coordinators responsible for the nursing care delivery in each clinic<br>- the benefits and gains of the PLN can be presented at the annual NGHA international nurses day and in the achievement reports on NGHA, as well as integration into the basic nursing curriculum |

In summary, therefore, the approach to operationalization has been outlined so that the guidelines for the implementation of the model are actioned mindful that a change introduced within an open system or subsystems must be monitored for challenges that may arise and which would need to be reviewed, aiming for effectiveness. The model would be considered for implementation within an organizational setting of nursing leadership whereby nurses at the site and setting for the implementation of the model would have the appropriate leadership support concurrent to the social embedding of changes in nursing practice that are value-driven within the overall functioning of a nursing services. The four (4) point key leadership areas to focus on are aligned internationally to the ICN and are relevance, effectiveness, impact and sustainability (REIS), which are contributory areas of focus when implementing the model as a work program. It is intentional that the descriptive guidelines that follow are not prescriptive, and therefore guidelines will be given comprehensively without specification as to whether it would be at the level of the nursing executive, area nursing supervisor, unit coordinator or registered nurse. The detailed aspects of the guidelines will be described for implementation of the nursing model.

### 7.2.2 Descriptive outline of guidelines for the implementation of the nursing model

The outline of the guidelines for the implementation of the nursing model as a work program is recommended to follow the quality improvement technique of the Plan-Do-Check-Act (PDSA) model which has been highly recommended by the JCI in accreditation surveys (JCI 2005:94, Kelly 2007:40). The steps of planning, doing, checking and acting will be outlined and applied as guidelines to implement the model subsequent to the nursing services leadership agreeing to the approach as outlined above in section 7.2.1.

Planning:

- prepare a written plan for the implementation of the model that includes the specific ambulatory care clinics
- arrange for a presentation to key stakeholders that include members of the healthcare team and the support staff
- design a floor plan for the clinic area and a patient flow corresponding with the staff desks for flow of documents
- generate a spreadsheet that would serve as a checklist for the PLN sessions that reflect the major categories of patient concerns and include a column for 'other'
- submit a request for the information technology department to load all the information sheets for the PLN onto the related computers to be used in all the clinics
- prepare an internal advertisement that includes a profile description of the registered nurses required for the PLN role
- arrange a series of small group training sessions for selected PLN candidates

- design a patient feedback checklist that can be completed after a PLN session and posted for patient relations to review
- prepare an information list of contact numbers and the network of referrals that the PLN can utilize as an immediate resource
- submit requests for venues in the related areas on site for daily briefing and afternoon debriefing for all the PLNs
- design an organization-wide notification on the commencement of the PLN sessions as a procedure for use in PLN services.

Doing:

- involves implementing all actions listed on the written plan
- the visibility of nursing leadership would be essential to the staff at the clinic sites
- follow-up courtesy calls to the major stakeholders would be proactive so that when concerns are raised, prompt responses are actioned
- documentation on the status and progress of each item on the planning list would be crucial to the implementation of the nursing model

Checking:

- the nursing leadership organizes focused meetings to review the data on the actions that have been implemented according to the plan
- concerns and problem areas are identified and action is planned as needed so that the PLN sessions meet the expectations of the functional role of the RN as PLN
- feedback is communicated to the key stakeholders and members of the healthcare team and the supportive team

- the factors driving success are identified and maintained while opportunities to improve are utilized aimed at the overall goal of effective implementation of the nursing model
- data from the briefing and debriefing sessions of the PLN are used for further training and focus

Act:

- at this stage, the nursing leadership designs the policy and procedures to stabilize the new work program and standardizes the information sources for reporting and data feedback
- presentations are made that include patient feedback, PLN input and the administration's report on the impact of the PLN on continuity of care by ensuring patient concerns are attended
- return to the planning list of actions and modify as the cycle is repeated.

The guidelines for the implementation of the nursing model would be revised and refined as a team collaborative effort that includes RNs who have experienced the functional role of RN as PLN. An essential document for use (see appendix 51) during the implementation of the model is the NGHS mission, vision and core values (NGHA 2009) that would be the overarching guide that steers operationalization.

## 7.3 EVALUATION OF THE STUDY

The study was evaluated by use of the tool that is provided in appendix 52. There are two (2) parts to the evaluation tool as follows:

- Part A comprised of the Burns and Grove (2007:472-479) criteria for evaluation that are provided as standards for review of the study
- Part B which contains the research objectives that were formulated at the commencement of this study.

The criteria (Burns & Grove 2007:472-479) that were used to evaluate this research study were selecting for the following reasons:

(i) the standards are designed to trigger four (4) critical thinking phases within the research critique process, (a) comprehension, (b) comparison, (c) analysis, and (d) evaluation

(ii) specific critique questions are provided to guide the evaluation process (see appendix 52)

(iii) each standard that is given embraces the evaluation criteria from the overall and comprehensive perspective, without separating out specific phases within the research process.

The evaluation criteria set out as standards by Burns and Grove (2007) were used in the earlier first edition (2001) by Høye and Severinsson (2007:61) to critique eight (8) qualitative nursing research papers and are regarded as excellent for the purposes of critiquing research. The five (5) standards by Burns and Grove (2007:472) include substandards as necessary aimed at examining depth in research studies. The five (5) standards are (i) descriptive vividness, (ii) methodological congruence, (iii) analytical and interpretive preciseness, (iv) philosophical or theoretical connectedness, and (v) heuristic relevance. Each standard will be described in turn with substandards where applicable.

Descriptive vividness:

This standard entails articulation throughout the study in relation to details that provide a striking and prolific formation of images or abstraction that are rich and clear to the reader aimed at understanding the concepts, the relationships, experiences, and the findings.

Methodological congruence:

Consistency is the essence of this standard as to the detailed description of the purpose, the participants, the context, and the methods used to conduct the study. The in-depth review includes four (4) substandards that review the adequacy of documentation on the participation of respondents, careful attention to the procedural approach, adherence to ethical standards, and auditability.

Analytical and interpretative preciseness:

This standard pertains to the processes and series of transformations that occur with concrete or empirical data as linked to meaningful findings or abstraction in the outcome of analyses in the study process.

Philosophical or theoretical connectedness:

For this standard, the links between the study assumptions, methodological procedures, analytical approaches and the philosophical or theoretical underpinnings are to be accordant and in harmony throughout the study and congruent to nursing knowledge that is generated in the study of the phenomenon.

Heuristic relevance:

For this standard to be met, the results of the study must be recognizable as related to the phenomenon that was studied, as well as either contributing to and/or validating the body of nursing knowledge. The three (3) substandards involved here include intuitive recognition of the findings by readers and therefore would be meaningful to the knowledge base of an individual, have a relationship to the existing body of knowledge and science, and the applicability of the study and its findings to nursing practice, research or education.

Table 7.2 that follows provides an evaluation synopsis of the research study subsequent to the review using the selected criteria in appendix 52.

**Table 7.2** A synopsis of the evaluation conducted on this research study based on criteria for the critique of qualitative research by Burns and Grove (2007:472) and the research objectives of this study

**PART A: Criteria for evaluation and comments from review**

**STANDARD 1: DESCRIPTIVE VIVIDNESS**

- the study purpose is discussed comprehensively with contextual background integrated with importance of the study
- sections of the text in chapter one (1) were revised and refined to achieve vividness to the reader, especially section 1.11 that was added to convey my approach as the researcher and writer so that my unconventional style in the structure and writing of the thesis is known upfront
- the quotations taken from empirical data generating from the critical incident technique and reflective journaling, and vignette responses were critiqued by the supervision promoters of this study as being 'dull' which triggered the wider use of the field notes and memoing for the purpose of adding depth to the interpretation of empirical data
- it was often helpful to go to the original data scripts and re-read the excerpts within the context of the authorial voice of the respondents, which gave greater depth, richness and evocative tones within the interpretive paradigm used

**STANDARD 2: METHODOLOGICAL CONGRUENCE**

**Substandard 2.1** ***Adequate Documentation of the Participants***

- the participants are described as an outline in chapter two (2), section 2.8 initially and comprehensively within chapter three (3) on the respondents who participated by submitting reflective journals, and in chapter four (4) on the participants who responded to the vignettes
- the conceptual framework on the concepts is presented in detail and constitute the greater part of chapter five (5)
- the purposive sampling is the operant technique throughout the qualitative process of inquiry that includes the respondents as described in chapters three (3) and four (4), as well as the literature on the concepts that were used as purposive for alignment in fulfilling the research objectives
- the description of the context was extensive and maintained as a congruent thread throughout the study so that the political, economic, social, technical, legal, academic and geographical factors were considered and explicated as required during the conceptual phase of this research study, and enriched or incremented as needed in response to the model evaluation process

**Substandard 2.2** ***Careful Attention to the Procedural Approach***

- the theoretical and philosophical basis of the study was strengthened after subjecting the model to the evaluation criteria
- the data collection procedures are provided in detail and justified in relation to their contribution to the overall purpose of the study
- careful attention was given to maintaining anonymity and confidentiality of the respondents, which is detailed with the respective data collection methods that were used
- as the researcher, I conducted the information session with all potential participants as detailed respectively in chapter three (3), section 3.2 and 3.3, and chapter four (4), section 4.3, which included disclosure that I was a doctoral student and that measures were taken to respect anonymity and confidentiality

**Substandard 2.3** ***Adherence to Ethical Standards***

- all potential participants were informed verbally and in writing about their rights for participation and their right to withdraw without providing justification
- signed informed consents were received prior to commencement of the data collection procedures
- the rights of the participants were protected by the data being password protected on the data processor, and the original scripts locked in a cupboard by the administrative assistant, and by the system of double-coding as described in chapter three (3), section 3.3 with reference to appendices 11, 12 and 13
- ethical permission in relation to institutional consents were obtained prior to data collection, renewed after five (5) years, and for the use of the NGHA achievement reports (see respective appendices 1, 2, 4, 5, 6 & 31)
- scientific integrity and the preceding ethical stance of the researcher are extensively discussed in chapter one (1), sections 1.9 and 1.10 respectively

**Substandard 2.4** ***Auditability***

- the decision trail used in arriving at the conclusion statements were unclear initially, however, after further reading and search of the literature, the approach was tightened as discussed in chapter one (1), section 1.11.1 on authorial voice and section 1.11.2 on making convincing arguments. Within the latter section, a conclusion statement formula was derived that readily assisted in linking the data meaningfully to the interpretations in the findings
- the reference method inserted after direct quotations from the reflective journals and vignette responses are numbered to correspond with the original scripts that was recoded with a research code during the transcription process by the administrative assistant from handwritten data to typed data
- the empirical excerpts that were used are rich in support of the findings and in particular, the data and field notes contained thick data on the phenomenon of the functional role of the RN as PLN

**STANDARD 3: ANALYTICAL AND INTERPRETATIVE PRECISENESS**

- the categories, themes and findings contributed to the larger picture facilitated by the clarity in abstraction by using the scientific context of knowledge for a conceptual framework so that as the researcher, I maintained mental clarity between concepts in world one (1), world two (2) and world three (3), as discussed fully in chapter five (5), section 5.2
- the analytical preciseness was evidenced by concept identification and concept classification as presented in chapter five (5), sections 5.4 and 5.5 respectively and shown in figure 5.1
- the early stages of the model involved the review by members in the nursing leadership as discussed in chapter six (6), section 6.4.1 on an initial appraisal for demonstrating trustworthiness
- the final set of figures were shown to the same members of the nursing leadership who concurred with the representation as accurate illustrations of the system
- there were four (4) members in the data analysis team, as discussed in chapter three (3), section 3.4 for the process of data analysis, which was enhanced in terms of rigor by a system of co-checking
- a procedure that was central to the process of data analysis was the procedure of memoing by the data analysts to the researcher, as discussed in the second paragraph in chapter three (3), section 3.4.1 on field notes and memoing in data analysis

**STANDARD 4: PHILOSOPHICAL OR THEORETICAL CONNECTEDNESS**

- the connectedness was refined iteratively during the process of evaluation of the model as discussed in chapter six (6), section 6.4
- the connectedness is evident throughout the study because data analysis used the interpretive paradigm, and therefore as such, the interpretations were made in the context of nursing practice
- referencing of citations and literature is thorough and extensive, which supports the philosophical and theoretical stances adopted in this study as described in chapter six (6), sections 6.4.2, 6.4.3 and 6.4.4 on the evaluation of the model using the work of Chinn and Kramer (2008), Fawcett (2005), Meleis (2007) respectively

**STANDARD 5: HEURISTIC RELEVANCE**

**Substandard 5.1 *Intuitive Recognition***

- congruency of descriptive terms and approaches were ensured to facilitate recognition of the phenomenon by the reader
- the meanings reflected in the experiences that were explored and described within the context of the phenomenon of the functional role of the RN as PLN are lucid in the description of the model with specifity for nursing practice, and relatedness to nursing administration, nursing education and nursing research

**Substandard 5.2 *Relationship to the Existing Body of Knowledge***

- as a researcher, I was driven by a consuming thought that the gold standard for a doctoral study is to contribute to the body of existing knowledge, which often triggered my supervision promoters to advise me to 'stop reading and write!'
- the study is submerged in the existing body of knowledge on the phenomena of the functional role of the RN as PLN within the ambulatory care context of a Middle Eastern teaching hospital
- the unique aspects identified include the combined use of the critical technique with reflective journaling and vignette responses to generate data for use in the process of model development
- section 1.11.3.1 on appendices in chapter one(1) is unique to the scientific process of qualitative inquiry because it highlights the value of appendices with logical justification for inclusion

**Substandard 5.3 *Applicability to Nursing Practice, Research, or Education***

- the finding have immediate relevance to ambulatory care nursing, while relevancy in nursing administration, nursing education and nursing research is dependent on the implementation of the model in clinical nursing practice
- in the Middle Eastern setting, the major thrust and focus is on tertiary and quarternary inpatient care, while the paradox is that ambulatory care services, which is not seen as highly 'specialized' care, is the site for follow-up visits by patients who are discharged early perhaps from the quarternary level of care due to the unresolved bed crisis and the overwhelming demand for hospital care
- suggestions for further studies are presented as recommendations in this study

**SUMMARY COMMENTS**

- the transferability of the findings in this study and the nursing model for the functional role of the RN as PLN would require careful study of the contextual settings, concepts and interrelationships before use at another site in addition to reviewing for appropriateness and relevance of the methods and approaches used.

**PART B: Evaluation of the research objectives in this study**

**Research objectives of this study**
**Phase 1 objectives: the process of concept identification and description**

1. *To explore, describe, and interpret the lived experience of the functional role of the RN as PLN within in the ambulatory care context of a Middle Eastern teaching hospital.*
   - achieved using the critical incident technique and reflective journaling as shown in chapter three (3)

2. *To explore and describe the functional role of the RN as PLN from a nursing management team perspective in the ambulatory care context of a Middle Eastern teaching hospital*
   - achieved using vignette responses as shown in chapter four (4)

3. *To identify, classify, clarify and describe the core and related concepts from the empirical data on the functional role of the RN as PLN and in relation to the literature.*
   - achieved as shown in chapter three (3), four (4) and five (5) resulting in figure 5.1

**Phase 2 objectives: the process of model development and description**

4. *To describe the conceptual framework of the study on the functional role of the RN as PLN.*
   - achieved as presented in chapter five (5)

5. *To formulate and describe relational statements in order to describe a model for the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.*
   - achieved as shown in chapter six (6), section 6.3, especially section 6.3.4.3 that utilizes the data in table 6.1, which is the summary of statements concluded from the conceptual framework in chapter five (5)

6. *To evaluate the described model according to preset theoretical criteria.*
   - achieved as presented in chapter six (6), section 6.4

7. *To formulate guidelines for the implementation of the model on the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital.*
   - achieved as given in the final chapter seven (7)

**SUMMARY COMMENTS**

- AAACN (2011:1) has just published their position statement on the role of the RN in ambulatory care, which heralds winds of change by the assertive tone of the position statement elements as follows:
  - RNs enhance patient safety and quality and the effectiveness of care delivery and are thus irreplaceable in the provision of patient care services in the ambulatory setting
  - RNs are responsible for the design, administration and evaluation of professional nursing services within the organizational standards of care
  - RNs provide leadership necessary for collaboration and coordination of services, which includes defining delegation of tasks among licensed healthcare workers
  - RNs are fully accountable in all ambulatory care settings for all nursing services and associated patient outcomes under their direction.

The logical next step perhaps for NGHA and the nursing services would be to embrace the above elements of the position statement aimed at positioning the functional role of the PLN within the context of ambulatory care of a Middle Eastern teaching hospital using this practice model that is patient-centered, and that includes the major elements of the AAACN position statement, which actually are the major and related concepts with interrelated connectedness in this model.

## 7.4 LIMITATIONS OF THE STUDY

The limitations of the study relate to the contextual aspect of the research setting and some methodological and professional considerations.

The context of the study, although unique, is a limitation with regard to transferability of the findings. The NGHA teaching hospital in Riyadh, Saudi Arabia has distinct features and scope that are not similar to the other NGHA hospitals in Saudi Arabia, and particularly in relation to the stand-alone ambulatory care center. While aspects of the study may be transferrable perhaps similar to JCI accredited teaching hospitals in the Middle East, it nevertheless would require further analysis and research before the findings are readily adapted.

The methodological limitations are innate in research design because all the research methods used were dependent on the predecessor method. Arising from the empirical findings of the reflective journals were reality-based excerpts of data that were used in the creation of the vignettes in phase one. The conclusion statements that represented the findings in phase one were then imported to phase two for the processes of concept identification and classification, which resulted in the conceptual framework that led to model description. This layered approach of methods required rigor and congruency with precision, otherwise the model description as the final element in the qualitative research process of inquiry could be faulty and erroneous, which created an interdependence between research methods used that may not necessarily exist in other studies.

The professional aspect of how the nursing profession is regulated presently and in the future was not explored in this study for several reasons. First, the website of the

Saudi Nursing Council was entirely in the Arabic language during the conceptualization of this study. The office-bearing members of the Saudi Nursing Council are female, which would mean gender considerations would have to be anticipated as a male researcher. Furthermore, all expatriate nurses practise on their nursing licenses of their home country, while at present, the process for acquiring Saudi nursing licenses has become essential in most hospitals. The major limitation here therefore in relation to this study is that the future possibility of the functional role of the RN as PLN could not be postulated as to whether it would necessarily always be a unique element of the RN, or become the forerunner perhaps to an advanced nurse practitioner.

Notwithstanding the limitations above, the recommendations of this study will be presented.

## 7.5 RECOMMENDATIONS OF THE STUDY

The recommendations of the study comprise nursing practice, nursing education and nursing research.

Nursing practice:

- Use of the model of the functional role of the RN as PLN to develop problem-solving, decision-making and critical thinking in the setting of ambulatory care nursing
- Focus on interdisciplinary and multidisciplinary mechanisms within the ambulatory care setting to promote interprofessional collaboration and cooperation

- Develop an awareness campaign aimed as marketing the PLN role in the English and Arabic languages to promote wider use of the PLN aimed at decreasing patient defaulting on care regimens
- Initiate bilingual name tags to identify the PLN team clearly so that their visibility and profile are raised in the healthcare team and within the patient population
- Commence a support group of experienced PLN members aimed at professional networking and for the purpose of documenting their experiences, search the literature and aim at presenting in-service sessions to in-patient nursing units for a wider scope of patient education.

Nursing education:

- Design and present education training workshops to include an interdisciplinary approach were relevant aimed at sharpening the knowledge and interpersonal skill sets that are used in core nursing actions in the PLN role
- Conducting a series of briefing and debriefing sessions with the clinic nurse coordinators and nursing supervisors to whom the PLN team reports for the purpose of structural support and for managerial intervention as needed
- Refresher courses can be offered in relation to clinical management of the most common disease presentations so that the PLN team has advanced clinical knowledge to assist decision-making
- Contribute to BSN curriculum development aimed at consolidating concepts of nursing autonomy and interdisciplinary collaboration within the process of socializing undergraduates into the profession of nursing.

Nursing research:

- A research agenda can be generated on the PLN role within the ambulatory care setting as to greater depth on the rationale for patients either missing

appointments or being confused as to their follow-up Gregorian and Hejira calendar dates, which in turn would enrich the patient orientation programs on the system

- Research on the physicians' actual perceptions on the apparent effectiveness of the role could enhance this nursing model on aspects that perhaps did not emerge in this study
- The PLN team are in a prime role to conduct direct patient satisfaction surveys or interviews, which could contribute meaningful empirical data on how the ambulatory services and systems could improve to achieve continuous patient satisfaction
- This nursing model can be refined by empirical data, and in turn could be tested as part of a post-doctoral nursing study.

## 7.6 FINAL REFLEXIVITY

A final reflexive moment at the end of the journey reveals a different landscape in qualitative research than when I first conceptualized this study more than seven (7) years ago. It can be explained by the use of the desert metaphor because it was a desert of qualitative researchers; yes, there were nurse researchers, but all followed a quantitative paradigm.

Over the past five (5) years, qualitative research studies have steadily begun to emerge. The most recent count was five (5) qualitative studies as follows:

- Morrow (2006) on the factors that impact the preparation of nurses for clinical teaching in Saudi Arabia

- Hemmelder (2008) on the nursing management experience in a Middle Eastern hospital
- Lovering (2008) on the Arab Muslim nurses' experience of the meaning of caring
- AlBuhairan (2009) on patient safety walkrounds using a healthcare organization as a case study
- Abu Ghori (2010) on nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision in general medical units in Saudi Arabia

Encouraging! It is not an oasis yet for qualitative researchers because there is still the pervasion of quantitative research as the mainstream which is considered 'real research'. This thesis is therefore not an end but refreshingly a beginning so that nursing research and qualitative research can join with quantitative nurse researchers to represent the full spectrum of scientific inquiry with mixed methodology being supported for the strength of both paradigms.

Numbers in quantitative research have always presented a challenge for me due to childhood dyslexia, and therefore I am humbled that with the genre of qualitative inquiry, I no longer exclude myself from scientific enterprise.

Around an oasis the desert stills pervades, but perhaps in another five (5) years the number of oases will have increased so that any trip in the desert will stop at a nearby oasis!

## 7.7 CONCLUSION OF THE STUDY

In this final chapter, the operationalization of the nursing model was described, and the evaluation of the study, its limitations and recommendations, and a final stop at reflexivity were made. This chapter also heralds the conclusion of the study and this thesis, which is difficult at some levels because of the years of engagement, but also exhilarating because this is not a stop, but is the point of starting again so that evidence always underlies my clinical nursing practice with the patient and the family at the center of all my actions. The British poet Alfred, Lord Tennyson (1809-92) (Collins 2006:1246) aptly wrote:

*How dull it is to pause,*

*To make an end,*

*To rust unburnished;*

*Not to shine in use!*

I have reached the end, but it is only heralds the beginning of operationalizing the model on the functional RN role as PLN in the ambulatory care context of a Middle Eastern teaching hospital.

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# APPENDICES

# from

# 1 to 52

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المملكة العربية السعودية
الحرس الوطني – الشؤون الصحية
مدينة الملك عبدالعزيز الطبية

**NURSI**
**Mail C**

P O Box 22490
Riyadh 11426

Tel:
Ext:
Fax: **1659**
Date: **11th November 2002**

Beep #: **7705**
Ref. No. NSG.MB296/02

**Memorandum**

To: **Dorothy Ferguson**
*Associate Executive Director, Nursing Services*

From: **Morris E. Bodrick**
*Director, Clinical Nursing, Ambulatory Care*
*PhD Student, University of Witwatersrand, South Africa*

Subject: **Request for Permission to Conduct PhD Research Study in Nursing Services, Ambulatory Care**

As a requirement for the Ethics Committee for Human Research at the University of Witwatersrand, Johannesburg, South Africa, permission to conduct nursing research is required for further scientific and ethical review of the research protocol.

