TRAVERSING THE PATH OF THE INTENSIVE CARE
NURSING EXPERIENCE: A GROUNDED THEORY STUDY

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Thesis submitted in fulfilment of the requirements for the degree of Master of Science (Hons).

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June 2005
Declaration

I certify that this thesis has not already been submitted for any degree and is not being submitted as part of a candidature for any other degree.

I further certify that this thesis has been written by me and that any assistance I have received in preparing this thesis, and all the sources used, have been acknowledged in this thesis.

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ABSTRACT

Nursing in the contemporary Australian healthcare system, particularly in speciality areas, is acknowledged as a highly stressful and difficult undertaking. A range of factors has contributed to this situation including changes in staffing levels, patient acuity, resourcing of the healthcare system and nurse recruitment and retention.

A number of studies on the intensive care environment have identified factors that cause stress and role strain in nurses. Other research has explored the coping mechanisms these nurses implement to manage work stresses. To date, no Australian studies have sought to provide an encompassing explanation of why and how nurses choose to remain working in this challenging area of practice. This study seeks to develop one possible explanation for this phenomenon.

Grounded theory was selected as the most appropriate means of achieving this aim. It explores behavioural patterns and how these develop into interactive social processes. Furthermore, Grounded theory investigates and reveals how people manage problematic life situations, enabling emergence of a substantive theory, which is grounded in context and situation dependent research data.

This research study was undertaken in three intensive care units in one area health service in New South Wales. Utilising Benner’s work (1982; 2001) as a guide, ten participants were recruited; all were registered nurses currently working in intensive care, with a minimum of three years experience in this speciality. Data were gathered through observation of the nurses and from semi-structured interviews. The constant comparative
analysis method was used, revealing that nursing in the intensive care environment is a stimulating, challenging experience, which at times is also frustrating and demoralising. The emergent substantive theory was titled “Traversing the path of the intensive care nursing experience”.

This study achieves two objectives. It adds to the accumulated knowledge base related to intensive care nursing by offering an explanation of why and how these specialist nurses remain practising at the bedside. Furthermore, it substantiates the results from previous research that investigated stressors and stress management in nursing within the intensive care environment.

There are a number of implications for nursing education, research and practice that can be drawn from this study. Impacting on all levels of nursing, these include the development of effective stress management, interpersonal communication techniques, recognition of competence and its assessment, and conflict mediation and management. Further research is needed into understanding nurses’ self-concept and the effect of the working environment on the delivery of effective nursing practice.
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Acknowledgements

Throughout the course of my undertaking this postgraduate degree I have been privileged to have had the benefit of expertise, advice, guidance, encouragement and support from many people. They have seen me through the best and worst moments of this exhilarating, stimulating and at times frightening and frustrating journey. Without their input and constancy I would not be at the point where I am penning these words. It is to these people that I wish to express my gratitude.

To my principal supervisor, Professor John Daly, for his encouragement, support and willingness to give of his time and expertise throughout the progressive stages of this work.

To my co-supervisor, Dr. Ann Bonner for her unstinting readiness to invest time and expertise into the development and writing of this thesis, and for contributing in no small part to my enhanced comprehension and appreciation of grounded theory.

To the nurses who agreed to participate in this research study, I extend my gratitude for their time, support and cooperation without which this research would not have been possible.

To my husband, Stephen, who has weathered the ups and downs of this degree with me and without whose support this thesis would not have been completed.

Finally, to the many other colleagues, friends and family members who have “been there” for me when I needed someone with whom to debrief, bounce ideas off or simply take time out. Your input, understanding and support enabled me to continue with and complete this study. Thank you.
CHAPTER ONE
INTRODUCTION TO THE STUDY

INTRODUCTION

The practice of nursing in the contemporary Australian healthcare system ranges across many different specialty areas. These include accident and emergency, intensive care, cardio-thoracic, coronary care, nephrology, operating theatre, orthopaedics, neurology and neurosurgery. There is evidence to support the claim that the ability of nurses within these specialty areas to effectively meet their responsibilities to patients, relatives, healthcare team members, institutions and the public is currently being strained (Senate Community Affairs References Committee [SCARC], 2002). Safe nursing practice is being compromised by the current international and Australian nursing shortage and the growing complexity and evolving level of responsibility attached to the role of nursing within healthcare (Australian Universities Teaching Committee [AUTC], 2002; SCARC, 2002). The nursing shortage is particularly evident in specialty areas, for example intensive care/critical care (SCARC, 2002).

This chapter draws attention to the nature of the practice of nursing in the intensive care environment and introduces the reader to the broad context in which this study was undertaken. It includes a review of previous research on nursing in the intensive care environment. A rationale for undertaking this present study and the use of grounded theory is provided. In addition, the chapter provides a guide to the organisation and structure of the thesis.
INTENSIVE CARE NURSING: A SYNOPSIS

The specialty of intensive care nursing had its origins in Denmark (Berthelsen & Cronqvist, 2003; Wiles & Daffurn, 2002). The first recognised intensive care unit was established in Copenhagen in 1953 (Berthelsen & Cronqvist, 2003; Wiles & Daffurn, 2002). The intensive care unit (ICU) was seen as a place where critically ill patients, who required the use of life saving devices, rapid response to needs and constant medical and nursing surveillance and supervision, could be treated twenty-four hours a day (Berthelsen & Cronqvist, 2003; Galbally, 1966). The purpose and primary goal of the ICU was and is the restoration and maintenance of vital organ functioning, leading to an increased chance for patient survival and recovery in the context of life threatening illness (Berthelsen & Cronqvist, 2003; Galbally, 1966). Advances in science and medical technology during the mid 1950’s to mid 1960’s led to the development of machinery and techniques that would revolutionise the care of critically ill patients (Wiles & Daffurn, 2002). These developments included artificial kidneys, expired air resuscitation, external cardiac massage, external defibrillators, cardiac monitors, pacemakers and the increasing use of sophisticated ventilators and monitoring systems (Wiles & Daffurn, 2002). These scientific and technological advances assisted in stimulating the growth of intensive care units internationally (Wiles & Daffurn, 2002). Their impact on medicine and nursing led to the continuing development of the specialty of intensive care medicine and the emergence of critical care nursing (Wiles & Daffurn, 2002).

Nursing practice in this environment has developed alongside the science of ICU medicine and advances in technology. Nurses who choose ICU as their area of practice need to attain highly sophisticated levels of knowledge and skills competency to effectively meet the complex needs of patients (Wiles & Daffurn, 2002). The evolution of this specialty nursing
role continues to keep pace with advances in medical science and technology that are inherent to the effective management of a critically ill patient (Wiles & Daffurn, 2002). This is a complex and dynamic field of nursing endeavour that is a highly difficult and demanding undertaking. Nurses choose to work in this practice area for a number of reasons. It is stimulating, exhilarating, exciting, challenging and fulfilling. It is also physically, emotionally and mentally draining. Nursing in this environment is acknowledged as a highly stressful occupation (Erlen & Sereika, 1997; Huckabay & Jagla, 1979; Robinson & Lewis, 1990; Sawatzky, 1996; Seyle, 1974). The nurses’ ability to effectively manage stress encountered throughout their tenure in this environment affects their self-esteem, job satisfaction and ultimately whether they remain practising in this area of nursing.

Kritek (2001) suggests that the intensive care environment is inherently one of crisis and complex needs, primarily concerning the health of the patient. These often overwhelming needs then become a crisis for the patients’ family and friends (Kritek, 2001). Intensive care nurses are expected to meet these needs, not only of patients, but also those of their relatives and friends. They also have responsibilities to their colleagues, the hospital and the public. The scope of these nurses’ requisite knowledge, skills and expertise is wide and varied as intensive care (IC) nursing is a multidimensional, complex process (Bassett, 2002). The nurses need to be multi-skilled, well versed and competent in their chosen area of practice, good managers of people and resources, effective communicators, patient advocates, diplomats and problem solvers (Duffield, et al., 2001).

According to the Australian College of Critical Care Nurses [ACCCN], (2001) maintaining an adequate number of available nurses in the ICU environment, particularly qualified IC
The Australian Health Workforce Advisory Committee [AHWAC] (2002) identified the 1999-2000 vacancy rates for ICU registered nurses in both the public and private sectors across States and Territories as being between “7.29% and 13.51%” (p. 65) of the number of positions available. AHWAC (2002) noted that the vacancy rates in the private sector were higher than in the public sector, especially in Western Australia.

This shortage of expertise has led to a decrease in the availability of ICU beds and services to the Australian public (ACCCN, 2001). The lack of available ICU beds has led to a potential for harm to critically ill patients who are unable to access these resources (ACCCN, 2001). This situation can lead to crises where demand for critical care outstrips resources. Tensions emerge where the system is unable to provide critical care on demand. Implications are a compromised system, compromised services and the potential for an increase in the human cost because of system failure.

According to the Commonwealth Department of Employment and Workplace Relations [DEWR], the National Skills Shortage [NSS] List for February 2002 identified a national shortage of nurses in Australia, which is evident across all states and territories (DEWR, 2002). These shortages were particularly evident in specialty nursing areas (for example, intensive care/critical care, cardiothoracic, operating theatre, accident and emergency and renal/dialysis) (DEWR, 2002). The ACCCN (2001) suggests that the shortage of specialist ICU qualified nurses is due to a number of factors. Firstly, the huge increase in demand for IC units and beds. For example, admissions to ICU’s in New South Wales almost doubled in the period 1994-5 to 1999-2000 from 36,410 admissions to 61,710 admissions (ACCCN, 2001). Secondly, rapid advances in technology; thirdly, increased
knowledgeability and acuity of patients (AUTC, 2002) and lastly, decreased retention of nurses in the area. This reduction in the number of intensive care nurses, particularly those with specialist qualifications has led to substantial increases in workload, work complexity and stress on those remaining at the bedside (ACCCN, 2001).

Difficult, stressful situations are often viewed by ICU nurses as challenges to be overcome, though these situations can lead to some nurses feeling not only stressed, but also distressed (Sawatzky, 1996). Discovering what leads these nurses to contemplate resignation and understanding the factors that sway their decision to remain at or leave the bedside, and potentially the profession is vital in the climate of the current nursing shortage. This thesis is based in part on the assumption that exploration of ICU nursing from the nurses’ perspective will enable development of insight and understanding of why nurses choose and are able to remain practising in this specialty area. Research-based information such as this has the potential to lead to the development and implementation of more effective, preventative policies, procedures and strategies that enable nurses to sustain practice in this specialty area. The policy, procedure and strategy recommendations would involve nursing curricula at undergraduate and postgraduate levels and nursing in the workplace.

**REVIEW OF PREVIOUS RESEARCH ON NURSING IN ICU**

**Intensive Care Nursing**

Internationally the bulk of research-based information on intensive care nursing has emanated from the United States of America [USA] (Leino-Kilpi & Suominen, 1997; VanCott, Tittle, Moody, & Wilson, 1991). This is possibly a reflection of international differences in nursing as a profession that is, nursing in the USA compared to other countries in the western world. From the early 1970’s to the late 1980’s there was a
substantial increase internationally in the amount of research being undertaken in this area of nursing when compared to the late 1950’s and 1960’s (VanCott et al, 1991). The research ranged across a wide variety of topics and was primarily quantitative in nature though a very small percentage of studies employed qualitative methods (VanCott et al, 1991). Table 1.1 (pp. 7-8) provides an overview of previous research in intensive care nursing.

One means of easily categorising these broad research areas is to catalogue the research according to the viewpoint from which the research was undertaken. These include the patient, the relatives or the nurses. Some studies have used both qualitative and quantitative methods to gather data and then triangulated the results (Burr, 1996). The significance and importance of the patient-nurse relationship has also merited investigation (Anthonypillai, 1993). Significant numbers of research studies have addressed such topics as everyday nursing practice in ICU, for example, assessment of patient needs (Benzer, Mutz, & Pauser, 1983; Campbell, Minors, & Waterhouse, 1986; Moser, Dracup, & Marsden, 1993) or communication (Jenny & Logan, 1996); the nature of caring in ICU (Bassett, 2002; Wilkin & Slevin, 2004); what constitutes learning to ICU nurses (Endacott, Scholes, Freeman, & Cooper, 2003; Little, 1999); critical care clinical nursing research priorities (Daly, Chang, & Bell, 1996) and clinical decision making (Aitken, 2003; Benner, 1982; Benner & Tanner, 1987; Benner, Tanner, & Chesla, 1992; Erlen & Sereika, 1997; Soderberg & Norberg, 1993). Much contemporary research has focused on identifying and describing ICU nurses’ role stressors and coping strategies. These include the nurses’ well-being, workload and other stressors (Buxman, 2000; Cavanagh, 1988; Ehrenfeld, 1990; Goodfellow, Varnam, Rees, & Shelly, 1997; Hague, 1987; Jezewski, 1994; Le Blanc, de Jong, de Rijk, & Schaufeli, 2001; Pelletier-Hibbert, 1998).
Table 1.1 Previous Research in Intensive Care Nursing

<table>
<thead>
<tr>
<th>Research Focus</th>
<th>Quantitative</th>
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<td>Decision making</td>
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<td>Jenny &amp; Logan, 1996</td>
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<td>Communication</td>
<td>Anthonypillai, 1993</td>
<td>Odell, 2000; Puntillo, 1990</td>
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<td>Experiences</td>
<td>Dracup et al, 2003; Evangelista, Doering &amp; Dracup, 2003; Evangelista, Moser, Dracup, Doering &amp; Kobashigawa, 2004; Robson, 2003; Simpson, 1991</td>
<td>Russell, 1999</td>
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<td>Touch</td>
<td>Glick, 1986; Longworth, 1982; Quinn, 1984; Schoenhofer, 1989</td>
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<td><strong>Relative's Viewpoint</strong></td>
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<td>Influences</td>
<td>Moser, Dracup &amp; Marsden, 1993; Moser, Dracup &amp; Doering, 1999</td>
<td>Martensson, Dracup &amp; Fridlund, 2001</td>
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<td>Stressors; Coping</td>
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<td>Nursing Staff</td>
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Chapter 1: Introduction to the Study
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<td>Communication</td>
<td>Anthopillai, 1993; Bergborm-Engberg &amp; Haljamae, 1993</td>
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<td>Elliot &amp; Wright, 1999; Trovo de Araujo &amp; Paes da Silva, 2004</td>
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<td>Touch</td>
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<td>Estabrooks, 1989; Estabrooks &amp; Morse, 1992</td>
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<td>Clinical Research Priorities; Learning Interests</td>
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<td>Daly, Chang &amp; Bell, 1996; Hewitt-Taylor &amp; Gould, 2002; Little, 1999; Lopez, 2003</td>
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<td>Caring</td>
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<td>Wilkin &amp; Slevin, 2004</td>
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<td>Socialisation</td>
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**Table 1.1 Previous Research in Intensive Care Nursing (cont’d).**

*Chapter 1: Introduction to the Study*
A number of the studies has identified that despite nurses frequently being ideally placed to meet the needs of patients’ families, these are not always met entirely or satisfactorily (Burr, 1996; Holden, Harrison & Johnson, 2002). Nurses acknowledge the necessity and advantages of endeavouring to meet the needs of patients’ families, helping them to cope more successfully at a difficult time, while enhancing the ideal of holistic care for the patient (Appleyard et al, 2000; Hammond, 1995). However, nursing in ICU can be an emotionally and physically demanding undertaking (Holden et al, 2002). Numerous nurses concede that meeting the needs of families who are relying on them for a great deal of support is difficult to cope with and is another stressor with which they have to deal while practising in this environment (Hupcey, 1998).

These studies began the process of building a research-based accumulation of knowledge on various problem areas that were encountered within the ICU environment. It was from this early research that areas requiring alteration to meet patient and relative needs were identified. There was however a limitation to this growing research-based knowledge. Understanding and explanation was available primarily and in greatest volume from research embracing the rigidly scientific perspective of knowledge (Denzin & Lincoln, 1994; Streubert & Carpenter, 1999). At that time understanding and explanation from the personal, subjective perspective was lacking (Denzin & Lincoln, 1994; Streubert & Carpenter, 1999). Consequently, there was the potential for the growing fund of research-based knowledge to be founded on data that was incomplete. It lacked the in-depth subjective, personal, explanatory detail related to needs, feelings, perceptions and emotions that is best gathered using qualitative methods. It was from the early 1990’s that interest in undertaking research using qualitative methods in general and specifically grounded theory
blossomed and occurred across many areas of nursing (Schreiber & Stern, 2001). It is suggested by Schreiber and Stern (2001) that in current published nursing research grounded theory is the second most popular qualitative research method undertaken.

**REASONS FOR UNDERTAKING THIS RESEARCH**

There has been a plethora of research undertaken on nursing in the intensive care environment (Lambert & Lambert, 2001; Leino-Kilpi & Suominen, 1997). Despite this growth in studies researching patients, family members and nurses’ experiences, none offer an explanation of why and how nurses choose to practise in ICU, decide to remain there and the processes and means by which they continue to do so.

Previous studies have investigated various aspects of intensive care nursing, particularly the stressors encountered and to a lesser extent the coping strategies employed. These studies have focused on one aspect of ICU nursing or another, rather than achieving a broader explanation of the entire experience.

The present study was undertaken because of the perceived lack of research into Australian ICU nurses, which satisfactorily describes and explains the journey that nurses travel when choosing to undertake a career in intensive care nursing in the contemporary healthcare system. The undertaking of this research was also influenced by the recruitment and retention problems being experienced within the contemporary Australian and international healthcare environments. It was hoped and anticipated that the findings from this study would help to shed some new light on the factors that effect recruitment and retention of experienced nurses to this speciality nursing area.
REASONS FOR USING GROUNDED THEORY IN THE STUDY

Grounded theory is an interpretative research methodology and method that is effective in exploring and revealing how people manage the problematic situations in their lives (McCallin, 2003; Schreiber & Stern 2001; Stern, 1980). Because of this, when researching why and how registered nurses choose and continue with a career in bedside nursing in intensive care, the use of grounded theory is ideal.

This methodology enables the development of substantive theory that is grounded in the research data and is context and situation dependent (Eaves, 2001; McCallin, 2003; Schreiber & Stern 2001). The theory that develops is able to describe and explain the behavioural patterns that mould the social processes used by individuals in their interactions with others (Glaser, 1998). This is because grounded theory is founded on the belief that common patterns of behaviour develop as individuals within groups define situations for themselves and others over time (McCallin, 2003; Schreiber & Stern 2001).

According to Schreiber and Stern (2001), grounded theory is well suited to nursing inquiry because it explains what is actually occurring in a situation at a certain time, not simply describing what is predicted to occur (McCallin, 2003). It is the method of choice when knowledge about how people organise their lives within the framework of nursing challenges in the contemporary healthcare system is being sought. It is an effective way of discovering the participants’ primary concern, the basic social problem, and how the participants handle these life circumstances, the basic social process (Glaser & Strauss, 1967; McCallin, 2003; Schreiber & Stern 2001). McCallin (2003) suggests there are two main advantages in using grounded theory. Firstly, as the grounded theory researcher interacts in some way in the research, this necessitates that they define their problems and
concerns within the research context (McCallin, 2003). This aids in setting parameters within which the data is analysed and enhances trustworthiness. Secondly, because grounded theory explicates actual events in real life rather than theorised predictions, it provides the researcher with another focusing mechanism when exploring practice environments and social interactions (McCallin, 2001).

**STUDY AIM**

To explore and develop an understanding of how and why experienced intensive care registered nurses commit to and continue with a career in bedside nursing in this area of practice.

**STUDY OBJECTIVES**

The objectives of this research are to:-

1. Generate a detailed description of the social processes involved in being a registered nurse in intensive care.

2. Generate a theoretical analysis of the shared meanings and behaviours of registered nurses working in intensive care.

3. Develop a substantive theory that explains the process of nursing in the intensive care environment within three units in one area health service in metropolitan New South Wales.

4. Develop explanatory proposals regarding the process of nursing in intensive care in an effort to meet nurses’ needs, make the workplace a less stressful environment and bolster nursing retention rates.

**ORGANISATION OF THE THESIS**

This thesis consists of seven chapters. Chapter One presents a brief synopsis of nursing in the intensive care environment. A review of previous research into ICU nursing is presented. The reasons for undertaking this current research and for using grounded theory are explicated. The objectives of this study are also presented.
Chapter Two includes a review of research that gained pertinence throughout the data analysis process. The role of self-esteem/self concept in the development and effective implementation of coping mechanisms is examined. The influence of the contemporary Australian healthcare system in relation to stressors, particularly nursing recruitment and retention rates, is also investigated.

Chapter Three explains the grounded theory methodology and methods used in this study. Secondly, the essential features of grounded theory and its developmental history are identified and discussed. Thirdly, the significance of constructivism and symbolic interactionism to this study and their applicability to grounded theory are explicated. Fourthly, the particular grounded theory methods used in this research are presented. These include observation, semi-structured interviews, theoretical sampling and coding procedures. Finally, issues of trustworthiness and rigour are discussed.

Chapter Four presents the substantive grounded theory. In chapters Five and Six the findings from the study are presented. These are illustrated through the use of data from interviews and observation sessions. Chapter Five presents the Basic Social Problem. Chapter Six presents the Basic Social Process.

The final chapter, Chapter Seven, discusses this study’s findings in light of previous nursing research. The limitations of this study are also identified and discussed. Finally, the implications arising from this study and the recommendations for nursing practice, education and research are outlined.
CHAPTER TWO
LITERATURE REVIEW

INTRODUCTION
This chapter explores and critically analyses the process of nursing in the intensive care environment. Stressors and coping mechanisms previously identified by nursing research within the intensive care environment are examined and analysed. The role self-concept/self-esteem plays in hindering or helping nurses to deal with ICU is examined. The influence of the contemporary Australian healthcare system in relation to stressors, particularly nursing recruitment and retention rates is also investigated. Lastly, workplace abuse, bullying and violence is explored.

This current study of nursing in intensive care seeks to understand and develop an explanatory theory of how and why experienced, intensive care registered nurses commit to and continue with a career in bedside nursing. Nurses practising in intensive care are confronted on a daily basis with complex and dynamic situations that are highly stressful and demanding. The effective management of these situations requires nurses to have developed high levels of professional knowledge, skill competence and communication abilities. Despite possessing the requisite skills and abilities, there are instances when meeting the needs of vulnerable patients, relatives and the multidisciplinary healthcare team becomes stressful, wearing and demoralising for ICU nurses. The ability to effectively manage and overcome stressful situations leads to some nurses continuing with their careers at the bedside. Discovering how nurses accomplish this and why they do so is important in the current climate of decreased nursing retention and recruitment in the Australian and international healthcare systems.
SELF ESTEEM

The concept of self-esteem alludes to an individual’s perception of their self worth and is based on life experiences and self-perception as reflected in the attitudes of others (Burnard, Hebden, & Edwards, 2001; Sasat, et al., 2002; Terry, Hogg, & White, 1999). Self-esteem has been described as the evaluation an individual makes about himself or herself, which expresses self-approval or disapproval (Randle, 2003). This evaluation consists of two component parts. Firstly, the subjective component involving self-evaluation and secondly, social construction, which is the comparative component (Reeve, 2000). Self-esteem development is a dynamic, continuing process with the product, self-esteem, being consistently reappraised and updated over time. This is consistent with the psychologist Kelly’s (1955) theory of “constructive alternativism” (p.11). Kelly’s (1955) theory is based on the belief that individuals play an active role in creating personal knowledge and understanding, whether of themselves, other persons or events. They achieve this through applying personal patterns of understanding called “constructs” (p.7) to events and situations in which they are involved. The individual’s knowledge and understanding of their reality is consistently being updated and altered by the continuing input of information over time (Kelly, 1955). An individual’s reality construction is influenced and moulded by their subjective experience and perception, self-appraisal and feedback received from significant others (Ellis, 1999; Lauder, 1996; Rawlinson, 1995).

Individuals who have a high self-esteem are able to minimise the effects of stress and anxiety (Burden et al, 2001), have self-respect, consider themselves to have worth and have pride in their achievements (Rosenberg, 1985). High self-esteem leads to nurses feeling good about themselves, being confident and taking pride in their work and all they do and continuing in the face of adversity (Anderson, 1993; Cook, 1999; Randle, 2003). A
positive self-image develops and their interactions with colleagues and patients are defined by respect and concern (Sasat, et al., 2002). Whereas, individuals with low self-esteem are highly self-critical, lack confidence and consider themselves to be less worthy, capable and competent in comparison to others (Battle, 1981; Rosenberg, 1985). It has been suggested that because self-esteem is a basic human need, the work-role of a nurse and the professional self-image that develops is an important factor in how nurses appraise their own worth (Battle, 1981; Rosenberg, 1985).

There is a body of literature that suggests that the nurse’s professional identity is integrated with their personal identity (Arthur, 1992; Boughn, 1988; Fagermoen, 1997; Horn & Holzemer, 1991; Meleis & Dagenais, 1981), with the existence of a personal identity being a precondition for the development of a professional identity (Fagermoen, 1997). Ohlen and Segesten (1998) suggest professional identity is founded on nurses’ self-esteem and is reflected in their personal and professional self-images. Fagermoen (1997) argues that professional identity develops through a process of self-formation, the fundamental elements of which include self-reflection and social interaction. According to Mead (1934) and the tenets of symbolic interactionism, self-formation is a reciprocal process that occurs in social interaction between a person and their cultural and social context. Integral to this process is the internalisation by the nurse of values and beliefs, which guide their thinking, actions and interactions with patients, relatives and other members of the healthcare team (Fagermoen, 1997).

Professional identity encompasses the nurses’ belief in their ability to practise nursing skilfully and responsibly, whilst also implying an awareness of personal limitations and resources (Ohlen & Segesten, 1998). A number of authors suggest that the perception of a
strong, positive professional identity and self-image are necessary preconditions for nurses in the development of effective therapeutic relationships with patients and relatives and their ability to perform worthwhile work, effectively managing patient needs (Arthur & Thorne, 1998; Freshwater, 1998; Ohlen & Segesten, 1998; Reeve, 2000). It is this ability to perform worthwhile work that affects the nurse’s perception of their performance, role status, personal control and productivity. According to Randle (2003), there is a well-defined relationship between nurses’ self-esteem and their ability to effectively manage patient needs and meet their responsibilities within the multidisciplinary healthcare team. If nurses’ self-esteem is low then they feel powerless, become frustrated and angry, psychologically exhausted and more likely to consider leaving the profession (Jackson, Clare, & Mannix, 2002; Randle, 2003). According to Cowin (2002), high self-esteem is critical to nurses’ perception of a positive professional identity, which in turn is related to job satisfaction, retention rates and stress levels. Cowin (2002) also suggests that nurses need to maintain a positive self-perception as an imperative to them effectively fulfilling their position of trust and responsibility within the healthcare team. High self-esteem enables nurses to develop and implement coping strategies to effectively manage the many and varied stresses encountered when nursing in the intensive care environment.

**COPING**

Nursing in the intensive care environment is a challenging, exciting, complex and demanding undertaking (Crickmore, 1987; Nay & Pearson, 2001). The work can be psychologically, emotionally, and physically exhausting. This can leave nurses feeling anxious, angry, frustrated, helpless and inadequate (Chapman, 1993; Cheng et al, 2000; Dewe, 1987; Erlen & Sereika, 1997; Goodfellow et al., 1997; Matrunola, 1996). The resultant stress that develops from these emotions can negatively affect nurses’ physical,
emotional and mental health and day-to-day functioning (Ehrenfeld & Bar-Tal, 1995). ICU nurses need to develop effective, appropriate and adequate coping abilities to manage the stress encountered in this work environment (Crickmore, 1987; Dewe, 1987; Ehrenfeld & Bar-Tal, 1995; Hutchinson, 1987). There is a significant body of knowledge on how nurses in ICU cope with stress and the behaviours they use to improve their ability to manage stress (see for example Bryant, 1994; Buxman, 2000; Crickmore, 1987; Ehrenfeld & Bar-Tal, 1995; Fletcher, 1987; Hutchinson, 1987; Ogus, 1990; Pelletier-Hibbert, 1998; White & Tonkin, 1991).

Much of the research on coping identifies broad groupings of nurses’ coping strategies without detailing to any great extent the specific strategies that fall into that grouping (Healy & McKay, 2000; Webb, 1996). Other research either identifies a range of coping strategies but fails to fully describe or explain their significance and effects (Crickmore, 1987; Ehrenfeld & Bar-Tal, 1995; White & Tonkin, 1991) or concentrates on one specific coping strategy (Buxman, 2000; Fletcher, 1987; Ogus, 1990). This researcher has only been able to locate a very small number of research studies that have identified in detail a range of specific coping strategies used by ICU nurses that are accompanied by in-depth explanations as to their significance and effects (Hutchinson, 1987; Pelletier-Hibbert, 1998).

An individual’s appraisal or perception of a problem will determine the coping strategies they will use to manage that problem (Healy & McKay, 2000). According to Lazarus and Folkman (1984) coping strategies can be delineated into “problem-focused coping” and “emotion-focused coping” (p. 179). Problem-focused coping entails efforts to alter or manage a problem and includes the pursuit of information and problem solving (Bucknall...
& Thomas, 1997; Lazarus & Folkman, 1984; Webb, 1996). Emotion-focused coping involves the regulation of a persons’ emotional reaction to a problem and includes behaviours such as seeking comfort in the company of others, looking on the bright side of things or distorting reality through a denial of the facts (Bucknall & Thomas, 1997; Payne, 1991). It has been suggested that coping is a process that enlists an individual’s cognitive appraisal of a problem and is context, situation and stressor dependent (Bucknall & Thomas, 1997; Lazarus & Folkman, 1984; Parkes, 1986; Webb 1996). Research indicates that individuals generally employ both problem-focused and emotion-focused coping strategies when managing a problem (Healy & McKay, 2000; Webb, 1996). Healy and McKay (2000) found that the most frequently used coping strategy by nurses was planned problem solving. The emotion-focused coping strategies of seeking social support and self-control were the second and third most frequently used by nurses. Buxman (2000) however, suggests no one strategy is necessarily appropriate to deal with every stressful situation that will be encountered. It is necessary for nurses in ICU, therefore, to develop a number of effective personal response behaviours to safeguard self-care (Buxman, 2000; Hutchinson, 1987).

Hutchinson’s grounded theory study (1987) identified five (5) self-care or coping strategies that nurses employed, including “acting assertively, cultivating, catharsis, withdrawing and humor” (pp193-195). Each of these strategies subsumed a number of sub-strategies. The coping strategies employed by nurses identified by Webb (1996) are “confrontive, escape-avoidance, distancing, self-controlling, seeking social support, accepting responsibility, painful problem solving, positive reappraisal and self blame” (p. 966). Pelletier-Hibbert (1998) identified six (6) major categories of coping strategies including “exercising control,
It is possible to identify aspects from the categories identified by Hutchinson (1987), Pelletier-Hibbert (1998) and Webb (1996) that could allow them to be classified as either problem-focused or emotion-focused coping. Nurses who understand and acknowledge the need to be aware of personal coping strategies and the necessity for continually refining they actively instigate critical self-analysis and evaluation of their responses to events. They do this to assess the effectiveness and appropriateness of their coping and so that they can consciously map out plans for contending with stress (Hutchinson, 1987; Pelletier-Hibbert, 1998; Webb, 1996).

