GUIDELINES TO IMPLEMENT AN EDUCATIONAL PROGRAMME TO INTERNALISE AND OPERATIONALISE THE NURSING PROCESS IN THE GYNECOLOGY WARDS OF THE TRAINING HOSPITALS OF NAMIBIA

By

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Submitted in the fulfillment of the requirements for the degree

DOCTOR IN NURSING SCIENCE

of

THE UNIVERSITY OF NAMIBIA

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April 2007

DEDICATION

I DEDICATE THIS DISSERTATION TO

My Heavenly Father who has guided me all my life in all that I have undertaken.

My late father, John, and brother, Andries, whom I wish had seen my academic success. I will always remember them.

My loving husband, Chris. Thank you for the support, encouragement, patience and sacrifices. You help me to remain strong.

My mother, Gerrie , who was my role model through out my life and who always believed in me. You, Mother, taught me that wisdom starts with serving the Lord and that was your prayer for me throughout my academic career. Thank you!

My dear father- and mother-in-law, Dad Willem and Mom Rita. Thank you for your support and prayers.

My children Jasper, Gerrilize and Amanda. My loving grandchildren Amanrie and Basson. I love you with all my heart!

DECLARATION

I , M van der Vyver, declare that "Guidelines for implementing an educational programme to internalise and operationalise the nursing process in the gynaecology wards of training hospitals in Namibia" is a true reflection of my own work and that all the sources used have been acknowledged by means of text citation and a bibliography. This work or part thereof has not been submitted for a degree in any other institution of higher education.

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M van der Vyver

ACKNOWLEDGEMENT

I would like to convey my sincere gratitude to the following people who contributed to the success of this study:

- Professor Agnes van Dyk, my supervisor from UNAM, for sharing her expertise with me. Thank you, Professor, for your patience, support and guidance throughout the study and throughout my academic career.

- Professor Karien Jooste, my supervisor and examiner from University of Johannesburg, for her valuable input in making this study a success.

- Professor Louis Small (UNAM) for assisting me with various aspects of the study and particularly with my data analysis process.

- Professor Eugenie Potgieter, my examiner from UNISA, for her valuable input in the final product of my report.

- Dr Hoffnie who shared her knowledge with me. Thank you Käthe for encouraging me throughout my study.

- Professor Marie Poggenpoel (consultant from University of Johannesburg). Thank you for your guidance and support and, above all, for your patience.

- Professor Chris Myburgh (consultant from University of Johannesburg). Thank you for sharing your expertise with me.

- Mrs Christa Fourie for the excellent quality of typing of my dissertation.

- Ms Alexa Barnby (UNISA) for editing my dissertation.

- All the nurse managers and professional nurses who always received me in a way that made me feel special. Without you I could not have done this study.

The valuable data, the core of the study, came from you, my friends and colleagues.

- Mrs Nunes, a special word of thanks to you who always went out of your way to assist me at Oshakati Hospital.

- Gerhard van der Vyver who assisted me with all the technological difficulties.

- The Ministry of Health and Social Services for allowing me to conduct the study and utilise their facilities.

- The University of Namibia for financial assistance in conducting the study.

ABSTRACT

Since its implementation in 1985, the nursing process in Namibia has been utilised with difficulty. The reasons for this were, however, unknown.

Worldwide nurses agree that the nursing process is desirable but too lengthy and too time consuming. In Namibia, patient records and Nursing Board of Namibia disciplinary hearings bear witness to this. Patient safety has been put at risk and, as a result, registered nurses have faced legal action.

The purpose of this study was to develop an educational programme to internalise and operationalise the nursing process and to draw up guidelines for implementing the programme. The postmodernism paradigm, also referred to as the naturalistic paradigm, was used for the study. A qualitative, explorative, descriptive and contextual design was used to perform this study, which was directed to internalise and operationalise the nursing process in the gynaecology wards of training hospitals in Namibia through an educational programme and according to certain guidelines.

The study was performed in four phases: Firstly, a situation analysis was carried out to explore and describe the educational needs of registered nurses in internalising and operationalising the nursing process. Secondly, a conceptual framework was drawn up from the results of phase 1. Thirdly, a programme was developed to internalise and operationalise the nursing process. And finally, guidelines were drawn up for the implementation of the programme.

The situation analysis revealed that the nursing process was utilised ineffectively. Thus, the specific content identified for an educational programme to internalise and operationalise the nursing process was based on the assumptions that registered nurses' belief systems and attitudes should be reframed, that registered nurses should work smarter not harder and that the nursing process was a prerequisite for effective nursing care.

The activities included by Dickhoff, James, and Wiedenbach (1968) in the survey list of their Situation-Producing Theory were used to describe the framework for this study. This survey list encompasses context, agent, recipient, dynamics, procedure and terminus.

The educational programme to internalise and operationalise the nursing process was presented in four sessions comprising the following learning content:

Session 1: Reframing the belief system and attitudes of registered nurses

Session 2: Work smarter not harder

Session 3: The nursing process as a prerequisite for effective nursing care

Session 4: Internalisation and operationalisation of the nursing process

Finally, guidelines for internalising and operationalising the nursing process through programme implementation were drawn up. Since guidelines are important tools in the quest for evidence-based practice, the guidelines included recommendations and activities that turn guidelines into actions.

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CHAPTER 1

RATIONALE AND OVERVIEW OF THE RESEARCH

1.1   INTRODUCTION

The manner in which nursing practice is carried out constitutes an experience for the patient and his family. The evolution of modern nursing clearly demonstrates that professional nursing is not only a highly technological health service with preventive, promotive, curative and rehabilitative dimensions, but also an intermediate, interventive, supportive and co-ordinating service for patients or clients (Searle 2000:162). In the fulfilment of all these services, nursing is an autonomous discipline with a unique role to play within the health care system (Ziegler, Vaughan-Wrobel & Erlen 1986:31).

Today, the practitioner's role of the nurse still involves those actions that the nurse undertakes when assuming responsibility for meeting the health care and nursing needs of individual patients, their families and significant others. This role is the nurses' dominant role in health care delivery institutions and can only be achieved through the use of the nursing process.

History illustrates the evolution of nursing. The following historical highlights relate to the nursing process and indicate some of the nursing profession's constant efforts to meet the criteria for a profession and to become autonomous.

The growth of nursing as a profession has necessitated the use of a logical and rational method of problem solving in making decisions about patient care, instead of relying on an unsystematic and intuitive process. Although Florence Nightingale originated the concept of a nursing process, the first person to refer to nursing as a process was Hall in 1955 (Ziegler et al. 1986:10). This was followed by authors such as Johnson (1959), Orlando (1961) and Wiedenbach (1963) who were among the first to use the term "nursing process" to refer to a series of steps describing what nurses ought to do (Wilkinson 1996:5).

In the 1950s and 1960s the need for consistency in the profession was recognised. During this period, several studies were done to identify patient problems requiring nursing intervention. These evolved into lists of nursing problems and client needs that might require basic nursing care. Examples of these lists are found in writings by authors such as Abdellah (1957) and Henderson (1961) (in Wilkinson 1996:130).

Abdellah (in Marriner-Tomey 1989:94) realised that for nursing to gain full professional status and autonomy, a strong knowledge base was imperative. She further believed that nursing needed to move away from the control of medicine towards a philosophy of comprehensive patient-centred care. Her typology of twenty-one nursing problems had a far-reaching impact on the profession and on the development of nursing theorists. Abdellah (in Marriner-Tomey 1989:96) contributed to a major extent to the image of the nurse who was believed to be not only kind and caring, but also intelligent, competent and technically well prepared to provide a service to the patient. Another essential aspect of nursing in Abdellah's

writing was problem solving, that is, the process of identifying nursing problems and interpreting, analysing and selecting appropriate courses of action to solve these problems. According to Abdellah, the patient will not receive quality nursing care if the steps to problem solving are followed incorrectly.

Lyon (1990:28) argues that we still do not know exactly what nursing is because of a lack of autonomy. Autonomy, she says, is universally seen as the main attribute of a profession. Autonomous practice constitutes self-directed diagnosis and treatment. Self-directed implies self-determined and controlled action that does not require authorisation from another professional, in other words, it means ownership.

In 1950 the American Nurses' Association approved a research programme to examine nursing functions. The results of the research demonstrated that nurses were doing tasks previously done by physicians and that nursing functions overlap with the functions of other health professionals (Ziegler et al. 1986:8).

The nursing process is seen by many nurses as describing an independent role for nursing that parallels the role of the physician: nursing history parallels medical history; the nurses' health assessment, the physician's medical examination; the nursing diagnosis corresponds with the physician's diagnosis; nursing orders correspond with medical orders; the plan of nursing care relates to the plan of medical management and nursing evaluation to medical evaluation. It would seem that the medical model has been followed but that there has been a modification in

the language that makes it possible to legally justify the role of the nurse in therapy (Henderson 1982:107).

In their daily practice, nurses work with other health professionals of which physicians are just one group. There is evidence in the literature of physicians who respect and promote the overlapping of medicine with nursing and view it as collaboration instead of competition between the two professions. Lawrence Weed (1997) and Barbara Bates (1970) in Duffy & Hoskins (2003:78) are examples of physicians who support the idea of both groups identifying patients' problems rather than a single diagnosis. Watson (in Duffy et.al. 2003:78) speaks about the essence of nursing (caring) as being separate, but complementary to medicine (curing).

The nursing process was introduced in the United States of America and the United Kingdom at a time when there was considerable dissatisfaction with the task-centred, disease-oriented approach to care (Walton 1986, in Mason & Attree 1997:1046). There was also a growing desire to highlight the boundaries of nursing practice as a distinct yet complementary discipline to medical care. The nursing process offered an ideal method for achieving this (de la Cuesta 1983 & Field 1987, in Mason & Attree 1997:1046). From a scientific perspective, the logic and order associated with the nursing process offered nurses a simple and attractive means to develop a client-nurse centred framework for education and practice (Altschul 1978, Atkinson & Murray 1990, in Mason & Attree 1997:1047). It also offered the potential to provide uniformity of practice through research (Walton 1986, in Mason & Attree

1997:1047) and at the same time allowed nurses to retain links with the scientifically based biomedical model (McKay 1992, in Mason & Attree 1997:1047).

Furthermore, the changes in the health environment mandated the use of an organised approach to nursing care, so that patients can have their specific health and nursing care needs met: ever since the nursing process has invariably been presented as a series of different phases. Despite the fact that the nursing process is an orderly process, it is not simply a quantitative approach. It has pervasive qualitative aspects that make the process vital. These qualitative factors, such as the relationship between the patient and the nurse, far outweigh the quantitative factors such as procedure-driven documentation (Leddy & Pepper 1993:292).

The nursing process is a deliberate problem-solving approach for meeting a person's health care and nursing needs (George 1995:15). By implication this means that the nursing process is a special way of thinking and acting. It also provides the framework in which nurses use their knowledge and skills to express human caring.

The question may be asked: Why does the nursing process need a special way of thinking? The answer is that nurses have to think critically about the nursing care they render. To think critically about nursing care is to examine nursing assumptions, clarify beliefs and propositions, and analyse the meaning of nursing care. Furthermore, it entails a special relationship of trust with the patient (Bandman & Bandman 1990:52).

George (1995:15) describes the nursing process as the essence of professional nursing practice, the tool and methodology of the nursing profession, and as such it assists nurses in arriving at decisions and in predicting and evaluating consequences. It is a deliberate intellectual activity through which the practice of nursing is approached in an orderly, systematic manner.

The nursing process has its roots in systems theory. According to Mason and Attree. (1997:1047), the nursing process, which is derived from general systems theory, which in its turn forms the basis for scientific inquiry, offers a scientific basis for nursing theory, research and practice. An open systems model demonstrates a cyclical pattern of activity in which the system maintains or improves its state by a process of input, throughput and output of energy (Pierce 1972; Daubenmire & King 1973, in Mason & Attree 1997:1045).

Each step of the nursing process evolves independently. The components of the nursing process, however, have been described by a multitude of authors. Rubenfeld and Scheffer (in Nichols 2005:13) provide the following definitions for each of the steps:

Assessment is the process used by nurses to draw conclusions about patients' strengths and health concerns. It is thinking about what information to collect, collecting information, thinking about the significance of that information, and drawing conclusions about how the patient is responding to his or her health or illness condition. The conclusions of assessment include two basic categories:

strengths and health concerns. Health concerns focus on firstly, issues the nurse can deal with independently (nursing diagnosis); secondly, issues that a nurse and another healthcare provider work on interdependently (multidisciplinary problems); and thirdly, issues that need to be referred to another health care provider, such as medical or nutritional problems.

Planning is the development of approaches to meet patients' needs. This includes how to help with the patient's response to his or her health or illness condition and working with the patient in deciding which problems have priority. Planning also involves developing patient goals and objectives and determining what the nurse and the patient need to do to attain these goals.

At first, the *formulation* of the nursing diagnosis was met with some resistance from physicians. How dare nurses diagnose patients! This was the physician's domain and nurses were not qualified to make a diagnosis. They were correct up to a point. The profession then decided to clarify what it was that nurses are qualified to diagnose, and how the findings should be worded. Nurses are licensed to identify and treat certain human reactions and potential health reactions associated with the illness or disease. A nursing diagnosis is a statement of a health problem, or potential health problem, that a registered nurse can treat. It is a problem for which the nurse can assume responsibility and accountability for the outcome (George 1995:22). To produce a statement about a patient's health status a nurse uses a reasoning process, and processes of cognitive analysis, synthesis and clinical judgment. Analysis takes place when data is taken apart, while synthesis is used when comparing the cue

patterns for various concepts in order to identify strengths and generate explanations for the client's symptoms. All the care prescribed is based on a proper nursing diagnosis, which provides a basis for choosing nursing interventions that achieve outcomes for which the nurse is responsible.

Implementation comprises the actual care provided by the nurse. This involves completing specific activities to help the patient meet the goals in the plan while continuing to think about what is being done, how it is being done, when, where, and why it is being done.

Evaluation is a determination of the patient outcomes and the quality of care. It involves thinking and collecting information about the patient's response after nursing care has been provided and working with the patient to determine whether the patient's goals and objectives have been attained and how well they have been attained.

Documentation refers to comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs and the recording of nursing actions that have been performed. Failure to keep a record of nursing care or to use the nursing process can lead to a breakdown in the quality of care that is provided.

According to Hogston (n.d.:2) the nursing process is a problem-solving framework that enables the nurse to plan care for a client on an individual basis. It should not, however, be seen as a linear process: it is a dynamic and ongoing cyclical process

involving all the six phases. Assessment, for example, is not a one-off activity but a continuous one. There is continuous reassessment until a problem is resolved completely.

Critical pathways were introduced because there were writers who alleged that the step-by-step approach to the nursing process places constraints upon nursing practice (Walsh 1997:39). A critical pathway is a pre-printed multidisciplinary plan that outlines crucial care to be given to all patients with a common condition. Complex clinical problems are not, however, suitable to be managed according to critical pathways, therefore the nursing process model still has to be used. Walsh (1997:42) is of the opinion that patient management through critical pathways is mainly for political convenience and it remains to be seen whether it will be fully adopted in the United Kingdom. It would therefore seem that the nursing process remains the most appropriate model.

Fonteyn and Cooper (1994, in Mason & Attree 1997) are of the opinion that the controversy over the utility of the nursing process has been perpetuated because it has never been fully implemented in clinical practice, in keeping with its implementation and theoretical developments in education and, increasingly, in research. Attree and Murphy (1999:592) are of the opinion that the nursing process has sustained vigorous debate in nursing over the past three decades. Critical assessment and evaluation in a discipline should be viewed as positive evidence of philosophical awareness and healthy critical scholarship.

1.2   RATIONALE

The researcher, as a lecturer in General Nursing Science, has a keen interest in the nursing process. This process forms a very important component of theory as well as clinical teaching. During the clinical practice of third-year students in the University Diploma in Comprehensive Nursing and Midwifery Science, it was observed that not all registered nurses utilised the nursing process in the wards. It is evident from patient records that patients are often not assessed correctly on an ongoing basis, do not have care plans, and their evaluation is therefore not done according to goals determined by registered nurses. If the nursing process was utilised at all, it was done so incompletely, in other words, the process as a whole was rarely applied. The heavy emphasis on the use of the nursing process in nurses' education and clinical practice would lead one to expect the process of clinical problem-solving to be well understood and applied. Nursing scholars cited by Taylor (2000:842), including McCarthy (1981), Jones (1998), Harbison (1991), Benner (1984) and Carnivali, Mitchell, Woods and Tanner (1984), are all of the opinion that there is a need for better understanding of the cognitive problem-solving strategies used by nurses in clinical practice.

In the light of the researcher's involvement in a subject that has a strong practice base, conducting a study in the practice setting to which students are allocated for their clinical teaching is of extreme importance. This is where the theoretical and practical knowledge is strengthened for the profession's knowledge base. Jarvis (1999:272) expresses his view on the importance of practice education strongly when

he claims that the future of practice education entails placing practice rather than theory at the heart of teaching. Jarvis (1999:270) is also of the opinion that the philosophical and scientific knowledge that practitioners acquire in the classroom has to be legitimated in practice.

George (1995:15) sees the nursing process as the underlying scheme that gives order and direction to nursing care. If this is then the case, the researcher asks the question as to what the implications would be if students were not guided in this direction to a certain order to nursing care in the clinical situation. This is the place where the foundations for the art of nursing should be laid.

Another motivation for the study was that registered nurses often express the need for the ward personnel to be included when lecturers guide their students during their clinical practice. This constitutes a clear expression of an unfulfilled need for in-service training with regards to the nursing process. Although training hospitals A and C have registered nurses in the personnel development unit who give clinical guidance, the researcher also came to realise that in training hospitals, such as Hospital B, personnel often leave the hospitals for greener pastures which places a heavy burden on the remaining personnel including those from the personnel development unit. Both the registered nurses on the wards and the nursing school lecturers play an extremely important role in the student's clinical training. The lecturer has to ensure that the student gets clinical and theoretical training that is based on sound knowledge gained from research. One would therefore assume that

these two categories of professional nurse, that is the lecturer and the registered nurse at the patient's bedside, are experts.

Taylor (2000:843) cites Eisenhower and Gendrop (1990:80) when referring to problem solving, who state that problem solving, as an inherent part of the practice of all professionals, starts when a patient problem is identified and continues to the point where a decision is made that will alleviate or solve the problem. Writers concerned with student learning believe that if educators, who (in the researcher's view) include registered nurses in training hospitals as well as lecturers, have an understanding of the process involved in clinical problem solving (nursing process) then it would be possible to teach those processes. If these processes could be taught, then student problem solving would develop more quickly and there would be a flow-on effect of improved care giving (Hammond, Kelly & Schneider 1976; Broderick & Ammentorp 1997; Gordon 1980; Pyles & Stern 1983 & 1986; Corcoran (1986), all in Taylor 2000: 843).

Research plays an important role in the continued improvement of nursing practice, while the nursing process forms the basis of nursing practice. As such, research forms the basis of theoretical knowledge, as well as clinical nursing practice. Girot (2000:288) argues that the recent reforms in pre- and post-registration education programmes in the United Kingdom and the national acceptance of the value of higher education predispose an automatic assumption that nursing practice will benefit. Ultimately, however, the application of research findings in practice is of the greatest importance. Rempusheski (1991:96) states that research findings have to be

applied in practice because that is one way to integrate the art and the science of nursing. In examining the statistical significance of research results not only is practice changed but also the clinical significance.

The nurse practitioner (clinician) has to be a research consumer because research forms the basis of professional nursing and of nursing care in general. This is a role one can only become comfortable with when you conduct research and use the results in practice. Benne, Chin and Bennis (1969 in Rempusheski 1991:96) state: "A practitioner who shapes and forms – or better re-shapes and re-forms materials of a certain sort must be something of an artist. He must have a 'feel' for the materials with which he works. His knowledge of these materials must go beyond 'knowledge about' them to 'knowledge by acquaintance with them'."

1.3   RESEARCH PROBLEM

1.3.1   BACKGROUND TO THE PROBLEM

Although the nursing process has become the standard for nursing worldwide for over thirty years, in many practice settings there is unfortunately the perception that although it is desirable it is too time consuming to be practical. This situation also prevails in Namibia.

In Namibia, the nursing process was implemented in 1985. Nurse administrators, nurse educators and professional nurses who have to apply it in everyday practice are

concerned about why it seems not to be operationalised twenty-one years after its implementation. If the nursing process is not valued it is not used, and many nurses continue to intervene in standardised nursing procedures on the basis of medical diagnosis rather than a rationale based on nursing assessment, planning, evaluating, record keeping and feedback. If the process is not used, the question may be asked as to how nurses assume accountability and responsibility for the patient and how the quality of nursing care may be measured. It would therefore also seem that there is no order or direction to nursing care.

Another aspect that flows from this lack of the nursing process is that of the public image of nurses as professionals. Nurses have made a significant endeavour to professionalise by developing a strong educational and theoretical base that could enhance the quality of nursing care and therefore the image of nursing. However, there is still the image of nurses being inferior to the doctor. If nursing professionals were seen to be dependent on other health professionals, such as the doctor, for the nursing care to be rendered, they would be deprived of autonomous practice (Takase, Kershaw & Burt 2001:819). Many researchers suggest that the negative image of nurses contributes to job dissatisfaction and a devaluation of the nursing role (French & Kahn 1962; Dawis & Lofquist 1978; Holland 1985; Mottaz 1985; Kulick and Oldham 1987; Daugherty 1992, all in Takase et al. 2001:824).

Many nurses do not use the nursing process as a deliberate method of practice. Yet the challenge for many institutions is to help professional nursing staff refine their

understanding of nursing diagnosis and charting skills in order to identify patient problems and propose appropriate care plans (Ting-Ting 2005:1).

It may be argued then that most nurses do not perceive the care for their clients as being based on the rational procedure of the nursing process. The term "nursing process" is seldom heard in practice settings. However, one often hears of care plans. One might even say that the term "nursing process" is somewhat elusive in many practice settings. The problem then would appear to be that the nursing process is not an accurate description of how nursing is actually performed.

Research on the nursing process or parts of it continues all over the world. Littlejohn (in Clerkin 2004:2), for example, refers to a qualitative evaluation of nursing care plans carried out in five clinical areas in Northern Ireland, which found little research evidence to show that improved care plans have any effect on patient outcome. However, this does not prevent care plans from providing a useful description of how nursing ought to be performed.

According to Leddy and Pepper (1998:294-295) the nature of nursing should be based on a model of autonomous professional practice. In an autonomous nursing model, the focus is on supporting the client by using nursing knowledge in order to improve wellbeing status and potential. The specific model of nursing accepted by the practitioner can have a major impact on the knowledge needed and the nature of practice. Benner (1984, in Clerkin 2004:3) acknowledges that the nurse's careful monitoring and early detection of problems are the patient's first line of defence.