Kindly consider for approval, that the research study be permitted in Nursing Services, Ambulatory Care. Subsequent to approval by the scientific and ethical committees of the university, as discussed, the actual research detail will be presented in early 2003 to the Nursing Executive Council for approval of the actual study.

Thank you for your consideration.

***Permission to conduct Nursing Research Study in the Division of Nursing Services, King Abdulaziz Medical City in Riyadh.***

Approved:

**Dorothy Ferguson**
Associate Executive Director
Nursing Services

cc: File

**P.O. Box 22490, Riyadh 11426**
**Tel. 2520088**
**Telex: 403450 NGRMED SJ**

ص . ب ٢٢٤٩٠ الرياض ١١٤٢٦
تلفون : ٢٥٢٠٠٨٨
تلكس NGRMED ٤٠٣٤٥٠

KFH- MATERIALS 14574 ( 05/96 ) ( ORACLE : 29795 )

مطابع الحرس الوطني ٣٨/٢٠٨

**Kingdom of Saudi Arabia**
**National Guard-Health Affairs**
**King Abdulaziz Medical City**

المملكة العربية السعودية
الحرس الوطني – الشؤون الصحية
مدينة الملك عبدالعزيز الطبية

**NURSING SERVICES**
**Mail Code:** 1522

P O Box 22490
Riyadh 11426

Tel: **252 0088**
Ext: **1865**
Fax: **1659**
Date: **07 January 2003**

Beep #: **7705**
Ref. No. NSG.MB010/03

**Memorandum**

To: **Dorothy Ferguson**
*Associate Executive Director, Nursing Services*
*Chair, Nursing Executive Council*

From: **Morris E. Bodrick**
*Director, Clinical Nursing, Ambulatory Care*
*Nursing Researcher / PhD Student, University of Witwatersrand, South Africa*

Subject: **Approval to conduct Nursing PhD Research Study: A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

Thank you for the inclusion of the above research study for review and consideration today for approval by the members of the Nursing Executive Council.

It is agreed that, should any nursing practice issue be identified during the course of data collection in this research study, the matter will be referred back to the Nursing Executive Council for consideration as a Nursing Services matter. Further, it was agreed that in such an event, the anonymity of the participants would remain confidential, as the action would be considered from a system or process perspective.

On this basis, kindly grant approval to conduct the research study.

Thank you and kind regards.

***Approval to conduct Nursing PhD Research Study in Ambulatory Care Nursing Services, King Abdulaziz Medical City in Riyadh.***

Approved:

**Dorothy Ferguson**
Associate Executive Director, Nursing Services
Chair, Nursing Executive Council

cc: Members, Nursing Executive Council
Chrono File

**P.O. Box 22490, Riyadh 11426**
**Tel. 2520088**
**Telex: 403450 NGRMED SJ**

ص . ب ٢٢٤٩٠ الرياض ١١٤٢٦
تلفون : ٢٥٢٠٠٨٨
تلكس NGRMED ٤٠٣٤٥٠

KFH: MATERIALS 14574 ( 05/96 ) ( ORACLE . 29795 )

University
of the Witwatersrand,
Johannesburg

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7 York Road, Parktown 2193 South Africa • Fax: +27-11-643 4318 • Telephone: +27-11-717-2000 • Telegrams: 'Witsmed'

Mr ME Bodrick
Department: NURSING EDUCATION

17 February 2003

**NOTIFICATION OF SCHEDULED TIME FOR PRESENTATION OF PROTOCOL**

Candidate:.....*Mr ME Bodrick*.....protocol will be assessed

at time:.....*14:00*.....on Wednesday, 26 February 2003

in:.....*Medical School, 4B02d Faculty Corridor*.....Faculty of Health Sciences

Supervisor/s:.....*Prof H Klopper and Mrs J Bruce*.....

Supervisors are requested to attend the presentation with the candidate. 20 minutes per presentation has been allocated. Please keep your presentation within that time frame as there are a large number of students to be assessed.

**Allocated times will not be changed.**

Students who do not attend or miss their appointments will have their protocols deferred, and will have to resubmit their protocol to the next Assessors meeting.

The Postgraduate Committee will not interview students who attend without their supervisors unless prior arrangements have been made with the Postgraduate Office.

Yours sincerely

pp Alison McLean
**Alison McLean**
**Postgraduate Office**

cc Supervisor/s

*Faculty of Health Sciences*
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

7 York Road PARKTOWN Johannesburg 2193 Telegrams WITSMED Telex 4-24655.SA
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MR ME BODRICK
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PO BOX 22490
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11426
SAUDI ARABIA

APPLICATION NUMBER 8806298H
STATUS ( DEG 39 ) ( MD011 ) PZZ

2003-03-29

Dear Mr Bodrick

**Approval of protocol entitled** A model for patient liaison nursing in the ambulatory care context of a middle eastern teaching hospital

I should like to advise you that the protocol and title that you have submitted for the degree of Doctor Of Philosophy (Full-Time) have been approved by the Postgraduate Committee at its recent meeting. Please remember that any amendment to this title has to be endorsed by your Head of Department and formally approved by the Postgraduate Committee.

Dr HC Klopper, Mrs JCM Bruce has/have been appointed as your supervisor/s. Please maintain regular contact with your supervisor who must be kept advised of your progress.

Please note that approval by the Postgraduate Committee is always given subject to permission from the relevant Ethics Committee, and a copy of your clearance certificate should be lodged with the Faculty Office as soon as possible, if this has not already been done.

Yours sincerely

ME Fick (Mrs)
Faculty Registrar
Faculty of Health Sciences

Telephone 717-2075/2076

Copies - Head of Department____Supervisor/s

*Plan your career and first-year curriculum online - explore our website: www.wits.ac.za/ec2*
The University seeks to serve South Africa by furthering access to equal opportunity while striving for excellence in teaching, learning and research

**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)**
Ref: R14/49 Bodrick

**CLEARANCE CERTIFICATE** **PROTOCOL NUMBER** M03-01-27

**PROJECT** A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital

**INVESTIGATORS** Mr ME Bodrick

**DEPARTMENT** School of Therapeutic Sci, Johannesburg Hospital

**DATE CONSIDERED** 03-01-31

**DECISION OF THE COMMITTEE** Approved unconditionally

Unles otherwise specified the ethical clearance is valid for 5 years but may be renewed upon application
This ethical clearance will expire on 1 January 2008.

DATE 03-02-28 CHAIRMAN.....(Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Prof H Klopper
Dept of School of Therapeutic Sci, Wits Medical School
Works2\Iain0015\HumEth97.wdb\M 03-01-27
==========
DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress form. I/we agree to inform the Committee once the study is completed.

DATE 5 May 2003 SIGNATURE .....

PLEASE QUOTE THE PROTOCOL NO IN ALL QUERIES .: M 03-01-27

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**
**R14/49 Bodrick**

| | |
|---|---|
| **CLEARANCE CERTIFICATE** | **PROTOCOL NUMBER M080568** |
| **PROJECT** | A model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital |
| **INVESTIGATORS** | Mr ME Bodrick |
| **DEPARTMENT** | School of Therapeutic Science |
| **DATE CONSIDERED** | n/a |
| **DECISION OF THE COMMITTEE*** | Unconditionally approved<br>Re-certification of M030127 for a further 5 years |

**Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.**

**DATE** 08.06.09 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof H Klopper

---

**DECLARATION OF INVESTIGATOR(S)**

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES



*University of the Witwatersrand, Johannesburg*

*Faculty of Health Sciences*
*School of Therapeutic Sciences*
*Department of Nursing Education*

**Research Project:**
A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital

---

**Guidelines for Method of Critical Incident and Reflective Journaling**

## 1. INTRODUCTION

The importance of reflection in professional practice, both in nursing and teaching, was highlighted by the work of Donald Schon in 1983 and 1987. The essence of reflection in the profession of nursing lies in its close relationship to learning within the professional practice setting which includes clinical nursing practice. [3,4,5]

Reflection in nursing is a process that guides the individual to examine their own practice[3] with the aim of achieving enhanced insight into actions and omissions and thereby generate knowledge for future professional nursing practice.

### 1.1 What does 'Reflection' mean?

'Reflection' is best understood by considering what it means 'to reflect'. **'Reflect'** from the Latin word, *reflectere* means:

- *to consider carefully*
- *to think quietly and calmly*
- *to remember or realize*
- *to study closely*
- *to express a thought or an opinion formed as a result of serious thought or consideration*[3]

Following on this, **'reflection'** means:

- *a thought, idea or opinion formed or a statement made as a result of reflecting*
- *a mental process of reviewing experiences, concepts or ideas with an approach to discover new relations or drawing conclusions for the guidance of future action or deliberation.*

Reflection, as a mental process, is related to other cognitive processes, for instance, meditating, reasoning, considering, contemplation and deliberating. These processes are fundamental to the activities of problem-solving and decision-making that uses the capability of human beings in rational thinking which is a characteristic of the human mind.[2,3,4,6.]

### 1.2 Introduction of Patient Liaison Nursing in Ambulatory Care

The functional role of the patient liaison nurse (PLN) was introduced in Ambulatory Care in December 2001 as a response by Nursing Services initially to contribute to improving the care to patients who were experiencing an interruption in their treatment regime.

This functional role was outlined as follows:

- *receive and interview patients with problems that could potentially interrupt / compromise treatment*
- *retrieve the medical record to review the patient treatment file*
- *document the problem and identify possible related causes*
- *contact the physician and/or health professional(s) concerned and liaise appropriately on alternatives for action to continue treatment*
- *direct and/or advise patients accordingly, aimed as a contribution to quality patient care by preventing interruption of treatment*
- *facilitate a follow-up appointment for the patient with the attending physician, or health professional, as appropriate*
- *document the episode on the patient's medical record or on the appropriate available record*

The functional role has not been evaluated formally despite being perceived as successful in improving quality patient care by nursing intervention. By the use of the reflective journaling technique, this functional nursing role will be studied and reviewed to understand the professional nursing approach used by the patient liaison nurse in contributing to improved patient care.

## 2. A PROCESS OF REFLECTIVE PRACTICE IN PROFESSIONAL NURSING

The reflective cycle from the work of Gibbs (1988)[3] has been adapted and further developed by integrating the critical incident technique by Flanagan (1954)[1,2] for the purpose of reflective journaling as a technique in professional nursing practice.

Below are seven (7) steps for use in the process of reflective practice in professional nursing. A separate quick-guide will be provided to assist in daily recording according to the 7 steps.

**Step 1 – Selection**

Select a critical incident in your professional nursing practice situation.

**Guidelines for Selection:**

Reflect on all your experiences that occurred during your day in your role as a practicing professional nurse. Use the following categories[3] as you consider the different experiences:

*A. your participation was required because the process of care / communication was faulty (breakdown) which could negatively affect patient care*

*B. your identification of a chronic patient situation that impacted negatively on the care / treatment regime*

*C. your intervention made a difference to the outcome of patient care*

*D. your judgment that a particular situation was particularly demanding and stressful*

*E. your input contributed to events going unusually well / positive for the patient*

*F. your regard for an outcome that captured the essence of professional nursing care*

**Step 2 – Description**

Include the following components [1] when recording the description of the critical incident that you have selected:

(i) the *factors, causes or situation that led* to the critical incident that you have identified

(ii) the *actions or behaviors* of the *patient* and/or the *family* in the situation

(iii) the *results or outcome* of the *actions / behaviors* by the patient / family in the *situation* before intervention by the professional nurse

(iv) identify / summarize the *situation / problem* in *nursing terms*.

**Step 3 – Perception**

Identify what you were thinking and feeling at the time of experiencing the situation that you have selected and described in steps 1 and 2. This includes awareness derived through your senses as you recognize feelings and observe behaviors in the situation.

**Step 4 – Exploration**

Define or explain what was positive, negative or neutral about the experience related to the situation. Include further thoughts or ideas relating to the experience that occur while thinking about the positive, negative or neutral aspects in the situation.

**Step 5 – Analysis**

Think about the individual aspects that you have written down in step 4. Consider each carefully in comparison to the whole incident or situation. Is it truly as it presented itself in the situation or are there other considerations or interpretations that come to your mind/ Write down these new thoughts or ideas about your experience in the situation. Repeat this thinking process for each of the aspects that you identified in step 4.

**Step 6 – Evaluation**

Consider the experiences of the situation as a whole and ask yourself what else could you have done if it were possible.

**Step 7 – Renewal**

Describe what you would do if you were to experience the situation again in the future.

## 3. CONSIDERATIONS FOR RECORDING IN REFLECTIVE JOURNALING

Use the template provided (appendix 1) to record your professional reflection of an experience in the professional nursing practice situation and use the following considerations for documentation:

- ***Exclude*** *identifying information, descriptions or diagnosis that would identify either yourself, the patient, a team member or a specific clinic. In this regard, patient names and MRN (medical record number) are to be* ***strictly omitted*** *to maintain confidentiality and privacy of the patient.*
- *Use the standard the standard documentation style of 'focused notes' to record your critical incident and process of reflection and maintain this style by using short, concise sentences or phrases to describe experiences, situations, feelings and perceptions.*
- *Avoid the use of jargon, abbreviations or colloquial language. Where idiomatic expressions or "sayings" are used, kindly provide a brief explanation in parentheses / brackets.*
- *Set the time aside either at the end of your day, or at the beginning of the next day for the process of reflection and journaling. During the actual writing activity, arrange your environment accordingly, or use a room that is quiet without interruption to complete the reflection process.*
- *Avoid preparation of texts before writing on the reflective journal template. Write directly without re-writing and avoid deleting. Submit all original text. In situations where you have new ideas or thoughts that may contradict previous written statement, write additional notes to indicate your change of mind and include your new thoughts and ideas as well.*

**Immediately after completion** of the reflective journaling, ensure that your personal data code is entered on your completed reflective journal page, place in the envelope marked **RJ** *(for reflective journal)* and forward it **daily** to the CRN. Thank you.

## 4. CONCLUSION

Reflection in professional nursing has the potential to enrich the practice of an individual and would enhance autonomy and accountability as the nurse considers her or his own actions then decides on a renewed way forward in practice. The patient, without doubt, can only benefit from this approach of increased awareness of the impact of actions and omissions in professional nursing practice.

**References**


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3. Quinn FM. (Ed) 1998. **Continuing Professional Development in Nursing: A Guide for Practitioners and Educators**. London: Stanley Thornes.
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5. Riley-Doucet C. & Wilson S. 1997. A three-step method of self-reflection using reflective journal writing. **Journal of Advanced Nursing** 25, 964 – 968.
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**QUICK-GUIDE for REFLECTIVE JOURNALING by the PATIENT LIAISON NURSE (PLN)**

## 1. PROCESS OF REFLECTIVE PRACTICE IN PROFESSIONAL NURSING

**Step 1 – Selection :** Select a critical incident in your daily professional nursing practice situation as a patient liaison nurse using the guidelines below.

**Guidelines for Selection:**
Reflect on all your experiences that occurred during your day in your role as a practicing professional nurse. Use the following categories as you consider the different experiences:

*G. your participation was required because the process of care / communication was faulty (breakdown) which could negatively affect patient care*
*H. your identification of a chronic patient situation that impacted negatively on the care / treatment regime*
*I. your intervention made a difference to the outcome of patient care*
*J. your judgment that a particular situation was particularly demanding and stressful*
*K. your input contributed to events going unusually well / positive for the patient*
*L. your regard for an outcome that captured the essence of professional nursing care*

**Step 2 – Description:** Include the following components when recording the description of the critical incident that you have selected:

(v) the *factors, causes or situation that led* to the critical incident that you have identified
(vi) the *actions or behaviors* of the *patient* and/or the *family* in the situation
(vii) the *results or outcome* of the *actions / behaviors* by the patient / family in the *situation* before intervention by the professional nurse
(viii) identify / summarize the *situation / problem* in *nursing terms*.

**Step 3 – Perception:** Identify what you were thinking and feeling at the time of experiencing the situation that you have selected and described in steps 1 and 2. This includes awareness derived through your senses as you recognize feelings and observe behaviors in the situation.

**Step 4 – Exploration:** Define or explain what was positive, negative or neutral about the experience related to the situation. Include further thoughts or ideas relating to the experience that occur while thinking about the positive, negative or neutral aspects in the situation.

**Step 5 – Analysis:** Think about the individual aspects that you have written down in step 4. Consider each carefully in comparison to the whole incident or situation. It is truly as it presented itself in the situation or are there other considerations or interpretations that come to your mind. Write down these new thoughts or ideas about your experience in the situation. **Repeat this thinking process for each of the aspects** that you identified in step 4.

**Step 6 – Evaluation:** Consider the experiences of the situation as a whole and ask yourself what else could you have done if it were possible.

**Step 7 – Renewal:** Describe what you would do if you were to experience the situation again in the future.

## 2. CONSIDERATIONS FOR RECORDING IN REFLECTIVE JOURNALING

- ***Exclude*** *identifying information, descriptions or diagnosis. Patient names and MRN (medical record number) are to be* ***strictly omitted*** *to maintain confidentiality and privacy of the patient.*
- *Use 'focused notes' to record your critical incident and process of reflection, that is using short, concise sentences or phrases to describe experiences, situations, feelings and perceptions.*
- *Avoid the use of jargon, abbreviations or colloquial language. Where idiomatic expressions or "sayings" are used, kindly provide a brief explanation in parenthesis / brackets.*
- *Set the time aside either at the end of your day, or at the beginning of the next day for the process of reflective journaling.*
- *Write directly without re-writing and avoid deleting. Submit all original text. In situations where you have new ideas or thoughts that may contradict previous written statement, write additional notes to indicate your change of mind and include your new thoughts and ideas as well.*

**Immediately after completion** of the reflective journaling, ensure that your personal data code is entered on your completed reflective journal page, place in the envelope marked **RJ** *(for reflective journal)* and forward it **daily** to the CRN.

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*School of Therapeutic Sciences*
*Department of Nursing Education*

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| ***Please note:*** *Kindly enter the date and your personal data code on each submission* | | | | | | |
|---|---|---|---|---|---|---|
| ***Today's Date:*** | ***Personal Data Code*** | | | | | |

**REFLECTIVE JOURNALING - PATIENT LIAISON NURSING (PLN)**

***Using the guidelines provided at your training session, kindly complete the steps in reflective journaling below:***

**Step 1: Selection** *(Identify a critical incident that you experienced as the PLN during your day)*

**Step 2: Description** *(Briefly describe the critical incident selected in step 1)*

**Step 3: Perception** *(Identify what you were thinking and feeling during the experience.)*

**Step 4: Exploration** *(Explain positive, negative or neutral aspects about the experience)*

***Please turn the page to complete steps 5 to 7***

**Step 5: Analysis** *(Consider each component and record new thoughts and ideas that arise)*

**Step 6: Evaluation** *(Think about the whole experience and ask what else you could have done in the situation)*

**Step 7: Renewal** *(Describe what you would do if the same experience occurs again in the future)*

**Other comments you would like to make related to the experience or any of the above steps:**(*mention which step you are referring to)*

***PLEASE NOTE:***

*On completion of the daily reflective journaling form, please post it in an internal brown envelope and place it in the box provided in the CRN office.*

*Thank you for your time daily in completing reflective journaling. It is much appreciated.*

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**INFORMATION SHEET**

**Research Project:**
A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital

---

Dear Registered Nurses in Ambulatory Care Center,

- Patient Liaison Nurses (PLN)
- Clinic Nurse Coordinators (CNC)
- Clinical Resource Nurses (CRN)
- Assistant Nursing Supervisors (ANS)
- Nursing Supervisor (NS)

As you are aware, the functional role of patient liaison nurses (PLN) was introduced in ACC in December 2001 and is in the third year of implementation. The purpose was to assist patients in ACC who would potentially experience problems in their treatment and/or an interruption in their care. There were frequent reports from the nursing staff at ACC and some physicians that this new functional role of the patient liaison nurse (PLN) was regarded as successful. However, until now, it cannot be explained why this professional nursing role is perceived as successful. Some of you stated that it was a challenging role because the practicing registered nurse acted autonomously to assess the patient's situation and responded accordingly to assist the patient. All actions were stated as contributions to ensure that quality patient care is promoted.

This functional role has been recognized as essential at KAMC-R and was taken to be making a potentially significant contribution to care of patients in ACC. Some members of the ACC Executive Committee are supportive of this functional role possibly becoming a classified nursing job description in ACC. Before this occurs, the role and function of the patient liaison nurses require further study and professional review. For this purpose, I have selected the functional role of the patient liaison nurse as part of my research studies.

I am a student pursuing a post-graduate PhD program in the Department of Nursing Education, Faculty of Health Sciences at the University of the Witwatersrand, Johannesburg, South Africa. The research interest in my studies is the professional nursing approaches of registered nurses in ambulatory nursing clinical practice. Specifically for a qualitative research protocol, I have chosen to study the functional role of the patient liaison nurse (PLN) in the ambulatory care context, as it would be of benefit to KAMC-R and ambulatory care nursing.

You are invited to participate in this study, especially as the functional role of the patient liaison nurse (PLN) has neither been described in the literature nor studied before in nursing research. Two documents introduce and outline the research study. The first is an information document for you as a potential participant and the second is an informed consent form that provides you with information on ethical considerations should you wish to participate in the research study.

Your participation in the study is requested as voluntary and by explicit informed consent. Be assured that your participation and research responses are <u>not</u> linked to your employment contract, performance evaluation, the merit or promotion systems, or operational reviews, and will have <u>no</u> consequences whatsoever, on any respondent, either personally or professionally.

Thank you for taking time to consider your possible participation in this study, which will ultimately benefit the patients at KAMC-R by a researched professional practice approach in ambulatory care nursing.

Thank you for your time and best regards,

_____

**M. E. BODRICK**
*PhD student*
*Department of Nursing Education, University of the Witwatersrand, Johannesburg, South Africa*

*University of the Witwatersrand, Johannesburg*

*Faculty of Health Sciences*
*School of Therapeutic Sciences*
*Department of Nursing Education*

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## Informed Consent for Participation in Nursing Research Study

| Title: **A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital** |
|---|
| PhD Student: **M. E. BODRICK** *RN MPH MSc (Nsg)* |

I, *(print full names)* _____ attended an information session on *(enter date)* _____ at the National Guard King Abdulaziz Medical City, Riyadh (KAMC-R) at which the following aspects of the above nursing research study was addressed:

***(Please tick ☑ and initial the items that were actioned)***

| Tick | Initial | Item (s) |
|---|---|---|
| ☐ | | 1. A participant information sheet on the proposed research study was received. |
| ☐ | | 2. Summary and objectives of the research study were presented. |
| ☐ | | 3. Data collection methods as they apply to my voluntary participation was discussed. |
| ☐ | | 4. The voluntary and consenting basis of participation by respondents was explained. |
| ☐ | | 5. The use of coding on written responses to protect individual identity was explained. |
| ☐ | | 6. The availability of open-door appointments with the Nurse Researcher and/or Associate Executive Director, Nursing Services for any matter related to participation in this research study. |
| ☐ | | 7. **Declaration of the Nurse Researcher**:<br>7.1 that research responses are **not** being linked to performance evaluation, the merit or promotion system, or operational reviews, and have no professional or personal consequence on individuals who participate in the research study. |
| ☐ | | 7.2 the **right to withdraw** without giving reasons or explanations to the researcher |

Based on the above, I agree voluntarily to participate in this nursing research study on the following terms:

(1) I agree to voluntarily participate in the research study, which may, or may not benefit me directly, but will provide new knowledge and information which will benefit the practice and knowledge in Ambulatory Care Nursing, both at the KAMC-R and internationally.