**Being Assertive**

Assertive behaviour is neither aggressive nor intimidating, but is the identification by nurses of their wants and needs in a direct, forthright manner (Hutchinson, 1987; Tulloch, 1993). Use of this type of behaviour is directed toward achieving an individual’s desires. Assertive nurses have high levels of self-belief and self-esteem and are confident in their abilities to effectively manage situations (Ohlen & Segesten, 1998). This leads to personal and professional empowerment (Kilkus, 1993). Examples of acting assertively include requesting assistance or time away from the unit, delegating responsibility for a limited period of time, directing the unfolding of a situation, intervening to ensure safety, offering individuals alternatives, expressing opinions and setting limits (Hutchinson, 1987).

Pelletier-Hibbert’s (1998) category of “exercising control” (p. 232) was a form of assertive behaviour. The nurses managed their reactions to grief in the presence of the patient’s
family to decrease the family’s distress and maintain their ability to support the family.

The nurses felt that by doing this they were balancing their need to express emotion against the need of the patient’s family for support (Pelletier-Hibbert, 1998). They took the opportunity to vent their emotions at a more appropriate time. These strategies indicated that the nurses were taking control of the situation and by doing this reduced anxiety and stress (Averill, 1973). According to Hutchinson (1987), the use of assertive behaviours had positive consequences for the nurses who employed them. Even though the nurses may not have always achieved what they wanted, they were consoled by the fact that they had exercised some influence and control over events, even if this was solely taking responsibility for their own actions and reactions.

**Developing Support Networks - Cultivating**

Nurses implement ‘cultivating’ strategies to encourage the development of sharing and good will among colleagues, peers and other co-workers and patients’ families and friends (Hutchinson, 1987). This is done in an effort to encourage similar reciprocal behaviour in others, thereby developing shared social networks that give support, are a buffering system against stress, provide a stable work environment and promote work satisfaction (Donovan, 1981; Hay & Oken, 1972; Ogus, 1990). Means of cultivating social support systems include offering to assist colleagues with difficult patients, supporting colleagues in times of need, listening to and expressing interest in people, for example, wardpersons, and socialising with colleagues. The practice of nursing is undertaken as part of a team effort. Nurses are interdependent and rely on the development of supportive relationships and networks to maximise their ability to effectively manage patient needs and minimise work environment, personal and patient stress and anxiety (Crickmore, 1987). Positive relationships have been identified between social support and physical and mental health in
nurses (Constable & Russell, 1986), with lack of these supportive networks leading to increasing stress and anxiety and ultimately nurse burnout (Burke, 2003).

**Effecting Catharsis**

Catharsis is a process in which repressed emotion is freed and eliminated thereby releasing the sufferers from the effects of those emotions (Hutchinson, 1987; Tulloch, 1993). Emotional venting occurs as a means of releasing feelings that are building up and preventing the nurse from functioning effectively. According to Hutchinson (1987), following a cathartic event nurses were able to refocus on what needed to be done, as they no longer had to contend with the oppressive weight of their emotions. Cathartic behaviours used by nurses vary depending on the personality of the individual and the degree and type of stress they are under. Some of these behaviours include crying loudly or screaming, using profanity, talking things over with colleagues, supervisors, family or friends or undertaking some form of physical activity (Burnard, Edwards, Fothergill, Hannigan, & Coyle, 2000; Crickmore, 1987; Hutchinson, 1987; White & Tonkin, 1991).

Talking things over with a colleague, friend or family member allows nurses to lessen their tension levels through the process of sharing the load with someone (Burnard et al., 2000; Crickmore, 1987; Hutchinson, 1987; White & Tonkin, 1991). “Positive reappraisal”, “maintaining normality” and “seeking emotional support” are cathartic behaviour categories identified by Pelletier-Hibbert (1998, p. 233). In their search for meaning in an event nurses undertook positive reappraisal after the stressful event was over in an effort to identify what good had come out of a sad and emotionally wearing situation (Pearson, Robertson-Malt, Walsh, & Fitzgerald, 2001; Pelletier-Hibbert, 1998; Webb, 1996). This seemed to make the death of the patient more bearable and gave the nurses a measure of
“Maintaining normality” was achieved through continuing to look after the patient, though dead, by instituting basic nursing care to make them look comfortable. They did this to show respect for the patient, give comfort to the family, to care for themselves and their colleagues and to express their humanness (Pelletier-Hibbert, 1998). “Seeking emotional support” (Pelletier-Hibbert, 1998, p. 233) is a cathartic behaviour that relies on nurses having cultivated support networks among their colleagues, co-workers, family and friends. It is a process of sharing that is similar to Hutchinson’s (1987) “talking things over” (p. 195). It provides nurses with safe environments in which to share their thoughts and feelings about what has occurred and how they feel about it (Crickmore, 1987; Pelletier-Hibbert, 1998; Webb, 1996).

While cathartic behaviours are beneficial to those using them, these displays need to occur in settings where the nurses’ professionalism is not compromised and patients or their relatives are not offended, upset or caused concern about the nurses’ competence (Hutchinson, 1987; Pelletier-Hibbert, 1998; Webb, 1996). Cathartic behaviours provide necessary, though only short-term release from the extremes of stress-induced turmoil, granting nurses short respites from the necessity of maintaining a controlled professional exterior (Hutchinson, 1987).

**Withdrawing or Distancing**

Withdrawing (Hutchinson, 1987, p. 195) or “distancing”, “exercising control” and “taking time out” (Pelletier-Hibbert, 1988, p. 232) are counterbalancing behaviours that increase nurses’ emotional control over stressful situations and help to protect them from chronic emotional drain. They have also been labelled anxiety-avoidance behaviours or avoidance coping strategies by some researchers (Crickmore, 1987; Healy & McKay, 2000). These
behaviours can be physical or psychological. They include leaving the unit for a period of
time, working night shift, taking time out or seeking solitude, staying cool and calm and
compartmentalising work from home (Crickmore, 1987; Healy & McKay, 2000; Pelletier-
Hibbert, 1998; Webb, 1996; White & Tonkin, 1991). These behaviours help to create
space between nurses and the stressful situation. This provides nurses with the time
necessary for maintaining or regaining their composure so that they can meet their
responsibilities. If nurses get into the pattern of continually distancing themselves from
patients, as a form of protection from stress and painful emotions, this can effectively lead
to the masking of the real person from themselves and others (Carlisle, 1985).

Avoidance coping has been associated with increases in depressed mood and decreased job
satisfaction (Healy & McKay, 2000). Nurses do not have infinite supplies of energy,
therefore withdrawing or distancing from stressful situations to recharge energy supplies is
a necessary reality (Hutchinson, 1987). The use of these behaviours becomes
counterproductive only when they become the norm; being used by nurses to deal with
actual or anticipatory stress.

**Using Humour**

Humour is a coping mechanism that allows people to reduce stress and anxiety by venting
stress in socially acceptable ways (Buxman, 2000). It is a self-care behaviour that
facilitates the use of other coping behaviours used by nurses (Healy & McKay, 2000;
Hutchinson, 1987; Webb, 1998). Despite the usefulness of humour as a facilitator of other
coping strategies it is not necessary for their implementation. Its use depends on the
individual nurse, the personal coping strategies they have developed, their previous
experiences and the situation in which they find themselves. Humour has three main
functions in healthcare environments: psychological, social and communication, plus has a therapeutic physiological effect (Buxman, 2000).

Psychological

The greater the stress nurses are under the less creative and more easily irritated and angered they become (Buxman, 2000). Humour cultivates good feelings, lightens the mood and helps to dispel feelings of frustration, sadness, anxiety, anger or hopelessness. Through its ability to relieve stress and tension, humour serves as a cathartic. It also facilitates the maintenance of a tolerable interpersonal climate within the unit (Crickmore, 1987). This is because humour increases nurses’ flexibility of perception, feelings of control and mastery over situations, and aids the nurse in putting situations into a proper, balanced perspective (Buxman, 2000; Crickmore, 1987; Hutchinson, 1987; Pelletier-Hibbert, 1998). This behaviour also makes it possible to distance themselves momentarily from stress and unpleasant feelings, thereby gaining time to refocus and reharness energy (Hutchinson, 1987). Hay and Oken (1972) identified that ICU nurses often implemented cheerful denial as a coping mechanism. This phenomenon was a defence against the stress of situations in which the nurses found themselves.

Social

The sharing of amusement and the cultivating of pleasant feelings between people leads to an experienced commonality that creates a bond among those who have participated in the sharing experience; humour draws people together (Buxman, 2000; Crickmore, 1987; Hutchinson, 1987). There are a number of types of shared humour including self-effacing humour and insider humour (Buxman, 2000). The use of self-effacing humour opens up the user’s flaws to the inspection of the listener. According to Buxman (2000), this
exposition of personal vulnerability and flaws assists in the growth of rapport and the development of an empathetic atmosphere that assists in relationship building or enhancing (Hutchinson, 1987). Insider humour, frequently used in ICU’s, leads to people feeling part of a particular group or team through the sharing of knowledge common only to that group. This can lead to feelings of acceptance and support by the group and the growth of group cohesion (Buxman, 2000; Crickmore, 1987; Hutchinson, 1987).

**Communication**

Humour is an often-used form of communication that allows people to present concerns in a joking format (Buxman, 2000; Hutchinson, 1987). Harnessing the feel good power of humour to negate harsh feelings enables nurses to be effectively assertive when pointing out to supervisors, doctors, administrators or colleagues the absurdities of situations or their requirements (Buxman, 2000; Hutchinson, 1987). It is a means of effectively getting a message across in a relatively non-threatening way (Hutchinson, 1987). Effectively interpreting and understanding the meaning behind humour requires ICU nurses to develop skills that allow them to hear past the laughter (Buxman, 2000).

**Coping Outcomes**

When coping strategies are effective nurses achieve self-care, feeling that they have a degree of control over themselves and what they are doing (Hutchinson, 1987; Pelletier-Hibbert, 1998). Achieving effective coping is an active process that in part stems from the nurses’ belief in the necessity and advantages of personal nurturing and is enhanced by and in turn enhances the nurses’ self-esteem (Ohlen & Segesten, 1998). It also requires nurses to be vigilant and develop and continuously monitor and update self-knowledge through introspection. This constant process of assessment of both themselves and their
environment allows nurses to meet the specific parameters of different situations when they develop (Ohlen & Segesten, 1998). Effectively coping with stressors confronted in the working environment ultimately provides the nurses with a perception of control, a sense of personal power, a heightening of self-esteem. This extends not only to the individual but also to the stressful situations and relationships they encounter in their working lives (Averill, 1978; Healy & McKay, 2000; Hutchinson, 1987). Personal power such as this leads to enhanced job satisfaction, decreased turnover and increased retention (Averill, 1978; Cowin, 2002; Healy & McKay, 2000; Hutchinson, 1987).

**STRESS**

According to Myers (1998) and Farrington (1995), stress is a difficult concept to define. These authors suggest that the term “stress” is at times used to describe threats or challenges people encounter in their personal and professional lives (Farrington, 1995; Myers, 1998). At other times the same term is used to describe individual responses to threats and challenges or the process by which these individuals relate to their environment (Farrington, 1995; Myers, 1998). Conceptually therefore, stress is not solely a stimulus or a response but also includes cognitive appraisal of a situation (Farrington, 1995; Myers, 1998). It is an individual’s perception of the activating event that will determine whether or not it is threatening, challenging or harmless (Farrington, 1995; Myers, 1998). When stressors are perceived as challenges, their effects can be positive, motivating individuals to find ways of effectively managing problems (Myers, 1998). When stressors are perceived as threats, their effects can be negative, endangering status, job security and self-image (Hobfoll, 1989).
Stress becomes manifest in individuals or groups when situations are ambiguous, unclear, very complex and highly demanding in regard to competence (Stordeur, D’hoore, & Vandenberghe, 2001). Stress in ICU, whether experienced by the patient (Baker, 1984; Cornock, 1998; Fisher & Moxham, 1984; Hansell, 1984; Kiely, 1973; Odell, 2000; Puntillo, 1990), relatives (Johansson, Hildingh, & Fridlund, 2002; Turner, Tomlinson, & Harbaugh, 1990) or the nurse (Bucknall & Thomas, 1996; Cavanagh, 1988; Hague, 1987; Le Blanc, de Jonge, de Rijk, & Schaufeli, 2001; Sawatzky, 1996; Snape & Cavanagh, 1993; White & Tonkin, 1991) has received much attention in research studies. The stress endured by patients and relatives has been a focus of investigation from the early days of research into the ICU environment and has been studied in far greater depth and detail than nurse stress (Fletcher, 1987). The shift away from research emphasising patient stress to that experienced by nurses working in intensive or critical care units began in earnest from the 1970’s (Dewe, 1987; Leino-Kilpi & Suominen, 1997). This change in focus was initiated firstly by a desire on the part of researchers to study the stress of nurses working in these complex and dynamic environments (Dewe, 1987; Farrington, 1995). Another major factor that influenced the move by researchers to concentrate on nurses’ stress was the budgetary and financial constraints placed on health services by governments at the time (Dewe, 1987). These budgetary and financial constraints have continued to the present time. Many of the stressors experienced by nurses are generated by the organisations in which they are employed. Stordeur et al. (2001) confirm this when they suggest that many potential sources of nursing stress are organisational in origin and include situations that can be psychological, social or physical in nature.

The following sections explore stress and stressors that are inextricably linked to nursing in the ICU. These include role stress that is a result of the ambiguity of the nursing role, the
nursing shortage and abuse, aggression, violence and bullying in the workplace. Stressors are the pressures, problems or tensions that develop along the path of intensive care nursing, which place high demands on the physical, emotional and mental energy levels of nurses. They have the potential, if not managed effectively, to lead nurses in ICU to “losing direction” and failing to meet their responsibilities to patients, relatives, members of the healthcare team or themselves.

**Role Stress**

The notion of role stress developed from role theory, which is derived from symbolic interactionism (Longres, 2000). According to Bowers (1989), a basic assumption of symbolic interactionism is that each person comprises multiple selves. These multiple selves change over time and may exist simultaneously or consecutively (Bowers, 1989). This implies that individuals take on multiple roles in life, for example nurse, spouse, child, sibling, parent (Bowers, 1989). The role an individual undertakes at a particular time is dependent on the social situation and context in which they find themselves. Callero (1994), suggests roles may be conceptualised as both a source of sustenance and a source of strain.

Role stress is a result of incongruity between what an individual is actually achieving in the particular role they currently hold and that individual’s perception and understanding of the characteristics inherent to that role (Chang & Hancock, 2003, Lambert & Lambert, 2001). Role stress occurs when there is discord between perceived role expectations and achievement (Chang & Hancock, 2003, Lambert & Lambert, 2001). The voluminous research on this topic has indicated a number of factors that lead to the development of role stress in ICU nurses. These include environmental factors such as decreased control in
one’s job and work environment, lack of autonomy, lack of support from peers and nursing managers/supervisors, and high job demands (Chapman, 1993; Cheng et al., 2000; Dewe, 1987; Erlen & Sereika, 1997; Goodfellow et al, 1997; Matrunola, 1996; Webster & Hackett, 1999). Other identified causes of ICU nurses’ role stress include work overload, lack of essential resources, grieving and being moved from ICU to work on another ward (Dewe, 1987; Foxall, Zimmerman, Standley, & Bene, 1990; Healy & McKay, 1999; Snape & Cavanagh, 1993). Added to these already identified stressors is the continuing emergence of new technologies and the necessity to teach other staff how to use them plus increased data collection and record-keeping practices. As a result nurses have to contend with increased workloads and pressures. This has resulted in nursing being perceived as offering fewer inherent rewards, giving less satisfaction and being more stressful than previously (Chang & Hancock, 2003). This has resulted in increased staff turnover with many nurses seriously contemplating leaving nursing altogether (Buchanan & Considine, 2002). This situation has developed because many nurses feel they no longer want, or are able, to cope with the increasing demands being placed on them.

Ambiguity of the Nursing Role in ICU

There is significant literature on ambiguity in the nursing role in ICU, an area that began to attract great investigative attention during the 1970’s and 1980’s (Dewe, 1987; Leino-Kilpi & Suominen, 1997). It was from this time that massive changes to healthcare systems worldwide and to nursing itself began to occur and have continued to occur to the present day (Lambert & Lambert, 2001). Societal attitudes about nursing as a career and the role nurses played within the healthcare team began to change (Hemsley-Brown & Foskett, 1999). As these changes have occurred, the traditionally accepted parameters that have defined the role of the nurse in the healthcare team have dissipated. What has emerged is

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an ambiguity about the role of the nurse and the concept of nursing (Rushforth & Glasper, 2000).

This ambiguity continues because nursing remains a difficult concept to define and defend. This derives partly from the broad scope of contemporary nursing work environments and the marked variations that exist between settings (Jones & Cheek, 2003). The certainty that emerges from this ambiguity is that contemporary nursing is an increasingly complex, dynamic and demanding undertaking (Nay & Pearson, 2001).

Contemporary nurses need to have developed knowledge and skills that allow them to deal with the diversity that is evident in contemporary nursing workplaces and practice. The dynamic nature of the practice environment, particularly acute care environments such as ICU, necessitates that nurses are multi-skilled and highly flexible in their approach to managing situations they encounter. They need to be strategic planners, risk managers, human resource experts and operational managers, plus appreciate the complexity of the clinical area in which they practise. Nurses are expected to be leaders who encourage, coach and direct patients, relatives and other staff (Duffield, et al., 2001).

The lack of definition of nursing as a concept and the resultant ambiguity surrounding the role of nurses within the healthcare team leads to the emergence of role conflict and role stress. According to O’Driscoll and Beehr (1994), a dependably proven link exists between psychological stress/strain, job satisfaction, role ambiguity, increased nurse turnover and burnout. These findings are particularly relevant in the complex, dynamic and emotion-charged intensive care environment. This is also congruent with SCARC (2002), which has identified that the growing complexity within the nursing role and a number of other
factors are contributing to nurses feeling dissatisfied and alienated from their work. These factors include the following. Firstly, even though nurses are becoming an increasingly experienced and educated workforce, their role in healthcare does not seem to acknowledge this evolution (AUTC, 2002; SCARC, 2002). Secondly, there is a demeaning of the nurses’ role by the continued and increasing use of unqualified or semi-skilled persons to perform nursing duties. According to SCARC (2002), this lends credence to the perception that the provision of nursing care requires little if any specialist skills, knowledge or educational preparation and leads nurse to feel unappreciated and undervalued (SCARC, 2002).

In ICU the intensity of the needs of patients and their relatives are often magnified because of the number and type of stresses with which they have to deal. These stresses result from the cause and nature of the reason for admission, the modes of treatment, concern about the patient’s progress, feeling intimidated and lacking control and feeling emotionally and physically exhausted. This leads to an increased dependence and reliance on nursing staff by the patients and relatives. Nurses are the primary sources of contact for patients and relatives. Essential interactional relationships develop between the nurse and the patient, and the nurse and the relatives. They support patients and relatives physiologically, psychologically and emotionally. In addition, nurses are the information conduits to and from the rest of the multidisciplinary healthcare team (Chinn & Kramer, 1999; Duffy & Hoskins, 2003), demonstrating that they are the cement that holds the healthcare team together (Duffield, et al., 2001; Duffy & Hoskins, 2003). The expectations placed on nurses and the responsibilities they have to meet, therefore, are many and varied. The development of nurse-patient relationships and nurse-relative relationships require ‘emotional labour’ and are considerably demanding of the nurses’ time, energy and abilities.
(Phillips, 1996). The multiplicity of expectations that are directed towards nurses becomes at times stressful and emotionally, physically and psychologically exhausting (Garrett & McDaniel, 2001; Janssen, de Longe, & Bakker, 1999).

**Nursing Shortage**

Nurses are still being expected to assume an ever-increasing degree of responsibility for patient management, particularly in ICU (Sawatzky, 1996). They also continue to be faced with not just demands for technologic excellence but effective management of the impending crises of patients and relatives (ACCCN, 2001; Garrett & McDaniel, 2001; Oehler, Davidson, Starr, & Lee, 1991; Oskins, 1979; SCARC, 2002). These increased expectations placed on nurses combined with the ongoing upheavals in the healthcare system have had negative outcomes for nurses and patient care (AUTC, 2002; Chang & Hancock, 2003; SCARC, 2002). It has meant that the stress endured by nurses has increased (AUTC, 2002; Chang & Hancock, 2003; Sawatzky, 1996; SCARC, 2002).

These stressors are major factors in the development of the Australian and international nursing shortage currently being experienced (AUTC, 2002; Chang & Hancock, 2003; SCARC, 2002). The primary areas of difficulty that have led to the current shortage are twofold. These are the inability to recruit sufficient numbers of students into undergraduate nursing degree programs and the falling retention rates of nurses in the workforce beyond one to two years of practice (AUTC, 2002; Chang & Daly, 2001; SCARC, 2002). In Australia this has led to a decreased number of nurses who are available to safely meet the needs of increasing numbers of patients. This factor combined with increased levels of responsibility and the necessity for nurses to perform duties outside their speciality area
due to the reduced staffing levels leads to increased stress levels in nurses and undermines the quality of available healthcare (Chang & Hancock, 2003; SCARC, 2002).

According to the Australian Nursing Federation [ANF] (2002), these problems are compounded as there is no national level workforce planning in Australia, and as a result there are no mechanisms in place to assess future nursing labour force needs. Currently, States and Territories undertake nursing workforce planning, with decisions often occurring without reference being made to the needs and difficulties in other jurisdictions (ANF, 2002). This fragmentation and splitting of roles and responsibilities between the different tiers of government has engendered a call for the development of a national nursing management supply strategy. The aim of this strategy is to find an answer to the current shortages and maintain a satisfactory supply of nurses in the long-term (SCARC, 2002).

A great deal of research information on this topic area has been collected and disseminated (see for example, ACCCN, 2001; AUTC, 2002; Chang & Daly, 2001; SCARC, 2002). How nurses contend with the stress of their professional role within this ever-changing environment continues to be of interest to nurses, researchers, hospital and healthcare administrators and governments (Lambert & Lambert, 2001). This is particularly relevant today as nurses, researchers and administrators look for ways of solving the current nursing shortage and preventing its reoccurrence.

**Abuse, Aggression, Bullying and Violence in the Workplace**

Violence in the workplace and in societies generally is increasing in nature and frequency (Jackson et al., 2002; O’Connell et al., 2000; Rippon, 2000; Wells & Bowers, 2002). This has become a significant problem internationally for the healthcare professions, particularly
nurses (Jackson et al., 2002; Lipscomb & Love, 1992; Rippon, 2000). This is because nurses are more at risk of workplace assault than other health professionals as they are regularly involved in dealing with both the victims and perpetrators of violence (Carter, 2000). In Australia the five sites where aggressive acts towards nurses most commonly occurred were reported as medical wards, surgical wards, accident and emergency departments, geriatric wards and intensive care units (O’Connell et al., 2000). Acts of violence and threats of violence are major stressors for nurses with the suggestion that work-place aggression is seen as the facet of nursing work that provokes the highest levels of anxiety in many nurses (Farrell, 1999; Leppanen & Olkinuora, 1987; O’Connell et al., 2000). The perpetrators of the violence against nurses are numerous, including patients, relatives, other visitors, intruders, co-workers and managers/supervisors (Nabb, 2000; O’Connell et al., 2000; Rippon, 2000). The forms of the abuse and violence include physical aggression and assault, verbal abuse, rudeness, humiliation, sexual harassment and bullying (Carter, 2000; Farrell, 1999; Kinross, 1992; Lanza, 1996; O’Connell et al., 2000; Whitehorn & Nowland, 1997). The aggression and violence encountered by nurses and the resultant anxiety and stress they endure may have a direct causal link to poor nursing recruitment and retention rates (Jackson et al., 2002). This is confirmed in one Australian study by a higher than normal resignation rate in victims of bullying (Workplace Bullying Project, 1997). Other consequences of workplace aggression and violence include increasing numbers of nurses suffering from anxiety, decreased work performance (Robbins, Bender, & Finnis, 1997), sleep disorders (Fisher, et al., 1995) and the effects of post-traumatic stress disorder (Whittington & Wilkes, 1989).

The nature of violence in the workplace is not limited to the overtness of verbal abuse, sexual harassment or physical assault, but can take the form of bullying and intimidation

Chapter 2: Literature Review
A number of studies have identified poor collegial relationships leading to intrastaff aggression and bullying as being highly anxiety producing and a prominent source of dissatisfaction for nurses (Cox, 1987; Farrell, 1999; McMillan, 1995; Taylor, White, & Muncer, 1999). The after-effects of these acts include anger, hurt, fear, anxiety, loss of self-esteem and self-confidence, demoralisation, feelings of vulnerability, a negative attitude to the work environment and higher staff turnover (Fisher, et al., 1995; Nabb, 2000; O’Connell et al., 2000).

The most common perpetrators of bullying are nurses to other nurses (McMillan, 1995). Nurses have identified nurse-managers as the consistent originators of acts of bullying, intimidation and violence (Farrell, 1999; McMillan, 1995; O’Connell et al., 2000). Dealing with these forms of aggression has been reported by nurses as being more anxiety producing and stressful than being confronted by aggression from staff in other disciplines or the assault threats posed by patients (Farrell, 1999; 2000). Furthermore McDaniel and Strumpf (1993) have identified that the development of constructive, supportive work cultures, built on the basis of the development of good collegial relationships leads to increased employee morale and retention and decreased patient mortality.

This culture of violence affecting the nursing work environment means that many nurses perceive the workplace as dangerous. This leads to concerns for personal safety and rising levels of stress and anxiety, which can exacerbate other work stressors (Jackson et al, 2002). In general, nurses feel that there is insufficient appropriate support from management for staff in relation to workplace violence. According to Farrell (2001), management response to incidents of overt acts of patient aggression reported by staff is lacking in promptness and support. This apparent lack of concern by management for staff
safety leads to rising staff stress, anxiety, anger, demoralisation, job dissatisfaction and turnover.

**Conclusion**

The aim of this chapter was to review and critically analyse the literature pertaining to the human and practice context factors that positively and negatively influence ICU nurses’ choosing to remain at the bedside in this area of nursing practice. From this it is evident that nurses practising in this environment require a sufficiently high self-esteem in order to counteract the stress and anxieties encountered and maintain confidence in their ability to be effective. Secondly, the importance of developing and implementing coping strategies to ensure continuation at the bedside was explored. The significance of the relationship between how effectively ICU nurses manage the stress and anxieties encountered, their levels of self-esteem and ability to meet their responsibilities was made apparent. Thirdly, the various causes of stress within the ICU environment and their negative consequential effects on the nurses’ ability to practise effectively were analysed. It was apparent that a lack of effective management of these stressors would lead to the nurses becoming disillusioned and demoralised, and questioning their ability to confidently and competently do their job.

The current study was undertaken in an effort to discover why and how experienced, intensive care nurses commit to and continue with a career in bedside nursing in this area of practice. This was motivated by the perceived lack of research into Australian ICU nurses, which satisfactorily describes and explains the journey that nurses travel when choosing to undertake a career in intensive care nursing in the contemporary healthcare system.

Previous research into intensive care nursing has investigated various aspects of practice in
this specialty, particularly the stressors encountered and to a lesser extent the coping strategies employed. These studies have focused on one aspect of ICU nursing or another, rather than achieving a broader explanation of the entire experience. This present study attempts to provide one such explanation of the experience of nursing in the practice environment of intensive care.

The following chapter, chapter 3; Research Methodology and Method, will explore and explain the theoretical framework on which this research was based.
INTRODUCTION

The purpose of this study was to understand how and why experienced, intensive care registered nurses commit to and continue with a career in bedside nursing in this area of practice. This was accomplished by meeting the following objectives. Firstly, generating detailed descriptions of the social processes involved in being a registered nurse in intensive care. Secondly, generating a theoretical analysis of the shared meanings and behaviours of registered nurses working in this environment. Thirdly, developing a substantive theory that explains the process of nursing in the intensive care environment within three units in one area health service in metropolitan New South Wales. Lastly, developing explanatory proposals regarding the process of nursing in intensive care in an effort to meet nurses’ needs, make the workplace a less stressful environment and bolster nursing retention rates.

In this chapter both the methodology and the methods selected for conducting this study are presented. Methodology encompasses the philosophical principles, the building blocks from which the method, the techniques used to uncover the grounded theory is developed (Appleton & King, 1997; Polit & Hungler, 1999). Grounded theory, how it developed, its foundational underpinnings, and those aspects that make it unique are presented. Discussion of the methods will then follow and this will encompass research design, data collection and analysis, issues of trustworthiness and rigour and finally, ethical considerations.
METHODOLOGY

Inquiry in the Qualitative Paradigm

The processes and systems for the development of knowledge and understanding about the nature of truth and reality have historically traversed many periods of thought and reasoning. From these developmental phases have emerged numerous schools of thought on this topic. Each school of thought can be seen to display distinctively different characteristics in philosophical position and purpose (Meleis, 1997; Reed, 1995). These distinctive periods of thought began with premodern thought, which was dominated by reasoning influenced by metaphysics and religion (Reed, 1995). This approach to reasoning about reality and truth altered over time as thinkers and philosophers began to divide the paths to truth into component parts “that separated philosophic ‘beliefs’ from empiric ‘knowing’ ” (Reed, 1995, p.71). Modernity or modernism began during the eighteenth century in western societies, and developed through a process of social upheaval. The upheaval resulted in the growth of rationalist thought (Edwards, 2002; Giddens, 1987). Modernism, which became known as empiricism or the positivist paradigm, postulated that there was one, overall meaning and explanation of reality. From this perspective a single explanation of reality could be demonstrated through the development of comprehensive theories (grand narratives) (Agger, 1991), which were based on “essential truths” (Reed, 1995, p. 71) or “true knowledge” (Mitchell, 1996, p. 202). This was because modernist philosophy proposed that people are reducible, measurable objects who are not shaped or influenced by cultural, social and historical contexts (Edwards, 2002). Empiricism accepts that essential truths emerge from patterns identified in data generated from methods based on scientific experimental principles (Meleis, 1997; Mitchell, 1996; Reed, 1995).
Scientific principles value skepticism, doubt, objectivity and detachment, are based on rigorous data collection, analysis and interpretation and should be reproducible and generalisable (Edwards, 2002; Stajuhar, Balneaves & Thorne, 2001). Modernism was seen as promoting order and control and the advancement of human thought. It was accepted that this would lead to enhanced levels of social understanding, moral progression, justice and human happiness (Edwards, 2002). The positivist paradigm defined that real knowledge of a particular situation can only be gained from valid and reliable scientific knowledge that has been subjected to rigorous empirical testing. According to Reed and Procter (1993), knowledge development based on positivist principles was and continues to often be valued as superior and of higher academic status than knowledge developed from other philosophical perspectives. Despite the high value placed on knowledge based on positivist principles a number of philosophers began to question the fullness of its explanatory power and its appropriateness to all situations. There was a developing realisation that rationality, technology and modernism were not able to provide all the answers to questions regarding reality, human experience and truth (Edwards, 2002; Kuhn, 1962). This led to a new search for understanding about truth and reality. It was from this new search that postmodern philosophical thought began to emerge (Stajuhar et al, 2001).