Acceptance of the professional model mandates the acceptance of responsibility for nursing knowledge based on a rationale for practice. The nursing process provides a systems approach to nursing practice. The logical elements of the process remain the same regardless of which framework or model is used to integrate theoretical formulation.

If this were applied in practice then the following types of case would not have been reported to the Nursing Council:

- incomplete patient assessment

- failure to monitor all forms of diagnostic and therapeutic interventions at reasonable intervals

- failure to keep clear and accurate records of patient progress

- failure to supervise the execution of the nursing process

- failure to give specific care to high-risk patients

- emergency management not performed in time, such as in the case of a patient who died of an acute ectopic pregnancy because of failure to recognise, diagnose and manage patient effectively

- incomplete recording of assessment data

- nursing diagnoses not stated in a problem-oriented way

- nursing interventions prescribed incompletely and non-specifically

- outcomes managed and recorded badly

A project facilitated by Fagan (2001:2) reveals similar conclusions in a study based

on complaints by patients, their families and friends, physicians and nurses about a decline in the quality and availability of nursing services in hospitals in the United States of America. These results were as follows:

- The burden of care for nurses, patients and families has demonstrably increased since 1990.

- Pressures on families are particularly severe when a patient has been sent home from hospital after a shortened stay or has received outpatient care for problems formerly dealt with in hospitals.

- There is considerable evidence that nurses and families are very concerned about the erosion of care and are anxious about hospital safety.

- Nurses report increasing dissatisfaction with their work in hospitals that have cut staff, that require frequent overtime, and that have replaced nurses with assistive personnel. Research has shown that these phenomena are related to adverse nurse and patient outcomes.

- The supply of nurses is diminishing because the nursing workforce is aging.

Manley, Hardy, Titchen, Garbett and McCormack (2005:5) hold the opinion that the vulnerability of the nurse practitioner to legal action is dictated by the extent to which any practitioner is able to acknowledge his or her own limitations and set limits to his or her own practice. Meticulous practice, good record keeping, thorough educational preparation, ongoing self-assessment and critical appraisal with colleagues is essential in alleviating the burden of vulnerability for nurse practitioners.

The researcher conducted a study on the "Standard of nursing care of patients undergoing hysterectomies in training hospitals in Windhoek" for her master's degree in Nursing Science (Bester, 2000). The results of this study showed that the standard of nursing care appeared to be unsatisfactory. It indicated that although 71,9 percent of the research population had nursing care plans, there was a lack of scientific approach evident throughout the study, that is, from admission to discharge of patients (Bester 2000:85).

These results are supported by many other authors. Hargraves (1981 as cited by Bowman, Thompson & Sutten 1983:125) is of the opinion that it would seem that the nursing profession worldwide is slow to change its attitudes and, particularly, to accept change in the practice of nursing care. Ziegler et al. (1986:14) believe that until recently nurses have relied heavily on tradition, authority, intuition, and trial and error as sources of knowledge for planning nursing care. It would seem that this is also the case in Namibia.

1.3.2   PROBLEM STATEMENT

It is unclear whether the nursing process is operationalised in the gynaecology wards of training hospitals in Namibia. The consequences could be that patients/clients are put at risk of not receiving the quality of nursing care that should be reasonably expected from professional nurses. Patients have the right to receive high quality services, and nurses have a responsibility to provide the care.

1.4   RESEARCH PURPOSE AND OBJECTIVES

1.4.1   PURPOSE

The purpose of the study was to explore and describe the operationalisation of the nursing process among registered nurses who work in the gynaecology wards of Namibian training hospitals, to develop a programme, to facilitate the utilisation of the nursing process and to develop guidelines for its implementation.

1.4.2   OBJECTIVES

The first objective of the study was to carry out a situation analysis to explore and describe how the nursing process was utilised in the gynaecology wards of Namibian training hospitals. This objective served to explore practice in the training hospitals that had never been studied before.

The second objective was to explore and describe the educational needs of registered nurses and midwives in utilising the nursing process in Namibia. It was only through this objective that the programme could be developed exclusively for the registered nurses in this context.

The third objective was to describe an educational programme for the utilisation of the nursing process in the gynaecology wards. The researcher regarded this as the

communication channel, the means by which the research would be shared with the rightful owners of practice, that is, the registered nurses of the gynaecology wards.

The fourth objective was to draw up guidelines for implementing the educational programme.

1.5   PARADIGMATIC PERSPECTIVE

The post-madern paradigm, also referred to as the naturalistic paradigm, was used for this study. Old ideas of the registered nurses about utilization of the nursing process was taken apart during the data analysis and through synthesis an educational programme was designed to meet their educational needs pertaining to the utilization of the nursing process. Post-modern thinking emphasizes the value of deconstruction, that is, the taking apart old ideas and structures and reconstruction, that is, putting ideas and structures together in new ways (Polit & Hungler 1999: 11).

A paradigm is a worldview, a general perspective on the complexities of the real world (Polit et.al. 1999:10). Assumptions flow from a paradigm and are often embedded in thinking and behaviour and uncovering them requires introspection (Burns & Grove 2005:39).

1.6   METATHEORETICAL ASSUMPTIONS

Metatheoretical assumptions are important beliefs that the researcher has about the

person (patient), the environment (clinical set-up), the nurse and the health of people. The theories that were used during the course of this study are the nursing process, Dickhoff, James and Wiedenbach's (1968) practice-oriented theory, cognitive learning theory and Knowles' andragogical learning theory.

The nursing process is based on the system's theory which consists of the concepts input, process and output. Person, nurse and environment are considered as input and these factors form the structure without which the nursing process (process) cannot be facilitated. The output is the person's health.

Person

In this study the term "person" refers to the patient or the client who is in need of nursing care in a gynaecology ward of the training hospitals of Namibia. Although health is a priority for most people, there will always be people in need of nursing care. Of all the concepts, person is the core concept because nursing cannot exist or develop as a science or a professional practice field without a patient/client (George 1995:1).

Members of the public have become more aware of their health needs. This presents a special challenge to nurses.

Nurse

The registered nurse is the professional who is at the patient's bedside in the gynaecology ward for twenty-four hours of the day. He/she practises the art and science of nursing in this discipline by utilising the nursing process as a tool for addressing the patient's health care needs, which arise in reaction to a disease process. He/she is an independent autonomous professional who is accountable for his/her own actions. Nurse professionals are aware of the boundaries of their own knowledge and skills and undertake care for which they are prepared, competent and confident. Nurses function within a code of conduct. Although nurse practitioners employ independent practice they work collectively as a team in the person's (patient's) best interests (Manley et al. 2005:4).

Caring is unique to nursing and it provides the basis for all nursing activities. It signifies a feeling of concern and interest. As such it has a profound influence on nursing philosophy, education and research. Nursing practice involves processes, dynamics and interactions that can only be fully understood when science, ethics, aesthetics and personal knowing come together to form a whole (Chinn & Kramer 2004:1). Ziegler et al. (1986:14) refer to the foundation of the knowledge that registered nurses use in their practice as scientific knowledge (being conceptual nursing knowledge and research), ethics of practice (moral component of nursing knowledge) and practice wisdom (tradition, intuition, authority, personal experience and trial and error). These concepts should be captured in the operationalisation of the nursing process.

There are two important assumptions that give direction to and provide order in the work of the registered nurse through the nursing process. They are, firstly, that nursing is interpersonal in nature, and secondly, that registered nurses view patients as holistic, well, beings. Thereby acknowledgement is given to the wholeness of mind and body.

Environment

The environment is the context in which the registered nurse interacts with the patient and other health professionals, as well as the student nurse. In the context of this study the environment encompasses the entire gynaecology situation that surrounds the patient and where the nursing process is applied. There are three gynaecology wards in the three training hospitals involved in this study, that is, one in each training hospital. Two of these hospitals are in Windhoek and one is in Oshakati. The gynaecology wards included in the study are those where state patients only are admitted. The average bed capacity of each of these wards is thirty patients.

The most common conditions of the patients admitted here during the data collection period were post-abortion, cancer, pregnancy-related complications, genital conditions, pelvic inflammatory disease, dysfunctional vaginal bleeding and disorders treated with hysterectomy (Ministry of Health and Social Services Midnight Census reports 2003).

The positions and the number of nurses allocated to these wards during the data collection period were two principal registered nurses, nine senior registered nurses, eight enrolled nurses and seven nursing assistants.

At the time of the 2002 Ministry of Health and Social Services: Annual Report, the most common causes of death seemed to be abortion and puerperal sepsis.

Health

People are constantly exposed to factors that influence their health, and as a result of the health needs that then arise they may be admitted to hospital. The condition and the health needs for which they are admitted vary in degree. The nursing process leads to health.

The discipline of nursing is committed to the betterment of humankind. The terminus of nursing activity concerns health, the quality of living, lived experience as well as dying.

1.6.1   THEORIES

NURSING PROCESS

The nursing process is a special way of problem solving using the logical-deductive mode. The steps of this process are no different from those used by scientists

embarking on research or a physician making a medical diagnosis. It is a systematic way of collecting information, which is then analysed in order to arrive at some tentative hypotheses about what the client/patient needs so that a plan of nursing care may be drawn up and implemented and an evaluation of the effectiveness of the intervention carried out.

PRACTICE-ORIENTED THEORY

Dickhoff et al.'s (1968:434) practice-oriented theory of was utilised to fulfil the purpose of the study, namely to facilitate the utilisation of the nursing process. The activities that Dickhoff et al (1968:438) include in their situation producing theory were used as a reasoning map. The reasoning map is described in chapter 4.

These activities include identifying the following components:

- Who or what performs the activity?

- Who or what is the recipient of the activity?

- In what context is the activity performed?

- What is the end product of the activity?

- What is the guiding procedure, technique, or protocol of the activity?

- What is the energy source for the activity?

COGNITIVE LEARNING THEORY

Cognitive learning theory was used in the formulation of the educational programme. According to this theory, learning takes place through meaningful discovery. Registered nurses have pre-existing knowledge at their disposal therefore it was appropriate to use cognitive learning theory to make up the knowledge deficit that was evident from the data analysis.

KNOWLES' ANDRAGOGICAL LEARNING THEORY

Knowles' andragogical approach was used in the development of the programme.

1.7   DEFINITIONS OF KEY CONCEPTS

The **registered nurse and midwife** is seen as a person with unique knowledge who is licensed to practice nursing in the field that she is registered in, at least that of general nursing and midwifery science. She/he communicates his/her knowledge through different means to patients/clients, colleagues and other members of the health care team. The nurse views any given situation in a unique manner. It is the function of the registered nurse to ensure that the nursing process is utilised correctly.

The **nursing process** is a methodology and is the essence of professional nursing practice. It is the "tool" that helps nurses to arrive at decisions about a patient's/client's health needs. It is cyclical process and takes place in phases:

Phase 1: entails an assessment that is performed by the nurse using special knowledge and skills, communication and interaction. Analysis of data allows for the identification of gaps in the data.

Phase 2: comprises a nursing diagnosis that entails clinical judgement of actual and potential health needs.

Phase 3: consists of planning that involves prioritising and setting goals or expected outcomes and identifying nursing interventions that will allow for outcomes for which the nurse is accountable.

Phase 4: entails implementation, which refers to the actual giving of nursing care.

Phase 5: involves the evaluation of whether goals have been met and expected outcomes achieved. It leads to reassessment and the cyclical continuation of the process (Smith 1991:74).

Internalisation refers to the integration of an attitude, belief and behavioural regulation to operationalise the nursing process (Asakawa & Csikszentmihalyi 2000:1).

Operationalisation of the nursing process refers to its everyday use in practice.

Recording forms an integral part of the whole process and refers to the written documentation of the whole process. This requires the nurse practitioner to have effective writing skills.

Training hospitals in Namibia refers to Windhoek Central Hospital (A), Katutura State Hospital (B) and Oshakati State Hospital (C). Student registered nurses are allocated to these hospitals for their clinical learning experience. Hereafter, these hospitals will be referred to as Hospital A, B and C.

Education is seen as a continuous process of growth and development in the theoretical and the clinical situation to, among other things, equip the professional nurse for utilising the nursing process.

Programme refers to the plan of action developed to internalise and operationalise the nursing process for registered nurses and midwifes in the gynaecology wards of training hospitals in Namibia after a situation analysis had been carried out. The themes identified were used to describe the educational programme.

Professional conduct refers to the framework that helps the nurse make professional decisions, carry out his/her responsibilities and exhibit high standards of professional behaviour.

Accountability refers to the nurse's individual accountability for his/her own professional practice within the framework of the professional legislation and the Namibian Constitution, with special reference to the rights of all citizens.

Professional values refer to nurses' commitment to service, belief in the dignity and worth of each person, and commitment to education and autonomy.

Time management refers to the organisation of the self in order to make optimum use of the time available.

Cognitive knowledge refers to the acquisition of knowledge, which involves complex cognitive processes, namely perception, learning, communication, association and reasoning.

Reflective practice profile refers to a teaching aid to help registered nurses reflect on personal experience in applying cognitive knowledge and skills to practice and to improving nursing practice through this means.

Guidelines refer to systematically developed interventions to assist registered nurses in implementing the educational programme in order to internalise and operationalise the nursing process.

1.8   SUMMARY

In this chapter the reader was orientated to the study. In the introduction an overview of the problem in question was given and the rationale for the research was described. The background to the problem was sketched and the research problem stated, as well as the research purpose and the objectives. The demarcation of the study was described, as was the paradigmatic perspective with regard to the meta-theoretical assumptions, that is, the person, nurse, nursing environment and health. The theoretical assumptions were outlined, namely the nursing process, Dickhoff et al.'s (1968) practice-orientated theory, cognitive learning theory and Knowles' andragogical theory. Operational definitions of key concepts were provided. In the next chapter the research design, strategy and method will be described.

CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1   INTRODUCTION

In the previous chapter the rationale and overview of the study were presented. As a registered nurse, and later as a lecturer, the researcher often asked herself the following questions: "In what way can I contribute to the clinical areas of training hospitals in Namibia to which student nurses are allocated for their clinical nursing education?" and "What is it about the nursing process that does not seem to work?"

2.2   PURPOSE OF THE RESEARCH

The overall purpose of the research was to develop and describe a programme to internalise and operationalise the nursing process and to develop and describe guidelines for implementing the programme.

2.3   RESEARCH DESIGN AND METHOD

2.3.1   RESEARCH DESIGN

A research design is a plan for conducting a study that maximises control over factors that could hinder the validity of the eventual results (Burns & Grove 2005:6). In this study a qualitative, descriptive, exploratory and contextual design was used.

Qualitative

A qualitative design was selected for this study because the researcher wanted to explore and describe the utilisation of the nursing process in the context of the gynaecology wards of training hospitals in Namibia. Mateo and Kirchoff (1999:280) and Coffey (2004:325) view qualitative research as being appropriate for addressing issues in clinical settings where nurses work in order to understand how a particular phenomenon is being dealt with. Without the insight from qualitative research methodology it would not have been possible to understand the "how", "what", "why", and "why not" (Thorsen & Mäkelä 1999:17; Vishnevsky & Beanlands 2004:234). Furthermore, Donalek (2004:409) states that qualitative research in nursing generally begins with the researcher's curiosity about an aspect of the health/illness experience.

Exploratory

The aim of exploratory research is to establish the facts, to gather new data, to determine whether there are new patterns in the data and to gain new insights into phenomena (Mouton 1996:103; De Vos 1998:24). The aim of this research is to explore, through the participation and experiences of registered nurses, the nature of the contents of a programme for utilising the nursing process in order to facilitate the programme's implementation.

For an exploratory study to be successful, the researcher needs to be open to new ideas and possibilities as they arise. Mouton and Marais (1999:45) state that the researcher should not have preconceived ideas or perceptions that could steer the study in a certain direction. The researcher, who has been active in the clinical field where the nursing process should be used, bracketed her ideas and perceptions. In doing so she laid aside what is known about the phenomenon being studied.

Descriptive

The data that materialise from a qualitative study are descriptive in that the researcher is interested in process, meaning and understanding. According to Burns et al. (2005) descriptive refers to the accurate portrayal of particular individuals in real-life situations for the purpose of discovering new meaning. Babbie and Mouton (2001:270) and Kohi, Makoae, Chirwa, Holzemer, Phetlu, Uys, Naidoo, Dlamini and Greeff (2006:404) see the primary goal of qualitative research as being to describe and understand human behaviour from the perspective of the research participants themselves, their own beliefs, history and context. This results in the "insider" or "emic" view. The emphasis in this study was on building inductively on the interpretations of registered nurses with regard to the utilisation of the nursing process.

This study will describe what the participants believe should form part of a programme to facilitate the utilisation of the nursing process for registered nurses. The process took us into an open search for new and possibly better ways of doing

things (the nursing process). This called for a process of thinking that is rational and that challenged the research to explore ideas.

Contextual

The context involves situating the object of the study within its immediate setting. It avoids the separation of components from the larger context (De Vos 1998:281).

The context in which the research was conducted was the gynaecology wards of all training hospitals in Namibia. The reason for selecting this context was because the researcher lectures in nursing care of different disciplines, among others, the gynaecology discipline. For their clinical training, students are therefore allocated to gynaecology wards in all three training hospitals. Theoretical relationships in qualitative research must be placed within a context of theory in order to be useful for practice (Mouton 1996:41).

In addition, the researcher had previously conducted a study in the same discipline with the title "The standard of nursing care of patients undergoing hysterectomies in the training hospitals in Windhoek" (Bester 2000). This context was therefore the most appropriate because the context was familiar to the researcher.

Three wards were included in the study, namely the gynaecology wards of two training hospitals in Windhoek and one in Oshakati. The reason for this was that the researcher wanted to describe and understand whether and how the registered nurses

utilised the nursing process in this particular context. As with all qualitative research, the researcher had no intentions of generalising the results, although readers may apply the findings should they so wish. Mouton (2001:277) cites Guba and Lincoln (1984) when referring to the importance of a qualitative study to demonstrate transferability by sufficient detailed descriptions of data in context and report them with sufficient detail and precision.

The training hospitals are the places where students learn to develop professional judgement in the decision-making process. Girot (2000:289) views professional judgement as something that cannot be prescribed. Nurses have to develop certain skills, such as cognitive, psychosocial, psychomotor and affective skills, to enable them to cope with the uncertainties and challenges of everyday clinical practice in a very complex and individual way. Paul and Heaslip (1995, in Durgahee 1996:420) support this view when they refer to genuine knowledge that is obtained through intellectual effort in figuring out and reasoning about the problems that are encountered in practice. Edwards, Smith, Courtney, Finlayson and Chapman (2004:249) go further when they claim that the clinical education setting is the most influential in the development of nursing skills, knowledge and professional socialisation, stressing the importance of the learning climate within the clinical educational environment.

Registered nurses in these hospitals are thus the mentors, clinical guides and professional role models of student nurses. It is therefore important that research is conducted in the world of practice. Field (2004:565) is of the opinion that the

practice educator (registered nurse) belongs to both the clinical and educational worlds and that he/she has to promote the implementation of theoretical knowledge in practice.

2.3.2   RESEARCH METHOD

The research method that was used in this study was the questioning approach through interviews. Delivering a programme to people typically involves making decisions about what to offer, how to offer it and how to evaluate it. This study has therefore been divided into four phases.

PHASE 1

In order to make a decision on what to offer, a situation analysis was done to explore and describe what a programme for internalising and operationalising the nursing process should consist of in order to facilitate its implementation.

POPULATION

The population included all registered nurses on day duty in the gynaecology wards of training hospitals in Namibia, which was a total of eleven. The reason for not including registered nurses on night duty was because they are not allocated solely to gynaecology wards, that is, they are in charge of a mixture of disciplines, for example gynaecology and urology.

SAMPLE

The sample size was not predetermined because data was collected until saturation occurred (Vishnevsky & Beanlands 2004:234). Qualitative research, because of the in-depth nature of studies and the analysis of the data required, usually relates to a small, selective sample (Cormack 1991, in Carr 1994:716).

SAMPLING

In this study purposive sampling was used. Purposive sampling was appropriate because the registered nurses selected had to have a minimum of one year's experience on the gynaecology ward. This criterion was used since experience in the utilisation of the nursing process in the field of gynaecology nursing was important for ensuring a good understanding of the question that was posed. Devers and Frankil (2000:2) see purposive sampling strategies as being conducive to enhancing understandings of selected individuals' or groups' experiences or for developing concepts. This goal could only be accomplished by selecting "information rich" cases, that is, individuals who provide the greatest insight into the research question (McSherry, Cash & Ross 2004:934). Miles and Huberman (1994, in Devers & Frankil 2000:2) note that cases that have the greatest pay-off in purposive samples are the typical cases, that is, those that are "average" for those being studied.

The following aspects were attended to during data collection: pilot interview, preparation of the field and data collection.

Pilot interview

In preparation for the study, the researcher conducted pilot interviews. The question: "Tell me about the utilisation of the nursing process in your ward" was posed to two registered nurses from two surgical wards in Hospital A and B. An audiotape was used to tape these interviews. This helped the researcher to become acquainted with the question, the technical aspects of the audiotape and the interview process itself.

In assessing these pilot interviews the researcher took into consideration the nature of the question, the characteristics of the audience and the researcher's procedures. The results of the pilot interviews were similar to the actual study in terms of the main categories identified. As a result of this outcome, the researcher gained experience in guiding questions, structuring a logical flow of questions and probing for more explicit responses during the actual study.

Preparing the field

Data collection for the study began with preparation of the context (field). Streubert and Carpenter (1995:22) refer to the field as the "setting" for qualitative research.

Although the researcher handled clinical education sessions with students in these wards, no specific attention was given to the utilisation of the nursing process by registered nurses on a regular basis over a long period. It had, however, been done on an ad hoc basis. The researcher had to establish a relationship with the registered nurses in order to gain their trust, support and cooperation. This was done by making regular visits to these wards, and holding discussions with registered nurses on their views on nursing practice and the teaching of students. The most important aspect of the research, that is, to improve nursing practice, was also explained to them.

Devers and Frankil (2000:3 & 264) are of the opinion that developing and maintaining good relationships are important for effective sampling and for the credibility of the research. If the researcher is unable to secure the subjects' participation, the research cannot take place. Thus, the research became very familiar to the registered nurses in the gynaecological wards, good interpersonal relationships were maintained with them.

Conducting the interviews

In-depth interviews were conducted to obtain the views of the participants on the utilisation of the nursing process. The participants, who are considered experts (in this case registered nurses), play a very important role in gathering research data from "the real world" (Ducharme, LéVesque, Gendron & Legault 2001:183).