(2) I also understand that I have the right to withdraw from this research study at any time, with no consequences, be it professional or personal. Further, I am aware that I will be invited by the nurse

researcher for an optional exit interview, which I have the right to attend or **not**. If not, I retain the right **not** to provide reasons for my withdrawal from the study.

(3) I give permission to the nurse researcher to use the written data appropriately within the research plan, and to contact me individually for the purposes of clarity or further explanation on my documented responses. Further, I give permission for the nurse researcher to publish or report the findings at scientific meetings in the future, knowing that my identity will not be revealed. It is expected that the nurse researcher will present and explain the results on completion of this research study.

Signed, on this *(enter today's date)* _____ at the National Guard King Abdulaziz Medical City, Riyadh, Saudi Arabia.

| | |
|---|---|
| **Last name of participant**: *(please print)* | |
| **First name of participant**: *(please print)* | |
| **Position held by participant**: | |
| **Signature of participant**: | |
| **Date:** | |

Your time is both valued and appreciated. Thank you.

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**Personal Data Coding System for**

**Journaling of Reflective Practice by Patient Liaison Nurses**

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**Follow the steps below to create your own personal data coding system.**

**After creating your personal data code – keep this sheet with you.**

1. **Excluding** the city in which you live, write down the name of **your most favorite city** in the world in the blocks below *(one letter per block):*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

2. Using one digit per block enter the year in which you **first qualified** as a nurse:

| | | | |
|---|---|---|---|
| | | | |

3. Take the first two letters from item 1 – your favorite city, and enter it to the left of the bold line, then the last three numbers from item 2 – your year of qualifying.

| | | | | |
|---|---|---|---|---|
| | | | | |

4. Enter your personal data code on the sheet provided and forward to the CRN.

***This code will be known strictly only to yourself and the CRN to maintain confidentiality and is to be entered on your daily reflective journal completion form.***

Thank you

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**Personal Data Coding System for Patient Liaison Nurses**

---

**Personal Data Code:**

| | | | | |
|---|---|---|---|---|
| | | | | |

**Family Name:** _____

**First Name:** _____

**Badge #:**_____

**Clinic:**_____

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**Guidelines for Data Collection Process by Admin Assistant (AA) and Clinical Resource Nurse (CRN)**

**Reflective Journal (RJ) Returns**

---

1. CRN collects handwritten data RJ return sheets with personal data codes.

2. CRN logs accordingly before forwarding to AA.

3. AA recodes the data with research data codes and retypes.

4. AA are reviews typed data to ensure exact written journal responses of participants.

5. AA circles (in pencil) any descriptions / statements that would potentially identify the participant, clinic of origin and/or patient or staff members.

6. AA returns typed data and corresponding handwritten data to CRN to review, including assessment of circled items.

7. CRN leaves the circles that are in agreement to concur with AA, or erases penciled circles after assessment, as appropriate.

8. CRN return data (handwritten and typed) to AA, who inserts five (5) digits with RJ XXX (2 alpha & 3 numerical) to replace of any identifying description.

9. Data is forwarded to AA, then to principal investigator (nurse researcher) for analysis.

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**CRITERIA FOR BROAD CATEGORIES OF CRITICAL INCIDENTS**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

**Category 1**

Patient situations related to the **potential for or actual interruption to medication / treatment** regime.

**Category 2**

Patient situations related to **ACC system problems, patient eligibility, faulty procedures by members of staff, or incomplete investigations** *(excludes situations related to appointments)*.

**Category 3**

Patient situations related to the **appointment or referral systems**. This includes **missed appointments, incorrect appointments, patients without appointments, incorrect specialist clinics, and appointment defaults (no show patients)**.

**Category 4**

Patient situations related to **patient-initiated consultation with PLN, patient social circumstances, patient satisfaction, customer service issues, and patient incidents**.

**Category 5**

**Incomplete** or **nil responses** from PLN participants.

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**Reflective Journaling Data Analysis**
**Classification of Data into Broad Categories of Critical Incidents - Selection / Description**

***A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital***

| No. | Category 1 | Category 2 | Category 3 | Category 4 | Category 5 |
|---|---|---|---|---|---|
| 1. | RJ 001 | RJ 002 | RJ 005 | RJ 008 | RJ 015 |
| 2. | RJ 006 | RJ 003 | RJ 007 | RJ 018 | RJ 027 |
| 3. | RJ 013 | RJ 004 | RJ 010 | RJ 032 | RJ 029 |
| 4. | RJ 026 | RJ 009 | RJ 012 | RJ 042 | RJ 035 |
| 5. | RJ 030 | RJ 011 | RJ 016 | RJ 047 | RJ 050 |
| 6. | RJ 031 | RJ 014 | RJ 020 | RJ 056 | RJ 058 |
| 7. | RJ 041 | RJ 017 | RJ 021 | RJ 061 | RJ 069 |
| 8. | RJ 049 | RJ 019 | RJ 028 | RJ 062 | RJ 070 |
| 9. | RJ 051 | RJ 022 | RJ 036 | RJ 065 | RJ 077 |
| 10. | RJ 052 | RJ 023 | RJ 037 | RJ 066 | RJ 091 |
| 11. | RJ 054 | RJ 024 | RJ 043 | RJ 075 | RJ 095 |
| 12. | RJ 074 | RJ 025 | RJ 044 | RJ 076 | RJ 103 |
| 13. | RJ 078 | RJ 033 | RJ 045 | RJ 079 | RJ 107 |
| 14. | RJ 082 | RJ 034 | RJ 046 | RJ 080 | RJ 110 |
| 15. | RJ 085 | RJ 038 | RJ 048 | RJ 081 | RJ 118 |
| 16. | RJ 087 | RJ 039 | RJ 053 | RJ 083 | RJ 123 |
| 17. | RJ 093 | RJ 040 | RJ 060 | RJ 084 | RJ 125 |
| 18. | RJ 100 | RJ 055 | RJ 063 | RJ 088 | RJ 128 |
| 19. | RJ 105 | RJ 057 | RJ 068 | RJ 099 | RJ 133 |
| 20. | RJ 114 | RJ 059 | RJ 073 | RJ 102 | RJ 158 |
| 21. | RJ 124 | RJ 064 | RJ 086 | RJ 104 | RJ 163 |
| 22. | RJ 136 | RJ 067 | RJ 096 | RJ 113 | |
| 23. | RJ 141 | RJ 071 | RJ 097 | RJ 117 | |
| 24. | RJ 149 | RJ 072 | RJ 098 | RJ 120 | |
| 25. | RJ 153 | RJ 089 | RJ 108 | RJ 132 | |
| 26. | RJ 159 | RJ 090 | RJ 109 | RJ 137 | |
| 27. | RJ 164 | RJ 092 | RJ 111 | RJ 140 | |

| | | | | | |
|---|---|---|---|---|---|
| 28. | | RJ 094 | RJ 115 | RJ 150 | |
| 29. | | RJ 101 | RJ 116 | RJ 152 | |
| 30. | | RJ 106 | RJ 119 | RJ 155 | |
| 31. | | RJ 112 | RJ 121 | RJ 162 | |
| 32. | | RJ 127 | RJ 122 | RJ 165 | |
| 33. | | RJ 131 | RJ 126 | | |
| 34. | | RJ 138 | RJ 129 | | |
| 35. | | RJ 143 | RJ 130 | | |
| 36. | | RJ 144 | RJ 134 | | |
| 37. | | RJ 157 | RJ 135 | | |
| 38. | | RJ 161 | RJ 139 | | |
| 39. | | | RJ 142 | | |
| 40. | | | RJ 145 | | |
| 41. | | | RJ 147 | | |
| 42. | | | RJ 148 | | |
| 43. | | | RJ 151 | | |
| 44. | | | RJ 154 | | |
| 45. | | | RJ 156 | | |
| 46. | | | RJ 160 | | |
| 47. | | | RJ 166 | | |
| 48. | | | | | |
| 49. | | | | | |
| 50. | | | | | |

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**TRAINING GUIDE FOR DATA ANALYSTS**

**Phase 1: Data Analysis Method for Reflective Journaling**
*(Adapted from Tesch 1990 in Creswell 1994:154)*

**1. PURPOSE:**
To implement a system of coding to reduce the data to themes or categories.

**2. OVERVIEW OF PROCESS:**
(i) Segmentation of data
(ii) Development of coding categories from data
(iii) Generation of revised categories, themes or patterns

**3. INITIAL QUALITATIVE DATA ANALYSIS USING INITIAL CODING PROCEDURE:**

**Action 1:**
- Review entire data script
- After reading step 1 and 2, write down your ideas
- Continue reading the data script and write down aspects relating to professional actions that are striking in the text (steps 3 – 7)

| Complete action 1 for three (3) respondent data scripts |
|---|

**Action 2:**
- Of the three (3) data scripts, select the most interesting (to the least interesting for you)
- Read through the entire data script again and ask the following three (3) questions
  ***Q 1. What is the professional nursing action occurring in this data script?***
  ***Q 2. Avoid looking for substance and focus on extracting <u>meaning</u> in the professional actions / reflections of the nurse***
  ***Q 3. Is there therapeutic or professional value in the actions of the nurse***
    - ***under 'comments' write down your ideas / topics that arise from Q1 to Q3***
    - ***repeat for all three (3) data scripts***

**Action 3:**
- Review the topics on all three (3) data scripts and cluster these into major themes. Write these at the end of the 'comments' space on the original data script.
  - *At this point exchange with your co-checker and each has reviewed the other's analysis; discuss your respective analysis to achieve agreement on the emerging themes. If agreement is not agreed, set it aside for the larger group discussion.*
- on the separate sheet provided, record the research data code, and list the major themes you have extracted from the three (3) data scripts
- from the three (3) data scripts, also identify what you may consider as either a
  - unique theme; or
  - redundant / non-essential theme

**Action 4:**
- Using the data codes, the next thirty (30) data sets are analysed per week, and the relevant data code written next to the corresponding data texts.

**Action 5:**
- At the end of thirty (30) data sets, the separate sheet with the themes are reviewed. Descriptions are generated to cluster these further into broad categories. The aim is to reduce the total list of categories by further grouping of the content according to how they relate. Draw lines between categories where although they cannot be in the same category, there is an interrelationship. Make notes on your ideas of this interrelationship.

**Action 6:**

- Review the categories, interrelationships and related notes. In the larger group, these categorizations will be finalized and the coding confirmed in alphabetical order.

**Action 7:**

- Rearrange the data material according to this final alphabetical set of category codes, and undertake a preliminary review of analysis of the data scripts to establish the validity of the categorization.

**Action 8:**

- Based on the preliminary review of analysis in action 7, recode the data if necessary.

Thank you for participating as a data analyst in this nursing research project.

**M. E. BODRICK**
*PhD student*
*Department of Nursing Education, University of the Witwatersrand, Johannesburg, South Africa*

*University of the Witwatersrand, Johannesburg*

*Faculty of Health Sciences*
*School of Therapeutic Sciences*
*Department of Nursing Education*

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**Guidelines for Data Collection Process**

**Clinical Resource Nurse (CRN) & Admin Assistant (AA)**

---

1. CRN collects handwritten data VT return sheets with personal data codes.

2. CRN logs accordingly before forwarding to AA.

3. AA recodes the data with research data codes and retypes.

4. AA are reviews typed data to ensure exact written journal responses of participants.

5. AA circles (in pencil) any descriptions / statements that would potentially identify the participant, clinic of origin and/or patient or staff members.

6. AA returns typed data and corresponding handwritten data to CRN to review, including assessment of circled items.

7. CRN leaves the circles that are in agreement to concur with AA, or erases penciled circles after assessment, as appropriate.

8. CRN return data (handwritten and typed) to AA, who inserts five (5) digits with VT XXX (2 alpha & 3 numerical) to replace of any identifying description.

9. Data is forwarded to AA, then to principal investigator (nurse researcher) for analysis

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**List of Qualitative Analyst & Sticker Color Codes**

**for RJ and VT Responses**

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| Data Analyst | Name | Color Code |
|---|---|---|
| **RJA / VTA** | **MB** | **yellow** |
| | | |
| **RJB / VTB** | **KM** | **green** |
| | | |
| **RJC / VTC** | **MS** | **blue** |
| | | |
| **RJD / VTD** | **RH** | **red** |

**KEY:**

**RJ** = Reflective Journaling

**VT** = Vignette Technique

**A, B, C, D** = analyst

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**Reflective Journaling Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 1 | 6 | M | A | R | 0 | 3 | ***Research Data Code*** | **R** | **J** | 0 | 3 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Selection** | **Data Analysis** |
|---|---|
| Patient came to the clinic complaining that she was not given enough medication to last for three months. | |

| **Step 2: Description** | **Data Analysis** |
|---|---|
| Patient claim that the medication prescribed by the Doctor is not enough to last for three months & beside she is living outside Riyadh. | |

| **Step 3: Perception** | **Data Analysis** |
|---|---|
| ➢ Quality of patient care not being met.<br>➢ Doctors should prescribed enough medication for the patient. | |

| **Step 4: Exploration** | **Data Analysis** |
|---|---|
| ➢ Patient will travel from far place just to ask additional medication to last for three months thus patient will be so exhausted for a long trip. | |

| *Research Data Code* | R | J | 0 | 3 | 1 |
|---|---|---|---|---|---|

| **Step 5: Analysis** | **Data Analysis** |
|---|---|
| ➢ Coordinate with patient, Doctor & pharmacy so that patient will be given enough medication.<br>➢ Patient should be given right doses so that her condition will improve. | |

| **Step 6: Evaluation** | **Data Analysis** |
|---|---|
| ➢ Remind doctors to prescribed medication enough for the patient's next appt.<br>➢ Advise the patient not to miss ~~their~~ appointment. | |

| **Step 7: Renewal** | **Data Analysis** |
|---|---|
| ➢ Recheck the prescription given by the doctor if the patient was given enough medication. Collaborate also with pharmacy because sometimes they missed to give the refill meds. to the patient. | |

| **Comments** | **Data Analysis** |
|---|---|
| | |

| **Data Analysis Comments** |
|---|
| |

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**Reflective Journaling Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 3 | M | A | R | 0 | 3 | ***Research Data Code*** | **R** | **J** | 0 | 9 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Selection** | **Data Analysis** |
|---|---|
| Medication refill | |

| **Step 2: Description** | **Data Analysis** |
|---|---|
| Patient husband came to the clinic with an old prescription since March 3 asking for another one as pharmacy refuse to give him the medicine.<br><br>The patient thought as long she has some medicine home should use it first and then to get the new prescription. | |

| **Step 3: Perception** | **Data Analysis** |
|---|---|
| - The pt should get a new prescription as her app still 3/52 time.<br>- Nurses and unit assistant should instruct pt properly to get their prescription at the same day. | |

| **Step 4: Exploration** | **Data Analysis** |
|---|---|
| - it is good that pt follow us earlier not wait until her app.<br>- As we are short of staff in the clinic the float out nurses should be oriented about the clinic routine.<br>- The nurses and unit assistant should be informed in the weekly meeting to direct pt properly to get their prescription in the same day or 1 day often at most. | |

| *Research Data Code* | R | J | 0 | 9 | 3 |
|---|---|---|---|---|---|

| **Step 5: Analysis** | **Data Analysis** |
|---|---|
| - float nurses should be oriented about clinic routine.<br>- Nurses and unit assistants should direct pt properly. | |

| **Step 6: Evaluation** | **Data Analysis** |
|---|---|
| Not sure. Nothing more as pt get her new prescription at the same day & went home. | |

| **Step 7: Renewal** | **Data Analysis** |
|---|---|
| Not sure. | |

| **Comments** | **Data Analysis** |
|---|---|
| | |

| **Data Analysis Comments** |
|---|
| |

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**Reflective Journaling Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 8 | A | P | R | 0 | 3 | ***Research Data Code*** | **R** | **J** | 3 | 6 | 9 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Selection** | **Data Analysis** |
|---|---|
| Missed appointment. | |

| **Step 2: Description** | **Data Analysis** |
|---|---|
| Patient came for follow-up today but unfortunately wasn't able to be seen by his treating doctor since the date and day in hegira calendar doesn't correlate with the Gregorian calendar, as written in his appointment slip. I explained to him that his doctor's clinic day was yesterday. He started to yell and bit angry since he came from a far place just to keep his appt with the doctor. | |

| **Step 3: Perception** | **Data Analysis** |
|---|---|
| I felt sorry for him and can't blame him for being angry coz it's not easy to travel from a long distance just to be in the hospital for an appointment. | |

| **Step 4: Exploration** | **Data Analysis** |
|---|---|
| It would have been better for the appointment desk to double check the date/day of appointment printed in the slip before handing over to the patient. They should be very vigilant and extra careful in their print-out so as to avoid conflict. | |

| *Research Data Code* | R | J | 3 | 6 | 9 |
|---|---|---|---|---|---|

| **Step 5: Analysis** | **Data Analysis** |
|---|---|
| The patient would have been informed (by any means) regarding the correct day of his appointment with his doctor before hand so that unnecessary waste of time could be avoided. | |

| **Step 6: Evaluation** | **Data Analysis** |
|---|---|
| Re-scheduling the patient the soonest possible time is the best way to help and comfort the patient in this particular situation. I could have also directed him to go to the ER however, his case is considered non-urgent. | |

| **Step 7: Renewal** | **Data Analysis** |
|---|---|
| To help and give the best service to the pt. | |

| **Comments** | **Data Analysis** |
|---|---|
| | |

| **Data Analysis Comments** |
|---|
| |

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**Reflective Journaling Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 9 | A | P | R | 0 | 3 | ***Research Data Code*** | **R** | **J** | 3 | 7 | 6 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Selection** | **Data Analysis** |
|---|---|
| Wrong booking. | |

| **Step 2: Description** | **Data Analysis** |
|---|---|
| New pt. presented to the clinic and found out that she has been booked wrongly. Discussed the matter to the patient and I assure her that I'll do all my effort to help her. I phoned my colleague – PLN of another unit and presented the case of the patient. Discussed with the relevant doctor and eventually accepted the patient to be seen in his clinic. | |

| **Step 3: Perception** | **Data Analysis** |
|---|---|
| Teamwork among colleague really plays an important role in providing service to our patient. | |

| **Step 4: Exploration** | **Data Analysis** |
|---|---|
| Since necessary arrangement have been made to see the patient, she was so happy and thankful that her time & effort was not wasted. | |

| *Research Data Code* | R | J | 3 | 7 | 6 |
|---|---|---|---|---|---|

| **Step 5: Analysis** | **Data Analysis** |
|---|---|
| As a PLN, good judgment and wise decisions in solving any problems are very important qualities to consider. | |

| **Step 6: Evaluation** | **Data Analysis** |
|---|---|
| Patient went home happily & satisfied since the best service has been provided to her. | |

| **Step 7: Renewal** | **Data Analysis** |
|---|---|
| To help pt. & act accordingly to provide the necessary service needed by the pt. | |

| **Comments** | **Data Analysis** |
|---|---|
| | |

| **Data Analysis Comments** |
|---|
| |

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**Research Project:**
A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital

| ***Today's Date:*** | ***Personal Data Code*** | | | | | |
|---|---|---|---|---|---|---|

**Vignette Technique on Patient Liaison Nursing (PLN)**

## VIGNETTE NO. 1 (Please tick **no. 1** on the response form attached)

The patient's medication was finished and the next appointment was in one month's time. The medical record showed that there was sufficient medication to last until the next appointment. When this was told to the patient, he became upset and stated it was the fault of the pharmacy because they did not give him enough to last until his appointment next month.

While talking to the patient, it was discovered that he was taking his medication three times (x 3) a day, instead of twice (x 2) a day. This explained the shortage. Although I was trying to help him, he began shouting at me because he said that he told the doctor that he needs his medication three times (x 3) a day because the last time when it was changed to twice (x 2) a day, he became ill within a week and was admitted to the hospital.

As the patient liaison nurse (PLN), I understood why he was upset even though he was shouting at me. My approach was to let him know that I understood why he was so angry. He calmed down when he realized that I was trying to assist him to rectify the problem. I informed him that his doctor was not in the clinic today, but that I will bleep her. The doctor responded immediately and stated that she could come to the clinic in an hour to review the medication. I kept explaining to the patient that I understood the reasons for him to be so upset. I also apologized to the patient for the inconvenience. He settled, and eventually the doctor arrived and the problem was solved.

Maybe, I should have given the patient positive feedback because he showed insight into his medical condition by coming back to the clinic and questioning why his medication was finished. I did not do much for this patient except for letting him know that as the patient liaison nurse I fully understood his situation, and that I was there to assist him to obtain more required medication to maintain his health status.

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| ***Today's Date:*** | ***Personal Data Code*** | | | | | |
|---|---|---|---|---|---|---|

**Vignette Technique on Patient Liaison Nursing (PLN)**

## VIGNETTE NO. 2 (Please tick **no. 2** on the response form attached)

It was the third time this patient arrived with the same urgent referral from another clinic. On both of the previous occasions, the patient was given the incorrect day when the specific doctor did not have a clinic. Today the patient said that she was pleased when she arrived in the morning because it was the correct day, and the correct doctor. Now she was anxious because she was told that her file is missing and cannot be found. She was even more anxious because she overheard the doctor saying that he will not see a patient without a file. Her concern was that it would take another six (6) weeks before she can obtain another appointment. The patient said that all the appointment problems were unfair to her. She said that she was annoyed because when she came to clinic the last time she was told that her blood results were on the computer, therefore she knows that she has a file.

As the patient liaison nurse (PLN), this situation was also unfair to me because this problem was not my fault. I was angry because it meant somebody did not do their job properly. I was also annoyed because I had to explain this to the doctor. We need a better system for Medical Records to prevent these problems happening. I will report this to the clinic nurse coordinator (CNC) and bring it up at the staff meeting because it is not fair to the patient and also not fair to the PLN who gets given a problem that cannot be solved.

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|---|---|---|---|---|---|---|

**Vignette Technique on Patient Liaison Nursing (PLN)**

## VIGNETTE NO. 3 (Please tick **no. 3** on the response form attached)

There was so much confusion with this patient. We realized the patient had two files and there were two different instructions from two different consultants. The wife who was the patient then stated that she did not like the first doctor and preferred the second doctor. At this point, I did not know whether the husband was angry with me or his wife. I kept trying to achieve clarity of the situation as I asked them to help me in providing information on the reasons for seeing two different consultants. After careful listening, I then realized that the one consultant had referred the patient to another consultant in the same clinic, but different specialties. It also became clear that when the patient came back for the second time, the file was missing and she forgot the appointment slip at home. Somehow she was given a new file and a new number and was seen by the second consultant who spoke to the first consultant on the phone.

As the patient liaison nurse (PLN), I now understood the situation and explained to both the husband and wife that the first consultant wanted a second opinion from the second consultant before recommending a surgical intervention. Both husband and wife were relieved to hear this, and stated that they were worried that the wife was very sick. I spoke with the first consultant who asked that they return in four week's time, which will give him a chance to review all the tests and discuss the case with the second consultant.

