

ABSTRACT

Linda Maas Burhans. WHAT IS GOOD NURSING CARE? THE LIVED MEANING OF QUALITY NURSING CARE FOR PRACTICING NURSES (Under the direction of Dr. Martha R. Alligood) College of Nursing, May, 2008.

Healthcare quality in the United States of America (USA) is the subject of intense criticism. Although quality nursing care is vital to patient outcomes and safety, meaningful quality improvements have been disturbingly slow and incremental. Practicing nurses are rarely involved in developing improvement programs and their definitions of quality nursing care have not been known. The lived meaning of quality nursing care for practicing nurses was unknown and not addressed in the literature. A premise of this study was that effective efforts to improve quality nursing care must be meaningful and relevant to nurses. It was proposed that uncovering the lived meaning of quality nursing care would facilitate development of effective improvement approaches.

The purpose of this study was to uncover the lived meaning of quality nursing care for nurses practicing in acute care hospitals. This lived meaning was revealed through analysis of practicing nurse interviews using van Manen's (1990) hermeneutic phenomenology, a research approach designed to explore and uncover the lived meaning of pragmatic experiences. The research question asked: "What is the lived meaning of quality nursing care for practicing nurses in the USA?" Participants were 12 nurses practicing on medical or surgical adult units at general or intermediate levels of care within acute care hospitals who

participated in semi-structured interviews. Emerging themes were discovered through empirical and reflective analysis of audiotapes and transcripts.

The lived meaning of quality nursing care for practicing nurses was meeting human needs through caring, empathetic, respectful interactions within which responsibility, intentionality, and advocacy form an essential, integral foundation. The lived *experience* of quality nursing care resided within nurse-patient interactions. The lived *meaning* of quality nursing care for these practicing nurses was within the art of nursing rather than the science of nursing.

Practicing nurses, managers, administrators, educators, researchers, and policy makers may use these findings to further define the discipline of nursing and to facilitate practice changes, driving improvements in the quality of nursing care. Future studies based on this understanding of the lived meaning of quality nursing care could begin to address this focus in an effort to improve quality patient care.

WHAT IS GOOD NURSING CARE? THE LIVED MEANING OF QUALITY
NURSING CARE FOR PRACTICING NURSES

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The Faculty of the College of Nursing

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by

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CHAPTER ONE: INTRODUCTION

Healthcare quality in the United States of America (USA) has been the subject of intense criticism in recent years. The Institute of Medicine (IOM, 2000) heralded the need for improvement in patient safety and quality of care with publication of *To Err Is Human: Building a Safer Healthcare System*. Their documentation of 98,000 hospital deaths annually due to errors by health care providers sent shock waves through both professional and public arenas. In *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001) a vision for safe, high quality care that is evidence-based, patient-centered, and systems-oriented was delineated. The six aims of safe, effective, patient-centered, timely, efficient, and equitable care were recommended for adoption by all healthcare disciplines and organizations. In response to both of these reports, healthcare professionals were challenged to take responsibility and be accountable for the quality of their own practice and to actively improve the quality and safety of USA healthcare. In the 2004 report titled *Keeping Patients Safe: Transforming the Work Environment of Nurses*, the IOM validated research indicating that nursing care was directly related to improved patient outcomes and that nursing vigilance protected patients against errors. This report also proposed that threats to patient safety resulted from nursing management, workforce issues, work processes, and organizational cultures that negatively influence nursing practice.

The importance and value of nurses in the USA healthcare system is undeniable. Nurses are by far the most numerous professional healthcare providers and demand for their services continues to escalate, resulting in enduring shortages caused by inadequate supply. Nurses are the healthcare providers most proximal to patients in acute care settings. Patients are admitted to acute care hospitals for medical procedures because they need the assessment and interventions afforded by professional nurses. Otherwise, those procedures could be done on an outpatient basis. Acute care nurses are present in hospitals 24 hours a day, 7 days a week, observing, intervening, and reporting patient condition changes. Nurses are hands-on caregivers that make major contributions by advocating for patients' needs and assuring their comfort. Not only is the care of patients by nurses a necessity but the quality of nursing care matters. The quality of nursing care makes a vital difference in patient outcomes and safety.

Attention to quality care and quality improvement has long been an essential component of healthcare and of nursing practice. In addition to changing and enhancing existing approaches, numerous innovative programs, focused on patient safety and improved quality of care, have been implemented in response to the IOM reports and similar calls to action. Unfortunately, meaningful improvements have been disturbingly slow and incremental. Indeed, Clarke and Aiken (2006) state, "There is consensus that the goal proposed by the IOM to halve the rate of medical errors within 5 years has not yet been

achieved” (p. 3). As members of an independent, self-regulated healthcare profession, nurses are responsible for the part they play in both the positive and negative aspects of the healthcare delivery system including this noted slow pace of change. *Nursing: Scope and Standards of Practice* (ANA, 2004a) clearly stipulates that accountability for the quality and systematic improvement of nursing practice lies within the profession.

High-quality nursing care is explicitly defined in these standards as being consistent with current professional knowledge and increasing the likelihood of desired patient outcomes. Although this definition closely mirrors the IOM's definition, there is limited research on whether the definition accurately reflects the meaning of quality to practicing nurses. (Burhans, 2007, p. 41)

Because there are 2.6 million nurses in the USA it is notable that thousands of them evaluate the quality of nursing care delivered to patients every day but currently do so without specific knowledge of a shared meaning or definition of quality nursing care. The discipline's existing literature focuses primarily on the measurement of quality nursing care through the lenses of specific patient outcomes and patient satisfaction. Although these data provide information important for nurses' study, reflection, and action, they are not reflective of the essence of quality nursing care. Patient satisfaction measures provide limited patient and family stakeholder perceptions of nursing care quality. These vary, sometimes significantly, from the evaluations by other stakeholders,

including those of practicing nurses (Jennings & Staggers, 1999; Lang & Mitchell, 2004).

Patient outcomes such as infection rates, prevalence of decubitus ulcers, and patient falls have been researched and endorsed as indicators of quality nursing care by nurse leaders and professional organizations. These measures are among the National Database of Nursing Quality Indicators (NDNQI) (ANA, 2006) and Magnet Hospital (ANCC, 2005) indicators of quality nursing care. The National Quality Forum (NQF) endorses these same measures, with the addition of failure to rescue and restraint prevalence, as National Voluntary Consensus Standards for Nursing-Sensitive Care (NQF, 2007). Outcome measures have been correlated with nursing standards and best practices; with nurses' educational preparation; with nurses' staffing patterns; and with professional nursing models in multiple studies (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Kramer & Schmalenberg, 2005; Laschinger, Shamian, & Thomson, 2001; Sochalski, 2004). It is not known, however, if practicing nurses embrace and internalize these measures. It is not known if the related criteria address the nurses' own view of nursing practice, their care delivery, or their evaluation of the delivery of quality nursing care administered by themselves or by others. This knowledge is not currently presented or reflected in the literature.

Although practicing nurses have been subjects and participants in studies measuring the quality of nursing care, evidence of their active participation or input into the development of these tools is lacking. The developers and authors

of these measures have often been nurse leaders, administrators, educators, and researchers who, by virtue of their positions, are removed from practicing nurse care delivery roles. Measurement tools have primarily evaluated administrative data to determine quality outcomes. Survey instruments administered to practicing nurses have often lacked clear definitions of quality nursing care indicators. As a result, the value of nurse responses in these studies may be limited. Studying quality nursing care and developing measurement systems without the direct involvement and input of practicing nurses is problematic. Their meanings of quality nursing care may not be adequately represented.

It was, therefore, proposed that current outcome measures and common quality criteria fail to capture the heart of nursing and the true lived meaning of quality nursing care for practicing nurses. It was further proposed that this void may have contributed to the slow pace of improvement in quality nursing care. The current efforts being expended to improve the quality of nursing care may be misdirected or even meaningless to the nurses at whom they are focused. If current approaches are incongruent with the lived meaning of quality nursing care for practicing nurses, the pace of improvement is unlikely to increase.

The discipline of nursing has responsibility to fill this knowledge gap through exploratory research. Uncovering the lived meaning of quality nursing care to practicing nurses may potentially prove essential to improving nursing care and the resulting patient outcomes. It was proposed that the pace and

success of change in the quality of nursing care will potentially increase if practicing nurses embrace and identify with improvement strategies congruent with their lived meaning of quality nursing care. Therefore, the topic of interest in this study was the lived meaning of quality nursing care as understood and articulated by practicing nurses. Understanding this lived meaning served to expand knowledge within the nursing discipline.

Definitions

The following definitions were used throughout this study:

Nurses - professional, licensed Registered Nurses (RNs) educated at the Baccalaureate level or above.

Practicing nurses - those providing direct, hands-on, bedside, clinical patient care within acute care hospitals. Their employment titles (formal and informal) may include: Staff Nurse (SN); Registered Nurse (RN), RN I, RN II, RN III, RNIV; Charge Nurse (CN); Unit Educator (UE); and Assistant Nurse Manager (ANM). Nurses in Nurse Manager (NM), Nursing Administrator (NA), Clinical Nurse Specialist (CNS), Educational Nurse Specialist (ENS), and other organizational leadership positions are specifically excluded from participation.

Lived meaning - the way that a person experiences and understands his or her world as real and meaningful. Lived meanings describe those aspects of a situation as experienced by the person in it (van Manen, 1990, p. 183). Lived meanings reveal the essence of a phenomenon.

Lived experience - the lifeworld – the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it (van Manen, 1990, p. 9).

Essence - a universal which can be described through a study of the structure that governs the instances or particular manifestations of the essence of that phenomenon. Essences manifest themselves in the structures of lived experience (van Manen, 1990, p. 10).

Quality improvement - an ongoing effort to make performance and resulting outcomes better through the analysis of performance and outcomes and the implementation of systematic actions or strategies to improve it.

Statement of the Problem

Published studies related to the meaning of quality nursing care for practicing nurses can be summarized in three groups: (1) definitions of quality and excellence in nursing, (2) the ways in which quality nursing care is represented and evaluated, and (3) nurses' meanings and perceptions of quality nursing care. Definitions of quality and excellence in nursing are often anchored in Donabedian's (1966/2005) structure, process, and outcome categories. While these three categories have been useful and easy to apply, their mechanistic focus on external, visible system inputs and outputs has led to superficial applications when compared to the complexity of Donabedian's original work. Definitions of quality and excellence in nursing as explored conceptually by Attree (1993, 1996) and Hogston (1995b) resulted in proposed models

expanding and building on these three categories. Magnet Hospital studies by Laschinger et al. (2001), Sochalski (2004), and Kramer and Schmalenberg (2005) likewise reported workload (structural) and unfinished clinical care and patient safety problems (process) issues reflective of the mechanistic view. These mechanistic definitions tend to be functional and do not reveal the lived meaning of quality nursing care for practicing nurses.

In a contrasting approach, Coulon, Mok, Krause, and Anderson (1996) identified themes of professionalism, holistic care, practice, and humanism in nurses' quest for excellence. The importance of these elements was supported by Gunther and Alligood's (2002) conclusion that "high quality nursing equates with competence in the cognitive, affective, and psychomotor domains" (p. 357). Likewise, Glen (1998) argued that "high quality nursing care is influenced predominantly by values" (p. 38) and that "the key to improvement in practice may be the improvement of emotional and motivational tendencies" (p. 42). However, although these researchers attempted to define quality nursing care, it is not known if or how the identified themes or elements relate to the lived meaning of quality nursing care from the perspective of practicing nurses.

The second category of studies identified various ways in which quality nursing care has been represented and evaluated. The findings of Attree (2001), Hogston (1995a), and Idvall and Rooke (1998) respectively supported evaluation criteria including: resources, care, interpersonal processes, and patient-focused outcomes; structure, process, and outcome elements and prerequisites (i.e.,

staffing and equipment/environment variables) and elements of performance. Thus, both external system influences on quality nursing care and internal characteristics evident through interpersonal processes and elements of performance were identified in these studies. Using the revised Nursing Work Index (NWI-R), Aiken and Patricia (2000) reported on the external, system influences used to measure organizational traits of hospitals that are characterized as professional nursing practice environments. The presence of these professional environments was correlated with high quality nursing care. But again, it is not known if these elements and correlations relate to the lived meaning of quality nursing care for practicing nurses.

The third group of studies explored nurses' meanings and perceptions of quality nursing care. A middle range theory by Williams (1998) proposed that nurses' perceptions of quality care included themes of patient need fulfillment and therapeutic effectiveness and were mediated through a process of selective focusing. Interpersonal relationships with patients and effective leadership were identified as strong quality indicators for practicing nurses by Redfern and Norman (1999a, 1999b). Austin, Luker, Caress, and Hallett (2000), and Luker, Austin, Caress, and Hallett (2000) studied community palliative care nurses. Early referral, resource availability, relationships with caregivers, and nurses "knowing the patients" defined quality nursing care for these nurses practicing in hospice settings. However, these studies were not designed to address the lived meaning of quality nursing care.

Many of the referenced studies were conducted with nurses in the United Kingdom (Attree, 1993, 1996; Austin et al., 2000; Hogston, 1995a, 1995b; Luker et al., 2000; Redfern & Norman, 1999a, 1999b) or Australia (Coulon et al., 1996; Williams, 1998) and offered models and middle range theories of the meaning of quality nursing care developed through grounded theory and critical incident technique methodologies. Collectively they identified varying elements of professionalism, caring, interpersonal skills, resources, patient outcomes, and expert practice. However, testing of these models and theories in the USA has been limited. For example, of 19 Cumulative Index of Nursing & Allied Health Literature® (CINAHL) citations using Williams' substantive grounded theory, only one (Bowers, Lauring, & Jacobsen, 2001) was based in the USA. Because of the differences in health care delivery systems in other countries, the practice of nurses in other countries is also significantly different. Therefore, the published study outcomes may be of interest but they are not generalizable to practice in this country. Magnet Hospital studies, initially conducted with USA nurses, more recently included comparisons of nurses in the USA, Canada,, England, Scotland, and Germany (Aiken, Clarke, & Sloane, 2002; Aiken, Clarke, Sloane, & Sochalski, 2001; Aiken, Clarke, Sloane, Sochalski, Busse, Clarek, Giovannetti, Hunt, Raferty, & Shamian, 2001). These comparisons showed cross-national similarities when assessing nurse staffing, work environments, and the relationship of these to quality of patient care but it is not known if these

similarities apply to the lived meaning of quality nursing care for nurses practicing in these varied systems.

From this overview of the literature, it was evident that research related to the meaning, definition, and perception of quality nursing care is limited. The dearth of published studies addressing the unique perspective of the nurse was specifically addressed by Lynn, McMillen, and Sidani (2007). They indicated that without knowing nurses' perspectives, the evaluation of quality patient care is incomplete and ineffective. In fact, the definition and meaning of quality in all healthcare disciplines remains elusive, subjective, and stakeholder-specific, resulting in measurement and improvement challenges (Burhans, 2007). As noted, although healthcare quality has often been explained within Donabedian's (1966/2005) structure/process/outcome triad, the superficial application as an explanatory structure in healthcare studies offered little insight into the meaning of quality care for nurses.

The lived meaning of quality nursing care for practicing nurses has not been specifically identified in the nursing literature. In order to be effective, efforts directed toward improvement in quality nursing care must be meaningful and relevant to the nurses at whom they are focused. If current outcome measures and common quality criteria do not address the lived meaning of quality nursing care for practicing nurses, it follows that uncovering the lived meaning may result in true improvements in quality nursing care.

Therefore, a new approach was proposed to explore and uncover the lived meaning of quality nursing care. An exploratory, qualitative study, using van Manen's (1990) approach to hermeneutic phenomenology, was proposed. Semi-structured interviews elicited the lived meaning of quality nursing care for practicing nurses in the USA. Empirical and reflective methods and procedures (van Manen, 2002b) enabled this exploration of the lived meaning of quality nursing care for the study participants, beginning the process of knowledge development in this important arena. While the referenced studies in other countries have used a variety of qualitative exploratory and grounded theory approaches, this study differed in that it was focused on experienced practicing nurses working in acute care hospital settings in the USA. In addition, hermeneutic phenomenology was identified as the qualitative research approach through which to capture the lived meaning of quality nursing care for those nurses.

The importance of uncovering the lived meaning of quality nursing care resonated strongly for this researcher. Having directly and indirectly evaluated nursing care delivery and the resulting positive and negative patient outcomes over many years, interest in this study topic grew out of experiencing the reactions of practicing nurses to quality improvement initiatives. The majority usually responded with skepticism about administration motives and with lack of interest in and commitment to the changes being recommended or required. Indeed, implementing practice change was often a long, difficult process because

initiatives were generated *at the top* and did not emanate from the nurses.

Practicing nurses were quick to point out that nursing leadership was *out of touch* with the demands of bedside nursing and with the *real* needs of patients.

Nursing care improvement strategies focused on measures valued by nurses and identified by them as the core lived meaning of quality nursing care have the potential to result in more rapid, effective changes and improvements in nursing quality care. Related improvements in patient outcomes may be influenced by these changes. Nurse-valued measures can only be developed if the lived meaning of quality nursing care is clearly identified. This initial study focus on practicing nurses working in acute care hospitals in the USA was justified because significant improvement efforts are currently focused in this arena. Future studies may explore the lived meaning of quality nursing care for practicing nurses in other settings, seeking to further establish the universality of the identified lived meaning. Understanding the lived meaning of quality nursing care for practicing nurses may potentially result in the development of policies, procedures, and organizational structures which would better support the delivery of quality nursing care.

Purpose

The purpose of this study was to uncover the lived meaning of quality nursing care for nurses practicing in acute care hospitals. The lived meaning of quality nursing care for practicing nurses in the USA was unknown. This study proposed to uncover an understanding of quality that had not been addressed in

the nursing literature. It was proposed that the lived meaning of quality nursing care would be revealed through analysis of staff nurse interviews using van Manen's (1990) hermeneutic phenomenology, a research approach designed to explore and uncover the lived meaning of pragmatic experiences.

Research Question

The research question in this study was:

“What is the lived meaning of quality nursing care for practicing nurses in the USA?”

To elicit the data through phenomenological inquiry using a semi-structured interview, each participant was asked to respond in their own words to these questions preceded by the introductory comment:

I am really interested in Quality Nursing Care.

- *Tell me about quality nursing care.*
- *What does quality nursing care mean to you?*
- *What is it like when you give quality nursing care?*
- *Describe an example of when you delivered quality nursing care.*
 - *What did you do?*
 - *How did you feel about that?*
- *What is it like when you observe another nurse giving quality nursing care?*
- *Describe an example of when another nurse delivered quality nursing care.*

- *What did you observe?*
- *What did they do?*
- *How did you feel about that?*
- *Is there anything else I need to know about what quality nursing care is like?*

Theoretical and Philosophical Perspective

“The tension between our science and our practice serves as the primary impetus for qualitative research in nursing” (Boyd, 2001, p. 65). Lack of knowledge about the lived meaning of quality nursing care for practicing nurses in the USA served as the starting point in this qualitative research journey that has the potential to travel from discovery and description, through theory and hypothesis development, and on to validation testing as more is learned about this phenomenon in the qualitative-quantitative cyclical research continuum described by Munhall (2001a).