The interviews were conducted in a special room in the ward where no interruptions could take place. The best time for these interviews was arranged with the participants prior to the interview so that patient safety was not compromised. Participants were given the opportunity to make arrangements in advance. The participants who were on night duty in the gynaecology wards (of which there were two nurses) were not part of the investigation because they were always the only registered nurses on duty for the night and, as interruptions were inevitable, they could not included in the sample. These arrangements were made for all three hospitals (two in Windhoek and one in Oshakati), that is, the context of the study. In spite of the fact that dates for the interviews were made and confirmed in advance, the appointment with one of the respondents had to be rescheduled five times.

On the scheduled dates, participants were met in the interview room, put at their ease and certain aspects explained using an information guide. The purpose of this guide was to ensure that certain information was given to all the registered nurses before the interview and certain information recorded for all interviewees. This included, for example, the purpose and objectives of the study, information on permission obtained to conduct the study, the opportunity to withdraw from the study and the assurance of anonymity of data.

Participants were further informed about the use of the audiotape and could say whether an audiotape be used or not. However, the use of audio recording is important because information obtained from interviews can be complemented with audio recordings and provide a good record with referential adequacy, an aspect

which ensures credibility (Streubert & Carpenter 1995:45; Fain 1999:116; Babbie & Mouton 2001:277).

After the profile (Annexure C) of the ward was completed the following question was posed to each participant:

"Tell me how you utilise the nursing process in your ward."

With regard to the language of communication during the interview, it was concluded that the interview should be done in English or Afrikaans depending on the individual interviewee's choice. According to Yang, Gau, Shiau, Hu and Shih (2004:642), during an in-depth interview participants should be encouraged to express themselves in their own way and in their own words. The interviews that were conducted in Afrikaans were translated into English because English is the official language of Namibia.

Participants were given ample time to ask questions if there was something that was not clear. If language barriers resulted in misunderstanding or a lack of clarity, concepts were explained. Fain (1999:116) is of the opinion that the presence of the interviewer allows for clarification of essences of the phenomenon and decreases the possibility of vague answers. Streubert and Carpenter (1995:43) are of the opinion that the effective interviewer needs to bring knowledge, sensitivity and flexibility into a situation that is reciprocal in nature.

The use of an interview to collect data was appropriate because an interview is essentially a conversation in which the interviewer establishes a general direction and pursues specific topics raised by the participants. Thus, interviewing is a flexible technique that allows for the exploration of greater depth of meaning (Burns & Grové 1997:355; Mouton 2001:288).

Field notes

During each interview the researcher kept field notes. These included non-verbal communication such as gestures, lack of interest, enthusiasm and uncertainty. According to Guba and Lincoln (1990:175) humans collect data best through the direct employment of their senses: talking to people, observing their activities and responding to non-verbal cues.

Through interaction and observation, data were collected in an unstructured manner and complemented with field notes. Nine interviews were conducted after which it was found that the data were saturated. This resulted in three interviews being held in each hospital where the study was conducted.

After each interview the audiotapes were labelled with the name of the registered nurse as well as the date of the interview. The tapes were then transcribed verbatim by the typist. These tapes were kept safely in case the registered nurses wanted to listen to them with the member checking. After that they were destroyed.

The results from this phase formed the foundation of phase 2 and 3, which consisted of the conceptual framework and the development of the programme respectively.

PHASE 2: CONCEPTUAL FRAMEWORK

A conceptual framework was described on the basis of the results in phase 1 and the literature control. This framework formed the basis for the programme and is described in detail in chapter 4.

PHASE 3: DEVELOPMENT OF AN EDUCATIONAL PROGRAMME TO INTERNALISE AND OPERATIONALISE THE NURSING PROCESS

The third phase consisted of developing a programme to internalise and operationalise the nursing process. Themes extracted from the transcripts of the in-depth focused interviews and the information derived from exploring the literature assisted in developing the programme.

The programme was developed exclusively for the gynaecology wards of the training hospitals. It was therefore developed from the data analysis of the in-depth focused interviews. The programme is described in chapter 5.

PHASE 4: GUIDELINES FOR PROGRAMME IMPLEMENTATION

During phase 4 guidelines were drawn up for implementing the programme that had been developed. These guidelines were based on the conceptual framework and were aimed at putting the programme into actual practice specifically for the registered nurses in the gynaecology wards. The guidelines are discussed in chapter 6.

2.4   ETHICAL MEASURES

The ethical considerations that were utilised for this study are described as follows: The registered nurses' informed consent (Annexure D) was obtained for this study in the following way:

- Registered nurses were given a statement of the research purpose.

- The data collection procedures were explained, that is, the in-depth focused audio taped interviews. Any foreseeable discomfort, whether physical or emotional, was minimised where possible. Physical or emotional discomfort included any lengthy interviews that might have been exhausting, any disruption of the ward administration or organisation that might have resulted (Babbie & Mouton 2001:522).

- They were given information on the benefits of the study, including an improvement in the utilisation of the nursing process. This was explained as being advantageous for consumers of health services as well as for nursing personnel

and that it could result in the improved accountability and responsiveness of health services.

- The anonymity and confidentiality of interview data were maintained. Although interviews were audio taped, this was done only for the purpose of analysing the data thoroughly using open coding. The identity of the registered nurses and patients were not referred in any way at any time that could harm them in a psychosocial or emotional way. The audiotapes were destroyed after the members had checked what had been done. Babbie and Mouton (2001:521) are of the opinion that the clearest instance of this norm in practice concerns revealing information that would embarrass subjects. This might particularly be the position with information gained in this study because there were so many factors that influenced the utilisation of the nursing process. According to Olsen (2003:124), qualitative research does not usually involve the risk of physical harm, but it does carry a greater risk of social and psychological harm, particularly from breaches of privacy. The direction that inquiry will take in qualitative research cannot be fully anticipated in advance.

- The researcher offered to answer questions raised by registered nurses. Detailed contact information was provided for this purpose.

- Registered nurses were given the option to discontinue participation at any time. In the interests of the trustworthiness of the results, however, the researcher

reduced the possibility of subjects withdrawing as much as possible by supplying participants with ample information early on in the study.

Olsen (2003:130), in a report from a working group for the study of ethical issues in international nursing research, maintains that obtaining proper informed consent requires shared understanding of the meaning of the research and the nature of its risks and benefits.

2.5   PERMISSION

The following permission was obtained for this study:

- Institutional approval was obtained from the Research Committee of the University of Namibia to ensure that the proposed research complies with minimum standards (Annexure A).
- Approval was obtained from the Research Committee of the Ministry of Health and Social Services (Annexure B) where data from registered nurses were collected and the programme implemented and evaluated. The research proposal was attached so that authorities from the Ministry were informed of the exact research procedures, purpose and objectives.

Devers and Frankil (2000:266) state that researchers have to negotiate access by securing permission from "gatekeepers" such as organisational officials in charge.

Understanding these officials' views is critical for maintaining the integrity and credibility of the research.

2.6   TRUSTWORTHINESS

Trustworthiness, that is, the neutrality of the study or decisions, was ensured through qualitative strategies. Graneheim and Lundman (2003:109) are of the opinion that research findings should be as trustworthy as possible and every research study must be evaluated in relation to the procedures used to generate the findings. Lincoln and Guba (1985, in Babbie & Mouton 2001:276) share a similar view of trustworthiness, believing the key criterion of good qualitative research to be the neutrality of its findings.

2.6.1   MEASURES FOR TRUSTWORTHINESS

The measures of credibility, dependability, transferability and inferential validity that were used to ensure trustworthiness for this study are described in the following sections.

2.6.1.1 Credibility

In this study credibility was achieved through the following procedures:

- Prolonged engagement. In this study in-depth focused interviews with nine registered nurses in all three training hospitals were conducted until the data were saturated. Each interview took at least forty-five minutes to an hour, thus the views of the registered nurses on the utilisation of the nursing process could be explored and described in depth. All the training hospitals in Namibia were included in the study, that is, the two training hospitals in the centre of Namibia, Hospitals A and B in Windhoek, and the training hospital in Oshakati, in the north of the country, Hospital C. This increased the possibility of shedding light on the research question from various aspects and a rich variation of the phenomena under study as supported by the views of Patton (1987), and Adler and Adler (1988) in Graneheim and Lundman (2003:110).

- Persistent observation and a deliberate attempt on the part of the researcher to understand the views of the registered nurses or to get an insider perspective on the utilisation of the nursing process was important for the credibility of this study. In-depth interviews, which were used for the collection of data, helped the researcher to deliberately attempt to understand what it was that registered nurses were trying to tell her about the utilisation of the nursing process. Although ideally the respondent does most of the talking, questions could be posed because an interview allows for interaction between the interviewer and the respondent. Asking questions that lead subjects to tell their own stories is one way in which a researcher consistently pursues interpretations (Mouton 2001:277).

- Referential adequacy. In this study an audiotape recorder and field notes were used to collect data. Verbatim transcripts were then typed by a typist, which resulted in sufficient data that could be referred to where necessary.

- Peer debriefing. In this study a colleague outside the context of the study, with a general knowledge of the nursing process as well as the nature of the research process, was asked to review insights and views, and to perform co-coding of the data. Botes (in Rossouw 2000:193) argues that a critical discussion of data analysis and interpretation by a co-coder is an important aspect of the research in order to verify that conclusions are supported by the data collected. According to Woods and Cantanzo (1988) in Graneheim and Lundman (2003:110) dialogue among co-researchers is valuable for credibility because various experts and researchers should agree with the way that data are labelled and sorted.

Member checks were done by giving the typed scripts to the registered nurses interviewed to identify any shortcomings and misinterpretations (Graneheim, Worberg & Jansson 2001:259). Some of the interviewees stated that the scripts contained data that was strange to them. It was then explained that scripts are a verbatim reproduction, typed up according to the naturalist approach, which implies that every recording is described in as much detail as possible including stutters, involuntary vocalisations and pauses (Olivier, Serovich & Mason 2005:1273). The tapes remained in the researcher's possession in case they wanted to verify the scripts. They were again reassured that anonymity would be

maintained and that texts should be seen as part of the whole. After the member check, the audiotapes were destroyed.

- Limitation of subjectivity. In this study subjectivity was limited by using open coding as a data analysis method. Botes (in Rossouw 2000:191) refers to data collection, data analysis and interpretation as methods that have an impact on credibility. This is because the qualitative researcher is subjectively involved in data collection and analysis, and measures need to be implemented that ensure that the data are impartial and trustworthy. Open coding is therefore an important means of moving from subjectivity to intersubjectivity, which is one of the basic rules of qualitative research. This means that data belonging to a particular individual is subjective and data on which a group has reached consensus is intersubjective. This consensus is reached within a research community (peer group interaction) together with the respondents (member checking). According to Graneheim and Lundman (2003:106) text always involves multiple meanings and there is always some degree of interpretation, which is an essential issue when discussing the trustworthiness of findings in a qualitative content analysis. This is also true of the researcher's interpretation of the text in this study. The researcher has been involved in nurse education for many years, not only in the classroom situation but also in the clinical situation where the nursing process is utilised. This necessarily resulted in a personal experience and perspective of the matter under investigation. It was therefore necessary for the researcher to bracket pre-existing knowledge by setting aside what was already known about the phenomenon (Lesson: Qualitative Researcher: no page number).

2.6.1.2 Transferability

As this research constitutes a qualitative study, the extent to which findings can be applied to other contexts will not be discussed because a large, representative sample was not possible. In this study a purposive sampling method was used, that is, registered nurses within the context of the gynaecology wards in Namibian training hospitals and the phenomenon of the utilisation of the nursing process was studied contextually. According to Botes (in Rossouw 2000:195), another researcher may make a decision to transfer the findings to similar contexts on the basis of the saturation of data. Therefore the characteristics of the context were described in detail, as well as the way in which the research is implemented.

2.6.1.3 Dependability

The dependability of this study was ensured by describing the research methods in detail so that another researcher would obtain the same results if the same question were posed to the same group of registered nurses under the same circumstances. The reliability of the data was ensured by using open coding as the data analysis method, and utilising a co-coder as well as member checking. Triangulation was assured by using the interview transcripts of the registered nurses, the researcher's experience and field notes.

The concept of dependability refers to the consistency of research findings in a qualitative study. Indirectly, the measures of credibility will ensure dependability. Directly, the dependability in this study was assured as follows:

- A thick description of the research methods was provided so that the possibility of repeating the study was created.
- An investigative audit was carried out to determine how reliably the data were presented so that the consistency of data could be confirmed.

2.6.1.4 Inferential validity

After the data analysis the inferential validity of this study was assured by undertaking a literature review. Findings were then described and arguments were put forward in light of existing research, which was important since this was a qualitative descriptive study. Paterson, Thorne, Canam and Jillings (2001); Sandelowski and Barasso (2002); Sandelowski, Docerty and Emden (1997) in Thorne, Kirkham and O'Flyn-Magee (2004:4) and Bergman and Coxon (2005:11) and Botes in Rossouw (2000:197) emphasise the importance of validity and intellectual rigor within the qualitative tradition so that the results of such enquiries can be effectively applied and realistically synthesised into the disciplinary knowledge.

In this study the results of the situation analysis in phase 1 were used to describe a conceptual framework. This framework formed the basis for an in-service

programme. From here on guidelines were drawn up for implementing the programme. According to Botes (1992:36), the usefulness of research results to improve the practice of nursing is an important criterion for validity.

2.7   REASONING STRATEGIES

2.7.1 INDUCTIVE

Inductive logic was used to explore the experiences of registered nurses in order to determine the if, why and why not of the utilisation of the nursing process, because nothing was so far known about this issue. Inductive reasoning, says Chinn et al. (2004:87), is reasoning that takes place from the particular to the general.

2.7.2 DEDUCTIVE

After data from the in-depth focused interviews were analysed and described in-depth in order to obtain a thorough understanding of the issue, the researcher carried out a literature study. The data obtained from the interviews could then be linked to existing theories, that is, the nursing process, practice-oriented theory (Dickhoff et al. 1968), cognitive learning theory and Knowles' andragogical learning.

In deductive logic, the premises, as the starting point for the research, embody two variables that may be categorised as specific in relation to each other. This therefore entails reasoning from the general to the specific (Chinn et al. 2004:87).

2.7.3 ANALYSIS

The masses of information that resulted from the in-depth focused tape-recorded interviews were listened to and transcribed verbatim. The aim of such an analysis is to produce a detailed and systematic recording of issues that were addressed in interviews (Burnard 1991:462). The data analysis carried out on the interviews was based on Tesch's method of qualitative analysis (Tesch 1990:142). This is an inductive, qualitative form of analysis in which themes are systematically identified from the data. This method was chosen because it is a systematic approach and its procedures have been clearly described. The stages of analysis include the following:

1. Making sense of the whole
2. Identifying topics
3. Identifying categories
4. Identifying themes

2.7.4 SYNTHESIS

Synthesis, which refers to a higher order of logic, is the process through which a new whole is developed and interpreted into existing knowledge (Meleis 1991:140). In this study the results of the data analysis were synthesised to formulate and describe an educational programme to operationalise the nursing process.

Table 1: An exposition of the methods proposed for phases 1 to 4.

Phase	Design	Population/ Unit of analysis	Sample	Data collection	Data analysis	Result
1 and 2	Qualitative Exploratory and descriptive	Registered nurses in gynaecology wards	Purposive sampling	Pilot interview Focused interview	Qualitative analysis of open coding	Experiences regarding utilisation of nursing process
3	Educational Programme development Descriptive	1. Experiences of registered nurses 2. Conceptualised concepts of the study 3. Literature	Past ten years or more	Results derived from phase 1 Inductive process Deductive process Analysis Synthesis	None	Educational Programme
4	Guideline development Descriptive	Programme				Guidelines for operationalisation of educational programme

2.8   SUMMARY

In this chapter the reader was introduced to the research design and method for the study. The objectives of the research were once again briefly stated, because the research design, strategy and method were chosen in accordance with these objectives. The qualitative, exploratory, descriptive and contextual nature of the research design was described, as well as the strategy and method that would be used. The focused interviews that were conducted were also described.

In this chapter the research strategy that would be used, that is, the guidelines for programme implementation, was only touched on briefly as it is described at length in chapter 5.

The research method for the study comprises three phases, which were described in detail: phase 1 consists of a situation analysis, phase 2 comprises the development of the programme and phase 3 consists of the development of guidelines for implementing the programme. The ethical measures taken and the informed consent obtained were described. Trustworthiness was described in terms of the credibility, applicability, dependability and conformability of the research. Reasoning strategies were also described under the headings of inductive, deductive, analysis and synthesis.

In the next chapter the results of the situation analysis will be described and the literature study discussed.

CHAPTER 3

DISCUSSION OF RESULTS AND LITERATURE CONTROL

3.1   INTRODUCTION

In chapter 2 the research design, strategy and method were described. The purpose of this chapter is to describe the findings from interviews on the experiences of the registered nurses in utilising the nursing process.

In this study the data analysis occurred simultaneously with data collection, because the moment the researcher began listening to the descriptions of the particular phenomenon analysis occurred.

In this study inductive data analysis was used based on Tesch's (1990:142-145) method of open coding. Basit (2003:147) and Hutchinson (2005:1) hold the opinion that the analysis of qualitative data is complex and involves a dynamic, intuitive and creative process of inductive reasoning. Tesch (1990:79) states that the central idea in data analysis is to classify the many words in the text into much fewer content categories. These categories should be relevant to the research purpose.

The texts based on the original interviews and the interview summaries formed the data for this study. Throughout the analysis the researcher attempted to gain a deeper

understanding of the registered nurses' experiences and the interpretation of the data was continuously refined.

3.2   STEPS FOLLOWED IN DATA ANALYSIS

On completion of the data collection an analysis was carried out in the following manner:

- Transcription of data:

The nine interviews were audio taped and subsequently typed up verbatim. Olivier et al. (2005:1273) view this transcription of the data as being pivotal to qualitative inquiry. The practice approach that was employed for this study was naturalism, which implies that every utterance is transcribed in much detail as possible including stutters, involuntary vocalisations and pauses (Olivier et al. 2005:1273).

- Reduction of data

After data was transcribed, the interviews were read through several times to obtain a sense of the whole.

Transcriptions were the read through again with the purpose to identify topics. These topics were noted in the margins of the transcription document. Topics were then recorded in columns according to interviews 1 to 9, on a double page folio.

The verbatim transcripts of the registered nurses' experiences in the gynaecology wards with regard to the utilisation of the nursing process formed the unit of analysis.

Thereafter topics with the same meaning were linked with lines of different colours. This resulted in the identification of categories. Eight categories were identified and that included: no need for the nursing process was seen, there were negative and positive attitudes and beliefs, the nursing process is time consuming and lengthy, staff shortage hampers the utilisation of the nursing process, management do not demonstrate support for the utilisation of the nursing process, registered nurses experience a lack of in-service education in utilising the nursing process, the nursing process includes repetition and the nursing process is not relevant.

Categories were then linked to form themes and ultimately generating an educational programme to internalise and operationalise the nursing process. Three themes were concluded, namely: registered nurses experience the nursing process as esoteric, registered nurses experience the nursing process as labour intensive, and optimum utilisation of the nursing process is determined by cognitive impediments.

The categories and themes were summarised on page 62, table 2 and described as from page 62 of the research report.

Basit (2003:152), in support of this procedure, states that although qualitative research involves a smaller sample and does not deal with large datasets, it requires an intense and prolonged period that may take months, requiring considerable expertise on the part of the researcher. Williamson (2005:1) refers to the challenge that the qualitative researcher faces when organising and analysing the copious amount of data generated.

Burnard (1991:461) and Pollack (1991, in Arthur & Clifford 2004:234) maintain that the aim is to produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together in a category system. They do, however, caution that attempts should be made to represent the thoughts and feelings of others in a systematic but honest way. Basit (2003:151) believes that it is the richness of the responses that should be focused on and not how many of the interviewees feel positively or negatively about something, because this is not the intention of qualitative inquiry. The idea is to ascertain "what" they feel, and "why" they feel that way.

These processes are inseparable. Therefore, the importance of the reduction process cannot be overemphasised. Writing down any ideas, feelings or responses that emerge during data collection supports reductive phenomenology. Although the transcribed data were divided into topics, categories and themes, which may be taken out of context, it remained comprehensible. This is supported by McLafferty and Morrison (2004:449) and Drew (1989:431) in Streubert and Carpenter (1995:45).

- Description of results was the following step and is described next.

3.3   DESCRIPTION OF RESULTS

The description of the results of the study took place according to the final themes and corresponding categories that emerged from the registered nurses' experiences of

utilising the nursing process. These categories and themes were generated and drawn up by the researcher. The names chosen were those that seemed most logically related to the data (Fain 1999:212; De Vos, Strydom, Fouché & Delport 2002:347; Cottee-Lane, Pistrang & Bryant-Waugh 2004:171).

The data analysis process shortened the text immensely as it was an enormous amount of data (Annexure D) to deal with,a process which is supported by Freshwater and Avis (2004: 8). The researcher did, however, take care not to influence the richness of the data during this process. Findahl and Höirjer (1981), Cavanagh (1997) and Coffey and Atkinson (1996) in Graneheim and Lundman (2003:106) refer to this process as reduction (decreasing the size), distillation (abstracted quality of the text) and condensation (process of shortening while still preserving the core).

This chapter will be presented in accordance with table 2 on page 62: Themes and categories. Only the themes that emerged will be discussed here. The significance of certain aspects was based on data saturation of similar experiences on the particular theme; examples will be given by quoting the exact words of the participants in italics. The intention is to highlight the quality of their experiences. Individual experiences are included so as to ensure that the meaning is maintained.

The following categories and themes were arrived at.

Table 2: Themes and categories

Themes	Categories
Registered nurses experience the nursing process as esoteric	• No need for the nursing process is seen • Negative and positive attitudes and beliefs
Registered nurses experience the nursing process as labour intensive	• The nursing process is time consuming and lengthy • Staff shortage hampers the utilisation of the nursing process • Management do not demonstrate support for the utilisation of the nursing process
Optimum utilisation of the nursing process is determined by cognitive impediments	• Registered nurses experience a lack of in-service education in utilising the nursing process • The nursing process includes repetition • The nursing process is not relevant

3.3.1 **THEME 1: REGISTERED NURSES EXPERIENCE THE NURSING PROCESS AS ESOTERIC**

The nursing process is the essence of the thinking and doing in nursing practice. At present this is the means by which nurses worldwide identify patients' responses to illness situations, design ways to assist patients in dealing with those situations,

implement the nursing care required, and determine the effectiveness of that care by looking for changes in patient behaviour.