I explained to the patient that there were two ways of treating her condition and assured her that according to the doctor, the problem would not become worse at the present time. They appreciated that the surgical procedure was not the first option. They left feeling happy that the confusion was cleared. As the PLN, I was pleased for the patient because surgical intervention was not the first choice and her case was being discussed fully by two experts before action.

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| ***Today's Date:*** | ***Personal Data Code*** | | | | | |
|---|---|---|---|---|---|---|

**Vignette Technique on Patient Liaison Nursing (PLN)**

## VIGNETTE NO. 4 (Please tick **no. 4** on the response form attached)

We could not assign a patient liaison nurse today because we were very busy and are short of staff. If patients have problems they will have to wait because tomorrow will be a less busy day, then I can do the patient liaison job.

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**Guidelines for Use of the Vignette Technique**
**for Clinical Operations Management Responses to Patient Liaison Nursing situations**

## 1. Introduction

Vignettes are concise narratives of situations or events that are designed to elicit responses by participants.[3] The structure of the vignette descriptions are designed to invite the participant's perceptions, professional opinion or judgment about the situation or phenomenon.

The value of vignettes lies in the design of narrative stories that are constructed from real-life case scenarios relating to people's experience of situations.[1] The response to the vignettes by participants provide an opportunity to share personal or professional experiences, or reveal related judgments or opinions.[1,2] The respondents provide a focused response to the theme being reviewed. The approach to vignettes is determined by the guidelines provided for vignette responses.

The vignette technique is a method selected for use by the clinic nurse coordinators (CNC) and assistant nursing supervisors (ANS) in their review and assessment of patient liaison nursing situations specifically in the Ambulatory Care Center (ACC).

## 2. Introduction of Patient Liaison Nursing in the Ambulatory Care Center

The functional role of the patient liaison nurse (PLN) was introduced to Ambulatory Care in December 2001. It served initially as a response by Nursing Services to contribute in improving the care to patients who were experiencing an interruption in their treatment regime.

This functional role was outlined as follows on introduction to ACC:

- *receive and interview patients with problems that potentially would interrupt / compromise treatment*
- *retrieve the medical record to review the patient treatment file*
- *document the problem and identify possible related causes*
- *contact the physician and/or health professional(s) concerned and liaise appropriately on alternatives for action to continue treatment*
- *direct and/or advise patients accordingly, aimed as a contribution to quality patient care by preventing interruption of treatment*
- *facilitate a follow-up appointment for the patient with the attending physician, or health professional, as appropriate*
- *document the episode on the patient's medical record or on the appropriate available record*

The role of the PLN has not been formally evaluated to date, but is perceived as necessary in Ambulatory Care services. To this end, the clinic nurse coordinators and assistant nursing supervisors are provided with an opportunity, using the vignette technique, to respond from their clinical operations management experience of the patient liaison nurses functioning within the Ambulatory Care context.

### 3. The Process for the Vignette Technique Responses

The vignettes are constructed from the real-life lived experiences of the patient liaison nurses. Each vignette is constructed from multiple sources and are therefore in a sense, hypothetical scenarios.[1] All identifying descriptions are excluded to protect the confidentiality and anonymity of patients and PLN participants.

### 3.1 Steps in Vignette Technique Responses

**Step 1 - Synopsis**

Read the entire vignette to gain an overall understanding of the situation that is portrayed. Write down in not more than two sentences a **brief summary** of your understanding of the **patient's situation**.

**Step 2 – PLN Attitude & Approach**

Review the vignette again, if required. With the use of one sentence, **comment** on the PLN **approach and attitude** in the situation.

**Step 3 – PLN Helping Skills**

Briefly comment on whether you regard the **PLN skills as helpful** to the patient or not. Give **reasons** for your assessment.

**Step 4 – Knowledge-in-action[4]**

In your professional opinion, did the PLN demonstrate **sufficient clinical nursing** or **operational knowledge** to assist the patient with the problem? **Explain your answer** briefly.

**Step 5 – Contribution to Quality Care**

Review the vignette again, if necessary, to examine the situation for **evidence of quality care** by the **PLN**. In essence, did the **PLN contribute positively** either to the **structure**, **process** or **outcome of patient care** in this vignette?

**Step 6 – Professional Suggestion(s)**

Kindly offer **professional suggestion(s)** that you think the PLN could use to **further improve** or **advance the PLN role** to provide better patient care.

## 4. Conclusion

In responding to the vignette technique, the clinic nurse coordinators (CNC) and assistant nursing supervisors (ANS) provide a perspective from clinical operations management on the effectiveness and efficiency of the intervention by the PLN. In this way, both the experience of the PLN is considered, and the experience of the CNC and ANS on the functioning of the PLN is captured.

**References:**


[1] Hughes R. 1998. Considering the Vignette Technique and its Application to a Study... **Sociology of Health & Illness**. 20(3), 381 – 400. [on-line] <http://web25.epnet.com/> (29 March 2003).

[2] Hughes R. & Huby M. 2002. The application of vignettes in social and nursing research. **Journal of Advanced Nursing**. 37(4) 382 - 386

[3] Polit DF, Beck CT. & Hungler BP. 2001. **Essentials of Nursing Research – Methods, Appraisal, and Utilization**. 5th ed. Philadelphia:Lippincott.

[4] Quinn FM. 2000. **Principles and Practice of Nurse Education**, 4th ed. London: Stanley Thornes.

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| ***Please note:*** *Kindly enter the date and your personal data code on each submission* | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***Today's Date:*** | ***Personal Data Code*** | | | | | | |

**RESPONSE TEMPLATE FOR VIGNETTE TECHNIQUE on PATIENT LIAISON NURSING (PLN)**

| *Please* ***tick*** *below which vignette you are responding* | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Vignette No.** | **1** | | **2** | | **3** | | **4** | |

**Step 1: Synopsis** *(Provide a* ***brief summary*** *of your understanding of the* ***patient's situation****)*

**Step 2: PLN Attitude & Approach** *(Your comment in one sentence)*

**Step 3: PLN Helping Skills** *(Assess* ***helpfulness of PLN****, give* ***reasons*** *for your comment)*

**Step 4: Knowledge-in-action** *(Assess* ***clinical nursing*** *or* ***operational knowledge of PLN*** *in assisting patient)*

***Please turn the page to complete steps 5 to 6***

**Step 5: Contribution to Quality Care** *(Review vignette for **evidence of positive contribution** to **structure, process or outcome of care**)*

**Step 6: Professional Suggestions** *(Provide your **professional suggestions** on how the **PLN can improve** or **advance the role** to provide better patient care)*

**Other comments that you would like to make about your experience of patient liaison nurses in the clinical setting:**

***A special thank you for taking the time to complete the vignette response.***

***It is both valued and appreciated.***

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**Vignette Technique Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 3 | A | P | R | 0 | 3 | ***Research Data Code*** | **V** | **T** | 0 | 1 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Synopsis** | **Data Analysis** |
|---|---|
| Pt used a wrong dose of medication, instead of using twice he was taken it 3 times daily that's why the medication was finished before next appt. | |

| **Step 2: PLN Approach & Attitude** | **Data Analysis** |
|---|---|
| It was not very convenient for pt, she need to give hi more explanation in a very supportive way. | |

| **Step 3: PLN Helping Skills** | **Data Analysis** |
|---|---|
| She called MD to clarify the med with him she can also call pharmacy. | |

| **Step 4: Knowledge-in-action** | **Data Analysis** |
|---|---|
| First she need to calm pt down by giving him good support she can call pharmacy to clarify the dose with them, call MR to get chart & see doctor order if MD is not available. Inform MD ask for his advice, let pt talk to MD by phone for more secure. | |

| Research Data Code | V | T | 0 | 1 | 1 |
|---|---|---|---|---|---|

| Step 5: Contribution to Quality Care | Data Analysis |
|---|---|
| Pt meet the quality of care. | |

| Step 6: Professional Suggestions | Data Analysis |
|---|---|
| Improve the way of handling the problem how to deal with angry people. How to suc people anxiety. | |

| Other Comments | Data Analysis |
|---|---|
| To be more friendly, understandable specially in angry situation. | |

| Data Analysis |
|---|
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**Vignette Technique Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 3 | A | P | R | 0 | 3 | ***Research Data Code*** | **V** | **T** | 0 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Synopsis** | **Data Analysis** |
|---|---|
| Patient are out of medication and to him it is almost life threatening. | |

| **Step 2: PLN Approach & Attitude** | **Data Analysis** |
|---|---|
| I liked it, understanding and non-judgmental. | |

| **Step 3: PLN Helping Skills** | **Data Analysis** |
|---|---|
| Understanding and she also was listening to what patient was telling. | |

| **Step 4: Knowledge-in-action** | **Data Analysis** |
|---|---|
| She checked the prescriptions and worked out how many tablets patient received and she did a good job. | |

| Research Data Code | V | T | 0 | 2 | 1 |
|---|---|---|---|---|---|

| Step 5: Contribution to Quality Care | Data Analysis |
|---|---|
| - Lack of communication between Dr & patient should look into that.<br>- Make sure patient are checking his prescriptions in future to make sure he understands how to take medication and why. | |

| Step 6: Professional Suggestions | Data Analysis |
|---|---|
| | |

| Data Analysis |
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**Vignette Technique Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 3 | A | P | R | 0 | 3 | ***Research Data Code*** | **V** | **T** | 1 | 3 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Synopsis Step 1:** | **Data Analysis** |
|---|---|
| 2 files on pt b/c 2nd visit missing file & a new file & number created??? | |

| **PLN Approach & Attitude Step 2:** | **Data Analysis** |
|---|---|
| Sounds like planned approach – systematic PLN had a calm – demean. | |

| **PLN Helping Skills Step 3:** | **Data Analysis** |
|---|---|
| - active listening & asked with confidence for them<br>- help (husband & wife) as she was collecting her data<br>- handled discovered incident – with proper explanations<br>- ↓ anxiety & turned the incident into a positive (job well done) | |

| **Step 4: Knowledge-in-action** | **Data Analysis** |
|---|---|
| - active listening<br>- ↓ anxiety in husband & wife (by involving them) in situation.<br>- Spoke to the Dr.<br>- Turned this incident into a positive for the patient – i.e. understanding & support) & the PLN feel gratification herself. B/C indeed medical management is first before SX. | |

| *Research Data Code* | V | T | 1 | 3 | 3 |
|---|---|---|---|---|---|

| Step 5: Contribution to Quality Care | Data Analysis |
|---|---|
| | |

| Step 6: Professional Suggestions | Data Analysis |
|---|---|
| | |

| Data Analysis |
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**Vignette Technique Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 3 | A | P | R | 0 | 3 | ***Research Data Code*** | **V** | **T** | 1 | 5 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Synopsis** | **Data Analysis** |
|---|---|
| Pt's medication was finished before the next appointments, even he was given the all medication for the all period before the appointment. | |

| **Step 2: PLN Approach & Attitude** | **Data Analysis** |
|---|---|
| Polite & professional attitude lead to calm down the pt. | |

| **Step 3: PLN Helping Skills** | **Data Analysis** |
|---|---|
| The best way to solve the problem after checking with the pharmacy is to get the chart & to page the doctor. This what actually done by PLN. | |

| **Step 4: Knowledge-in-action** | **Data Analysis** |
|---|---|
| He look highly knowledgeable person. | |

| *Research Data Code* | V | T | 1 | 5 | 1 |
|---|---|---|---|---|---|

| Step 5: Contribution to Quality Care | Data Analysis |
|---|---|
| | |

| Step 6: Professional Suggestions | Data Analysis |
|---|---|
| | |

| Other Comments | Data Analysis |
|---|---|
| | |

| Data Analysis |
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**Vignette Technique Data Collection**

**A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

| ***Date:*** | 2 | 3 | A | P | R | 0 | 3 | ***Research Data Code*** | **V** | **T** | 1 | 7 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Step 1: Synopsis** | **Data Analysis** |
|---|---|
| Pt. unaware that medication had been decreased therefore had not taken the decreased dosage and pt aware that if lowered dose taken he would be ill. | |

| **Step 2: PLN Approach & Attitude** | **Data Analysis** |
|---|---|
| The way she handle the situation appears to have been professional by calming patient, sharing understanding and empathy and resolving the situation. | |

| **Step 3: PLN Helping Skills** | **Data Analysis** |
|---|---|
| PLN was faced with an issue where patient required medication, PLN was very helpful. | |

| **Step 4: Knowledge-in-action** | **Data Analysis** |
|---|---|
| PLN realized that patient needed the medication as even decreasing to 2 tablets had made him ill originally therefore had applied good clinical judgement. | |

| Research Data Code | V | T | 1 | 7 | 1 |
|---|---|---|---|---|---|

| Step 5: Contribution to Quality Care | Data Analysis |
|---|---|
| PLN realized that there was a problem, calmed patient down, ascertained facts and dealt with in a professional manner. | |

| Step 6: Professional Suggestions | Data Analysis |
|---|---|
| PLN needs support as she acted professional and appropriate, questioned that she have given positive feedback. Good that she recognizes room for improvement. | |

| Data Analysis |
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# EVALUATION TOOL for a NURSING MODEL

| **PART A.**<br>**LINCOLN AND GUBA (1985) CRITERIA OF TRUSTWORTHINESS** | |
|---|---|
| **DESCRIPTION OF CRITERIA** | **EVALUATOR COMMENT** |
| 1. Credibility (truth-value) whereby the participants' perceptions are matched in resemblance to the portrayal of meaning provided by the researcher. | |
| 2. Transferability (applicability) wherein the findings from one context can be useful in another similar setting. | |
| 3. Dependability (consistency) that is focused on the process of inquiry in relation to the researcher's responsibility to ensure accuracy, adequacy and traceableness of decision-making processes in scientific activities. | |
| 4. Confirmability (neutrality) whereby the data, interpretations and findings contribute to an audit or decision trail that facilitates others to judge the manner in which research objectives had been achieved so that links to assertions, data, evidence and findings can be discerned easily. | |
| **SUMMARY COMMENTS** | |
| **Lincoln and Guba (1985:290)** | |

| **PART B.**<br>**CHINN & KRAMER (2008) EVALUATION CRITERIA FOR A NURSING MODEL** | |
|---|---|
| **CRITERIA FOR EVALUATION**<br>with trigger questions | **EVALUATOR COMMENTS** |
| **1. CLARITY of the Model**<br><br>**a. Semantic clarity**<br><br>• Are the concepts clearly defined?<br>• Are the definitions understandable and coherent? | |
| **b. Semantic consistency**<br><br>• Are the concepts congruent and in harmony with the definitions, purpose and aligned to the relationships featured in the theory? | |
| **c. Structural clarity**<br><br>• Are the illustrated connections and logical reasoning coherent with the descriptive elements of the theory? | |
| **d. Structural consistency**<br><br>• Do the structural forms used for illustration as a conceptual map enhance clarity and comprehension of the descriptive elements of the theory? | |
| **2. SIMPLICITY of the Model**<br><br>• Are the number and differentiation of concepts and interrelationships least in simplicity or acceptable in complexity?<br>• Does the contextual situation warrant the various concepts to enhance understanding of the concepts and their interrelatedness in the theory?<br>• Does the theory serve to describe, explain and/or predict concepts or their interrelatedness in practice? | |

| | |
|---|---|
| **3. GENERALITY of the Model**<br><br>• Do the breadth of scope and specificity of purpose appraise the broad empirical experiences of concepts for the purpose of nursing?<br>• Are ideas arranged to facilitate application to practice and the health care team while embodying nursing as a discipline?<br>• Are the concepts of the individual, health, environment and society featured broadly in the general application of the model? | |
| **4. ACCESSIBILITY of the Model**<br><br>• Would the concepts be identifiable as empirical indicators in practice within the realm of nursing?<br>• Do the definitions of the concepts adequately manifest their meanings in the nursing practice setting that is specified?<br><br>• Despite either the simplicity or complexity of the model, do the concepts create conceptual meanings in the clinical practice setting? | |
| **5. IMPORTANCE of the Model**<br><br>• Does the model have clinical value or practical significance in the targeted area of clinical nursing practice?<br>• Is there futuristic and pragmatic value in the applicability to lead future practice of nursing in the targeted area?<br>• Does the theory in the model create understanding and the potential for nursing education and research?<br>• Does the theory differentiate the focus or nature of nursing as a discipline separate to other service professions? | |
| **SUMMARY COMMENTS** | |
| **Chinn and Kramer (2008:234-249)** | |

| **PART C.**<br>**FAWCETT (2005) FRAMEWORK FOR EVALUATION OF NURSING MODELS** | |
|---|---|
| **CRITERIA FOR EVALUATION** with trigger questions | **EVALUATOR COMMENTS** |
| **Step 1:**<br>**Explication of Origins**<br>• Are the philosophical claims on which the nursing model is based explicit?<br>• Are the scholars who influenced the model author's thinking acknowledged and are bibliographic citations given? | |
| **Step 2:**<br>**Comprehensiveness of content**<br>• Does the nursing model provide adequate descriptions of all four concepts of nursing's metaparadigm?<br>• Is the practitioner given sufficient direction to be able to make pertinent observations, decided that an actual or potential need for nursing exist, and prescribe and execute a course of action that achieves the goal specified in a variety of practice situations? | |
| **Step 3:**<br>**Logical Congruence**<br>• Does the model reflect more than one world view?<br>• Does the model reflect characteristics of more than on category of nursing knowledge?<br>• Do the components of the models reflect logical translation or reformulation of diverse perspective? | |
| **Step 4:**<br>**Credibility of the nursing model: social utility, social congruence, social significance**<br>• Are education and special skill training required before applying the nursing model in nursing practice?<br>• Is it feasible to implement practice protocols derived from the nursing model and related theories?<br>• To what extent is the nursing model actually used to guide nursing research, education, administration, and practice?<br>• Does the nursing model lead to nursing activities hat meet the expectations of the public and health professionals of various cultures and in diverse geographic regions?<br>• Does application of the nursing model, when linked with relevant theories and appropriate empirical indicators, make important and | |

| | |
|---|---|
| positive differences in the health conditions of the public? | |
| **Step 5:**<br>**Contributions to the discipline of Nursing**<br><br>• What is the overall contribution of the nursing model to the discipline of nursing? | |
| **SUMMARY COMMENTS** | |
| **Fawcett J (2005:53-58)** | |

| **PART D.**<br>**MELEIS (2007) ADAPTED CRITIQUE OF THEORY CRITERIA** | |
|---|---|
| **CRITERIA** with units of evaluation | **EVALUATOR COMMENTS** |
| **Criteria 1: Relationship between structure and function.**<br><br>a. Clarity<br>b. Consistency<br>c. Simplicity/Complexity<br>d. Tautology/Teleology | |
| **Criteria 2: Diagram of theory**<br><br>a. Visual and graphic presentation<br>b. Logical representation<br>c. Clarity of graphics | |
| **Criteria 3: Circle of contagiousness**<br><br>a. Geographical origin of theory and geographical spread<br>b. Influence of theorist on implementation | |
| **Criteria 4: Usefulness in clinical practice**<br><br>a. Procedure for care delivery<br>b. Guidelines for patient care | |
| **Criteria 5: Usefulness in nursing administration**<br><br>a. Structure of care<br>b. Organization of care | |
| **Criteria 6: External components**<br><br>**Criteria 6.1 Personal and professional values**<br><br>a. Theorist assumptions<br><br>**Criteria 6.2 Congruence with other professional values**<br><br>a. Complementarity<br>b. Collaboration<br><br>**Criteria 6.3 congruence with social values**<br><br>a. Beliefs, values, customs<br>b. Value to society | |
| **SUMMARY COMMENTS** | |
| **Meleis (2007: 257-264)** | |

Kingdom of Saudi Arabia
National Guard Health Affairs
Chief Executive Officer's Office
President, King Saud bin Abdulaziz
University for Health Sciences

المملكة العربية السعودية
الشؤون الصحية بالحرس الوطني
مكتب المدير العـــام التنفيـــذي
مدير جامعة الملك سعود بن عبدالعزيز
للعلوم الصحية

# EXECUTIVE COMMUNIQUE

☐ CONFIDENTIAL ☐ URGENT

| REF: EC / 1 / 13896 / 2010 | DATE: 29 / 12 / 2016 | Link: |
|---|---|---|

**National Guard Health Affairs**

- ☐ Chief Medical Officer
- ☐ Chief Operating Officer
- ☐ Commander, Military Field Medicine
- ☐ Director, CEO Office
- ☐ Exec. Administrator, CEO Office
- ☐ Exec. Dir., Administrative Affairs
- ☐ Exec. Dir., Financial Affairs
- ☐ Exec. Dir., Internal Audit
- ☐ Exec. Dir., Information Systems & Informatics Division
- ☐ Exec. Dir., Infection Prevention & Control Program
- ☐ Exec. Dir., Logistics & Contracts Management
- ☐ Exec. Dir., Business Center
- ☐ Exec. Dir., National Family Safety Program
- ☐ Chief Engineer, Engineering Services
- ☐ General Director, Anti-venom Center
- ☐ General Director, Business Development
- ☐ Director Corporate, Employee Social Club
- ☐ Associate Executive Director, Corporate Communications
- ☐ Director, Public Relations & Media Affairs
- ☐ Senior, Legal Advisor
- ☐ Secretary General, Health Affairs Executive Committees

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- ☐ Exec. Regional Director, Eastern Region
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**King Saud bin Abdulaziz University for Health Sciences, NGHA**

- ☐ Vice President, Educational Affairs
- ☐ Vice President, Postgraduate Education
- ☐ Vice President, Development & Quality
- ☐ Dean, College of Medicine
- ☐ Dean, Postgraduate Education & Academic Affairs
- ☐ Dean, College of Nursing, CR- WR-ER
- ☐ Dean, College of Public Health & Health Informatics
- ☐ Dean, Admissions, Registration & Student Affairs
- ☐ Exec. Dir., Training & Development
- ☑ Exec. Dir., King Abdullah bin Abdulaziz International Center for Research

Other(s): AED, NURSING SERVICES, ICAME - R

**Required Action**

- ☐ Action
- ☑ Action and feedback
- ☑ Approved for implementation
- ☐ As per policy
- ☐ Discuss with me
- ☐ Follow up
- ☐ Information
- ☐ Investigate and submit findings
- ☐ Review and feedback
- ☐ Correct & resubmit
- ☐ See remarks

**Comments:**

**DUE DATE:**
**Sending Time:**

**Dr. Bandar Al Knawy**
**Chief Executive Officer, NGHA**
**President, KSAU-HS**

NGHA Printing Press

Health Affairs Executive Office
25/12/2010 13:58 Kingdom of Saudi Arabia
File # 13896/2010

National Guard-Health Affairs
King Abdulaziz Medical City

المملكة العربية السعودية
الحرس الوطني - الشؤون الصحية
مدينة الملك عبدالعزيز الطبية

## Memorandum

Date: (G) **21 December 2010** / (H) **15 Muharram 1432** — Ref No. NSG/MBD_034.10

To : **His Excellency Dr. Bandar Knawy**
*Chief Executive Officer*
*National Guard Health Affairs, Kingdom of Saudi Arabia*

Recommended by: **Dr. Mohammad Al Jumah**
*Executive Director, Research*
*National Guard Health Affairs, Saudi Arabia*

22 DEC 2010

Through : **Ms. Joan Murray**
*Associate Executive Director, Nursing Services*
*King Abdulaziz Medical City in Riyadh*

From: **Mustafa Morris E. Bodrick**
*Director Clinical Nursing, Nursing Services KAMC-R*
*Doctor of Philosophy Candidate*
*University of the Witwatersrand, Johannesburg, South Africa*

21 DEC 2010

Subject : **APPROVAL AND ENDORSEMENT OF PHD RESEARCH STUDY Completed in Nursing Services at KAMC-R: 2003-2010**

Title of PhD Thesis: **A MODEL FOR PATIENT LIAISON NURSING IN THE AMBULATORY CARE CONTEXT OF A MIDDLE EASTERN TEACHING HOSPITAL.**

---

Reference is made to following attachments:

- Approval from KAMC-R Nursing Services ref: NSG.MB010/03 dated 07 Jan 2003
- Approval by the University Human Research Ethics Committee (unconditional) ref: R14/19 Clearance Protocol M03-01-27 dated 28 Feb 2003 (original approval for 5 years).
- Approval received from the University Postgraduate Committee of research protocol and title ref. application 8806298H dated 29 Mar 2003
- Approval by the University Human Research Ethics Committee ref R14/49 Protocol M080568 dated 09 Sep 2008 (re-approval for further 5 years)
- PhD candidate 8806298H University registration as at 4 Nov 2010.