Postmodern thought emerged first through the work of the pragmatists in the 1930’s. The influence of this approach on reasoning about truth and reality did not really take on substance until after World War II, and was strongly influenced by the work of French literary theorists such as Derrida and Foucault in the 1960’s (Cheek, 2000; Meleis, 1997; Mitchell, 1996; Reed, 1995). Postmodernism challenges the modernist view of only one explanation of reality. Postmodernism is based on the belief that reality is made up of a
multiplicity of voices, views and meanings and that each representation of such will be
time and context dependent (Agger, 1991; Cheek, 2000; Reed, 1995).

The development of qualitative inquiry can be seen as a reaction against or as a counter to
positivism and is founded on the basic set of beliefs espoused by postmodernism (Edwards,
2002). Qualitative inquiry involves understanding and explaining phenomena from a more
personal, subjective, emic (insider), viewpoint rather than from the detached, etic
(outsider), impersonal, and rigidly scientific perspective of positivist thought (Benoliel,
1984; Denzin & Lincoln, 1994; Streubert & Carpenter, 1999). There are two primary
principles that underpin the qualitative philosophical perspective on truth and reality.
Firstly, that understanding human beings and their “social worlds” (Benoliel, 1984, p. 3) is
not achievable without acknowledging that human beings create these worlds, or their
understanding of the world they inhabit. Secondly, that “shared meanings and negotiation”
(Benoliel, 1984, p. 3) provide the fuel for the ongoing processes of social existence.
Qualitative inquiry aims to discover the experience of the situation from the informant’s
point of view, finding answers to questions that revolve around social experience, how it is
created and how this gives meaning to human life (Denzin & Lincoln, 1994).
Consequently this implies that rather than there being only a single overall meaning and
explanation of reality, as postulated by the positivist paradigm, there is a multiplicity of
explanations of reality. Qualitative inquiry acknowledges and values the existence of these
different explanations of reality and is actively seeking them out. This is in an effort to
build greater more comprehensive knowledge and understanding of the processes of social
existence.
Each of the previously identified research paradigms or basic sets of belief encompasses different values and principles regarding the development of knowledge and understanding of reality (Guba & Lincoln, 1994; Meleis, 1997). They provide for the user definition and representation of the nature of their world, their place within that world, their potential relationships to that world and its myriad parts (Guba & Lincoln, 1994). The basic sets of belief answer such philosophical questions as “what is the form and nature of reality?” (Guba & Lincoln, 1994, p. 108), “what is the relationship between the …would be knower and what can be known?” (Guba & Lincoln, 1994, p. 108), and “what strategies need to be used to discover what there is to be known?” (Guba & Lincoln, 1994, p. 108). The choice by an individual researcher to work within a particular paradigm is underpinned, influenced and moulded by the background and values of that individual, and the values espoused within the paradigm itself (Glen, 1999; Prior, 1998). According to Glen (1999) and Woodd (1997), values encompass ideas, beliefs and criteria/standards that act as a guide and give direction to the choice of what is worthwhile in an individual’s life. Lincoln and Guba (2000) believe that these values influence the choices made by a researcher throughout the process of inquiry. These choices include the research problem, paradigm, theoretical framework, data collection and analysis (Lincoln & Guba, 2000, p.169). These personal values and beliefs have led this researcher to the philosophical stance of constructivism.

**Constructivism**

Constructivism had its beginnings in the work of psychologist George Kelly (1955). Kelly (1955) developed personal construct theory based on the philosophical position of “constructive alternativism” (p.11). He believed that each individual takes an active part in creating personal knowledge and understanding, applying “constructs” (Kelly, 1955, p.7),
which are personal patterns of understanding. The individual’s knowledge and understanding of reality is continually being updated and altered by the continuing input of information over time (Kelly, 1955). This continuing input of information occurs through self-appraisal and from feedback the individual receives from significant others. There are many different ways therefore for any person or situation to be construed, as each individual’s reality is influenced and shaped by their subjective experience and perception (Ellis, 1999; Lauder, 1996; Rawlinson, 1995). This implies that each individual is a scientist, an explorer of knowledge who is continually developing and reappraising his or her own idiosyncratic pathway to knowledge and understanding of reality (Averill, 1973; Kelly, 1955). This would seem to be the basis on which Guba and Lincoln (1994) describe the ontological position of the constructivist paradigm as being “relativist” (p.110).

Therefore, realities are understandable “…in the form of multiple, intangible mental constructions” (Guba & Lincoln, 1994, p.110). The shape and substance of these intangible mental constructions is reliant on the values, principles and experiences of the individuals or groups who hold those constructions (Guba & Lincoln, 1994). This means that each individual’s perception or construction of reality is different because of their differing personal experiences, values and principles.

By taking the ontological position of individually constructed experiences, the epistemological stance consistent with this requires the researcher to undertake an interactive relationship with the participant (Appleton & King, 1997; Guba & Lincoln, 1994; Lincoln & Guba, 2000). Guba and Lincoln (1994) describe this relationship as having a “…subjectivist” approach (p.111). Constructivist researchers believe that to gain knowledge of the “multiple views of reality that may exist” (Appleton & King, 1997, p.14), there must be interaction between the participants and researcher. The application of
interpretation techniques, which aid in the understanding of the significance of human action and interactions assist the researcher in locating the basic meanings of the personal constructions which emerge from the data (Appleton & King, 1997; Charmaz, 2000; Guba & Lincoln, 1994; Lincoln & Guba, 2000; Streubert & Carpenter, 1999).

**Constructivism and Grounded Theory**

According to several authors (see for example Annells, 1997 & Charmaz, 2000) it is both appropriate and necessary to modify and adapt grounded theory methodology. This is to allow grounded theorists the flexibility to operate effectively in the current environment of inquiry diversity and meet the challenges posed by postmodernism (Annells, 1997; Charmaz, 2000; MacDonald & Schreiber, 2001). Whether this involves implementing Glaser and Strauss’s (1967) classic mode grounded theory within a constructivist paradigm, Strauss and Corbin’s (1990) mode within a positivist paradigm, or a combination of procedural aspects of both modes within any paradigm of the researcher’s choice (Annells, 1997; Charmaz, 2000). This flexibility with grounded theory offers methods for the application of qualitative research in the new millennium (Charmaz, 2000; MacDonald & Schreiber, 2001).

Constructivist grounded theory, which was used in this study, acknowledges the relativist multiplicity of the social realities of the participants and the researcher (Charmaz, 2000; Guba & Lincoln, 1994). It also gives credence to the co-creation of knowledge by these persons, with the goal being interpretation of the data to gain a fuller comprehension of participants’ meanings (Charmaz, 2000) and development of a substantive theory. A substantive theory is one that “evolves from the study of a phenomenon situated in one particular situational context” (Strauss & Corbin, 1990, p. 174), or “substantive area”
(Strauss & Corbin, 1998, p. 23). Charmaz (2000) and MacDonald and Schreiber (2001) suggest that the application of grounded theory within a constructivist framework upholds the undertaking of research within natural settings, while encouraging the researcher to focus on discovering the meaning of the social processes that are identified from the data. This is seen as enhancing the “interpretative understanding” (Charmaz, 2000, p. 510) that can come from the data rather than limiting it. In this study, procedural aspects of Strauss and Corbin’s grounded theory and classic mode grounded theory were blended within a constructivist paradigm. This mode was selected as it took into account the researcher’s personal philosophical perspective in relation to inquiry, the intended product of the study and the theoretical underpinning appropriate to the method (Annells, 1997; MacDonald & Schreiber, 2001).

**Symbolic Interactionism**

Symbolic interactionism represents not only a theory of human behaviour but also an approach to studying the lives and conduct, actions and interactions of humans within societal groups (Annells, 1996; Benzies & Allen, 2001; Blumer, 1969; Bowers, 1989). According to Denzin (1992) symbolic interactionism is a study of the intersecting of interaction, personal experience and social structure in a particular moment in time.

According to Blumer (1969), there are three basic premises that underpin symbolic interactionism. Firstly, people act and react to things based on the meanings these things have for them (Blumer, 1969). Secondly, it is from the social interaction between individuals that the meaning of things is formed (Blumer, 1969). Finally, an individual, through an interpretative process that is constantly changing, is continually reassigning and modifying the meaning of things encountered (Blumer, 1969). An important principle of
symbolic interactionism is the inseparability of the individual and the context in which that individual exists (Benzies & Allen, 2001; Blumer, 1969; Bowers, 1989; Crooks, 2001). Truth is therefore provisional. This is because meaning is dependent upon the individual and the context, and changes for the individual as the context changes (Benzies & Allen, 2001; Blumer, 1969; Bowers, 1989; Crooks, 2001).

Symbolic interactionists emphasise that individuals and groups are active participants in creating meaning within situations. This is because people, individually and within groups, construct their realities from the symbols around them through interaction (Bowers, 1989; Cutcliffe, 2000). These symbols include verbal and nonverbal gestures, clothing and artifacts (Bowers, 1989; Cutcliffe, 2000). Symbolic interactionism merely attempts to understand the symbolic meanings of things.

**Symbolic Interactionism and Grounded Theory**

Grounded theory was developed for the purpose of studying social phenomena from the perspective of symbolic interactionism (Bowers, 1989; Crooks, 2001; Cutcliffe, 2000; Eaves, 2001; Glaser & Strauss, 1967; Goulding, 1998; Smith & Biley, 1997). Strauss trained with Blumer at the University of Chicago and brought to the development of grounded theory “field research and symbolic interactionism” (Charmaz, 2000, p. 512). Strauss’s contribution to grounded theory was further influenced by the “pragmatist philosophical study of process, action, and meaning” (Charmaz, 2000, p. 512). Glaser’s contribution to grounded theory was a rigorous methodological training at Columbia University, where he was “strongly influenced by Lazarsfeld, Hyman, Barton, McPhee and Bereldson” (Glaser, 1992, p. 16-17) which fostered his views on systematic approaches to data analysis. He was also influenced by “Merton, Zetterberg, Lipset and Gouldner”
(Glaser, 1992, p. 17), in relation to the generation of inductive theory from both qualitative and quantitative data (Glaser, 1992). Glaser (1992) also shared with Strauss a belief in the “active role of persons in shaping the worlds they live in through the processes of symbolic interaction” (p. 16).

Glaser and Strauss (1967) state that their aim in developing grounded theory in the first place was to identify “how the discovery of theory from data – systematically analysed in social research – can be furthered” (Glaser & Strauss, 1967, p. 1). Social research looks at people, their interactions and systems of behaviour (Wilkes & Krebs, 1984). According to Strauss and Corbin (1994), grounded theory provides both description and explanation of the system of behaviour being studied. This explanation is situation and context dependent and subject to change over time. Description and explanation of social behavioural systems develops from understanding how a group of people defines their reality. This is achieved through the discovery of the social patterns and “social psychological processes” in the interactions of the group (Eaves, 2001, p. 655). Because of the historical links of Strauss with symbolic interactionism, the stated agreement of Glaser with Strauss’s belief in symbolic interactionism and the identified aims of grounded theory, it is possible to see the linkages between grounded theory and symbolic interactionism.

Finally, Charmaz (2000) believes that symbolic interactionism offers the grounded theory researcher an abundance of “sensitizing concepts” (p. 513), for use throughout the data collection, analysis and theory development phases. According to Charmaz (2000), if there are “emphases on action and process … meaning and emergence” (Charmaz, 2000, p. 513) then it is possible from a constructivist stance to see symbolic interactionism as complementing grounded theory.
Symbolic Interactionism, Constructivism and Contemporary Grounded Theory

MacDonald and Schreiber (2001) suggest that the central principle of the intellectual terrain of postmodernism postulates that there are no “basic givens” (p. 39) or firm base to any system of beliefs or philosophical principles. These authors also suggest that from the postmodernist perspective any belief or ideology presented as truth is open to challenge (MacDonald & Schreiber, 2001). This is especially true of any theory or grand narrative that suggests universal explanations (Agger, 1991; Mitchell, 1996). Postmodernism has been criticised for this “outright rejection of authority in all forms” (MacDonald & Schreiber, 2001, p. 39) and its willingness to embrace a relativist worldview. According to Norris (1990) the postmodernist rejection of the authority of established ideologies is a form of destruction for its own sake. This author also suggests that postmodernism fails to provide anything to take the place of the discredited philosophies and theories that were previously purported as the truth (Norris, 1990). In doing so it is suggested that people are left in a quandary about how to make judgments and construct meaning without the safety of interpretative indicators in their world (MacDonald & Schreiber, 2001). To counter this argument Lyotard (1984) suggests that despite a lack of interpretative indicators or universal explanations (Agger, 1991; MacDonald & Schreiber, 2001; Mitchell, 1996) it continues to be possible for people to make critical distinctions, gain a balanced viewpoint and construct meaning. This is achievable, according to Lyotard (1984), through the consideration of the situation, context and time specifics in which human action and interaction occurs. This way of constructing meaning recognises and gives credence to human differences. The celebration of difference is particularly relevant to postmodern philosophy (MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001). This is because postmodernists and constructivists acknowledge that truth, that reality is constructed and reconstructed individually and collectively and is multiple and shifting (MacDonald & Schreiber, 2001).
Schreiber, 2001; Milliken & Schreiber, 2001). A feature of the postmodern culture, the constructivist culture is the retaking and reworking of older forms in the light of contemporary situations and contexts (MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001). Hence postmodernism advocates a new understanding of what constitutes authenticity, as everything is viewed as equally authentic, whether it is a reproduction or the original production (MacDonald & Schreiber, 2001). This is because creation and recreation are dynamic, continuing and indistinguishable processes as individuals construct their social realities (Anderson, 1990).

Symbolic interactionism, a theoretical perspective rooted in pragmatist philosophy, is a central tenet of grounded theory (Blumer, 1969; Glaser & Strauss, 1967; Kendall, 1999; Milliken & Schreiber, 2001). Grounded theory is primarily concerned with the relationship between individuals and society (Milliken & Schreiber, 2001). Its main aim is developing understanding and knowledge of how individuals construct and reconstruct their lives in light of their experiences and the meanings they assign to these (MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001). A fundamental assumption of grounded theory is that people need to create personal order and meaning in the universe, making sense of the world and interacting with it in personally meaningful ways. The grounded theory researcher looks for and endeavours to explicate, elucidate and reconstruct from the data the order inherent within those interaction processes (Bowers, 1989; Charmaz, 2000; Glaser & Strauss, 1967; Milliken & Schreiber, 2001). The reconstruction of that order by the grounded theorist is vital to the data analysis process when implementing any constructivist or interpretivist methodology, and in postmodern terms is an authentic construction (Charmaz, 2000; Crooks, 2001; MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001). The researcher, therefore, in part “fashions” the results. Grounded
theory researchers accept responsibility for the constructions they make from the data, and do not claim that they are anything other than their interpretation of that data (Strauss & Corbin, 1994). However, the application of the pragmatic criteria of “fit, work and grab” (Glaser, 1978, pp 4-5) ensures that the emergent substantive theory is in accord with the experiences and understandings of the participants. The application of these pragmatic criteria stems directly from grounded theory’s philosophical foundations, symbolic interactionism and pragmatism (Crooks, 2001; MacDonald & Schreiber, 2001).

Constructivism, symbolic interactionism and grounded theory share many ideas that are congruent (Bowers, 1989; Crooks, 2001; MacDonald & Schreiber, 2001). Firstly, they share recognition that people construct and reconstruct personal truth as they live their lives, rather than truth being discovered (Glaser & Strauss, 1967; Guba & Lincoln, 1989; Kelly, 1955; Lauder, 1996; MacDonald & Schreiber, 2001). Secondly, symbolic interactionists and constructivists share belief in the openness of the future that is undetermined, unpredictable and yet to be constructed (Crooks, 2001; Kelly, 1955; MacDonald & Schreiber, 2001; Strauss, 1993). Thirdly, both constructivism and grounded theory espouse the concept of human action and reality being dependent on situation, context and the individual, and being modifiable over time (Bowers, 1989; Kelly, 1955; Lyotard, 1984; MacDonald & Schreiber, 2001). Fourthly, constructivism, symbolic interactionism and grounded theory hold consistent views relating to the continual creation of the self in union with others (Anderson, 1995; Bowers, 1989; Blumer, 1969; Kelly, 1955). Fifthly, to both constructivists and grounded theorists the authenticity of a construction or reconstruction stems from its basis in the experiences of an individual and its meaning to that person (Ellis, 1999; MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001). Hence each grounded theory is meaningful, that is, authentic, in the
context of the specific situation under study and has the potential to continue to evolve over time. According to MacDonald and Schreiber (2001), therefore, as long as each version of the grounded theory fulfils the criteria of fit, work and grab, they are equally authentic. Consequently, it is possible to view grounded theory as postmodern (Annells, 1996; Charmaz, 2000; MacDonald & Schreiber, 2001; Stajduhar et al, 2001). Finally, grounded theorists and constructivists believe that it is impossible to abstract a person from the historical, intellectual, cultural, political and socio-economic contexts in which they act and interact (MacDonald & Schreiber, 2001; Stajduhar et al, 2001). They believe that studying human beings in their cultural and social contexts is the best way of gaining knowledge and understanding (Glaser & Strauss, 1967; Kvale, 1995; MacDonald & Schreiber, 2001; Miller, 1997).

This present study was based on the philosophical perspective that emerges from the congruence of beliefs between symbolic interactionism, grounded theory and constructivism. The following section will firstly define grounded theory and discuss theoretically the component parts of a grounded theory study. Following this, an explanation of what occurred in this present study will be given.

**RESEARCH METHOD**

**Grounded Theory – Definition**

A “grounded” theory is one that is inductively derived from the study of a phenomenon within a substantive area, employing rigorous systematic, concurrent data collection and analysis procedures of constant comparison (Eaves, 2001; Glaser, 1992; Strauss, 1987; Strauss & Corbin, 1990, 1994). Grounded theory is an exploratory method of research (Eaves, 2001; Glaser & Strauss, 1967; Goulding, 1998; Heath & Cowley, 2004; McCallin,
This research method does not start out from the circumstance of predefined concepts or an existing theory, but as the researcher gathers, codes and analyses data the concepts and properties or characteristics emerge (Backman & Kyngas, 1999; Glaser & Strauss, 1967; Heath & Cowley, 2004; McCallin, 2003). Grounded theory is often alluded to as the constant comparative method because at each tier of theory development coded data are constantly compared with other data and concepts (Cutcliffe, 2000; Eaves, 2001; Heath & Cowley, 2004; McCallin, 2003; Schreiber, 2001). At every analytical juncture the researcher generates “hypotheses” or intuitive leaps about possible relationships between and among categories that are then tested against the data (Glaser & Strauss, 1967; Heath & Cowley, 2004; Schreiber, 2001; Strauss & Corbin, 1998). The emerging conceptualisations that result from testing these intuitive leaps continue to be compared against the data until core categories become apparent and an explanatory theory of participants behaviour is put forward (Eaves, 2001; Heath & Cowley, 2004; Schreiber, 2001).

Glaser and Strauss (1967) initially defined their concept of a grounded theory as being able to “fit” (p.3) what is being researched, that is, account for all data, codes and categories (Crooks, 2001; Schreiber, 2001). Categories should be indicated by and recognisably applicable to the data being studied. The theory must “work” (Glaser & Strauss, 1967, p.3), it must be able to clearly explain what occurs and predict what could happen (Crooks, 2001; Schreiber, 2001). Grounded theory is parsimonious, but at the same time broad in scope and is modifiable as new data are found (Backman & Kyngas, 1999; Crooks, 2001; Glaser & Strauss, 1967; Heath & Cowley, 2004; Schreiber, 2001).
Grounded theory was developed as a means of enabling the systematic discovery of theory, which “respects and reveals the perspectives of the participants” (Glaser, 1992, p. 17), from the data of social research (Eaves, 2001; Glaser and Strauss, 1967; McCallin, 2003). To ensure that the participant’s perspectives are respected and revealed, both Glaser and Strauss share the need to “stick to the data”, and “be in the field” (Glaser, 1992, p. 17). Grounded theory methods enable the researcher to view participants as full members of the worlds in which they live. Secondly, it allows the researcher to understand the lives, activities and experiences of the participants from their personal perspectives. Finally, it enables the researcher to conceptualise the behaviour of participants as authentic and meaningful and as a direct expression of their views (Crooks, 2001; MacDonald & Schreiber, 2001). Grounded theory method is ideal for the exploration of the unique worldviews and social relationships of participants (Crooks, 2001; Stern, 1980).

Grounded theory method comprises a number of fundamental elements. These are theoretical sampling, constant comparative data collection and analysis, literature review, application of theoretical sensitivity, and theoretical saturation (Annells, 1997; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). These elements will now be discussed.

**Literature Review**

Glaser and Strauss (1967) originally recommended that grounded theory researchers omit the usual, traditional literature review in favour of investigation of the concerning phenomenon and suspend or disregard any prior knowledge held about the area being researched. This was to ensure that the researcher’s efforts to generate concepts from the data were not contaminated, stifled or constrained by preconceived ideas, which may have
hindered the emerging theory truly being grounded in the data (Cutcliffe, 2000; Glaser, 1992; Smith & Biley, 1997; Stern, 1980). Glaser and Strauss’ (1967) original stance on this issue has been modified slightly to account for the assumption that no researcher is capable of approaching a study in a state of complete lack of knowledge, experience, ideas or presuppositions (Backman & Kyngas, 1999; Glaser, 1978, 1998; Heath & Cowley, 2004; McCallin, 2003; Schreiber, 2001; Strauss & Corbin, 1998).

It is impossible and unfeasible to expect researchers to enter a field of study completely devoid of the influence of previous reading and experience (Heath & Cowley, 2004; McCallin, 2003; Schreiber, 2001). According to Glaser (1978, 1998) and Strauss and Corbin (1998) there are methodological reasons for undertaking a review of the literature. Firstly, reading related and unrelated technical and popular literature effectively expands the researcher’s ideas about the phenomena under study aiding in the development of theoretical sensitivity (Glaser, 1998; McCallin, 2003; Schreiber, 2001; Strauss & Corbin, 1998). Secondly, the researcher can clarify many of their existing conceptualisations, ideas and understanding of the phenomenon being researched by subjecting them to ongoing comparison with data (Glaser, 1998; McCallin, 2003; Schreiber, 2001; Strauss & Corbin, 1998). The salient point is that reading literature has a place in contemporary grounded theory research because everything is data and contributes another perspective to the understanding of observed social processes (Backman & Kyngas, 1999; Glaser, 1998; Heath & Cowley, 2004; McCallin, 2003; Schreiber, 2001). Previous knowledge can be integrated into a study using constant comparative analysis to refine emerging concepts and categories (Backman & Kyngas, 1999; McCallin, 2003; Schreiber, 2001).
Despite what has been stated in the previous paragraphs both Glaser and Strauss continue to differ widely in the role they see for the literature within a grounded theory study and when literature should be used (Heath & Cowley, 2004). The focus of both researchers’ ideas is discovery; the researcher enters the field of study open to discerning new meaning and through the ongoing process of data collection and analysis a core problem emerges that accounts for and integrates the majority of concepts (Backman & Kyngas, 1999; Heath & Cowley, 2004; McCallin, 2003). Glaser (1978) continues to iterate that a researcher’s prior understanding should be centred on the general problem area rather than the specific problem under investigation (Charmaz, 1994). Researchers should read broadly to increase their receptivity to a wide range of possibilities in the data; to enhance theoretical sensitivity (Glaser, 1978). More focused reading should only be undertaken when the emergent theory is at a stage of sufficient development where the literature can be used as extra data (Glaser, 1978; Heath & Cowley, 2004). Whereas for Strauss (1987) the use of the literature and the researcher’s previous knowledge and experience are influential early in the process. Strauss (1987) iterates that widespread understandings develop sensitivity or receptivity, with specific understandings gained from the literature and past experience being used to rouse and enhance theoretical sensitivity and generate hypotheses (Backman & Kyngas, 1999). No matter which perspective is selected by the researcher, the important issue is to be open and ready to identify and acknowledge that the data may be presenting issues that differ from existing knowledge (Becker, 1993; McCallin, 2003).

**Theoretical Sensitivity**

Theoretical sensitivity refers to insight, a quality the grounded theory researcher develops through immersion in the data (Strauss & Corbin, 1990, 1998). This insight facilitates the researcher’s ability to recognise what is important in the data, helping to formulate theory.
that remains true to the reality of the sensory facts under study (Glaser, 1978). It is the researcher’s ability to think inductively, moving from specific data to the general or abstract in order to assemble theory from the observation of particulars (Heath & Cowley, 2004; Schreiber, 2001). In being theoretically sensitive a researcher has to be able to apply creativity and imagination in testing against data a range of possible explanations of what the data say (Heath & Cowley, 2004; Schreiber, 2001; Strauss & Corbin, 1998). The researcher can be said, in part, to shape the data through their interpretations, and in turn is shaped by the data with validation occurring through use of constant comparison (Heath & Cowley, 2004; Schreiber, 2001; Strauss & Corbin, 1998).

Theoretical sensitivity is a means by which the researcher can guard against potential biases that can threaten the rigour of a study. Firstly, it aids in restraining potential bias from the researcher’s previous experience and knowledge. Secondly, it decreases the likelihood of bringing the study into disrepute through the premature ending of analysis in favour of the researcher’s preconceived notions (Glaser, 1978; Heath & Cowley, 2004; Schreiber, 2001; Strauss & Corbin, 1990, 1998). Cultivation of theoretical sensitivity necessitates that the researcher is continuously reflective, challenging personal theories and biases against data. Enhancement of theoretical sensitivity can be achieved through the researcher acknowledging and investigating all possible explanations for what is observable in the data (Heath & Cowley, 2004; Schreiber, 2001; Strauss & Corbin, 1998). This is particularly important with what appears to be data that invalidate or challenge emerging hypotheses (Glaser, 1992; Goulding, 1998; Heath & Cowley, 2004; Schreiber, 2001).

Memoing, writing out one’s preconceived ideas and theories and putting them aside for later comparison against the data, is one technique the researcher can implement to promote
theoretical sensitivity (Backman & Kyngas, 1999; Charmaz, 1994; Cutcliffe, 2000; Heath & Cowley, 2004). Another strategy helpful in promoting theoretical sensitivity is testing how the theory does or does not fit together through discussing with others the emerging theory, the categories and their characteristics (Glaser, 1978; Schreiber, 2001). This exercise assists in ensuring the analysis stays grounded in the data as it helps the researcher to maintain perspective and not get lost in the analytical processes (Backman & Kyngas, 1999; Schreiber, 2001). The ongoing challenge for the researcher is remaining open to the theories in the data without getting lost in the process of theorising or detoured by minor details in the data (Backman & Kyngas, 1999; McCallin, 2003; Schreiber, 2001).

**Theoretical Sampling**

This form of sampling is most frequently used in grounded theory research and involves simultaneous collecting, coding and analysing of data to generate theory (Backman & Kyngas, 1999; Glaser, 1978; Goulding, 1998; Schreiber, 2001; Smith & Biley, 1997). Grounded theorists are not concerned with how representative their sample is in relation to total population, but are seeking instead rich sources of data. Participants are chosen because of their expert knowledge of the phenomenon being investigated, rather than on the basis of their representativeness (Reed, Proctor, & Murray, 1996; Smith & Biley, 1997). Prior to the collection and analysis of data there are no emerging hypotheses/theories to guide sampling, therefore, the sampling process is initiated by the researcher interviewing significant individuals, who have broad knowledge and experience of the area under study (Backman & Kyngas, 1999; Coyne, 1997; Cutcliffe, 2000). These individuals are chosen as they are relevant sources of data, and this relevance is determined by what is necessary to generate and delimit the theoretical codes. The grounded theory researcher initially enters into a process of purposeful sampling, which is gradually
replaced by theoretical sampling once the data/hypotheses identify the direction in which future sampling will follow (Backman & Kyngas, 1999; Coyne, 1997; Cutcliffe, 2000).

Theoretical sampling provides flexibility in the research process as it is guided by the concepts that emerge during data analysis (Strauss & Corbin, 1990), and is founded on the notion of comparison making (Schreiber, 2001; Strauss & Corbin, 1998). The purpose of making comparisons achieves two things. Firstly, it directs the researcher to those persons, occurrences or areas that will offer the best opportunities for the discovery of variations, (the properties and dimensions or characteristics) among the concepts. Secondly, making comparisons aids in developing a degree of compactness among emerging categories in relation to their characteristics and scope (Strauss & Corbin, 1998).

The discovery of variations in data challenges the researcher to advance explanations for these variations and unite them at a higher level of abstraction into a theory. Theoretical sampling enables the grounded theorist to investigate the variations and develop explanatory hypotheses. This process of sampling continues as categories emerge. The researcher targets particular groups or subgroups, firstly to test and refine emerging categories and later to expand, develop and saturate these categories (Goulding, 1998; Schreiber, 2001; Smith & Biley, 1997). Categories are saturated when new data does not reveal any new concepts that could be incorporated into the theory (Cutcliffe, 2000).

**Analysis of Data**

**Constant Comparative Data Analysis**

This is a repetitive, data centered process conducted throughout the course of grounded theory research. Its aim is to ensure the researcher remains open and sensitive to the participant’s interpretations and meanings of the situation under study, within their social world and context (Heath & Cowley, 2004). This leads to the emergence of a theory, which contains and explains the greatest variation in behaviour as is possible, that is, it has “parsimony, scope and modifiability” (Heath & Cowley, 2004, p.146). This process ensures that the theory is a true representation of the data (Glaser & Strauss, 1967; Sheldon, 1998; Smith & Biley, 1997; Strauss & Corbin, 1994). Similarities and differences of incidents can be identified through the application of this method, eventually leading to the defining of the basic characteristics of a category (Glaser, 1978; Munhall, 2001; Strauss & Corbin, 1998). The identification of differences between incidents allows boundaries to be established with the relationships between categories becoming clearer throughout the process of constant comparison (Glaser, 1978; Munhall, 2001).

Originally, Glaser and Strauss (1967) emphasised that ideas generated during the ongoing reflection and analysis of coding, category generation and memo writing were subject to further comparisons, verification and description. Deduction and verification occurred to service emergence and theory generation (Glaser, 1999) with induction being the pivotal process (Glaser, 1978, 1992). Verification by all data of ideas generated was essential, necessitating the continuous refitting of categories to accommodate (Glaser, 1978; Heath and Cowley, 2004). Glaser has stayed faithful to this pledge whereas Strauss, in early works with Corbin (1990, 1994) appears to have moved away from this original stance, though later work (Strauss & Corbin, 1998) evidences a revision of these ideas (Heath & Cowley, 2004).
Deduction and verification dominate Strauss and Corbin’s (1990, 1994) early approach to analysis, as they allege that the importance of induction was exaggerated in the original development of grounded theory (Heath & Cowley, 2004). This emphasis on deduction has been evaluated by a number of experts (for example Charmaz, 1994; Glaser, 1992; Heath & Cowley, 2004; Robrecht, 1995) as taking the researcher away from the data rather than enhancing their sensitivity and openness to what the data are saying. In Strauss & Corbin’s (1998) later work induction through continual data comparisons is more prominent, though they continue to iterate not overstressing its role (Heath & Cowley, 2004). In this later work Strauss and Corbin (1998) describe the ensuring of emergence through deduction followed by validation and inductive data elaboration. Strauss and Corbin (1998) suggest that shaping of the data occurs through researcher interpretations, guaranteeing more than mere analytical description, with validation protecting against misrepresentation (Heath & Cowley, 2004).