Pope, van Royan, and Baker (2005) supported the use of qualitative methods as appropriate in determining what really matters to caregivers in the arena of healthcare quality. They stated that, “the emphasis in qualitative research on understanding meanings and experiences makes it particularly useful for quality assessment and for unpacking some of the complex issues inherent to quality improvement” (p. 148).

This study was informed by Max van Manen’s (1990) hermeneutic phenomenological approach to human science research. His methodology,

philosophically based in both the descriptive traditions of Husserl and the interpretive traditions of Heidegger, strives to grasp the essential meaning of an experience. Phenomenological research is: “the study of lived experience; the explication of phenomena as they present themselves to consciousness; the study of essences; and the description of the experiential meanings as we live them” (van Manen, 1990, pp. 9-11). “Phenomenology-as-a-practice is especially relevant to persons interested in the study of lived meaning in the domains of ... the health sciences, and related academic and professional fields” (van Manen, n.d., p. 1). Hermeneutic phenomenology can serve to uncover pragmatic meaning patterns. As such, it was an appropriate approach in this search for the lived meaning of quality nursing care for practicing nurses.

Because little is known about this topic, a first level, exploratory, descriptive qualitative research study was proposed. Such first level studies commonly lack a theoretical framework (Wood & Ross-Kerr, 2006). Additionally, there is most often no explicit theoretical orientation in phenomenology. Rather, the lived meaning of an experience is built through the research process. The method for this proposed study was guided by van Manen. However, at the completion of the research process, the potential existed to consider theoretical viewpoints to better situate the study findings within a nursing perspective. Very few of the qualitative studies reviewed and cited above had done this, with Gunther and Alligood (2002), Idvall and Rooke (1998), and Lynn et al. (2007) being the notable exceptions.

Delimitations

To explore the lived meaning of quality nursing care for practicing nurses in the USA, study participants were hospital-employed, experienced, baccalaureate prepared RNs who provide direct, hands-on, bedside, clinical patient care. The study participants formed a purposeful convenience sample of practicing nurses recruited from medical and surgical adult units at the general or intermediate, step-down levels of care within acute care hospitals in the southeastern USA.

The methodology consisted of a single, semi-structured, tape-recorded interview of no more than 40 minutes with each individual practicing nurse participant. Through phenomenological inquiry using van Manen's (2002b) empirical and reflective methods, this study sought to uncover the lived meaning of quality nursing care for practicing nurses. Data validity and trustworthiness were assured through triangulation, researcher verification of transcript accuracy, and the use of verbatims as low inference descriptors.

The researcher was well prepared through both education and experience to conduct this study. With over 38 years experience in nursing staff, management, and administrative roles in large, acute care hospitals, her experience included extensive background in quality management and quality improvement. Through reflection upon her belief system about quality nursing care and the process of phenomenological reflexivity, biases were identified and addressed in a reflexive journal for review and synthesis throughout the analysis

process. In addition to personal notes, this journal documented theoretical and methodological notes.

Limitations

As is common in qualitative studies, a purposeful, convenience sampling procedure was proposed. A homogenous sample, meeting the stated inclusion criteria, enabled discovery of the lived meaning of quality nursing care for USA nurses practicing with adult general and intermediate level patients in acute care hospitals in the southeastern USA. Results were limited, however, to the individuals interviewed and to their experience. Results were not generalizable to other nursing populations. As is always the case in qualitative, hermeneutic phenomenological studies, the findings were subject to alternative interpretations.

Significance of the Proposed Study

The lived meaning of quality nursing care for practicing nurses had not been identified, particularly for nurses practicing in acute care hospitals in the USA. This study began the process of uncovering that lived meaning with the goal of providing new knowledge for the discipline that will influence the nursing profession. Practicing nurses, educators, researchers, administrators, and policy makers may be able to use this new knowledge. Collective nursing knowledge of the lived meaning of quality nursing care for practicing nurses may potentially further define the discipline and facilitate practice changes, driving improvements in the quality of nursing care.

Practicing nurses may be able to use knowledge of their shared meaning to inform their own practice and in evaluating the quality of nursing care delivered by themselves and other nurses. This statement is based on the belief that improvement strategies focused in areas valued by practicing nurses and identified by them as the lived meaning of quality nursing care may potentially result in more rapid, effective changes and improvements in nursing care delivery and thus in improved patient outcomes and enhanced patient safety. Educators may identify the need for changes in nursing education curricula. Implications for the continuing education of experienced nurses may also be identified from study findings.

For administrators and policy makers, understanding the lived meaning of quality nursing care for practicing nurses may potentially result in the development of policies, procedures, and organizational structures which would better support quality nursing care delivery in acute care hospitals. Publication of these study findings in the nursing literature will provide the opportunity for discussion and examination of their potential influence on current descriptions, definitions, and indicators used to measure and improve quality nursing care. Revised, more valid measurement systems could be developed by researchers. If the lived meaning of quality nursing care for practicing nurses varies from or adds depth to currently identified best practices, research and professional dialog to address the differences will be indicated. If the lived meaning of quality nursing care for practicing nurses in the USA varies from that reported in international

research, research comparisons of cultural, educational, and practice environments and approaches will be indicated.

Summary

Nursing science is defined as the “knowledge of practice produced through the unique interrelationship of theory and research in approaches aimed at understanding the phenomena of interest to the discipline” (Alligood & Marriner Tomey, 2006, p. 522). Both nursing and human beings are phenomena of interest to our discipline, making quality nursing care an appropriate research phenomenon.

Nursing is not adequately measured or defined by the medical, risk management, and liability prevention models emphasized in the patient safety and quality care work of organizations such as the Institute for Healthcare Improvement (IHI). The delivery of quality nursing care is a strongly-held nursing value, made explicit in the standards of nursing care (ANA, 2004a), and is an essential determinate of desirable patient outcomes. Despite the investment of significant resources into improving quality of care and patient outcomes, progress is slower than desired, missing the IOM (2000) goals as noted by Clarke and Aiken (2006). The quality criteria and issues identified as important by Aiken and Patricia (2000), Williams (1998), Coulon et al. (1996), Glen (1998), and others may or may not address the lived meaning of quality nursing care. The fact that we did not currently understand the lived meaning of quality nursing care from the practicing nurse’s perspective may be directly related to the slow

progress of quality improvement efforts and results. This knowledge and understanding are essential if we are to truly influence improvement efforts. Therefore, this proposed study was needed. It made a contribution to the discipline by adding new nursing knowledge through revealing the lived meaning quality nursing care for practicing nurses in the USA. It made a contribution to the profession by making faster, more effective improvement in quality nursing care, and the resultant outcomes of that care, potential realities.

CHAPTER TWO: REVIEW OF THE LITERATURE

Purpose

The purpose of this study was to uncover the lived meaning of quality nursing care for nurses practicing in acute care hospitals. The lived meaning of quality nursing care for practicing nurses in the USA was unknown. This study proposed to uncover an understanding of quality that had not been addressed in the nursing literature. It was proposed that the lived meaning of quality nursing care would be revealed through analysis of staff nurse interviews using van Manen's (1990) hermeneutic phenomenology, a research approach designed to explore and uncover the lived meaning of pragmatic experiences.

This review explored literature related to quality nursing care. Issues relevant to interdisciplinary healthcare quality were first addressed. Then the literature explicating the current state of quality nursing care was explored. Finally, the literature related to the meaning of quality nursing care for practicing nurses was examined in three subgroups: (1) definitions of nursing care quality and excellence, (2) ways of representing and evaluating quality nursing care, and (3) describing nurses' meanings and perceptions of quality nursing care.

Interdisciplinary Healthcare Quality

In today's healthcare environment, quality care and patient safety are at the forefront. Practitioners and healthcare organizations are concentrating efforts and resources to implement evidence-based care standards and to achieve meaningful improvements in quality of care. Definitions and measures of

healthcare quality abound but differ in relation to source, focus, and specifics. In Webster's Online Dictionary (2001), relevant definitions of quality include "of superior grade" (noun), "a degree or grade of excellence or worth" (adjective), and "refers to how good something or somebody is." The IOM (2000) defines healthcare quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p. 12). In spite of the recent extensive use of IOM concepts and approaches in national quality measurement systems and organizational quality efforts, however, this definition has not been universally adopted.

The Institute for Healthcare Improvement (IHI) (2007) embraces IOM concepts and promotes worldwide quality improvement efforts to "change health care profoundly for the better" (p. 1). The current *Five Million Lives Campaign* aims for healthcare for all with no needless deaths, no needless pain or suffering, no helplessness in those served or serving, no unwanted waiting, and no waste. Like the majority of quality improvement and patient safety efforts being actively promoted in hospitals, the IHI-recommended strategies are primarily focused on the implementation of evidence-based medical protocols. Despite efforts to be more inclusive, initiatives have primarily targeted the work of physicians rather than nurses. Risk management and liability prevention are often the primary drivers of this focus within hospitals.

The Baldrige National Quality Program (2007) uses their *Health Care Criteria for Performance Excellence* to focus on an integrated approach to organizational performance management. This emphasis is intended to result in “ever-improving value to patients and other customers, contributing to improved health care quality” (p. 70). These criteria do not, however, specifically define health care quality or quality care for practicing professionals.

The Joint Commission (2007) emphasizes the importance of developing and improving systems critical to the safety and quality of care, treatment, and services, and repeatedly references patient safety and quality of care throughout their standards. The concept of quality is essentially the primary thread, repeated again and again, throughout The Joint Commission standards. Unexpectedly, however, neither quality nor quality healthcare are explicitly and specifically defined. Quality is what The Joint Commission says is important, but yet a single, succinct, usable definition that can be embraced by healthcare professionals is lacking in their standards.

The definition of quality provided by the internationally recognized American Society for Quality (ASQ, n.d.) specifies that quality is a subjective term for which each person has his or her own definition. This subjectivity is repeatedly seen in the literature and contributes to the lack of agreement on a definition of quality among healthcare practitioners.

A review (Burhans, 2007) of the definitions and references to quality in the professional standards and literature of the four disciplines of nursing, medicine, pharmacy, and physical therapy, found that:

Four similar themes dominate the explicit or implied quality definitions within the four examined disciplines: deficiency-free excellence; conformity and consistency with standards and current professional knowledge; stakeholder-specific subjectivity; and congruence with the structure-process-outcome quality triad. These themes point to similarities in the definitions of quality used by nurses, physicians, pharmacists, and physical therapists, but they also highlight differences. The differences are evident in the predominant therapies and approaches used by the practitioners in each discipline and in the communication among disciplines. When healthcare professionals talk about *quality*, the same term denotes different, discipline-specific meanings (pp. 42-43).

This lack of agreement creates barriers to the consistent, effective, and meaningful quality improvement initiatives that are most needed within today's healthcare system. Healthcare quality cannot be improved if there is no agreement on what it is or should be. Collaborative intradisciplinary and interdisciplinary improvement efforts are not possible unless the members of professional disciplines ascribe to uniform definitions of quality within their professions. Specifically of interest in this study is the lack of evidence of a

uniform definition or meaning of nursing care quality in the nursing literature and among practicing nurses.

Quality Nursing Care

Any discussion of quality nursing care inevitably turns to the effects of workplace issues and the nursing shortage. Surveys of 4,108 hospital RNs in 2002 and 1,697 hospital RNs in 2004 (Buerhaus, Donelan, Ulrich, Norman, Williams, & Dittus, 2005) assessed the effect of the nursing shortage on the quality of care. Seventy-nine percent of the 2004 surveys indicated that the shortage was a major problem for quality care as evidenced by inadequate time for patients, for detection of patient complications, to maintain patient safety, and for team collaboration. The study attempted to measure the six IOM aims and at least 65% of respondents indicated that the aims were negatively affected by shortage issues. In spite of a nationwide increase of 185,000 hospital employed nurses in the 2002-2004 timeframe, the assessment of these indicators had not improved, and in fact, some had worsened. The study recommended continued efforts to increase the size of the nursing workforce but, recognizing that this could be an example of looking at the wrong issues, also recommended designing alternative solutions. Understanding the lived meaning of quality nursing care may be a first step toward identifying and developing these alternatives.

Redfern and Norman (1990) voiced fears that, "The planning and delivery of individual nursing care is threatened by a preoccupation with cost-

effectiveness that is in danger of swamping” (p. 1,260) English nurses’ traditional concern with quality of care. The study noted that “top-down” approaches to quality measurement “involve the use of preformulated generic instruments and the application of ‘expert-generated’ criteria and standards” and do not require clinical nurse participation (p. 1,268). The value of these approaches was questioned because they “prevent clinical nurses from making the commitment that is necessary in order to assess and improve the quality of their nursing practice” (p. 1,260). This study supported the premise of the proposed research. By identifying the lived meaning of quality nursing care, practicing nurses will have building blocks on which to base reliable assessments and interventions.

An ANA-commissioned review of the 1995 to 2000 quality measurement literature led by Bostick, Riggs, and Rantz (2003) synthesized the results with those of 2 prior reviews. The hospital-based measurement studies showed a trend toward multidisciplinary approaches that primarily focused on the development of clinical pathways for various specialty patient groups. Traditional quality outcome measures, including the NDNQI criteria, and adverse event reports were well represented in the studies, “partly because of the wide availability of these data within and across acute care settings” (Bostick et al., 2003, p. 99). Neither the meaning nor the definition of quality nursing care was addressed in these reviews.

Under the auspices of the National Institute of Nursing Research (NINR), nurse-led intervention research studies have been conducted. These have been defined as:

... studies either questioning existing care practices or testing innovations in care that are shaped by nursing's values and goals, guided by a strong theoretical basis, informed by recent advances in science, and designed to improve the quality of care and health of individuals, families, communities, and society. (Naylor, 2003, p. 382)

Unfortunately, these studies have not been well disseminated, particularly to practicing nurses, and Naylor recognized that without strong, clear communication of the results to practicing nurses, they do not adequately influence the quality of nursing care delivered by individual nurses in a timely manner. Researchers and scholars conduct this research without adequate input from and feedback to practicing nurses.

Nursing shortage, workforce, and environmental issues affecting quality nursing care were well represented in the literature, as were reports of outcome measures and adverse event reports. The lack of adequate involvement of practicing nurses in the development and dissemination of research results was also addressed. It remains challenging to communicate research in ways which influence and improve practice. Perhaps this is, in part, influenced by the inability to link results to the lived meaning of quality nursing care for practicing nurses.

Definitions of Nursing Care Quality and Excellence

The “elusive and complex concept of quality nursing care” was explored by Redfern (1993, p. 141). This study indicated that part of the challenge in measuring quality resulted from the difficulty of maintaining the integrity of a holistic concept while dividing it into measurable elements and advocated reassembling the pieces after measurement to arrive at a true vision of quality nursing care. Redfern indicated that nurses and patients should be the definers of quality nursing care.

Almost 15 years ago, Attree’s (1993) review of the available literature failed to offer a definition, as intended, due to the complex, multi-dimensional nature of quality nursing care. The subsequent development of a provisional conceptual model of quality care (Attree, 1996) reflected this complexity, lacked a succinct definition, and incorporated the often-used quality triad of structure, process, and outcome (Donabedian, 1966/2005) to organize the complex elements identified. The complexity of this model limited its usefulness and further testing was not evident in the literature.

Using a modified grounded theory approach, Hogston (1995b) relied on the same structure, process, and outcome categories to summarize results from interviews with 18 English nurses and identified criteria that must be present if quality is to exist. More study participants identified quality in terms of process and outcomes, rather than in terms of structure. Process issues of competence, expertise, personal values and beliefs, and teamwork were discussed. Outcomes

of patient satisfaction, meeting patient needs, and giving information were identified as essential to quality. However, the structural elements of skill mix, staffing, time, and workload, while not usually under the control of the individual nurse, were targeted as most significantly influencing quality nursing care.

In their Magnet Hospital review, Kramer and Schmalenberg (2005) noted that “insufficient attention has been given to the perspectives of SNs [staff nurses] that are so vital in the linkage between structure and patient outcome” (p. 283). Nurses are consistently held accountable for the quality and safety of patients’ daily and continuing care within the healthcare system. Nursing leaders, regulatory and accreditation bodies, and consumer groups explicitly or implicitly indicate that the quality of patient care depends significantly upon practicing nurses, and look to them to improve outcomes by improving the quality of nursing care. The lived meaning of quality nursing care for practicing nurses may differ significantly, however, from the standards and criteria espoused by these leaders and organized groups. The lived meaning of quality nursing care for practicing nurses in the USA may prove valuable in improving nursing care quality in the future.

Nursing education and socialization place a high priority on the delivery of quality nursing care. The *Nursing: Scope and Standards of Practice* published by the American Nurses Association (ANA) (2004a) established the expectation that nurses accept responsibility and accountability for the delivery of quality care to their patients. Registered nurses are expected to systematically enhance the

quality and effectiveness of nursing practice. Quality nursing care is explicitly defined in these standards as being consistent with current professional knowledge and increasing the likelihood of desired patient outcomes. While this definition closely mirrors that of the IOM, it is not universally applied throughout the nursing quality literature and there is no research on whether it accurately reflects the definition or meaning of quality nursing care to practicing nurses.

Instead, the subjective, stakeholder-specific (Jennings & Staggers, 1999; Lang & Mitchell, 2004) nature of quality is evident throughout the nursing literature. Nurses evaluating quality may focus on assessment, planning, or the effectiveness and skill with which treatments and medications are delivered. Patients, in contrast, are likely to care more about the communication, listening, kindness, and responsiveness of their nurses. Meanwhile, nursing administrators and managers often favor a focus on the organizational elements of efficiency and cost-effectiveness. These differences reflect the knowledge, views, and values of differing participants in the healthcare experience. Stakeholder-specific subjectivity is congruent with the often stated directive that the outcomes of quality healthcare, by definition, must meet or exceed the needs and expectations of consumers.

Focusing evaluation of quality on patient satisfaction and outcomes, however, may contribute to confusion in the meaning of quality for nurses (Gunther & Alligood, 2002). Outcomes evaluation places an external focus on the product delivered, rather than on the services (nursing processes and activities)

provided. Gunther and Alligood identified high quality nursing as “competence in the cognitive, affective, and psychomotor domains” (p. 357) and offered evidence that deficits in the affective domain were most often responsible for evaluations of poor nursing quality by both nurses and consumers. The roles of communication and positive nurse-patient relationships were important in seeking to identify nursing actions related to high quality nursing care among USA nurses. Likewise, Glen (1998) argued that “high quality nursing care is influenced predominantly by values” (p. 38) and that “the key to improvement in practice may be the improvement of emotional and motivational tendencies” (p. 42). It was not known, however, if or how any of these categories or issues was related to the lived meaning of quality nursing care for nurses.