The following categories were arrived at:

➢ **Nurses do not see the need for the nursing process**

If people do not see the logical value of any process or tool that is being used in any situation, then it is difficult to use or apply it. The findings revealed that some participants found it difficult to understand the usefulness of the nursing process. Participants felt that they know what to do concerning nursing care. The following statement is evident of that:

"… ons weet dat as 'n pasient van teater af kom, moet jy vir die pasient iets gee vir pyn. Ek sal die pasient gemaklik maak. Nee, die nurses weet, ons almal weet dit. Nou as dit op 'n papier kom, dit is maar net dat dit staan ons het dit gedoen. Ek weet nou nie vir wat staan dit eintlik nie, maar eintlik dink ek maar dit is net papier mors'." (We know that if a patient comes from theatre, you have to provide something for pain. I will make the patient comfortable. No, the nurses know everything, but if it has to be written down, it just shows that it has been done. I don't really know what the meaning is. I think it is just a waste of paper.)

According to Tanner (1987), as cited by Fonteyn and Cooper (1994:316) and Rovithis and Parissopoulos (2005:1), during problem solving experienced nurses are less likely to use an analytical process that provides them with an "intuitive grasp" of the whole situation, as they do not need a step-by-step approach to achieve this "grasp". Fonteyn (1991) as cited by Fonteyn and Cooper (1994:317) suggests developing a repertoire of problem-solving strategies rather than depending on one standard problem-solving method only.

Another participant stated the following:

"I don't see the need to utilise the nursing process. I know what to do."

This statement is a clear indication that the participant has a different view of delivering nursing care. The nursing process is a systematic method for delivering individualised nursing care consisting of, in turn, assessing the patient, identifying nursing problems, applying nursing care to solve these problems and evaluating the outcome (Yura & Walsh 1978, in Hurst, Dean & Trickey 1991:1444). It is therefore important to utilise this process. Registered nurses should be able to undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients. Furthermore, they should also provide a rationale for the nursing care delivered that takes into account social, cultural, spiritual, legal, political and economical influences.

These roles and functions of the nursing process are clearly described in the regulation on the scope of practice for registered nurses in Namibia (Government Gazette 2040:65):

(a) The diagnosis of a health need and the prescription, provision and execution of a nursing regimen to meet the need of a patient or a group of patients or, if necessary, by referral to a registered person;

(b) the execution of a programme of treatment prescribed by a registered person;

(c) the treatment and care, including monitoring the patient's vital signs;

(d) the prevention of disease …… by teaching and counselling individuals and groups; and

(e) prescription, promotion or maintenance of hygiene, physical comfort and reassurance of the patient.

If nurses do not see the need to utilise the nursing process how will they be able to practice within their scope of practice?

➢ **Negative and positive attitudes and beliefs**

Nursing is a science that focuses directly on humanity in a highly complex and technical world. This focus on humanity means that values and beliefs are very important. Nurses have values and beliefs, and it is these values and beliefs that strongly influence their daily practices. Furthermore, these values and beliefs interact directly with conditions in their environment, that is, the hospital ward.

Therefore, the nurses' philosophy of nursing is critical to the practice of professional nursing. Philosophy in this context encompasses the professional nurse's belief system as well as the quest for knowledge. According to Leddy and Pepper (1993:183) one's belief system and understanding are strong determinants of the way one thinks about a phenomenon or situation and are also strong determinants of one's actions. By implication this means that nurses' belief system about the nursing process will determine how they utilise it.

The findings of the study revealed negative as well as positive beliefs about the utilisation of the nursing process. Some of the negative statements are included below:

"Ek sal ook sê is ons eie houding. Sommige van ons is negatief." (It is also our own attitude. Some of us are negative.)

"… een hou daarvan, die volgende een hou nie daarvan nie, die volgende een kan nie die nut daarvan sien nie" (… one might like it but the next one might not see the benefit of it.)

"Sometimes they also give up because others are not doing it."

"I believe in doing nursing care as I am used to."

"Nurses don't learn from bad experience – they don't know how important a nursing

care plan is.”

“Nurses like talking and sitting at the post but don't plan the nursing care.”

One of the registered nurses indicated that the operationalisation of the nursing process is important. This was stated as follows:

“... people don't really visit the disciplinary hearings. If they go there and listen what you are supposed to do ..... how important is the nursing care plan. ... they don't learn from experience. ... I don't know how to make nurses. ... don't know ..... how to motivate staff. ... also self-development, they don't want to learn. It's (nursing process (sic)) not difficult, just maybe the time will catch you. ... people are having time, they are talking, sitting at post, talking, talking, talking and people don't have nursing care plans.”

Field (1987:564) explains that the influence of the nurse's own emotional or subjective response to a situation has to be taken into consideration when addressing decision making. Nurses are not value-free, they have biases that have developed from previous experiences, which have to be explored and examined. Unexplored prejudice may cloud

or influence a nurse's judgment. Attree and Murphy (1999:595) are of the opinion that any tool is as good as its operator and the system within which it operates.

CONCLUDING RELATION STATEMENT WITH REFERENCE TO THEME ONE: REGISTERED NURSES EXPERIENCE THE NURSING PROCESS AS ESOTERIC

Nurses' belief system, emotions or subjective responses in not seeing the need of the nursing process in evidently influence their attitude to the utilisation of the nursing process. It was therefore imperative to reframe the belief system and attitudes of registered nurses in the educational programme in order to internalize and operationalise the nursing process (See figure 1 (Reasoning map) page 91, figure 6 (Dynamics (interactive facilitation) page 114 and figure 8 (An educational programme to internalise and operationalise the nursing process) page 133 session 1).

3.3.2   THEME 2: NURSING PROCESS PERCEIVED AS LABOUR INTENSIVE

A labour-intensive process refers to the requirement for large amounts of human effort. Any care service is usually labour intensive. The registered nurses in this study rightfully experienced the nursing process as a labour-intensive process. One of the aspects that is directly related to labour-intensive processes is a shortage of personnel. It is argued that many developed and developing countries are experiencing serious nursing shortages in meeting the needs of their populations. One very important reason for this seems to be the advances in medical practice and technology and new diseases and infections such as the

human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) (Mulira n.d.:9).

Over the years many professionals have left the government service to work in the private sector where the environment is more conducive to the provision of quality nursing services. This has undoubtedly had an effect on the health care professionals who have remained in the public sector, such as the training hospitals included in this study. Schreiber (1994) in Rogers (2000:1) is of the opinion that such changes create unsettling environments in which to work. It is only recently that the impact of these changes and their fallouts on the work setting have been acknowledged, as employers are discovering that the "survivors", for example the professional nurses in the case of this study, are not always ready and able to settle in to work after these changes have occurred in their workplaces. Noer (1993) in Rogers (2000:2) refers to "layoff survivor sickness", a generic term that describes a set of attitudes, feelings and perceptions that occur in employees who remain in organisational systems.

Participants stated the following with regard to their experience of the nursing process as labour intensive:

"Those who are in the profession they resign and most of them who are staying, they overwork themselves and they become sick."

The following categories were arrived at:

➢ **The nursing process is time consuming and lengthy**

The nursing process, as used in Namibia, requires proper assessment of the patient, analysis and synthesis of data to arrive at a nursing diagnosis, the formulation of goals and expected outcomes, the identification of nursing interventions, the implementation of the process, the evaluation thereof and meticulous documentation. By implication this means that time is a factor.

The results revealed positive and negative opinions concerning the time factor. A positive remark entailed the following:

"... people are having time, they are talking, sitting at post, talking, talking, talking and people don't have nursing care plans."

The negative experiences were the following:

"Other nurses feel it is a waste of time." "Why are you supposed to take time to ask the patient if you are not going to provide for her."

"... so you do the rounds, you give the medicine, you do everything, so there is no time for the nursing process."

Another participant stated:

> *"... the ward is always full; it is not possible time wise to write a nursing care plan for each and every patient."*

> *"Ons gebruik meer op hierdie pasiënte wat groot operasies gehad het." (We mostly use the nursing process on patients who have had major surgery.) "If we are not too busy, then I will try to write the nursing care plan."*

Time management is an important aspect of everyone's daily practice and more so in hospital wards. The planning of care, although often misunderstood or regarded as a waste of time, is an essential part of health care because it provides a "road map" to guide all who are involved with a patient's care (Sox 2005:1).

Time management means the effective and efficient use of time. It is regarded as the effective planning and scheduling of work time to ensure that the most important work is completed and that sufficient time is left for unexpected emergencies and crises that may occur (Sullivan & Decker 1992:211). It is, however, important to remember that there are only twenty-four hours in a day. Therefore the activities that the registered nurses spend their time on are what make the difference in patient care in the end. By implication this means that registered nurses and first line managers should determine their goals, list their responsibilities, prioritise their tasks and schedule for their accomplishment

(Booyens 1998:292). One of the important aspects of time management is organisation, because an organised structure facilitates goal achievement that saves time.

> **Shortage of staff**

From the data analysis of this study it was found that nurses indicated a shortage of staff as being an important reason why the nursing process was not utilised. It would seem that the shortage of nurses is an issue in the nursing labour market in general, and not just in Namibia. Fey and Miltner (2000:126) state that in the United States of America many health care markets are in the midst of a nursing shortage because of hospital re-engineering efforts.

One participant expressed herself as follows:

"The shortage of staff is the main problem … we tell management how many staff we need, but really they say they don't have staff."

Another participant verbalised her experience of the shortage of staff as follows:

"… those who are in the profession they resign and most of them who are staying, they overwork themselves and they become sick."

It would seem that the shortage of nurses is a contemporary issue in the nursing labour market (Edwards et al. 2004:249). The International Nursing Labor Market (2004:iii) and Stordeur, D'hoore and Vandenberghe (2001:534) support this view. In a study performed by Baumann, Blythe, Kolotylo and Underwood (2004:iii) it was found that the main reason for developing countries experiencing nurse shortages is because local nurses migrate to more affluent countries. Uncompetitive salaries and unfavourable working conditions seem to be the reason for this. The findings of this study show that professional development and nursing education should receive more attention if nurses' professional status is to be improved.

Whether nurses are able to provide high quality care in the presence of staff shortages is questionable. This was also stated by Khowaja, Merchant and Hirani (2005:32), who are of the opinion that nurses are an increasingly precious resource in societies and that hospitals face serious challenges to provide high quality care with the current nursing resources available.

The nursing process is the tool that nurses have to use in order to facilitate the rendering of nursing care. The question to be answered is how staff shortages influence the utilisation of the nursing process. It could be argued that less time is spend with individual patients and that nursing care is generalised and prioritised according to the seriousness of the situation.

Furthermore it could also be argued that nurses' work and work environment, including stress, heavy workloads and poor relations with other professions, may affect their physical and psychological health, which in turn could result in inefficiency and nursing shortages owing to increased sick leave and turnover. Pressures such as larger nurse-to-patient ratios lead to complications and poorer patient outcomes (Commitment and care, no author).

Factors that influence nurses' numbers are, according to a position paper with the title: "Working with others", by the National Council of State Boards of Nursing of the United States of America (2003:3)

- a critical nursing shortage because of an aging nurse population;
- an increased need for nursing services due to changing demographics such as the increased survival rate of people with chronic diseases;
- a "war for talent" with other health and service professions; as well as
- more nursing care delivered in non-health care settings.

This means that the nursing profession has to determine how to continue providing safe, effective nursing care with decreasing numbers of nurses caring for increasing numbers of clients.

➢ **No support from management**

Another category that emerged from this study is the experience of no support from management pertaining to the utilisation of the nursing process in the gynaecology wards. Ward managers expressed their deepest concern about not receiving guidance from their supervisors in achieving the goals of the ward. This was evident from the following statements:

"… there was a meeting, delegation (sic), of head office to come and visit each ward, … each ward was having care plans … and the records are put up to date. Even the chief, the supervisor, chief registered nurses, … come down from their offices to the wards, they are involving in the wards, stock and everything, and now, with the PS (Permanent Secretary [sic]) not coming, everybody is in his place and sister in charge has to answer for everything. … must be a combined effort."

"… we tell management how many staff we need, but really they say they don't have staff."

It is imperative for nurses to work with and through others; and the ability to delegate, assign, manage and supervise has never been as critical and challenging as in the complex and complicated world of 21st century health care (Working with others 2003:3).

"It is extremely discouraging for a ward sister when appeals to utilise something that is for the good of patients continuously falls on deaf ears."

In a study done by Davis, Billings and Ryland (1994:967) on the evaluation of nursing process documentation, it was concluded that many ward managers displayed a poor understanding of the principles of the nursing process and that they have to be supported

in their attempts to implement the nursing process. Mead and Bryer (1992) in Mason and Attree (1997:1046) point out that the top-down approach to the introduction of the nursing process in the United Kingdom met with resistance from which British nursing has never recovered. De la Cuesta (1983), Mead et al. (1992), and Jolley and Brykcynska (1992) in Mason and Attree (1997:1046) in particular, express their concern about the initial promotion of the nursing process by theorists and not practitioners, and of theory rather than clinical experience or research. This was compounded by the logistics of its implementation in which it was imposed by senior nurses on clinical staff who were not oriented to general systems theory, and who were consequently ill-prepared for the fundamental changes that the nursing process would bring to practice (Chambers 1998 in Mason & Attree 1997). It is therefore not surprising that the nursing process was internalised as a new and cumbersome system of documenting care that had little or no impact on actual nursing care (Jolley & Brykczynska 1992 in Mason & Attree 1997:1046). De la Cuesta (1983), in Chang and Gaskill (1991:813), reports that the implementation of the nursing process (clinical problem solving) has been less than successful and that the factors underlying this are concerned with cognition, skill and attitudes.

From the following statement from one of the participants it is evident that nursing care in Namibia is also heavily burdened with an increasing number of patients. This has resulted in an inability to operationalise the nursing process, which was, as in other parts of the world, introduced in a top-down manner.

"… number of patient are increasing. … patient-nurse ratio not balancing" "… the one who was starting … nursing care plan, … people from the management level, nursing division, and later on they include UNAM people, but you see only UNAM people coming here and not the nursing division. This also demoralise people."

In achieving the goals, mission and vision of any institution, all involved, as well as the institution in general, need supervision, guidance and support. Nurses need support on the job from managers who understand their work, respect their expertise and can offer a sense of security. This means rebuilding a team approach to nursing where the focus can be on the patient. It also means a manageable workload (Baumann, Brien-Pallas, Armstrong-Stassen, Blythe, Bourbonnais, Cameron, Doran, Kerr, McGillis Hall, Zina, Butt & Ryan 2001: no page numbers).

Mrayyan (2003:327) has accentuated the vital role of nurse managers in influencing registered nurses' autonomy, work environment and quality of working life, and in facilitating nursing care.

CONCLUDING RELATION STATEMENT WITH REFERENCE TO THEME TWO: NURSING PROCESS PERCEIVED AS LABOUR INTENSIVE

The nursing process is the method used by registered nurses to solve patients' problems. It consists of a certain number of steps and procedures which have to be followed in order

to utilize the process correctly and professionally. Factors such as that the process is time consuming and lengthy is a fact. Patient numbers are on the increase and this factor together with other factors in the field of staffing do result in a shortage of staff. The only way that registered nurses can utilize the nursing process in spite of all these factors, is to utilize their time and energy wisely. That requires from registered nurses to work smarter not harder (See figure 1 (Reasoning map) page 91, figure 6 (Dynamics (interactive facilitation) page 114 and figure 8 (An educational programme to internalise and operationalise the nursing process) page 133 session 1).

3.3.3   THEME 3: OPTIMUM UTILISATION OF THE NURSING PROCESS IS DETERMINED BY COGNITIVE IMPEDIMENTS

Utilisation of the nursing process requires scientific knowledge, clinical problem-solving skills and a positive attitude towards the nursing process. Scientific knowledge facilitates critical thinking skills that are appropriate to the demands of contemporary nursing practice. Cholowski and Chan (2004:85) are of the opinion that clinical problem solving in nursing is based on the nursing process. In this, prior and interconnected knowledge play an immensely important role.

The scope of practice as identified in the regulations outlines the role of the registered nurse clearly by referring to acts that are performed by the scientifically based physical, chemical, psychological, social, educational and technological means applicable to health care practice (Government Gazette 2040:65). This undoubtedly makes it clear that

registered nurses have to be competent in utilising the nursing process because it is the only way in which the scope of practice can be adhered to.

The following category emerged from this theme:

- > **Lack of in-service education**

Although in-service education training sessions on the nursing process were provided, there are logistical impediments, such as the shortage of staff and time, which prevent nurses from attending these sessions. The lack of in-service education results in nurses having difficulty in understanding the nursing process, which results in an inability to apply it to guide students.

A participant expressed her need for in-service education :

"Al word indiensopleiding gehou, dan is ons miskien tekort in die staff, en dan kan jy nie daai indiensopleiding gaan bywoon nie." (Even if in-service training is given, we might have a shortage of personnel and the in-service training cannot be attended.)

Another participant emphasises the need for in-service education:

> *"… sal bly wees as al die registered nurses indiensopleiding kry dat ons dit verstaan"* (will be glad if all registered nurses can get in-service training so that we can understand it.)

Participants found the nursing process difficult to understand and not all registered nurses who participated in the study had been trained to use the nursing process. For some it had taken a great deal of effort on their own part to apply it. It may have been that nurses had been trained abroad where teaching of the nursing process had not been part of the particular curriculum or that they had not worked in hospitals where it was applied in practice. It may also have been that registered nurses had trained before the introduction of the nursing process. The following statements emerged from the data:

> *"… in baie gevalle, weet jy self nie wat om te skryf nie."* (in many instance you don't know what to write.)

If one does not understand something then it is difficult to apply it. If nurses have no knowledge of the nursing process, they will not be able to apply it. During the interviews, it was rightfully pointed out that the nursing process is lengthy. It takes time to apply all the steps correctly and to document the care meticulously. In the interviews with some of the participants a lack of knowledge was evident. The following statements bear witness to this:

> *"… al wat ons insit is daai vraelys, maar die nursing care plan self is 'n probleem"*

"Die dokter se diagnose maak jou soms deurmekaar – skryf query, query, query." (The diagnosis made by the doctor tends to be confusing – writes query, query, query.)
"Sometimes we don't actually know the problem."
"… iemand kom in wat geaborteer het … het nie klagtes nie …bloeding het gestop, het nie pyn nie. Hoe begin jy dan nou met 'n plan vir so 'n pasiënt?" (Somebody is admitted with abortion … does not have complaints … bleeding has stopped, has no pain. How do you now start with a plan for this patient?)

In a study by Erhenberg and Ehnfors (1999:65) on the patient problems, needs and nursing diagnosis reflected in Swedish nursing home records, it was suggested that nurses still direct nursing care from the viewpoint of the medical diagnosis instead of demonstrating independence and autonomy in planning and performing care. In this study evidence of a similar situation was clear:

"Ek gee vir iemand 'n probleem wat sy nie vir jou gesê het nie." (You give a problem to someone that she did not mention to you.)

Lack of knowledge and difficulty in applying the process necessarily result in difficulty in guiding students. Registered nurses have a teaching responsibility as student nurses are allocated to clinical practice to learn the art of nursing. If registered nurses do not have

the time or the knowledge to guide students in the application of the nursing process, the vicious circle of non-utilisation of the nursing process will continue. The following statement emerged from the data:

"… but the first-year students, … sometimes you neglect them, … they don't really get somebody to lead them, … you just rush with your routine, you are behind" "… sometimes I regret I didn't pay attention to them, the students (sic) and I still feel guilty."

> **The nursing process includes repetition**

The results revealed that some participants experience the nursing process as merely record keeping. This is evident from the following statement:

"You just repeat, repeat, repeat the things in the same time, but I think it's not necessary here because it is just repetition with the report you write already and the whole nursing process."

The records nurses keep and the documentation of the nursing care given and the responses of the patient to such care are an indispensable part of the communication system as it relates to patient care. However, to be able to record information and the actions taken with regard to patients, the phases of the nursing process should be followed. Record keeping cannot be separated from the nurse-patient relationship.

Therefore the role and function of the nurse in this relationship is a vital means of communication (SA Nursing Association 1994:4).

The nurse should maintain a definite relationship with the patient. This relationship is characterised by communication and interaction and through this the nurse will become aware of the patient's needs. Knowing the patient and his needs does not entail repetition; it means that the nurse observes the patient's needs, which are constantly changing for the better or the worse, and accepts responsibility for initiating action directed at improving the patient's health.

> **The nursing process is not relevant**

In the nursing profession it is assumed that theory and practice should be correlated. The nursing process is taught in theory and it should be applied as such in practice. Participants mentioned that what is taught in theory cannot be applied in practice as it is not relevant. One participant stated:

"Die saal bly altyd net vol, en is dit prakties nie moontlik nie om vir elke pasiënt daai nursing care plan voor te skryf nie." (The ward just remains full and it is not possible to write a care plan for every patient.)

Although it is true that wards are full and nurses cannot sit down for hours to write a nursing care plan, the utilisation of the nursing process can be done in many ways. What is of importance is that the principles of the different stages are applied.

Although the nurses are busy, the continuum of nursing practice may be exploited with strategies that arouse curiosity and may challenge the registered nurse to do the best she can under difficult circumstances. In this regard the importance of prioritisation and relevance cannot be overemphasised. According to Rogers in Quinn (2000:55) theoretical concepts like the nursing process should be framed by the context of the real world – the busy hospital ward. Instead of sitting for long hours writing a nursing care plan, the needs of patients could be prioritised and dealt with. Furthermore, decisions on patient care should follow after the patients' needs have been prioritised.

The nursing process is part of the curriculum of the registered nurse and nurses should be able to integrate the theory in this regard into their daily practice. However, to be able to do this the environment should be conducive for doing so. The role of the first line manager in this regard is important and, according to the humanistic approach, is regarded as that of helper and facilitator (Mashaba & Brink 1994:130).

The role of the first line manager may be seen as a facilitator, that is, in utilising the nursing process. A facilitator does not intervene or act on behalf of the professional nurse, but enables action without stifling performance. The facilitator anticipates, assists, reassures and encourages as a professional equal, smoothing the path and oiling the

machinery. The best facilitators are barely noticeable, particularly in group activities (Mashaba & Brink 1994:130).

Integrating theory into practice and prioritising nursing activities are part of the decision-making process. It has been argued that the nurse's willingness and ability to generate alternatives is crucial to the process of decision making, prioritising and integrating theory into practice, and utilising the nursing process.

The integration of theory and practice cannot be over-emphasised. The question that needs to be answered is: How can we prepare nurses better to apply the nursing process in practice? The answer remains that the environment in which nurses work must improve in order for them to grow and develop continuously (Billingham 2003:22).

CONCLUDING RELATION STATEMENT WITH REFERENCE TO THEME THREE: OPTIMUM UTILIZATION OF THE NURSING PROCESS IS DETERMINED BY COGNITIVE IMPEDIMENTS

nursing process. This result in negative responses such as that the process includes repetition and that it is not relevant. If registered nurses have the knowledge and skills, then the utilisation of the nursing process follows spontaneously and easily. It was therefore imperative to assist registered nurses through the programme and guidelines to utilise the nursing process as prerequisite for effective nursing care process (See figure 1 (Reasoning map) page 91, figure 6 (Dynamics (interactive facilitation) page 114, and

figure 8 (An educational programme to internalise and operationalise the nursing process) page 133 session 3).