Coding

The process of conceptual coding enables the researcher to transform raw data into theory (Backman & Kyngas, 1999; Schreiber, 2001). Through coding data and the comparison of codes with the data, categories are identified and their characteristics or properties emerge (Heath & Cowley, 2004; Schreiber, 2001). In the original grounded theory text, Glaser and Strauss (1967) discussed two tiers of coding, substantive and theoretical. Strauss and Corbin (1990) developed three coding tiers rather than two, namely open, axial and selective. Neither Strauss nor Glaser, in any joint or separate publications, has indicated that the stages of coding are linear or separate in their application (Heath & Cowley, 2004; Schreiber, 2001). The procedural descriptions of what occurs in Glaser’s (1978) substantive coding and Strauss & Corbin’s (1990) open coding are similar, differing only
in the emphasis given to emergence (Cutcliffe, 2000). This difference is highly significant in relation to safeguarding both the relevance and elegance of the theory (Heath & Cowley, 2004). According to Heath and Cowley (2004) the coding procedures advocated by Strauss and Corbin (1990) veer away from emergence and increasingly force the researcher towards a “positivistic linearity” (p. 146) through use of a paradigm model (Cutcliffe, 2000). Their later work (Strauss & Corbin, 1998) indicates a modified stance in relation to coding and theory construction. Consequently the dominance of the paradigm model’s role has declined significantly, not dictating coding frameworks or the form of the final theory (Heath & Cowley, 2004). Glaser’s (1978) coding procedures begin with multiple, data relevant coding in which comparison and emergence are repetitive themes, necessitating the continual fit and refit of codes and concepts in relation to category development (Heath & Cowley, 2004). Glaser also encourages the grounded theorist to develop flexible coding frameworks that enhance sensitivity and will make plain the relationship subtleties within the data (Glaser, 1978; Heath & Cowley, 2004). This flexibility and freedom to follow the data permits theory discovery instead of theory construction centred on a pre-established framework (Heath & Cowley, 2004; Schreiber, 2001).

First level or substantive coding incorporates two phases. In the first phase small portions of data are conceptualised at a time, using the participant’s words to produce in vivo codes as frequently as possible (Heath & Cowley, 2004; Schreiber, 2001; Stern 1980). Codes multiply rapidly at this stage, with the researcher searching for and identifying similarities and differences by comparing incident to incident (Schreiber, 2001). New codes are only generated and added to the code list when the data presents new uncoded information (Schreiber, 2001).
The second phase of substantive coding, second level coding, is continuous with the first but is a step up in abstraction (Heath & Cowley, 2004; Schreiber, 2001). In this phase the researcher examines and collapses codes into higher-level relational concepts or categories (Glaser & Strauss, 1967; Heath & Cowley, 2004; Smith & Biley, 1997; Streubert & Carpenter, 1999). Second level coding commences when similarities in the concepts in first level coding are identified and requires the comparison of first level codes with existing and new data. This leads to the identification of categories that are in turn compared with the data and codes and refitted as necessary to accommodate the new information (Glaser & Strauss, 1967; Heath & Cowley, 2004; Schreiber, 2001; Smith & Biley, 1997). The researcher is repetitively going from specific incident to abstraction and back to detect similarities and differences, the aim of which is to generate the emergence of categories and their characteristics that “fit the data, work, and are relevant for integrating into theory” (Glaser, 1978, p. 56).

Theoretical or third level coding commences when many of the first level codes have been fruitfully collapsed into categories, with the focus now being on examining the relationships between and among categories (Cutcliffe, 2000; Schreiber, 2001; Smith & Biley, 1997). According to Glaser (1978), it is theoretical coding, the conceptualisation of how substantive codes potentially interrelate as hypotheses, that facilitates their theoretical integration. Theoretical coding nominates previously unidentified or unarticulated connections in the data. It has the capacity to enable a rich and full cognisance of the social processes and interactions being studied, enhancing explanatory theory development (Cutcliffe, 2000; Smith & Biley, 1997).
Memoing

Memoing is the continual process by the researcher of making notes to themselves throughout the data collection, coding and analysis process (Backman & Kyngas, 1999; Schreiber, 2001; Smith & Biley, 1997). It serves a number of purposes for the grounded theory researcher. Firstly, to make clear the researcher’s pre-existing assumptions thereby opening them up for examination. Secondly, to record ideas, questions and thoughts generated at the various stages of data collection and analysis. Thirdly, to analyse and postulate about the data, which may encompass new codes and categories, relationships between categories or with existing theoretical models, analytical schemes or hunches and abstractions. Lastly, to record methodological decisions made about the management of the research and to act as an audit trail of the researcher’s decision-making process (Backman & Kyngas, 1999; Glaser, 1978; Glaser & Strauss, 1967; Milliken & Schreiber, 2001; Schreiber, 2001; Smith & Biley, 1997; Streubert & Carpenter, 1999). Memoing can take two forms, written memos and diagramming.

Written memos

According to Schreiber (2001), memoing commences in the planning stages of the study and continues until the study is concluded. Constant memoing throughout the study allows ideas to be recollected later during analysis and to expand data with analytical ideas. This aids in the development and integration of category characteristics and the generation of hypotheses and theory (Backman & Kyngas, 1999; Baker, Wuest, & Stern, 1992; Charmaz, 1994; Milliken & Schreiber, 2001; Schreiber, 2001). Memos may suggest areas for data collection, links between and among categories, or a diagram that may effectively visually portray the emerging theory (Schreiber, 2001; Strauss & Corbin, 1990, 1998). Memos are emergent and evolving, they therefore need to be dated, titled and cross-referenced so that
they can be easily retrieved when needed (Charmaz, 1994; Glaser, 1967; Strauss & Corbin, 1990, 1998).

**Diagramming**

The process of diagramming is an effective visual tool that assists the researcher to ruminate on and comprehend the linkages between and among emerging categories (Schreiber, 2001; Strauss & Corbin, 1990, 1998). Diagrams are the graphic representations of abstract thinking about data, portraying the relationships between concepts (Strauss & Corbin, 1990, 1998). According to Strauss and Corbin (1990) diagrams like written memos increase in conceptual “complexity, density, clarity and accuracy” (p. 198) as the data collection, coding and analysis process progresses. Undertaking the drawing and re-drawing of diagrams gives the grounded theorist the opportunity to step back and gain an overall visual conceptualisation of the full theory (Schreiber, 2001). This can then be “validated” against the data.

**Core Category**

Glaser (1978) indicates that the purpose of grounded theory is to develop from the data a beginning or substantive theory, which can account for “a pattern of behaviour which is relevant and problematic for those involved” (p. 93). The grounded theorist achieves this by generating a theory around a core category that emerges from the data (Glaser 1978; Schreiber, 2001). The core category is the main concern or central phenomenon for the participants, encasing the essential features of a consistently repetitive, recurring pattern of behaviour seen in the data and summing up what is happening (Glaser, 1978; Glaser & Strauss, 1967; Schreiber, 2001; Smith & Biley, 1997). Core categories emerge from the constant comparison of categories, are broad in scope, subsuming and interrelating
concepts and hypotheses and accounting for the majority of variation found in behaviour patterns (Glaser & Strauss, 1967; Smith & Biley, 1997; Streubert & Carpenter, 1999).

Core or central categories exhibit several properties. Firstly, they can be any type of theoretical code including a process, condition or consequence. Secondly, these categories have to have significant explanatory power or “grab” (Glaser, 1978, p. 96). They have so much explanatory power that the researcher needs to guard against superimposing them onto data they do not fit (Glaser, 1978; Schreiber, 2001). Thirdly, it must have “carry through” (Glaser, 1978, p. 96). This means that use of the core category, because of its relevance and explanatory power, enables the grounded theorist to carry through the analysis and not get led into dead ends (Glaser, 1978; Schreiber, 2001). Fourthly, it is completely variable. It is readily variable and modifiable through its central, frequent, dependent relations with other categories (Glaser, 1978). As conditions vary in these other categories the core category easily modifies to accommodate these changes, while maintaining its explanatory power and analytical carry through. Finally, because of its grounding in the data the core category does not develop from logico-deductive elaboration or from already known concepts of sociological interest. Though on occasion what emerges from the data exhibits similarities to a concept or concepts that have previously been identified (Glaser, 1978; Kearney, 2001; Morse, 2001; Schreiber, 2001)

**Basic Social Process**

A Basic Social Process (BSP) is a particular type of core category (Glaser, 1978). The distinction between BSP’s and other core categories is that a BSP is processural in nature. It has more than one state of being (Schreiber, 2001), that is, it has at minimum “two or more clear emergent stages” (Glaser, 1978, p. 97). These emergent stages should be able to discriminate between and provide an explanation for variations in the pattern of
behaviour that is of interest. Other core categories can use all other theoretical codes but do not have stages.

BSP’s display a number of defining properties other than emergent stages. These include pervasiveness, full variability and change over time (Glaser, 1978). BSP’s theoretically reflect and summarise patterns of social behaviour that people go through (Glaser, 1978). They display durability and stability over time, achieving this through “accounting for change over time” (Glaser, 1978, p. 101), with a high degree of “ease of meaning, fit and workability” (p. 101). BSP’s are usually labelled with a gerund (an “ing” word), which embraces the sense of change over time plus embodying the participant’s actions (Glaser, 1978, 1996; Schreiber, 2001). Analysis of social behaviour from the viewpoint of an emergent BSP enables the grounded theorist to develop a new and greater comprehension and appreciation of the phenomenon being studied (Morse, 2001; Schreiber, 2001).

**Theoretical Saturation**

According to Strauss and Corbin (1990, 1998), theoretical saturation or redundancy is the state that is reached when the categories and theory are thoroughly explained with no new information about the core processes emerging from continuing data collection. According to these authors theoretical saturation ensures that each category is “well developed in terms of its properties and dimensions demonstrating variations” (Strauss & Corbin, 1990, p. 212) and there are “well established” (p. 212) relationships between each category. It is at this point that the collection of additional data ceases. Finally, theoretical saturation of all categories ensures that the emergent theory is conceptually dense, richly explanatory and evenly developed (Glaser, 1978; Strauss & Corbin, 1990, 1998).
Criteria for Evaluating Qualitative Research - Trustworthiness and Rigour

The issues of trustworthiness and rigour in qualitative research have been, and remain, a concern for those researchers employing these methods (Davies & Dodd, 2002; Hall & Callery, 2001; Koch & Harrington, 1998). Streubert and Carpenter (1999) suggest “rigor [sic] in qualitative research is demonstrated through the researcher’s attention to and confirmation of information discovery”, the goal of which is to “accurately represent study participants’ experiences” (p. 28). According to Graneheim and Lundman (2004) the trustworthiness of every qualitative research study needs to be evaluated in relation to the procedures implemented to generate the findings.

The concepts used to describe trustworthiness and rigour in the qualitative and quantitative research traditions differ (Graneheim & Lundman, 2004). These differences stem from the philosophically different sets of belief that underpin these research traditions’ ontological and epistemological positions. The quantitative research tradition employs standardised evaluation criteria for trustworthiness and rigour of validity, reliability and generalisability (Graneheim & Lundman, 2004; Koch & Harrington, 1998). According to Davies and Dodd (2002) if rigour is only comprehensible in terms of a “structured, measurable, … neutral approach” (p. 280) then research methods that sanction and encourage the incorporation of subjectivity, flexibility and values will continue to be assessed as “sloppy” (p. 280) and lacking in credibility.

Lincoln and Guba (1985) were among the leaders in challenging the appropriateness of the application of quantitative research’s standardised evaluation criteria to qualitative research studies. These authors argue for credibility, transferability, dependability and confirmability to establish trustworthiness in a constructivist paradigm (Guba & Lincoln,
Sandelowski (1986) and Beck (1993) advocate credibility, fittingness and auditability. Lomborg and Kirkvold (2003) suggest a reinterpretation of the concepts of fit, work, relevance and modifiability in specific relation to grounded theory. The concepts fit, work, relevance and modifiability are closely internally related with fit forming the basis for the other three (Lomborg & Kirkvold, 2003). These sets of terms, despite the different labels, are looking for similar if not the same characteristics from the research. Credibility or fit and work relate to processes that will enhance the likelihood that the findings produced will be credible. That is confidence in how vivid and faithful is their representation of the phenomenon of interest and how effectively data and the analytical processes address the intended focus (Chiovitti & Piran, 2003; Graneheim & Lundman, 2004; Koch & Harrington, 1998). Credibility, fit or work is demonstrated when participants and readers of the research who have had similar experiences recognise the described experiences as similar to their own (Chiovitti & Piran, 2003; Lomborg & Kirkvold, 2003). There are a number of elements necessary to ensure qualitative research credibility. Firstly, choose participants with different experiences to enhance the likelihood of gathering information from a variety of aspects (Graneheim & Lundman, 2004). Secondly, decide on the most appropriate method for data collection and the amount of data to be collected. Thirdly, select the most meaningfully descriptive category labels throughout the analytical abstraction phase (Chiovitti & Piran, 2003; Graneheim & Lundman, 2004). Fourthly, ensure that no relevant data have been inadvertently left out or irrelevant data retained in the final write up of the research. Lastly, show representative quotations from the text so that assessment of category similarities and differences can be made (Chiovitti & Piran, 2003; Graneheim & Lundman, 2004).
Dependability is met through ensuring the credibility and relevance of findings (Lomborg & Kirkvold, 2003; Streubert & Carpenter, 1999). This aspect of trustworthiness looks for ways of taking into account the extent to which data alter over time and the changes the researcher’s decision-making process undergoes throughout every stage of the research process (Chiovitti & Piran, 2003; Graneheim & Lundman, 2004; Koch & Harrington, 1998). There is a close link between the term dependability described by Graneheim and Lundman (2004) and auditability described by Chiovitti and Piran (2003) and Koch and Harrington (1998). Auditability alludes to the original researcher providing sufficient evidence of their thinking and decision-making processes throughout data analysis that another researcher is able to follow the methods used and the conclusions reached (Beck, 1993; Burns & Grove, 2001; Chiovitti & Piran, 2003). Implementation of the following strategies ensures the dependability or auditability of qualitative research findings. These strategies should specify the criteria that guided the researcher’s thinking (Chiovitti & Piran, 2003). This is achievable through the keeping of written or diagrammatic records, which detail and justify what occurred at each step of the research process (Burns & Grove, 2001; Mateo & Kirchhoff, 1999). These records should include firstly, description of the data collection process (Burns & Grove, 2001; Chiovitti & Piran, 2003; Mateo & Kirchhoff, 1999). Secondly, there needs to be explicit identification of decision rules, which guided the researcher’s arrival at judgements, for example how and why study participants were selected (Burns & Grove, 2001; Chiovitti & Piran, 2003; Mateo & Kirchhoff, 1999). Thirdly, the nature of decisions and the data and reasoning on which these decisions were based needs to be recorded, for example the relationships between codes in categories (Chiovitti & Piran, 2003; Mateo & Kirchhoff, 1999). Lastly, the presentation of evidence justifying the conclusions reached is required (Chiovitti & Piran, 2003; Mateo & Kirchhoff, 1999). The identification and delineation of these criteria enable
researchers to audit their approach throughout the research process and also provides an “audit trail” (Chiovitti & Piran, 2003, p. 432) or “decision trail” (Burns & Grove, 2001, p. 677) for other researchers to follow.

Transferability, also known as fittingness or modifiability, looks to the probability or extent that findings from a research study will have meaning to other similar situations, settings or groups (Chiovitti & Piran, 2003; Graneheim & Lundman, 2004; Koch & Harrington, 1998; Streubert & Carpenter, 1999). Graneheim and Lundman (2004) suggest that to promote transferability it is useful for the researcher to instigate a number of strategies. Firstly, delineate the parameters of the research, describing in detail the culture and context in which the research took place, the selection criteria and participant characteristics, means of data collection and the analysis processes used (Chiovitti & Piran, 2003; Graneheim & Lundman, 2004). The provision to research readers of the demographic characteristics of participants and setting attributes aids in their better visualising the context from which the grounded theory and its categories emerged (Chiovitti & Piran, 2003). Secondly, delineate the level of the emergent theory, whether substantive or formal; this enhances the readers’ ability to assess fittingness or transferability (Chiovitti & Piran, 2003). Thirdly, describe the literature that was pertinent to the emergence of each category in the theory (Chiovitti & Piran, 2003). According to Graneheim and Lundman (2004), the instigation of these strategies facilitates the transferability of the emergent theory.

According to Koch and Harrington (1998), confirmability occurs when issues pertaining to credibility, transferability and dependability have been addressed successfully. Confirmability requires an audit trail (Lincoln & Guba, 1985) or auditability, which allows another individual to follow the researcher’s thought processes and decisions that lead to

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the conclusions reached (Chiovitti & Piran, 2003). This then requires the original researcher to ensure that all evidence and thought avenues, which have led to conclusions, are clearly illustrated throughout the various stages of data collection and analysis. Guba and Lincoln (1994) believe that these techniques are the most appropriate to judging the goodness or quality of research in the constructivist paradigm.

Koch and Harrington (1998) add another level to the debate suggesting that legitimisation of a research study is dependent upon explication of the paradigm within which the study was conducted and the usefulness of the research product. They suggest that it is necessary to incorporate “reflexivity” into research (Koch & Harrington, 1998, p. 887). Reflexivity ensures measures within the research process signal to readers what is going on; that from within the research product itself evaluation criteria for that research can be generated. This can be achieved through detailed and contextual writing and a reflexive recounting of the research process used. Koch and Harrington (1998) claim that these measures increase the ease with which readers of the research will be able to traverse the “worlds of the participants ...and researchers” (p. 887). The readers are then more readily able to decide for themselves if the text produced is “believable or plausible” (Koch & Harrington, 1998, p. 887). Believable and plausible are terms that Koch and Harrington use to indicate rigour.

**METHOD DESIGN – Description of the Study**

The following section will identify and explain the processes of grounded theory method that were applied in the present study.
Literature Review

Before data collection commenced I undertook a preliminary literature review to assist in identifying the current gaps in knowledge in the area of interest. This also assisted in the development of a rationale for the current research being proposed. As the analysis process progressed the literature was consulted more frequently and in a more focused manner. The information gained from the literature was used as another perspective on the basic social processes being studied. Through the implementation of constant comparative analysis the data from the literature helped to refine and enrich emerging concepts and categories. This data also offered insights into areas where further theoretical sampling was undertaken, which lead to data collection that enhanced the explanatory capacity of the emergent theory. Literature review data also assisted in refining relationships between and among the emerging concepts and categories.

Setting

This study was conducted in three Intensive Care Units (ICU’s) across an Area Health Service in New South Wales, Australia. Two of the units (A and B) were established ten to fifteen years after the third unit (C). Unit A was divided into three physically separate intensive care units, ICU 1, ICU 2 and ICU 3, which were connected by a single uniting corridor. ICU 1 and 3 received general intensive care patients, and ICU 2 was specifically dedicated to cardio-thoracic patients. Unit A had a combined occupancy capacity of up to thirty patients. Unit B was a combined general intensive care, high dependency unit with ten beds allocated to general intensive care patients and five to high dependency patients. Unit C was a combined ICU, Coronary Care (CCU) and high dependency unit. The total number of beds available in unit C was ten.
Sample

Participants in the research (n = 10), were all experienced registered nurses currently working in one of the ICU’s, on either a permanent full-time or part-time basis. The participant selection criterion was limited to one aspect; each participant was required to be a registered nurse who had been working in an ICU for at least three years. According to Benner (2001), Benner and Tanner (1987) and Benner, Tanner, and Chesla (1992), three years’ ICU experience was identified as being the stage at which these nurses would have had sufficient time and experience within this environment to have developed personal and professional strategies to cope with what was asked of them. The nurses would also have been capable of viewing their actions in terms of long-range goals or plans (Benner, 2001). The situations these nurses would encounter within this working environment would, after this length of exposure, not be new to them. They would have the ability and confidence to apply abstract and analytic thinking processes to patient care situations, which were encountered (Benner, 2001; Benner et al., 1992).

<table>
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<th>Participants</th>
<th>Gender</th>
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<th>Years of ICU experience</th>
<th>Position held in ICU</th>
<th>Basic Nursing Qualification Degree/Dip/Cert</th>
<th>Undertaken/ing ICU Qualification</th>
<th>Undertaken/ing post graduate university degree</th>
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Table 3.1 Participant Demographic Data
Participant Recruitment

Following ethics approval from the Area Health Service, and with the agreement of the various Chief Executive Officers, Directors of Nursing and Nursing Unit Managers, a time was organised by the researcher to speak with the nursing staff in the respective units about participation in this study. At these information sessions I provided those attending with “An Invitation to Participate” (see Appendix A) and “Participant Information Sheet” (see Appendix B), which outlined the aims of the study. The nurses were also informed that participation was entirely voluntary and should a participating nurse wish, they could withdraw at any time, with total confidentiality and anonymity assured.

The purpose of the study was outlined and what their commitment would entail, if they decided to participate the research. The notion of informed consent was maintained as during the briefing sessions I outlined to the nurses what would be expected of anyone who agreed to participate. They were informed about the data collection procedures, the observation sessions and semi-structured interviews and of the approximate amounts of time these would take. I explained to the nurses that while I was observing them in their work environment I would be making notations of what I was observing. The necessity for tape recording interviews was also discussed. The nurses were assured that to maintain confidentiality any notes or tape recordings would be codified and only I would be privy to the identity of the participant from whom the data came. I also informed them that some participants could be asked for further inputs of time for second and possibly third data gathering sessions. These would most likely be interviews rather than observation sessions and would possibly be briefer than the first interviews. A total of 10 registered nurses agreed to participate. They were asked to sign a consent form (see Appendix C).
Data Collection

For the purposes of this thesis, data collection methods will be discussed first, followed by data analysis techniques. Two data collection methods were employed in this study, namely observation and semi-structured interviews.

Observation

Grounded theory requires research in the field, in the participants’ natural setting, to be undertaken, if, as Glaser (1992) states, “one wants to understand what is going on” (p. 15). Observation is seen as an ideal method to achieve this end (Streubert & Carpenter, 1999), though not all researchers undertaking grounded theory research employ this strategy in the gathering of data. According to Mulhall (2003) and Turncock and Gibson (2001), an unstructured or open approach to observational data collection is implemented to interpret and understand social and cultural behaviour. This form of data collection is based within the constructivist paradigm, which recognises the importance of context and the co-construction of knowledge between the researcher and study participants (Mulhall, 2003).

In this study each participant was observed on two separate occasions for two to four hours at a time. The length of each observation session was dependent upon the situation in each unit at the time of observation. The observation sessions were carried out for seven of the participants during day shifts. Two of the participants each had one observation session during a day shift, with the second session occurring when they were rostered on evening shifts. One of the participants only worked night shift, hence their observation sessions occurred during this shift.
The literature (Adler & Adler, 1994; Gold, 1958; Mulhall, 2003; Streubert & Carpenter, 1999; Turncock & Gibson, 2001) identifies four modes of participant observation. The mode or modes chosen by the researcher must be consistent with the aims and objectives of the research being undertaken. A researcher may find that it is necessary to use a number of the modes, depending on the circumstances that present throughout the data gathering process (Mulhall, 2003; Streubert & Carpenter, 1999; Turncock & Gibson, 2001). The modes are as follows, firstly the “complete observer”, secondly, the “observer as participant”, thirdly, the “participant as observer” and lastly, the “complete participant” (Mulhall, 2003; Streubert & Carpenter, 1999, p. 25-26). In the first mode, the researcher and participants have no interaction (Adler & Adler, 1994; Gold, 1958; Mulhall, 2003; Turncock & Gibson, 2001). The predominant researcher activity in the second mode is observation, with minimal interaction (Adler & Adler, 1994; Gold, 1958; Mulhall, 2003; Turncock & Gibson, 2001). In mode three, the researcher is most interested in becoming part of the group, whilst continuing to gather data (Adler & Adler, 1994; Gold, 1958; Mulhall, 2003; Turncock & Gibson, 2001). Mode four participant observation requires the researcher to conceal their purpose from the participants, with complete participation in the life of the group (Adler & Adler, 1994; Gold, 1958; Mulhall, 2003; Turncock & Gibson, 2001). In modes three and four there is the possibility that the researcher could “go native”, and become too involved with the group being studied and lose sight of their primary purpose for being there (Gold, 1958; Streubert & Carpenter, 1999).

In this study I was an “observer as participant”, that is, mode two. I only had brief interactions with the participants, mainly observing them as they worked. In two of the units, it would have been very easy to fall into mode three, as I knew many of the registered nurses on staff from previous long-term association. In some instances, it was difficult
achieving the level of detachment, from the participants or the setting that Bogdan and Biklen (1992), Gold (1958) and others suggest is necessary. It was too easy to fall into the embrace of sociability and familiarity. I had to keep reminding myself, that even though I was comfortable in the ICU environment and with the people, I was there to observe as unobtrusively as possible. I attempted to distance myself from participation by employing a number of strategies. I would seat myself in an out of the way corner and virtually fade into the scenery, during the observation sessions. This must have been successful, as on a number of occasions, the nurses I was observing forgot I was there. I ensured that there was a degree of formality attached to my interactions and conversations with participants and others, whilst I was observing. This created a non-threatening but tangible sense of what was, and was not acceptable, in relation to interaction, between myself and research participants and others within the ICU environment.

Despite these strategies there were times when my participation levels increased. Because staff in the units knew I was intensive care trained, and many of them had previously been my students, I was at times asked to keep an eye on a patient for a short time while they went to get something or do some job away from the bedside. This was difficult to refuse, as the nurses were very busy and short staffed. There were times when other staff members, who knew I was a lecturer, would use me as a reference source to clarify how to reference various forms of literature or to help them begin a literature search on a particular topic. There were even a few times when all staff were engaged elsewhere that I answered the phone in the unit. These situations were difficult to avoid. Refusal to assist could have had a negative effect on rapport, alienating staff and potentially affecting ease of future access to the area.
Fieldnotes

Ensuring the successful outcome of an observation exercise relies on taking and maintaining extensive, detailed and accurate field-notes. Field-notes provide a written record of what the researcher has seen, heard, experienced and thought whilst in the process of collecting and reflecting on the data, in a qualitative study (Bogdan & Biklen, 1992; Mulhall, 2003). “The production of field-notes is the observer’s raison d’être: if you do not record what happens you might as well not be in the setting” (Fielding, 1993, p. 161).

Field-notes were recorded at my observation point during all observational sessions. Each notebook contained the field-notes for two participants, one being recorded at the front of the notebook and the other recorded from the back of the notebook. The notes were written in the presence of the participant, at the time they occurred. The field-notes were transcribed verbatim and written up following each observation session. None of the participants asked to see the notes I had written during their observation sessions, though I would have happily obliged if they had. Some of the nurses who were not involved in the study asked me who I was, what I was doing and why during these sessions. I replied to these queries with brief but polite responses. I told these nurses what and who I was observing and why and let them know I had some ICU experience and knowledge. My responses seemed to satisfy their curiosity and in general I was accorded the status of non-threatening, knowledgeable, quasi-insider.

The observation sessions allowed me to view the nurses as they practised. From the data collected at these sessions, many inferences were made concerning nursing behaviours. The observation sessions added depth and breadth to the interviews, and assisted in guiding the researcher in finding the answers to contextual questions, that would not have
presented themselves if interviews alone had been used for data gathering (Morse & Field, 1996).

Semi-Structured Interviews

The qualitative research interview is a “construction site of knowledge” (Kvale, 1996). This purposeful conversation or interchange of views is employed to gather rich, descriptive data in the participants’ own words (Hewitt-Taylor, 2002). This is to facilitate the researcher developing insights into how the participants interpret some piece of the world (Kvale, 1996). Qualitative interviews vary in the degree to which they are structured. At one end of the structured/unstructured continuum there is the rigidly structured interview, where the participant has difficulty telling their story. At the other end of the continuum there is the open-ended interview, where the participant is encouraged to talk in the area of interest, with the researcher picking up on issues initiated by the participant, and probing further (Morse & Field, 1996). With the semi-structured interview format, the researcher is confident of gaining comparable data across participants. There is a degree of standardisation provided by the broad, topic driven interview schedule. Delivery flexibility ensures the participant is able to tell their story in their own words and time (Bogdan & Biklen, 1992).

In this study, semi-structured interviewing took place. I always began and ended each interview by thanking the participant for their time and re-assuring them that what was said in each session was confidential and would remain so. I would then start the tape recorder and note the date, time and with whom the recording was being made. I went into each session with a set of general areas of questioning, which had been enhanced by analysis of the data collected at observation sessions. These included, for example, “tell me why you
choose to work in ICU?”, “what do you like/dislike about working in ICU?”, “how do you deal with working in ICU?”. The participants did not display any difficulty talking about their feelings, perceptions and experiences once they were reassured that there was no set, expected way for them to respond; they were free to respond as they wished. They were frank and open with their responses and gave generously of their time. During many of the interviews I found it necessary to probe for clarification of what the participant was saying, or to get them to expand on a point they had alluded to. This probing was guided by analysis of data gathered at observation sessions and previous interviews. None of the participants ever voiced or indicated at any time that they were uncomfortable or unhappy with the topics under discussion or the depths to which the probing was leading. The nursing unit managers and other staff members were also very understanding and accommodating of the time needed to undertake these interviews. They generously ensured that all the interviews could be completed with minimal or no interruption. The time factor was at the forefront of my mind when doing these interviews. If necessary I would have accommodated any situation that necessitated the participant interrupting an interview to meet needs in the unit. This necessity did not eventuate.

The interviews were arranged for the participants’ convenience, at a location and time chosen by them. This was usually a private office located near the ward. Nine out of the ten participants were interviewed. These interviews lasted between one and a half to two hours each. The majority of interviews were undertaken when the participants were rostered on day shift. Two interviews were conducted when participants were working evening shift and one when a participant was on night shift. There was a degree of rapport between researcher and participants at the interviews, as we had become reasonably familiar and comfortable with each other, through the observation sessions. My experience
and knowledge as an ICU nurse also gave us grounds of commonality, which assisted in fostering easy communication and participation in the interview (Ashworth, 1995; Briggs, 1986). The data gathering process was interesting, informative and invigorating. I gained a renewed and enhanced appreciation of those nurses who decide to continue with careers at the bedside. There was another by-product of this process and the people I met while undertaking it. My resolve to ensure that the participants’ experiences of the intensive care environment were given voice and explained from their perspective was reinforced.

**Data Analysis**

A major feature of grounded theory is the simultaneous data collection and analysis. Through the use of the constant-comparative method (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998), analysis and data collection inform each other. In employing this method, the researcher progressively moves from the concrete to the abstract.

Substantive or initial coding was the first analytical process I undertook. This first run at coding the data necessitated the breaking down, the fracturing and re-conceptualisation of data, line by line, into discrete parts with continuous comparison for similarities and differences. Early in this process I restrained myself from making too hasty leaps to “clumping” what seemed to be similar codes into more abstract concepts or categories, until more data had been initially coded. This was quite difficult at times, as there seemed to be many naturally occurring conceptual associations in the codes. All available data were coded, with a large number of codes/concepts emerging. Many of these were “in-vivo” codes, which were made up of the exact words/actions used or displayed by the
participants. I tried to stay with in vivo codes as much as possible as these in most instances seemed to portray most appropriately what the data was saying.