In a survey of the effect of Magnet characteristics in Canadian hospitals, Laschinger et al. (2001) reported that practicing nurse perceptions of quality of care were positively influenced by the trust in management which is generated through implementation of nursing work environments featuring autonomy, control over practice, and positive physician relationships. Nurse perceptions of quality, considered outcome variables in this study, were measured by summing three items in which nurses rated the quality of care on their unit on their last shift, rated the likelihood of recommending their hospitals to others in the future, and generally rated care quality through use of a single four-point (poor to excellent) scale. Definitions of quality care, if provided to these study participants,

were not specified in this report. If not provided, the nurses subjectively used their own definitions and that variability was not explained in the results.

Nurses in Pennsylvania were surveyed (Sochalski, 2004) to “examine the effects of nurse staffing and process of nursing care indicators on assessments of the quality of nursing care” (pp. II-67). Both structure (workload) and process indicators (unfinished clinical care and patient safety issues) were associated with assessments of quality of nursing, “with the relationship strongest between process of care and quality” (pp. II-67). Only a single four-point (poor to excellent) scale rating care on the last shift worked was used to assess quality of nursing care in this study. While repeatedly found to be strongly associated with structure, process, and outcome measures, such a general, undefined, stakeholder-specific question did not add to our understanding of what quality nursing care means for practicing nurses.

In contrast, a qualitative study of Australian students and nurses by Coulon et al. (1996) identified themes of professionalism, holistic care, practice, and humanism as significant in nurses’ quest for excellence. “Findings suggested that the client is the central focus of excellent nursing care at all times” (p. 817). Competence and effective interpersonal relationships were identified as essential elements in the identified model. The link to improved health outcomes was evident in feedback from the experienced nurses. Although it intuitively seemed possible, it was not known if the meanings of nursing care excellence in this study were similarly significant for USA practicing nurses.

Clearly, there are multiple definitions of nursing care quality and excellence without universal agreement throughout the nursing profession. In addition, the existing definitions may reflect viewpoints that are not necessarily useful to practicing nurses as they deal with their daily realities in delivering patient care. Existing definitions may not be reflective of nurses' perceptions of quality nursing care or of the lived meaning of their experiences. The research needed to answer these questions had not yet been conducted.

Representation and Evaluation of Quality Nursing Care

Studies by Hogston (1995a), Idvall and Rooke (1998), and Attree (2001) explored the ways in which quality nursing care is represented and evaluated. A grounded theory study conducted by Hogston (1995a) with 18 English nurses sought to examine the methods used by nurses to evaluate quality nursing care. Both formal and informal methods were revealed but informal methods of peer review, intuition, tacit knowledge, and patient satisfaction were dominant. This informality again invoked the subjective, stakeholder-specific approach to identifying and evaluating quality nursing care.

Focus groups were conducted (Idvall & Rooke, 1998) with 20 Swedish surgical ward [direct care] nurses to determine their perceptions of important aspects of nursing care that influence their quality of care. Fifteen categories of care were condensed into two dimensions which the researchers identified as possible starting points for developing quality indicators. The dimension called elements of performance included detecting and acting on signs and symptoms

and acting on behalf of the patients. The prerequisites dimension included staffing, routines, competence, teamwork, values and beliefs, and attitudes.

English nurses, doctors, managers, patients, and families were interviewed using a grounded theory approach to identify the criteria used to represent and evaluate quality care (Attree, 2001). All of the groups described similar criteria, although it was sometimes easier for participants to describe the lack of, rather than the presence of, quality. Three categories of care resources (human, material, and financial), care processes (nature of practice and nature of practitioner), and care outcomes (patient-related, health-related, and going home) were identified and were similar to those identified in other studies. This congruence and similarity indicated that these can possibly be considered valid, reliable variables for evaluating quality care. They did not, however, specifically address the lived meaning of quality nursing care for practicing nurses.

The ANA, through their American Nurses Credentialing Center (ANCC), maintains the Magnet Nursing Services Recognition Program (Aiken, Havens, & Sloane, 2000) to formally evaluate, identify, and recognize hospitals providing excellent nursing and patient care. The criteria used in the Magnet Hospital Program, are built upon the ANA (2004b) *Scope and Standards for Nurse Administrators*. Although not offering a concise, universal definition of quality nursing care, this program has become the premier national leader in promoting and recognizing excellence in USA nursing practice

The historical development of the Magnet Hospital Program and its focus on identifying those hospitals providing the best quality patient care was reviewed by Kramer and Schmalenberg (2005). Fourteen “Forces of Magnetism” were used to identify and evaluate hospital nursing departments. The Forces include: quality of nursing leadership, organizational structure, management style, personnel policies and programs, professional models of care, quality of care, quality improvement, consultation and resources, autonomy, community and the hospital, nurses as teacher, image of nursing, interdisciplinary relationships, and professional development (ANCC, 2005). Quality of care in this paradigm has been defined as: “an environment in which high-quality care can be provided; ... an organizational priority; and staff perceive that they are providing it” (Kramer & Schmalenberg, 2005, p. 279). Unfortunately, this is not a specific, clear, useful definition that serves to facilitate agreement within the profession and support improvement efforts. In addition, the staff perception element of the quality of care definition demonstrates the influence of subjectivity. As with other sources, the Magnet Hospital Program does not succinctly describe the meaning of quality nursing care to practicing nurses.

Nurses’ perceptions of quality nursing care may be related to the quality of care and quality improvement Magnet Forces. The perceptions of practicing nurses may reflect, or be reflected in, the components of these two Forces. It is also possible that components of other Forces, such as professional models of care, autonomy, nurses as teacher, interdisciplinary relationships, and

professional development, are related to nurses' perceptions of quality nursing care. On the other hand, "ANCC defines all of the Forces as *structural* features within the SPO [structure, process, outcome] paradigm, except for 'Quality care.' One aspect of their definition (staff perceive that they can practice quality care) is an *outcome*" (Kramer & Schmalenberg, 2005, p. 279). It may be that the Forces of Magnetism reflect only organizational traits and do not relate directly to the lived meaning of quality for nurses.

In a series of studies, Kramer and Schmalenberg (2004a; 2004b; 2004c; 2004d; 2004e) developed the Essentials of Magnetism (EOM) tool identifying eight environmental attributes essential to nurses' ability to deliver quality care and tested it with 3,602 nurses in Magnet and non-Magnet hospitals. The eight EOMs were identified as: good nurse-physician relationships, autonomous nursing practice, patient-focused culture, clinically competent co-workers, control over nursing practice, perceived adequacy of staffing, support for education, and nurse manager support (Kramer & Schmalenberg, 2004a, p. 366). These structures and processes, as used in this tool, facilitate quality nursing care but do not describe the meaning of quality nursing care for practicing nurses. Therefore, the results based in use of this tool were not applicable to the questions of interest for the proposed study.

International studies from the USA, Canada, England, Scotland, and Germany (Aiken, Clarke, & Sloane, 2002; Aiken, Clarke, Sloane, & Sochalski, 2001; Aiken, Clarke, Sloane, Sochalski, Busse, Clarek, Giovannetti, Hunt,

Raferty, & Shamian, 2001) used the Magnet hospital research tools to explore quality of care reports from over 43,000 nurses. While strongly indicating (85 to 94%) that nurses are clinically competent, few nurses (12 to 36%) rated the quality of care on their own unit as excellent. In all five countries, quality of care was identified as declining over the year prior to the study, with 47% of the USA nurses agreeing that this was the case. Staffing, work environment, and organizational/managerial issues were directly related to nurse-assessed quality of care and quality of care was related to patient outcomes. Once again, definitions of quality care were not directly provided for use with a four-point scale rating quality care, but several quality-related *markers* were referenced: oral hygiene, skin care, patient or family teaching, comforting/talking with patients, developing or updating care plans, and preparing patients and families for discharge. Nurses reported that these were necessary activities but that when they were left undone it was indicative of decreased quality. It was not evident, however, that these tasks constituted the lived meaning of quality nursing care for these nurses.

The National Quality Forum's initiatives focused on health care quality measurement and reporting included the development and endorsement of 15 National Voluntary Consensus Standards for Nursing-Sensitive Care in 2004. Patient-centered outcome measures included failure to rescue, pressure ulcer prevalence, falls prevalence, falls with injury, restraint prevalence, urinary catheter-associated infections, central line catheter-associated infections, and

ventilator-associated pneumonia. Nursing-centered intervention measures included smoking cessation counseling for patients with acute myocardial infarction, heart failure, and pneumonia. System-centered measures of skill mix, nursing care hours per patient day, practice environment, and voluntary nursing turnover were also included.

As 'nursing-sensitive,' these consensus standards include measures of processes and outcomes – and structural proxies for these processes and outcomes (e.g., skill mix, nurse staffing hours) – that are affected, provided, and/or influenced by nursing personnel – but for which nursing is not exclusively responsible (NQF, 2007, p. 2).

Reliable data on the use and reporting of these standards is not yet available. NQF is undertaking a project to study implementation of these standards into nursing practice. As with other efforts, however, the consensus-building process considered feedback from nurse leaders rather than from practicing nurses, so may not reflect their lived meaning.

In a notable exception, the Nurses' Assessment of Quality Scale – Acute Care Version (NAQS-ACV) (Lynn et al., 2007) was developed using the language obtained from practicing acute care nurses during qualitative interviews. Factors of interaction, vigilance, individualization, advocate, work environment, unit collaboration, personal characteristics, and mood were components of quality nursing care for the study participants. It was identified that "when an instrument is derived from the population for which it is to be used,

future participants will benefit from the ‘like me’ orientation of the items” (Lynn et al., p. 334). While this study was not designed to identify lived meaning, the instrument developed was representative of practicing nurses’ perceptions and meanings of quality nursing care.

The representation and evaluation of quality nursing care in the literature is diverse. Approaches included informal methods including intuition and tacit knowledge (Hogston, 1995a); elements of performance and prerequisites (Idvall & Rooke, 1998); care resources, processes, and outcomes (Attree, 2001); the Forces and Essentials of Magnetism (Kramer & Schmalenberg, 2005); the National Voluntary Consensus Standards for Nursing-Sensitive Care (NQF, 2007); and the NAQS-ACV (Lynn et al., 2007). These represented only a sample of the many approaches taken to evaluate the quality of nursing care. None specifically addressed the lived meaning for practicing nurses.

Nurses’ Meanings or Perceptions of Quality Nursing Care

While a significant body of literature addressed patient perceptions of quality care, this review of the literature yielded very few articles researching, exploring, or defining the perceptions or meaning of quality nursing care for practicing nurses. In addition, the available studies were, for the most part, conducted outside the United States, so their applicability to nurses in this country is uncertain.

Based on a qualitative, grounded theory study of Western Australian nurses’ perspectives on the delivery of quality nursing care, Williams (1998)

published a model delineating the elements of her resultant theory. Ten practicing nurses from four surgical specialty wards in an acute care public hospital were interviewed. Meeting the physical, psychosocial, and *extra care* (i.e., care that went above and beyond normal expectations) needs of individual patients was identified as the core of quality nursing care. Quality of nursing care was described on a four level scale as exemplary, high quality, basic, or low quality and outcomes were categorized as therapeutically effective (high quality) or therapeutically ineffective (low quality). The context of care, identified in terms of the amount of time available for nursing care delivery (i.e., abundant, sufficient, minimal, and insufficient), was identified as a major determinant of the ability of nurses to deliver quality nursing care. The inability to consistently deliver quality nursing care to all patients was acknowledged as a reality and was identified as a major source of dissatisfaction and stress in nurses. A four phase (i.e., self focusing, needs focusing, patient focusing, and quality focusing) social psychological process, named *selective focusing* by Williams, was influenced by the time available and was used by nurses to balance their own work satisfaction and stress. This construct was identified for the first time in this study.

To date, more than 19 studies have referenced Williams (1998) and the construct of selective focusing in studying the meaning of quality nursing care for nurses but have not specifically researched or tested the model and its application. Only one of these studies (Bowers et al., 2001) was based in the USA.

In contrast to grounded theory, Redfern and Norman (1999a; 1999b) used an adaptation of Flanagan's critical incident technique (Norman, Redfern, Tomalin, & Oliver, 1992) to explore perceptions of quality nursing care by both nurses and patients in England. The study sample included 7 managers and charge nurses, 21 registered nurses, 17 enrolled nurses, 35 students, and 96 patients. The research revealed considerable congruence in patient and nursing perceptions. Important elements of quality nursing care for nurses in this study included both the delivery of psychosocial, therapeutic, and thorough care and the ability to work with knowledgeable, committed colleagues, supervisors, and educators. Interpersonal aspects of care delivery were highly valued.

Also using critical incident technique, Austin et al. (2000) and Luker et al. (2000) identified good rapport with family members and spending time with patients above and beyond expectations as indicative of high quality palliative nursing care for community hospice nurses in England. These elements echoed the importance of trusting relationships and "extra care" described in Williams' (1998) model.

An article examining quality nursing care in Thailand (Kunaviktikul, Anders, Srisuphan, Chontawan, Nuntasupawat, & Pumarporn, 2001) related quality nursing care to the degree to which the patient's physical, psychosocial, and extra care needs were met. It did not, however, provide detail concerning the definitions and coding of those needs, limiting the ability to compare and contrast the results with those of other studies.

Irish nurses' perceptions of the attributes of quality nursing care in a long term care setting were determined using a modified hermeneutic phenomenological approach (Murphy, 2007). This study's focus on "nurses' perceptions and experiences of providing quality care for older people" (p. 479) drove the choice of a phenomenological method. Themes of "it should be like home, striving for excellence, and making a difference" (p. 479) were identified. Words such as holistic, individualized, and family centered were used to describe excellence. The issue of inadequate time for caregiving, similar to that identified by Williams (1998), was one of many issues identified as limiting nurses' ability to provide quality nursing care.

The complexity, subjectivity, and multi-dimensionality which challenge attempts to define and explain the meaning of quality care were repeatedly addressed in the literature on this topic (Attree, 1993; 1996; Donabedian, 1966/2005; Hogston, 1995b; Idvall & Rooke, 1998; Kunaviktikul et al., 2001; Norman et al., 1992). Similar challenges were likewise evident in Williams' (1998) substantive grounded theory. Williams offered, however, a unique model primarily centered on the perceptions of practicing nurses. Further studies are needed to validate and extend this model and its component elements.

The referenced studies were primarily conducted in sociologically-based grounded theory or critical incident methodologies. It was not known if the meanings and perceptions described in these studies were reflective of the lived

meaning of quality nursing care for practicing nurses as uncovered in the proposed research study.

Proposed Research Study

It was evident that the lived meaning of quality nursing care held by practicing nurses had not been identified in the nursing literature. Uncovering this lived meaning was important to the discipline of nursing and to patient care. From the review of the literature, there was no agreement on the meaning, representation, evaluation, or perception of quality nursing care. The existing definitions were usually stakeholder-specific and were often explained within Donabedian's (1966/2005) structure, process, and outcome triad. Studies in England, Ireland, Australia, and Canada offered multiple models and middle range theories of the meaning or perception of quality nursing care that included varying elements of professionalism, caring, interpersonal skills, resources, patient outcomes, and expert practice. The meaning of quality nursing care to practicing nurses in the USA had been only minimally studied, however. One such study by Boswell, Lowry, and Wilhoit (2004) was limited by its focus on new nurses rather than experienced nurses. Magnet Hospital and related international studies correlating staffing and organizational/managerial factors with quality of care failed to adequately define the meaning of quality nursing care.

Because so little research on this topic had been conducted, the meaning of quality nursing care for practicing nurses in the USA remained unknown. The lived meaning of quality nursing care for those experiencing and delivering direct

bedside care had not been explored. Filling this knowledge gap may potentially have significant influence on our profession's ability to improve the quality of nursing care delivered to patients across all care settings. It is difficult, if not impossible, to improve what we do not first understand, define, and explain.

Therefore, a qualitative, hermeneutic phenomenological research study of the lived meaning of quality nursing care for USA practicing nurses was proposed. Because we currently knew so little, an exploratory study using a sample sufficient to reach data saturation was planned. The lived meaning of quality nursing care was uncovered through the hermeneutic interpretation of interview responses using empirical and reflective methods as defined by van Manen (2002b). To elicit the data, phenomenological inquiry using a semi-structured interview with each participant was conducted.

Conclusion

The results of this proposed qualitative study contributed new and important knowledge about the lived meaning of quality nursing care for practicing nurses in the USA. This has implications for nursing administrators, managers, educators, and for practicing nurses themselves. This knowledge will potentially influence the development of strategies that support nurses in the identification and delivery of quality nursing care. It is possible for practicing nurses to know if the lived meaning of quality nursing care is shared among them and if they are talking about the same thing as they plan, deliver, and evaluate nursing care with their nursing colleagues. Understanding the lived meaning of

quality nursing care potentially will make both intradisciplinary and interdisciplinary discussions about quality nursing care more clear and effective and will facilitate discussions meant to arrive at a common meaning of quality patient care with other disciplines. If there is a relationship between the lived meaning of quality nursing care and the Magnet Hospital Forces of Magnetism, there may potentially be an additional impetus for broader use of these Forces by nurses.

Identification of the lived meaning of quality nursing care for practicing nurses revealed shared meanings and will thus allow the components of the lived meaning to become part of the common language of nurses. A uniform understanding of quality nursing care, meaningful to practicing nurses, will potentially result in a more organized and realistic approach to improvement strategies from which patients will ultimately benefit. These outcomes may subsequently influence nurse satisfaction and retention, positively affecting nursing workforce issues.

Research beyond this initial study may explore the lived meaning of quality nursing care for nurses working in different settings (e.g., critical care; pediatric or neonatal care; long-term or rehabilitative care; or home and community health care) and for nurses with differing levels of experience and education. Subsequent studies have the potential to reveal if the lived meaning of quality nursing care for nurses working in non-Magnet hospitals is different from that of those in Magnet Hospitals. The relationship of the identified themes and

lived meaning with the many differing definitions, standards, and quality measurement criteria from multiple sources, including ANA, NDNQI, JCAHO, and IOM, may potentially be explored. The quality nursing care models proposed by Williams (1998), Attree (1996), Conlon et al. (1996), and others could be tested, validated, and extended using this knowledge of the lived meaning of quality nursing care. Each study potentially leads us closer to a universal understanding of the lived meaning of quality nursing care for practicing nurses.

CHAPTER THREE: METHOD

The purpose of this study was to uncover the lived meaning of quality nursing care for nurses practicing in an acute care hospital. The lived meaning of quality nursing care for practicing nurses in the USA was unknown. This study proposed to uncover an understanding of quality that had not been addressed in the nursing literature. It was proposed that the lived meaning of quality nursing care would be revealed through analysis of staff nurse interviews using van Manen's (1990) hermeneutic phenomenology, a research approach designed to explore and uncover the lived meaning of pragmatic experiences.

This chapter introduces the study design and its philosophical base. It describes the researcher's qualifications and preparation to conduct this study. It reviews the study population, sample selection criteria, study methods, and ethical considerations. The data collection, analysis, and interpretation processes are explained. Lastly, strategies for data validity and trustworthiness are addressed.