In this regard:

- Phase 1 comprised of data collection, data analysis and oral presentations at international clinical and qualitative research conferences between 2003 to 2008.
- Phase 2 comprised of the generation of a theoretical model for the patient liaison nurse and completion of PhD thesis between 2009 to 2010.
- It is confirmed that all nurse participants consented in writing, and were data-coded for anonymity and confidentiality.
- There was zero reference to the patient names and/or clinical records in the entire research process.



P. O. Box 22490, Riyadh 11426
Tel. 2520088
Telex : 403450 NGRMED SJ

ص. ب ٢٢٤٩٠ الرياض ١١٤٢٦
تلفون : ٢٥٢٠٠٨٨
تلكس NGRMED ٤٠٣٤٥٠

KFH-MATERIALS 14574 (05/96) (ORACLE 29795)

٣٨/٢٠٨

Your Excellency kindly is requested in principle to approve and endorse the use of the NGHA published achievements reports in this PhD nursing research thesis for submission and subsequent publication. Acknowledgement of NGHA in the thesis is therefore appropriate to ensure due recognition of our unique clinical settings at KAMC-R.

Sincere appreciation is expressed for the invaluable opportunity afforded to produce a theoretical practice model for the patient liaison nurse in the ambulatory care setting of NGHA.

Thank you and best regards.

Approved by:

**His Excellency Dr. Bandar Knawy**
Chief Executive Officer
National Guard King Abdulaziz Medical City
in Riyadh, Saudi Arabia

cc: Chrono



P. O. Box 22490, Riyadh 11426
Tel. 2520088
Telex : 403450 NGRMED SJ

ص. ب ٢٢٤٩٠ الرياض ١١٤٢٦
تلفون : ٢٥٢٠٠٨٨
تلكس NGRMED ٤٠٣٤٥٠

KFH-MATERIALS 14574 (05/96) (ORACLE 29795)

٣٨/٢٠٨

Kingdom of Saudi Arabia
National Guard-Health Affairs
King Abdulaziz Medical City

المملكة العربية السعودية
الحرس الوطني – الشؤون الصحية
مدينة الملك عبدالعزيز الطبية

NURSING SERVICES
Mail Code: 1522

P O Box 22490
Riyadh 11426

Tel 252 0088
Ext: 1865
Fax: 1659
Date: 07 January 2003

Beep #: 7705
Ref. No. NSG.MB010/03

## Memorandum

To: **Dorothy Ferguson**
*Associate Executive Director, Nursing Services*
*Chair, Nursing Executive Council*

From: **Morris E. Bodrick**
*Director, Clinical Nursing, Ambulatory Care*
*Nursing Researcher / PhD Student, University of Witwatersrand, South Africa*

Subject: **Approval to conduct Nursing PhD Research Study: A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital**

Thank you for the inclusion of the above research study for review and consideration today for approval by the members of the Nursing Executive Council.

It is agreed that, should any nursing practice issue be identified during the course of data collection in this research study, the matter will be referred back to the Nursing Executive Council for consideration as a Nursing Services matter. Further, it was agreed that in such an event, the anonymity of the participants would remain confidential, as the action would be considered from a system or process perspective.

On this basis, kindly grant approval to conduct the research study.

Thank you and kind regards.

***Approval to conduct Nursing PhD Research Study in Ambulatory Care Nursing Services, King Abdulaziz Medical City in Riyadh.***

Approved:

**Dorothy Ferguson**
Associate Executive Director, Nursing Services
Chair, Nursing Executive Council

cc: Members, Nursing Executive Council
Chrono File

**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)**
Ref: R14/49 Bodrick

**CLEARANCE CERTIFICATE** **PROTOCOL NUMBER** M03-01-27

**PROJECT** A Model for Patient Liaison Nursing in the Ambulatory Care Context of a Middle Eastern Teaching Hospital

**INVESTIGATORS** Mr ME Bodrick

**DEPARTMENT** School of Therapeutic Sci, Johannesburg Hospital

**DATE CONSIDERED** 03-01-31

**DECISION OF THE COMMITTEE** Approved unconditionally

Unles otherwise specified the ethical clearance is valid for 5 years but may be renewed upon application This ethical clearance will expire on 1 January 2008.

DATE 03-02-28 CHAIRMAN .....(Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Prof H Klopper
Dept of School of Therapeutic Sci· Wits Medical School
Works2\lain0015\HumEth97 wdb\M 03-01-27

==========

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress form. I/we agree to inform the Committee once the study is completed.

DATE 5 May 2003 SIGNATURE ..... Morris E. BODRICK

PLEASE QUOTE THE PROTOCOL NO IN ALL QUERIES : M 03-01-27

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Endorsed **Mustafa M. Bodrick** 16 AUG 2008

*Faculty of Health Sciences*
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

7 York Road PARKTOWN Johannesburg 2193 Telegrams WITSMED Telex 4-24655.SA
FAX 643-4318 TELEPHONE 717-2075/2076
E-MAIL healthpg@health.wits.ac.za

MR ME BODRICK
MAIL CODE 1522
PO BOX 22490
RIYADH
11426
SAUDI ARABIA

APPLICATION NUMBER 8806298H
STATUS ( DEG 39 ) ( MD011 ) PZZ

2003-03-29

Dear Mr Bodrick

**Approval of protocol entitled** A model for patient liaison nursing in the ambulatory care context of a middle eastern teaching hospital

I should like to advise you that the protocol and title that you have submitted for the degree of Doctor Of Philosophy (Full-Time) have been approved by the Postgraduate Committee at its recent meeting. Please remember that any amendment to this title has to be endorsed by your Head of Department and formally approved by the Postgraduate Committee.

Dr HC Klopper, Mrs JCM Bruce has/have been appointed as your supervisor/s. Please maintain regular contact with your supervisor who must be kept advised of your progress.

Please note that approval by the Postgraduate Committee is always given subject to permission from the relevant Ethics Committee, and a copy of your clearance certificate should be lodged with the Faculty Office as soon as possible, if this has not already been done.

Yours sincerely

ME Fick (Mrs)
Faculty Registrar
Faculty of Health Sciences

Telephone 717-2075/2076

Copies - Head of Department_____Supervisor/s

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**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**
R14/49 Bodrick

| | |
|---|---|
| **CLEARANCE CERTIFICATE** | **PROTOCOL NUMBER M080568** |
| **PROJECT** | A model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital |
| **INVESTIGATORS** | Mr ME Bodrick |
| **DEPARTMENT** | School of Therapeutic Science |
| **DATE CONSIDERED** | n/a |
| **DECISION OF THE COMMITTEE*** | Unconditionally approved<br>Re-certification of M030127 for a further 5 years |

**Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.**

**DATE** 08.06.09 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof H Klopper

---

**DECLARATION OF INVESTIGATOR(S)**

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Mustafa M. Bodrick
16 AUG 2008

Ref: R 14/49
Protocol number: M03-01-27
- Original date of approval 31 January 2003
- Renewal date: 9 June 2008

Faculty of Health Sciences
Medical School, 7 York Road, Parktown, 2193
Fax: (011) 717-2119
Tel: (011) 717-2745

Reference: Ms Tania Van Leeve
E-mail: tania.vanleeve@wits.ac.za
04 November 2010
Person No: 8806298H

Mr MME Bodrick
Mail Code 1522
P O Box 22490
Riyadh 11426
09966
Saudi Arabia

Dear Mr Bodrick

**Confirmation of details of registration**

I am pleased to confirm the details of your registration as at 04 November 2010 in the Faculty of Health Sciences for the **Doctor of Philosophy**, **Year of Study 2**, **Full Time** for the year 2010.

According to our records you are registered for the following units:

| Unit Code | Unit Description | Class | Calendar |
|---|---|---|---|
| NRSE9000/1 | PhD Thesis | - | B4-2010 |

Should there be any inaccuracies contained in this letter, please contact the Faculty Office as soon as possible.

You are reminded that if you wish to withdraw from a unit and if you are permitted by your faculty, you must complete the appropriate form that is available from the Faculty Office. Please consult the Fees Booklet regarding cancellation deadlines. You are also reminded to notify the Faculty Office in writing of any changes of address and, in addition, you are requested to check carefully that your name **Mustafa Morris Elston Bodrick** is correct. This name must conform with that printed on your birth/marriage certificate as, unless you are registered as an occasional student, it is the name that will be printed on your graduation certificate.

If you have not already obtained your student card for this year, please do so as soon as possible. You must take this letter with you as proof of your registration.

I wish you every success in your studies at Wits.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
University of the Witwatersrand

## A model for patient liaison nursing in the ambulatory care context of a teaching hospital in Saudi Arabia

**Mustafa Morris Elston Bodrick, RN, MScN, MPH**
Nursing Services, National Guard King Abdulaziz Medical City, Riyadh, Saudi Arabia
**Hester C. Klopper, PhD, MBA, RN**
School of Nursing Science, North-West University, Potchefstroom, South Africa
**Judith C. Bruce, PhD, RN**
School of Therapeutic Sciences, University of the Witwatersrand, Johannesburg, South Africa

A nursing practice model for patient liaison nursing in Saudi Arabia was developed in a two-phase research process of a doctoral study. These were:

**Phase 1:** Data was collected from ambulatory care nurses in a teaching hospital. The initial method used a combination of the critical incident technique and reflective journaling over ten (10) weeks. The respondents were nurses who delivered care daily as patient liaison nurses. Midway at week five (5), real-life case scenario vignettes were crafted from the data that emerged from the reflective journals. The next level of respondents was nurses to whom the patient liaison nurses reported in line structure. Both sets of empirical data were analyzed and the concepts that emerged were identified and classified to form a conceptual framework.

**Phase 2:** The empirical data and conceptual framework from phase one were used to generate a nursing practice model for patient liaison nursing in the ambulatory care context for a teaching hospital in Saudi Arabia.

The presentation includes seven (7) diagrams that illustrate how the layered practice model was generated to portray the unique context of the Saudi Arabian National Guard health system wherein the registered nurses practice. Included are vivid excerpt descriptions from anonymous participants of the reflective journals and portrayals of real-life scenario vignette from the contextual nursing practice setting.

In essence, the practice model for patient liaison nursing illustrates the crucial role in continuity of care undertaken by nurses in an ambulatory care context when physicians and other healthcare team members are absent. Thereto the nursing practice model illustrates the autonomy of the patient liaison nurse and the resultant direct impact on quality patient care in Saudi Arabia.

**Learning Objectives #1:**
The learner will gain knowledge of model development on nursing practice for patient liaison nursing in the ambulatory care context of Saudi Arabia.

**Learning Objectives #2:**
The learner will gain knowledge on how empirical qualitative data from the Saudi Arabian nursing practice setting were used to construct a practice model.

**Purpose/Target Audience:**
The purpose of this presentation is to reveal a model for patient liaison nursing that was generated using qualitative research methods on responses from nurse participants in the ambulatory care setting of a teaching hospital in Saudi Arabia.

**Keywords:**
Saudi Arabian teaching hospital, model development and nursing practice model

## The leadership context of practice-based nursing research in Saudi Arabia

**Mustafa Morris Elston Bodrick, RN, MScN, MPH**
Nursing Services, National Guard King Abdulaziz Medical City, Riyadh, Saudi Arabia
**Judith C. Bruce, RN, PhD**
School of Therapeutic Sciences, University of the Witwatersrand, Johannesburg, South Africa
**Hester C. Klopper, PhD, MBA, RN**
School of Nursing Science, North-West University, Potchefstroom, South Africa

**Purpose and Background:**
Research in Saudi Arabia was in the domain of physicians until the first doctoral nursing research study was received for approval at an academic hospital in 2003. This occurrence triggered a review of nursing research in the preceding three years and thereafter the ensuing seven years of nursing research leadership development through the lens of qualitative research methodology. The clinical nursing leadership, in the context of research, had to embrace the organizational rhetoric that practice-based research perhaps did not have the same professional esteem as research-based practice. Herein was the challenge for clinical nursing leadership to provide a basis through nursing research on the way forward for nursing as a profession in Saudi Arabia.

**Methods:**
The initiation of qualitative research inquiry included self-reporting by reflective journals, the critical incident technique, creation of real-life vignettes and model development as a trigger that positioned nursing research as distinctive from traditional physician research protocols.

**Results:**
A practice model was generated for the nursing aspects of ambulatory care practice in an academic hospital in Saudi Arabia that embraced nursing autonomy, collaborative liaison, continuity of care within the context of patient-centeredness.

**Conclusion:**
Nursing leadership moves forward with autonomy for a nursing research committee to entrench practice-based research alongside research-based practice in a collaborative manner that promotes nursing research within the discipline of nursing in Saudi Arabia.

**Learning Objectives #1:**
The learner will be able to describe the leadership context of research within clinical nursing practice setting of an academic hospital in Saudi Arabia.

**Learning Objectives #2:**
The learner will be able to discuss how a nursing research culture was developed within the practice setting of Saudi Arabia.

**Purpose/Target Audience:**
The purpose of this presentation is to stimulate leadership in the context of nursing research in the practice setting in Saudi Arabia. A trail of more than ten (10) years in clinical practice in Saudi Arabia will be illustrated through the lens of qualitative research development.

**Keywords:**
Leadership in nursing practice and research, nursing practice context of Saudi Arabia

مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة
Jeddah Branch - فرع جدة

**5th Nursing Symposium**
***Excellence in Health Care: A Joint Venture***
**1– 2 May 2011**

## ABSTRACT FORM

| Office use: Abstract Submission # | | ☐ I ☐ N ☐ L ☐ KJ |
|---|---|---|

**PRESENTATION TITLE**

# A MODEL FOR AMBULATORY CARE PATIENT LIAISON NURSING AT A NGHA HOSPITAL


| PRESENTER(s)*: ☐ MR | AUTHOR(S)** |
|---|---|
| | Professor KLOPPER Hester C. PhD; RN; MBA |
| BODRICK MUSTAFA MORRIS | Professor BRUCE Judith C. PhD; RN |
| Last First Middle | ** Including co-researchers & members who added significant scientific contribution, who will be acknowledged in abstract booklet |

* maximum 2 speakers per presentation


☐ **PRESENTATION (20 min)**

The Scientific Committee may request abstracts forwarded for oral presentation to be considered for poster presentation


**ABSTRACT** (Max. 250 words)

**Introduction (to the topic)**
This nursing practice model illustrates the delivery of quality care by patient liaison nurses in an ambulatory care context

**Purpose (of the presentation)**
The purpose is to show how a practice model for patient liaison nursing was generated in ambulatory care nursing at the NGHA (National Guard Health Affairs) Riyadh hospital.

**Outline (of the presentation)**

A nursing practice model was developed in a 2-phase research process for patient liaison nursing. These were:

**Phase 1:** Data collected from ambulatory care registered nurses. The initial method over a ten (10) weeks was reflective journaling from nurses functioning as patient liaison nurses. Midway at week 5, real-life case scenario vignettes were created from the reflective journals, and used to elicit responses by the next level of nurses in the line structure. The data were analyzed and concepts identified. A classification of concepts formed a conceptual framework.

**Phase 2:** The empirical data and conceptual framework from phase one were used to generate a nursing practice model for patient liaison nursing.

The presentation includes (7) diagrams that illustrate the crafted practice model in the unique context of ambulatory care nursing. Vivid excerpt descriptions from reflective journals will be given and shown how real-life case scenarios were used to craft the vignettes.

In essence, the nursing practice model for patient liaison nursing will illustrate continuity of care by ambulatory care nurses in the absence of physicians and other health care team members as a valued impact on quality patient care. **(248 words)**


**Key words:** nursing practice model; patient liaison nurse; ambulatory care nursing

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King Faisal Specialist Hospital & Research Centre

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**1– 2 May 2011**

## ABSTRACT FORM

| Office use: Abstract Submission # | | ☐ I ☐ N ☐ L ☐ KJ |
|---|---|---|

**PRESENTATION TITLE**

**REAL-LIFE CLINICAL SCENARIOS USED AS VIGNETTES IN NURSING RESEARCH**


| PRESENTER(s)*: ☐ MR | | | AUTHOR(S)** |
|---|---|---|---|
| | | | Professor BRUCE Judith C. PhD; RN |
| BODRICK | MUSTAFA | MORRIS | Professor KLOPPER Hester C. PhD; RN; MBA |
| Last | First | Middle | ** Including co-researchers & members who added significant scientific contribution, who will be acknowledged in abstract booklet |

* maximum 2 speakers per presentation


☐ PRESENTATION (20 min)

The Scientific Committee may request abstracts forwarded for oral presentation to be considered for poster presentation

**ABSTRACT** (Max. 250 words)


**Introduction (to the topic)**

Real-life scenarios from clinical nursing practice were used from participants' reflective journals to create vignettes within the research process while ensuring ethical considerations were maintained.

**Purpose (of the presentation)**

The purpose is to illustrate the measures taken to uphold nursing research ethics when using real-life excerpts from reflective nursing journals from clinical nursing practice.

**Outline (of the presentation)**

Firstly, the term "double blind' is associated usually with drugs that are being tested in clinical trials. In this qualitative study, the principal investigator described how the anonymity of nurse participants were protected using a "double blind" method alongside the self-reporting method of reflective journaling. Secondly, the creation of vignettes is usually from fictitious content, whereas in this research study actual excerpts from lived experience were used to ensure authenticity.

The presentation includes the method of creating vignette from real-life scenarios from reflective journals in clinical nursing practice that is a first within the Middle East. The methodology was refined in collaboration with social researchers from Australia and King's College, London. The crafting of three (3) vignettes will be demonstrated to reveal the research trail that portrays the reflective journal entries and the related generation of vignettes alongside the emerging qualitative themes. The nurses' meanings of the lived experience from patient interaction while preserving anonymity.

The delivery will conclude by showing that practice-based research in nursing potentially has its own position and value that is independent yet concurrent to research-based practice in Saudi Arabia. (**246 words**)


**Key words:** reflective journaling in research; real-life clinical vignettes; nursing research ethics

**A Practice Model in Ambulatory Care Services for Patient Liaison Nursing in Saudi Arabia**

**Mustafa M. E. Bodrick, RN, MSc(Nsg), MPH**
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**Hester C. Klopper, PHD, MBA, RN, RM, BA CUR, M CUR**
School of Nursing Science, North-West University, Potchefstroom, South Africa, Johannesburg, South Africa

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**Purpose:** To develop a practice model that explained how patient liaison nursing was used to prevent the interruption of treatment in chronic disease management whereby quality care was attained in the context of ambulatory care in a university hospital in Saudi Arabia.

**Methods:** A qualitative research process of reflective journaling and the vignette technique as data collection methods was used from reality-based scenarios in chronic disease management to generate primary empirical data from registered nurse participants. These results were used in the development of a practice model using theory generation process that explained how nursing care was delivered.

**Results:** A practice model using emergent themes and relational statements arising from nursing activities in ambulatory care of chronic disease management.

**Conclusion:** The value of contextual practice-based research is emphacized above research-based practice as a means of moving the nursing profession forward within the Middle Eastern setting of Saudi Arabia.

**ETHICAL ALARM BELLS: Can a male nurse researcher in a conservative Arab male-dominant culture collect data in a female nursing environment?**

**Morris E. BODRICK**

*National Guard King Abdulaziz Medical City, Riyadh, Saudi Arabia*

*University of the Witwatersrand, Johannesburg, South Africa*

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**For ORAL Presentation**

- **Background:** The human ethics committee (HEC) of a university in a democratic country raised ethical concerns about data collection by a male nurse researcher in a "conservative Arab male dominant culture". The concerns or misperceptions included potential coercion of female nurse participants, and consequences related to possible lack of anonymity and confidentiality.

- **Presentation objectives:** (1) to describe the ethical issues raised as reason for initial disapproval of the research project, and rationale for the disbelief response by the male researcher, (2) to discuss the theoretical process of response to the ethics committee, and (3) to argue the inclusion of added data collection methods to ensure protection of human rights in the unconditionally approved project, and thereby counteract the misconceptions of research practice in an Arab country.

- **Presentation content:** Details of concern are provided to include potential coercion of female participants, and the consequences related to the possible lack of anonymity and confidentiality. It argues that perhaps that possible media-related perspectives influenced the initial disapproval. Insightful perspectives are given from a process of reflection by the male researcher resulting in an advanced level of rigor in the research process comprehensively, such as measures taken to ensure scientific integrity in the data collection and safekeeping.

- **Conclusion:** Heightened organizational awareness is evident on ethical issues in research, and related human right aspects pertaining to the conduct of research, irrespective of a "conservative Arab male cultural setting", including the description of organizational systems in place to uphold ethical aspects at an international level.

***TITLE**:*

**Deployment through a Different Lens: The Health Care Context in a Foreign Setting**

***OBJECTIVES:***

The **purpose of this paper** is to reveal the multiple challenges encountered, and the corresponding approaches required by healthcare administrators in the context of a foreign country. The **objectives** are: **(1)** to examine the multiple dimensions of context encountered by healthcare administrators in foreign deployment; and **(2)** to illustrate a diversity of approaches that can be used in response to these multiple foreign contextual aspects.

***PRESENTATION DESCRIPTION:***

The presentation opens through the research lens on cultural diversity in a multinational expatriate nursing workforce from eight (8) major recruitment sources, namely; Asia, Australia, Canada, Europe, Philippines, South Africa, UK and the USA. It moves on to view healthcare administration analytically by examining the diversity of contextual factors encountered by healthcare administrators in a foreign setting.

These include: (1) **situational factors** that impact on healthcare delivery such as geography, environment, culture, society, gender, economy, technology, religion, politics, legal systems, ethics; and (2) **dynamic relational factors**, for instance, interpersonal and intrapersonal dynamics, sensitive vs. relaxed methods of communication, challenges to personal and professional values, media-generated vs. reality-based assumptions of cultural norms, interpreting authority, autonomy and accountability when the rules are different, and limited access to the patient population, or fellow health professionals when the language of a foreign country is different.

A diversity of professional practice approaches are provided in response to these multiple contextual aspects that potentially are encountered. The range of approaches include; **(a)** Professional Self-Concept, **(b)** Managing the Unknown, **(c)** Grounding on Client Systems, **(d)** Cultural Competence in Diverse and International Communities, **(e)** Influence through Helping Relationships, **(f)** Development as a Model of Change, and **(g)** Building Inter-organizational Commitment.

The presentation closes by suggesting that three (3) methods of reflective practice be used to capture the enriching experience of a foreign deployment. These are (i) reflection **on** practice, (ii) reflection **in** practice and (iii) reflection **with** others **about** practice.