3.4 SUMMARY

This chapter described the results and the literature control. This phase of the research helped the researcher to come to understand the phenomenon as an insider.

The data analysis was based on Tesch's method of open coding and the themes and categories identified were described in detail. The three themes and the categories that emerged included the following:

- Registered nurses experience the nursing process as esoteric. The categories that led the researcher to identify this theme were that it was perceived that there was no need for the nursing process, the nursing process involves repetition and it is not relevant. The researcher envisaged that a reframing of the belief system and attitudes of registered nurses had to be addressed in the educational programme and guidelines.
- Nurses experience the nursing process as labour intensive. The categories identified under this theme were that the nursing process was time consuming and lengthy, staff shortages hamper the utilisation of the nursing process and there is no support from management as far as the utilisation of the nursing process is concerned. This would necessitate that registered nurses be assisted to work smarter not harder.

- Optimum utilisation of the nursing process is determined by cognitive impediments. This category entailed a lack of in-service education for utilising the nursing process. Registered nurses should therefore

The essence identified here was that the nursing process was not utilised and that registered nurses blamed external factors for this. The researcher also discussed the literature that was reviewed and placed the results within the context of what was already known about the topic. These results facilitated the generation of an in-service education programme for the gynaecology wards.

In the following chapter the conceptual framework for the study will be described.

CHAPTER 4

CONCEPTUAL FRAMEWORK

4.1 INTRODUCTION

In the previous chapter, the results of the data from the in-depth interviews with the participant registered nurses on the utilisation of the nursing process were presented. All interviews were transcribed verbatim and the transcripts were then analysed using the open coding method. This is an inductive, qualitative form of analysis in which themes are systematically identified from the data. It was chosen as the method of analysis because it is a systematic approach and its procedures have been clearly described. Registered nurses' experiences in the utilisation of the nursing process were sought and explored. Results were reported according to a theme and category scheme.

The purpose of this chapter is to conceptualise the empirical findings shown in table 2 on page 62 (Themes and categories) as phase 2 of the study with the ultimate aim of developing guidelines to implement an educational programme to internalise and operationalise the nursing process in the gynecology wards of the training hospitals in Namibia. The description of this chapter was done in accordance with the reasoning map.

4.2 REASONING MAP

The reasoning map used in this research, which refers to a structure of concepts, is that of Dickhoff et al. (1968). Chinn and Kramer (1995:69) define conceptual as "pertaining to

concepts" and framework implies features of a structure or network. The conceptual framework reflects the thinking map of Dichoff et al. (1968).

4.3   CONCEPTUAL FRAMEWORK

Dickhoff et al. (1968:433) are of the opinion that a theory is a conceptual framework invented for some purpose. The three essential ingredients of this theory are: 1) goal content specified as the aim for activity; 2) prescriptions of activity to realise the goal content; and 3) a survey list to serve as a supplement for presenting prescription for activity towards goal attainment.

For the purpose of this study, the activities that Dickoff et al. (1968:433) include as the survey list in their situation-producing theory were used to describe the framework for conducting the study. This survey list encompasses context, agent, recipient, dynamics, procedure of the activity and terminus. According to Meleis (1991:169) the survey list should respond to six crucial questions for prescriptive theory:

1.   Who or what performs the activity? (Agency)

2.   Who or what is the recipient of the activity? (Patiency or recipient)

3.   In what context is the activity performed? (Framework or context)

4.   What is the energy source for the activity? (Dynamics)

5.   What is the guiding procedure, technique, or protocol of the activity? (Procedure)

6.   What is the end-point of the activity? (Terminus)

The use of reasoning maps is a powerful and useful approach for modelling knowledge and qualitative reasoning. Thus, a reasoning map is a structure of concepts for a specific domain (Alejandro, Humberto & Agustin 2005:no page numbers).

Figure 1: Reasoning map

(Dickhoff et al. 1968:438)

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┌─────────────────────────┐          ┌─────────────────────────┐
│         Agent           │◄────────►│       Recipient         │
│       Researcher        │          │     Registered nurse    │
└─────────────────────────┘          └─────────────────────────┘
                    │            │
                    └─────┬──────┘
                          │
              ┌────────────────────────┐
              │        Context         │
              │   The gynecology wards │
              │   Nursing Council      │
              │   Nursing Act and      │
              │   Regulations          │
              │   Constitution         │
              │   Ethics               │
              └────────────────────────┘
                          │
              ┌────────────────────────┐
              │       Procedure        │
              │  Guidelines to implement an │
              │  educational programme to │
              │  internalise and       │
              │  operationalise the nursing │
              │  process               │
              └────────────────────────┘
                          │
              ┌────────────────────────┐
              │       Dynamics         │
              │     (Interaction)      │
              │  Reframe the belief system │
              │  and attitudes         │
              │  Work smarter not harder │
              │  Nursing process       │
              │  prerequisite for quality care │
              └────────────────────────┘

              ┌────────────────────────┐
              │       Terminus         │
              │  Internalisation and   │
              │  operationalisation of the │
              │  nursing process.      │
              └────────────────────────┘
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4.3.1   AGENT: RESEARCHER

Figure 2: The agent: researcher

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                    ┌─────────────────────┐
                    │                     │
                    │   Agent: researcher │
                    │                     │
                    └─────────┬───────────┘
          ┌──────────────────┼──────────────────┐
┌─────────────────┐ ┌─────────────────┐ ┌─────────────────┐
│                 │ │ Clear clinical  │ │ Characteristics │
│  Interpersonal  │ │      role       │ │ of empowerment  │
│  relationships  │ │                 │ │   and support   │
└─────────────────┘ └─────────────────┘ └─────────────────┘
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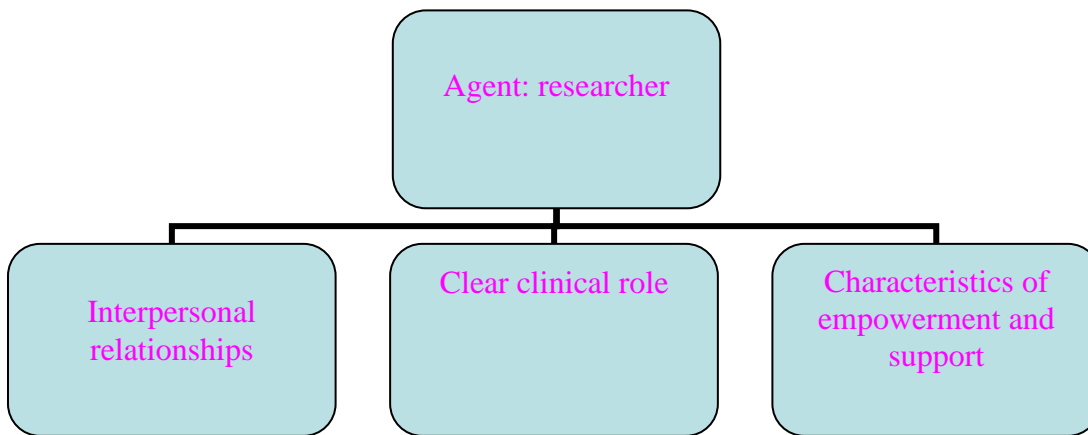
For the purpose of this study the researcher is the agent who has to provide the activity, namely the educational programme and guidelines, for operationalisng the nursing process. This requires, firstly, that she possess the personal qualities needed to build good interpersonal relationships with the recipients, namely the registered nurses. Secondly, being a nurse lecturer, she should have a clearly identifiable clinical role in guiding and supporting registered nurses in the clinical setting.

From the data analysis it became clear that registered nurses need guidance and support. This was evident in their experience of the nursing process as an esoteric activity with

little relevance for their professional practice and in their perception of the nursing process as labour intensive.

An agent is a person who creates awareness among service providers of the acceptable quality of services by providing access to services, maintaining integrity and dignity, providing information and maintaining responsibility for patients/clients.

Cherry (1991:302) is of the opinion that an agent is a person whose presence has a positive effect on something such as a programme. This statement correlates with the fact that the researcher of this study is the agent who provided the activity, that is, developed a programme to guide the registered nurse (the recipient) in the utilisation of the nursing process programme.

In providing the activity, that is, the educational programme to facilitate the utilisation of the nursing process, the agent should have certain personal qualities that enable her to do so. One of the personal qualities that the agent should have is the ability to build good interpersonal relationships with the recipients (registered nurses).

In terms of relationship with others the agent should be able to

- establish and maintain positive relationships based on mutual trust

- work collaboratively

- accept compromises when appropriate

- communicate effectively

- listen to problems encountered by recipients (registered nurses)

The agent, who in this case is a nurse lecturer, should have a clearly identifiable clinical role, together with the clinical ability to guide and support the registered nurses in utilising the nursing process. Girot (1993) as cited by Humphreys, Gidman and Andrews (2000:312) indicates that a clearly identifiable clinical role for nurse lecturers, together with clinical ability, are essential features of the nurse lecturer's role, and are an indicator of high quality nurse education. Advanced nursing practice is characterised by depth and breadth of knowledge in a nursing specialty and the ability to incorporate knowledge in teaching and nursing practice. The advanced nurse practitioner guides the practice and critical thinking of nursing and incorporates scientific knowledge into practice (Scope and standards of nursing practice 2005:5). Therefore the programme had to be of such a quality that it would motivate the registered nurses to make a difference in the utilisation of the nursing process. Smith and Morgaine (2004:263) argue that professionals are practitioners who contribute to the wellbeing of others by basing their work on a body of specialised knowledge and using practical applications of specialised knowledge such as the nursing process as a basis for their work.

Furthermore, the possession of certain characteristics by the agent that will empower and support the process is mandatory. These characteristics are:

- **Competency**. According to Cook (1999:1) the agent has to have expert clinical knowledge and skills for her role as lecturer and for that of guiding and supporting the registered nurse in facilitating the utilisation of the nursing process.

- **Open-mindedness**. The open-minded agent has a firm view of her beliefs yet is open to the views of others without compromising the patient's safety (Sellman 2003:17).

- **Empathy**. This is an essential characteristic in relationships with colleagues as well as with patients. Empathy allows the agent to recognise and to some extent share the emotions of others and to understand the meaning and significance of particular behaviour (Glanze, Anderson, Anderson, Urdang & Swallow 1986:392).

- **Justice**. Marriner-Tomey (1990:34) holds the opinion that this characteristic stands in a direct relationship with the provision of the best possible care for all and the freedom of choice on the part of the registered nurse and the consumer.

- **Logical reasoning**. The agent should be a role model for the cognitive skill of logical (deductive) reasoning (Lumney 2006:1). This is of particular importance in the application of the nursing process because it implies the transforming of knowledge from past experiences and adapting it to another type of situation.

- **Perseverance.** Courage and perseverance are the primary determinants of professional success. Perseverance gives the agent the clarity to know what is right and to keep on doing the right thing irrespective of obstacles (Tye 1997:1).

- **Trust and respecting relationships**. Trust is the foundation of all successful interpersonal relationships. It implies the ability on the part of the agent to join with the registered nurses in overcoming the doubts and the unknown, among other

things, with regard to the utilisation of the nursing process (Building trust in the workplace: a valuable topic for leadership training 2006:1).

- **Courage, commitment and confidence**. The agent has to be courageous which implies that she should be an example of not giving up easily. Commitment implies providing the "extra" to meet the needs not only of patients but also of colleagues. To be confident implies that the agent has to value her own strengths and to be open to opportunities for improvement (Rinaldi 1989:1; Satkowski 2006:2; Bulley 2006:1).

Of further importance for this study is the fact that the researcher as agent was trained as a professional nurse during the 1960s when the nursing process had not yet been introduced into practice and into teaching. This made it a great challenge for her to carry out a study on this important aspect of nursing in such depth that the researcher, students and registered nurses could benefit from it. The researcher furthermore regards it as an honour to give something back to the Namibian population amongst whom she has had the privilege of working for so many years.

At the time of conducting this study, the researcher is tutor to third-year students registered for the Diploma of Comprehensive Nursing and Midwifery Science. The researcher is therefore responsible for teaching the theory and practice of the operationalisation of the nursing process to registered nurses of the future.

As members of a profession, teachers, clinicians, researchers and administrators have a responsibility to contribute in some substantial manner to the development of a nursing knowledge base. In today's world of health care delivery one's ability to contribute tends to be tempered by the pragmatic realities of a shrinking economy and competition for resources (Grossman & Hooten 1993: 866).

CONCLUDING RELATION STATEMENT CONCERNING AGENT: RESEARCHER

The agent, here the researcher, is the person who provides the educational programme for internalising and the guidelines for operationalising the nursing process in the gynaecology wards of the training hospitals of Namibia. This requires establishing a special relationship with the recipients. It furthermore requires characteristics of competency, open-mindedness, empathy, justice, logical reasoning, perseverance, trust, respectful relationships, courage, commitment and confidence.

The development and description of the educational programme for internalising, and guidelines operationalising the nursing process by the researcher was a unique contribution to nursing knowledge.

4.3.2   RECIPIENT: REGISTERED NURSE IN A CLINICAL SETTING

Figure 3: Recipient: registered nurse in clinical setting

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              ┌─────────────────────┐
              │ Recipient: registered│
              │   nurse in clinical  │
              │       setting        │
              └─────────────────────┘
          ┌───────────┼───────────┐
┌──────────────┐ ┌──────────────┐ ┌──────────────────┐
│ Professional │ │ Professional │ │ Professional values│
│ relationships│ │characteristics│ │                  │
└──────────────┘ └──────────────┘ └──────────────────┘
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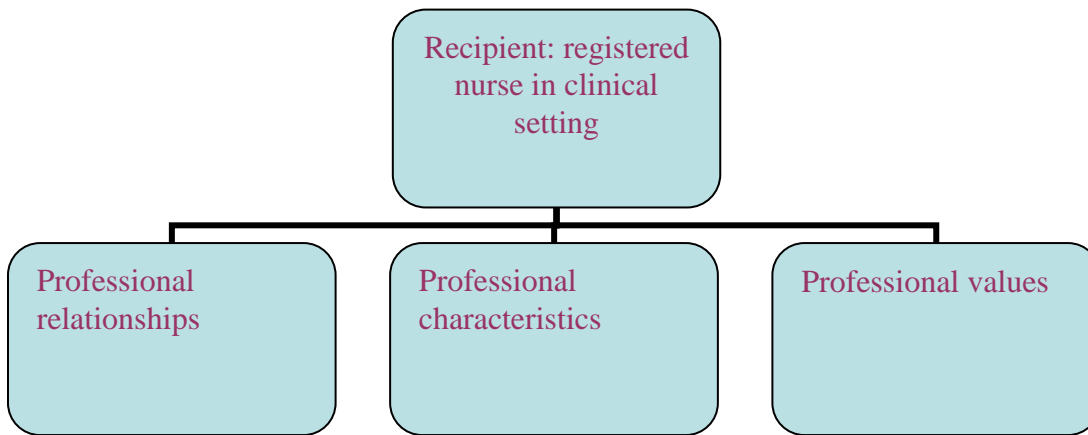
Recipient is defined as a person who receives (*Collins Concise Dictionary of the English Language* 1985:956). According to the thesaurus a recipient is the beneficiary of something, an addressee, a receiver. From the results of the data analysis it was clear that the registered nurse lacks knowledge and skills pertaining to the nursing process. For registered nurses to be the recipients of the educational programme and the guidelines for implementing the programme, they need to revisit their professional day-to-day

relationships, the characteristics that are required from her to internalise and operationalise the nursing process and the professional values needed to be committed to applying the knowledge and skills pertaining to the nursing process.

In this study the nurse practitioners in the gynaecology wards of Namibian training hospitals were the recipients of the activity, namely the programme for the utilisation of the nursing process. The recipients are registered nurses who may also be first line managers (supervisors).

The purpose of the programme was to empower the registered nurses to utilise the data from the study, which emanated from the nurses themselves. The frequently changing practical situation means that practitioners do not always have the competence, or the knowledge, to respond to its uniqueness. Consequently they have to learn in and from practice.

It became clear that nurse practitioners experience some negative effects as a result of having to utilise the nursing process. Many changes have taken place in the nursing environment, such as the restructuring of services and the effects of HIV/AIDS on the Namibian population that they serve and on their colleagues and on their own lives and those of their families. Yet, listening to their "stories" related in the in-depth focused interviews, it would seem that they had not experienced any of the support from nurse managers or the Personnel Development Department that one would have expected even given reasonable circumstances.

In this study the nurse practitioner was viewed as being a partner in many relationships – with the doctor, the patient, the sub-professional nurses, the managers, the researcher/ lecturer, the students, the registered nurses from the Personnel Development Department and colleagues – and in each of these relationships she played a unique role. These relationships were not static, but involved ever-changing roles and interaction to which the nurse practitioner had to constantly adapt – mostly unknowingly.

The recipient should possess certain characteristics, which may facilitate the utilisation of the nursing process:

- **Curiosity**. The registered nurse uses intellectual curiosity, cognitive knowledge and critical thinking, and sound reasoning through the use of the nursing process to facilitate a patient's progress towards optimal health.

- **Organisational skills**. Without organisational skills, a registered nurse will not be able to manage herself and her time wisely.

- **Enthusiasm**. Without the quality of enthusiasm a registered nurse cannot strive to improve her clinical skills despite the many aspects that influence the environment negatively.

- **Emotional intelligence**. This characteristic goes hand in hand with self-awareness. These two qualities are important for ongoing development.

- **Motivation**. This characteristic is a combination of desires, values and beliefs that drives the registered nurse to take and maintain action.

- **Responsibility**. The application of the nursing process is one of the professional responsibilities of a registered nurse.

- **Accountability**. Registered nurses are accountable for their own professional practice. The profession is regulated by the Nursing Council of Namibia, which is set up by Parliament to protect the public by ensuring that nurses provide high standards of care for patients and clients.

- **Good interpersonal relationships and communication**. Good interpersonal relationships are critical for sound leadership in the nursing process and are based on effective and open communication.

CONCLUDING STATEMENT CONCERNING RECIPIENT: REGISTERED NURSE IN CLINICAL SETTING

Professional registered nurses practise within organisations that have goals, values and mission. Integration into an organisation's value system and identification with organisational goals means that employees should develop similar feelings about the adequacy and quality of performance and the nursing process.

The formal structure of an organisation may value quality health care, but the behaviour needed to provide quality care is based on the attitudes and values of the employees – in this case the professional nurses.

Since it was concluded that one of the reasons why the nursing process was not utilised is because of internal factors such as a negative attitude, it will be necessary to reframe the belief system of the registered nurses (recipient).

4.3.3   CONTEXT: GYNAECOLOGY SETTING

Figure 4: Context – gynaecology setting
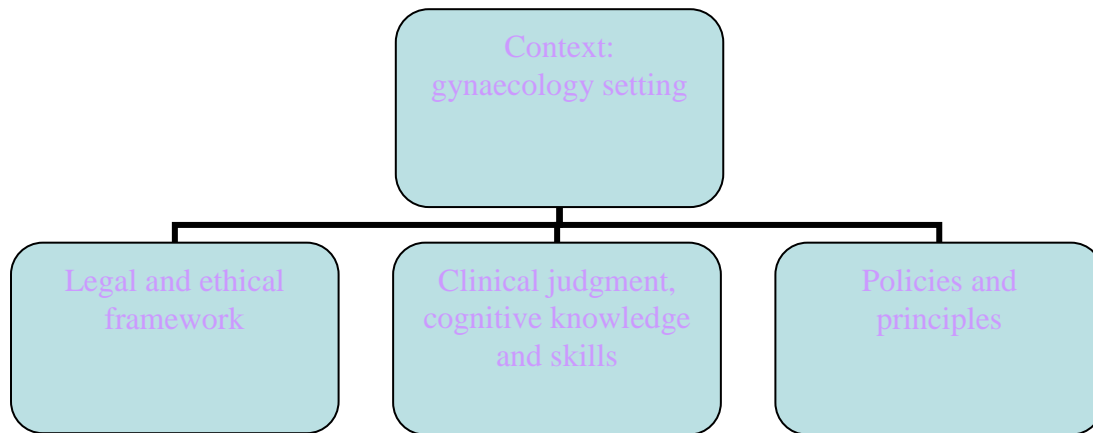
"Work settings where learning is part of the culture and structures are in place to provide support and learning opportunities either formal or informal, (then) everyone gains" (Spouse 2001:13). Since the study is contextual in nature, data were obtained from the

registered nurses in the gynaecology wards and the educational programme and guidelines were developed and described for this context only.

According to the thesaurus (computer tool), context is a situation, a framework, a milieu, an environment or a background. For the purpose of this study, the context was defined as an environment or a milieu consisting of the gynaecology wards (clinical setup) of the training hospitals where the study was conducted, as well as the legal and ethical framework within which the nursing process should be utilised, the clinical judgement, knowledge and skills that the registered nurses require to operationalise the nursing process, and the policies and principles of the organisation.

The Nursing Council of Namibia is a statutory body governed by the Nursing Act (Act No. 8 of 2004) and has the responsibility for regulating the education, training and practice of nurses. The Nursing Council advocates the utilisation of the nursing process to ensure quality of care.

The importance of the clinical setup where nursing care is rendered cannot be over-emphasised. The practice of professionals in clinical settings comprises clinical judgements, laws, policies, knowledge, skills, principles, the use of specialised skills and the acceptance of the patient as an autonomous being with his or her own inherent rights (Reilly & Oerman 1985:1).

Professional nurses practice within a legal and ethical framework that has an impact on the quality of nursing care and subsequently on health care services.

Constitution of Namibia

The Constitution of Namibia protects the human rights of patients, that is, dignity, physical integrity and privacy of all Namibians. It is therefore important to practise nursing sensitively and to constantly ensure an improvement in the services rendered.

Patient charter

According to the patient charter each patient should be examined and treated as soon as reasonably and practically possible.

Professional body

The professional body that governs the nursing profession is the Nursing Council of Namibia. The Nursing Council is a statutory body that is accountable for the highest standard of nursing care for all people of the Republic of Namibia by upholding professional, social and democratic values in its regulation of the profession. As a quality

assurance body it ensures that the highest quality of ethically based nursing care is rendered to all people in the country.

Professional nurses should therefore be able to assess and meet the health care needs of individuals such as the patients in the gynaecological wards. Furthermore, they should strive to improve the health status of the people through active involvement and participation in terms of the competencies and scope of practice of nurses and midwives. Nurses are expected to practise professionally with independence and autonomy in decision making as far as the nursing process is concerned (Nursing Act No. 8 of 2004) – scope of practice for registered nurses.

Professional values

The registered nurse brings to a situation certain personal values, such as societal laws, culture and prejudices in relation to sex, race and religion, which might cloud or influence her judgement in unexpected ways, irrespective of the techniques in use, such as the nursing process (Henderson, in Field 1987:563).