Philosophy and Study Design

The lived meaning of quality nursing care for practicing nurses is not addressed in the literature. Yet it is an enduring explicit and implicit expectation that nurses consistently deliver high quality nursing care. It is taken for granted that nurses assess and evaluate the quality of their own and others' nursing care daily but is not clear what definitions or meanings they use to do this.

An exploratory phenomenological study eliciting the lived meaning of quality nursing care for practicing nurses in the USA was proposed.

As a field of concentration in philosophy, *phenomenology* is the study of the structures of experience as they present themselves to consciousness. As a research tradition it is the investigation of what life experiences are like. ... Therefore, the task of phenomenology is to return to and to reexamine what we believe we already know and understand by reflectively bringing into awareness that which has been taken for granted. The unifying thread in phenomenological research is that it always asks about the nature or meaning of the human experience – ‘What is it like?’ (Powers & Knapp, 2006, pp. 127 -128)

Max van Manen’s (1990) hermeneutic phenomenological approach to human science research was used to inform this study. According to van Manen, phenomenological research is: “the study of lived experience; the explication of phenomena as they present themselves to consciousness; the study of essences; and the description of the experiential meanings as we live them” (pp. 9-11). His methodology, based philosophically in both the descriptive traditions of Edmund Husserl and the interpretive traditions of Martin Heidegger, strives to grasp the essential meaning of an experience. As such, it was an appropriate approach in this search to uncover the lived meaning of quality nursing care for nurses.

Husserl, interested in the foundations of human consciousness, knowledge, and belief, focused solely on descriptions of phenomena or experiences in the world of individuals. He sought to “focus attention on the *meaning* of phenomena rather than on the peculiarities of particular experiences” (Solomon, 2001, p. 22). In contrast, Heidegger “replaced the concept of knowing with that of understanding” (Fleming, Gaidys, & Robb, 2003, p. 115). He believed that hermeneutic interpretation was the road that led to understanding. Building on both traditions, van Manen (n.d.) stated,

...my approach to phenomenology is ‘practical’, existential and hermeneutic (but not theoretically philosophical). Thus when the word ‘phenomenology’ is used it usually means interpretive (hermeneutic) phenomenology. ‘Phenomenology’ refers to the method associated with our attentiveness to the lifeworld or lived experience, and hermeneutics refers to the notion that all explication of meaning is always and inevitably interpretive. (p. 2)

The philosophical assumptions of phenomenology include beliefs that reality is subjective; that tradition and culture overlie events and experiences; that each phenomenon may have essential components that are universal to the human experience of them; that all description of experience is interpretive; and that the focus is on human involvement in the world, that is, on lived experience or lived meaning. For van Manen (1990),

The essence of a phenomenon is a universal which can be described

through a study of the structure that governs the instances or particular manifestations of the essence of that phenomenon. In other words, phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience. (p. 10)

Several other relevant phenomenological assumptions and concepts, as used by van Manen (1990), informed this study. These included intentionality as the “inseparable interconnectedness of the human being to the world” (p. 181); phenomenological reflexivity or rigorous reflection as the process of recovering original awareness or perception “to come to an understanding of the essential structure of something” (p. 185); and reflection, rather than bracketing as identified by Husserl, as the act of identifying and considering the impact of one’s biases throughout the process of identifying the essence or lived meaning.

In this study, van Manen’s (1990) hermeneutic phenomenological method was used for the analysis and interpretation of descriptions of personal meanings and experiences by practicing nurses. The interviews were analyzed and interpreted using empirical and reflective methods in a search for the lived meaning of quality nursing care. This approach was chosen because it is a pragmatic process, directly applicable to both the discipline and profession of nursing. It made sense to inform this study of practicing nurses with a method that honored the importance of their lived practice experience. “The rationale of this form of inquiry must be consistent with a form of reflection that is animated by the practical interests of our professional and personal lives...” (van Manen,

n.d., p. 1). Nursing is specifically included in van Manen's list of professions whose interests are well-suited to exploration and research with this method. "Phenomenological research originates in practice, and through careful descriptive and interpretive scholarship, enlightens practice" (Van der Zalm & Bergum, 2000, p. 217).

Researcher Qualifications

The researcher, a masters-prepared nurse with over 38 years of experience in staff, management, and administrative roles in large, acute care hospitals, was well-equipped to be a *research instrument* as the interviewer and interpreter in this study. Her experience includes an extensive background in quality management and quality improvement. For twenty years, she held a variety of positions in one of the study hospitals, including five years as the Administrator for Quality Management.

Having been in a position to evaluate, both directly and indirectly, nursing care delivery and the resulting positive and negative patient outcomes over many years, the importance of quality nursing care resonated strongly for this researcher. Interest in this study topic grew out of experiencing the reactions of practicing nurses to quality improvement initiatives. Although some new programs generated enthusiasm and engagement from a limited number of nurses, the majority usually responded with skepticism about administration motives and with lack of interest in the recommended or required practice changes. Indeed, implementing practice changes generated at the top rather

than from the nurses themselves was usually a long, difficult process, often ending in partial or complete failure. Practicing nurses were quick to point out that nursing leaders were *out of touch* with the demands of bedside nursing and with the *real* needs of patients.

The researcher had assessed multiple examples of exemplary, high quality, basic, and low quality nursing care, measuring these against her own lived meanings and internal biases about what quality nursing care is or should be. Through initial reflection upon her own beliefs and values regarding quality nursing care, the researcher identified the following beliefs and biases:

- nurses are the primary gatekeepers for the care delivered to hospitalized patients;
- nurses have the responsibility to act as the primary advocates for hospitalized patients;
- compassionate, caring communication and behaviors are the hallmarks of quality nursing care;
- thoughtful, effective nursing practice often makes the difference between positive and negative patient outcomes;
- nurses have the responsibility to maintain their ongoing competencies, to remain professionally current, and to be accountable for the consistent use of evidence-based practices; and
- unfortunately, nurses frequently fail to fulfill important responsibilities in the quality care and patient safety arena.

Through this initial awareness and subsequent reflection on the study findings, as recommended by van Manen, the researcher addressed these biases as part of the process of phenomenological reflexivity in order to effectively recognize and integrate their influence on the study implementation and findings.

Study Population

Professional Registered Nurses (RNs) practicing in acute care hospitals were the population of interest for this study. Nationally, most RNs, by a small majority, practice in acute care hospital settings. To date, the most publicized concerns regarding patient safety and quality of patient care have referenced acute care hospitals. Therefore, these RNs were an appropriate sub-population from which to select participants for this study of the lived meaning of quality nursing care for practicing nurses.

Study Sample Selection

Twelve selected study participants formed a purposeful, convenience sample recruited from acute care hospitals within a single hospital system in the southeastern USA. Nine participants were employed by the system flagship academic teaching facility, formally recognized as a Magnet Hospital. The other 3 nurses worked in three smaller regional hospitals within the system. All participants were female with an average age of 37.5 years (range = 25 to 52 years). One participant was African American and the others were Caucasian. The first 12 respondent nurses meeting all selection criteria were interviewed.

The participants were practicing nurses who provided direct, hands-on,

bedside, clinical patient care for 100% of their worked hours. While all functioned in a charge nurse capacity on an intermittent basis, they retained patient care responsibilities while functioning in this role and none were in formal supervisory or managerial roles. Thus, they came from the practicing nurse consciousness in responding to the study questions. In contrast, nurses working or serving in roles that result in spending more time in managerial, educational, committee, quality-related, or other roles may change their frame of reference resulting in responses that are less representative of the typical practicing nurse's experiences and lived meanings.

All participants were hospital-employed RNs routinely working 12 hour shifts for 20 to 40 hours week. Most also worked overtime hours on an intermittent basis as unit and personal needs indicated. These nurses were thus likely to have a significant self-identification with the hospital practicing nurse role, whereas nurses working fewer hours may possess a more significant self-identification in parental, student, or other personal roles. Supplemental, traveling, or agency nurses were not recruited to participate. Because they are in transient roles, they may not identify closely with the traditional hospital nurse role and may repeatedly be in an orientation (i.e., novice or beginner) mode in relation to new hospitals, unfamiliar units, or specific experiences. These nurses were also less accessible by virtue of their variable employment status.

Participants possessed from 3 to 24 years (mean = 11.6 years) nursing experience and 1 through 12 years (mean = 5.2 years) experience in their

assigned units. These nurses were anticipated to have moved beyond the novice or beginner level of practice in the profession and within their work environment. They were thus more likely to be able to focus on describing their lived meaning of quality nursing care rather than being focused on the basic survival priorities of the novice and beginner.

All had less than 1 year experience in a Licensed Practical Nurse (LPN), Military Medic, or Nursing Assistant roles prior to achieving RN status. In an unpublished pilot study (Burhans, 2005) with 2 practicing nurses, quality nursing care was identified almost solely as successful completion of basic nursing or personal care tasks such as baths and mouth care. Although Aiken, Clarke, Sloane, Sochalski, Busse, Clarek, Giovannetti, Hunt, Raferty, and Shamian (2001) identified oral hygiene and skin care as among markers of care quality, it was possible that the study nurses' prior experience in LPN roles (2 years and 11 years, respectively) may have influenced the identification of these basic tasks as the lived meaning of quality nursing care. To avoid the possible confounding effects that socialization to a non-professional nursing or ancillary role may have on the lived meaning of quality nursing care for the individual, only nurses without significant experience in these positions were included in this study.

Nursing education at the baccalaureate level or above was identified as a significant influence on patient care outcomes (Aiken et al., 2003). Specifically, in hospitals with higher proportions of baccalaureate nurses, surgical patients experienced lower mortality and failure-to-rescue rates. While it is not known if

nurses with differing educational levels possess differing lived meanings of quality nursing care, there was the potential for an educational level influence on staff nurse responses in this study. To maintain a homogenous study sample, only baccalaureate-prepared nurses were included in this study. Among the participants, 7 were prepared at the nursing associate degree level prior to completing their nursing baccalaureate degree. They practiced at an ADN level prior to obtaining a BSN degree for an average of 10 years (range = 4 to 21 years). The interviews did not reveal any differences in the lived meaning of quality nursing care among these nurses that were attributable to their educational preparation. Future studies may further explore the relationship of differing levels of educational preparation to the lived meaning of quality nursing care.

Nurse participants worked on inpatient, acute care adult medical and surgical units at the general or intermediate, step-down level of care and staffing. This purposely homogenous sample had similar lived nursing experiences in their work environments. The lived meanings of quality nursing care described in the interviews of these practicing nurses revealed commonalities. This delimitation also successfully controlled for the presence of confounding patient acuity and time factors that could have, due to differing ancillary supports and staffing ratios, influenced the lived meaning of quality nursing care among the nurses. Nurses working in intensive/critical care units, emergency departments,

or in specialty areas such as pediatrics, obstetrics, or rehabilitation did not participate in this initial study as their lived experience and meanings may differ.

Although this relatively homogenous group was selected for the purposes of this study, the sample also possessed diversity representative of the general nursing population. For example, the age of individual participants did not necessarily relate directly to their years of experience. Four participants obtained their nursing education in their late 20s through mid-40s as a second career or after parenting and thus integrated the resultant diverse adult life experiences into their nursing education and experience. As was already noted, only 5 participants were initially educated at the BSN level while 7 first completed associate level degrees. Although all are currently working in intermediate or general level units, the majority possessed other nursing experiences developed through work in a broad range of intensive care, post-anesthesia recovery, emergency, pediatric, obstetric, rehabilitation, long term care, home care, or ambulatory care settings.

Sample size was determined based on data saturation, that is, when no new themes were emerging from the interviews. Initially, it was anticipated that interviews with approximately 10 to 12 participants were needed to reach saturation in this study. Morse (1994, as cited in Sandlowski, 1995) recommended that “phenomenologies directed toward discerning the essence of experiences include about six participants” (p. 182), but also noted that less experienced researchers may require higher numbers of participants to be able

to reach saturation. While saturation was evident after the first six interviews, the researcher chose to complete a total of 12 interviews to fully assure saturation.

Study Methods

Recruitment of participants was accomplished through distribution of advertising flyers (see Appendix A). These were initially distributed in nurses' unit mailboxes and posted on the adult medical and surgical acute care intermediate and general care units of the study hospitals. Initial responses were limited. Therefore, recruitment of participants was expanded through personal and e-mail interaction with nurses in leadership and academic roles who assisted by personally contacting nurses and sharing additional flyers to interest them in study participation.

Data and material for this study were collected through one-on-one, semi-structured interviews conducted in a private, quiet, convenient, and comfortable location outside of the participant's own work unit or by telephone as preferred by each individual participant. Six participants selected face-to-face interviews in private conference rooms at their employing hospital. The other 6 participants preferred telephone interviews. Each individual interview was immediately preceded by an explanation of the study purpose and protocol and the verbal collection of demographic data. The research consent document (see Appendix B) was read aloud and signed on site with face-to-face participants. The same consent document was read aloud in its entirety to the telephone participants, verbal consent was obtained, and the consent documents were then mailed with

a self-addressed return envelope. All participants retained a signed copy of the consent. This preliminary consent period took no more than 10 minutes with each participant. The semi-structured, audiotape-recorded interview with each nurse ranged in length from 14 to 26 minutes (mean = 19.25 minutes). Thus the total time required for each interview was 36 minutes or less. The researcher personally conducted all interviews and completed the process of phenomenologic inquiry including empiric and reflective methods seeking to uncover the lived meaning of quality nursing care for the practicing nurses.

The research question for this study was: "*What is the lived meaning of quality nursing care for practicing nurses in the USA?*" This lived meaning was uncovered through the hermeneutic interpretation of practicing nurses' interview responses using empirical and reflective methods as defined by van Manen (2002b). The data were elicited through phenomenological inquiry using a semi-structured Interview Guide (see Appendix C). Each participant was asked to respond in their own words to the following questions preceded by the introductory comment:

I am really interested in Quality Nursing Care.

- *Tell me about quality nursing care?*
- *What does quality nursing care mean to you?*
- *What is it like when you give quality nursing care?*
- *Describe an example of when you delivered quality nursing care.*
 - *What did you do?*

- *How did you feel about that?*
- *What is it like when you observe another nurse giving quality nursing care?*
- *Describe an example of when another nurse delivered quality nursing care.*
 - *What did you observe?*
 - *What did they do?*
 - *How did you feel about that?*
- *Is there anything else I need to know about what quality nursing care is like?*

If additional probing was needed to elicit detail or depth, to refocus the participant's attention on the central issue of quality nursing care, or to refocus discussion on what quality nursing care *is* rather than what it *is not*, probing or *pocket* questions including the following were used:

- *Tell me more about....*
- *What was that like?*
- *What did that look like?*
- *How did you feel about that?*

The initial 2 interviewees in this study spontaneously stated that they did not equate quality nursing care with competence or skill capabilities. Therefore, subsequent participants not spontaneously addressing this issue were

additionally asked if there was any relationship between quality nursing care and the competence or skills possessed by the nurse.

Ethical Considerations

The protection of the rights of human subjects in research studies requires that appropriate protocols and processes are stringently implemented. Munhall (2001b) draws attention to the fact that qualitative studies pose unique challenges and brackets her own beliefs that nursing advocacy for the study participants must take precedence over the research if a conflict develops; that participants are actually collaborators in the research process; and that informed consent, normally a static process, needs to include allowance for changes in response to research events.

Ethical considerations were given a high priority in the conduct of this study. The Combined Institutional Review Board (IRB) at a University/Health System in the Southeastern United States (see Appendix D) approved the study prior to the recruitment of participants and data collection. The Chief Nursing Officer and President of the study hospital system gave permission for recruitment of participants as part of the IRB application. Upon IRB approval, recruitment was accomplished through the distribution of advertising flyers (see Appendix A) seeking volunteers for a study on nursing practice and patient care. The flyers were developed with attention to avoiding unintended influence on participants and did not directly address the topic of quality nursing care. Respondents were briefly screened and their questions were answered by

telephone using the inclusion criteria. The first 12 respondents meeting all selection criteria were chosen for participation. Additional respondents meeting inclusion criteria were kept on an alternate list in case more participants were needed to reach data saturation or if initial participants withdrew from the study. A minor incentive for participation (i.e., \$10.00 gift certificate) was offered upon completion of the study interview.

The voluntary nature of the interview; the option of withdrawal at any time; and the planned use of the data obtained were explained in detail. The opportunity to decline participation prior to or at any time during the interview was offered. Each participant was informed that a summary of the findings would be shared with them upon completion of the written report. A copy of the signed Consent Document (see Appendix B) was provided to each participant.

I was the sole contact with the participants and conducted the confidential interviews individually in a private, reserved conference room at their hospital or by telephone as chosen and preferred by each participant. Handwritten notes and an audiotape recorder were used to record the participants' responses during their individual sessions. The interview tapes were transcribed verbatim by a transcriptionist who signed a confidentiality agreement. The transcriptionist works in a city at least 90 miles from the study hospitals and had no known relationship with any of the participants. The transcriptionist would have ceased transcription and immediately notified the researcher if familiarity with any participant was recognized. Interview tapes and transcribed documents were

validated for accuracy using the supporting field notes. Anonymity of the participants was ensured by not audio-recording their surnames or other identifying data. Audiotapes and documents were coded to maintain anonymity and the participants were assigned pseudonyms. Confidentiality of the research materials was maintained. All documents, notes, and tapes were stored in a confidential locked drawer in the researcher's office at all times and will be destroyed according to IRB requirements.

Data Analysis and Interpretation

The interview data was analyzed, interpreted, and synthesized using van Manen's (1990) qualitative hermeneutic phenomenological research approach.

Six research activities were specified:

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented [nursing] relation to the phenomenon;
6. balancing the research context by considering parts and whole. (pp. 30 – 31)

Using empirical and reflective methods, the transcripts were analyzed to uncover emerging themes. The initial coding identified words and phrases which seemed salient to the research question. These were then clustered into categories during a secondary coding process. These categories were then combined, based on similar properties, into a central theme or statement specific for each participant. Finally, the similar elements from each participant's central theme were combined to create the overarching common themes that signified the lived meaning of quality patient care for these practicing nurses.

Data Validity and Trustworthiness

Debate concerning the use of the concepts of validity and reliability in evaluating qualitative research continues, with those opposed indicating that they are appropriate only in quantitative studies. Tobin and Begley (2004) make an argument, however, that "Rigor is the means by which we show integrity and competence: it is about ethics and politics regardless of the paradigm" (p. 390). They recommend the use of triangulation "to establish completeness or consideration of the comprehensive, multiple realities possible in the findings of qualitative studies" (p. 393).

Rigor or trustworthiness (Sandelowski, 1986, 1993; Tuckett, 2005) of this qualitative research study was established in several ways. The use of audiotapes, audited transcripts, and field notes for validation and enhancement assured data accuracy and contributed to the credibility or truth value of the research materials. The presence of the *phenomenological nod* of agreement,

obtained from 3 non-participant nurses in response to a phenomenological text known as a linguistic transformation, indicated that the written interpretation of the phenomenon resonated with readers, offering additional evidence of credibility.