**The Impact of Context as a Methodological Consideration**

**Morris E. BODRICK**
***National Guard King Abdulaziz Medical City, Riyadh, Saudi Arabia***
***University of the Witwatersrand, Johannesburg, South Africa***

**Professor Hester C. KLOPPER**
***University of Alberta, Canada***

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**For ORAL Presentation**

Initially the context of this research project was considered in terms of the clinical site, and the Middle Eastern geographical setting. As the research proposal progressed, a multitude of contextual aspects impacted on the research process. Theory on context (Mason 2002, Patton 2002, Ritchie & Lewis 2003), and a framework for reviewing context (Klopper 2004) were used to unpack the various components of context. These included: (1) science dimensions, namely, ontological, epistemological, teleological, and methodological; (2) situational factors, namely, geographical, political, economical, sociological, technological, legal, ethical and environmental; and (3) dynamic characteristics, namely, interpersonal / relational attributes, cultural / value attachments, and assumptions / paradigmatic perspectives. This rigorous review culminated in a stand-alone dissertation chapter that specifically addressed the context of this research project. Methodological considerations and related findings specific to context are discussed, and conclude with reflections on the research process.

**Methodological Considerations: Data, Data Everywhere; Where To From Here?**

**Morris E. BODRICK**
***National Guard King Abdulaziz Medical City, Riyadh, Saudi Arabia***
***University of the Witwatersrand, Johannesburg, South Africa***

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**For ORAL Presentation**

This paper commences with vivid sample dialogue of a PhD student to the supervisor, for instance, "… all this data … so what? … perhaps I'm stuck! ... maybe the methodology needs review …" These collage of questions and reflections during the research process raised methodological considerations: Is this phenomenology? Or perhaps grounded theory? Possibly interpretive description? The essence of the paper represents an introspective journey of inquiry, which reveals debate on methodological issues, literature consultation, related dialogue with the research supervisor, and the benefits of participation in two recent IIQM (AQM) conference workshops (Juliet Corbin 2003 & Sally Thorne 2004). The paper concludes on a discussion of how momentum was regained to move the research project forward.

**Symposium Title: VIGNETTES**
*What Are They? Who Cares? What Do They Have to Offer to Health Related Research?*

**Chair:** *Professor Julianne CHEEK, University of South Australia*

The papers in this symposium represent our journey as researchers in health related areas with respect to what a vignette is; how vignettes interface with qualitative research; how we have and might use vignettes in health related studies; and, what we have learnt from doing so. The papers collectively represent a multidimensional look at what has emerged as a complex and not always well understood part of qualitative research, but one which has much to offer.

**Co-Authors:**
***Morris E. BODRICK*** *(Papers 1 and 3), University of the Witwatersrand, South Africa*
***Dr. Rhidian HUGHES*** *(Papers 1 and 3), King's College London, UK*

**VIGNETTES: What's Behind A Name**
**(Paper 1 of Symposium)**

What are vignettes and what are they not? Is "vignette" simply another name for narratives or illustrative case studies? In what ways are the form and content of vignettes important considerations for research design? Qualitative health studies in Australia, the Middle East and England trigger a journey of discovery into vignettes. International collaboration commenced at a Canadian conference, continued in a London café, and has been sustained by electronic communication thereafter. The first paper in this symposium presents a critical overview of some of the writing around vignettes and how they have been used in health and social research. This paper raises questions about the use of vignettes in qualitative health research which this and subsequent papers in the symposium address.

**VIGNETTES in Action: A Tale of Two Studies**
**(Paper 3 of Symposium)**

This paper highlights differences and similarities in the use of vignettes in two qualitative health research studies. We explore the processes of questioning, creating, participating, collecting and reporting within the context of these studies. The first tale unfolds in England where vignettes were used to study drug injecting and HIV risk behaviour. The second tale occurs in the Middle East where the clinical experiences of multinational registered nurses were studied. The two studies become connected through dialogue on the use of vignettes and methodological considerations in the research process.

***TITLE**:*

**Championing Change through a New Functional Role – The Patient Liaison Nurse (PLN) – in the Context of a Middle Eastern Teaching Hospital.**

***OBJECTIVES:***

The **purpose of this paper**, which is based on a doctoral qualitative research study, describes how a model for a professional nursing approach was developed that is specific to the functional role of the patient liaison nurse (PLN) in the ambulatory care context of a Middle Eastern teaching hospital. The **objectives** are: **(1)** to describe how a study on the meaning and lived experience of patient liaison nurses in ambulatory care generated empirical data for the process of concept development, and model description for a professional nursing approach; and **(2)** to illustrate how change was championed by embracing autonomy of nursing practice in the context of the Middle East within the new functional role of the PLN in ambulatory nursing care.

***PRESENTATION DESCRIPTION:***

In December 2001, the Directorate of Ambulatory Care Nursing Services in a Middle Eastern teaching hospital embraced the opportunity for enhancing autonomy in nursing practice by responding to an identified organizational need in ambulatory patient care. A new functional role, namely the patient liaison nurse (PLN), was created. This role forged a new partnership with members of the multidisciplinary team by illustrating the valuable contribution that registered nurses, as patient liaison nurses (PLNs), can make in averting potential interruption to the treatment and care regimes of ambulatory care patients with chronic manageable conditions, and thereby contributes to quality patient care.

Three (3) months later, this new functional role of the PLN was hailed as successful because it contributed positively to the continuity of ambulatory patient care. The unexplained reasons for the success of this innovative new nursing role were considered to be a phenomenon, given that the professional nursing approach was not described specifically in literature, nor had it been studied empirically to date.

This presentation includes a description of the phenomenological research methods that were used to generate empirical data from a study on the meaning and lived experience of the PLN specifically. Innovative methodological approaches included daily reflective journaling technique that was used by each PLN for ten (10) weeks, and the vignette technique that was used by middle nursing management to collect data. A process of concept development was used to identify, classify, clarify and analyze the core and related concepts in the empirical data generated from the initial phenomenological component of the study. It was the **overall aim of this research study** to describe a model for a professional nursing care approach and to formulate implementation guidelines for use of the model specifically in the functional role of the PLN within the ambulatory care context of a Middle Eastern teaching hospital. The PLN informants disclosed their experience of enhanced clinical decision-making, and improved autonomy in their professional nursing practice.

The presentation is enriched by the integrated use of excerpts from the original data texts of the informants, which are indicative of the cultural diversity in a multinational expatriate nursing staff from seven (7) major recruitment sources, namely; Australia, Britain, Canada, Europe, Philippines, South Africa and the USA.

***TITLE:***

**Forging New Frontiers for International Consideration in Ambulatory Care Nursing Research:** ***Reflections on Specific Ethical Issues in a Middle Eastern Contextual Study.***

***OBJECTIVES:***

The **purpose of this paper** is to consider new frontiers in qualitative research from an international perspective in Ambulatory Care Nursing that are addressed in the following **objectives**. These are: **(1)** to describe research challenges that were encountered specific to ethical issues and related methodological considerations in the cultural context of the Middle East healthcare setting, **(2)** to explain how innovative research strategies were devised to maintain the integrity of universal research principles aimed at respecting the local cultural context within the global context of qualitative research, and **(3)** to forge a spirit of discovering new qualitative research frontiers in the international practice arena of Ambulatory Care Nursing.

***PRESENTATION DESCRIPTION:***

At the outset, a western-oriented university Human Ethics Committee reviewed the doctoral qualitative research proposal for a study based in the context of Ambulatory Care Nursing of a Middle Eastern healthcare setting, and expressed concerns for potential coercion and the possible lack of anonymity and confidentiality of the participants. The central concern was the conduct of the proposed research activities by a ***male*** nurse-researcher, who was in a ***position of perceived authority***, in a ***male-dominant Arab culture*** of a conservative Middle Eastern country.

The nurse-researcher reflected on these valid concerns and responded by devising research strategies for data collection and data analysis that maintained universal principles of research ethics, while using innovative methodological approaches. This paper is aimed at showing how these strategies were implemented in the research process and activities, while achieving the objectives of the original study. A nexus between specific contextual ethical issues, innovative methodological approaches, and practice-based considerations in Ambulatory Care Nursing is described as central to professional nursing development in the Middle East, within the cultural diversity context of international nursing staff from seven (7) major cultural backgrounds, namely; Australia, Britain, Canada, Europe, the Philippines, South Africa and the USA.

The presentation culminates with a reflective note demonstrating that universal standards of scientific adequacy were achieved in this qualitative research project despite the use of non-traditional methods, and that new research frontiers were discovered. These will be discussed from an international perspective of a research agenda for Ambulatory Care Nursing within the global context of qualitative research.

**ETHICAL ALARM BELLS: Can A Male Researcher With Perceived Organizational Authority Be Permitted To Collect Data In A Conservative Male-Dominant Middle Eastern Cultural Setting?**

**Morris E. BODRICK**
***University of the Witwatersrand, Johannesburg, South Africa***

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**For ORAL Presentation**

The ethics review committee (ERC) of a western university raised ethical concerns on a research protocol set in a conservative Middle Eastern context. The concerns included potential coercion of female participants, and consequences related to possible lack of anonymity and confidentiality. The male researcher consulted literature by ethicists (Sales & Folkman 2002, and Shamoo & Resnik 2003) and theoretical perspectives on ethics in qualitative studies by de Laine 2000, Mason 2002, Mauthner, Birch, Jessop & Miller 2002, and Patton 2002. A presentation to the ERC resulted in unconditional ethics approval for the study to proceed. This paper comprises: (1) descriptions of the ethical issues, (2) reasons for an initial reaction of disbelief, (3) the theoretical process in response to the ERC, and (4) implementation of additional data collection methods to ensure protection of human rights in the research process. The conclusion describes reflections on the ethical perspectives throughout the study.

**Innovative Use Of The Vignette Technique Using Real-Life Material From Reflective Journals And The Critical Incident Technique (CIT).**

**Morris E. BODRICK**
***University of the Witwatersrand, Johannesburg, South Africa***

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**For ORAL Presentation**

Hughes & Huby (2002) identify methodological pitfalls of vignettes when respondents encounter disjuncture between real-life experience and fictitious vignette characters. Authenticity was considered (Manning 1997) which led to the use of real-life data from reflective journaling, which were integrated with the critical incident technique (CIT). The vignettes were designed midway through a ten-week data collection period from the consented material of the daily reflective journals. The paper commences by theoretically positioning the use of vignettes (Finch 1987, Ely, Vinz, Downing & Anzul 1997, and Hughes 1998), raises the methodological considerations (Seale 1999, Morse & Richards 2002), and describes how the data from the original reflective journals were used in the research design process (Denzin & Lincoln 1998, Creswell 2003) in relation to the vignette technique (Hughes & Huby 2002). The presentation is enriched with vivid excerpts from the reflective journals and portrays their inclusion in the vignettes.

**Organizational Obstacles in Qualitative Data Collection: Maintaining Scientific Integrity**

**Morris E. BODRICK**
***University of the Witwatersrand, Johannesburg, South Africa***

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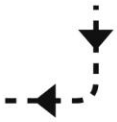
**For Oral Presentation**

At a premier teaching hospital in the Middle East, the implementation of the functional role of the patient liaison nurse was initiated, which has neither been described before by the AAACN, nor researched empirically (Robinson 2001). The multidisciplinary team members regard this functional nursing role as beneficial in the treatment of patients with chronic diseases. In essence, the patient liaison nurse functions in an advocacy role to prevent the interruption of treatment regimes by intervening on behalf of the patient so that continuity of care and quality improvement are attained. A research protocol using qualitative research methodology, namely phenomenology, was designed to study this new functional role (Streubert & Carpenter 1999). The purpose of this paper is to describe how the criteria of scientific integrity (Guba & Lincoln in Krefting, 1991) was maintained alongside balancing organizational culture during the process of qualitative data collection (Polit, Beck & Hungler 2001).

The researcher identified aspects of the organizational culture at the teaching hospital that had to be respected alongside conducting the research study. For instance, the use of recording devices, such as cameras, tape recorders or video recorders is not permitted as a regular practice, except with explicit permission. Also, the use in-depth interviews as a qualitative data collection method that involve gender-mixing would not necessarily be appropriate in the cultural context. This scientific research challenge resulted in the researcher selecting two data collection methods, namely Reflective Journaling Technique (Schon 1983, 1987 in Quinn 2000), and the Vignette Technique (Hughes & Huby 2002), which respected the organizational culture, yet maintained scientific integrity and rigor. The purpose of the study was to explore and describe the professional nursing practice approach of patient liaison nurses (registered nurses) from multinational backgrounds in an ambulatory care clinical nursing setting. Inclusive are considerations of confidentiality to protect patient privacy in keeping with universal ethical standards. This paper therefore illustrates the maintenance of scientific integrity despite the restriction on recording devices in fulfillment of the scientific research process.

**Table 5.7** Legends for figures 5.5 and 5.7

| | |
|---|---|
|  | Patient concern for attention |
|  | Patient concern being attended by PLN |
|  | Patient concern attended |
|  | Direction and exchange of communication and collaborative liaison |
|  | |
|  | Feedback flow on quality patient care |
| P | Patient |
| G | Goal: quality patient care |
| ACN | Ambulatory care nurses |
| PLN | Patient liaison nurse |

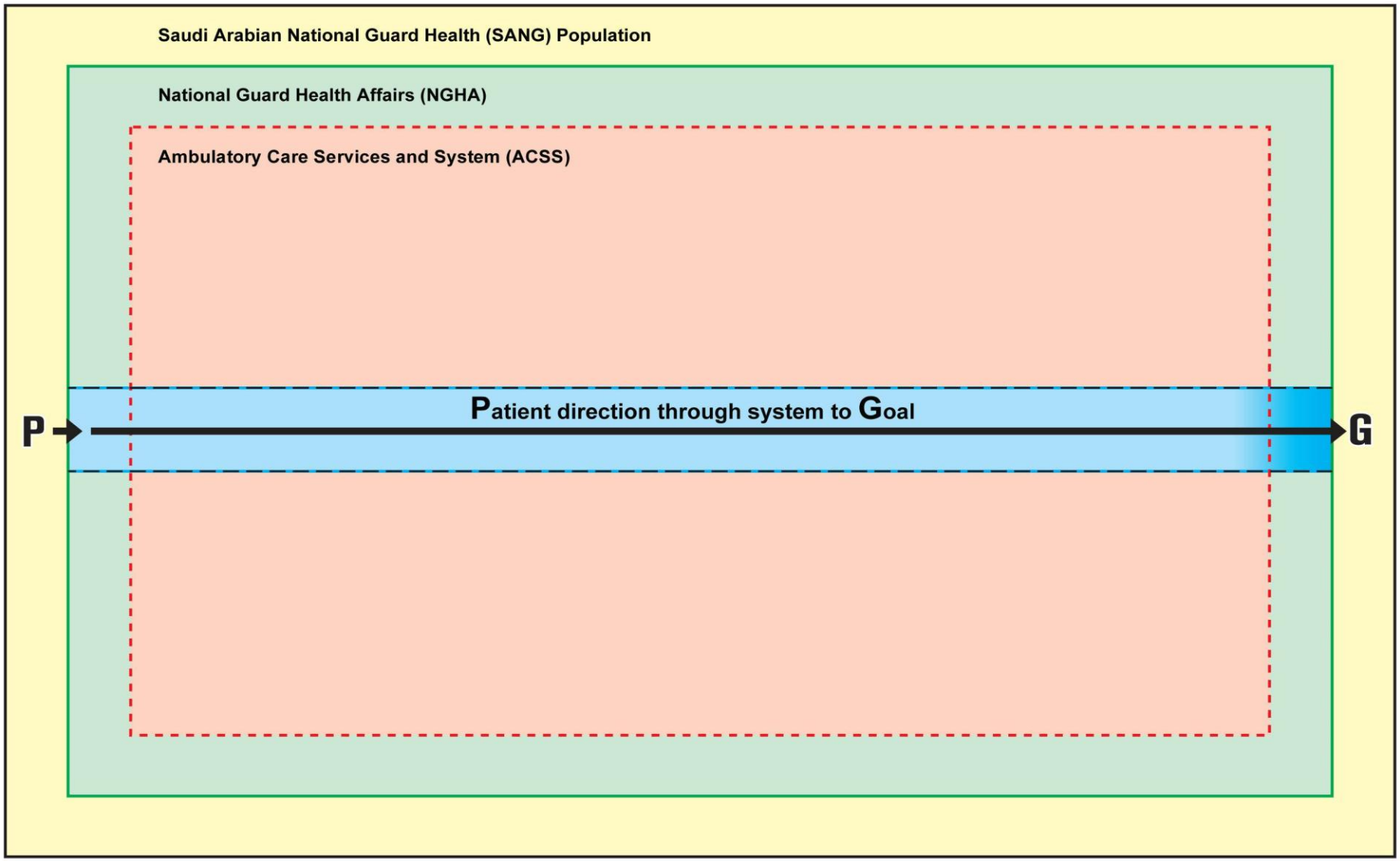



**Figure 5.3** The ambulatory care context of a Middle Eastern teaching hospital with the patient focus centered in the healthcare delivery system.

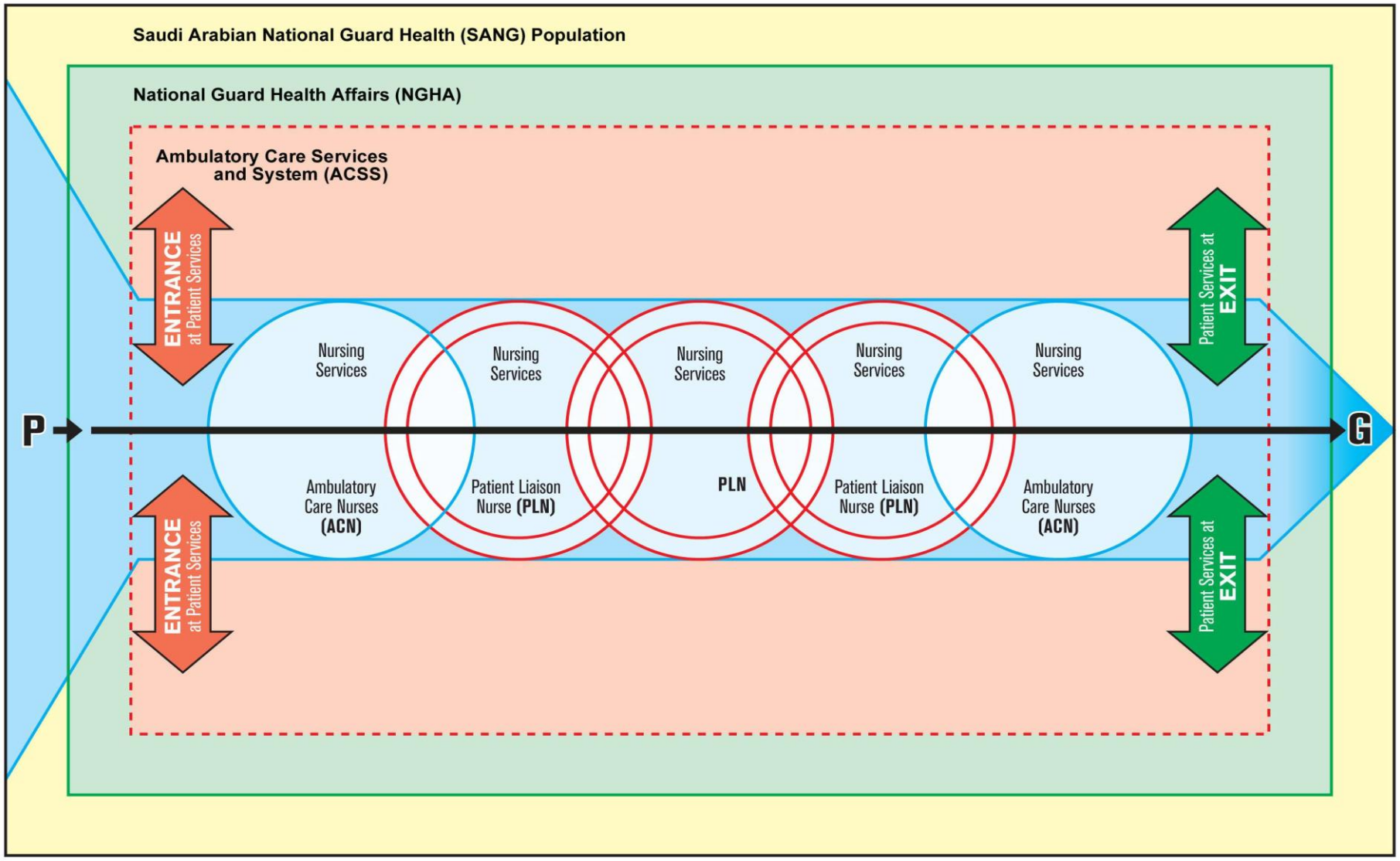



**Figure 5.4** Nursing Services situated in the ambulatory care context of a Middle Eastern teaching hospital.

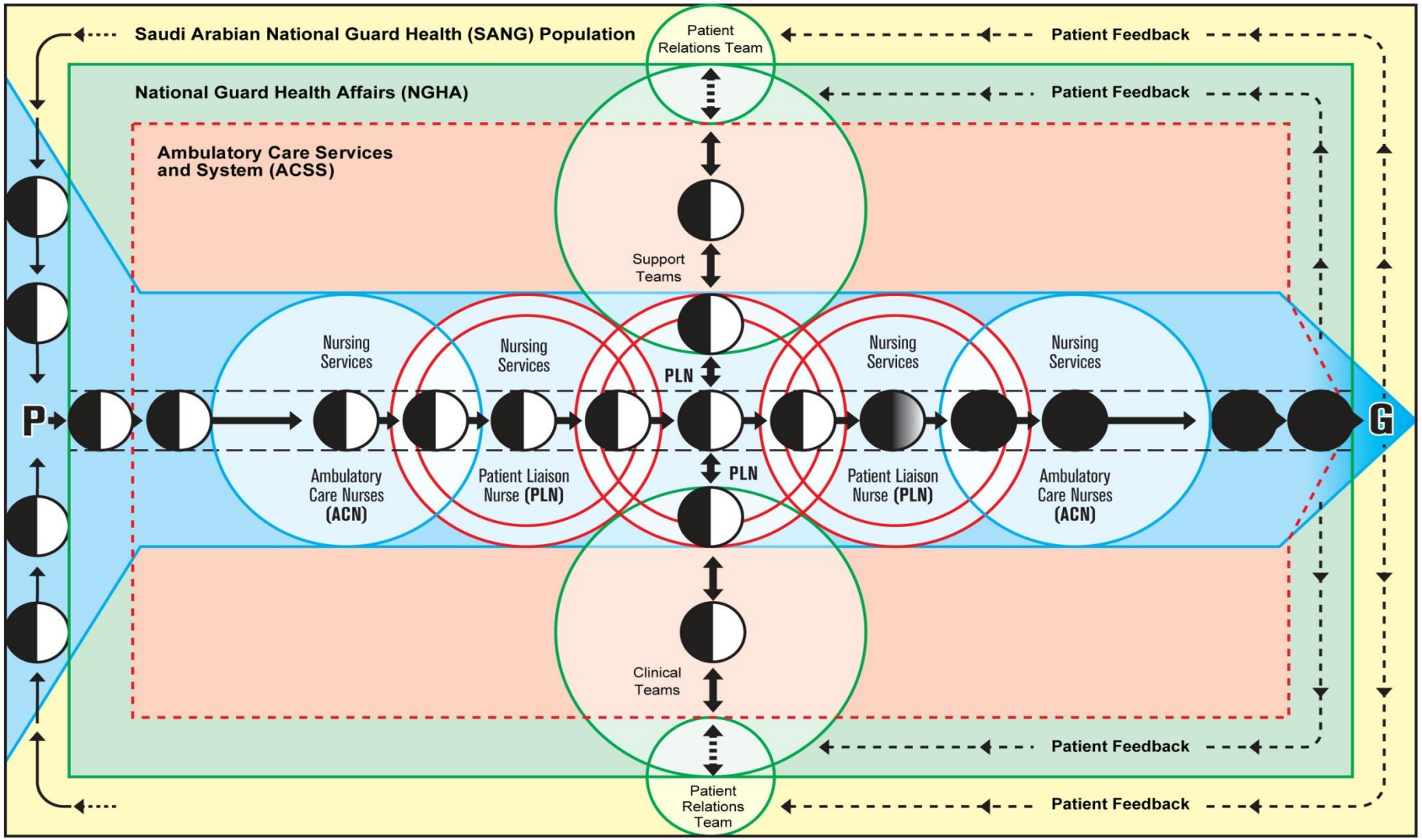



**Figure 5.5** The context of the patient pathway towards the goal of quality patient care that shows the point of access to care and the patient experience for continuity care aimed at quality patient care.