Operational level

The operational level is where the actual environment conducive to nursing care has to be created by first line managers who are professional nurses, because this environment

influences one's ability to develop professional effectiveness (Leddy & Pepper 1998:46). Thus, the operational level is crucial and challenges first line managers in that they have to see that the nursing process is utilised even under difficult circumstances. Considering the legal and professional implications of the different levels, the professional nurse at the operational level is challenged by the responsibility to create an environment that will facilitate the utilisation of the nursing process.

Using deductive analysis, a concluding relationship statement may be formulated to direct the researcher in developing the programme and describing the guidelines for the context.

CONCLUDING STATEMENT CONCERNING THE CONTEXT

The dynamics involved in utilising the nursing process occur within legal, ethical and professional boundaries at different levels. The implementation of teamwork and the strengthening of support systems will facilitate the utilisation of this process.

4.3.4 PROCEDURE: EDUCATIONAL PROGRAMME AND GUIDELINES

Figure 5: Procedure – educational programme and guidelines

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                    ┌──────────────────────┐
                    │ Procedure:educatio   │
                    │ nal programme and    │
                    │ guidelines:          │
                    │ Reframe belief       │
                    │ system and           │
                    │ attitudes            │
                    │ Work smarter not     │
                    │ harder               │
                    │ Nursing process as   │
                    │ prerequisite for     │
                    │ effective nursing    │
                    │ care                 │
                    └──────────┬───────────┘
        ┌──────────────────────┼──────────────────────┐
┌───────────────┐    ┌──────────────────┐    ┌──────────────────┐
│ Mode of       │    │ Reflective       │    │                  │
│ interaction   │    │ reasoning        │    │ Competence and   │
│ and           │    │ and logical      │    │ effectiveness    │
│ facilitation  │    │ argumentation    │    │                  │
└───────────────┘    └──────────────────┘    └──────────────────┘
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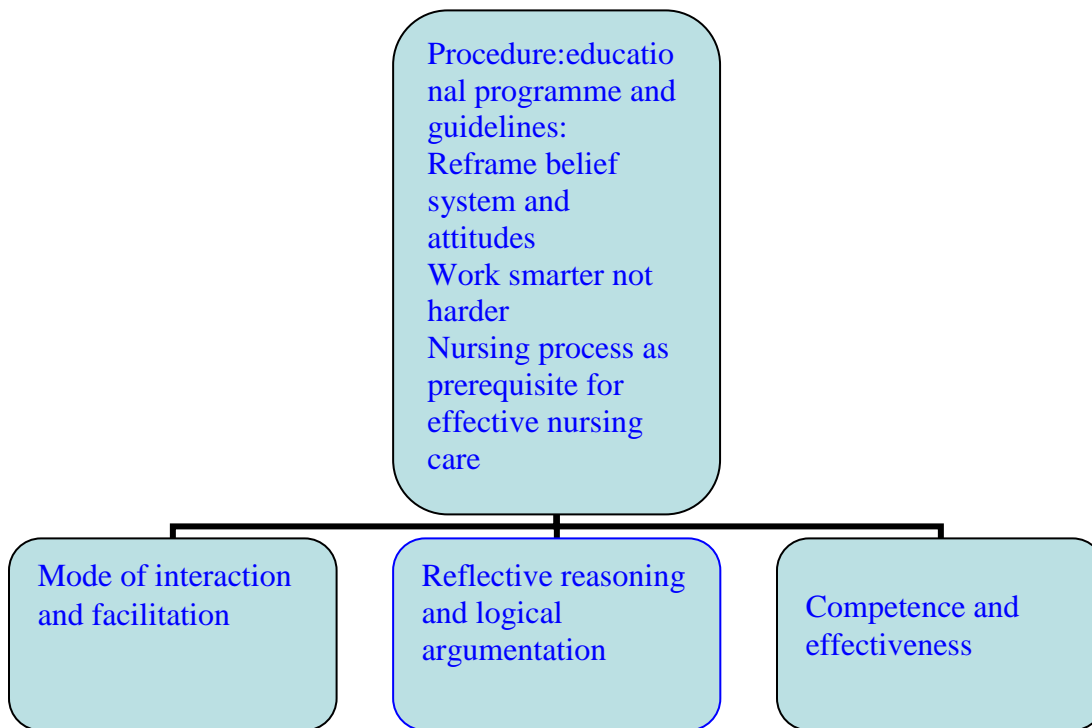
From the results of the data analysis it became clear that the purpose of the educational

programme envisaged for internalising the nursing process and developing guidelines for

operationalising this process is to produce registered nurses who will be able to make rational decisions and solve patients' problems in order to improve the quality of nursing practice. At the functional level, the registered nurse is expected to function independently and autonomously as required by the Nursing Council of Namibia.

The educational programme and the guidelines address the learning needs that were identified from the data analysis, namely, to reframe the belief system and address the attitudes of registered nurses, to ensure that registered nurses work smarter not harder and get nurses to realise that the nursing process is a prerequisite for effective nursing care.

The nursing process is a systematic rational method for planning and providing nursing care. Its goal is to identify the patient's actual or potential health care needs, to make plans to meet the identified needs, to deliver specific nursing interventions to meet those needs and to record every aspect of the process.

The nursing process has a number of important characteristics:

- **The nursing process is dynamic and cyclic.** Each step of the nursing process ends in a product. After assessing the client, the nurse records the findings: thus creating a complete database on the patient. The nursing diagnosis statement is a product of the nurse's cognitive process of diagnosis. On the basis of this nursing diagnosis a care plan is drawn up: the nursing care plan is a product of the planning step. The actual client outcomes resulting from specific nursing interventions are a product of the

implementing step. A statement about the client's achievement of the goal, the outcome evaluation, is a product of the evaluating step.

- **The nursing process is client-centred.** The care plan is organised in terms of patients/clients' problems rather than nursing goals.

- **Nursing care is individualised**. The nursing process model suggests that nursing action is individualised through specific nursing actions directed by the etiology component of the nursing diagnosis.

- **The nursing process is planned and goal directed.** Interventions are carefully considered on the basis of principles rather than tradition.

- **The nursing process is universally applicable**, because it can be used on any patient with any diagnosis.

- **The nursing process is problem-orientated.** This means that care plans are organised according to patient problems.

- **The nursing process is a cognitive process.** It involves the use of intellectual skills in problem solving and decision making. Critical thinking skills are used to apply nursing knowledge systematically and logically to patient data to determine its meaning and plan appropriate care. Nurses must also be able to function independently when they provide nursing care.

Making a nursing diagnosis is an independent function of the professional nurse. It includes those activities that nurses initiate and perform under their own professional licence. Interdependent functions are those functions that the nurse performs under the

direction of a physician or other member of the health care team (Ziegler et al. 1986:2; Wilkinson 1996:6, 7).

THE STEPS IN THE NURSING PROCESS

Phase 1: Assessment

This phase entails the registered nurse collecting certain information from the patient. It comprises several steps, namely data collection, verification, organisation, interpretation and documentation (Seaback 2006:7).

Phase 2: Diagnosis

Diagnosis entails the classification of the patient's responses. It is based on scientific evaluation of data, diagnostic studies, and signs and symptoms (Seaback 2006:7).

Phase 3: Planning and outcome identification

This phase involves the formulation and documentation of the care plan. It involves prioritising the nursing diagnosis, identifying goals and expected outcomes, and determining nursing interventions that will aid in the resolution or prevention of each problem (Seaback 2006:8).

Phase 4: Implementation

Implementation involves carrying out the nursing care plan and continuous assessment of patient's condition before, during and after each intervention has been carried out. Implementation includes activating the care plan, carrying out planned interventions, doing ongoing assessment as interventions are carried out, and recording and documenting the care provided, the interventions carried out and the client responses (Seaback 2006:10).

Phase 5: Evaluation

Evaluation involves the nurse determining whether the goals were met, partially met or not met. During their daily practice professional nurses continuously assess and evaluate the patients' progress and the decisions that have been made, and this plays an important part in nursing care. Decisions made should be reliable, valid, practical and complete because it is the life of a patient that is at stake.

QUALITIES NEEDED FOR THE SUCCESSFUL USE OF THE NURSING PROCESS

Intellectual (cognitive) skills

The care that nurses plan for patients is based on facts that are continuously collected and analysed throughout the nursing process. Skills vital for this process include critical thinking, problem solving and decision making (Lumney 2006:1).

Interpersonal skills

The registered nurse should be able to use the nursing process effectively working with and through others. She/he needs to communicate effectively with colleagues and patients to facilitate a successful product through the nursing process.

Technical skills

There are a number of technical skills that the registered nurse requires in the utilisation of the nursing process. These skills include the psychomotor skills needed to carry out procedures and use equipment.

Creativity and curiosity

Problem solving through the use of the nursing process requires the registered nurse to continually develop and implement new and better solutions. Creative thinkers are curious individuals who listen to their curious inner selves and to the ideas and opinions of others.

Adaptability

The utilisation of the nursing process requires more than just cognitive skills of the registered nurse. Attitudes and mental habits are important components of adaptability. Those attitudes and mental habits that increase adaptability include being willing to listen to others' ideas and beliefs, making decisions on the basis of what one has learnt rather than how one feels and the ability to put oneself in another's position.

CONCLUDING STATEMENTS ON THE PROCEDURE

The utilisation of the nursing process will ensure continuity and individualised care for the patient, and will increase client/patient participation. There are also some benefits for the nurse, such as increased job satisfaction, enhanced learning experiences, increased self-confidence and improved standards of practice. The use of this process will also help

people to understand what nurses do within the complex nature of the phenomenon nursing (Wilkinson 1996:13).

Thus it may be concluded that the utilisation of the nursing process is a prerequisite for quality nursing care.

4.3.5   DYNAMICS (INTERACTIVE FACILITATION)

Figure 6: Dynamics (interactive facilitation)
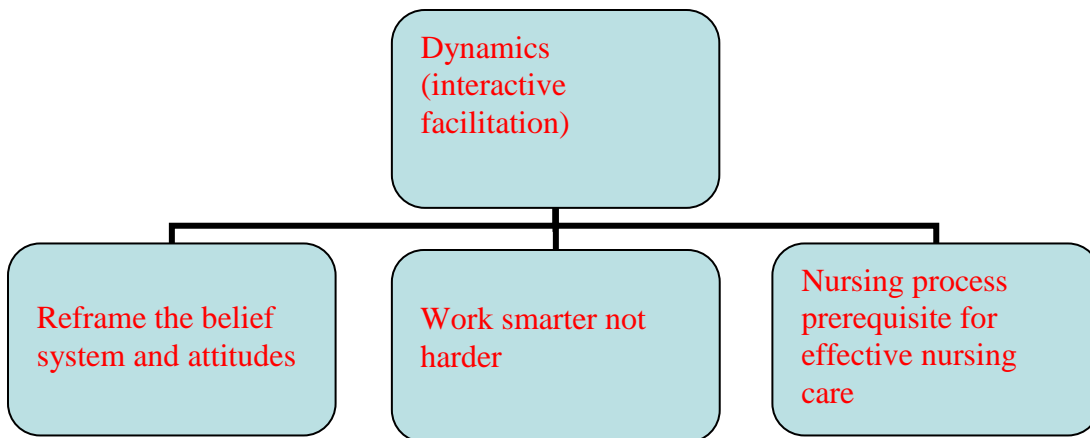
The dynamics for internalising and operationalising the nursing process include the mode of interaction and facilitation to reverse the themes that were concluded in chapter 3,

namely to reframe the belief system and attitudes, to work smarter not harder and to see the nursing process as prerequisite for effective nursing care.

The concept "interactive" may be defined as the state of being mutual, reciprocally active, acting upon or influencing each other (*Concise Oxford Dictionary* 1985:709), while "facilitation" may be defined as something that is enabling, concerned with making things possible for another through a process that makes it simpler for people to achieve their goal (Mellish, Brink & Paton 1998:75).

These two definitions suggest interactive facilitation as a dynamic through which the utilisation of the nursing process may be enabled. It involves mutual and purposeful interaction between colleagues, as well as the professional nurse and patient, in utilising the nursing process.

From the categories and themes that were drawn from the data analysis, it would seem that the reasons for not utilising the nursing process are to a great extent centred on external factors, that is, lack of time, lack of managerial involvement, too many patients, and the fact that it is viewed as a waste of time, as repetitious, and as an irrelevant and esoteric activity. To a lesser extent personal and professional factors were referred to, namely cognitive impediments and negative attitudes, and lack of leadership communication in the utilisation of the nursing process.

MODE OF INTERACTION AND FACILITATION

Communication

The business of professional nursing is communication – communication between the nurse and the patient and between the nurses themselves – because mutual goals cannot be defined or achieved in this relationship without effective communication (Leddy & Pepper 1998:337).

In the nursing process, the patient and the nurse both undergo emotional experiences as a function of the communication process between them. It is therefore important for the professional nurse to clearly understand the power of communication in shaping relationships (Leddy & Pepper 1998:336). The professional nurse not only communicates with patients but also with colleagues in the multidisciplinary health team and with peers. Thus, human beings influence each other primarily through communication, which may be described as the "matrix" for all thought and relationships between people. Interpersonal communication defines our humanity and underpins our personal and professional relationships with other people (Murray & Zentner 1979:62, as cited in Leddy & Pepper 1998:337; Quinn 2000:462).

To utilise the nursing process requires verbal (spoken, written) and non-verbal communication. The purpose of communication is to inquire, to inform, to persuade and to entertain, and the professional nurse may attempt to achieve any of these purposes with patients/clients, the health care delivery system, peers, other personnel and even the self.

In attempting to achieve these purposes the professional nurse transmits certain messages (Leddy & Pepper 1998:339).

Young, Van Niekerk and Mogatlane (2003:292) have identified a number of functions of health communication:

- Diagnosis – which involves obtaining information, interpreting and analysing the information and identifying and solving the problem.
- Gaining co-operation – this involves relationship building in order to obtain compliance and consent from a patient.
- Counselling – this refers to the therapeutic nature of the nurse-patient relationship.
- Education – providing health information.

Taking these functions into consideration it becomes evident how important the utilisation of the nursing process is, because the dynamics of the communication process are the cornerstone of the nurse-patient relationship and relationships with colleagues. If problems are not communicated to each other and to first line managers, how can they be resolved? If there is no proper communication with patients how will it be possible to solve their problems?

Leadership

Leadership in the health professions is a crucial element in the development of a health care practitioner. Leadership is a complex process through which a person influences others to accomplish a mission, task or objective and directs the organisation in a way that makes it more cohesive and coherent (Bennis 2002:1). Furthermore, in fulfilling obligations and attaining goals, the professional nurse must assume the leadership role in many relationships: with peers, as well as with clients/patients. Thus, leadership involves interaction between members of a group that initiates and maintains improved expectations and competence in solving problems and attaining goals (Leddy & Pepper 1993:382).

According to Chapman (2001:55) leaders must develop a capacity for leadership that goes beyond acquiring leadership skills. Leadership capacity refers to the ability of a healthcare professional to lead in difficult situations that were previously unknown. Participants in the study indicated the difficult circumstances under which they sometimes have to provide nursing care, owing to an excessive workload and staff shortages. At these times, first line managers should lead professional nurses through difficult situations by using the nursing process.

First line managers (leader) can demonstrate leadership qualities by empowering their followers, that is, the professional nurses. According to Jooste (2003:217) empowerment refers to a dynamic process of interaction between the follower and the leader. It refers to the use of a person's potential and competencies, the discovery of new expertise, and the creation of new opportunities to apply such competencies. Thus, the health care leader is

in interaction with the environment (context), which includes the management and organisational structures, as well as the followers in the health care organisation.

Foster 2001:324 (as cited in Jooste 2003:217) describes the fundamentals of interaction as follows:

- Mutuality – followers enjoy mutual support.

- Recognition of personal achievement.

- Belonging – individuals need understanding, cohesive and friendly relations.

- Bounded power – the authority, personal accountability, challenges and opportunities for growth inherent in teamwork are strongly evident.

- Creative autonomy – employees enjoy the opportunity to give outlet to their creativity and potential.

It may be assumed that if these fundamentals are adhered to, individuals and groups will be influenced to take an active part in the process of achieving agreed-upon goals; in this case the utilisation of the nursing process, as this is an agreed goal of the health institution.

It could also lead to the development of a personal philosophy of leadership which shows health care professionals how to be whole, how to draw on the deepest dimensions of why they are, how to lead their followers and how to be committed to their work and organisation (Jooste 2003:19)

REFLECTIVE REASONING AND LOGICAL ARGUMENTATION

The use of the nursing process in meeting the health-related needs of patients demands that professional nurses be encouraged to engage in arguments and learn to justify their opinions, facts, thoughts and feelings on the basis of evidence. To develop higher order thinking attitudes and skills, Botes (2000:30) asserts that nurses should make a deliberate effort to seek information that is in opposition to their own views. In this way nurses can develop open-mindedness. Relieving cognitive dissonance involves the critical analysis of thoughts and feelings by examining the components of a situation, identifying existing knowledge, challenging assumptions and exploring alternatives, which is an essential component of interaction (Atkins & Murphy 1993:1997).

COMPETENCE AND EFFECTIVENESS

Taylor (2002:11) cites Potter (1999) when referring to nursing as a unique profession because of its broad focus on understanding and managing a person's health. This makes it essential that nurses are educated and are able to assess the health status of patients and are able to make nursing judgements based on this assessment. This enables nurses to share a common approach to the provision of care.

Within the context of this programme to facilitate the utilisation of the nursing process, the recipients are registered nurses. This means that they are adult learners and as such

are capable of self-directed learning, taking responsibility for their own professional and intellectual development and critical thinking. The interviews delivered rich information on the views of registered nurses pertaining to the difficulties that were experienced when attempting to carry out the nursing process and therefore the scope of practice.

According to Lillesand and Korff (1983:9) the nursing process is the major product of any hospital. As one of the foundations of nursing practice it defines the area of responsibility and accountability of the professional nurse. Its successful utilisation is closely associated with the accountability and competence of registered nurses. Competence is defined by McGregor (1990 in Garrett 1999:40) as the level of knowledge or skill required to function at a given level of practice.

The key to expertise in practice lies both in a person's knowledge and skills. Nursing has always had a strong manual skills component and, to the extent that the nurse is in a role that contains this level of activity, gentleness, speed and accuracy remain hallmarks of excellence.

CONCLUDING RELATION STATEMENTS WITH REFERENCE TO THE DYNAMICS IN THE UTILISATION OF THE NURSING PROCESS

Interaction is a dynamic process, which entails communication, leadership, reflection, reasoning and logical argumentation as well as competence and effectiveness. First line managers must facilitate these qualities, as this will enable professional nurses to see the

importance utilising the nursing process and not to see it as a waste of time, duplication, a routine execution of tasks or labour intensive.

According to Atkins and Murphy (1993:1190), an essential component of interactive facilitation is to engage the registered nurses in the construction of their own clinical knowledge and skills. Because participants indicated by their responses that their workload is too heavy and that they do not always have an understanding of the nursing process, it seems that they should be guided to work smarter not harder.

4.3.6   TERMINUS   INTERNALISATION   AND   OPERATIONALISATION   OF THE NURSING PROCESS

Since the data analysis revealed that the nursing process was not being utilised, the terminus or endpoint of the educational programme has to be internalised and operationalised.

Figure 7: Terminus: internalisation and operationalisation of the nursing process

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                    ┌─────────────────────┐
                    │     Terminus:       │
                    │  internalisation and│
                    │ operationalisation of│
                    │  the nursing process│
                    └─────────┬───────────┘
          ┌───────────────────┼───────────────────┐
    ┌─────┴─────┐       ┌──────┴──────┐      ┌──────┴──────┐
    │  Autonomy │       │ Competence  │      │ Relatedness │
    └───────────┘       └─────────────┘      └─────────────┘
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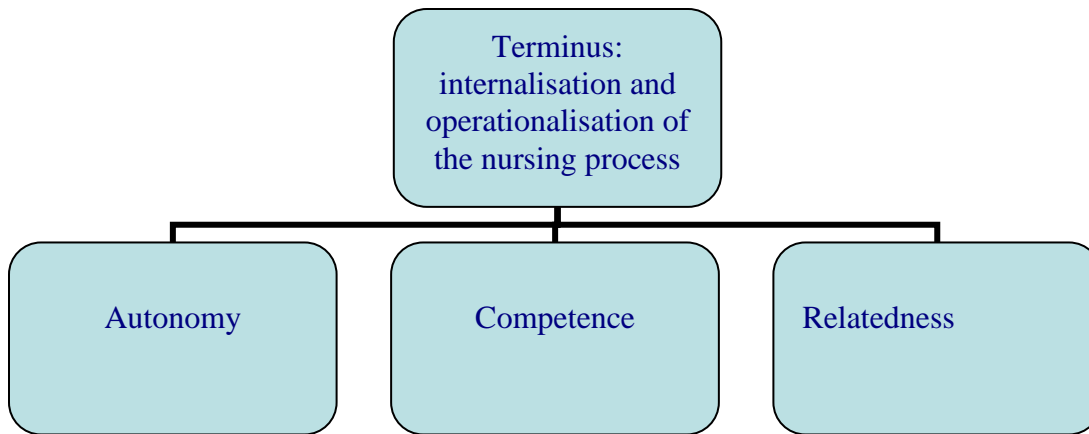
The terminus is the last stop, the end or finishing point. The terminus in this study is that professional nurses should first internalise the utilisation of the nursing process and then make it operational. This internalisation requires autonomy, competence and relatedness. Secondly, there should be ongoing in-service education and backup in this regard.

Internalisation and operationalisation

Internalisation means taking an attitude, belief or behavioural regulation acquired from the environment in which one is socialised and transforming that attitude, belief or regulation into a personal value, goal or principle of organisation (Asakawa & Csikszent-Mihalyi 2000:1). These authors further point out that three factors promote internalisation, namely autonomy, competence and relatedness.

Autonomy may be explained as self-governing. By implication this means when people perceive themselves to be autonomous, they feel free with respect to their own behaviour and feel as if they are in control of their behaviour. As a result of the process of professionalisation, the philosophy of the nurse has come to contain aspects of autonomy and accountability based on a personal and individualised care system (Esterhuizen 2006:104). Nursing is distinctive or autonomous when it is by law accountable to the public and when all career advancement is possible within the profession itself (Searle 1988:150).

Competence refers to an understanding of how to attain intended goals and being effective in activities related to those goals. It could be argued that a person who is competent is more likely to feel in control of his/her situation. Nurses should practise according to certain determined standards and assess their competence in this regard on a regular basis. Accountability for standards of practice is judged by fellow professionals (Robertson & Sanders 2005:4).

Relatedness refers to the experience of feeling connected to others in a social environment. It involves the emotional and personal bonds that people form with each other. By implication this means that if registered nurses feel related to their professional group, they will be more likely to identify with and internalise their beliefs and values.