Defined by Johnson (1999) as “cross checking” information and conclusions through the use of multiple procedures or sources, triangulation in this study was achieved through independent reading and interpretation of participant interviews by nurse colleagues. This dialogical interpretation established corroboration of my analysis and interpretation. The process of investigator triangulation is considered peer review or auditability by some authors. “Auditability is the ability of another investigator to follow the thought processes, decisions, and methods used by a researcher” (Scannell-Desch, 2005, p. 603). Since this was dissertation research, the chair and committee members also reviewed the processes and conclusions of this study, further contributing to consistency and dependability.

While triangulation sometimes includes returning transcripts and interpretations or analyses to participants for validation, I chose not to do this. I was interested in obtaining spontaneous, pre-reflective descriptions of the lived experience of quality nursing care for this study. By returning transcripts for feedback and further input from participants, their responses to the material and interpreted lived meaning may become conceptualized and intellectualized rather than describing and directly reflecting their lived experiences. In addition, by

using van Manen's human science research method, I interpreted and gleaned meanings from the participant stories, anecdotes, and examples to create the essence that I came to understand. In hermeneutic phenomenology, this was not a restructuring of the participants' statements which they could easily read, recognize, and validate as reproductions of their individual statements. Instead, a new essence was created and was better shared with non-participant nurses for validation as noted above.

Reflexivity, the "continual process of critical self-reflection on one's personal biases, preconceived notions, assumptions, theoretical predispositions, and ideological commitments" (Powers & Knapp, 2006, p. 148), was another strategy supporting rigor or validity. Reflexivity is characterized by the reflection on reflections that is characteristic of the iterative analysis processes in this study. Through reflexivity, equal weight was given to participant voices. Reflecting repeatedly on the audiotapes, transcripts, and analysis documents in whole and in part eliminated any biases based on participant style or content.

Ongoing reflective processes also identified the influence of my personal biases and subjectivity on the research process and conclusions. To accomplish this, I recorded reflexive field notes throughout the study with a tri-fold purpose. In theoretical notes, I interpreted or attached meaning to my observations. In methodological notes, I recorded details, instructions, and reminders about the observations or data and about any changes needed in subsequent interview sessions. In personal notes, I documented my feelings, beliefs, biases, and

thoughts at the inception of the study and throughout the research process. The field notes recorded in my reflexive journal actively informed the isolation of themes and thematic statements throughout the study analysis

Lastly, verbatims were used as low inference descriptors. These direct verbatim quotations allow the readers of the report “to experience for themselves the participants’ perspectives” (Johnson, 1999, p. 162). Trustworthiness of the verbatims was supported through my direct verification of transcript accuracy against the audiotapes and against field notes. The interview questions were open-ended and I maintained neutrality during the interviews.

In summary, the lived meaning of quality nursing care for practicing nurses was uncovered, through the use of a hermeneutic phenomenological approach, in this exploratory descriptive research study. An understanding of quality that had not been previously addressed adds new knowledge for the discipline of nursing and has the potential to influence the profession.

CHAPTER FOUR: FINDINGS

The lived meaning of quality nursing care for practicing nurses in the USA was unknown. This study uncovered an understanding of quality that had not been addressed in the nursing literature. The lived meaning of quality nursing care for nurses practicing in acute care hospitals was revealed through analysis of staff nurse interviews in this exploratory descriptive research study. Hermeneutic phenomenology (van Manen, 1990) was selected as the research approach because it is designed to explore and uncover the lived meaning of pragmatic experiences.

The interview data were analyzed, interpreted, and synthesized using the six research activities specified by van Manen's (1990) qualitative hermeneutic phenomenological research approach. These were enumerated in Chapter 3 (p. 63). These activities were used throughout the iterative research processes of this study and were also subsequently used to organize and present the study findings in this chapter.

Turning to the Phenomenon

In this first research activity, we are "turning to a phenomenon which seriously interests us and commits us to the world" (van Manen, 1990, p. 30). Quality nursing care was the phenomenon of interest for this study. Quality nursing care is a lived experience for patients and for nurses alike. While it is a shared experience between them, it is also a unique lived experience for each of them. The lived meaning of quality nursing care for the practicing nurse was the

specific phenomenon explored and uncovered in this study. What is the nature of quality nursing care as experienced in the lives of nurses who are providing direct patient care? The task of this phenomenological study was to “construct a possible interpretation of the nature of a certain human experience” (van Manen, 1990, p. 41). The first step in this quest was to identify why I turned to this phenomenon and chose to do this study.

Throughout my years of nursing, quality management, and quality improvement experience, I lived with quality nursing care in my being. The delivery of quality nursing care drove my own clinical practice and was a consistent, enduring motivation for my career choices. Because van Manen (1990) does not advocate that we totally disassociate ourselves from personal lived experiences, I identified and maintained an effective awareness of these experiences while conducting this phenomenological research study. In doing so, I reflected repeatedly upon my lived experiences, biases and preconceptions. To achieve an effective understanding of the meaning of my own lived experiences and identify my personal beliefs and values related to quality nursing care, I reflected upon my own lived meanings and internal biases prior to and throughout this study. These beliefs and values were listed in chapter 3 (p. 53). Initially identified at the study outset, these remained consistent throughout the research period.

Through this initial awareness and subsequent reflection on the study findings, these preconceptions and biases were repeatedly addressed as part of

the process of phenomenological reflexivity. I consciously used them to connect to the lived experiences of the participants and to grasp the essence of their experiences. I did not identify intrusive influences on the study implementation or findings and did not recognize any need for resultant study adjustments. Instead, these preconceptions assisted me in the study analysis

As I reflected on participant experiences throughout the study, I recalled and recorded several meaningful examples of quality nursing care from my own experiences as a practicing nurse. These included:

- *What does quality nursing care mean? Ten year old Brian, with severe chronic nephrosis, returned repeatedly in ever-deepening episodes of infection and kidney failure. Confused and lethargic upon each admission, Brian's care required minute-to-minute assessment and painful procedures. Holding and rocking him slowly when his parents had to leave to get some rest, he clung to me in spite of the pain I inflicted daily. This 'farm-grown' boy later demanded that this 'city-grown' nurse come to the farm and learn to milk a cow! Seeing him bounce around the barn, laughing at this 'city-slicker's' ineptitude, totally validated the common quality nursing care experiences that successfully placed us in that barn together.*
- *What is it like when you give quality nursing care? It's the feel of that three pound neonate clasping your little finger in her hand for the first time.*

Reliving memories of experiences such as these served to ground and focus my mind on the nature of the lived experiences shared by the study participants. I then used phenomenologic inquiry in seeking to uncover the lived meaning of quality nursing care for these practicing nurses within their lived experiences.

With my interest in the nature of this human experience established through personal experience and initial reflection, the research question for this study was developed: “*What is the lived meaning of quality nursing care for practicing nurses in the USA?*” I completed a hermeneutic interpretation of practicing nurses’ interview responses using empirical and reflective methods as defined by van Manen (2002b). I asked each participant to respond in their own words to the semi-structured interview questions listed in chapter 3 (pp. 60-62).

Investigating the Lived Experience

In this second research activity, we are “investigating the experience as we live it rather than as we conceptualize it” (van Manen, 1990, p. 30).

The point of phenomenological research is to ‘borrow’ other people’s experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience. (van Manen, 1990, p. 62)

Data and material for this study were collected through one-on-one semi-structured interviews.

In hermeneutic phenomenological human science the interview serves very specific purposes: (1) it may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon, and (2) the interview may be used as a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of an experience. (van Manen, 1990, p. 66)

I documented participant responses during individual interviews with an audiotape recorder and handwritten field notes. Following verbatim transcription of the audiotapes, I validated the accuracy of the transcribed documents against the audiotapes by listening to the audiotapes, proof-reading the transcripts, and referencing the supporting field notes.

Emerging themes were discovered within the audiotapes and transcripts generated from the interviews through empirical and reflective methods. Throughout the analysis process, I dwelt with the audiotapes and verbatim transcripts as I repeatedly reviewed them in this search for meaning. While reading and re-reading the verbatim transcripts and listening and re-listening to the audiotapes to both see and hear what the nurses were truly saying, I was immersed in the process. "Generally, we can take three approaches toward uncovering or isolating thematic aspects of a phenomenon in some text: (1) the wholistic or sententious approach; (2) the selective or highlighting approach; (3) the detailed or line-by-line approach" (van Manen, 1990, pp. 92-93).

In this study, these three approaches were combined to isolate the thematic statements in the interview audiotapes and transcripts. Combing through the data materials was an iterative process that moved from each whole interview, through selected excerpts, to emerging themes, back to the whole interviews, and finally led to the creation of a narrative text. These activities often took place simultaneously and always included flowing back and forth repeatedly among the whole and the parts of the audiotapes, transcripts, and analysis documents. Commonalities among the 12 interviews were explored to uncover the essential, universal elements discovered within the interviews. In this way, I discovered and uncovered the lived meanings of quality nursing care for the study participants.

More specifically, my reflective analysis process was one of living with the audiotapes and transcripts. It included repeatedly listening to and reading the data materials while returning again and again to various steps in the process as I lived with them. In addition to uncovering fundamental meanings and essential themes, several incidental themes were also revealed.

The diagram presented in Figure 1 is a simplistic depiction of the iterative reflective analysis process used in this study. A two-dimensional model does not adequately explain the non-linear, repetitive, redundant, and simultaneous manner in which the reflective analysis activities took place. The double-ended arrows are intended to show that movement goes multiple ways but do not show clearly that activities also moved across each other in multiple ways. At the heart

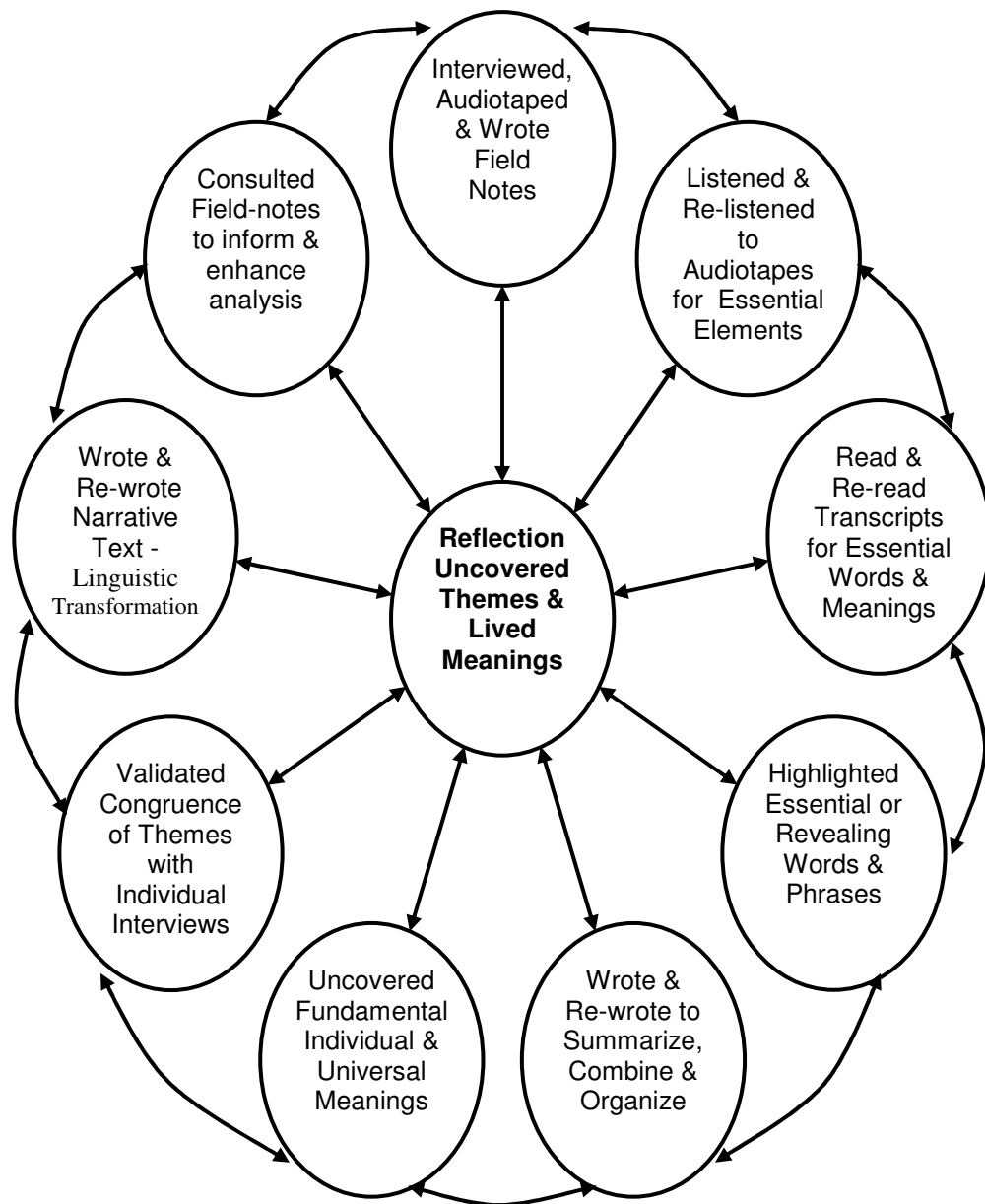


Figure 1. The iterative reflective analysis process.

of the process is the iterative reflection or reflexivity that ultimately uncovered the essential themes and lived meanings of quality nursing care for the practicing nurses in this study.

Reflecting on the Essential Themes

In this third research activity, we are “reflecting on the essential themes which characterize the phenomenon” (van Manen, 1990, p. 30). As I dwelt with these audiotapes and texts, I moved within the iterative analysis process and uncovered the lived meaning of quality nursing care for practicing nurses. The study findings were presented in four iterations: (1) the uncovered essential themes were identified; (2) phrases capturing the fundamental meanings or main significance of quality nursing care within each participant text as a whole were provided; (3) participant anecdotes and stories of quality nursing care were shared; and (4) a comprehensive view of the experience of quality nursing care was presented through a narrative phenomenological text known as a linguistic transformation.

After completing the interviews with all 12 participants, I had clearly achieved saturation. I recognized strong similarities among the interviews and did not hear any new themes being revealed. Following transcription, I listened to the audiotapes three separate times while simultaneously reading the transcripts. During the third reading and listening, I highlighted words and phrases on the transcripts that seemed “essential or revealing” (van Manen, 1990, p. 92) of quality nursing care. I then listened again to the audiotapes to validate that the

highlighted words and phrases seemed essential to the phenomenon of quality nursing care in the participants' own words.

I interpreted and named the revealed themes as I perceived them in the participants' words. This sometimes included their actual use of the word itself but most often was based on the theme as it resonated for me as I repeatedly listened to and read their words. I sometimes used my field notes to clarify meaning. Recognizing that alternative interpretations are possible in hermeneutic phenomenological studies, I consulted with my dissertation chair for validation if I was undecided.

- Advocacy was interpreted in phrases such as: *"look out for your patient," "protecting them," "watch out for them," "calling, questioning physicians," "supporting their decisions," "patient advocates all the way,"* and *"be bold in communication."*
- Caring was revealed in words and phrases such as: *"caring," "kind," "a caring heart," "to know somebody cares," "best possible care," "has aspect of caring," "holding her and she died," "helping somebody," "went into nursing to take care of people,"* and *"sat down and talked with him."*
- Empathy was interpreted in phrases such as: *"appreciating the patient's experience," "visualizing person as if it were you or your parent," "treat and view the patient as either yourself or your loved one," "get good rapport with patients,"* and *"being empathetic with the patient."*

- Intentionality was interpreted as the nurse's intention to deliver quality nursing care. It was revealed in phrases such as: *"actually wanting to give that good care," "here to help them get better," "good and thoughtful care," "giving the best I can to the patient," "know you did everything you could," "just day to day commitment to doing,"* and *"we know when we do it."*
- Respect was interpreted in phrases such as: *"meet personal needs first," "treat them all with respect and dignity," "teach them how they can do for themselves," "don't lie to them," "met patient choice and desire," "take that sacred trust to the bedside every time," "brought her real self to their care,"* and *"takes as much time as the patient needs."*
- Responsibility was revealed in words and phrases such as: *"honoring the typical 5 rights," "assuming your responsibilities," "made a difference," "make sure that things aren't missed and omitted," "creative and thinking outside the box," "doing the right thing," "doing the best thing that I can possibly be doing,"* and *"have to understand why you do what you do."*

Additional themes including vigilance, comfort, empowerment, personhood, presence/touch, mutuality, compassion, and empowerment were also identified through the analysis. These were not, however, consistently revealed among the participants. They were interpreted in only a minimal number of interviews.

In contrast, the themes revealed in the interviews of at least half of the participants were interpreted as essential to the lived experience of quality

nursing care. The essential themes uncovered in the responses of the study participants were responsibility, caring, intentionality, empathy, respect, and advocacy. The lived meaning of quality nursing care for these practicing nurses was thus revealed through the iterative analysis process.

I continued to dwell with the audiotapes, transcripts, and analysis documents in subsequent analysis steps. To test and validate the six uncovered themes, I organized them by participant interview to assure that they remained salient when interpreted in that way. I then summarized, collated, and re-organized the themes by individual interview question across participant interviews to assure relevance and consistency from that perspective. These activities required writing and re-writing. I listened again to the audiotapes while consulting my field notes and included relevant content to clarify or enhance the analysis documentation. I reflected on the essential themes characterizing the phenomenon of quality nursing care, seeking to uncover additional themes and meanings but none were discovered. I then reviewed the analysis documents and recorded the essential elements identified universally across interviews. Only the theme of responsibility was present in all 12 interviews, while caring and intentionality were each present in the responses of 11 participants.

Once the essential themes were interpreted and validated, I next reviewed the audiotapes and transcripts again in their totality, seeking “what phrase may capture the fundamental meaning or main significance” (van Manen, 1990, p. 92) of each participant’s text as a whole. These representative phrases and

statements were discovered through the iterative analysis process. I interpreted the phrases presented here as being most representative of the fundamental meanings of quality nursing care for each practicing nurse participant in this study. I viewed them as a microcosm of quality nursing care for each nurse.