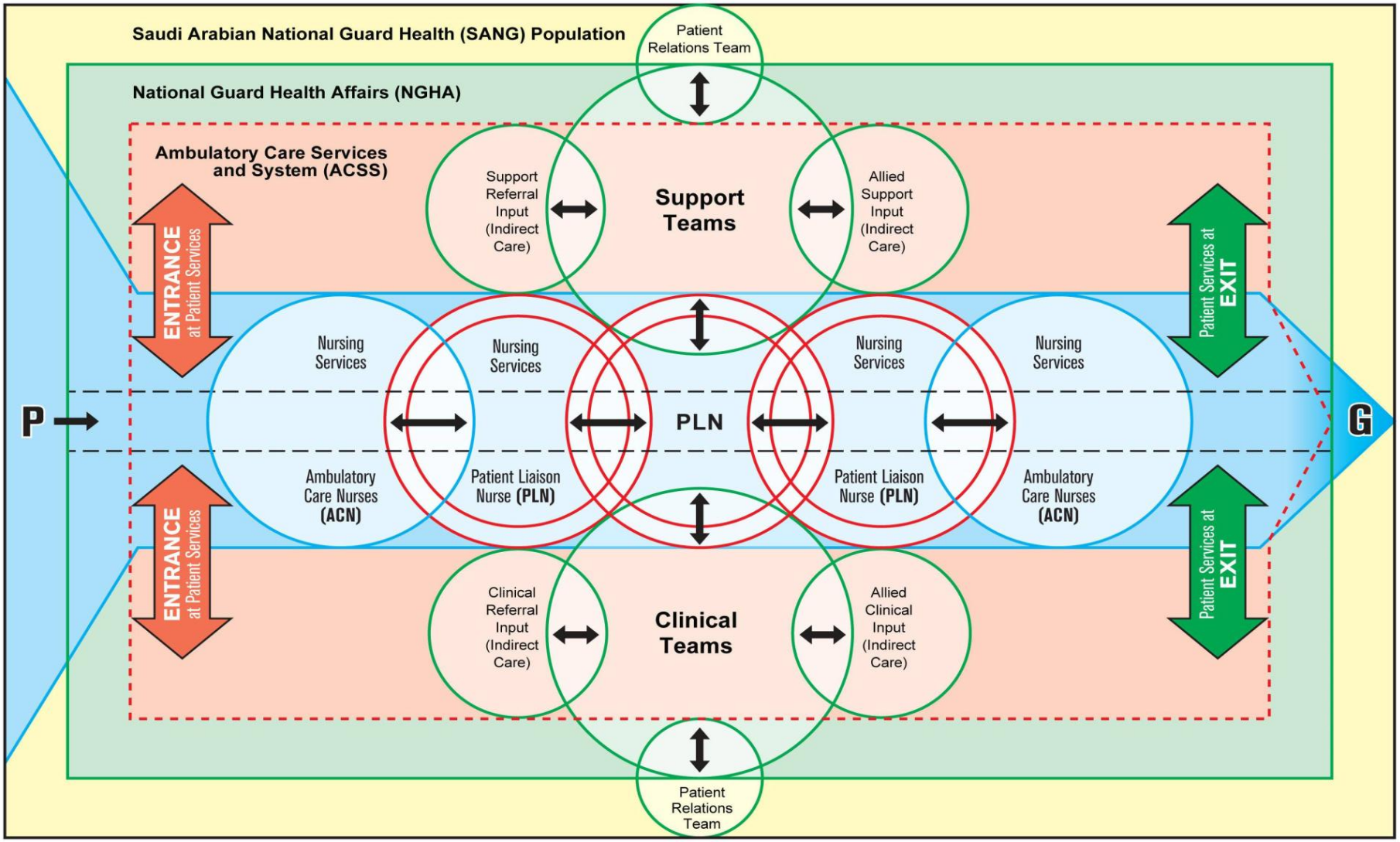



**Figure 5.7** Patient liaison nursing situated in the ambulatory care contextual structure showing the exchange of collaborative liaison as a communication interchange.

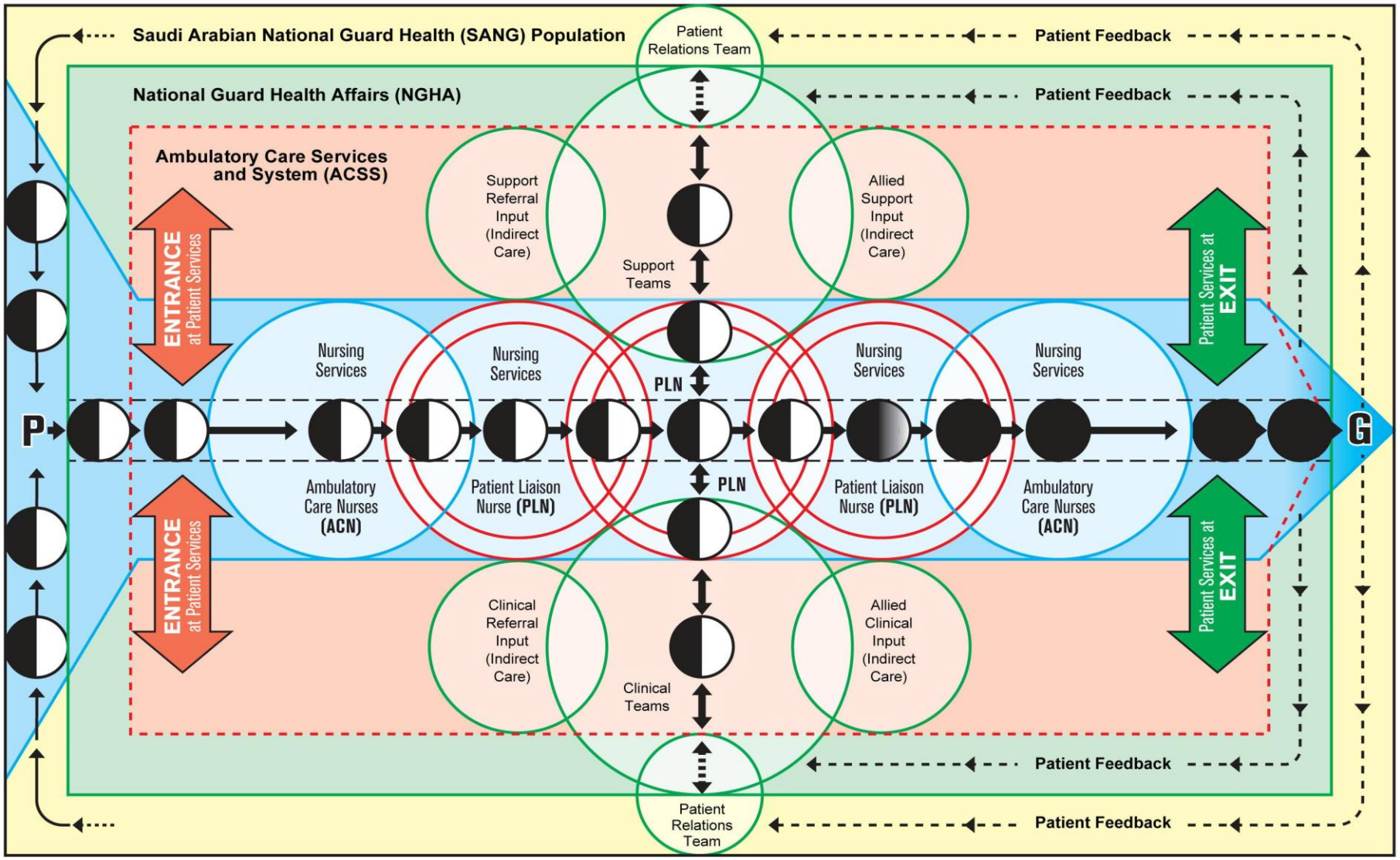



**Figure 6.1** A model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital.

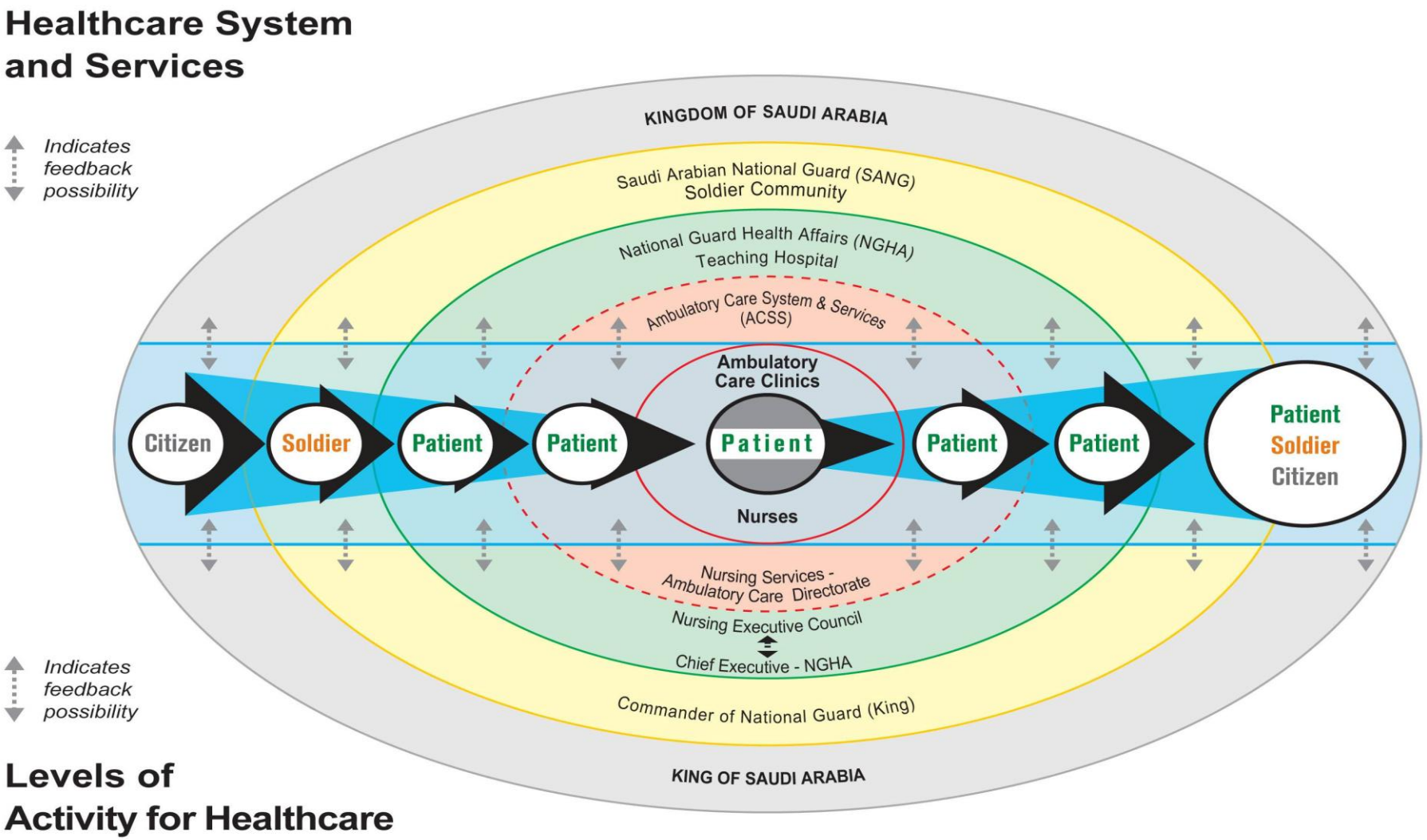



**Figure 5.2** The context showing the patient in the Saudi Arabian National Guard community and how the patient moves through the healthcare system and services.

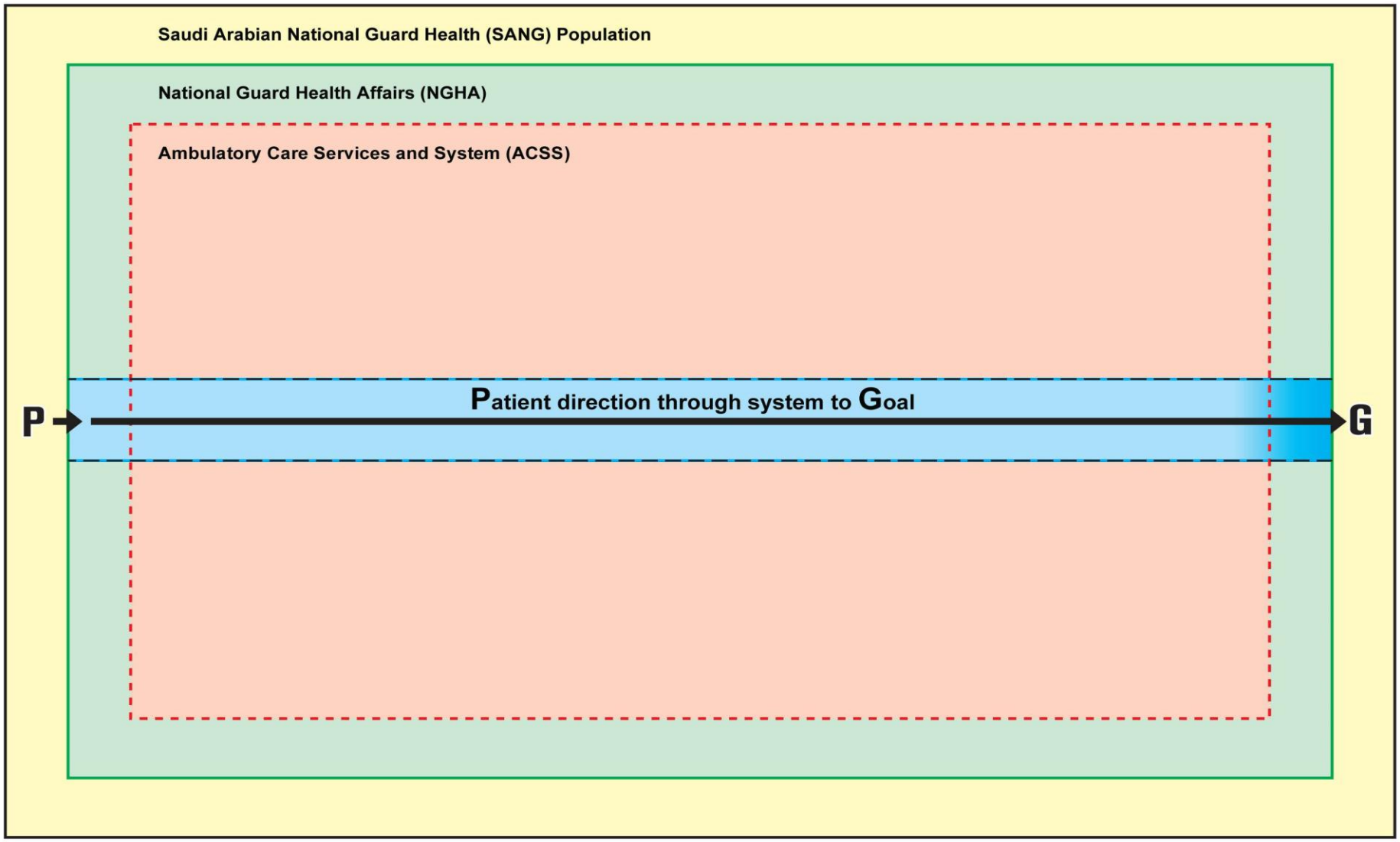
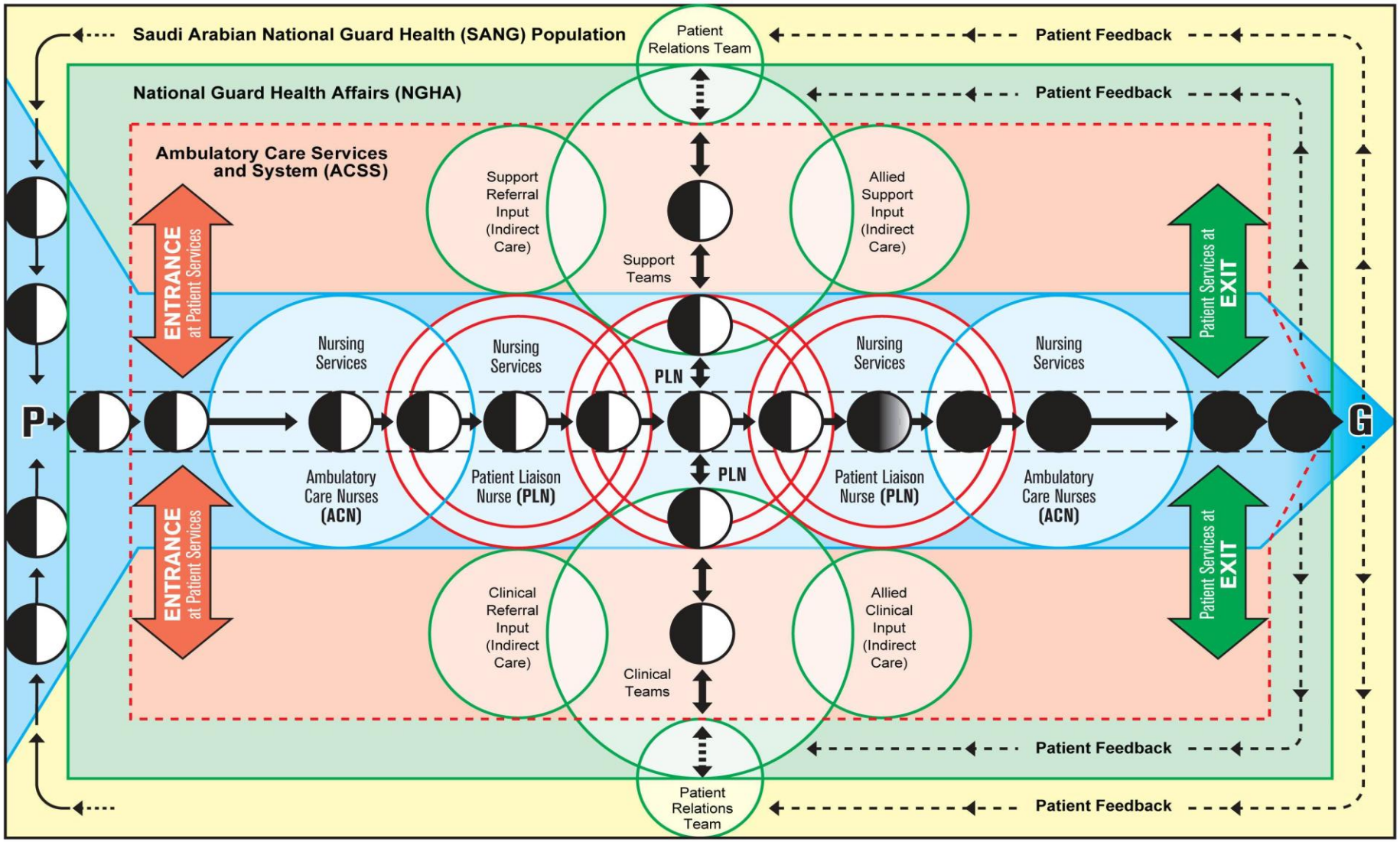



**Figure 5.3** The ambulatory care context of a Middle Eastern teaching hospital with the patient focus centered in the healthcare delivery system.