I transcribed all initial codes and began “clumping” similarities under slightly more abstract labels, continuously referring back to the data to ensure that these higher-level abstractions were consistent with the data. The fitting of concepts under higher and higher level abstract labels continued and categories began to emerge. According to Strauss and Corbin (1990), a category is a “classification of concepts” in which concepts that relate to a similar phenomenon are clustered together “under a higher order, more abstract concept” (p. 61). Throughout this process I was writing memos detailing and explaining my thinking about the conceptual clumping and category formation and diagramming. I was beginning to make intuitive leaps about theory possibilities and the relationships among and between categories. Diagramming my initial ideas about these relationships helped me gain an overall perspective on where I had gotten to with the analysis and where further data needed to be gathered. The two phases of substantive coding were virtually seamless. The flow from initial coding to the emergence of more abstract groupings simply appeared to be a natural occurrence.

From the data there began to repetitively emerge similar sets of problems and processes. This was confusing initially as there appeared to be a number of emergent central categories. In an effort to clarify this situation, further memos were developed that were attempts at explaining what the data were saying. This required many hours’ immersion in the data checking to ensure that the explanations were grounded in the data. Finally, after much time spent pondering on conceptual and category relationships, going back and forth to the data and consulting pertinent literature, a central or core category “Finding Your
Way” began to emerge. Refining and refitting categories so that the subtleties of the relationships within the data could be made explicit was difficult. Working through and explicating the relational nuances was time consuming and often frustrating. Again diagramming was most useful during this period as it allowed me to express more succinctly what the data were saying. It was from working with a later stage diagram that I was finally able to visualise and explain the category relationships around the core category.

During this entire process, at the various stages of theory discovery, frequent discussions with my supervisors and other interested colleagues assisted in providing different perspectives from which to view what was emerging from the data. It was from one of these discussions that the pictorial representation for the substantive theory developed. The discussions helped to identify potential category links and dissonances, which necessitated further searching of the data for potential explanations. These interested parties were also good sounding boards in evaluating the congruence of the category relationship linkages and theory.

**Trustworthiness and Rigour**

In this study credibility, dependability, transferability, conformability and reflexivity were achieved firstly by my being immersed in the setting and repeatedly interacting with the participants. Secondly, I implemented two complementary data collection methods, observation and semi-structured interviews. Thirdly, implementation of the constant-comparative method of analysis necessitated the continual checking of developments that emerged from the data against each other. Fourthly, I ensured that all participants were made aware of my background in ICU nursing. Fifthly, memoing and diagramming were
employed to ensure an audit trail was available through the documenting of the conceptual
decisions made throughout the theory development. Finally, self-critique and self-appraisal
were undertaken, by continuously rechecking with the data, to ensure that the conceptual
linkages I made were consistent with what the data were telling me.

**Ethical Considerations**

Prior to the commencement of this study, permission was sought from the University’s
Ethics Committee and the Area Health Service Research Ethics Committee. Invitation to
Participate sheets (see Appendix A) were distributed throughout the ICU’s involved and
nurses interested in participating were given Participant Information sheets (see Appendix
B). These sheets explained the aims of the study, gave details of the procedures that would
be involved in data gathering, gave an overview of participants’ rights and the measures
that would be taken to safeguard anonymity and confidentiality. Prior to the Consent
Forms being signed (see Appendix C), verbal information was given to the participants
with any queries/questions/concerns they had being addressed. Participants were advised
of the voluntary nature of their participation, and their right to withdraw at any time from
the study. No participants withdrew consent once the study had commenced.
Confidentiality was maintained by ascribing a numerical code and fictitious name to each
participant, with the principal researcher being the only person with access to the legend.
All non-participants who were mentioned in either the observation session write-ups or the
verbatim transcripts, had their names deleted and were assigned position title substitutes,
such as physiotherapist, occupational therapist, visiting medical officer.


**Conclusion**

This chapter provides the reader with an understanding of the philosophical perspective on which this study is based and explains and describes the method used to gather and analyse the data. It also provides the reader with situational and contextual information, which enhances their preparedness to progress to the following chapters.

The foundational philosophical principles that underpin this study have been identified, explained and justified. This includes the development of qualitative enquiry relating to constructivism and the postmodern perspective on truth and reality. In addition, the interconnectedness of symbolic interactionism, constructivism and grounded theory within this perspective has been discussed.

Grounded theory and its distinctive aspects were presented and explicated. These include the unique literature review processes and the meaning and methods used to achieve theoretical sensitivity, sampling and saturation. The constant comparative method of data analysis was outlined with discussion of coding procedures as was the significance of memoing and diagramming. The term ‘core category’ was defined including its emergence from the analysis of data and its structural elements. A basic social process, its processural elements and significance to a grounded theory as a core category was discussed as were its differences to other types of core categories.

The criteria for evaluating qualitative research, that is, its trustworthiness and rigour, were expounded. The processes of the grounded theory method that were applied in this present study were detailed and explained. These included the initial superficial, broadly focused
literature review to identify knowledge gaps and facilitate writing of the research proposal and the more focused use of the literature throughout the data analysis process.

The setting for the study was described to situate the reader within the context from which the data would come. The sample, the number of nurses who agreed to participate in the research, was clarified with demographic characteristics provided in a table format. The methods employed in participant recruitment were then described and detailed. Data collection methods used, such as field observation, the taking of fieldnotes and semi-structured interviews, were discussed together with a brief synoptic recounting of what occurred.

How the data were analysed throughout each phase of analysis, including the emergence of the core category, was described. Following this, the strategies that were used to ensure the trustworthiness and rigour of this grounded theory study were clarified. Ethical implications pertaining to this study were discussed.

In the following chapters, four, five and six, the substantive theory and its major elements, the basic social problem and the basic social process are outlined and explained, in that order. Chapter seven will provide the reader with a discussion of the study findings in relation to the current literature with recommendations being made for nursing practice, education and further research.

*Chapter 3: Research Methods*
INTRODUCTION

This chapter provides an interpretation of the substantive grounded theory, “Traversing the path of the intensive care nursing experience”, which has emerged from the data. It provides an explanation of how and why registered nurses working in the intensive care environment deal with the pressures and difficulties they confront on a daily basis in striving to meet their responsibilities. From the data, the pressures and difficulties of working in intensive care emerged as the basic social problem. The basic social problem was conceptualised as “losing direction”. The basic social process that describes the behaviours implemented by these nurses to deal with the problem was conceptualised as “finding your way”.

The chapter provides an explanation of this specific substantive theory. In addition, it contains a description and analysis of the major components of the theory, the basic social problem and the basic social process. How these components interlink and why, is also discussed.

THE SUBSTANTIVE GROUNDED THEORY

As previously explained in chapter 3 (p. 52), a substantive theory is one that unfolds and develops from data gathered in specific situational and contextual locales. The phenomenon studied in this research was how and why experienced, intensive care registered nurses commit to and continue with a career in bedside nursing. What has become apparent from this research is that nurses who choose a career in intensive care
nursing do so because they gain great satisfaction and fulfilment from what they do. This is despite the frequency of the many different types of problems and difficulties they deal with on a daily basis. These nurses continue in intensive care because they gain levels of stimulation, challenge and satisfaction. Intensive care nursing is rarely boring or mundane. Each new experience that is afforded by working in this environment holds the potential for stimulation and challenge. Working in this environment is comparable to undertaking a journey of discovery. Undertaking the journey of discovery, that is, “traversing the path of the intensive care nursing experience,” suggests a desire to realise growth and development in knowledge, skills and understanding in both the personal and professional spheres of life.

The concept “traversing” suggests something more than meandering or wandering among the experiences available in intensive care nursing; it suggests a struggle to get through and to successfully meet responsibilities and expectations. The responsibilities and expectations are those owed by the nurses to themselves, their patients, the patient’s relatives and to their colleagues. This path of nursing experience comprises those situations, people and events, whether challenging, confronting, stimulating, frustrating or uplifting that are encountered by these nurses as they strive to practise their profession responsibly and effectively. To traverse implies a deliberate and consciously made choice to investigate the experiences that are available in a particular situational context or environment (Tulloch, 1994). To have successfully traversed these available experiences, to find your way, suggests the discovery of what is necessary to continue nursing in the intensive care environment. Traversing therefore implies that this theory is an expose of what the participating nurses encountered, managed or overcame and how they achieved this in their efforts to continue nursing in intensive care. The data suggested that when the nurses were effective in finding
their way, they not only met their responsibilities but also thrived in their chosen area of practice. They were renewed in their belief that this was the type of nursing for them. Belief in their ability to effectively manage any experience they may come across was also renewed.

“Losing direction” occurred when the problems and difficulties encountered along the intensive care nursing pathway become overwhelming and the nurses perceived that they were being hindered in meeting their responsibilities. This is a stage where the data suggested that these nurses developed high levels of exasperation and frustration with themselves and with the perceived cause or causes of these hindrances. The nurses felt unable to effectively manage what was expected of them and began to doubt their own abilities; leading to their self-assurance diminishing. This happened because they felt overwhelmed by the number of problems confronting them, or the high level of emotional, mental and physical input needed to do so, or a combination of both. These nurses were feeling the stress. Their perception was that they were losing their grip on situations, which prior to this they felt more than adequate to meet. Mental, emotional and physical exhaustion were setting in. They often become fed up with the entire situation and contemplated resignation. All of the participants in this research had at one time or another contemplated resignation, but none had ever gone through with it. Each participant was able to explain how s/he had successfully found their way along this path and had developed the necessary strategies to achieve this.

“Finding your way” identified the strategies, approaches and personal characteristics the nurses discovered were necessary to continue nursing in intensive care and successfully manage the problems and difficulties that could lead to “losing direction”. The nurses
discovered that they needed to develop ways of “maintaining morale” and “creating calm”. To achieve “maintaining morale” necessitated their “being fulfilled in the work environment” and implementing strategies for “easing the stress” encountered. “Being fulfilled in the work environment” meant that the nurses had achieved levels of “knowing self”, that is they were aware of personal strengths and weaknesses, needs, motivators and disincentives. They were aware of the strategies that needed to be implemented to achieve personal and professional fulfilment. Achieving happiness and fulfilment in the work environment was also a cause and consequence of their “being self assured”; feeling sufficiently confident in their knowledge and abilities to meet the responsibilities inherent to their role as a registered nurse in intensive care. “Creating calm” required that the nurses were effective in “sorting out the situation” and in “maintaining effective control”. To be effective in “sorting out situations” the nurses implemented various aspects of “calming the situation”, “problem solving” and “putting the situation into perspective”. This then assisted the nurses’ to effectively maintain control, by utilising the strategies of “having a grip on things”. How effective the nurses were in “maintaining morale” affected their ability in “creating calm” and vice versa. Implementation of these strategies fostered success for the nurses in finding their way along the path.

Below is a diagrammatic representation of the substantive grounded theory. In this diagram the central spiral visually represents the path of the intensive care nursing experience that the nurses traversed. This spiral represents the many and varied situations and experiences that were encountered by the participants in this challenging area of nursing. The central spiral is flanked by two elongated ovals. Both of these ovals have arrows indicating the direction along the path, either up or down, that the experiences in intensive care can take the nurses. The oval to the left of the central spiral identifies the direction along this path when the nurses were
“losing direction”. The oval to the right of the spiral indicates the direction along the path when the nurses were successfully “finding your way”.

![Diagram 4.1 Traversing the Path of the Intensive Care Nursing Experience.](image)

**Basic Social Problem – Losing Direction**

A basic social problem was the focus of concern that emerged from the data for all the participants. It represented the “problematic nature” (Glaser, 1978) of the pattern of behaviour that was being accounted for by the core category, which in this theory was the basic social process. In this theory, the basic social problem was given the conceptual label of “losing direction”, which emerged from the data as the most effective, encompassing descriptor for the difficulties and problems encountered by all participants within the intensive care nursing environment. The characteristics of “losing direction” included “becoming exasperated”, “losing your grip”, “feeling overwhelmed” and “diminishing self assurance”. Throughout any period of nursing work time in the intensive care environment,
it was possible for nurses to be labouring under at least one if not more of these characteristics. How well they handled these situations and continued with their nursing careers in the intensive care environment depended on how effective they were in “maintaining morale” and “creating calm”. Both of these characteristics formed the basic process, “finding your way”, used by all participants to deal with the problem of “losing direction”.

The data suggested that the nurses had an expectation and acceptance that there would be, at any given time in the intensive care environment, a level of activity going on that was normal and should be coped with normally. This was due to the level of routine activities, which normally occur in the ICU environment. The difficulties and problems, which emanated from these activities, were expected by all nurses and could be readily controlled. At these times the expectations placed on nursing staff by themselves, their colleagues, their working relationships and reliance upon each other were within limits that the participants judged they could manage without becoming swamped by the speed or intensity of developing situations. When these normal limits were breached, problems and their effects intensified. The problems and difficulties could emanate from any number of sources, the patients or their conditional status, their relatives, other nursing staff, medical staff, nursing management or the nurses themselves. These groups of difficulties and problems may have developed on a number of fronts at any one time and come to bear on the participants at the same time or they may have followed so closely one after the other that the effect was the same as if they had all occurred together.

“Losing direction” emerged from the data as the major area of concern for these nurses. When they were “losing direction” the participants became exasperated with what was
occurring in the ICU, because they were “being on the firing line” and “being let down by management”. “Losing direction” often resulted from the nurses’ control of the situation being decreased; the nurses being exhausted, physically and psychologically and being expected much of the time, to take on multiple roles per shift. This led to them feeling overwhelmed and their self-assurance diminished.

When these nurses felt overwhelmed they reacted to situations rather than being able to think about what would be the most appropriate response to a situation. These reactions were in response to their frustration, the emotional load being dealt with and their feelings of panic. The nurses displayed symptoms of high stress through being irritated with others and themselves, becoming quite cynical about people and situations. Some endured panic attacks and became more vulnerable to personalising situations and taking them to heart. In this frame of mind their belief in their own abilities was further diminished through feeling unable to do anything properly. Confidence decreased with them becoming sad and dejected and often reluctant to go to work. The nurses developed guilt feelings about their responses to situations and began to doubt the veracity of their perception of how they were handling these situations. They felt overwhelmed by what was happening and their apparent inability to handle the situation effectively, leading to their feeling that they could not take any more. The nurses had lost direction and were feeling confused, dispirited and defeated.

**Basic Social Process (BSP) – Finding Your Way**

As previously explained in chapter 3 (p. 65), a core category or phenomenon represents the nexus of a grounded theory. The core category or central phenomenon in this theory was “finding your way”. This category emerged from the data and represented the main
category of this study, around which all other categories were integrated and related.

“Finding your way” provided an overall, logical explanation of what the data were saying.

“Finding your way” effectively provided an explanation for how and why nurses in the
intensive care environment continued to traverse this particular nursing path, despite the
many difficulties and problems they encountered along the way. “Finding your way”
subsumed two separate but interacting sub-categories, namely “maintaining morale” and
“creating calm”.

“Maintaining morale” and “creating calm” were exercised in varying degrees depending on
the particular situation/s being managed by the nurses. Both sub-categories worked
together to allow nurses to find their way along the intensive care nursing path. The degree
to which the various characteristics within the categories were accessed and utilised was
dependent upon the situations encountered and the disposition of the individual nurse at the
time. This fluidity of access and utilisation allowed the myriad of conditional variations
that could occur within the intensive care environment to be handled on an individual and
situational basis. This was necessary as no two situations that developed were ever
identical and those responsible for managing these occurrences, their state of mind and
capabilities varied with experience.

“Maintaining morale”, the first of the two major sub-categories of “finding your way”
included two properties, firstly, “being fulfilled in the work environment” and secondly,
“easing the stress”. The nurses needed to feel happy and contented, knowing they were
appreciated and valued.
Knowledge of self, their reactions to situations, how they maintained their equilibrium, what motivated them to continue, what personal wants and needs they had was necessary. The nurses achieved this self-knowledge and continued to better themselves and their performance through constant self-appraisal and assessment. These engendered self-assurance, with them feeling confident and sufficiently secure to be assertive and take a stand in their dealings with others when necessary. They looked forward to taking up their responsibilities, accepting new responsibility and guiding new staff. This confidence and security came from them having worked out their place in the scheme of things and feeling at home in the ICU environment.

Limit setting was undertaken by the nurses for themselves and others through the setting of personal priorities, the compartmentalising of work from home life and the expression and actioning of personal interactional standards and expectations. Their ability to do these things was dependent upon how effective they had been in “easing the stress” of the situations in which they were involved. This was achieved by the nurses using facets of their personality and learned behaviour to lighten the situation. They played their part in supporting themselves and their colleagues and being supported by them and others when necessary.

The nurses knew to whom they could go to gain comfort when situations were becoming too much for them to handle on their own and what strategies to implement to allow them to effect catharsis. These nurses worked within an environment where it was vitally important that colleagues supported each other. An incredibly close bond, an “esprit d’corps” was formed between colleagues in the ICU. This developed through the enforced necessity of working so closely with and being highly dependent upon each other. Supporting
colleagues related to accommodating their needs, being able to empathise with the situations in which they found themselves and not wanting to needlessly add to their workload. Being supported and supportive was an important aspect of the nurses’ ability to continue working effectively in ICU.

“Maintaining morale” was central to the participants “creating calm” and ultimately successfully “finding your way”. How they felt about themselves and their work, affected their ability to be effective in “sorting out the situation” and “maintaining effective control”. When they were effective in these areas of “creating calm”, this had a positive effect on their morale, how they viewed themselves and their ability to function as an effective member of the ICU team.

“Creating calm”, the second major sub-category of “finding your way”, was a two-phase process that required situations to be sorted out and effective control to be maintained. “Sorting out the situation” involved a number of properties. Firstly, “calming the situation”, secondly, “problem solving”, and thirdly, “putting the situation into perspective”. The nurses were able to calm situations by being flexible in how they approached their management. This was achieved through the nurses’ ability to identify with the situation and those involved and adapt their strategies to meet the individual requirements presented. The nurses’ role as a mediator or communication conduit between the patients, relatives, medical and other nursing staff combined with their level of autonomy within the ICU hierarchy enhanced the effectiveness of these strategies. Consequently, this led to an environment that was driven less by emotion and fear than trust and was more likely to be conducive to effective problem solving being undertaken. Effectively “calming the situation” and “problem solving” necessitated that the nurse was
capable of “putting the situation into perspective”. This meant that the nurses were able to understand why and how situations developed from someone’s perspective other than their own and take this into account when implementing management strategies. This engendered confidence and trust in those who were feeling threatened and vulnerable and also allowed for innovative, individual ways of meeting the needs of situations to be considered.

“Maintaining effective control” comprised two properties; firstly, “having a grip on things” and secondly, “being a professional”. “Having a grip on things” implied that the nurses were in control; they were “careful and cluey”, had experience, and were able to manage situations effectively because they understood how and why these situations occurred. “Being a professional” implied that the nurses were able to do the job effectively and efficiently and could be relied upon when situations were difficult or complicated. They were aware of reality, knowing what could and could not be changed and were fully cognisant of the skill levels of their colleagues. This effectively assisted them “having a grip on things” and ultimately to effectively maintain control of situations.

**Explaining the Link: “Losing Direction”; “Finding Your Way”**

The intensive care environment continually presented situations that needed to be managed effectively and efficiently. Nurses working in this environment expected that the situations they encountered would be complicated and necessitate the use of high order levels of skill and knowledge. This was because the patients with whom they were dealing were very sick, highly dependent and their presenting problems life-threatening. The nurses identified and accepted that these occurrences were normal to the intensive care environment and that they would have to contend with them on every shift. They did not
view these expected problems and difficulties as causes of unacceptable stress, they did not in these situations feel that they were “losing direction”. This was because the degree of difficulty presented by the situations encountered had been met previously on many occasions and managed effectively. They felt confident in their ability to do so again successfully. In these situations the nurses felt they had a grip on things; knew and understood what and why events were occurring and believed that they would be able to deal with any possible variations that could develop with their critically ill patients.

When nurses were faced with situations that were unexpectedly complicated or unfamiliar, or were hampered in their ability to manage the patient’s situation as effectively as possible, stress levels rose and frustration and exasperation developed. Factors that led to this developing included relatives who did not want or were unable at that point in time to deal with the patient’s condition or prognosis; lack of resources; lack of sufficient experienced staff per shift and lack of support for ICU staff by nursing management. The nurses’ frustration and stress levels were also affected by their perception of their ability to effectively manage situations they were encountering. The problems and difficulties that developed from encountering unfamiliar, unexpectedly complicated situations never usually occurred as single events; they were more likely to occur in a cascade-like fashion. Consequently, the occurrence of multiple problems led to increased stress, frustration and at times self-doubt. These types of experiences were suggested by the data as leading the nurses to feeling they were “losing direction”. According to the data, the nurses’ response to these situations was in the main a recognition of their needs and a conscious implementation of various aspects of “finding your way”. This was done in an effort to ensure that their responsibilities to their patients, themselves, colleagues and healthcare team members were met.
Conclusion

This chapter included an explanation of the substantive grounded theory “traversing the path of the intensive care nursing experience”. To successfully traverse the intensive care nursing experience nurses implemented strategies that would allow them to effectively and efficiently manage all events or situations which occurred in this working environment. The basic social problem “losing direction” represented the conceptualisation of these problems and difficulties. The strategies used to manage these problems and difficulties have been conceptualised in this specific research study as the basic social process, “finding your way”. This concept implied that these nurses, despite what situations they encountered, had developed the means by which to be successful in “maintaining morale” and “creating calm”. They had succeeded and continue to succeed in preventing themselves from irretrievably “losing direction”. They had successfully found their way whilst traversing this nursing experience pathway, thereby continuing their careers in bedside nursing in intensive care.

The following chapter, five, will present the evidence from the data for the basic social problem “losing direction”. Chapter six will present evidence from the data for the basic social process “finding your way”. Chapter seven will discuss the findings from this current research study as put forward in chapters four, five and six in relation to previous research. Recommendations stemming from this research study for nursing education, research and practice will be presented.
CHAPTER FIVE
ANALYSIS OF FINDINGS - BASIC SOCIAL PROBLEM

INTRODUCTION
In this chapter the data derived basic social problem, “Losing Direction”, is discussed and analysed. This problem began to emerge during the initial coding process. As the coding process continued, this emergent problem gained structure and clarity and its relevance to the participants in the intensive care environment became apparent.

This chapter includes an analysis of the emergent problem specific to this research. An explanation of the components of this problem will then be provided. This will be achieved by presenting evidence from data gathered from both observation sessions and interviews. Finally, a summary of the basic social problem will be presented.

Losing Direction
The data suggested that “losing direction” occurred when the nurses’ view of how they would meet their responsibilities to patients, relatives, themselves, colleagues and other members of the healthcare team became clouded. All participants in this study described this loss of direction, though none had taken the ultimate step of resigning from their position in ICU. The factors that prompted this clouding to occur were both internal and external to the nurses. They included physical and psychological exhaustion, self-doubt, anxiety, lack of resources, lack of support, being abused and unreasonable expectations by self and others.
The characteristics that the data indicated were representative of this problem included “becoming exasperated” and “losing your grip”. The nurses described these characteristics singularly or in combination. This depended upon the type and degree of intensity of the situations with which they were dealing, the length of time they had been dealing with them and the level of support they had been receiving as they attempted to manage them.

Below is a diagrammatic representation of the basic social problem, “losing direction”.

![Diagram 5.1 Basic Social Problem – Losing Direction]

Each of the characteristics for “losing direction” will now be discussed in detail.

**Becoming Exasperated**

“Becoming exasperated” was the first characteristic within “losing direction”.

Exasperation implied extreme annoyance, irritation or having reached the end of one’s
endurance with a situation. This developed from enduring and continuing to be expected to endure over long periods of time high levels of frustration, which went unrelieved.

“It doesn’t change ... that’s frustrating and you feel ... ‘well what am I supposed to be?’ ... because I thought ’you have no idea [management] about what I want, and what I am hoping to achieve, so why should I be giving all this effort?’” (Khobi)

This characteristic contained two dimensions, “being frustrated” and “being fed up”. The lack of relief from highly frustrating situations led to the nurses feeling fed up. The nurses felt demoralised and disillusioned with what was occurring and what they were expected to continue to deal with. Feelings of demoralisation and disillusionment became apparent because they perceived a lack of interest and caring for their plight from nursing management and at times colleagues and other members of the healthcare team.

“you do get very frustrated and disillusioned …” (Khobi)

At times the nurses became dejected, discouraged and sad, often either not wanting to nurse at all or being reluctant to come to work. They developed guilt feeling about these events, which led to further dejection and a reinforcement of the feelings of wanting to resign and escape this highly uncomfortable, unfulfilling situation.

Frustration developed because the nurses felt that they were continually on the firing line dealing with difficult and time-consuming situations. They perceived that their efforts either lacked the support of, or were hampered in some way by, management or other members of the healthcare team. These perceptions exacerbated the feelings of frustration and exasperation.

“Other people [frustrate me], whether they be a nurse or doctor, who either don’t know what they are doing, don’t have the
The nurses perceived that their efforts, no matter how hard they worked were not valued and appreciated. The data suggested that the nurses felt that they were taken for granted by the patients, some medical staff, hospital management and the public in general. A perception developed that nurses were viewed as a commodity that would always be around when needed, but because their value was only pertinent to short periods of time in people’s lives then nurses and their work were easily forgotten. These nurses believed that their worth to the public was not truly appreciated because they only played an influential part in most people’s lives for a very short space of time.

“...we’re taken for granted. ... we are a short term investment ... Someone is always going to be left to take care of your loved ones, yeah, it is just really frustrating.”

(Brandon)

The nurses felt that their already heavy workloads were continually being added to without thought being given to the pressure they were being placed under or their level of physical, mental and emotional exhaustion.

“...the only times that it does get frustrating is when people don’t realise that you have other things running at the same time. ...”

(Khobi)

They got frustrated when their efforts to foster and teach new members of staff were seemingly ineffective because the persons being taught either were not interested in developing the knowledge and skill levels required, believed they already were at the necessary level or simply displayed disinterest and a lack of enthusiasm.
“It is a bit frustrating when you are trying to teach people, again and again and again and they are either not interested or they don’t give a shit.”

(Brandon)

Lack of support by management played a highly influential role in the development of frustration levels. “Not having resources” (Vivien) such as equipment necessary to do the job properly or sufficient staff to cover a shift safely created stress because it hampered the nurses in adequately and safely being able to meet their responsibilities.

Feeling as though they were not being given a fair go by management, that they were viewed as the culprits or the cause of situations led the nurses to become frustrated. Being treated as the perpetrators of situations and not being asked for their side of the story prior to being accused was highly demoralising.

“... we have had incidents with nursing staff where they have been accused of abusing substances, ... and the first thing that was asked ... was, ‘what did you take?’,... management just has to back up Nursing staff, not accuse them of causing the situation. ‘What did you do to cause this situation?’ That’s the initial question, not ‘what happened, are you okay?’ ”

(Brandon)

Incidents like that described above demonstrated to the nurses that those in whom they were trusting to support them did not trust them in return. This along with their belief that management were failing to protect them from threatening verbal or physical abuse by relatives of patients, led to high levels of stress, and exasperation in these nurses.

“… this father, was following nursing staff down to the cafeteria, and threatened to slit their throats, and nothing was done about it [by management].”

(Brandon)
It led to the nurses becoming fed up with the entire experience of working in the intensive care unit. These nurses did not like nor appreciate being accused of things, especially when not being first asked for their side of the story before being accused. They were quite prepared, if a mistake had been made, to deal with the consequences but viewed as highly unfair being accused automatically without all the facts of a situation being ascertained. These feelings of exasperation, “being fed up”, often led them to contemplate resignation as a means of escaping from the stress. The nurses wanted to get away from these situations, where there was a lack of collaboration and trust amongst colleagues, which was affecting their ability to effectively meet their responsibilities.

“There is a lack of collaboration, ... so you do get disillusioned, to the point where I was actually going to resign”.               (Khobi)

When these feelings of distress, disillusionment and anger developed and grew they affected the nurses’ ability to concentrate on what needed to be done. This led to them feeling that they were losing their grip on what was occurring in this environment.

**Losing Your Grip**

The second characteristic of “losing direction” was “losing your grip”. Nurses perceived that they were “losing their grip” when their control of a situation was decreased; were physically and/or mentally and emotionally exhausted; had been made to feel personally uncomfortable in some way; and were being expected to take on multiple roles or any combination of the above. These occurrences would lead nurses to perceive that their control over situations was diminished. Consequently, they began to feel overwhelmed by what was happening and were reacting to situations rather than thinking about what needed to be done. The nurses were feeling the stress of losing their grip on events. As a
consequence their self-assurance was reduced and they lost their ability to effectively manage the needs of their patients.

These nurses identified having some degree of control over most situations in which they had been allocated responsibility as being highly important. The maintenance of control was necessary to their ability to effectively and efficiently manage the situations encountered. When this control was diminished, no matter what the cause, it affected their ability to concentrate. Inability to concentrate effectively affected the nurses’ abilities in sorting out the priorities of what needed to be done for the patient and in what order. It also affected their ability to problem solve effectively.

For the nurses it meant that they could be less attuned to the first subtle warning signs of a developing patient problem. Rapid recognition and accurate assessment of these first warning signs could assist in either having prevented them from developing or could lessen their effects through early identification and implementation of simple strategies. To have achieved this early recognition and implementation of strategies required that nurses were fully concentrating on the patient’s needs; not being sidetracked by other cares and worries. Other worries included for example having at hand or being able to easily find the necessary resources to meet patient’s needs, whether this was their medical/nursing notes or the attention of the medical team. Difficulty in obtaining necessary, commonplace resources that should have been close at hand only added an extra degree of difficulty to the effort the nurse had to expend. For the nurses these were unnecessary difficulties that interfered with and distracted their concentration from meeting their patients’ needs.

“…everything is chaotic, some days are just like that. It is just annoying when you try and find the notes, you can’t
When the patient was not receiving the attention that was required for whatever reason, for these nurses the person who was at the centre of their efforts was being disadvantaged. This was unacceptable in their eyes. They found this to be tension producing and distressing.

“I do get stressed when the patient is affected. ... what stresses me is if I see a nurse not looking after the patient as they should be.” (Peta)

Having to effectively manage a patient’s conditional status and all that was entailed in achieving that goal was taxing and frequently led to the nurses being physically, mentally and emotionally exhausted. In particular, these feelings resulted from having to manage highly emotionally demanding situations for long periods of time. These situations involved the nurse not only managing the patient but also the family and their reactions to what was occurring to their relative.

“... to look after him all day and then come home you feel drained emotionally or physically, not physically so much, it is more emotion thing or psychological or mental.” (Vivien)

When this was continuously intertwined with the added pressure of tactfully dealing with emotionally volatile family members, who were suspicious and questioning of any and all procedures being performed on their relative, the level of mental and emotional stress under which the nurses were working increased dramatically. The situation became very constrained as the nurses felt they had to guard everything they said and did; otherwise they would be attacked in some way, usually verbally. This made providing nursing care highly stressful and exhausting.

Chapter 5: Analysis of Findings – Basic Social Problem
“... if you say the wrong thing, they snap your head off, they bite your head off, they'll have a go at you, they’ve had a go at a few members of staff,...” (Sally)

Exhaustion developed from a number of different causes. Many intensive care patients were totally or almost totally dependent on nursing staff for all facets of daily living. This often required the implementation of nursing strategies that necessitated the expending of high levels of physical energy in their management. These included frequent, long and involved wound dressings or frequent turning and positioning.