- *“Most of the time it is just the human touch, the human factor in the whole thing.” – AnnJo*
- *“When I give quality nursing care I’m doing what I’m supposed to do - as well as I could ...and I’ve done everything I can do in the situation to support the patient and family in a difficult decision.” - Breeana*
- *“I was going along side somebody on a journey [toward end of life] and you kind of help them make the journey a little bit better, hopefully, by your presence.” – Dede*
- *“I’ll take care of him or her better than the person who loves ‘em the most ... You make a difference in somebody’s life.” – Beverley*
- *“If you have a person that’s actually caring and compassionate and concerned about the welfare of that individual, it’ll take you farther than if you are an expert clinician.” – Dorothy*
- *“To be very bold in communicating ... not being afraid to ... be an advocate for the patient.” – Lenor*
- *“Quality-wise, I implemented the things the patient needed ...I caught something that the patient needed and the others had missed.” - Helen*

- *“This is what we’re here for ... a lot of talking and a lot of listening going on. ... A big part of it is ... is just who I am.”* – Cathy
- *“That’s what I went into nursing for ... was to take care of people and provide good care.”* – Joan
- *“It made me remember why I do what I do. ... It made me remember, we’re here for the patients.”* – Stacey
- *“We know when we do it [quality nursing care] ... good care and thoughtful care.”* – Maryrose
- *“It’s a simple thing that I called the doctor and told him that she was so sick ... she just ... it went so far for her.”* – Barbara

In the next iterative analysis steps I again wrote and re-wrote combining categories into the essential themes of each interview and combining similar elements from each participant’s fundamental meanings and essential themes to create overarching common themes that signified the lived meaning of quality nursing care for these practicing nurses. I did not uncover new themes in this process. The essential themes of responsibility, caring, intentionality, empathy, respect, and advocacy uncovered in the responses of the participants remained constant as the overarching themes. I next tested these for congruence with the individual participant interviews and analysis documents. In addition, through the reflexive processes of repetitive reflection, I began to uncover relationships among the themes.

In the next analysis iteration, anecdotes, stories, and examples led to further discovery or understanding of the phenomenon being studied. Anecdotes teach us by providing concrete examples of abstract concepts. Practical stories allow others to reflect upon the essences or lived meanings that are described. van Manen (1990) states, “The paradoxical thing about anecdotal narrative is that it tells something *particular* while really addressing the *general* or the *universal*” (p. 120). The lived meaning of quality nursing care for the practicing nurses in this study was discovered and uncovered within the verbatim quotations excerpted from these interview anecdotes and stories shared by the study participants. The essential themes in the responses were responsibility, caring, intentionality, empathy, respect, and advocacy. Each of these themes was then presented with supporting verbatim data.

Responsibility for their patients was uncovered in the shared stories of all participants in this study. It was clear that each of these nurses thought that their felt responsibility and accountability for the wellbeing of their patients was an essential component of quality nursing care. Examples revealing this essential theme of responsibility in quality nursing care included:

- *“I think there’s a lot of satisfaction in ... in going, umm, a step beyond to do something right and to, uh, monitor everything that’s being ordered and done for the patient to make sure things aren’t missed and omitted. And it’s so easy to miss things and especially things like antibiotics or just miss, you know, an order or have an order be missed*

by the doctor. And then, you know, there's a whole chain of backups that things are caught. But then it ... it really so much depends on the nurse who's, kind of, at the bedside and at the computer and at the ... in the middle of it to catch these things and monitor these things for the patients' safety." - Maryrose

- *"I think that's [quality nursing care] what we're all here for. So it's ... I ... that's what I would expect, especially if I was a patient on the other end. ... So, I mean, it's ... to me, it's ... it's what should be expected and, uh, it's a ... it's a good thing to see that being done".* – Stacey
- *"It's ownership. They're mine and I'm gonna take care of them. Whatever I need to do to take care is what I'll do."* - AnnJo

Caring was discovered in the anecdotes of eleven study participants. I initially chose caring as a theme because it was overtly described as such by many participants. There is some overlap between caring and empathy. Questions as to whether participant responses were indicative of caring or of empathy were resolved by listening to the participant's spoken words and their expressed feeling tones. I interpreted caring as reflective of interest, concern, and care-giving, while I interpreted empathy as understanding, emotional sensitivity, and experiencing something as the patient did. Examples uncovering the essential theme of caring in quality nursing care included:

- *"And he was talking about how basically we weren't gonna be able to make him better but he's terminal. And so immediately you just ... I just*

kind of put my hand on him, on his shoulder and I said well, yes, I, I know that, umm, you know. But I said we're gonna do everything possible just to make you feel good. And, umm, I just, you know, talked to him when he needed to ... to talk to me and he needed assistance getting up and going to the bathroom and he had to go to the bathroom like every hour. And he kept saying I'm sorry that I have to go so much and I just said no, it's not a problem. I said, you know, this is what we're here for and just made sure, umm, you know, he had ... he had clean linens as needed and, umm, just ... provided everything that he needed ... he needed." – Cathy

- *"But we all have that aspect of ... of caring. And then how do you define the word caring? Umm, but, uh, interest actually, in someone else and their well being or interest in who they are and where they ... what they have become and where they're going and, uh, it ... it's a self fulfilling, self rewarding aspect."* – Beverley
- *"It was all psycho social.....I mean I had to help this woman, umm, I had to, you know, turn off her ventilator. I had to give her the right drugs. I had to be there with her family. It was intense. Umm, as hard as that experience was, it was like I knew I was doing the right things at the right time for the right people, for the right reasons. I know I mean it was ... I was entrenched in it pretty much but I was able to keep my professional distance at the same time. You know, I mean, a*

woman died. I was holding her and she died and it was just a difficult situation but I know that I did a good job of being there. I mean as best as you can. You can't make it go away. They've gotta ride the, go through the trip themselves. I mean it's ... I guess that's what I see good nursing care is." - Dede

Intentionality, defined as the key role played by the nurse's conscious choice to provide quality nursing care, was uncovered in the anecdotes of ten participants. I interpreted stories of personal commitment and choice as intentionality. Nurses described this intention as an act of will directed toward providing quality nursing care. For me, this act of will differentiated intentionality from responsibility. Intentionality was identified as important in determining the quality of nursing care personally delivered by nurses and by the nurses with whom they worked. Examples revealing the essential theme of intentionality in quality nursing care included:

- *"You know we do things that make a difference ... they're gonna be doing exactly what needs to be done for that patient. And you know everybody may not do exactly the same thing but you know they're gonna do what they believe to be in the best interest of the patient verses somebody just going in and doing a job and collecting a paycheck." - AnnJo*
- *"It's not a big, enormous, firecracker experience. Just day to day commitment to doing ...then that is really high quality care. Just honest*

and good and following all standards of cleanliness and sterile technique and everything in an upright and honest way and just for the patient's benefit.” – Maryrose

- *“Quality nursing care is caring that you deliver quality care. And I think quality nursing care has to do with who the person is and actually wanting to give that good care.” - Barbara*

Empathy was discovered through the stories that nine of these practicing nurses told about the delivery of quality nursing care by themselves and by other nurses. Again, I interpreted these participant descriptions as empathy because they reflected understanding, emotional sensitivity, and experiencing something as the patient did. Examples uncovering the essential theme of empathy in quality nursing care included:

- *“Quality nursing care, quality nursing care to me means, umm, appreciating what the patient is going through. Appreciating their vulnerability and protecting that. Uh ... it means trying to understand the experience of being the patient. Trying to make sure that you're doing everything within, within the scope of your practice to help them get through whatever process it is they're trying to get through.” - Dede*
- *“Well, the first that comes to my mind is you have to treat and view the patient as either yourself or your loved one and then that really decides, when you do that ... that decides everything that ... that you do. So, I ask myself that question and then that helps me decide, you*

know ... just that helps me to provide the best care for them. And then just viewing them as either myself or either my family member uh, it just ... it just helps me provide the best care possible. And I think, you know, it's... it's simple things like just listening to them when they need somebody to talk to and explaining their medications and their treatment and encouraging them to ask questions.” – Cathy

- *“Well I think quality nursing care entails you visualizing that person in that bed, that you’re caring for at the time ... being individualistic and as if it were you or your mother and what would you want someone to do for your parent or for yourself.” – Dorothy*

Respect was evident in the stories provided by nine of the participants. I identified the theme of respect when the personhood of the patient held primacy for the nurse and when nurses specifically spoke about the importance of respecting patient needs, dignity, and preferences. Examples revealing the essential theme of respect in quality nursing care included:

- *“And it was just really important to me that he [an unresponsive and difficult care patient] was always treated like I would treat anybody else, you know. Even though he couldn’t talk back to me, you know, we would walk him through the process and tell him what I was doing, while we’re doing it and making sure that he’s not ignored. Even though he can’t tell you what he needs, try to be on top on that, you know.” - Lenor*

- *“You would want them to treat you with respect and dignity. You would want prompt service, as prompt as it can reasonably be. You would want them to refer to you, you know, by your name, treating you as a person and not just room 205 or appendectomy down the hall ... such things as that. You would like for people to ... if ... I mean, let you know what’s happening, what’s gonna be going on with me today? Why are you doing thus and so? When you come in the room, introduce yourself, tell me why you’re doing what you’re doing and just keep me informed. Speak to me. Talk to me. I’m a person.” – Dorothy*
- *“And when she would explain things to me or talk to me about some of the care she was giving, she would just be so excited and happy to say how wonderful it felt for her to watch these wounds heal and how she treated her patients with so much dignity and ... and kindness. And she just brought her real self to their care, to their bedside, or to their home I think that, to me, was a real quality. She’s a quality person and ... and she was giving quality care.” - Maryrose*

Advocacy was uncovered in the anecdotes of only half of the practicing nurses in this study but was expressed very strongly by all of them. As I listened to interviews and audiotapes, participants’ voices made the importance of this theme evident. Examples revealing the essential theme of advocacy in quality nursing care were:

- *“I can think of several nurses on the floor I work who are absolutely excellent. Many years on that floor and they are patient advocates all the way and so I, I want to mimic what they do. And I helped that family work through the process as well as the patient and make the decision to not pursue that amputation and to discontinue dialysis because she was at the end of her life. She was tired. She was ready to make those decisions and to be able to just to go home and to die in, in the dignity and peace that she wanted.” – Breeana*
- *“We have a lot of residents, we’re in a teaching facility so a lot of times you may know that something’s not appropriate where they’re still learning it and they haven’t quite gotten to that level yet, so you have to be willing to go up to them and say, look you know this isn’t, this isn’t really what you need to be doing, and I think that quality nursing ... that encompasses all of that. So it’s just, it’s knowing your patients, calling, questioning, calling the doctor and saying look ... you got ... they’re not tolerating this.” – Joan*
- *“I think with, umm, quality care, not only pertaining to the patient but also to the whole inter-disciplinary team, umm, communication, I think, is something that lacks a lot of the time. To be very, you know, bold in communicating to ...whether it’s the doctor or to the social worker, you know, not being afraid to, you know, to be an advocate for the patient. I guess that’s another aspect of quality care.” - Lenor*

Thus, throughout the iterative process of analyzing the anecdotes and stories related by the study nurses, the six themes of responsibility, caring, intentionality, empathy, respect, and advocacy were repeatedly uncovered and revealed as the essential components in this search for the lived meaning of quality nursing care for practicing nurses.

In discussing their lived experiences of quality nursing care, participants also consistently revealed incidental themes. These identified commonalities related to their roles or activities as practicing nurses and to their feelings in those situations when they delivered or observed quality nursing care. While these themes were incidentally related to the lived meaning of quality nursing care, they were not interpreted as essential themes. The nurse role or activity dimensions mentioned repeatedly by participants when describing quality nursing care included the comprehensiveness of nursing care, the impact of nursing values and ethics, and the significance of teamwork. Examples of comprehensiveness included: “*multifaceted*,” “*putting it all together*,” and “*global perspective*.” Examples of nursing values and ethics included: “*honest*,” “*trusting*,” and “*just the right thing to do*.” Teamwork references included: “*teamwork*,” “*glad to be part of team*,” and “*feel like we’re in this together*.”

Participants also identified shared, consistent feelings that accompanied the delivery of quality nursing care. Feelings experienced by the participants when personally delivering or observing others delivering quality nursing care included: “*makes me feel good*,” “*think it’s great*,” “*felt wonderful, as good as*

anybody can feel, “rewarding to have done your best,” “self-fulfilling,” and “lot of satisfaction.” Delivering quality nursing care also generated professional pride: “something to be proud of,” and “proud to be part of the profession.”

Even though worded differently, there was agreement among the nurses that clinical nursing skills were not essential elements of quality nursing care. Clear in the statements of every participant were comments such as: “*the human part is bigger than the skill element ... anyone can be taught to do any (skill),*” “*skill has nothing to do with it ... you can train a monkey to do skills,*” “*skills are critical but not as important as caring ... good caring with skills is more important than skills,*” “*need some of everything but skill can come from elsewhere,*” and “*if you don’t (communicate with the patient) it doesn’t matter how good technical skills are.*” Their statements suggested that as long as a nurse is basically competent quality of nursing care is determined more by their manner of delivery than by the level of knowledge or skill.

In fact, there was agreement among them that any nurse could learn the requisite skills but that nurses either *had* or *didn’t have* the capacity to provide quality nursing care. Descriptions of nurses who delivered quality nursing care included: “*compassion, emotional, caring part ... just gotta have it to have the total package,*” “*to do well and put the patient at ease takes more,*” “*they have admired qualities,*” “*approachable and responsive,*” “*quality person giving quality care,*” “*listening, touching, teaching is inherent ... just who I am,*” and “*it is who you are.*” Thus this capacity was described as an intrinsic characteristic of the

nurse whose care consistently reflects responsibility, caring, intentionality, empathy, respect, and advocacy.

This study intentionally focused on what quality nursing care *is*. Incidental statements indicative of the barriers and limitations that practicing nurses experience in striving to deliver quality nursing care were shared in some participant interviews. While the inability to consistently deliver quality nursing care is part of the overall lived experience of nursing care for these practicing nurses, it was not particularly relevant to uncovering the lived meaning of quality nursing care. It may be that the limitations and barriers that prevent nurses' realization of this lived meaning result in the frustration and dissatisfaction that plague the profession. These may also reflect an existing tension between organizational and professional imperatives. Healthcare financing and accreditation may contribute to this tension by establishing priorities that may not often support nurses in fulfilling this lived meaning. This raises the question: Do regulatory and accreditation imperatives address the essence of quality nursing care?

Based on the analysis iterations described above and the reflective insights about the thematic relationships that were gained throughout the process, I wrote and re-wrote to develop a succinct description of the essence of the phenomenon. *The lived meaning of quality nursing care for these practicing nurses was interpreted and found to be meeting human needs through caring, empathetic, respectful interactions within which responsibility, intentionality, and*

advocacy form an essential, integral foundation. The lived experience of quality nursing care resided within nurse-patient interactions that were consistently recognizable as such by nurses in their own practice and in that of their peers. These six themes of responsibility, caring, intentionality, empathy, respect, and advocacy were the essence of quality nursing care. These themes were essential to quality nursing care in the lived experience of these practicing nurses.

Describing the Phenomenon

Continuing the extensive process of reflecting on the essential themes, we are “describing the phenomenon through the art of writing and rewriting” (van Manen, 1990, p. 30) in this fourth research activity. This final step in the iterative analysis process resulted in what is often considered the culmination of the interpretive analysis in a hermeneutic phenomenologic research study. At this point, I created and presented a comprehensive view of the experience of quality nursing care through a narrative phenomenological text. I wrote and re-wrote a linguistic transformation several times to best express the lived meaning of quality nursing care.

“...human science research *is* a form of writing. Creating a phenomenological text is the object of the research process” (van Manen, 1990, p. 111). The process of writing and rewriting strengthens thinking and reflection and enables the uncovering of lived meanings. Writing in hermeneutic phenomenology is meant to clarify what we know, draw us closer to the experiences being revealed, put our thoughts into practice, make our

understanding more concrete, and enable us to see the essence of the lived meanings that have been shared by the participants. Writing also lets us show others, in a recognizable manner, the lived meanings we have uncovered.

Linguistic transformation is one type of phenomenological text recommended by van Manen (1990) and Munhall (2007). It is an exercise in phenomenologic reflection. "Composing linguistic transformations ... is a creative, hermeneutic process" (van Manen, 1990, p. 96) through which the lived meaning of a phenomenon is captured and communicated. As a result of reading the linguistic transformation narrative, others can come to understand the lived meaning of the phenomenon as interpreted by the author, can reflect on the lived meaning themselves, and can offer alternative interpretations.

The following linguistic transformation narrative was written to reveal the lived meaning of quality nursing care for practicing nurses. "The purpose is to capture in a narrative example the essence of the phenomenon under investigation" (Munhall, 2007, p. 228).

Margaretta has been a registered nurse for 12 of her 34 years.

When she graduated from college, she was filled with enthusiasm and excitement to be finally beginning the career she felt she was meant for. She believed that nursing was in her.

Her first few years were challenging. She felt ill-prepared for the realities of nursing: short staffing, high technology, unsupportive peers, raging physicians, demanding managers, and dissatisfied patients. By the

end of her fifth year in nursing, she didn't recognize the unhappy, short-tempered, dissatisfied person she faced in the mirror. Margaretta knew that she would leave nursing soon if something didn't change.

Remembering her childhood dreams, however, she took a step back and recognized that while she couldn't change 'things' and other people, she could change herself. The bottom line was that she was unhappy that the quality of her nursing care had become detached and automatic. She resolved to change the way she gave care. She was determined to remember that the patient was her primary focus. She vowed to care for and about each of them. She arranged a transfer to the surgical intermediate unit because she knew the environment would be more predictable. On most shifts she would care for four patients in one geographic pod of four rooms.

Today, Margaretta is admired as a competent nurse, recognized by her peers for the consistently high quality nursing care that she delivers to her patients. While the acuity of her patients' needs has increased over the past seven years, her assignments continue to feel manageable on most days. She recognizes that she is not always the most technologically expert nurse but feels free to ask for help when needed. Margaretta prides herself in taking full responsibility for the care and safety of her assigned patients. As soon as she greets a new patient, she assures them and their loved ones that she will care for them as she would for her own family –

that she will do whatever it takes! She consciously seeks the common humanity of even the most difficult patients.

When Margaretta's patients are frightened, she holds their hands. When they are in pain, she not only medicates them but also massages their feet to help them relax. She listens carefully to what they say, regardless of whether they are talking about their pets or about their desire for a peaceful death. She talks to them on their own level and continually teaches them and their loved ones about their disease processes and post-hospital care needs.

Margaretta makes a conscious daily commitment to doing the right things, for the right persons, at the right time. She intentionally strives to make a difference for her patients. She knows immediately and at the end of every day if, when, and how she has or has not provided quality nursing care. There are days when she far misses her own expectations and there are a few days when she far exceeds them. She reckons that on most days she does pretty good. She is compassionate in her interactions and appreciates what her patients are going through. She puts herself in their shoes and lets empathy guide her decisions, always with the goal of providing the best nursing care possible.

The desires and preferences of the patients on this high-tech unit are often lost in the rush of daily routines and emergent situations. Margaretta consciously strives to respect the individuality, needs, and

dignity of each of her patients. Even when their choices run counter to her own beliefs and practices, she fiercely defends their right to self-determination. She boldly and clearly advocates for her patients, feeling responsible to offer data and opinions based on her knowledge of the patient, to continually ask questions, and to clarify physician orders for the well-being of her patients and their families.