Ongoing in-service education and strengthening of values

The ongoing development and internalisation of the values of the nursing profession require active involvement by staff development units in health care delivery institutions, because the phenomenon of value formation and the development of professional values appear to mirror the novice to expert model (Schank & Weiss 2001:226).

The socialisation process in nursing education involves the modification of personal values and the internalisation of nursing values. Socialisation is a lifelong process through which a person learns the ways of a group in order to become a functioning participant. This can only be achieved through regular sessions of in-service education. Furthermore, socialisation is a process that produces the attitudes, values, knowledge and skills required to participate effectively as an individual. It is these attitudes and values that are needed to utilise the nursing process.

In a study undertaken by Fagermoen (1997:2) to determine the values underlying nurses' professional identity, the content analysis revealed two types of value, that is, moral and work values. Human dignity and altruism were the most prominent moral values, whereas the most significant work values were intellectual and personal stimulation.

Both moral and work values are important in the utilisation of the nursing process. The patient's dignity must always be respected, no matter what the condition of the patient. While intellectual and personal stimulation are important, there are always new

approaches, techniques and methods that should be used to benefit the patient. In conclusion of this section it may be said that although it is the responsibility of professional nurses to update their knowledge on a regular basis, they should also be assisted by nurses in managerial and administrative positions who imply their acceptance of responsibility for the nursing staff in ensuring that the boundaries of competence and responsibility are not infringed. They should also provide and ensure opportunities for nurses to gain experience and thereby reach a more competent and autonomous stage (Esterhuizen 2006:105). Practice contributes to value formation.

CONCLUDING RELATION STATEMENT WITH REFERENCE TO TERMINUS INTERNALISATION AND THE OPERATIONALISATION OF THE NURSING PROCESS

The health care environment requires registered nurses to have the ability to internalise and operationalise the nursing process. This requires them to modify their professional values through autonomy, competence and relatedness. The internalisation of the nursing profession's values is an ongoing process that requires the involvement of staff development units.

4.4   SUMMARY

In this chapter the conceptual framework of the study was described. The reasoning map that was followed was based on the survey list suggested by Dickhoff et al. (1968:435).

The survey list encompasses a context, agent, recipient, dynamics, procedure and a terminus.

Agent

The researcher is the agent who provides the educational programme for internalising, and the guidelines for operationalising, the nursing process. This requires the researcher to build special relationships and possess certain characteristics.

Recipient

The registered nurse, who works in the gynaecology wards of the training hospitals, is the recipient of the educational programme for internalising, and the guidelines for operationalising, the nursing process. This requires professional values and attitudes in providing quality nursing care through the operationalisation of the nursing process.

Since the data analysis revealed that the nursing process was not being utilised, it became necessary to provide an educational programme to reframe belief systems and attitudes, to assist registered nurses to work smarter not harder and to bring about the realisation that the nursing process is a prerequisite for quality care.

- **Procedure**

The purpose of the educational programme was to produce registered nurses who will be able to make rational decisions and solve patients' problems in order to improve the quality of nursing practice through the internalisation of the nursing process. There are also certain benefits for the registered nurse as an individual, namely increased job satisfaction, learning experiences and self-confidence and improved standards of practice.

- **Dynamics (interactive facilitation)**

The dynamics involved in this programme entail the engagement of the registered nurses in the construction of their own clinical knowledge and skills in order to reframe the belief system and attitudes, work smarter not harder .

- **Terminus: internalisation and the operationalisation of the nursing process**

The terminus is the internalisation and operationalisation of the nursing process in the gynaecology wards of training hospitals in Namibia. This requires a modification of professional values through autonomy, competence and relatedness.

The next chapter is based on the conceptual framework and will deal with the development of a programme to utilise the nursing process.

CHAPTER 5

PROGRAMME DEVELOPMENT

5.1   INTRODUCTION

In the previous chapter the conceptual framework was described in accordance with the reasoning map of the activities included by Dickhoff et al. (1968:433) in their situation-producing theory. These activities involve agent, recipient, context, procedure, dynamics and terminus.

The outcome of the data analysis conducted on the data collected from the interviews with the registered nurses was to bring into being a programme for these nurses to internalise and operationalise the nursing process: this comprised phase 3 of the study. Through this programme the void currently experienced in terms of a sound programme for registered nurses would be filled and an avenue would open up for supporting registered nurses to internalise and operationalise the nursing process.

After analysing the data and formulating a conceptual framework, it was possible to develop a programme on the basis of the needs that emerged from the themes.

5.2 MOTIVATION FOR THE PROGRAMME TO INTERNALISE AND OPERATIONALISE THE NURSING PROCESS

The motivation for a programme to internalise and operationalise the nursing process emerged from the experiences of registered nurses in rendering patient care and during the training and education of student nurses.

The educational programme sessions conducted on the nursing process in Namibian training hospitals are based on needs that have been identified in ways other than from empirical findings, such as by conducting retrospective audits. This does not seem to cover the range of the needs experienced and indicated by the participants as registered nurses.

What registered nurses think they know and what they ought to know are two different things. What they know about the nursing process is sometimes just ad hoc knowledge because some registered nurses were trained in countries where the nursing process was not taught in their curriculum, or in times when the nursing process was not applied as such.

5.3   LEARNING THEORIES

The educational programme for internalising and operationalising the nursing process was based on aspects of cognitive learning theory and Knowles' andragogical learning theory, which were described in chapter 1, page 25-26.

5.3.1   Cognitive learning theories

According to cognitive theory, learning is considered an internal process that involves higher order mental activities such as memory, perception, thinking, problem solving and reasoning (Hand 2006:57). This learning theory includes meaningful discovery learning that occurs as a result of interaction between new information that the individual acquires and the knowledge that the learner already has. This learning theory is appropriate for the implementation of the guidelines since the registered nurses already have existing knowledge, although a knowledge deficit was evident from the study. A further indication for the use of this learning theory was that the researcher could relate the learning to the needs that resulted from the data analysis.

5.3.2   Knowles' andragogical learning theory

According to Knowles (in Bullen n.d.:2), the key characteristics of adulthood are: a) self-directed; b) task or problem-centred orientation to learning; c) internally motivated; d) life experience is a rich source for learning; and e) readiness to learn develops from life tasks

and problems. The process elements of the andragogical model include: a) establishment of a relaxed, collaborative, informal and supportive climate for learning; b) mutual planning, diagnosis of needs, and setting objectives by learners and facilitator; c) use of learning projects sequenced by readiness; d) use of inquiry projects, independent study and experiential techniques; and e) criterion-referenced evaluation by learner and collected evidence validated by peers, facilitators and experts.

Registered nurses, who are the students for whom this programme is intended, are adults and, as such, are encouraged to take responsibility for their own learning. Reece and Walker (in Hand 2006:59) believe that an adult learning theory is highly relevant to professions such as nursing, suggesting that teachers need to provide patient-centred learning that is individualised and appropriate to the patients' needs.

Figure 8: An educational programme to internalise and operationalise

the nursing process

AGENT   **RECIPIENT**

Session 1
Reframe belief system and attitudes

Session 2
Work smarter not harder

Session 3
Nursing process prerequisite for effective nursing care

Session 4
Internalisation and operationalisation of the nursing process

5.4 PROGRAMME TO INTERNALISE AND OPERATIONALISE THE NURSING PROCESS

5.4.1 PURPOSE OF THE PROGRAMME

The purpose of the programme is to provide information sessions and self-activities based on the research findings of this study that will enable the registered nurse in the gynaecology wards to internalise and operationalise the nursing process.

5.4.2 LEARNING AND EXPERIENCE ASSUMED TO BE IN PLACE

Registered nurses have at least the knowledge and experience of nurses who have completed a Diploma in General Nursing and Midwifery Science and they have been practising nursing since registration.

5.4.3 LEARNING STRATEGIES

The learning strategies utilised in this programme are self-directed learning activities. These activities are based on the assumption that registered nurses are adult learners and therefore can implement a self-directed learning strategy because of prior knowledge and experience (Sparling 2001:199).

5.4.4 LEARNING ENVIRONMENT

The learning environment is the gynaecology wards of the training hospitals. Nursing is situational and much of the knowledge needed to practise effectively is situated in the practice itself (Edmund 2001:253).

5.4.5 PROCESS-ORIENTED OUTCOMES

The process-oriented outcomes of the programme were

1   reframed belief systems and attitudes of registered nurses

2   registered nurses who work smarter not harder

3   the nursing process as a prerequisite for effective nursing care

4   the internalisation and operationalisation of the nursing process

5.4.6 LEARNING CONTENT

The learning content is presented for the following sessions:

Session 1: Reframing belief systems and attitudes

- professional conduct

- accountability

- internalisation of professional values

- emotional intelligence

Session 2: Work smarter not harder

- time management and organisation of the self

Session 3: The nursing process as a prerequisite for quality nursing care

- cognitive knowledge on all the phases of the nursing process

Session 4: Internalisation and operationalisation of the nursing process

- taking it all together: reflective practice profile

5.4.7   ASSESSMENT CRITERIA

The registered nurse should be familiar with the assessment criteria for the programme so as to enable her to reach the process-oriented outcomes of the educational programme. The criteria for assessment include the following:

- The registered nurse demonstrates sound and accountable professional practice.
- The registered nurse demonstrates internalisation of essential professional values.
- The registered nurse demonstrates the wise management of work, of herself and of time.
- The registered nurse applies cognitive knowledge in all phases of the nursing process. The registered nurse

➤ collects patient data pertinent to the patient's health needs

➤ analyses the assessment data to determine the nursing diagnosis

➤ identifies goals and expected outcomes for a care plan individualised to the patient's needs

➤ develops a plan that prescribes strategies and alternatives for attaining goals and expected outcomes

➤ implements an identified plan of care

➤ evaluates progress toward attainment of outcomes

➤ records data accurately and according to principles

➤ completes a practice profile that reflects cognitive knowledge applied to improve nursing practice

5.4.7.1 Forms of assessment

The forms of assessment are indicated in each session and in the guidelines discussed in chapter 6 of this report.

5.4.8   PERSONNEL INVOLVED

- All registered nurses working in the gynaecology wards of Namibian training hospital of (Recipient)

- The ward and hospital managers

- The personnel development educators

- The lecturer (researcher who takes the role of agent)

- Any other experts in the area of clinical nursing

5.4.9   FACILITIES

- The clinical ward environment

- Textbooks

- Journal articles

- Stationery

- Nursing process records

5.4.10 PROGRAMME SESSIONS

5.4.10.1   Session 1: Reframing the belief system and attitudes

Session 1 provides knowledge and activities that will enable registered nurses to think differently about professional conduct, accountability and professional values.

5.4.10.1 a Aims and process outcomes

The aim of this session is for the registered nurses to acquire knowledge and explore skills that will enable professional conduct to be enhanced. The process outcome for this session is reframed belief systems and attitudes.

5.4.10.1 b Content

The content includes the concepts of professional conduct, accountability, internalisation and aspects of professional values.

5.4.10.1 c Compulsory learning materials

➢ Read the information on professional conduct, professional values and emotional intelligence on pages 140, 149 and 153 attentively.

➢ Look for any additional learning material on professional conduct and revisit your responsibility and accountability as a registered nurse.

➢ Study the scope of practice of a registered nurse and a registered midwife (Government Gazette 2040, 28 January 1999).

➢ Study any other available information on professional values.

5.4.10.1 d Expected learning outcomes

After reading the recommended material you should be able to

⇨ explore and describe the meaning of accountability for the self

⇨ reflect on your own weaknesses and strengths regarding your professional conduct in the utilisation of the nursing process

⇨ reflect on how you can utilise your strengths regarding your professional conduct to utilise the nursing process effectively in assisting a colleague who demonstrates weaknesses in this regard

⇨ reflect on the actions that you would take to strengthen your weaknesses pertaining to professional conduct and the utilisation of the nursing process

⇨ use the characteristics of the nursing process to internalise values as part of your professional practice

Professional conduct

The registered nurse is responsible and accountable for individual nursing practice. Responsibility means accepting the accountability associated with the performance of one's duties. Nurses are accountable for their own competency and have an obligation to both maintain and improve their skills. Accountability means nurses must explain how they perform their duties and provide reasons why, according to their professional judgement, they omitted actions.

There are certain preconditions for professional accountability. Firstly, the registered nurse needs to be able to carry out her/his obligations independently and this is reflected in the professional judgements she/he makes. These obligations also require knowledge, skills and attitude. Secondly, the registered nurse is responsible for the care that is provided. Thirdly, the right to professional practice is provided through her/his

registration as a professional, which only occurs when such a person qualifies for registration and has proved professional competence (Searle 2004:174).

<u>Activity 1</u>

Before you read further, pause to think about the meaning of accountability. Write down some examples of your obligations and explain how they are carried out.

The following might be an example of one of your obligations and how it is carried out:

- The physician prescribed Pethidine 50 mg 6 hourly intramuscular for pain.

- It is your duty to administer it and you are responsible for your own action.

- The way that you exercise this duty (obligation) includes:

    - Be knowledgeable about the medication that you administer.

    - The Medicines and Related Substances Control Act, No. 13 of 2003, governs the use of narcotics.

    - A prescription record should be kept containing the following essential information:

        ➢ full name and registration number of patient

        ➢ date of the order

        ➢ name of the drug to be administered (written clearly)

        ➢ dosage of the drug (including amount, times or frequency of

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administration)

- ➢ method of administration

- ➢ signature of physician

- Wash hands.

- You and a colleague check the prescription record for the prescription.

- The medication record is checked for the latest dosage the patient received.

- Both of you go to the drug cupboard, unlock it, and take out the pethidine 50 mg ampoules.

- Check the number of ampoules in stock and compare it to the number in the drug register.

- Take an ampoule and read the label of the container and the dosage aloud. Your colleague checks this with you.

- Check the expiry date and fluid for clarity.

- Using the pethidine 50 mg ampoule, antiseptic cotton swab and syringe, draw up fluid and place needles in a receiver; then both of you go to the patient.

- Draw the bed curtains for privacy.

- Check the patient's identity on the identification bracelet against that on the prescription record.

- Assess patient's physical status.

- Open the ampoule and draw up 50 mg.

- Expel excess air.

- Explain the procedure to the patient.

- Choose a site free of skin lesions, tenderness, or swelling that is appropriate

to the amount of medication; locate and clean the site (e.g. dorsogluteal or deltoid site)

- Holding the syringe with the dominant hand, pierce the skin at a 90º angle and insert the needle into the muscle.

- Aspirate by holding the barrel of the syringe steady. If blood appears, withdraw and discard the syringe and prepare a new injection.

- If blood does not appear, inject pethidine slowly.

- Withdraw the needle quickly and massage the site.

- Make the patient comfortable.

- Wash hands.

- Record the procedure on the medication record and in the drug register.

- Discard the needle according to the "Sharps policy".

- Evaluate the patient's response to the drug, such as relief from pain, or any adverse effects, and record as interim entry in progress record.

Activity 2

Now, pause and reflect on the accountability of the registered nurse with regard to the assessment of the patient who has to receive Pethidine before giving the injection.

The vital signs, in particular the respiratory status.

To understand the implications of professional conduct, it is essential that nurses recognise their professional accountability. This requires nurses to understand their responsibility to themselves and to other parties, namely, the patient, employer and health team members. Searle (2004:194) describes certain elements that should be present in the professional conduct of the registered nurse as well as in that of the employer. (In this text registered nurse also means registered midwife.)

The registered nurse assumes accountability for competence in nursing practice and functions autonomously in fulfilment of a variety of professional care actions. The nurse also assumes a role as employee. This means that the nurse has to consider and undertake the provision of nursing care. In this context the nurse has responsibilities as a clinician, an educator, a leader and an advocate. These responsibilities imply that the nurse needs appropriate theoretical knowledge and skills in an own area of practice. Nursing obligations require the registered nurse to remain competent (Searle 2004:194). The application of knowledge has to be used to meet patient's needs in conjunction with other registered nurses, the nurse administrator, the nurse educator and the nurse in a researcher role within the disciplinary team environment. The nurse administrator has to promote a practice environment that supports ongoing professional development and improvement in nursing practice. The nurse educator promotes a learning environment for professional development, while the researcher promotes a practice environment that supports research and integrates research findings to promote competent nursing practice (Standards of Nursing Practice 1999:5).

On the other hand, the employer also has certain obligations towards the nurse. These obligations include the responsibility for maintaining ethical and legal standards of practice. Furthermore practice environments conducive to safe, competent and ethical care, adequate supplies, a manageable workforce and professional development opportunities have to be provided (Searle 2004:194).

The nurse's obligations towards the patient require performing independent, interdependent and dependent functions to provide safe nursing practice. The registered nurse should, on admission of a patient, prepare a nursing care plan based on correct identification, history taking, physical examination, consideration of the medical diagnosis and treatment, and professional judgment (Searle 2004:195).

The registered nurse's scope of practice (Government Gazette 2040 1999:65) describes what each nurse is responsible and accountable for in practice. This scope of practice states clearly that acts should be performed by scientifically based physical, chemical, psychological, social, educational and technological means applicable to health care. The first section of the scope refers to the application of the nursing process, namely the diagnosis of a health need and the prescription, provision and execution of a nursing regimen to meet the needs of a patient or a group. Registered nurses therefore have clear responsibility and accountability for utilising the nursing process.

It is, however, also true that the registered nurse experiences certain constraints in exercising her/his obligations in such a clear manner. There are indeed staff shortages,

which result in immediate and serious long-term problems. Registered nurses find it extremely difficult to meet the rapidly rising demand for health care services that have resulted with the increase in HIV/AIDS amongst the Namibian population.

Activity 3

Read the information provided on professional conduct.

Arrange a group discussion for the registered nurses in the ward.

Identify a group leader.

Reflect on your understanding of the professional obligations or responsibilities that you, as an employee, carry out in your ward.

→ Share your views on this issue with the group.

→ Take a few minutes to identify your strengths pertaining to your professional conduct. The group leader writes these strengths down.

→ Now do the same with weaknesses.

→ Share with your group the way you use your own strengths to assist other colleagues who experience weaknesses.

Do you have weaknesses

→ in the clinical area? Are you still competent with regard to theoretical knowledge and skills?

→ in education? Do you promote a learning environment in which nursing practice is improved?

→ in leadership? Do you promote a practice environment that supports the operationalisation of the nursing process?

→ as patient advocate?

Well done if the above-mentioned areas are your areas of strength.

Activity 4

Read the information provided on professional conduct: the role of the employer.

Arrange a group discussion for the registered nurses in the ward.

Identify a group leader, other than the leader in the first activity.

Reflect on the role of the employer in your ward. Is the practice environment conducive to safe, competent and ethical care? Are there adequate supplies, is there a manageable workforce and is provision made for professional development issues?

→ The group leader undertakes to invite the manager to the ward for the next discussion. Explore how any shortcomings identified may be addressed.

→ Identify a date on which the manager could give feedback if applicable.

Well done if the manager joined you in the ward, if you held a group discussion and if you discussed shortcomings such as shortage of staff, staff that do not function effectively, shortage of supplies, or any other practices that result in unsafe patient care.

Activity 5

Read the information provided on professional conduct: the registered nurse's obligations

towards the patient.

Arrange a group discussion for the registered nurses in the ward.

Identify a group leader. (Ensure that all registered nurses get a chance to lead the group discussion.)

Reflect on a registered nurse's obligations in carrying out his/her independent, interdependent and dependent functions in the ward.

➔ Do you write up a care plan, based on correct identification, history taking, physical examination, and considering the medical diagnosis and treatment for each patient on admission as the first obligation of the registered nurse?

➔ Discuss this issue in the group and identify reasons for not doing so.

➔ As this is one of your obligations as a registered nurse, discuss measures for addressing shortcomings in this process.

➔ Utilise the phases of the nursing process for this exercise.

➔ If you do not write care plans based on sound assessment data:

  ➢ Do you perhaps not organise the personnel wisely?

  ➢ Perhaps you do not utilise the team method when allocating personnel?

Well done if you write care plans and, if not, you do not blame outside factors for this.

Emotional intelligence

The registered nurse has relationships with many people in the day-to-day human interactions in the ward. These include relationships with superiors, doctors, patients, families, other members of the multidisciplinary team, sub professionals, to name just a few. This requires her to have more skills than just the usual cognitive and technical skills to cope with the demands and pressures that these interactions necessarily impose.

Emotional intelligence is explained as a specific set of emotional abilities and a potential for certain behaviour in interpersonal relationships. Emotional intelligence entails certain components and these enable registered nurses to perform at a more than marginal level as Strickland (2000:112) refers to it. These components include self-awareness, self-regulation, motivation and empathy. They are explained by Strickland (2000:112) as follows:

- Self-awareness means having insight into one's own strengths, weaknesses, emotions, drives and needs. This implies that one has to know oneself and not hesitate to acknowledge and verbalise one's shortcomings as well as strengths.
- Self-regulation refers to one's ability to control one's impulses and channel one's moods constructively. This implies adaptability, the skill to manage your emotions in order to manage stress or solve problems.

- Motivation explains the innate drive to achieve that has nothing to do with compensation, title or perks. Motivated people are passionate about achievement for the pure joy of achievement. This necessitates using one's emotions to assist thought.

- Empathy is the ability to consider thoughtfully another's feelings while making intelligent decisions. This includes understanding other people's emotions.

- Lastly, the intelligent application of emotional intelligence results in a general mood of happiness. Happiness is an important source of human energy.

The registered nurses may ask what emotional intelligence has got to do with the operationalisation of the nursing process. The answer is simply that the results of the data analysis showed that registered nurses focus on many factors outside themselves in not operationalising the nursing process. Emotional intelligence is the one skill that will assist the registered nurse to focus on herself, as well as on all the people with whom she has relationships in the work environment, for the successful operationalisation of the nursing process. Freedland (2005:3) is of the opinion that a person is not individually accountable for another person's feelings and growth. Yet all people share a world and therefore all people are bound together. Resultantly, people's decisions, feelings and growth will have an influence on others.

Activity 7

After you have read the information on emotional intelligence and any additional

literature, pause and think about the concept of emotional intelligence.

➔ Organise a group discussion and discuss how you would use the components of emotional intelligence to address the weaknesses and strengths that you have identified in yourself and in others.

Were you able to make use of

➔ self-awareness to reflect on weaknesses pertaining to the operationalisation of the nursing process? What were they? Did you find it easy to verbalise weakness openly?

➔ self-regulation to reflect on the causes for not operationalising the nursing process and to solve these problems?

➔ motivation? Could you think of factors other than money and perks that motivate you? Discuss them in the group.

➔ empathy? How could you use empathy in this exercise?

➔ happiness? Is happiness an important factor for you as a person to function effectively? Is there perhaps a colleague who still experiences the opposite of happiness? Try to get to the root of this and decide how you would utilise the strengths of the group to assist.