“...that’s really stressful. ... Just because it is on the go, ... you just don’t sit down, and by the end of the day if you can get off on time, you’re aching and you’re just exhausted.”

(Sally)

Emotionally demanding situations were not uncommon occurrences in intensive care as was the emotional exhaustion that was suffered by staff managing these situations. The patients being nursed in this environment had undergone some form of trauma, whether planned or unplanned, and they and their relatives were in the process of having to deal with the consequences from that trauma. Though as identified in the data, some situations were more emotionally demanding and wearing than others. This most frequently happened when the staff of a particular unit did not often have to deal with the types of problems presented by the patient being nursed.

“… you know you’ve got to care for [patient’s name], the workload’s not bad, it’s just emotional. Because we are not used to getting that kind of stuff. So that’s what makes it hard.” (Sally)
On occasion, the nurses reached a level of emotional exhaustion where the panic and distress felt manifested itself in physical symptoms. For example:-

“...not sleeping, ...nausea, ...” (Charlene)

There were times when the mere thought of having to go back into the unit or being in the vicinity of the unit brought on an emotional response to the heightened levels of stress and distress being encountered and endured. The nurses while attempting to manage these very high levels of panic and frustration were reacting personally on an emotional level to what they were encountering in the ICU. They simultaneously had to deal with this and what was occurring each shift in the unit.

“I wasn’t feeling very confident at all, and I had three panic attacks, ... I was having, ... sensory associations, so the sun used to hit these plastic doors in the afternoon, and I would be self talking, ‘you want to do this, you want to be here, this is a great experience, instead of shit, shit, shit,’ ... and the heat would make this smell on the plastic, and as soon as I smelt it a panic attack would start.” (Charlene)

How situations were handled between more experienced and less experienced members of staff, especially when there was an emergency in progress, was important to maintaining the self-assurance levels of the less experienced staff in particular. To denigrate a less experienced member of staff in public was counterproductive and made the staff member feel thoroughly uncomfortable. These less experienced members of staff were usually eager to learn, but due to lack of experience their reactions to situations would be less automatic and speedy than a more experienced staff member. Making these nurses feel uncomfortable, unsure of themselves and to question their own abilities led to them to feel that they were “losing their grip”.
“… the first time I was in an arrest situation, somebody barked orders at me, and put me into a situation where I was totally uncomfortable.” (Khobi)

Experienced nurses also indicated that stress and personal discomfort increased, particularly when they had new staff on a shift for whom they were responsible.

“… having new staff is definitely something [that] causes stress and can be uncomfortable.” (Vivien)

They recognised the need for the less experienced nurses to learn and gain experience but the presence of new staff was also viewed as adding further responsibility to an already highly responsible position. Adding the variable of new staff to the equation of staff mix on a shift often meant that the experienced nurse in charge would have to take an increased patient load. This potentially meant that they would have decreased time to supervise other staff and to concentrate on the duties inherent to being in charge of a shift in ICU.

Being expected to take on the responsibilities of multiple roles within the span of a single shift was highly stressful for the nurses. They were concerned that they would be unable to adequately meet all of the obligations for which they were accountable.

“…sometimes people forget that it is not your job, … they tend to throw things in your way and expect that you as a clinician know what to do, you know how to do it, you just don’t have the time to do it, and it feels like you are always lagging behind and feeling the pressure. … you don’t feel like you are doing any job really well.” (Khobi)

This expectation also caused the nurses to question the value placed on their main role within the unit. They felt that there was a lack of appreciation and understanding of what
they did and its value to the overall efficient, effective daily working of the unit. This engendered the belief that management were out of touch with what really happened in the unit; that the staff in the unit were expected to cope no matter what pressure they were under.

“I was in charge that day, actually I had three jobs .... I was still employed in my main position was the educator that day, I was also asked to do charge ... you feel like, ‘well what am I supposed to be?’; and also you feel like your role isn’t that important really, when it can be fobbed off so easily, [by management]” (Khobi)

Being placed in charge of a shift was a major increase in responsibility for some of these nurses. It meant that they were responsible not solely for their one or two allocated patients on that shift, but for all the patients in the unit and for the smooth running of the unit. They were answerable to medical staff that were looking after the patients and to nursing management. This could be a tension filled undertaking even for experienced nurses who had been in charge many times.

“I feel sometimes my stress levels go all up when I am in charge, ... when there are a lot of patients in the ward and you don’t have beds, there is a problem with the medical staff and they don’t have the medical team, the emergency team, or the Director of Nursing trying to get the patients from emergency so they will meet the calls, ... and that really is a stress factor.” (Peta)

The nurses became irritated with the levels of tension and vulnerable to personalising occurrences because their confidence levels were dropping and they were angry and disillusioned.
“I tend to take things to heart, I tend to take things personally at times, ...” (Brandon)

They were overwhelmed by what was happening and their reactions were indicative of this state of discontent. When irritated they became annoyed easily and this became evident in their responses to those they see as causing further irritation.

“... annoying, because you are expecting to come on, get hand over and be more routine ...” (Emily)

When feeling overwhelmed by the number and intensity of the situations they were expected to manage, the nurses began reacting to situations rather than thinking about what would be the most appropriate and logical responses. This occurred when they were so busy trying to keep abreast of what was happening to the patient. These situations arose quickly and frequently, that the amount of input the nurses were getting became impossible to process in a controlled fashion.

“When it gets busy you've just got to keep going, you can't really stop and think about it.” (Sally)

In these types of situations the nurses felt they were losing their grip and began reacting to the emotional load, to the frustration they were feeling. This frustration developed from their perceived powerlessness to control these situations. It also developed because they were reacting to the panic these feelings of powerlessness engendered within them. They reacted to the emotional load because they were frustrated and exhausted and could emphasise with the situation and those in it.

“For me personally... it was so sad, he was so young, here was a mother, looking after her son, I'm a mother, ... just to see her looking at her son and wanting him to be alright and he wasn't going to be alright. It was just
Discord and disharmony developed at times among staff in the ICU. This was due, for example, to personal disagreements, lack of experience, feelings of insecurity, lack of staff numbers or lack of qualified, experienced staff on a shift. Medical staff delayed in making decisions regarding patient management, or contradictory orders from a number of different doctors or teams of doctors caring for the patient would be given. The indecisiveness and lack of congruence about patient management potentially endangered the patient and affected the nurses’ ability to care for them. Nursing management was often viewed as less than supportive when situations developed in the ICU. The nurses built up feelings of anger, resentment, and disillusionment to these occurrences. They became frustrated and reacted to them with obvious anger and discontent. The nurses were reacting to the frustration they were feeling as a consequence of feeling overwhelmed by events. They were also reacting to the panic they were feeling in relation to the potential consequences for the patient. At time their reactions took the form of angry outbursts and demands for immediate attention for the patient and their needs.

“I am snappy, I am demanding, because if something is not done straight away, if I think it is necessary, then I get really, really, pissed off.”

(Emily)

Being able to control and feel in control of situations for which they were responsible was important and necessary for these nurses. When in control they felt that they could effectively manage what needed to be done for the patient. When control was wrested from their grasp, feelings of powerlessness set in, no matter the cause. Whether it was through a lack of collaboration from other staff and/or management, personal and/or professional
disputes or cares intruding on the meeting of responsibilities, or the sheer volume and intensity of what was occurring. When they felt powerless their self-assurance began to decrease, confidence levels began to fall and self-doubt increased; they began to question what they knew and what they could do.

“When things happen or go wrong, you either cannot fix or can’t find the reason or explanation for, or that just aren’t resolving when they should....” (Brandon)

When this happened they began to feel that they were forgetting things that had been and should have been second nature to them. This caused alarm and panic in their minds and affected their efficiency and effectiveness in meeting their responsibilities. It also decreased their satisfaction with their performance. The nurses were “feeling overwhelmed” and this led to the perception that they were losing their grip.

“I am losing it, ... I am forgetting things, ... little things, that would have come second nature to me before, ... so I sort of feel a bit panicked by it” (Charlene)

With their confidence levels down the nurses were feeling sad and dejected. The optimism that had been evident in their attitude to the stress in the environment had disappeared. They believed that no matter how much effort was expended or how efficiently they responded to situations they would be faced with some manner of what would be perceived as defeat. This defeat could be the lack of a thank you, lack of any sign of appreciation for the amount of energy and effort invested.

“People don’t even say thank you anymore.” (Brandon)

If a patient died despite the best of efforts of all concerned those who were involved with the patient felt sad and dejected. They felt that in some way they had not met the standards
they had set for themselves. This type of outcome only served to reinforce feelings of defeat.

“... so it makes you feel a little bit down sometimes.”

(Vivien)

The dejection and sadness could cause disruptions to the nurses’ lives outside the intensive care environment. It could invade and pervade their thinking and demeanour in all situations.

“... having nightmares, not sleeping, com[ing] home crying, ...”

(Charlene)

These were the times when nurses needed to be supported by their colleagues and management. When the support was not offered or not available they became even more dejected and sad and began developing a reluctance to come to work. They wanted to feel satisfied and fulfilled from their work, not dejected, demoralised, disillusioned and defeated, no matter how much physical, emotional and mental energy they consumed in striving to achieve a positive outcome.

**Conclusion**

“Losing direction” along the path of nursing in intensive care occurred when nurses were overwhelmed by the number and intensity of problems and difficulties they were expected to manage and their own feeling of ineffectiveness and inadequacy. These feelings and events led to them becoming exasperated because they were frustrated and fed up with what was happening. They did not feel that they were capable of effectively managing what was happening; they were losing their grip and this led to dissatisfaction with themselves, the way events were managed in the environment and the levels of support and collaboration available from management and colleagues. Their confidence levels were falling. They
doubted their own worth as a nurse and their ability to function effectively within this demanding environment.

To ensure that they were able to successfully overcome these difficulties and problems and meet their responsibilities the nurses needed to develop patterns of behaviour that would allow them to meet these challenges. The patterns of behaviour that emerged from the data as those successfully implemented by the nurses will be described and discussed in the following chapter, chapter six, the basic social process “finding your way”.
CHAPTER SIX
ANALYSIS OF FINDINGS – BASIC SOCIAL PROCESS

INTRODUCTION
This chapter discusses and analyses the basic social process (BSP), “finding your way” which has emerged from this study into intensive care nurses and why they continue to work in this stressful environment. This pattern of behaviour or social process began to reveal itself during the initial stages of data analysis. As the analysis continued, the structure and clarity of this emergent social process and its relevance to the participants in the intensive care environment became apparent.

This chapter includes an analysis of the emergent social process specific to this research. Following this there will be an explanation of the components of this social process. This will be achieved by presenting evidence from data gathered from both interviews and observation sessions. Finally, a summary of the basic social process will be presented.

Finding Your Way
Conceptually, “finding your way” explained the behaviour of intensive care nurses that emerged from the data. It uncovered the strategies that were instituted by nurses to ensure that they continued to remain safe, effective and efficient practitioners in this demanding environment. The overriding impression that emerged from the data was that the nurses were constantly working to deal with, manage and contain many difficulties and problems that occurred while meeting their responsibilities to very ill patients.

“When you are here [in the ICU] you have a purpose to ... try and get them [the patient] well”  
(Vivien)
The nurses implemented these patterns of behaviour when they were confronted by problems and difficulties in the ICU. These patterns of behaviour came together conceptually as “finding your way”. To successfully find their way the participants had to have developed strategies for “maintaining morale” and “creating calm”.

As identified in chapter five, it became apparent from the data that the participants had an expectation and acceptance that there would be, at any given time in the intensive care environment, a level of activity, and common problems, that were normal and could be coped with and managed with relative ease. In this type of situation the nurses felt comfortable and knew how to handle what was happening. They were confident that their skill and knowledge levels were equal to what was expected of them.

“You know, there are times when it is very routine, ... and that’s not a problem, that’s nice. I have days when you really do need a nice routine patient.”  

(Brandon)

This degree of ease and confidence occurred as a result of experience and “finding your way” along this nursing path. These nurses had developed strategies to successfully manage many difficult situations, and these could be quickly implemented. There were times in intensive care when the number and degree of activities, problems and difficulties intensified beyond the familiar and expected.

“everything is chaotic, some days are just like that.”

(Emily)

It was at these times, in these situations that the nurses reverted to consciously employing various aspects and facets of “finding your way”.

“... what can we do, what needs to be done now to rectify this situation.”

(Vivien)
“Finding your way” conceptually encapsulated how the data suggested this was achieved.

This is schematically represented by diagram 6.1.

Diagram 6.1 Basic Social Process – Finding Your Way

MAINTAINING MORALE

“Maintaining morale” was the first major sub-category of “finding your way”. The ability to maintain morale was important for the participants and their ability to successfully create calm and find their way along the path of the intensive care nursing experience.

This sub-category subsumed the following characteristics, “being fulfilled in the work environment” and “easing the stress”. These characteristics suggested an ability to effectively deal with a person or persons, task/s, situation/s or problem/s that could arise at any time, and which added complexity to the normal routine in the intensive care. To successfully and effectively manage the problems and difficulties that developed in the intensive care environment, the nurses utilised varying aspects of the different characteristics identified above to achieve the maintenance of morale. For example:
“We just have a bitch” [Brandon & colleagues dealing with frustration] (Brandon)

OR

“... I think you need to have time away from work, have other hobbies, ...” (Khobi)

The degree to which morale could be maintained flowed over, and had an influential effect on the level of success that could be achieved in “creating calm”, the second major sub-category of the basic social process. “Creating calm” will be discussed in more detail later in this chapter.

*Being fulfilled in the work environment*

The first characteristic of maintaining morale was “being fulfilled in the work environment”. This characteristic revealed that the nurses needed to enjoy the work they were doing; needed to feel appreciated and valued; they had self-knowledge and were self-assured and confident. Fulfilment also occurred when their personal and professional goals were being met, which led to an increased motivation to achieve. These nurses thrived on challenges; they preferred variety and a fast paced work environment.

“I find it challenging, I like that. ...Everything seems to be different because, just because the people are different, different doctors, different people you are working with, not stagnant.” (Brigid)

The nurses’ preference was to view the results of their work in the short term, rather than having to wait weeks or months for what may only seem a miniscule change in a patient’s status. These nurses wanted to make a difference and see that difference occur.
“I would rather see something, where your patient has an outcome, sooner rather than later. ... you’ve done something that you can visualise and is measurable...”  (Brandon)

They gained great satisfaction from being able to pass on knowledge to the newer, less experienced members of the team, and this increased their fulfilment with working in the ICU. Seeing a passion for ICU nursing grow and develop in newer members of the team was a source of great satisfaction.

“I just love it. I love the fact that now at my stage I can also teach and train people and see the passion in them as well. So it is rewarding, I really enjoy it. Very selfish, I love it.... and I love watching other people use my teaching techniques, ... you feel a sense of achievement at what you are doing.”  (Khobi)

In a similar way, the nurses gained fulfilment when they were seen as a core or resource person who had developed their nursing knowledge and skills to an expert level in a particular area, for example renal, cardio-thoracic, neurological nursing.

“... I’m doing other things, not just patients, normally they [the staff] come and ask me questions... I guess they see me as a core person so they come and ask me.”  (Peta)

The resource person viewed this as a compliment, an acknowledgement of their experience, skill and hard work. It was an indication that they contributed to the work environment and that their efforts had been worthwhile and a valued and appreciated contribution.

“I do get a kick out of people coming up to me, ... and asking ‘can you help me with this. What’s going on here?’ ... even the doctor will come up ‘Brandon what do you think?’ Now
Being fulfilled in the work environment was underpinned by the nurse’s motivation to work and achieve in ICU. The data revealed a number of motivators. Firstly they were motivated by their personal need to gain knowledge, so that they could better understand and manage what could happen in situations. Secondly, they felt a responsibility to their patients and colleagues to not let them down. Finally, they wanted to make a difference.

“I [have] always wanted to know why everything was going on. Why? How does that work? And that sort of high level, why things were happening and questioning people, ...”

(Vivien)

The data suggested that these nurses in ICU were highly motivated and needed to strive to achieve personal goals to maintain motivation and interest and achieve both personal and professional satisfaction and fulfilment. One example of this was completing further education.

“I did my course last year, my ICU Cert. at the College and I have applied to do my ARC course next year”

(Emily)

The achievement of personal and job related satisfaction occurred via many different means. It could revolve around individual nurses furthering their career through the undertaking of advanced, higher level study, or through only working part time, so as to ensure that life outside the unit was savoured and enjoyed. Sally for instance stated

“I only work a few days a week, part time because my life is very important to me outside of work, that’s why I don’t work full time,”

(Sally)
No matter what the priorities were or the means needed to achieve them, it was the satisfaction gained by the nurses in having the requirements of a number of their personal needs accommodated and met that was important. This was important as it allowed the nurses to deal with the requirements and responsibilities that impinged on their lives in an ordered and satisfying fashion. This enabled and enhanced their feelings of satisfaction and fulfilment with their work.

Being able to make a difference in the lives of patients and colleagues was an important factor in being fulfilled in the work environment. The continual intellectual, emotional and physical challenges presented by nursing in the ICU were welcomed by these nurses as motivators to their continued tenure in ICU.

“I thrive on that sort activity. I enjoy that sort of level of activity. [complex, high pressure, fast paced situations] I didn’t come into nursing purely for a job to get money, ...I did it because I love the fact that I am able to care for somebody, make a difference, and progressing on from that now, seeing students and actually making a difference to their lives as well. And to see them reproduce those attitudes and values is great.”  

(Khobi)

Self-knowledge was vital in enabling the nurses to achieve fulfilment in the work environment. It allowed them to realistically self-assess and to appraise their actions and reactions. The ability to achieve this was not only vital to their ability to deliver safe effective care to their patients but also a component of being able to maintain morale.

“I am focusing on one area, and I am competent, ....”

(Brandon)
Balanced self-assessment provided a basis on which the nurses were able to make decisions about what in their performance was good and what needed improving. They were then able to decide what to do about these weaknesses and what steps were necessary to achieve improvement. Curiosity about how and why things work or occur and the need to find answers to satisfy this curiosity was explained by a number of participants. The following is one example of this.

“I am fascinated by anatomy and physiology, I am a why, why, why sort of person.”  
(Khobi)

Understanding by the nurses of what was needed to know self assisted in their ability to judge when and how to give them a break from the stress. This helped to efficiently manage their frustrations and not misdirect tensions and anxieties. Effective management of frustration and tension allowed the nurses to continue feeling contented and fulfilled and wanting to remain working in this environment.

“I usually talk it over, especially with someone here, who knows, like other nurses, or the medical team it has happened with, I always debrief with them, and we debrief with each other, or bitching, or whatever you want to call it, it is normally like that.”  
(Emily)

For the nurses in ICU, developing self-assurance was integral to their “being fulfilled in the work environment”. It gave them the confidence to practise in this environment and belief in their ability to handle any situation. This confidence and self-belief came from a number of factors. Firstly, it developed through their feeling in control of the situation. To achieve this feeling of control the ICU nurses needed to gain experience with the many and varied types of ICU situations that were likely to occur, and develop the practical skills to competently meet these challenges.
“... knowing what you’re doing and having control of the situation or control of what you are doing. ... you can answer questions, to a certain level, and you can be confident ... you give the impression that she knows what she is doing, or you do them [the procedures in] the right way.” (Vivien)

Secondly, self-assurance developed from feeling appreciated and valued. This came through acknowledgement by peers of a job well done. It included such things as improved performance in situation management, early recognition and prevention of potential problems for a patient or some other demonstration of advancement in knowledge and application of ability. Thirdly, knowledge and understanding of self, personal wants and needs and how to attain these, and finally, belief in the adequacy of their knowledge and skills and through an understanding of and feeling comfortable with their place in the ICU hierarchy.

When the nurses were self-assured they displayed a certainty, a level of self-possession and poise under pressure in their ability to handle themselves and any situation that they came in contact. They were confident in the decisions they made and felt sufficiently comfortable with their skill and knowledge levels that they were prepared to be assertive and confront problems.

“... it doesn’t affect me if someone says something to me I either not worry about it or say something back. Is it worth it? It is probably just having the experience to deal with that.” (Vivien)

If a situation necessitated, the self-assured nurse was willing to do things differently, as long as safety was not compromised. As a consequence of their being fulfilled in the work
environment and having worked at and achieved a high level of understanding of their own abilities and reactions to situations, their self-assurance and confidence grew. It should also be noted that being self-assured was instrumental in enhancing the nurses’ perceptions of fulfilment in the work environment.

Being self-assured enabled the nurses to forthrightly but tactfully confront and deal with problems or situations that may have had a negative effect on their ability to meet their responsibilities, ensure patient safety and meet personal goals. When possessing the confidence to be assertive the nurses could make a stand on issues they felt were pertinent to their patient and they could decide to do things differently to meet individual patient, self or situation needs.

“... this man next door to me, kept calling out to his nurse, and she was running, she had two patients ... she was going from one to the other, and she had just got out of the curtain and he called her again. ... I said ‘give her a break’, and he said, ‘well can you get me a piece of ice please?’, ... I said ‘can you just lay off, just for a little while
Patients or their relatives viewed at times these frightening situations as threats, and the staff in ICU was viewed as part of that threat. This was especially true of the relatives of a patient with a poor prognosis, who had just been told that there was nothing more that could be done for their loved one. It could also occur because they believed that the staff had not been doing everything possible to assist their relative to recover. Dealing with these behaviours could be difficult and distressing for nurses. The nurses understood on a professional level why this behaviour was occurring, though on a personal level, it could become difficult, if not impossible to continue to care for the patient, or deal with the relatives. Oftentimes patients and their relatives simply required reminding that the nurses were there to assist them, they were not the reason the situation had occurred. The nurses were simply in the ICU to do their job as effectively, efficiently and compassionately as possible.

"... see this is the hard part, ... trying to remember this patient is sick, or the relatives are stressed, it’s not like they are doing it on purpose, and so sometimes it is just a gentle reminder. ‘Remember us, we’re humans too’, … [or] … I’m not the enemy, why are you treating me like one?’ and they go ‘oh, okay, sorry I didn’t mean to start on you, I’ve got pain’ "

(Sally)

Effectively managing and diffusing these tension filled situations meant that the nurses perceived that their responsibilities to patients, relatives and colleagues were met, as were their personal goals and needs. Consequently, belief in and satisfaction with their ability to effectively meet the challenges posed through situations encountered in ICU were increased. The nurses’ sensation of fulfilment with the work environment grew.
Self-assured nurses had identified where they were placed within the intensive care hierarchy together with their level of credibility with their colleagues and peers. They had developed working relationships with colleagues, for example, doctors and nurses. These relationships were based on mutual respect for the individual, their knowledge and expertise within an atmosphere where there was agreement that meeting responsibilities to the patient was paramount. The nurses felt valued and appreciated as members of the ICU team. This understanding and respect, this mutual comfort with each other and level of trust in the working relationship allowed any member of the team to assertively refocus the efforts of the entire team when necessary.

This is exemplified by the following:-

“I just tell them [squatting staff] to go outside, and carry on with the bitch fight outside and come back inside and tell me what’s going to be best for the patient. I don’t give a shit what they do I don’t care. I think I am in pretty good stead with medical staff and nursing staff.”  (Brandon)

The more comfortable, accepted and trusted the nurses felt among their colleagues, coupled with a high degree of self belief and life experience, allowed them to become sufficiently emboldened to effectively deal with situations when they arose. As a consequence, the nurses felt fulfilled, as they perceived they were effectively meeting their responsibilities to the patients, the relatives, themselves and healthcare team members.

Feeling self-assured and fulfilled in the work environment motivated the nurses to want to pass on their knowledge to newer, less experienced members of staff. Teaching, showing new and/or inexperienced staff how to develop strategies to successfully find their way
achieved two things. It not only ensured that the patients received the appropriate level of
treatment, but also allowed the new or inexperienced staff member/s to achieve a feeling of
confidence and a degree of ease with what they were being expected to deal. They
developed this confidence and ease through gaining familiarity with, and developing
expertise in, managing the many and varied nursing procedures while having someone
senior to them to call on for assistance.

“... you need to sort of keep an eye out on them
[new/inexperienced staff in ICU], just sort of guide them
along and things like that.” (Brigid)

This was a means of assisting new/inexperienced staff to develop needed levels of self-
assurance, which over time ensured that a competent, effective member of the intensive
care team was nurtured and developed. The gaining of confidence by this new member of
staff then decreased the burden on the more senior, experienced staff. Higher levels of self-
assurance also emanated from the nurses working out where they stood within the societal
structure of the intensive care environment and from a developing sense of feeling at home
within that structure. Discovering that what they were going through was not unique to
them, that others had endured similar qualms and doubts and effects enhanced the sense of
belonging and comfort.

“And he was saying [a doctor] the same thing. So it is not
unique to me [a physical/emotional reaction to working in
ICU]. And I thought, it is funny, in this role, I am now
finding out, it is not unique.” (Charlene)

Being fulfilled and feeling comfortable and content allowed peace of mind. Peace of mind
in turn led to an ability to concentrate on what had to be dealt with rather than being
distracted by niggling worries and mental and emotional irritations due to discontent. The
nurses’ ability to be fulfilled in the work environment was dependent upon how effective they were in “easing the stress” of situations in which they were involved. The effective implementation of these behaviours enhanced the nurses’ confidence and self-assurance levels.

**Easing the stress**

The final characteristic of “maintaining morale” was “easing the stress”. The nurses were effective in “easing the stress” by being able to reduce the tension and anxiety experienced by themselves and others. This enabled them to feel in control, achieve fulfilment in the work environment and maintain morale. They achieved this in a number of ways. Firstly, by the application of humour, usually self-directed that helped to decrease tension levels. For example one of the nurses, Yvonne needed to get the medical officer to write up some medication orders for a patient who had just been admitted to the ICU. The RMO was not in the vicinity of the patient’s bed area but had been seen heading towards the other end of the unit.

[Yvonne goes to find the RMO, but comes back quickly, red faced and muttering to herself.]

“Better not chase him into the toilet”.

Secondly, through their ability to compartmentalise work life from their private life outside that environment. Thirdly, by supporting, that is giving strength and encouragement, to themselves and their colleagues when needed. The nurses knew to whom they could go to gain comfort when the intensive care became highly stressful. These nurses worked within an environment where it was vitally important that colleagues supported each other. An incredibly close bond, an esprit d’corps was formed between colleagues in the ICU. This developed due to the close working environment and being highly dependent upon each
other to work effectively as a team. Being supported and supportive was an important aspect of the nurses’ ability to continue working effectively within ICU.

The data suggested that personal traits and qualities of the nurses were important and useful tools used to alleviate highly tense situations. They utilised these qualities to ease the stress, to reset the tension levels within situations to achieve a lighter and less strained emotional pitch. This was done to benefit the individual nurse, the patient, nursing/medical colleagues, and relatives. This dimension of “easing the stress” allowed an insight into how these nurses did not take themselves too seriously, despite the seriousness of the work they undertake.

“here’s my sensitive new age guy streak coming through.”  
(Brandon)

The nurses appeared to have thought about what might be required from them to lessen the strain of situations in which they found themselves.

“I think you must have the type of personality where you’re a bit of a Type A, just sort of switch off when you need to,”  
(Brandon)

The data suggested that the overall mood of the nurses was one of optimism and hope combined with a determination to ensure, to the best of their ability, that the most effective outcome would be sought.

Encountering stressful and difficult situations within the ICU environment was not an uncommon occurrence when taking into account the highly critical nature of patients’ conditions and the circumstances that led to their admission to the unit. These situations were often frustrating and distressing for the nurses as well as the patients and relatives. In
an effort to ease the stress of a situation and support their personal striving for clarity of thought the nurses, at times, deemed it necessary to take a short break away from their patient.

“...if it is a very stressful situation at work, you’ve just got to say ‘look I’m going outside for five minutes, I’m going, someone watch my patient, I’m going outside, I’m going to have a coffee, I’m coming back, I’m going to get this sorted’ and that’s how I deal with it.” (Brandon)

Other nurses talked with nursing friends inside and outside the ICU in which they worked, their spouses or partners. Talking over situations with interested persons provided the nurses with a private outlet in which they were able to express their worries and frustrations. Verbalisation of their cares in a safe environment was often cathartic in itself, allowing the nurse to garner some peace of mind and closure to a distressing incident.

“‘I’ve been talking to friends about it, ... just venting how awful it is, what a difficult situation it is and how draining it is, ... it is more [an] emotion thing or psychological or mental.’” (Vivien)

Other nurses found different outlets for their frustrations and ways of achieving an easing of the stress felt. They kept a diary or would journal what had been happening each day as a cathartic exercise.

“normally I log a journal each day” [as a debriefing mechanism] (Khobi)

The nurses looked after self and gained comfort from the knowledge that they were able to share their experiences, worries and frustrations with their colleagues in the ICU, both nursing and medical. These colleagues had possibly been through similar situations themselves or had witnessed and/or been involved in the situation under discussion.
“I always debrief with them [colleagues], and we debrief with each other, or bitching, or whatever you want to call it, it is normally like that.”  
(Emily)

The evidence provided here establishes the prominence that members of this highly inter-reliant group of professionals accorded to providing support for each other. This support/supporting benefited not only the patient and the individual nurse, but their colleagues also. Supporting a colleague enhanced cohesiveness within the group. It enabled a valued and experienced team member to continue effectively meeting their responsibilities and helped to prevent greater burdens of responsibility being placed on other nurses’ shoulders, should the nurse who was in need be unable to continue working safely.

“I think we’re getting into the whole esprit d’corps type thing. ... if someone is having a problem then you’d say ‘Hey I’ll come outside with you and we can talk’ ...” 
(Brandon)

Other methods of looking after self involved rest and recreation, the maintenance of a healthy balanced lifestyle and the development of the ability to compartmentalise, to separate the personal from the professional in situations encountered in the working environment.

“You have to be healthy outside of work, you have to exercise, eat properly, and things like that, you’ve got to take care of yourself.”  
(Emily)

Compartmentalising helped to ensure that the responsibilities of the ICU and all that happened there did not become overly intrusive in the other roles undertaken by the nurses outside of ICU, for example, spouse, parent, child.
“I never bring my problems to work and when I did come here I just lost it so I actually went home and asked for leave, ...people don’t need to know my business and be punished because I’m not feeling good that day.”

(Khobi)

It also helped to ensure that the responsibilities inherent within these other roles did not intrude onto the nurses’ ability to fulfil their role as a registered nurse in the ICU. It was a useful mechanism in focusing concentration on something other than what was troubling or worrying. This was necessary as these outside influences could and sometimes did impede the nurses’ ability to think clearly and effectively.

“... I do find, in many cases, even when I have problems at home, that I separate myself from working here, & when I’m here, I normally forget, not all day, but for periods when I am doing my tasks, I forget a lot that’s happening. I think that is also why I do come to work.”

(Peta)

The nurses appeared to have recognised both inherently and through experience, the need to have some type of protective barrier in place to ensure that they achieved the privacy they required to live their lives as individuals and to function effectively in the ICU.

“.... so once I am out the door, I don’t take work home with me.”

(Sally)

They recognised that if they allowed themselves to carry over into their personal lives much of the stress they dealt with in the ICU that this could and would have detrimental effects on their relationships and themselves.