Margaretta is professionally happier and more satisfied than ever before. She gets daily positive feedback from her patients and their loved ones. In both verbal and non-verbal ways, they recognize that she cares for and about them in many big and little ways. She can tell by their behaviors and reactions that they feel comfortable and confident that she is focused on doing her best for them, even when things are not perfect. This positive feedback feeds her spirit, fueling her energy and determination to keep her focus on each patient. It gives her professional pride.

Interestingly, while Margaretta is competent in her nursing skills, she is not the best or brightest on the unit from a nursing knowledge or technical perspective. Many of her peers exceed her capabilities in these areas. Yet, they all say that Margaretta gives the best quality nursing care on the unit. They say she consistently goes above and beyond the normal expectations. She is the nurse they want to take care of them, their spouse, or their parents if they ever have to be admitted to the unit.

This linguistic transformation narrative was written to reveal the lived meaning of quality nursing care for practicing nurses. It was offered so readers can better understand the lived meaning as I interpreted it, can reflect on the lived meaning, and can potentially offer alternative interpretations.

Maintaining a Nursing Relation to the Phenomenon

In the fifth research activity, we are “maintaining a strong and oriented [nursing] relation to the phenomenon” (van Manen, 1990, p. 31). To be meaningful to the profession and discipline, hermeneutic phenomenologic studies must be relevant to the pragmatic practice of nursing. Nurse researchers are sometimes viewed with suspicion by practicing nurses or are dismissed as irrelevant to their daily work, needs, and challenges. To be powerful and have convincing validity, the texts developed through human science research must be “oriented, strong, rich, and deep” (van Manen, 1990, p. 151).

For this study to be oriented within nursing, it must maintain a strong connection between theory and the real lives of practicing nurses. For it to be strong, it must produce understandings, interpretations, and formulations specific to nursing. For this study text to be rich and thick, it must be concrete. The nurse, “as author, attempts to capture life experience (action or event) in anecdote or story, because the logic of the story is precisely that story retrieves what is unique, particular, and irreplaceable” (van Manen, 1990, p. 152) about the lived experience. Depth provides insight into the meaning of the lived experience while still challenging complete understanding.

To confirm the validity and power of the offered linguistic transformation narrative, I shared it with three practicing nurses who were not involved in the study. All stated that they had known nurses like Margaretta across their nursing careers and recognized her actions as quality nursing care. This *phenomenological nod* “occurs when people reading or hearing your presentation nod in agreement” (Munhall, 1994, p. 189) and is an additional determinate of methodological rigor. While stating that nurses like Margaretta were sometimes rare and hard to find, the nurse reviewers fully agreed that this narrative described quality nursing care for them. They voiced agreement with the stated opinion of the study participants that as long as a nurse is basically competent, it is not the level of knowledge or skill that determines the quality of nursing care. They agreed that any nurse could learn the requisite skills but that they either had or didn't have the capacity to provide quality nursing care. The essential themes of responsibility, caring, intentionality, empathy, respect, and advocacy resonated as identifiable and relevant components of quality nursing care in the real lives of these practicing nurses.

The essential themes uncovered in this study surprised me. I would have expected the participants to talk about the importance of nursing skills and competence in providing quality nursing care. I thought that they might discuss evidence-based nursing practice. I had anticipated that those working in a Magnet-designated hospital might reference those standards and activities. Because this was not the case, their ideas led me to begin thinking about what

was most significant for these nurses as they spoke with me. I was startled when I realized that the uncovered essential themes were more reflective of the art of nursing than of the science. Why was I so surprised? This led me to consider whether the emphasis on science has overshadowed these artistic qualities that have been long evident in the historic heritage of nursing. In response to the themes that were emerging, I reviewed the art of nursing literature.

A seminal research study by Johnson (1994) examined the works of 41 nursing scholars published between 1860 and 1992 to clarify the diverse interpretations of nursing art contained therein. Five separate conceptualizations of “nursing art” were identified:

1. the nurse’s ability to grasp meaning in patient encounters,
2. the nurse’s ability to establish a meaningful connection with the patient,
3. the nurse’s ability to skillfully perform nursing activities,
4. the nurse’s ability to rationally determine an appropriate course of nursing action, and
5. the nurse’s ability to morally conduct his or her nursing practice.

(Johnson, 1994, p. 3)

Three of these conceptualizations were described as more competence and skill-based than were the quality nursing care descriptions of the participants in this study. Grasping meaning in patient encounters had a strong intuitive element related to clinical care decisions. Skillfully performing nursing activities was related primarily to skill-based activities. Rationally determining an appropriate

course of nursing action was, likewise, described primarily in relation to clinical care activities. The nurses in the current study, however, spoke only minimally about their clinical and skill-based activities as part of their lived meaning of quality nursing care. A basic level of clinical competence was assumed and their anecdotes and stories were focused instead on the interpersonal, emotional, psycho-social, and spiritual aspects of nursing as being the lived experience of quality nursing care. All five of Johnson's conceptualizations become relevant to the described lived meanings of participants in this study if the conceptualizations are defined in a manner that emphasizes these non-clinical aspects of nursing care.

In a concept analysis of the art of nursing, Jenner (1997) reviewed relevant articles published between 1990 and 1996. "The literature reviewed indicated that the art of nursing is the intentional creative use of oneself, based upon skill and expertise, to transmit emotion and meaning to another" (p. 10). Again, this is directly relevant to the current study if the *skill and expertise* are interpreted in the interpersonal, emotional, psycho-social, and spiritual realms.

A theory of the art of nursing was discovered through a hermeneutic interpretation of the writings and conceptual system of Rogers' Science of Unitary Human Beings:

Thus, the art of professional nursing becomes the ability to balance respect for human freedom and individual rights with responsibility for

the welfare of others through knowing from the feeling attribute of empathy in the moral action that is nursing practice. (Alligood, 2002, p. 58) Responsibility, respect, and empathy in this theory of the art of nursing were identified as being related with the concept of caring. Thus, four of the six themes identified as the essence or lived meaning of quality nursing care were explained within this theory. In addition, the moral element of nursing practice was evident in the incidental study theme of nursing values and ethics.

Balancing the Parts and the Whole

In this sixth and final research activity, we are “balancing the research context by considering the parts and whole” (van Manen, 1990, p. 31). This hermeneutic phenomenologic research study of the lived meaning of quality nursing care for practicing nurses required ongoing mindfulness and balancing of the part-whole continuum. To avoid losing focus within the iterative analysis process, the research question was revisited repeatedly to re-focus on the *whole* that was being sought: “*What is the lived meaning of quality nursing care for practicing nurses in the USA?*” The individual interview questions, although independently interesting, were intended to uncover the *whole* lived meaning. Each question could, but was not intended, to stand alone. When participants drifted to discussion of what quality *was not* during their interviews, the probing or pocket questions designated for that purpose within the methods were used to focus on the main question. Because the content analysis process broke the participant interview responses into multiple discreet themes and meanings

across a variety of different iterations, it was necessary to repeatedly recall the goal. A unified picture of the essence of quality nursing care for practicing nurses, not the specific elements being delineated, was the desired outcome.

The findings within this research report were first presented as *parts* identified through the iterative analysis process and then integrated in the *whole* of the narrative phenomenological text. The *parts* included the essential themes, the verbatim phrases capturing the fundamental meanings or main significance within each participant text, and the verbatim participant stories, anecdotes and examples of quality nursing care. The integrated *whole* was presented through the linguistic transformation.

In summary, the essential themes uncovered were responsibility, caring, intentionality, empathy, respect, and advocacy. The verbatim phrases crystallized the fundamental meaning of quality nursing care for each participant. The verbatim excerpts of stories, anecdotes, and examples provided a broader context for the revealed themes. The lived meaning of quality nursing care for practicing nurses was unified into a whole, expressed, and validated through the linguistic transformation.

The lived meaning of quality nursing care for practicing nurses in the USA was uncovered through the use of the hermeneutic phenomenological approach explained in this exploratory descriptive research study. The lived meaning of quality nursing care for practicing nurses was interpreted and found to be meeting human needs through caring, empathetic, respectful interactions within

which responsibility, intentionality, and advocacy form an essential, integral foundation. The lived experience of quality nursing care resided within nurse-patient interactions that were consistently recognizable as such by nurses in their own practice and in that of their peers. These six themes were subsequently validated as the essence of quality nursing care in the lived experience of practicing nurses. This understanding of quality nursing care that had not been previously recognized or addressed in the literature added new knowledge for the discipline of nursing and has the potential to influence the profession.

CHAPTER FIVE: REFLECTIONS ON THE FINDINGS

The lived meaning of quality nursing care for practicing nurses in the USA was unknown. This study uncovered an understanding of quality that had not been addressed in the nursing literature. The lived meaning of quality nursing care for nurses practicing in acute care hospitals was revealed through analysis of staff nurse interviews in this exploratory descriptive research study. Hermeneutic phenomenology (van Manen, 1990) was selected as the research approach because it is designed to explore and uncover the lived meaning of pragmatic experiences.

In point of fact, all interpretive phenomenological inquiry is cognizant of the realization that no interpretation is ever complete, no explication of meaning is ever final, no insight is beyond challenge. Therefore, it behooves us to remain as attentive as possible to life as we live it and to the infinite variety of possible human experiences and possible explications of those experiences. At the same time, there is no denying that this phenomenology of everyday life is a deepening experience for those who practise [*sic*] it. And phenomenological inquiry has formative consequences for professional practitioners by increasing their perceptiveness and tactfulness. In the space of the text where these writings have taken place, the reflective experiences may bring about an intensified awareness of phenomena that sometimes seem profound and sometimes trivial. (van Manen, 2002a, pp. 7-8)

It is thus clear that hermeneutic phenomenologic reflection does not end when the data analysis is completed. In this chapter, I share reflections on the findings, discuss application of the study findings to nursing practice, education, and research, and make suggestions for future inquiries.

The lived meaning of quality nursing care for the practicing nurses in this study was interpreted as meeting human needs through caring, empathetic, respectful interactions within which the themes of responsibility, intentionality, and advocacy form an essential, integral foundation. The lived experience of quality nursing care resided within nurse-patient interactions that were consistently recognizable as such by nurses in their own practice and in that of their peers. The six essential themes were subsequently validated as the essence of quality nursing care in the lived experience of practicing nurses. This understanding of quality nursing care, not previously recognized or addressed in the literature, added new knowledge for the discipline of nursing and has the potential to influence the profession.

Reflection on Preconceptions and Biases

By reflecting on preconceived personal beliefs and biases about quality nursing care throughout this study, I recognized and considered their actual or potential influence on the study implementation, analysis, and findings. I strove to maintain an unknowing (Munhall, 1994) mindset during the interviews, thereby keeping the fact that the lived meaning of quality nursing care for practicing nurses was not known in the forefront of my thoughts during interactions with

study participants. My preconceptions were held in abeyance while I elicited the unique perspectives of the 12 participants. Throughout data analysis, I reflected on my preconceptions as I explored the nurses' lived experiences and discovered their lived meanings of quality nursing care.

In working through the iterative data analysis process, I uncovered the shared essential themes of responsibility, caring, intentionality, and advocacy within the participants' interview responses and within my identified beliefs and biases. Initially, I was unable to uncover the participant-identified themes of respect and empathy within my identified preconceptions. However, subsequent reflection upon participant descriptions allowed me to "return to and to reexamine what we believe we already know and understand by reflectively bringing into awareness that which has been taken for granted (Powers & Knapp, 2006, p. 128). With a phenomenological nod of agreement, I came to greater understanding of my own values as I discovered that these themes of respect and empathy resonated within my personal lived meaning of quality nursing care.

It is notable that, unlike the participants, none of my lived experiences come from working on adult medical-surgical units. My clinical practice after graduation from nursing school took place totally on general pediatric and adolescent units and in pediatric and neonatal intensive care units. Yet, we appeared to share similar essential lived meanings of quality nursing care as uncovered in this reflective iterative analysis.

My preconceptions about quality nursing care also included the responsibility to maintain ongoing competencies, to remain professionally current, and to be accountable for the consistent use of evidence-based practices. These were not identified by the practicing nurse participants as relevant to their lived meanings of quality nursing care. While assuming a basic level of competence, participants minimized the importance of clinical skills and competencies to the delivery of quality nursing care. Several participants mentioned evidence-based practice as an aside but did not describe this nor the need to stay professionally current as part of the core essence of this phenomenon. With the seeming pervasive emphasis on the science of nursing and the development of high-technology competencies and skills, this result surprised me. The emphasis of bodies such as the IOM (2001, 2004) and the IHI (2007) on caregiver competence did not equate to quality nursing care for these nurses. Upon reflection, it became evident that my biases in these areas were not related to my lived experience as a practicing nurse but rather to my lived experiences as a manager, administrator, and quality improvement professional. In these roles, nurse competencies, current professional knowledge, and evidence-based practice were the touchstones of quality nursing care. Upon further reflection, I was alarmed to realize that these same biases exist in the quality improvement initiatives heralded as essential to safe patient care and quality nursing care (Kramer & Schmalenberg, 2005; Naylor, 2003; NQF, 2007).

Current patient safety and quality improvement initiatives do not address the themes uncovered in the lived experiences of these practicing nurses.

Study participants validated my preconception that nurses fail to fulfill important responsibilities in the quality care arena. They stated that the delivery of quality nursing care was not consistently possible. While the interview questions were consistently redirected to uncover what quality nursing care *is* rather than what it *is not*, several participants indicated that staffing, scheduling, workload, and personal tendencies or professional priorities interfered with their intention of delivering quality nursing care. Although these perceptions of nurses' failure or inability to provide quality nursing care were shared, they were not relevant as part of the lived meaning of quality nursing care for the purposes of this study. The limitations and barriers that prevent nurses' realization of this lived meaning may result in frustration and job dissatisfaction. They may reflect an existing tension between organizational and professional imperatives that is fueled by healthcare financing, regulatory, and accreditation initiatives. This merits exploration in future research.

Reflection on Existing Literature and Practice

The initial study review of the literature indicated that the lived meaning of quality nursing care for practicing nurses had not been identified. There was little to no evidence of agreement on the meaning, representation, evaluation, or perception of quality nursing care. The existing published definitions were usually stakeholder-specific and explained within Donabedian's (1966/2005) structure,

process, and outcome triad. While studies in England, Ireland, Australia, and Canada offered multiple models and middle range theories of the meaning or perception of quality nursing care, the resultant elements of professionalism, caring, interpersonal skills, resources, patient outcomes, and expert practice were only minimally studied among practicing nurses in the USA. Magnet Hospital and related international studies correlating staffing, organizational, and managerial factors with quality of care also failed to adequately define the meaning of quality nursing care.

The lived meaning of quality nursing care for nurses delivering direct bedside care had not been explored. By beginning to fill this knowledge gap, this study has the potential for significant influence on our profession's ability to improve the quality of nursing care delivered to patients across all care settings. It is difficult, if not impossible, to improve what we do not first understand, define, and explain.

The lived meaning of quality nursing care for the practicing nurses in this study embodied the shared themes of responsibility, caring, intentionality, empathy, respect, and advocacy as identifiable and relevant in the real lives of nurses. It was noted that similar themes or components were identified as perceptions or meanings for nurses in some of the reviewed studies but none were specifically studied with the purpose of uncovering the lived meaning of quality nursing care. For example:

- Redfern (1993) referenced psychosocial and thorough care as quality care.
- Coulon et al. (1996) identified holistic, humanistic, client-focused care, and effective interpersonal relationships as important in quality nursing care.
- Idvall and Rooke (1998) spoke about the patient advocate role of the nurse.
- Williams (1998) associated quality nursing care with psychosocial care and care delivery above and beyond norms.
- Gunther and Alligood (2002) described the importance of the affective domain, communication, and nurse-patient relationships to quality nursing care.
- Murphy (2007) used holistic, individualized, and family centered care to describe excellence.
- Lynn et al. (2007) identified quality nursing care factors of interaction, vigilance, individualization, and advocate through qualitative interviews with nurses.

As the six essential themes of responsibility, caring, intentionality, empathy, respect, and advocacy were uncovered, they were noted to be consistent with the literature addressing the art of nursing and, as a result, this literature was reviewed. Similarities, differences, and relations between the art and science of nursing were explored by Peplau (1988). While the historical view

of nursing as art was identified as being much older than that of nursing as science, the scientific emphasis had dominated for much of the last century. Both art and science were evident in modern day nursing. The art of nursing was identified as always involving the nurse and patients in interpersonal situations. “The art is primarily ... an expression of sympathy, attitudes of concern, ethical and moral commitment, and sensitivity to the feelings of others” (p. 14). This description was consistent with the current participant nurses’ lived meanings of responsibility, caring, empathy, respect, intentionality, and advocacy. Nurse-patient interactions were at the heart of the lived meaning as uncovered in this current study.

Johnson’s (1994) seminal research study examined the works of 41 nursing scholars published between 1860 and 1992 to clarify their diverse interpretations of nursing art. Of the five identified conceptualizations of nursing art, some were described as more competence and skill-based than were the quality nursing care descriptions of the participants in this study who spoke only minimally about their clinical and skill-based activities. Participant nurses assumed a basic level of clinical competence and focused their anecdotes and examples instead on the interpersonal, emotional, psycho-social, and spiritual aspects of nursing as being the lived experience of quality nursing care. All five of Johnson’s conceptualizations can be considered relevant to these described lived meanings if these aspects of nursing care are emphasized.

Similarly, Jenner's (1997) concept analysis of the art of nursing reviewed relevant articles published between 1990 and 1996 and identified elements of skill and expertise. Again, these were directly relevant to the current study if skill and expertise were interpreted in the interpersonal, emotional, psycho-social, and spiritual realms.

In 1994, Rose and Parker viewed nursing as an integration of art and science. They identified intuition, reflection, and holism as indicative of the art in nursing. Holism was mentioned by several of the participants in this study but it was not assessed as being essential to the lived meaning of quality nursing care. The integration of art and science was also supported by LeVasseur (1999) who defined the art of nursing as, "...not an indulgent nicety, but instead, an essential activity grounded by practice and manifest in helping patients create coherence and meaning in lives threatened by transitions of many kinds" (p. 63).

LeVasseur (2002) conducted a phenomenological study of the art of nursing by examining nurse-assisted patient transitions using van Manen's methodology:

The study has found four possible objects of nursing art in the themes of (1) helping a patient connect and trust, (2) helping a patient through a hard time, (3) helping a patient see new possibilities, and (4) helping a patient change and take charge. (p. 24)

These transitions are congruent with the lived experience examples shared by the practicing nurses in the current study. Particularly of interest is the fact that

over half of the examples describing quality nursing care in this study involved end of life interactions between nurses and patients. Death and birth can be viewed as sentinel transitions in human lives.

Responsibility, respect, and empathy were related with the concept of caring in Alligood's (2002) theory of the art of nursing discovered through a hermeneutic interpretation of the writings and conceptual system of Rogers' Science of Unitary Human Beings. Thus, four of the six themes identified as the essence or lived meaning of quality nursing care were explained within this theory.