**Table 6.2** Legends for figure 6.1

| | |
|---|---|
|  | Patient concern for attention |
|  | Patient concern being attended by PLN |
|  | Patient concern attended |
|  | Direction and exchange of communication and collaborative liaison |
|  | |
|  | Feedback flow on quality patient care |
| P | Patient |
| G | Goal: quality patient care |
| ACN | Ambulatory care nurses |
| PLN | Patient liaison nurse |

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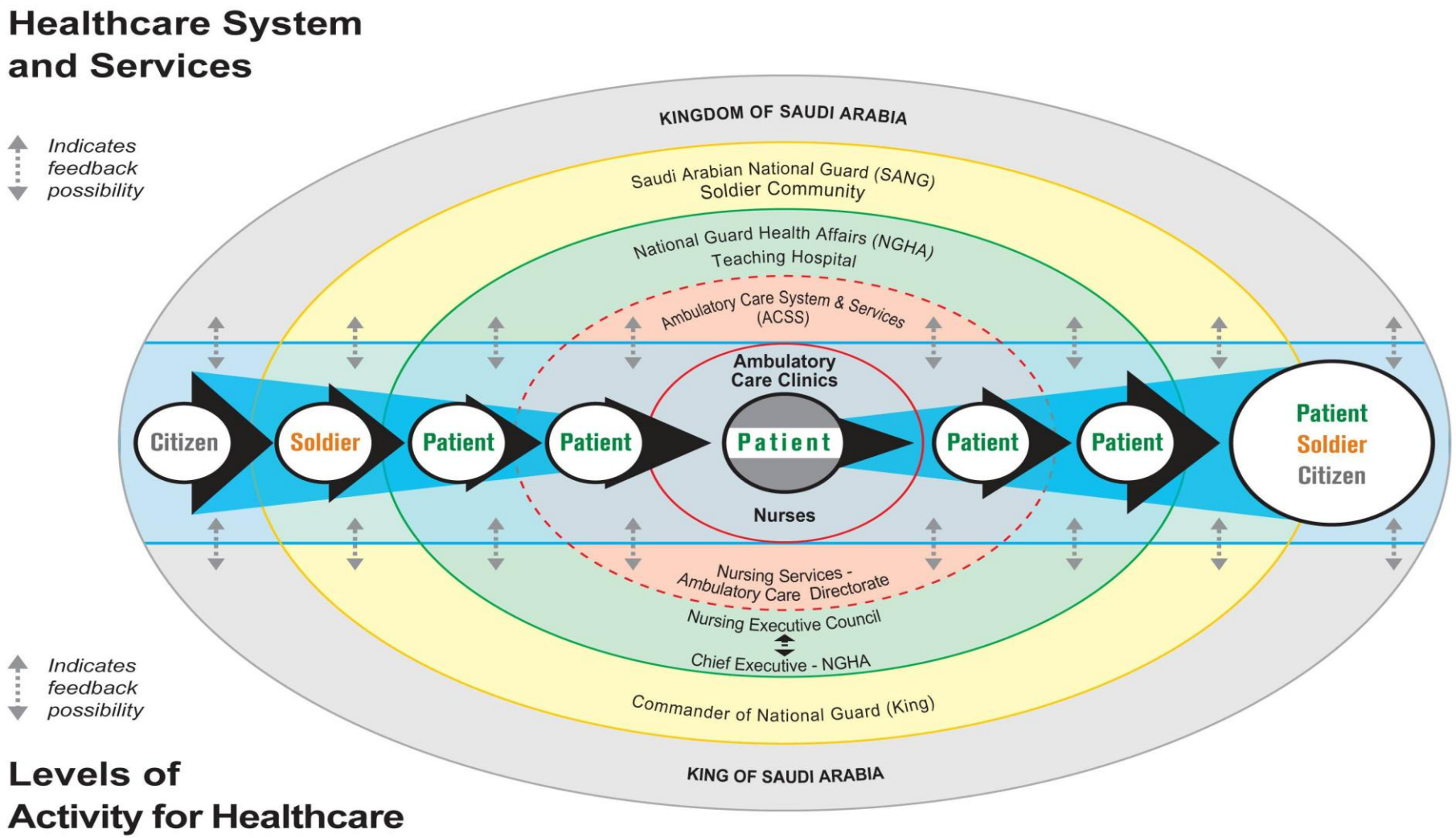


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| P | Patient |
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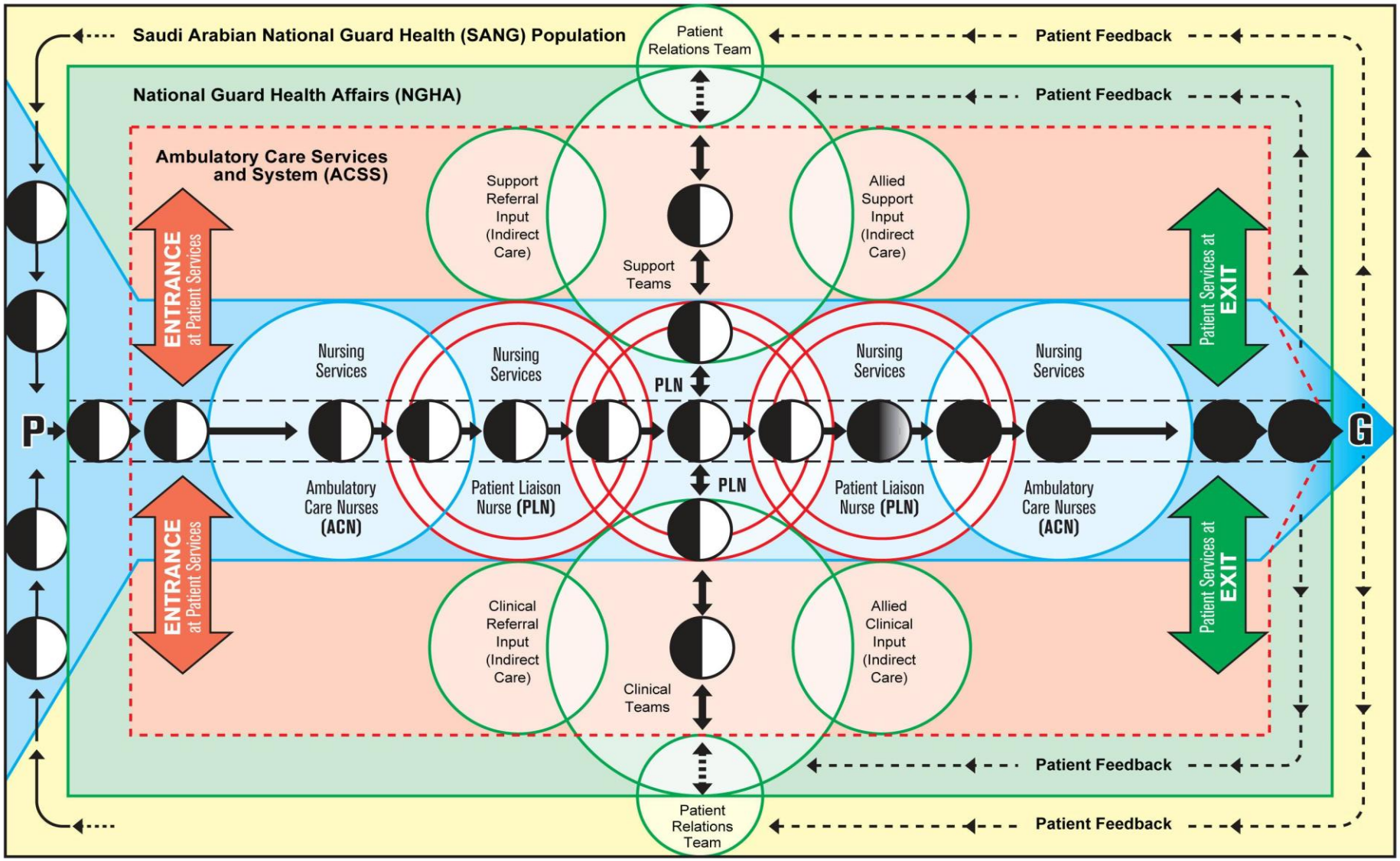



**Figure 6.1** A model for patient liaison nursing in the ambulatory care context of a Middle Eastern teaching hospital.

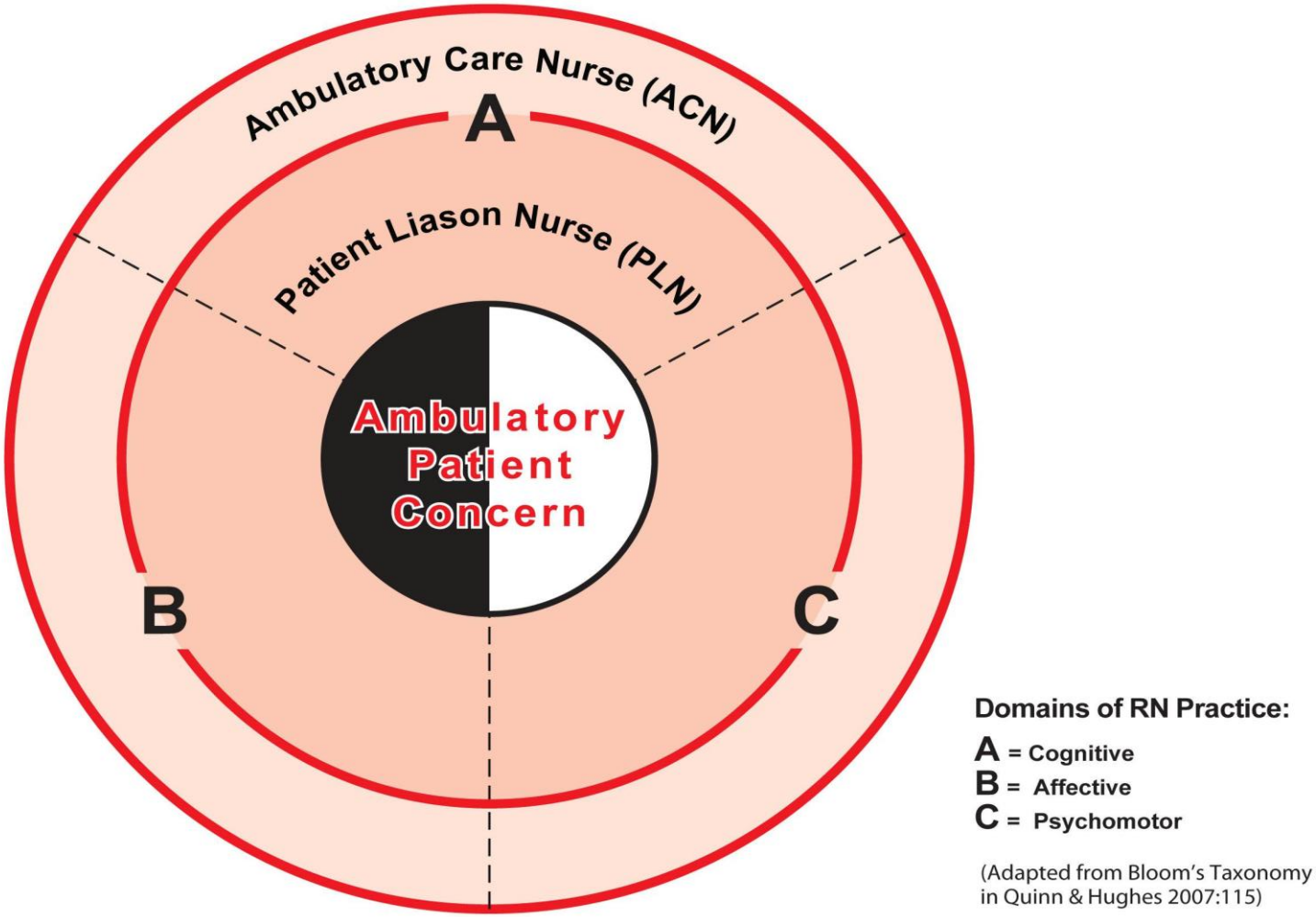
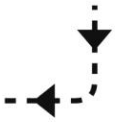



**Figure 5.6** The domains of RN practice illustrated in relation to the ambulatory care nurse (ACN) as the outer circle and the patient liaison nursing (PLN) functional RN role focus in the context as the middle circle. The inner circle represents the ambulatory care concern that is the center of nursing action.

**Table 5.7** Legends for figures 5.5 and 5.7

| | |
|---|---|
|  | Patient concern for attention |
|  | Patient concern being attended by PLN |
|  | Patient concern attended |
|  | Direction and exchange of communication and collaborative liaison |
|  | |
|  | Feedback flow on quality patient care |
| P | Patient |
| G | Goal: quality patient care |
| ACN | Ambulatory care nurses |
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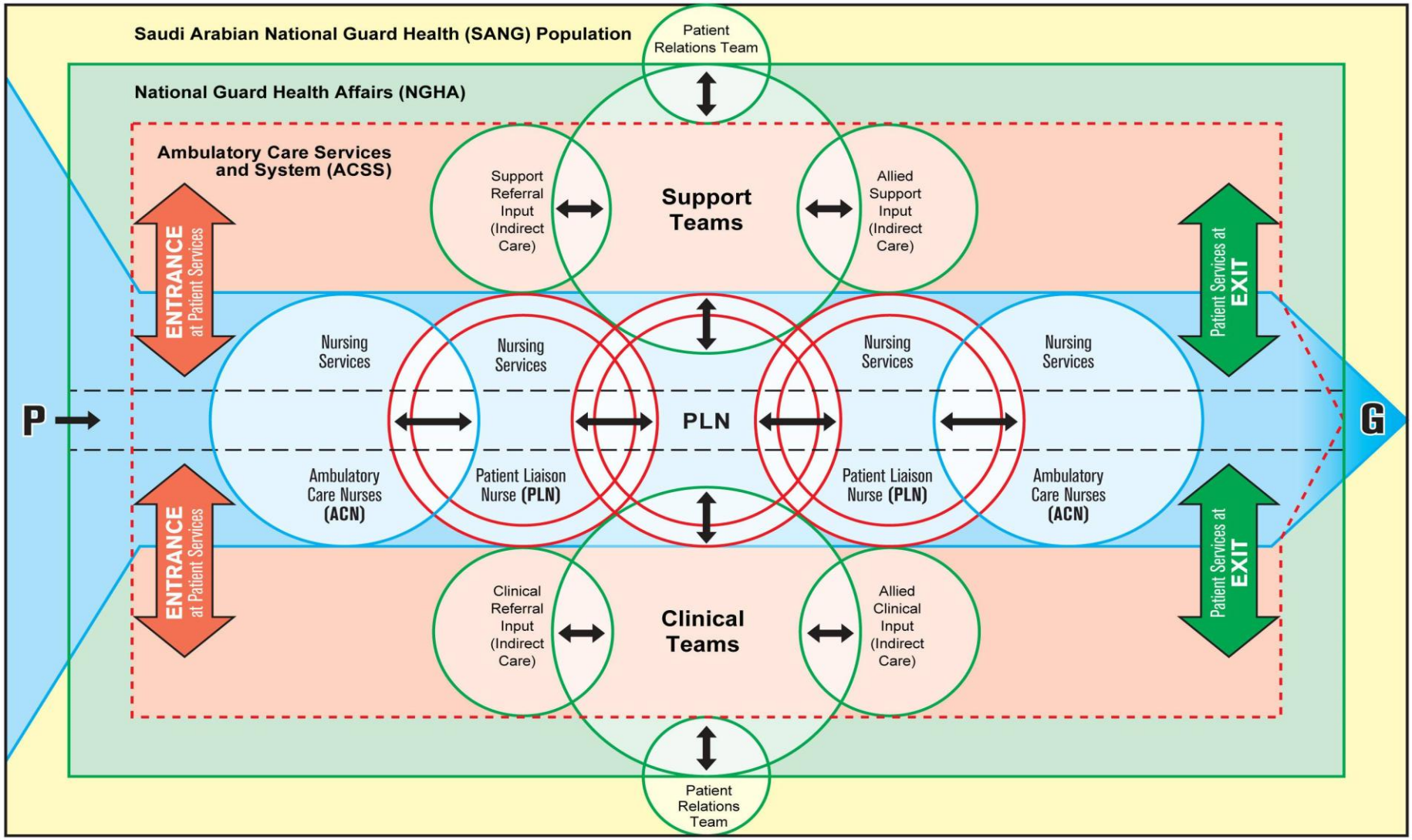


**Figure 5.7** Patient liaison nursing situated in the ambulatory care contextual structure showing the exchange of collaborative liaison as a communication interchange.

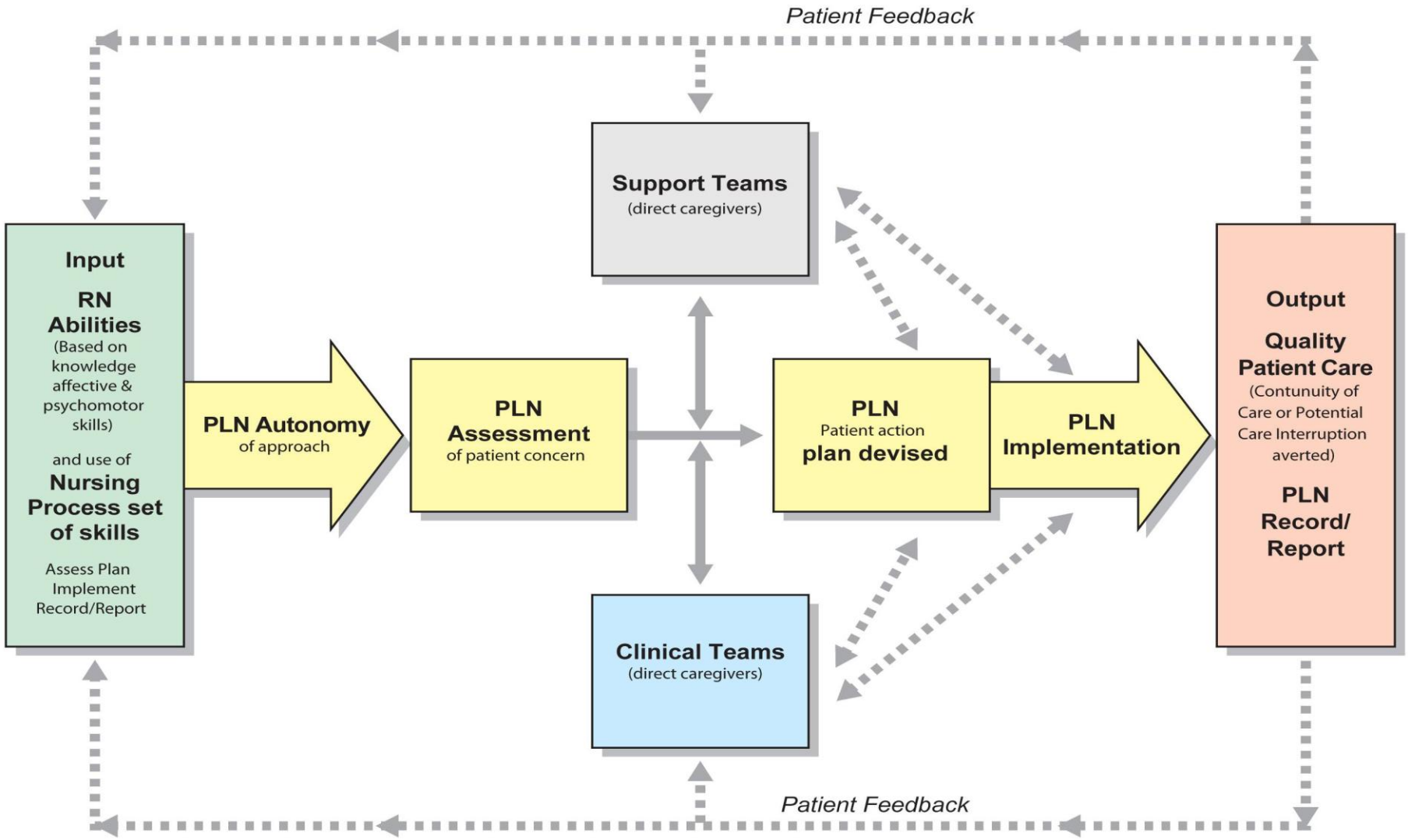


**Figure 6.2** Functional RN role illustrated in context of patient liaison nursing as the functional RN role.

April 22, 2009

**National Guard Health System** provides optimum healthcare to SANG personnel, their dependants and other eligible patients. NGHA also provides excellent academic opportunities, conducts research and participates in industry and community service programs in the health field.

## Vision

April 22, 2009

**National Guard Health System** will be recognized as internationally acclaimed centers of excellence to enhance individual and public health status.

## Core Values

**National Guard Health System** adhere to core values taken from religious, social and professional principles, abiding by:

- **Respect religious and social values**
- **Patient safety and satisfaction**
- **Quality performance**
- **Respect and dignity**
- **Transparency**
- **Teamwork**
- **Productive work environment**
- **Accountability**
- **Behavior and work ethic**
- **Excellence and innovation**

Source: NGHA website (http://www.ngha.med.sa/English/Pages/default.aspx)

# EVALUATION TOOL for the NURSING RESEARCH STUDY

| **PART A.**<br>**BURNS AND GROVE (2007:472) CRITIQUE PROCESS FOR QUALITATIVE RESEARCH** | |
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| **CRITERIA FOR EVALUATION** with **Critique Guidelines** | **EVALUATOR COMMENTS** |
| **STANDARD 1:**<br>**DESCRIPTIVE VIVIDNESS**<br><br>a. Was the significance of the study adequately described?<br>b. Was the purpose of the study clearly described?<br>c. Were the interpretations presented in a descriptive way that illuminated more than the quotes did? | |
| **STANDARD 2:**<br>**METHODOLOGICAL CONGRUENCE**<br><br>**Substandard 2.1**<br>**Adequate Documentation of the Participants**<br><br>a. Were the study participants described in detail?<br>b. Was the selection of participants reasonable? Was a rationale provided for participant selection?<br>c. Was the context and location of the study described with sufficient detail to determine if the findings are applicable to other settings?<br><br>**Substandard 2.2**<br>**Careful Attention to the Procedural Approach**<br><br>a. Did the researchers identify the philosophical or theoretical base of the study?<br>b. Were the assumptions underlying the study articulated? Were the assumptions and data collection procedures congruent?<br>c. Was adequate trust established with the participants? Was there an open dialogue with a conversational approach to data collection?<br>d. Were research questions articulated? Did the researcher ask questions that explore participant's experiences, beliefs, values, or perceptions?<br>e. Was the data collection process adequately described?<br>f. Did the researcher spend sufficient time with participants gathering data? Did the researcher conduct multiple interviews?<br>g. Was the approach of multiple data collectors similar?<br>h. Was the method of selecting and gaining | |

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| access to the study participants reasonable?<br>i. Was the role of the researcher during the interview process described? Were the researcher(s) qualitative credentials and expertise described?<br><br>**Substandard 2.3**<br>**Adherence to Ethical Standards**<br><br>a. Were participants informed of their rights?<br>b. Was informed consent obtained?<br>c. Were participants rights protected?<br><br>**Substandard 2.4**<br>**Auditability**<br><br>a. Was the decision trail used in arriving at conclusions described in adequate detail? Can the findings be linked with the data?<br>b. Were enough participant quotes included to support the findings?<br>c. Were the data sufficiently rich to support the conclusions? Were the findings validated by data? Did the participants describe specific examples of the phenomenon being investigated? | |
| **STANDARD 3:**<br>**ANALYTICAL AND INTERPRETATIVE PRECISENESS**<br><br>a. Do the categories, themes, or findings present a whole picture? Did the findings yield a meaningful picture of the phenomenon under study?<br>b. Were the findings returned to participants or experts in the area?<br>c. Did two or more researchers participate in data analysis? How were disagreements about data analysis handled? | |
| **STANDARD 4:**<br>**PHILOSOPHICAL OR THEORETICAL CONNECTEDNESS**<br><br>a. Was a clear connection made between the data and nursing practice?<br>b. Did the researcher identify the philosophical or theoretical basis for the study? Were citations provided for the philosophical or theoretical approach used?<br>c. Was the philosophical or theoretical basis of the study consistent with the study assumptions, data collection process, and analysis and interpretative methods used? Were citations provided for the philosophical or theoretical approach used? | |

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| **STANDARD 5:**<br>**HEURISTIC RELEVANCE**<br><br>**Substandard 5.1**<br>**Intuitive Recognition**<br><br>a. Can the reader recognize the phenomenon described in the study?<br>b. Are the findings consistent with common meanings or experiences?<br><br>**Substandard 5.2**<br>**Relationship to the Existing Body of Knowledge**<br><br>a. Did the researcher adequately examine the existing body of knowledge?<br>b. Did the researcher compare and contrast the findings with those of other studies?<br>c. Did the researcher describe the lacunae or omissions in current understandings that would account for unique findings?<br><br>**Substandard 5.3**<br>**Applicability to Nursing Practice, Research, or Education**<br><br>a. Are the findings relevant to nursing practice, research, or education?<br>b. Did the reader learn more than had been previously reported in the literature?<br>c. Do the findings have implications for related cases?<br>d. Are suggestions for further study identified? | |
| **SUMMARY COMMENTS** | |
| **PART B.**<br>**RESEARCH OBJECTIVES OF THIS STUDY** | |
| **Phase 1 objectives: the process of concept identification and description** | **EVALUATOR COMMENTS** |
| 1. To explore, describe, and interpret the lived experience of the functional role of the RN as PLN within in the ambulatory care context of a Middle Eastern teaching hospital. | |
| 2. To explore and describe the functional role of the RN as PLN from a nursing management team perspective in the ambulatory care context of a Middle Eastern teaching hospital | |

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| 3. To identify, classify, clarify and describe the core and related concepts from the empirical data on the functional role of the RN as PLN and in relation to the literature. | |
| **Phase 2 objectives: the process of model development and description** | |
| ~~4.~~ To describe the conceptual framework of the study on the functional role of the RN as PLN. | |
| 5. To formulate and describe relational statements in order to describe a model for the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital. | |
| 6. To evaluate the described model according to preset theoretical criteria | |
| 7. To formulate guidelines for the implementation of the model on the functional role of the RN as PLN in the ambulatory care context of a Middle Eastern teaching hospital. | |
| **SUMMARY COMMENTS** | |

# Notes