“I’ll go home, ‘how was your work today?’, ‘oh, you know!’. She’ll pick up [wife], what’s wrong, ‘did you have a shitty night at work?’, and you’ll go ‘yeah’, and you’ll go
into it briefly, of course you’re not going to say ‘well this happened, and… blah, blah, blah.’ … I tend not to try to bring work home.” 

(Brandon)

This separateness was important in providing the nurses with a necessary ‘breathing space’, away from the stress and tension found within the ICU. It enabled them to de-stress, clear their minds, enjoy themselves and re-centre their perspective.

“…try not to take your work home with you, so as soon as you walk out the door, forget that work and just have a good social life as well, like not just at home all the time, eat properly, and go out, and sort of like de-stress.”

(Emily)

For some nurses knowing there would be colleagues on shift, whom they liked, trusted and respected and whose company they enjoyed, was sufficient to ease any stress they may have been feeling prior to the commencement of a shift. They knew through the experience of working with them previously that these colleagues would be supportive and helpful.

“I’ve quite a few good friends now, it’s really enjoyable working with them, …they are really supportive too, …I usually like going to work, knowing they are here and we’ll have a good shift,…”

(Emily)

“Maintaining morale” was central to the participants effectively “creating calm” and ultimately finding their way as they traversed the path of the intensive care nursing experience. How they felt about themselves and their work, their emotional and mental state of mind affected their ability to be effective in sorting out the situation and maintaining effective control. When they were effective in these areas of creating calm, this had a positive effect on their morale, how they viewed themselves and their ability to function as an effective member of the ICU team.
Creating Calm

“Creating calm” was the second of the two major sub-categories within the basic social process of “finding your way”. It was the concept, which emerged from the data that most appropriately represented the intensive care nurses’ ability to bring a degree of composure and control to situations that had the potential to become disorganised and seemingly overwhelming. Order, organisation and the ability to think clearly and dispassionately were essential elements when striving to achieve the safe effective management of a patient in the ICU. This was especially true when unexpected or paradoxical situations developed. For example, when there was arterial bleeding or cardiac arrest, or hypotension in a patient who had been responding well to treatment. Any of the abovementioned is an example of a potentially highly disorganised situation, which could have developed in the treatment plan of a patient in intensive care.

These disorganised situations originated without warning, and needed to be dealt with quickly and appropriately to ensure that the patient did not suffer life altering or life threatening effects. To ensure that these situations were dealt with effectively, that calm was created, the intensive care nurses developed patterns of behaviour, which led to the effective “sorting out the situation” and “maintaining effective control”.

Sorting out the Situation

“Sorting out the situation” was the first of the two characteristics of “creating calm”. Sorting out a situation implied an ability to get to the centre of a problem, identify what was occurring and begin to work out why and how the situation had developed. This necessitated applying some form of order to a situation through disentangling and unravelling details. The first step in gaining this objective required the nurses to calm the
situation, that is decrease the overlying tension and emotion that clouded a clear understanding of what had occurred. They successfully calmed situations through the application and implementation of a number of strategies and behaviours. The nurses initially gained the trust of the persons involved by treating them with respect, not laying blame, listening to what they had to say and having compassion for their plight. This was followed by using their skills as a mediator to diffuse anxiety through their understanding of the causes of stress and its effects. These nurses were able, through the level of autonomy allowed by their position in ICU, to offer people choice options or make a deal with them that ensured the patient’s needs were met and safety was maintained. Lastly, the nurses brought flexibility and adaptability to their approaches to managing problems. They understood that to calm a situation the differences inherent to that situation and the people involved needed to be assessed and accommodated. Sensitivity to the needs and worries of individuals, building rapport and being reasonable were recognised by the nurses as foundational elements in not only calming a situation but ultimately in sorting out a situation and “creating calm”.

The second step in gaining the objective of “sorting out the situation” was “problem solving”. This necessitated the nurses gathering information, that is, finding out what there was to be known about the problem. Analysis of the situation was then undertaken, leading to identification of what had led to its occurrence and why. Lastly, the nurses needed to find a solution or a resolution to effectively manage the situation and then decide upon a course of action to achieve this. The chosen courses of action were based on identifying what was realistically possible and would provide the most good and least harm to the patient. This necessitated an experienced and knowledgeable assessment of
potential risks and side effects to the patient and identification of possible practical problems that could be encountered.

The third and final step in “sorting out the situation” was “putting the situation into perspective”. This step played an influential role in the previous two steps. This required the nurses to have a “sense of fair play”, that is, being fair to the people with whom and for whom they worked, also asking for explanations about occurrences rather than assuming or presuming knowledge and understanding of how events had developed. They maintained perspective through viewing both sides of a situation. This allowed the nurses to see the advantages and disadvantages in a situation from the perspectives of the healthcare team and the patient and their relatives. They were able to identify the difficulties faced by others and in doing so could incorporate these into their “problem solving” efforts and how they approached “calming the situation”.

A simple example of sorting out the situation is contained in the following, which was observed during a field observation session.

Vivien returned to what she had previously been doing before she had been interrupted, which was undertaking a familiarisation round of the unit. She spoke with each nurse, who was caring for each particular patient and also checking the charts to find out about patient care, observations and diagnosis.

By undertaking this familiarisation round Vivien was ensuring that she knew and understood what treatment each patient was receiving and why. This knowledge and understanding would enhance her ability to do her job as team leader for the shift. She would now be able to effectively calm a situation, problem solve and put each situation into
perspective as she now had the baseline information on which to build and apply her experience.

“Sorting out the situation” was comprised of three dimensions, which explained the breadth required to deal with difficult situations. These dimensions were “calming the situation”, “problem solving” and “putting the situation into perspective”.

**Calming the situation**

This was the first dimension of “sorting out the situation”. Situations that required calming could develop between health professionals, patients, relatives, and management. The causes were many and could be related to a perceived lack of care, as an out-pouring of the grieving process, or were related to personal or profession matters.

To calm a situation the nurses needed to be flexible and adaptable in their thinking and understanding and “try ... and diffuse their anxiety,” (Khobi). Intensive care nurses needed to be able to form a rapport with people, become a mediator and discover what it was that was upsetting them.

“I think I’m a mediator, that’s what I would call myself as well, between individual staff and the rest of the team. ...”

(Khobi)

To create calm, the nurses needed “to be able to have a bit more autonomy, ... ” (Brandon) to institute measures to resolve problematic situations. The nurses had attained this autonomy, because they had shown that they were level headed, reasonable, and had the knowledge and common sense to deal with situations reasonably.
Problem solving

“Problem solving” was the second dimension of “sorting out the situation” and played an integral part in the process of “creating calm”. “Problem solving” was influenced by the ability of the nurse to calm the situation. “Calming the situation” allowed any extraneous emotion, which could cloud the issues, to be put to one side. “Problem solving” necessitated that the nurses were continuously thinking about and assessing and analysing occurrences in the ICU, in their efforts to not only effectively manage the needs of their particular patient but to also support their colleagues.

“Yes thinking, yes, thinking about what you are looking for, and if it looks like that is happening, or they are not looking too good, thinking all the time.” (Vivien)

The data suggested that the nurses believed that it was possible to find some type of solution/resolution to any difficulty that arose. For example, Peta suggested that for every situation there was a possible solution, “I always see that there is a solution. ...”

It was also apparent that if a situation was not resolved it could continue to build in intensity and not be readily managed. This could have led to subsequent effects for others.

“I think you have to try and find a solution or a resolution to the problem because it will be continuing.” (Peta)

When consideration was being given to the possible courses of action that could be utilised in the management of difficulties, the consequences of those actions needed to be considered and accounted for in relation to their overall, long lasting effects on the patient.

“I have learnt now that if you divide the labour and divide up all the things that you need to do, it is a lot easier ...and I think that helps ...” (Khobi)
**Putting the situation into perspective**

“Putting the situation into perspective” was the third dimension of “sorting out the situation”. The gaining of a wider view, seeing the bigger picture and the understanding of how the circumstance or circumstances fitted into the enlarged panorama often assisted in “calming the situation”.

“It’s just a fine line. Trying to be sensitive to them, whether they are in pain or they’ve just been diagnosed with a terminal illness. You know, things like that, you’ve got to try and be sensitive to.”

(Sally)

To put a situation into perspective, the nurses needed to maintain their own balanced perspective of a situation.

“This is the hard part, ..., trying to remember this patient is sick, or the relatives are stressed, it’s not like they are doing it on purpose,”

(Sally)

There were always at least two interpretations of an event or circumstance. It was important that the nurse took into account all interpretations, and attempted to understand how these interpretations could have developed.

“I don’t think they [nursing management] have a true appreciation of what the day to day stresses are. ... I can see it from their perspective, their interest and their agenda is purely to make sure that the hospital runs smoothly, and I understand that, but you’ve also got to understand that, the workforce, if you want to keep them, and keep them happy, then you have to consider them as well.”

(Khobi)

How well ICU nurses were able to put a situation into perspective had the potential to affect their attitude towards and their ability to achieve effective sorting out of the situation.
encountered. This was because the degree of perspective that could be gained in relation to any situation affected understanding of that situation, thereby influencing situational management choices.

**Maintaining Effective Control**

“Creating calm”, the second sub-category of “finding your way” also conceptualised the data which explained how ICU nurses maintain effective control. “Maintaining effective control,” explained how nurses possessed the necessary experience, understanding, knowledge and skills to foresee potential problems and effectively manage these problems. The nurses also needed to remain alert to the development of further possible problems and difficulties, while striving to ensure that any potential consequences or side effects were minimised. To achieve this they needed to have a grip on things and to be professional in their approach to the management of these problems.

**Having a grip on things**

“Having a grip on things”, the first dimension of “maintaining effective control”, explained how nurses were experienced in dealing with patients who presented with similar needs to past patients. Nurses who had a grip on things were able to deal rapidly and effectively with dangerous situations that may have occurred in the patient’s progress towards recovery. These nurses understood in detail the physiological processes the patient was undergoing and were alert to any changes in signs and symptoms the patient presented. They felt they had the means, the skills and knowledge to control the situation.

“... thinking, yes, about what could happen, knowing what you are looking for, and if it looks like that is happening, or they are not looking too good, thinking all the time ... ”  
(Vivien)
When nurses were experienced in intensive care nursing, they had developed knowledge and experience that was refined through practice. They were able to tap into this knowledge and experience almost without thinking, when caring for their patients. It alerted the nurses to those situations that required close monitoring; enabling them to assess rapidly what was right and wrong with any situation. This knowledge allowed the nurses to feel in control of situations, that they had a grip on things.

“... knowledge is power, but knowledge is being in control of a situation, knowing, in the ICU, in relation to a certain event, to know what I am doing and why I am doing it, and how to cope with it, then I am in control,” (Vivien)

Competence and confidence, “being careful and cluey” (Brandon), stemmed from the experience they had gained in dealing with similar situations, their knowledge and understanding of how and why these situations developed, what could go wrong and what signs to look out for in assessing the patient’s progress. It ensured that the nurses knew when to intervene to maintain patient safety.

“you’re not going to let anything happen, something isn’t going to happen that you don’t look at [it] and say, (A) ‘should that be happening?’, or ‘that shouldn’t be happening’, and you do things so it is safe for the patient.” (Vivien)

“Having a grip on things” was an essential element in the nurses’ efforts in “maintaining effective control” of the situations that developed in managing the needs of highly dependent patients. This maintenance of effective control was assisted by and assisted the nurses in “sorting out the situation”, which in turn aided in “creating calm” effectively.
Through its influence on “creating calm” the effective exercising of the characteristics of “maintaining effective control” influenced the nurses’ efforts in “maintaining morale”.

**Being a professional**

“Being a professional” was the second dimension of “maintaining effective control”. This dimension implied that a professional was a person who was knowledgeable and skilled in a particular area of endeavour, dependable and able to do the job. These nurses were able to manage problems effectively. To function effectively as a nursing professional it was necessary to put aside personal reactions and responses to people and situations in deference to the identified needs and requirements of the patients.

“I am there to care for her [the patient]. ... and at the end of the day I may have a personal opinion of something, but it doesn’t enter into my thoughts as far as caring for the person. Nor should it.”

(Brandon)

Being a professional implied an ability to “do the job” that needed doing. To accomplish this the nurse had to be able to handle situations as they presented, with calm and logic.

“You try to present that attitude, [being laid back, cool about things with a caring attitude], you may be anxious and panicky within, but you have got try and present that, ... you’ve just got to keep your head ... you really can’t let it get to you, [the stress], ... you have got to get through it, and then you find yourself saying, shit how the hell did I do that.”

(Brandon)

Professionals were aware of the reality of the environment in which they worked and lived and the effect that events had on themselves, their patients, colleagues, and work institution. They had life experience and knew how the land lay. They needed to be aware of the
constraints these events produced and how these could affect their ability to safely and effectively care for their patients.

“All they [management] are concerned is about getting the numbers right and making sure it is staffed, and I understand their concern, but that’s why you don’t retain people and you don’t, you know, you don’t provide, if it is just a token, then people wake up to it after a while.”

(Khobi)

A professional had earned the respect and trust of their colleagues through their continued delivery of high quality care and the application of sound judgement to many and varied situations. Their colleagues had deemed them dependable and trustworthy.

“…if you can show that you know what you’re doing, you’re not going to be a spatter head and do something without asking or make a rash decision, without consulting anyone, and it is just mutual respect...”

(Brandon)

Part of being a competent, professional practitioner was an awareness of the availability of resources. Being aware of the skill levels of colleagues, which were viewed as resources, proved to be advantageous to the nurses, their colleagues and the patients.

“I guess working with friends that you know to a certain skill level, it is easier to know you can trust them,”

(Brigid)

Knowing who had expertise, and in what areas meant that a viable resource had been identified and could be utilised. This was an important part of being a professional as it enhanced the nurse’s ability to do the job effectively, and have a grip on things. A professional who was “maintaining effective control” knew where or to whom they could go when support or input was required to manage a patient situation effectively.

Knowledge regarding resource availability and capability was found to be important when
the professional was in a leadership position and needed to allocate and match staff to patient needs.

“you need to find out how much they know, [new/junior staff]” (Peta)

Being aware of the skill, knowledge and experience levels of co-workers, allowed the more experienced nurses to give assistance or guidance to a nurse who was new to the ICU, who might have been inexperienced or had never encountered a particular situation previously.

“You still need to come back [to check on the nurse’s progress], ... everyone has to start somewhere so, ... As long as they have a bit of a go, ....” (Brigid)

This was a means of ensuring the safety and comfort of the patients and the nurses. The utilisation of the strategies necessary for “having a grip on things” and “being a professional” assisted the nurses in “maintaining effective control”. This in turn combined with the outcomes from the application of the strategies associated with “sorting out the situation” resulted in “creating calm”.

**Conclusion**

“Finding your way” through the path of the intensive care nursing experience was not easily or quickly accomplished. A vital element in achieving success in “finding your way” necessitated that the nurses developed levels of knowledge and skills sufficient to ensure the effective management of the needs of critically ill, highly dependent patients. They needed to encounter and experience as much and as many of the possible situations that could and did develop in this environment. Being exposed to these experiences acted as a stimulus in the development of patterns of behaviour that allowed them to effectively meet their responsibilities to their patients, themselves, colleagues, management and the public.
These patterns of behaviour ensured that the nurses could maintain their morale. They achieved this through knowing themselves, being able to ease stressful situations, being happy and fulfilled in this work environment and feeling self-assured, confident and capable of controlling situations as they arose. Success in maintaining morale enabled the nurses to be effective in creating calm. The data suggested that a self-assured, confident nurse felt more capable of effectively sorting out situations whether simple or complex, and maintaining effective control over those situations. It was apparent from the above statements that for the nurses to successfully find their way it was essential that they developed appropriate and effective methods and strategies in “maintaining morale” and “creating calm”.

The following chapter, chapter seven will discuss the findings that emerged from this current research study in relation to previous research. Secondly, the limitations of this study will be identified. Thirdly, the implications of the current research findings will be identified. Lastly, recommendations stemming from this research study will be made for nursing education, research and practice.
INTRODUCTION

This study was undertaken using grounded theory in an effort to discover why and how experienced, intensive care nurses commit to and continue with a career in bedside nursing in this area of practice. To accomplish this aim, firstly the social processes involved in being a registered nurse in intensive care needed to be descriptively detailed. Secondly, a theoretical analysis of the shared meanings and behaviours of these registered nurses was required to be undertaken. In this study theoretical analysis was accomplished through the use of grounded theory, which fostered the emergence of a substantive theory from the data. This substantive theory presents one possible explanation of why registered nurses decide to pursue a career, and continue to do so, in this area of nursing and how they achieve this aim. The theory, titled “Traversing the path of the intensive care nursing experience” provides an exposition of the dilemmas and challenges faced by these nurses as identified in “Losing Direction” and how solutions or resolutions to successfully overcome these dilemmas and challenges were achieved, as identified in “Finding Your Way”.

This chapter includes a discussion of the findings that emerged in this study in relation to nursing in the intensive care environment within one area of the Australian healthcare system; the problems and difficulties or stressors that were encountered and the coping strategies employed to deal with situations that ensued. Finally, the limitations of this study will be identified, the implications of the findings will be made clear and recommendations will be made for nursing education, research and practice.
This study identified that nursing in the intensive care environment within the contemporary Australian healthcare system was an increasingly demanding, difficult and complicated undertaking. This stemmed not solely from the dilemmas and challenges that presented with each new patient and their individual set of needs. It may have also been a consequence of a healthcare system in crisis and the ever-increasing expectations and demands of the healthcare system and the public for nurses to manage effectively and efficiently no matter what situation they find themselves in. Jones and Cheek (2003) and Pearson (2003) support this finding. These authors found that nursing in the current healthcare system in Australia, whether in intensive care or in any other working environment is a highly stressful endeavour fraught with difficulty and complications. They identified that today’s nurses must possess knowledge and skills covering wide areas of expertise, not just in those areas traditionally associated with nursing (Jones & Cheek, 2003; Pearson, 2003).

This present study also identified that contemporary ICU nurses needed to be highly flexible and adaptable in their approaches to managing complex situations. This flexibility and adaptability was necessary because of the wide variation in the needs presented by patients and their families, the constraints within the healthcare system, and the use of multidisciplinary healthcare teams in the management of the patient’s condition. This finding is not unique to this present study. Erlen and Sereika (1997) have previously identified that the dilemmas and challenges faced by the nurses in this difficult and complicated working environment are often associated with issues related to patient care management. They further suggest that these dilemmas and challenges have been made more difficult and complicated because of a number of occurrences within healthcare itself.
(Erlen & Sereika, 1997). These occurrences include the advances in healthcare technology, the changes in healthcare delivery that have generated new nursing responsibilities and roles, the increasing complexity of patient health problems and the correspondingly increasing use of complicated technology that can result in increased patient morbidity and mortality (Erlen & Sereika, 1997).

The data revealed for the first time that nursing within the ICU environment, where potential dilemmas and challenges frequently arise, was a journey that couldn be both stimulating and frustrating. The conceptualisation of traversing this nursing experience pathway rather than merely travelling or touring along it, encapsulated a deliberation of choice and a determination by these nurses to seek out stimulating and challenging work experiences. No previous literature has conceptualised nursing, either in ICU or elsewhere, as a journey along a path of exploration and discovery. From the literature reviewed only Wuest (2000) suggests, “navigating troubled waters” (p.52) is a process to describe relationships in healthcare.

According to the data in the current study nurses provided a link between the patient, the multidisciplinary healthcare team members and any unseen outcomes. This suggested that the nurses working within the intensive care environment needed to be multi-skilled, have a high level of expertise and be highly adaptable to continually changing situations and requirements. This finding is similar to findings by Duffy and Hoskins (2003) who identified the nurse, no matter what environment in which they were practising, as the linchpin between the patient and the multidisciplinary team working for the patient. Duffield, et al. (2001) also support this finding as they suggest that it is vital nurses of today understand and appreciate the complexities of the clinical areas in which they practise. To
elaborate further, today’s nurses must function effectively and efficiently within that area of practice and have mastered or be gaining expertise in the use of technology, resource management, strategic planning and risk management (Duffield, et al., 2001). The findings from the present research expand on this body of knowledge in relation to nursing in intensive care.

The requirements for nurses to be highly adept and knowledgeable in many different areas of expertise within the constantly changing environment of the health system had the potential to add stress to situations which were already highly stressful. Despite this, stressful situations were not always viewed as negatives. Highly stressful situations were often seen as providing nurses with challenges that needed to be met and overcome. This finding is not unique to this present study. It is similar to what is suggested by Goodfellow, Varnam, Rees, and Shelly (1997), and Lazarus and Folkman (1984). These authors found that many stressors in the work environment are perceived as satisfying challenges rather than being distressing.

The challenges identified in the current study spurred the nurses to make greater efforts to enhance their knowledge levels, develop their skill proficiency and refine their management capabilities. The nurses who viewed the stressors as challenges were continuing to feel sufficiently motivated and able to successfully find their way through the intensive care nursing experience. This was apparent from the data, all the participants stated that they were about to undertake, were undertaking, or had undertaken further courses at higher levels of learning. They were all looking for challenges from their practice in intensive care; they expected, craved and even demanded the challenges as a means of maintaining their interest in this area of nursing practice. The data suggest that if
the nurses who were successfully “traversing the path of the intensive care nursing experience” believed that this environment ceased to provide sufficient challenges to their abilities, then they would become bored. Boredom would lead to the consideration of resignation and the finding of employment in some other, more stimulating and challenging area of nursing. The data from this study did not indicate what measures the nurses would take if they continued to lose direction; if they continued to perceive that they were unsuccessful in being able to meet the challenges they encountered and ultimately not meet their patients’ needs.

The level of motivation engendered by the challenges encountered and the continuing craving and demanding of these challenges by the research participants as stimulants to continuing their interest in this area of nursing has expanded previous research in this area. This continuing need for stimulation and challenge may be indicative of a number of characteristics of those nurses who choose to work in ICU. It may indicate that such nurses are motivated high achievers, or they have a tendency towards being higher risk takers than other nurses, or it could simply indicate that ICU nurses self-select into this particular area because it provides them with the levels of stress and stimulation they require for personal development. It could also, as suggested by Sawatzky (1996), be that ICU nursing attracts persons, who through their temperaments and personalities, tend to be challenged rather than threatened by stressful situations. This area requires further research.

Being able to meet challenges successfully allowed the nurses to feel in control of situations. When they were in control of situations the nurses felt confident in their ability to prioritise patient needs and sort out what was happening to the benefit of the patient.
They were able to effectively meet their patient’s needs. This finding is not unique to this present study, though it does add to the accumulated body of knowledge in this area. According to Sawatzky (1996), intensive care nurses’ perception of their level of control over situations plays a significant role in the level of stress they experience. Similarly, Averill’s (1973) work suggests that a reduction in stress reactions occurs in the majority of cases, when a person has, or perceives they have personal control over a situation in a context that is meaningful for them.

The data suggested that having a sense of control over what was occurring heightened the self-esteem and self-belief of the study participants. Their positive self-concept as an effective, contributing member of the healthcare team was reinforced. This impacted positively on their morale levels. They felt rejuvenated in their quest to continue traversing this particular nursing career path. When the nurses did not feel in control of situations or their morale levels were low, challenges were not being met successfully and they lacked motivation. For these nurses their perception of the stressors was overwhelming them, they were “losing direction” along this path of nursing experience. Their self-esteem and self-belief was low; they were feeling defeated and demoralised. Their ability to effectively meet their patient’s needs was diminished. This inability to function effectively in the role of nurse may, as Fagermoen (1997) suggests, lead to a decrease in the self-concept of these nurses both as nurses and persons. This loss of self-esteem and feelings of failure have the potential to lead to frustration, distress and exhaustion. As identified above this finding is not unique to this study, but it does expand on previous knowledge and reaffirm the need for nurses in ICU to maintain high levels of self-esteem and morale, as these areas can affect their ability to effectively meet patients’ needs.
The following two sections will discuss in detail the areas of “Losing direction” and “Finding your way”. These two conceptual categories identify the opposing directions that the path of nursing experience in ICU can take. It was apparent from the data, that for all the participants, despite the number and frequency of dilemmas and challenges encountered, or their intensity, that none wanted to leave the ICU environment. They had successfully identified and developed strategies that allowed effective management of these challenges for the benefit of the patient and the nurse. A means of “finding your way” had been achieved by all the participants of this research. What is distinctive about this study is the way in which the various characteristics and dimensions incorporate both previous and new information into a total, flowing and plausible explanation of how and why nurses choose to stay in a career in bedside nursing in ICU.

Losing Direction

The data from this study indicated that nursing in intensive care was a very stressful undertaking. This was despite the level of education achieved by the participants or the number of years of experience in this particular area of nursing; stress to some degree affected and at times continued to affect each of the participants. This is consistent with previous research, which has identified the intensive care environment as being highly stressful in which to work, even if the nurses are experienced, highly knowledgeable and skilled (Crickmore, 1987; Dewe, 1987; Ehrenfeld, 1990; Erlen & Sereika, 1997; Goodfellow et al., 1997; Laubach, Brown, & Lenard, 1996; LeBlanc et al., 2001; McNeese-Smith, 1999; Sawatzky, 1996; White & Tonkin, 1991). “Losing direction”, the basic social problem, developed when the stressors faced by the nurses increased in intensity or number or both and the nurses began to feel that they were unable to deal with
them effectively and meet their responsibilities to their patients. The stressors that were identified in the data included “becoming exasperated” and “losing your grip”.

“Becoming Exasperated”

This study found that the nurses became exasperated due to their becoming fed up and feeling frustrated with a number of problems and difficulties they faced in the ICU. They perceived a lack of support or trust from nursing management primarily, not the direct management within the unit but nursing administration. They were “being let down by management”. This lack of support meant that when these nurses needed resources, whether staff, hardware or moral support it was not or very rarely available. There was an identified perception by the nurses of a “them and us” mentality, with nursing and hospital administration on one side of the line and the nurses on the other.

The data identified that the nurses believed that when a situation developed they were more likely to be accused by nursing management of causing the situation even before being asked for their side of the story. This type of behaviour led to the nurses “being fed up”, with how they were treated, “being frustrated” with the perceived injustices and unfairness and ultimately “becoming exasperated”. This lack of understanding, trust and support from supervisors has been identified by a number of previous researchers as a typical problem often identified by nurses as a stressors (Crickmore, 1987; Dewe, 1987; Erlen & Sereika, 1997; Hutchinson, 1987; Taylor, White, & Muncer, 1999).

Sawatzky (1996) suggests that stress is increased for nurses working in the intensive care environment because they are increasingly being expected to assume greater levels of responsibility for the management of patient needs. This ever-increasing responsibility and
expansion of the expectations placed upon them leads these nurses to the perception that they are continually on the firing line. This is consistent with earlier research which found that nurses are not only faced with the need to have achieved technologic expertise and excellence but are continually being confronted by the real or potential crises of patients and their families (Erlen & Sereika, 1997; Laubach, Brown, & Lenard, 1996; Sawatzky, 1996). This study reaffirms these previous findings and extends the accumulated knowledge base in this area. It confirms that despite the multitude of previous research undertaken on the intensive care area, and the acknowledged stressors inherent to working in this highly stressful environment a number of problems continue to exist. Very little appears to have changed regarding the attitudes, expectations and efforts at support of some levels of management towards nursing staff in this area. This remains a major source of stress for ICU nursing staff.

The data from this study suggested that violence and aggression towards nurses in ICU was not an uncommon occurrence and could affect the nurses’ levels of tension, anxiety and ability to concentrate. The participants identified the more likely perpetrators of incidents of violence and aggression, were patient’s relatives. It was also identified that these incidents of violence and aggression seemed to be happening with greater frequency. These disturbing occurrences usually took the form of verbal abuse; though on infrequent occasion highly frightening verbal threats of physical harm to staff members were encountered. These findings contain some similarities and differences to previous research undertaken (Jackson, Clare, & Mannix, 2002; Lipscomb & Love, 1992; O’Connell, Young, Brooks, Hutchings, & Lofthouse, 2000; Rippon, 2000; Rosenthal, Edwards, Rosenthal, & Ackerman, 1992; Wells & Bowers, 2002). The prevalence and nature of violence and aggression occurs in most areas of nursing not solely in the ICU environment.
Violence and aggression among colleagues was not apparent from the data of this study. The data suggested that there were highly developed and maintained levels of collegiality, camaraderie and team spirit among the staff within the ICU environment. The emphasis in the data was on “sharing in the esprit d’corps” rather than the identification of aggression among colleagues. If a colleague was occasionally moody, grumpy or reacting in a way that was out of character, the data suggested that this was viewed as something that happened to everyone at some time, rather than a case of overt, spiteful aggression. These colleagues required support, not recrimination. Previous research has identified the patient as the primary instigator of violence and aggression towards nurses, followed by relatives, medical practitioners and other nurses (Jackson et al., 2002; O’Connell et al., 2000; Rosenthal et al., 1992; Wells & Bowers, 2002). Whereas, in this study the primary perpetrators were relatives of patients with little mention of patients and even less of medical staff and other nurses. Perhaps this finding is situation specific to the intensive care (IC) units in which this research was carried out. Another possibility is that the nursing and medical staff and other members of these healthcare teams have developed such a high degree of effective communication and team spirit that there are hardly any incidents of aggression, let alone violence among them. Finding answers to these questions identifies the need for further research to be undertaken in this area of interest, perhaps in the specific units used in this study.

All participants in this study whether male or female reported similar types of violent or aggressive incidents encountered and noted the increasing frequency of occurrence. This type of threatening encounter was identified as unpleasant at the physical level, though potentially understandable at the emotional level, as an outpouring of grief. This finding
was virtually unique to this study, as previous research has identified male nurses as the most likely targets of violence and aggression (Hegney, Plank, & Parker, 2003; Jackson et al., 2002; O’Connell et al., 2000; Rippon, 2000; Wells & Bowers, 2002). Only a report by the Queensland Government (2002) identified a higher likelihood of female nurses being harassed compared to males. What was identified in this present study, as even more upsetting and frustrating to the nurses, was the lack of action taken by nursing and hospital management to put in place measures to ensure staff safety and security, after having been informed of these threats to staff.

“Losing Your Grip”

“Losing your grip” subsumed stressors that include staffing levels, multiple role expectations, workload issues, perceived levels of exhaustion, the need to frequently manage emotionally demanding situations, a sense of powerlessness and lack of control, patient and relative behaviour, and interpersonal relationships with allied health staff. These issues impacted upon nurses’ self-perceived adequacy regarding their knowledge base and skill proficiency.

These findings are similar to a number of stressors identified by previous research (Bucknall & Thomas, 1997; Crickmore, 1987; Dewe, 1987; Ehrenfeld, 1990; Hutchinson, 1987; Erlen & Sereika, 1997; McNeese-Smith, 1999; Satwazky, 1996; Taylor, White, & Muncer, 1999). What this study did not identify as stressors were the intensive care environment, the use of high-level technology or the continuing need to keep abreast of developments in technology and enhance expertise and proficiency in the operation of this technology.
Cooper (1993) suggests that because this is such a highly technological environment the nurse’s focus of attention would be diverted from the needs of the patient as an individual to the needs of the machines; that the machines would become the focus of attention. This study found that despite the environment being highly technical, the central focus for all the study participants was the patient as an individual. The technology used within this environment was a tool that enhanced the ability of the nurses to effectively meet the needs of the patient. The technology did not supersede the patient as the central focus of the nurses’ efforts.