In summary, the six essential themes uncovered through this hermeneutic phenomenologic study of the lived meaning of quality nursing care resided within the realm of the art of nursing. The participant nurses consistently minimized the importance of nursing care aspects representative of the science of nursing as they shared their view of quality nursing care. Instead, nursing's oldest traditions, the art of nursing, were those that resonated within the lived experiences for these nurses and within which the lived meaning was discovered. Rather than thinking of this as a dichotomous view of art versus science, perhaps the art of nursing helps mediate, drive, and inform effective application of the science. If the separation of nursing art and science is artificial, can we consider one in isolation from the other? Is quality nursing care represented in both artful and scientific terms that were not uncovered in this investigation but might be in future ones? And finally, is the science perhaps reflected in the art?

Reflection on Utilization of the Method

Phenomenology was an appropriate approach for this initial research study of the human lived experience of quality nursing care for practicing nurses. Specifically, van Manen's (1990) hermeneutic phenomenological method was used for the analysis and interpretation of descriptions of personal meanings and experiences by practicing nurses. The interviews were analyzed and interpreted using the recommended empirical and reflective methods in this search for the lived meaning of quality nursing care. This approach was selected because it was a pragmatic process, directly applicable to both the discipline and profession of nursing. It made sense to inform this study of practicing nurses with a method that honored the importance of their lived practice experiences. "The rationale of this form of inquiry must be consistent with a form of reflection that is animated by the practical interests of our professional and personal lives..." (van Manen, n.d., p. 1). "Phenomenological research originates in practice, and through careful descriptive and interpretive scholarship, enlightens practice" (Van der Zalm & Bergum, 2000, p. 217). Thus, the lived meaning of quality nursing care was well-suited to exploration and research with this method.

In this exploratory descriptive study, a sample of 12 practicing nurses proved sufficient to reach data saturation and identify the essence of their experiences. To elicit the data, phenomenological inquiry using a semi-structured interview was conducted with each participant. The lived meaning of quality nursing care was uncovered through the hermeneutic interpretation of these

interview responses using the empirical and reflective methods suggested by van Manen (2002b).

Reflection on Integration of the Findings

The lived meaning of quality nursing care for practicing nurses was interpreted as meeting human needs through caring, empathetic, respectful interactions within which responsibility, intentionality, and advocacy form an essential, integral foundation. The lived experience of quality nursing care resided within nurse-patient interactions that were consistently recognizable as such by nurses in their own practice and in that of their peers. The six essential themes were subsequently validated as the essence of quality nursing care in the lived experience of practicing nurses.

A comprehensive view of the experience of quality nursing care, as uncovered in this research study, was presented through the linguistic transformation of the data and materials into a narrative phenomenological text. This allowed the reader to come to understand the lived meaning as interpreted, to reflect on the lived meaning, and to offer alternative interpretations, if desired. This understanding of quality nursing care, absent from the nursing literature, not only adds new knowledge for the discipline of nursing but also has the potential to influence the profession.

Application to Nursing Practice, Education, and Research

This study began the process of uncovering the lived meaning of quality nursing care for nurses in the USA with the goal of providing new knowledge for

the discipline that will influence the nursing profession. Practicing nurses, managers, administrators, educators, researchers, and policy makers may be able to use the findings of this study as new and important knowledge. Collective nursing knowledge of the lived meaning of quality nursing care for practicing nurses may potentially further define the discipline and facilitate practice changes, driving improvements in the quality of nursing care.

These findings give practicing nurses knowledge, for the first time, that the lived meaning of quality nursing care is shared among them. The fact that this shared lived meaning is anchored in the art of nursing, rather than in the science of nursing, will be surprising to many, if not most, practicing nurses. This finding contradicts prevailing beliefs. The general perception among nurses is that competencies and skills are the things that really matter in providing care to patients. It is assumed that nurses judge each other harshly when clinical skills are lacking. However, the nurses in this study held the opposite view of quality nursing care. They stated that the concrete clinical competencies and skills could be taught to or learned by anyone but that the abstract elements that really differentiated quality nursing care were more intrinsic than learned. The lived experiences of quality nursing care were centered in these nurses' interactions with patients and were consistently recognizable by nurses in their own practice and in that of their peers. The six essential themes of responsibility, caring, intentionality, empathy, respect, and advocacy were validated as the essence of quality nursing care in the lived experience of practicing nurses. Practicing

nurses may be able to use knowledge of these shared meanings to inform their own practice and in evaluating the quality of nursing care delivered by themselves and other nurses. Practicing nurses can, therefore, use this knowledge as nursing care is planned, delivered, and evaluated in collaboration with their nursing colleagues. Potentially, this understanding may make both intradisciplinary and interdisciplinary discussions about quality nursing care more clear and effective and may facilitate discussions meant to arrive at a common meaning of quality patient care with other disciplines.

With knowledge of these findings, nurse managers and administrators may be better able to influence the development of strategies that support nurses in the identification and delivery of quality nursing care. The environment of nursing care, addressed by the IOM (2004) from a patient safety perspective, must also support nurses in being able to consistently deliver quality nursing care reflective of the themes of responsibility, caring, intentionality, empathy, respect, and advocacy. It is significant that more than half of the participant examples of quality nursing care in this study addressed end of life situations. Can it be that nurse managers and nurse peers are more willing to give nurses the time and space needed to care for those whose life is ending? Is it harder to deliver quality nursing care consistently because those environmental supports, including managerial and peer support, are lacking? Do we need to re-vision our responsibilities to each other in addition to our patients? Does this reflect a

hidden value yet to be discovered? “A call to action is sometimes the most appropriate conclusion of a phenomenological study” (Munhall, 2007, p. 204).

Nurse managers and administrators may find that a unified understanding of quality nursing care, meaningful to practicing nurses, can result in a more organized and realistic approach to performance improvement strategies from which patients will ultimately benefit. This statement is based on the belief that improvement strategies focused in areas valued by practicing nurses and identified by them as the lived meaning of quality nursing care may potentially result in more rapid, effective changes and improvements in nursing care delivery and thus in improved patient outcomes and enhanced patient safety. In addition, the outcomes of addressing the lived meaning of quality nursing care for practicing nurses may influence nurse satisfaction and retention, positively affecting nursing workforce issues.

Nurse educators may identify the need for changes in nursing education curricula. Can the intrinsic qualities identified within these lived meanings of quality nursing care be modeled and taught to nursing students? Do nurse educators need to evaluate and adjust the art of nursing content in their curricula? There may also be educational implications for the continuing education of experienced nurses from these study findings. Does continuing education for practicing nurses address the art of nursing?

For administrators and policy makers, understanding the lived meaning of quality nursing care for practicing nurses may potentially result in the

development of policies, procedures, and organizational structures which would better support quality nursing care delivery in acute care hospitals and other patient care settings.

Publication of these study findings in the nursing literature will provide the opportunity for discussion and examination of their potential influence on current descriptions, definitions, and indicators used to measure and improve quality nursing care. Revised, more valid measures of quality nursing care may be developed by researchers. Because the lived meaning of quality nursing care for practicing nurses varies from and adds new dimensions to currently identified best practices, nursing research and professional dialog to address the differences and needed changes are indicated. If the lived meaning of quality nursing care for practicing nurses in the USA varies from that reported in international research, research comparisons of cultural, educational, and practice environments and approaches are indicated.

Suggestions for Future Inquiries

Based on the findings of this hermeneutic phenomenological research study of the lived meaning of quality nursing care for practicing nurses, suggestions for future study include:

1. Research exploring the lived meaning of quality nursing care for practicing nurses working in different care delivery settings is indicated. The relatively homogenous character of the participants in this study provided data only about specific nurses working on adult medical-

surgical intermediate or general care units within acute care hospitals. The lived meaning of quality nursing care for other acute care nurses remains unknown. Because environmental influences and patient care needs vary from setting to setting, studies uncovering the lived experiences and meanings for nurses practicing in critical or intensive care units, pediatric and neonatal units, obstetric and gynecologic units, rehabilitation units, long-term care facilities, and ambulatory care units are indicated. In addition, the current study should be replicated in other adult medical-surgical general and intermediate level units.

2. Do nurses caring for clients in community health and other aggregate-focused care delivery settings have significantly different lived experiences related to quality of nursing care? Do nurses in care management or tele-health nursing positions have significantly different lived experiences related to quality of nursing care? Similarities and differences among the essential themes and lived meanings of the nurses in diverse settings and roles can be explored.
3. Does the lived experience of quality nursing care differ among nurses with different educational preparation? While this study did not identify any differences between nurses educated at the generic BSN level versus the ADN-to-BSN level, further comparisons of the essential themes and lived meanings of quality nursing care for nurses with differing educational preparation are indicated.

4. Nine of the 12 participants in the current study were employed at a Magnet Hospital. No differences in the lived meaning of quality nursing care were noted among these nurses but this element merits additional research. If Magnet Hospital environments are more supportive of nursing practice, a measurable difference in the consistency of delivering care reflecting the essential themes and lived meanings of quality nursing care would be anticipated.
5. Are there alternative organizational structures for acute care hospitals that would provide different care environments and better facilitate the delivery of quality nursing care?
6. The quality nursing care models proposed by Williams (1998), Attree (1996), Conlon et al. (1996), and others included some elements of caring and interpersonal skills. This knowledge of the lived meaning of quality nursing care can be tested, validated, and extended within these models. Each study could compare lived meaning study results against the models and lead us closer to the universal lived meaning of quality nursing care.
7. Exploration of the relationship of the essential themes and lived meanings of quality nursing care in comparison with the many differing definitions, standards, and quality measurement criteria from multiple sources, including ANA, NDNQI, JCAHO, and IOM, is indicated. Because we can only measure what we can understand, define, and

explain, such studies would enhance quality improvement efforts. Can quality nursing care measurement systems inclusive of the lived meanings of quality nursing care for practicing nurses be developed?

8. Studies of the lived meaning of quality care for other healthcare professionals are indicated. A common quality improvement language does not currently exist, making collaborative improvement efforts complex, confusing, and often ineffective (Burhans, 2007). By identifying similarities and differences among the disciplines, the respective essential themes and lived meanings could lead to that common language.
9. Statements by a limited number of participants were indicative of barriers and limitations interfering with quality nursing care. While not specific to the essence of quality nursing care, this was an important finding that bears further examination. Is there a set of barriers and facilitators of quality nursing care that can be identified? Can studies uncover the lived meaning of delivering less than quality nursing care and discover lived meanings of existing barriers and limitations? If so, studies to develop strategies intended to mitigate or eliminate these barriers would be indicated.
10. All participants in this study were female. Is the lived meaning of quality nursing care different for nurses who are men?

Conclusions

The research question answered by this hermeneutic phenomenologic study was: *“What is the lived meaning of quality nursing care for practicing nurses in the USA?”* The lived meaning of quality nursing care for practicing nurses was interpreted and found to be meeting human needs through caring, empathetic, respectful interactions within which responsibility, intentionality, and advocacy form an essential, integral foundation. The lived experience of quality nursing care was uncovered within nurse-patient interactions that were consistently recognizable as such by nurses in their own practice and in that of their peers. The six essential themes were subsequently validated as the essence of quality nursing care in the lived experience of practicing nurses. This understanding of quality nursing care, not previously recognized or addressed in the literature, added new knowledge for the discipline and profession of nursing. This knowledge opened new horizons of understanding as professional registered nurses plan, evaluate, measure and improve the delivery of quality nursing care.

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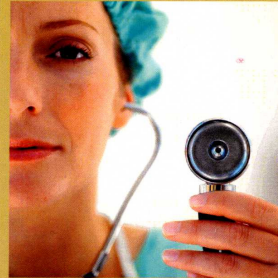
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APPENDIX A: ADVERTISING FLYER

**REGISTERED
NURSES
NEEDED**



TO PARTICIPATE IN A
NURSING RESEARCH STUDY
IF YOU WOULD LIKE TO SHARE YOUR VIEWS
ON
NURSING PRACTICE
IN A ONE HOUR CONFIDENTIAL INTERVIEW

Participant Requirements:

- BSN-prepared
- more than one year of RN experience
- work on adult medical or surgical intermediate, step-down, or general care units at PCMH

*Interviews will be scheduled at your convenience.
Participants will receive a small gift of appreciation.*

Please call: Linda Burhans, RN
East Carolina University School of Nursing
PhD Candidate

252-916-3801 (cell) or 252-237-5545 (home)

APPENDIX B: CONSENT DOCUMENT

CONSENT DOCUMENT

Title of Research Study: What IS Good Nursing Care? The Lived Meaning of Quality Nursing Care for Practicing Nurses.

Principal Investigator: Linda D. Burhans, RN, MSN, PhD(c)

Institution: East Carolina University School of Nursing - Student

Address: 5108 Brewer Court, Wilson, NC 27896

Telephone #: 252-916-3801 (cell) or 252-237-5545 (home)

INTRODUCTION

You have been asked to participate in a research study being conducted by Linda D. Burhans. This research study is a study of the Lived Meaning of Quality Nursing Care for Practicing Nurses.

PLAN AND PROCEDURES

You will be participating in a one hour private interview to discuss what quality nursing care means for you. The interview will take place in a private conference room or other setting of your choice. Ms. Burhans will tape record the interview so that she can create a word for word transcript for review and analysis. She will also take notes with paper and pen during the interview.

POTENTIAL RISKS AND DISCOMFORTS

This study poses minimal risks to you as a participant. The interviews will be conducted in a private location at a mutually agreeable time. Participation will be totally voluntary, you may withdraw at any time, and you are assured of anonymity.

POTENTIAL BENEFITS

This research may benefit you, the other participants, or other nurses and nurse leaders in helping you and them better understand the lived meaning of quality nursing care for nurses working in a large, acute care, teaching hospital. A summary of the findings will be shared with you and each other participant upon completion of the study. Individual responses will not be identified.

SUBJECT PRIVACY AND CONFIDENTIALITY OF RECORDS

All notes, transcriptions, and tapes will be maintained in confidential files which will be kept in the direct possession of the researcher or kept in her office and computer files at all times. Transcriptionist and data entry assistants will have access only to first names used on the tapes. No other persons will have access to the data. Upon completion of the study and documentation of the results in a dissertation and summary papers, the original notes and tapes will be destroyed.

COSTS OF PARTICIPATION

None

Version date: 2

Page 1 of 2

Participant's initials

UMCHB
APPROVED
FROM 8-21-07
TO 8-26-07

COMPENSATION

A gift certificate worth \$10.00 will be provided in appreciation for participation.

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. If you decide not to be in this study after it has already started, you may stop at any time without losing benefits that you should normally receive. You may stop at any time you choose without penalty.

PERSONS TO CONTACT WITH QUESTIONS

The investigator will be available to answer any questions concerning this research, now or in the future. You may contact the investigator, Linda D. Burhans, at phone numbers 252-916-3801 (cell - days) or 252-237-5545 (home - nights and weekends). If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914 (days), the hospital Risk Management Office at 252-847-5246 and/or the ECU Brody School of Medicine Risk Management Office at 252-744-2380 (days) and/or the ECU Risk Management Office at 252-328-6858.

CONSENT TO PARTICIPATE

Title of research study: What IS Good Nursing Care? The Lived Meaning of Quality Nursing Care for Practicing Nurses.

I have read all of the above information, asked questions and have received satisfactory answers in areas I did not understand. (A copy of this signed and dated consent form will be given to the person signing this form as the participant or as the participant authorized representative.)

Participant's Name (PRINT)	Signature	Date	Time
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If applicable:

Guardian's Name (PRINT)	Signature	Date	Time
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PERSON ADMINISTERING CONSENT: I have conducted the consent process and orally reviewed the contents of the consent document. I believe the participant understands the research.

Person Obtaining consent (PRINT)	Signature	Date
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Principal Investigator's (PRINT)	Signature	Date
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Version date:

Page 2 of 2

Participant's initials

UMCIRB
 APPROVED
 FROM 8-21-07
 TO 8-20-08

APPENDIX C: DEMOGRAPHIC QUESTIONS AND INTERVIEW GUIDE

Title of Research Study: What IS Good Nursing Care? The Lived Meaning of Quality Nursing Care for Practicing Nurses

Principal Investigator: Linda D. Burhans, MSN, RN, Nursing PhD(c)

Institution: ECU School of Nursing – Student

Address: 5108 Brewer Court, Wilson, NC 27896

Telephone #: 919-782-3211 ext. 265 (Office) or 252-237-5545 (Home)

Demographic Questions:

1. Age _____

2. Gender _____

3. Race _____

4. Nursing Education: _____ Diploma _____ AAS _____ BSN _____ MSN

5. Year Graduated: _____

5. Other Education –

Specify _____

6. Years of Nursing Experience as an RN _____

7. Years of Nursing-related Experience Prior to RN _____

7. Type of Nursing Experience: _____ Medical _____ Surgical

_____ Women's _____ Children's _____ Rehab _____ Psych

_____ Other – Specify: _____

8. Level of Nursing Experience: _____ General _____ Intermediate

_____ Intensive _____ Other- Specify: _____

9. Current Type and Level of Nursing Care: _____

10. Years of Other Experience – Specify _____

The following questions will guide the interview. Additional questions may be asked to further probe responses to these questions.

Interview Guide:

I am really interested in Quality Nursing Care.

- 1. Tell me about quality nursing care.**
- 2. What does quality nursing care mean to you?**
- 3. What is it like when you give quality nursing care?**
- 4. Describe an example of when you delivered quality nursing care.**
 - What did you do?**
 - How did you feel about that?**
- 5. What is it like when you observe another nurse giving quality nursing care?**
- 6. Describe an example of when another nurse delivered quality nursing care.**
 - What did you observe?**
 - What did they do?**
 - How did you feel about that?**
- 7. Is there anything else I need to know about what quality nursing care is like?**

APPENDIX D: INSTITUTIONAL REVIEW BOARD APPROVAL LETTER



University and Medical Center Institutional Review Board

East Carolina University

Ed Warren Life Sciences Building • 600 Moyer Boulevard • LSB 104 • Greenville, NC 27834

Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb

Chair and Director of Biomedical IRB: Charles W. Daeschner, III, MD

Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

TO: Linda Burhans, RN, 5108 Brewer Court, Wilson, NC 27896

FROM: UMCIRB *2007*

DATE: August 23, 2007

RE: Expedited Category Research Study

TITLE: "What IS Good Nursing Care? The Lived Meaning of Quality Nursing Care for Practicing Nurses"

UMCIRB # 07-0518

This research study has undergone review and approval using expedited review on 8.21.07. This research study is eligible for review under an expedited category because it is on collection of data from voice, video, digital, or image recordings made for research purposes.

Dr. C. Daeschner deemed this **Grant Funded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **8.21.07 to 8.20.08**. The approval includes the following items:

- Internal Processing Form (dated 8.1.07)
- Informed Consent
- Demographic Questions & Interview Guide
- Flyer: Registered Nurses Needed
- COI Disclosure Form (dated 8.14.07)
- Award Letter, Director-ECCNL, ECU (dated 6.4.07)
- Grant Application (dated 5.28.07)

Dr. C. Daeschner does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.