The data suggested that low staffing levels, and inadequate numbers of staff with the appropriate levels of experience and education, available to ensure patient safety each shift, were stressors. This is consistent with an earlier study by Erlen and Shereika (1997) who identified that nurses encountered higher levels of stress when there were increased workplace restrictions such as insufficient numbers of staff to do the work. Another noted cause of stress or frustration in the data was the perceived lack of willingness by nursing administration in returning ICU staff to ICU once the workload in that area had increased. The data in this study suggested that nurses in intensive care perceived nursing administration as not recognising how physically or psychologically demanding situations became. These nurses felt used by the system; this led to them becoming angry because they felt powerless to prevent this happening; their perception of their ability to manage and effectively control situations diminished. Farrell (1999) and Taylor et al. (1999) have identified similar findings in their research. Data from this current study suggested that these previously identified occurrences all served to heighten nurses’ perceptions that they lacked sufficient control over situations. This lack of control in turn added to their stress levels and lead to their feelings of being overwhelmed. Wolfgang (1988) drew a similar
conclusion when noting that nurses are often subjected to situations in which they lack control, and a response to this lack of control may manifest itself in the high stress scores exhibited by nurses.

It was indicated by the data in this study that when nurses became physically, mentally and emotionally exhausted, they felt less than effective in meeting their responsibilities. Exhaustion and powerlessness led to “diminishing self-assurance” and “feeling overwhelmed”. The nurses’ actual and perceived abilities to effectively manage patient needs were becoming compromised. These feelings led to the nurses acting in ways that were very different from their normally controlled and competent manner. They began reacting rather than thinking in response to situations and displayed signs of feeling stressed. This stressed behaviour when they were “feeling overwhelmed” was manifested by the nurses showing irritation, being cynical, snapping in response to questioning; they became demanding of time and input from other members of the healthcare team; they lacked patience with people and situations, and became vulnerable to taking occurrences or interactions personally; they began “taking things to heart”. The nurses were losing the ability to effectively compartmentalise the professional from the personal. Similar cause and effect situations have been identified elsewhere (Garrett & McDaniel, 2001; Janssen, de Longe, & Bakker, 1999). These factors were conceptualised in this study as “reacting not thinking”. Existing literature has termed this as “anger”, “irritability”, “depression”, “disorganisation”, disillusionment”, “blushing” and “inability to cope” (Taylor et al., 1999; Vives, Caminero, Oliver, Capo, & Casado, 1994; White & Tonkin, 1991). These terms imply flustered, emotion-laden responses, reaction without thought, but do not explicitly identify this study’s data or the consequences of these responses. This present study has
explicitly identified and grouped these consequences of emotions, to more clearly portray and highlight their potential effects on patient management and nursing morale.

The inability of nurses to compartmentalise, to separate personal from professional due to “feeling overwhelmed” coupled with the exhaustion, high workload expectations and lack of control when “losing your grip” assisted in the emergence of a “diminishing self-assurance”. This “diminishing self-assurance” had a negative effect on all the other areas previously mentioned. The nurses began to doubt their ability to be effective their area of nursing practice. They were frustrated because they did not believe that were able to fully concentrate on the needs of patients or their relatives or give sufficient attention to their personal ambitions and aspirations for career advancement. Feelings of having somehow lost some degree of control over what was occurring and how it was being managed became apparent. Their concept of themselves as an effective, resourceful, resilient nursing practitioner was being threatened. They were “being demoralised/dejected/sad” and at times “reluctant to come to work”. Stress levels were rising; job satisfaction levels were low. These nurses were being pushed to the limits of their abilities to maintain a reasonable perspective on what and why these things were occurring.

Despite the feelings generated by the frequency and intensity of the abovementioned dilemmas and challenges, all the research participants voiced their determination to discover the strategies and behaviours they needed to develop to effectively deal with the causes of “losing direction”. How the participants went about “finding your way” will be discussed in the following section.
“Finding Your Way”

As previously discussed in Chapter Six, “finding your way” identified how the study participants achieved the level of job and personal satisfaction that motivated them to continue nursing in the ICU environment. A detailed discussion of the strategies used to successfully meet and effectively manage the varied challenges in the ICU will be undertaken. As identified in Chapter Six, the major components of “finding your way” comprised “maintaining morale” and “creating calm”. “Maintaining morale” subsumed the characteristics of “being fulfilled in the work environment” and “easing the stress”. “Creating calm” comprised two major characteristics, “sorting out the situation” and “maintaining effective control”. “Sorting out the situation” subsumed “calming the situation”, “problem solving” and “putting the situation into perspective”. “Maintaining effective control” subsumed “having a grip on things” and “being a professional”.

All the participants in this study had been working in the intensive care environment for a minimum of three years, with the majority of the participants having at least five years experience. They remained because they enjoyed the work. The work sufficiently challenged and stimulated them to cause them to want to return and face the challenges again and again. These nurses were motivated to return to work each shift because they believed they were able to make a difference; they had something worthwhile to offer. Their confidence was high. They believed that they were capable of effectively managing the situations they encountered. This confidence and self-belief developed over time and through experience. These nurses had discovered what they need to do and how to achieve this, to successfully find their way through the intensive care nursing experience.

According to Laubach, Brown, and Lenard (1996), despite the continual necessity of dealing with high levels of stress, both psychologic and physical, there is longevity of
tenure by nurses who choose this speciality nursing area (ICU) in which to practise their profession.

Maintaining Morale

This study found that the focus of central importance and interest for the ICU nurses was human interaction and relationship development. These relationships developed through necessity, but also through the concern of one human being for another, between nurses, patients, patients’ families and the members of the multidisciplinary healthcare team. These interactional, supportive relationships developed in particular between the nurses working in ICU. The data suggested that these relationships allowed the participants to feel supported, appreciated and valued. Those relationships that developed with peers and colleagues were vital to “maintaining morale”. They provided a safe, secure environment in which support was given or received as circumstances dictated thereby “easing the stress”.

The data identified that an “esprit d’ corps” developed among colleagues in the ICU team. This was a high level of team spirit and bonding that developed when people worked closely together in circumstances of high stress and emotion. This finding is consistent with work by Biley (1989) and Gardner, Prazen, and Stewart (1980), who found that close relationship development and the exhibiting of high levels of team spirit and enthusiasm within the healthcare team is often seen in ICU’s. Working in the ICU environment often requires team members to rely on the knowledge, expertise and experience of each other in situations that rapidly become hectic, stressful and fraught with danger. Relying on someone who is known to you engenders confidence. You have interacted and assessed their level of competence prior to the development of an emergency situation, and this aids
in decreasing the stress felt by those team members dealing with the emergency. This knowledge and understanding leads to an atmosphere in which there is a team, which is capable of functioning at highly developed levels of coordination and cohesiveness of action. This benefits the patient, their family, the individual team members and the hospital system. Duffy and Hoskins (2003) suggest that this fostering of relationship development enhances the growth of cooperation among members of the healthcare team, plus providing a means of enhancing the coordination of the efforts of the entire team on behalf of and for the benefit of the patient and their family.

The forging of good working relationships between the participants and other members of the intensive care team was highly important in this fast paced environment. Colleagues needed to work closely together; they depended on each other; they developed trust in each other’s capabilities; they formed closely knit bonds. There was an expectation that colleagues would be competent and knowledgeable. Colleagues from these closely bonded environments not only provided backup for each other in situations that focus on the patient within the unit, they were also able, as suggested by LeBlanc, de Jong, de Rijk, and Schaufeli (2001), to provide social support to each other. Colleagues supported each other, whether the situation revolved around a patient difficulty, the staff members’ need for reassurance about an unfamiliar procedure or colleagues debriefing among themselves to release tension. This was precisely one of the means used by nurses to maintain morale. It was a strategy that aided in the maintenance of the nurses’ own morale and that of their colleagues. This giving of support to and being supported by your colleagues was not solely undertaken for altruistic reasons. Ensuring that known, knowledgeable, skilful, trusted and reliable colleagues remained on the team meant that workloads were maintained at manageable levels; that effective patient management remained possible and
the potential for mistakes to occur did not increase. These trusted and reliable colleagues provided outlet mechanisms for other colleagues with whom they could debrief, one of the many strategies identified that assist the participants in “effecting catharsis”. Crickmore (1987) suggests that this type of social support at work lessens the likelihood for the development of clinical distress.

The provision of social support was not the sole means used by the nurses in “maintaining morale”. They needed to develop an understanding of how they as individuals reacted to situations; how they maintained their equilibrium; what were their personal wants and needs; what motivated them and what were realistic self-assessment strategies to apply to their performance. There was a need to develop an awareness of self, a “knowing self”. The data identified that nurses acknowledged they needed to have developed this personal understanding, as it assisted in their “being fulfilled in the work environment”. When the participants were fulfilled in their work they were self-assured and confident in their ability to function as a fully participating team member. They displayed no hesitation in being assertive when needed, as they had sufficient confidence in their knowledge, skills and standing within the ICU community. Levels of confidence grew from the participants having worked out their place within the hierarchy of the particular ICU milieu in which they were working. This enabled them to develop the sensation of feeling at home within this community and within themselves. Self assurance and confidence led to nurses feeling capable of confronting problems directly, voicing their opinions regarding the management plan for the patient, advocating for the patient, taking up their responsibilities in guiding new staff, educating staff and enhancing the learning environment.
According to the data from this study, nurses who successfully maintained morale were able to effectively create calm and vice versa. The level of self-esteem perceived by the nurses, their concept of themselves as effective, efficient, contributing members of the healthcare team responsible for the safe management of their patient affected, and was affected by, their competence in “sorting out situations” and “maintaining effective control”. According to Cowin (2002), self esteem, a dimension of self-concept, was critical to the nurses’ perception of a positive professional identity, which in turn is related to job satisfaction, retention rates and stress levels. Cowin (2002) also suggests that nurses need to maintain a positive self-concept as an imperative to them effectively fulfilling their position of trust and responsibility within the healthcare team.

**Creating Calm**

As previously stated, this study found that the pivotal interest for ICU nurses was human interaction and relationship building. This finding is supported by Chinn and Kramer (1999) who suggest that the primary focus of nursing is human interaction. Duffy and Hoskins (2003) confirm this when they suggest that nursing is relationship-centred with the primary focus of the work of nurses being relationships with patients, their families and other members of the multidisciplinary healthcare team. According to the data from this present study, relationship development with patients, relatives and healthcare team members assisted the nurses in their efforts in effectively “sorting out the situation” and “maintaining effective control”; that is, in “creating calm”.

The study participants all exhibited understanding and empathy towards the needs of patients and a sensitivity towards the needs of those persons who were significant in the life of the patient. The data suggested that ICU nurses were cognisant of the importance of
incorporating significant others into any plan of management for a patient. This empathetic understanding and willingness by the participants to recognise and give credence to the individual needs and concerns of their patient and their families assisted in the development of trusting relationships. Walters (1995) supports this finding and suggests that an important factor in the development of a trusting relationship between the nurse, the patient and their significant others was the nurses responsiveness to the needs of the patient. This responsiveness included the nurse recognising and demonstrating a belief in the importance of the incorporation of relatives and loved ones in the effective management of a patient’s needs. This is, as Walters (1995) suggests, “recognition of the connectedness of people” (p. 492), which is a vital ingredient in growing trusting interpersonal relationships.

The data from this current study identified that those relationships based on human interaction developed for a number of reasons. They allowed the gathering of necessary and important information from the patient and their family, which was useful in the effective management of the patient’s condition; gaining the trust and confidence of the patient and family helped in alleviating many stressful situations that occurred in the course of a patient’s stay in the ICU; levels of cooperation between members of the healthcare team were heightened. The understanding of the individual needs and circumstances of patients and relatives, which developed from these relationships, guided the nurses in the utilising of flexibility and adaptability in their assessment and handling of situations and stressors.

The data suggested that mediation skills were often needed to ensure that the anxieties, stressors and hopelessness of situations felt by patients could be worked through to
highlight if not achieve some potential, positive outcome. The patient’s and their relative’s confidence and trust in the nurse grew; they felt they were dealing with someone who had an understanding, an appreciation of what they were going through and how they were feeling. This gaining of trust aided the nurses in the process of “problem solving”.

This finding is consistent with Rogers (1980) who suggests that the chief purpose of empathy is as the foundation for effecting therapeutic change or for helping. Kalisch (1973) and Tyner (1985) suggest that one of the primary purposes of empathy is to provide comfort to the patient through the sharing of pain, which relieves feelings of aloneness and isolation and displays a valuing of the patient’s point of view. Barrett-Lennard (1993) and Kalisch (1973) both indicate however, that for empathy to be effective it must be communicated to the appropriate person at the appropriate time; that is, it must take place at the moment of the patient’s need (Forsyth, 1980). In this study, patients and relatives trusted the nurse, they were more willing to give information to the nurse about areas that could be helpful in “analysing the situation” effecting the patient’s status. This information could then be relayed to the healthcare team.

“Putting the situation into perspective” allowed the nurses to see situations from the perspective of the patient and that of the healthcare team. It required the nurses to appreciate the fears, worries and hopes of the patient and their family and the responsibilities of the healthcare team to the patient. This balancing of perspectives aided in ensuring that information was relayed to patients and the healthcare team in terms that were understandable to each.
The data indicated that nurses within the healthcare team were crucial in instigating, organising, managing, coordinating and ensuring the overall smooth running of the patient’s management. These nurses were the members of the healthcare team who were with the patient and their families for the longest periods of time, whether that was over a twenty-four hour period or the patient’s entire stay in the ICU.

Nurses were often the port of access for information from patients/families to other health professionals or vice versa. The data suggested that it was the nurse who often informed or brought to the attention of other team members areas that needed to be investigated or activities that needed to be done for the patient. Nurses highlighted indicators of potential problem development, made other health team members aware of specific family needs and concerns and often bore the responsibility of providing a communication conduit between members of the healthcare team and the patient and their family. These findings are supported by Duffy and Hoskins (2003) who identify nurses as the cement that coheres the healthcare team.

To achieve the overall smooth running, management and coordination of the patient’s regimen required nurses to have developed ways of “maintaining effective control”. This occurred through their “having a grip on things” and “being a professional”. When “having a grip on things” nurses were effectively managing situations because they were feeling in control of the situations they encountered. This control and effective management came about through nurses being experienced in dealing with the same or very similar situations and as indicated by the data, “being careful and cluey”. “Having a grip on things”, meant that the nurses were experienced and confident; felt safe in their...
knowledge and ability to do what was needed for the patient; were organised and ready to react.

The data suggested that through experience nurses had developed a well-honed sense of when to intervene in a situation and when to leave it alone. They rapidly assessed what was right and wrong in a situation because they were well aware of the signs and symptoms to be alert for; they knew when to intervene for patient safety and when to ask for assistance. Nurses’ experience had developed their increased capabilities to understand why situations occurred. This led to efficient situation management for the patient. These nurses understood how problems developed and what was needed to improve a situation. They predicted potential problems and instituted measures to prevent these occurring again or lessen their consequences. These findings are congruent with previous research (see for example Benner, 1982; Benner & Tanner, 1987; Benner, Tanner, & Chesla, 1992; English, 1993; Herbig, Bussing, & Ewert, 2001; Paul & Heaslip, 1995). These authors found that when nurses have wide-ranging experience of particular patient conditions and clinical presentations they build an internal picture of what to expect when faced with similar sequences of events. Identification by nurses of any inconsistency or mismatch between what is occurring in the patient scenario and what is expected based on previous experience, allows nurses to respond appropriately to maintain patient safety.

In parallel with “having a grip on things” the data suggested the nurse was “being a professional”. “Being a professional” required nurses at times to suppress their true feelings about a situation in an effort to achieve the best outcome for the patient. A professional, through their actions, was doing the job. What this meant was that despite
what might be happening around them “being a professional” required the nurse to focus on the patient’s needs and safety as their prime objective.

Nurses in this study were not allowing situations or their reactions to situations to affect their ability to effectively manage those situations. They refrained from coming to conclusions before all the available information was available. This type of non-judgemental attitude provided an environment in which trusting relationships grew. These trusting relationships, as previously identified, were beneficial to the patient, their relatives, the nurse and the multidisciplinary healthcare team. They allowed for the exchange of important and necessary information which could be communicated to, and accessed by the appropriate people, that is nurses, healthcare team, or patients and relatives; anxieties to be relieved, and the “creating of calm” to be achieved. These findings are supported by previous research by Bishop and Scudder (1999). These authors defined the practice of nursing as the promotion of “patient well-being” (p. 26). This is achieved firstly, through the development between the nurse and the patient of a “direct personal-professional relationship” (Bishop & Scudder, 1999, p. 26). Secondly, based on the bond of the nurse-patient relationship, holistic, beneficial relationships can be developed with patients’ families and the multidisciplinary healthcare team (Bishop & Scudder, 1999). The data from the current study found that for the nurses these relationships, the building of which they worked at diligently, allowed them to meet their responsibilities to patients, thereby engendering a sense of accomplishment. This sense of achievement served as a necessary element for them to attain “being fulfilled in the work environment” and ultimately “maintaining morale”.
Limitations of the Study

The first limitation of this study relates to the number of participants and the number of intensive care units from which the participants were gathered. For readers of this study whose paradigmatic perspective is qualitative in nature, the small number of research participants and narrow range of sampling areas will have no untoward significance. This limitation has been included in the expectation that there will be readers of this research whose paradigmatic perspective is positivist, and for these readers, sample size and scope are significant. The number of participants was small; there were 10 participants and the range of environments from which they were drawn was limited to three intensive care units in New South Wales. This limitation could render some of the findings less readily able to be applied, whether in some other intensive care unit environment or in other speciality or non-speciality areas of nursing. Generalisability of findings was not an aim of this present study.

A second limitation relates to the lack of data gathered from registered nurses who were close to leaving intensive care nursing or who had already left this area of practice. The lack of exploration and data gathering in this area, within this present study has limited the explanatory range of this theory. The factors that ultimately cause nurses to decide that they no longer wanted to practise in ICU warrants further research.

Further exploration of this substantive theory needs to be undertaken to ensure its credibility and applicability to a wide range of environments and settings. This continuing exploration could be undertaken in acute care environments and in different areas of nursing, whether these are specialist areas (eg. Coronary Care, Accident & Emergency, Operating Room, Neonatal Intensive Care, Renal Units.), or other ward areas.
Recommendations

Based on the findings from this study there are a number of recommendations that can be made relating to the areas of education, research and practice. These will be outlined below.

**Education**

This study adds to the notion that nursing in the intensive care environment in the contemporary Australian healthcare system is a difficult, demanding and challenging enterprise. The stressors on individuals who undertake careers in this environment are many and varied. Learning how to effectively manage stress is an important and necessary tool with which to equip all nurses. Effective stress management techniques should help in decreasing the potentially damaging effects of accumulated, unresolved stress and assist in raising the retention rates of nurses in the healthcare system. Education in these areas for students in university courses is vital. For those nurses already in the healthcare system, in-service education based on similar principles and concepts should be undertaken.

Nurses need to understand the reality of the workplace, and be aware of the political and financial forces and undercurrents influencing what they do and the environment in which they do it. They need to develop an understanding of the importance of paying attention to and keeping abreast of what is going on about them, whether on the ward, in conversations with colleagues or in the media. This will hopefully sensitise them to potential troubles that may be encountered. Skills needed for successful conflict management, mediation and good communication need to be developed. The importance of self-awareness, of an individual knowing and understanding their personal needs, wants and goals is vital to this
process. Knowing self, being aware of personal actions and reactions in different circumstances through the process of reflection, plays an important part in the development of these skills. The necessity and importance of maintaining a professional perspective on events needs to be highlighted. How to succeed in this, the strategies that enable the achievement of this end are crucial to today’s nurses, because of the multicultural nature of our society and the rising expectations of the public.

The next recommendation is dependent upon further research into the knowledge and skill levels of all areas of management within hospitals in relation to conflict management, mediation and communication. Managers are those individuals who are seen to wield varying levels of power in the hospital system, but who are perceived to have more power than the nurse at the bedside. Managers need to have highly developed skills in the assessment and resolution of conflict and the mediation of problems. These skills are based on the development and implementation of advanced communication skills. Managers at all levels in the healthcare system need to attain and develop these skills. To do so they should be required to undertake appropriate courses at a tertiary institution and their skills assessed and updated through frequent in-service courses provided by either the institution that employs them or by the health department of the state in which they work.

**Research**

This study identifies a number of areas that require further research to assist in exploring some of the questions that have become apparent through the undertaking of this present study. The first of these centres on how well prepared healthcare managers are to effectively meet the responsibilities of their positions. Further investigation into the knowledge and skill competence of all levels of healthcare management in relation to
management principles, development of interpersonal relations, conflict management and communication is vital. As stated in the previous section on education, because of the power and influence wielded by managers they need to be knowledgeable about these areas and skilfully capable of handling situations that may arise when they are on duty. The attainment and maintenance of high levels of knowledge and skills in these persons will assist in ensuring that needs are met and stressors decreased within the realms of an ever-changing environment in which humans are involved.

The second area for further research concerns the self-concept of nurses. There is limited research in this area as it pertains to nursing. Firstly, the component elements that form nurses’ self-concept need to be further defined and elaborated. Secondly, how these elements affect the nurses’ ability to meet their responsibilities needs to be determined and thirdly, whether the meeting of any identified needs could be useful in stemming the flow of nurses from the profession needs to be assessed.

The third area that presents for further investigation relates to the causes of exhaustion for nurses and what, if any strategies could be put in place to lessen the effects of this stressor. As this study showed exhaustion can be physical, mental, emotional or a combination of these elements. Exhaustion leaves the nurse vulnerable to misreading a situation, not being as alert as needed and can cloud responses. Research needs to determine, in the state of the current health system, what are the main causes of exhaustion; what are the outcomes from the development of exhaustion; who is most likely to develop this problem and why; in which areas of nursing practice is exhaustion more likely to occur and what strategies are available or need to be instituted to lessen the effects of this stressor.
Practice

In the practice arena access to confidential support systems provided by the institution need to be made overtly available to all staff. This could be achieved through orientation programs for new staff and wide advertisement of facilities throughout hospitals for healthcare team members already on staff. Assurance of total confidentiality for the individual is mandatory in persuading staff members to even consider their use. Along with the offering of this institution-provided support there needs to be developed a culture that views the accessing of these support systems as a sign of normalcy not of inadequacy. Staff members need to feel that through their use of these facilities they will not be viewed as less than capable of effectively meeting the responsibilities of their position. Use of support systems such as staff counsellors should be portrayed as a mechanism that a high percentage of hospital staff will need to access at least once in their careers, no matter their position or level of education. Encouragement to access these support systems needs to be the norm.

Conclusion

The aim of this study was substantive theory development of how and why experienced intensive care registered nurses commit to and continue with a career in bedside nursing in this area of practice. The study has achieved its aim. Firstly, the social processes involved in being a registered nurse in intensive care were descriptively detailed, discussed and explained. Secondly, a theoretical analysis of the shared meanings and behaviours of these registered nurses was undertaken. This was achieved through the exploration and analysis of the data and the application of the procedures of grounded theory throughout the process. The use of grounded theory fostered the emergence of a substantive theory from
the data. This substantive theory presented one possible explanation of why registered nurses decide to pursue a career, and continue to do so in this area of nursing and how they achieve this aim. “Traversing the path of the intensive care nursing experience” outlined the dilemmas and challenges faced by nurses practising in this specialty as identified in “Losing Direction” and how solutions or resolutions to successfully overcome these dilemmas and challenges were achieved, as identified in “Finding Your Way”.

The basic social problem, “losing direction”, and its component elements were discussed in relation to previous research in intensive care nursing practice. Stressors, which emerged from the data, were identified. The effects these stressors had on the ability of nurses practising in this environment to meet their responsibilities to patients, relatives, the multidisciplinary healthcare team and themselves were discussed. The stressors that were identified in the data included “becoming exasperated” and “losing your grip”.

The reasons for nurses “becoming exasperated” and “losing your grip” were outlined and discussed. Firstly, nurses perceived a lack of support or trust from nursing management primarily, that they were “being let down by management”. Secondly, they believed that when a situation developed they were more likely to be accused by nursing management of causing the situation even before being asked for their side of the story. Thirdly, the forms of violence and aggression towards nurses in ICU and their effects were explained and discussed. Incidents of violence and aggression towards nurses in ICU were identified as increasing in frequency and leading to nurses enduring increased levels of tension, anxiety and a decrease in their ability to concentrate. Patients’ relatives were identified as the more likely perpetrators of nurse-directed violence and aggression. These stressors led to
nurses “being fed up” with how they were treated; “being frustrated” with the perceived injustices and unfairness, and ultimately “becoming exasperated”.

Other stressors were identified from the data as leading to “losing your grip”. These included the following: staffing levels; multiple role expectations; workload; physical and psychological exhaustion; the need to frequently manage emotionally demanding situations; powerlessness/lack of control; patient and relative behaviour, and lastly, difficult interpersonal relationships. These stressors were discussed in relation to nurses feeling used by the system, which led to their becoming angry because they felt powerless to prevent this happening and their perception of their ability to manage and effectively control situations diminished. Effective nursing management of patient needs was being compromised.

The basic social process “finding your way” identified how the study participants achieved the level of job and personal satisfaction that motivated them to continue nursing in the ICU environment. A detailed discussion of the strategies used by the participants to successfully meet and effectively manage the challenges encountered in the ICU was undertaken. “Maintaining morale” and “creating calm” emerged from the data as the major components of “finding your way”.

The strategies employed by nurses in “maintaining morale” and “creating calm”, which centred primarily on human interaction and relationship development, were explicated. These relationships were built on trust, developed through necessity, but also through the concern of one human being for another, between nurses, patients, patients’ families and the members of the multidisciplinary healthcare team. The relationships provided a safe,
secure environment in which social support was given or received as circumstances dictated thereby “easing the stress”. They also assisted nurses in effectively “sorting out situations” and “maintaining effective control”. Social support was not the sole means used by the nurses in “maintaining morale”. They needed to develop an awareness of self, that is, to develop an understanding of how they as individuals reacted to situations; maintained their equilibrium; their personal wants and needs; what motivated them and what were realistic self-assessment strategies to apply to their performance. This understanding of self assisted nurses in “being fulfilled in the work environment”. When fulfilled in their work nurses displayed increasing levels of self-assurance, confidence and assertiveness. These nurses were effectively “maintaining morale”.

According to the data, nurses who successfully maintained morale were able to effectively create calm and vice versa. The conceptual links between these categories were explained and discussed. How and why nurses’ self-image, their perceived level of self-esteem and concept of themselves as effective, contributing members of the healthcare team were affected by their competence in “sorting out situations” and “maintaining effective control” was explicated.

The limitations of this study were identified and explained. Recommendations for nursing education, research and practice were outlined and justified. These included the following. Firstly, the inclusion of subjects that teach communication, stress management, conflict management and conflict resolution techniques in undergraduate and post graduate nursing courses. Secondly, ensuring that managers within the healthcare system have and maintain appropriate levels of skill and knowledge in communication, conflict management and conflict resolution. Thirdly, undertaking research into how well prepared current
healthcare managers are to effectively meet the responsibilities of their positions.

Fourthly, further research into the self-concept of nurses, its component elements and its effects on nurses’ abilities to meet their responsibilities. Fifthly, identification of the causes of nurse exhaustion, its outcomes, the areas of practice in which nurse exhaustion is more likely to develop and what strategies are available or need to be instituted to lessen the effects of this stressor. Sixthly, institution-provided confidential staff support systems. Lastly, development of a workplace culture that views the accessing of these support systems as a sign of normalcy, rather than engendering a sense of inadequacy.

The findings from this present study confirm that despite the plethora of previous research undertaken on the intensive care area and the acknowledged stressors inherent to working in this highly challenging environment, a number of problems continue to exist. The theory explicated in the previous chapters explored and described in detail the many factors that influenced the nurse participants to continue practising their profession in this particular nursing speciality area. This theory also explored and described how these nurse participants managed the many and varied dilemmas, difficulties and problems that they encountered as they continued in “Traversing the path of the intensive care nursing experience”. The overall stated aim of this study has been achieved in that the substantive theory presented in this manuscript provides one possible explanation of how and why registered nurses continue with a career in bedside nursing in intensive care.
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APPENDIXES
APPENDIX A.

AN INVITATION TO PARTICIPATE

Are you a Registered Nurse with at least three (3) years current experience working in Intensive Care?

If so, you are invited to participate in a research project that intends to investigate the nature of nursing practice that has developed in the Intensive Care Unit and what part this plays in the delivery of effective nursing care.

Your participation in this study is entirely voluntary. You may, at any time over the course of the study decide not to continue your participation.

If you decide to participate in this study you may be assured of total confidentiality and anonymity. No identifying information will be used when the results of the study are published.

If you are interested in participating in the study, or have any questions regarding the study, please free to call:

Gabrielle Metelli,
University of Western Sydney,
Campbelltown Campus.

Phone:- (0414) 758246
(02) 46203416
APPENDIX B.

PARTICIPANT INFORMATION SHEET

Thank you for considering involvement in this research project. The aim of this research is to investigate the nature of nursing practice (work) in Intensive Care.

In order to achieve the above, the researcher will need to be in attendance in the Intensive Care Unit during some hours of some of your shifts. This is necessary to allow the researcher to observe you as you go about your normal duties, and engage you in conversation regarding various aspects related to what you are doing and why.

Towards the end of the data collection period you may be requested to attend 1 or 2 semi-structured interview sessions. These interviews may need to be in your own time, and may take between one and two hours each. This is to enable the researcher to clarify information already gathered and possibly expand on any areas that require such. These sessions will be audio-taped to assist in the accurate transcribing of data, so that effective analysis may take place.

Your participation in this research is entirely voluntary. You may, at any time over the course of this research decide not to continue your participation.

If you decide to participate in this study you may be assured of total confidentiality and anonymity. All information that could identify you will be kept locked away with only the researcher having access to it. You will be allocated a code designation, which will be used by the researcher on any written data. No identifying information will be used when the results of the research are published.

If you have any questions regarding the study or your part in it please call:

Gabrielle Metelli, University of Western Sydney.
Phone 02 46203416 or Mobile 0414 758246

This research project has been approved by the University of Western Sydney Macarthur Ethics Review Committee (Human Subjects). Any complaints or reservations about this research may be directed to the Ethics Committee through the Executive Officer, Claire Kaspura, phone (02) 46203641. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.
APPENDIX C.

CONSENT FORM

Nursing in Intensive care: Practice meanings, behaviour and theory.

I, .............................................. (name), have read and understood the Participant Information Sheet and this Consent Form. I understand that I am consenting to participate in audio-taped interviews and that I will be observed by the researcher on occasions, as deemed necessary, whilst on shift.

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time. I understand that I am guaranteed total confidentiality and anonymity if I agree to participate in this study and that no identifying information will be used when the results of this study are published.

I understand that my decision whether or not to participate in, or subsequently withdraw, from this study will not affect my current work or study relationships with either the South Western Sydney Area Health Service or the University of Western Sydney.

I understand the purpose of this study and what is being asked of me, and that I am able to cease participation at any time. With this understanding I agree to participate in the identified research.

NAME:  ________________________________

SIGNATURE:  ___________________________

DATE:  ______________________

WITNESS' NAME:  ______________________________________

WITNESS' SIGNATURE:  ____________________________________