Professional values

It seems that nurses have a good understanding of their professional obligations but that they appear to be unable to apply this understanding to their daily practice. There has been an increased emphasis on what comprises "good" practice. The question remains as to how we would ensure that "good" practice happens. What is "good" may be subject to individual perception. Therefore, values play an immensely important role in what each professional nurse sees as the right thing to do. Reflection on professional values, values that guide the decisions and actions of nurses, should therefore also be considered.

Values are acquired during socialisation in nursing from codes of ethics, nursing experiences, teachers and peers. As members of a caring profession, nurses' values relate to competence and compassion. Values include a strong commitment to service, a belief in the dignity and worth of each person, and a commitment to education and autonomy (Kozier, Erb & Wilkinson 1995:202). A factor influencing the non-utilisation of the nursing process in caring for patients may be a lack of the necessary values. Having knowledge of the nursing process, without a commitment to applying this knowledge, will not ensure the utilisation of the nursing process in the care of patients.

Schank and Weiss (2001:1) are of the opinion that ongoing development and internalisation of the nursing professions' values require active involvement of staff development educators.

The characteristics of the nursing process are described by Kozier et al. (1995:85) as follows:

> The nursing process provides the framework in which nurses use their knowledge and skills to express human caring and to meet their patients' health needs. The nursing process is *cyclic and dynamic*. It is *client centred* because the nurse organizes the plan of care according to client problems. It is *interpersonal and collaborative* because the nursing process requires open communication and the

development of rapport between the patient and the nurse. The nursing process is *universally applicable*, as it can be used for patients of any age at any point of the wellness-illness continuum. The nursing process is an adaptation of *problem-solving techniques* and *systems theory*. Both processes begin with data gathering and analysis, base interventions on a problem statement, and include an evaluative component. Nurses use a variety of skills namely interpersonal, technical, and intellectual skills in applying the nursing process. *Interpersonal skills* include communicating; listening; conveying interest, compassion, knowledge, and information; developing trust; and obtaining data in a manner that enhances the dignity of the patient. *Technical skills* include using equipment and performing procedures. *Intellectual skills* include analyzing, problem-solving, critical thinking, and making nursing judgments.

Activity 9

Please read through the characteristics of the nursing process.

- Note which characteristics present values of professional practice.

- Would it be possible to demonstrate professional values without utilising the nursing process? Give reasons for your answer (why/why not).

- What implication will this answer have for your practice of the nursing process in the future?

5.4.10.2 Session 2: Working smarter not harder

This guideline provides registered nurses with information on organising the self and on time management.

5.4.10.2 a   Aims and process outcomes

The aim of this session is for the registered nurses to explore the skills that will enable them to organise themselves and utilise time wisely. The process outcome is the wise management of time to enable registered nurses to facilitate the utilisation of the nursing process (as a role model for students).

5.4.10.2 b   Content

The content includes the concepts involved in effective time management.

- **Compulsory literature**

➢   Any nursing management textbook or article on the subject of time management

5.4.10.2 c   Expected learning outcomes

After reading the recommended material you should be able to

- make the best use of time by managing yourself
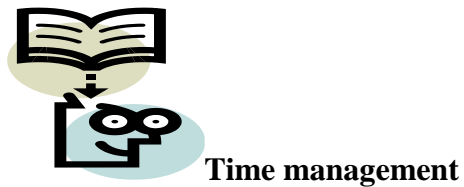
 Time management

Registered nurses are working harder than ever; therefore time management is more crucial than ever before. Actually time cannot be managed. We can however manage ourselves and the way we use time (Applebee 2005:1). The message from time management experts remains clear: in order to work smarter, not harder, registered nurses need to define their focus.

Poor time management results from being disorganised. This does not make registered nurses bad managers but it does decrease their efficiency.

Activity 1

Arrange a group discussion for the registered nurses in the ward.

Identify a group leader.

Reflect on your individual functions and determine a focus.

⇨ Identify your routines and tasks.

⇨ Clarify the key tasks of each of your positions.

⇨ Each registered nurse should define a focus.

⇨ Expand your thoughts by discussing this in the group and assist each other

   where necessary.

The routine tasks of the registered nurses in general might include:

➔ ordering stock

➔ escorting the doctors on rounds

➔ caring for theatre patients

➔ providing in-service training

➔ admitting patients

➔ attending daily meetings

➔ ward administration such as planning off duties

➔ controlling drugs

➔ discharging patients and doing home discharge planning

➔ applying the nursing process

➔ controlling the emergency trolley

➔ giving out medication

➔ controlling ward stock medication

Can you now identify the key functions for each position? You may come up with

many more functions and tasks than the ones listed above. Identify the focus of each

position.

Activity 2

Each registered nurse reflects on activities for the coming week and organises

him/herself by demarcating each day.

⇨ Picture the coming week as a container with seven compartments.

⇨ Make a drawing of this container with its seven compartments.

⇨ Make a list of your tasks for the next week and fit each of them into a compartment.

⇨ Choose what must fit into each compartment; this must include those things that you

have to do.

⇨ Fit those activities that only you can do into the compartments.

⇨ Circulate your list in your group and identify issues that were left out.

Example:

Day 1 Sunday	Day 2 Monday	Day 3 Tuesday	Day 4 Wednesday	Day 5 Thursday	Day 6 Friday	Day 7 Saturday
Admit	Oversee					Control

patients from regions; prepare patients for theatre; do work allocations	full washes and making of beds; theatre cases: care;					drugs; control ward stock medications; prepare beds for following day admissions; identify areas for spring cleaning and see that it is done

Activity 3

Take time to manage your time. Allocate 20 minutes at the end of each day to prioritise your tasks for the following day.

⇨ Prioritise your needs for the following day according to priority

⇨ Plan the ward organisation by preparing the allocation table for the staff

⇨ At the end of the next day take time to reflect on whether you have managed your time wisely.

Activity 4

Arrange a discussion group with the registered nurses and identify a leader. This activity serves to identify and manage time stealers. Hold an open discussion.

Reflect on the most common things that steal your time:

➢ Do you delegate effectively?

➢ Do you allow constant interruptions?

➢ Do you have difficulty saying "no, I won't be able to. I'm already committed"?

➢ Do you refuse to confront or address unacceptable behaviour of employees?

Activity 5

At the end of the first week, registered nurses reflect on their time management for the past week. Do you chose to take ownership of your own behaviour?

⇨ Identify the shortcomings

⇨ How can you solve these issues?

Form a group and reflect on activities in which you can implement effective time management.

Consider the following useful tips:

⇨ Learn to say no and to delegate.

⇨ Surround yourself with good staff.

⇨ Improve your skills where appropriate.

⇨ Start projects at the right time.

5.4.10.3 Session 3: Nursing process as a prerequisite for effective nursing care

Nurses should have a sound knowledge of the phases of the nursing process and how to apply them. This session will provide registered nurses with information on the phases of the nursing process.

Phase 1: Assessment

This phase entails registered nurses obtaining certain information from the patient. It involves several steps, namely data collection, verification, organisation, interpretation and documentation.

Phase 2: Diagnosis

Diagnosis is the classification of the patient's response. It is based on the scientific evaluation of data, diagnostic studies, and signs and symptoms.

Phase 3: Planning and outcome identification

This phase involves the formulation and documentation of the care plan. It also involves the prioritisation of the nursing diagnosis, the identification of goals and expected outcomes, and the determining of nursing interventions that will aid in the resolution or prevention of each problem.

Phase 4: Implementation

Implementation involves the execution of the nursing care plan and continuous assessment of the patient's condition before, during and after each intervention has been carried out. Implementation includes activating the plan of care, carrying out the planned interventions, continued assessment as interventions are carried out and recording and documenting the care provided, the interventions carried out, and the client responses.

Phase 5: Evaluation

Evaluation involves nurses determining whether the goals have been met, partially met or not met.

5.4.10.3 a   Aim and process outcomes

The aim of this session is for the registered nurses to explore the skills that will enable them to operationalise all the phases of the nursing process so that nursing care can be effective.

5.4.10.3 b   Content

The content includes the phases of the nursing process.

- **Compulsory literature**

➢ Any recent literature on the nursing process

➢ Seaback, W. (2006). *Nursing process: concepts and applications*. Canada: Thomson Delmar Learning.

➢ Arrange for a demonstration by a colleague who has updated skills on the utilisation of all phases of the nursing process.

> Any nursing textbook on gynaecology nursing care

5.4.10.3 c   Expected learning outcomes

After reading the recommended material you should be able to

o   collect subjective and objective data from a patient through interviews, conversations, and a physical assessment

o   analyse the data and formulate a nursing diagnosis

o   identify expected outcomes for an individualised patient plan

o   develop a plan that prescribes strategies for attaining expected outcomes

o   implement the identified plan

o   evaluate progress toward attainment of outcomes

Nursing process and providing care

The nursing process is defined as an organised, systematic method of planning and providing individualised care to patients. The nursing process is a tool that promotes the organisation and utilisation of steps to achieve desired outcomes.

Prior to 1955, the nurse provided care based on medical orders written by physicians. In the late 1950s early 1960s the nursing process model was introduced as a three-step model. The process gradually developed until it consisted of five steps: this process is

still in use today. In 1973 the American Nurses Association published its Standards of Clinical Practice and in the same year the North American Nursing Diagnosis Association (NANDA) started with the classification of nursing diagnosis. In 1980 the American Nurses Association published a social policy statement, which provided guidelines (standards) for individual nurses to follow in practice. In 1982 the National Council Licensure Examination (NCLEX) was revised to include concepts of the nursing process as a basis for organisation. In 1984 the Joint Commission on Accreditation of Health Care Organizations (JCAHO) launched its requirements for accredited hospitals pertaining to the use the nursing process as a means of documenting all phases of client care.

Activity 1

Before you read any further, pause and think about how you use the nursing process. Are you perhaps still only carrying out doctors' orders or are you on the level of using all the phases, as they ought to be?

Write down your thoughts and discuss them with your colleagues.

Currently, the nursing process is a five-step process consisting of the assessment, diagnosis, planning, implementation, and evaluation phases (Seaback 2006:3).

Phase 1: Assessment, interpretation and organisation of data

Standard 1: Assessment

The registered nurse collects comprehensive data pertinent to the patient's health need or the situation (American Nursing Association 2004, in Seaback 2006:4).

Learning outcomes

- Identify methods of assessment

- Identify types of assessment

- Collect data from a patient

 Assessment involves the activity of gathering data about the health status of the patient. It is the initial step, and is systematic and ongoing. The data provides a sense of the overall health status of the patient. Data should include physical, psychological, social, cultural, spiritual and cognitive areas. Data are gathered during an interview, a physical examination, and a review of diagnostic studies. Information is analysed and validated, and facts are clustered into groups of information to identify patterns of health and illness.

Types of data include two categories, namely subjective and objective data. Subjective data are also known as symptoms. These are statements, feelings or concerns communicated by the patient. An example is "I am having pain". Objective data, also referred to as signs, may be observed, measured or felt by someone other than the patient him or herself. Objective data supports subjective data. What the nurse observes and measures confirms what the client is feeling and experiencing. Methods of assessment include the Assessment Man method and the Biophysical Psychosocial Assessment.

- Head-to-toe:
  - head: mental, emotional, vision, hearing, mouth
  - trunk: respiration, circulation, temperature, skin, nutrition, fluid-electrolytes, elimination
  - extremities: movement, sensation
  - environment: sociocultural influences, significant people involved with the patient

- Biophysical Psychosocial Assessment:
  - neurological assessment
  - cardiovascular assessment
  - respiratory assessment
  - gastrointestinal assessment
  - integumentary assessment
  - musculoskeletal assessment

- ➢ genitourinary assessment

- ➢ reproductive/sexuality

- ➢ psycho/social assessment

- ➢ pain assessment

- ➢ activities of daily living assessment

- ➢ cultural spiritual assessment

Methods of data collection include observation, interview, and physical assessment:

- • **Observation**: the skill of watching thoughtfully and deliberately to detect client's overall appearance and behaviour.

- • **Interview**: communication exchange between the nurse and the client.

- • **Physical examination**: inspection, auscultation, palpation, percussion.

 Activity 2

Complete the following activity regarding assessment.

Ms Botha, a 25-year-old unmarried woman, is admitted to the ward with a two-day history of abdominal pain. She complains of nausea without vomiting. Her vital signs include blood pressure of 110/60, pulse 100 beats per minute, respiration 20/minute, temperature 38,6ºC.

Elaborate on the data that were left out in the assessment of this patient? Discuss this with your colleagues. Write down your findings.

 Did you include the following?

- unprotected sex; multiple sexual partners

- anxiety, fear of diagnosis

- knowledge deficit

- pain: type, location; palpation of abdomen for rebound tenderness – guarding behaviour

- reproductive system: vaginal discharge and status of perineal skin – pruritus and maceration

- urinary system: dysuria, frequency, urgency

- gastrointestinal symptoms: diarrhoea or constipation

- fluid balance: skin turgor

 Interpretation and organisation of data involves the analysis and interpretation of data. Data are compared against standards and clustered into groups of related cues.

Activity 2: analyse, interpret and cluster the data that were present

Consider the data that were found in activity 1. Read the scenario again. Perhaps you found the following additional data:

- pain with abdominal palpation; rebound tenderness

- facial expression of discomfort

- foul smelling vaginal discharge

- pruritus of the vulva

- excoriation of perineal area

- appears to be anxious

- asks frequent questions to the nurse

Could you manage to cluster the data as follows?

- Verbalisation of pain with subjective assessment, pain with abdominal palpation, rebound tenderness, facial expression of pain.

- Foul smelling vaginal discharge, excoriation of perineum, pruritus.

- Temperature of 38,6ºC.

- Anxiety

- Frequent questions

- Nausea.

Discuss the areas where you experienced difficulties.

Activity 3

In the form of a progress report, write the admission report and the documentation of the data under the S and O of the acronym of SOAP.

You may utilise the NANDA (North American Diagnosis Association) list of nursing diagnosis to assist you with the clustering of data.

Form a group and discuss your documents.

The following might help you with this activity:

23 August 2006. 12h00. Admission. Ms Botha, 25 years old, was admitted in a stable condition under the care of Dr Angula. She was placed in room 2 bed 4. She entered the ward walking and was accompanied by her mother. On assessment the following was found:

S: "I am having pain".

O: She has had a history of abdominal pain during the last 2 days.

Reproductive system: on abdominal palpation, pain is generalised over the lower abdominal area, there is a facial expression of pain and patient exhibits guarding behaviour. No abnormalities with regard to her menstrual periods, LMP 04 August. She has a steady friendship with her boyfriend. They practise unprotected sex. She uses the combination pill for family planning. She has a foul smelling vaginal discharge and the perineal skin is red and excoriated.

Gastrointestinal system: with abdominal auscultation normal bowel sounds are

present. Since yesterday she ahs passed 3 loose stools. She complains of nausea without vomiting.

Urinary system: urinary elimination is within normal range: no dysuria or other signs and symptoms indicative of urinary tract infection.

Cardiovascular system: blood pressure of 110/ 60, pulse 100 beats per minute and regular.

Respiratory system: respiration within normal limits of 20/minute and normal breathing sounds with auscultation.

Thermo regulation: pyrexia of temperature 38,6ºC, skin moist and warm to touch.

Musculoskeletal system: myalgia and arthralgia since yesterday.

Integumentary system: normal skin turgor, no evidence of dehydration.

Psycho/social: verbalises anxiety about her diagnosis. Fear that she might have a sexual transmittable infection.

Cognitive: asks frequent questions.

 Activity 4

Organise a group discussion to reflect on your existing knowledge of the pathophysiology of pelvic inflammatory disease. Where does the data fit in the pathophysiology of this disorder? If your knowledge is insufficient, arrange for a lecture to be given by one of you who is knowledgeable on the topic.

Activity 5

Each registered nurse now works individually. Select a patient and assess the patient

utilising the above information.

Now analyse, interpret and cluster your data.

Record your findings.

Form a group and reflect on your experiences with this exercise.

Repeat this activity until you are able to assess patients with confidence.

Phase 2: Nursing diagnosis

Standard 2: Diagnosis

The registered nurse analyses the assessment data to determine a diagnosis and other

issues (Carpentino 1995:50; American Nursing Association 2004, in Seaback 2006:4).

Activity 1

Pause and think: If you have to formulate a nursing diagnosis of the data given above,

how would you do it with the knowledge at your disposal?

Discuss this with your colleagues and criticise each other's work.

Learning outcomes

When you have studied the information on this phase you should be able to

- identify characteristics of a nursing diagnosis

- identify differences between a nursing and a medical diagnosis

- list components of actual and potential nursing diagnoses

- develop a nursing diagnosis

Diagnosis is the second phase of the nursing process. This is the phase in which you analyse the data in order to come to a conclusion about a problem, need or a health response that a patient has at a specific point in time. This requires you to use critical-thinking skills and judgment to analyse, organise and interpret assessment data. In the diagnosis phase, the patient's problems and potential problems are identified with an appropriate nursing diagnosis.

The characteristics of a nursing diagnosis describe the client's response to a physical, sociocultural, psychological and/or spiritual illness, disease or condition. Actual signs and symptoms are present.

Go back to activity 2 of assessment. Study the data that you clustered. Study the NANDA list for a nursing diagnosis and label the data.

Were you able to identify the following labels?

- pain

- impaired perineal skin integrity

- hyperthermia

- anxiety

- knowledge deficit

- nausea

Can you connect these to needs that the patient with pelvic inflammatory disease has?

The difference between a medical and a nursing diagnosis should be evident to you by now. A medical diagnosis is made by a doctor on the basis of certain medical examinations, and remains the same once it has been confirmed. A nursing diagnosis describes the patient's health response to the disease and may change from time to time or day to day as the patient's condition changes. Problems may be resolved and new ones may arise.

Nursing diagnoses are described as actual nursing diagnoses, that is, diagnoses that are present at a given time, and potential (risk) nursing diagnoses, which consist of complications that might develop. An actual nursing diagnosis consists of three components: the problem, etiology (written as "related to") and defining characteristics (written " as evidenced by").

Activity 3

Study the NANDA list of nursing diagnosis and identify a nursing diagnosis for Ms Botha. Remember to write the problem, etiology ("related to"*)* and defining characteristics ("as evidenced by"*)*. Complete the A (analysis) of the acronym SOAP in the patients progress report.

If you identified the nursing diagnosis as follows, you concluded Ms Botha's nursing diagnosis correctly:

- Pain (alteration in comfort) related to inflammation of the pelvic structures as evidenced by verbalisation of pain, facial expression and rebound tenderness on abdominal palpation.

- Skin breakdown of perineal area related to vaginal discharge and pruritis as evidenced by red excoriated perineal skin.

- Hyperthermia related to inflammatory process as evidenced by temperature of 38.6 degrees Celsius.

- Anxiety related to unknown cause of inflammation as evidenced by anxious facial expression.

- Knowledge deficit related to unfamiliarity of condition as evidenced by frequent questions.

- Nausea related to gastrointestinal irritation as evidenced by spells of nausea.

Activity 4

Reflect on the pathophysiology of pelvic inflammatory disease and identify potential problems.

If you identified the following, you were on the right track:

- Fluid volume deficit related to hyperthermia.

Discuss any other potential problems that you identified.

Activity 5

Formulate a nursing diagnoses for the patient you assessed in activity 5 of phase 1:

Arrange a group discussion and discuss your findings. Use critique and praise as group interaction methods.

Phase 3: Planning

Standard 3: Outcomes identification

The registered nurse identifies expected outcomes for a plan individualised to the patient or the situation (American Nursing Association 2004, in Seaback 2006:55).

Standard 4: Planning

The registered nurse develops a plan that prescribes strategies and alternatives for attaining the expected outcomes (American Nursing Association 2004, in Seaback 2006:55).

Learning outcomes

When you have studied the information on this phase you should be able to

- prioritise patient problems and interventions
- determine goals and expected outcomes in any given situation
- determine appropriate nursing interventions
- communicate and document care plan
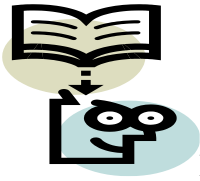
Planning is the third phase of the nursing process. In prior phases, data were collected, analysed and labelled with the appropriate nursing diagnosis. Nurses then developed a plan of care, which proposes a course of nursing action. Critical elements of planning include the identification of priority problems and interventions, setting realistic goals and expected outcomes, determining appropriate nursing interventions, and communicating and documenting the care plan.

Activity 1

Reflect on prior knowledge of priorities. What hierarchy of needs model do you utilise currently for identifying patients' basic needs?

Maslow's hierarchy of needs would be the correct answer.

- **Determining priorities**

The first step in planning is to determine priorities. Priority problems are those assessed as being more important or life threatening. Priorities are dealt with before less critical problems.

- **Priority 1: Physiological needs**

  ➢ Problems that interfere with ability to maintain physiological life processes, such as ability to breathe, maintaining a patent airway and maintaining adequate circulation.

  ➢ Problems that interfere with homeostatic physiological responses within the body, such as respiration, circulation, hydration, elimination and temperature regulation.

  ➢ Problems that interfere with the ability to be free of offensive stimuli, such as pain, nausea, and other physical irritation.

- **Priority 2: Safety/security**

  ➢ Problems that interfere with safety and security, such as anxiety, fear, environmental hazards, physical activity deficit, violence towards self and others;

- **Priority 3: Love and belonging**

  ➢ Problems that interfere with self-esteem, such as sensory-perceptual losses. Inability to maintain family and significant other relationships, isolation, loss of a loved one.

- **Priority 4: Self-esteem**

  ➢ Problems interfering with self-esteem, such as the inability to perform normal daily activities of living, change in physiological structure or function of body.

- **Priority 5: Self-actualisation**

  ➢ Problems interfering with one's ability to self-actualise, such as positive personal assessment of life events and achieving personal goals (Seaback 2006:59).

Activity 2

Use the scenario of Ms Botha and prioritise the nursing diagnoses that were identified.

Then prioritise the nursing diagnosis for the patient you identified in activity 5 of phase 1 and assessment and activity 5 of phase 2: diagnoses.

Discuss the outcome of this activity in a group of registered nurses.

Use praise and support to motivate each other.

The correct priority is the following:

Priority 1: Physiological needs

- hyperthermia (problems interfering with homeostatic physiological responses within the body)

- pain: problems interfering with ability to be free of offensive stimuli

- nausea: problems interfering with ability to be free of offensive stimuli

- perineal skin breakdown: problems interfering with ability to be free of physical irritation

Priority 2:

- anxiety: problems interfering with safety and security

- knowledge deficit: as above

● **Determine goals and expected outcomes**

The prioritisation of problems is followed by setting the goals and the expected outcomes. One overall goal is determined for each nursing diagnosis. A goal is a general statement indicating the desired change in the client's health status, function or behaviour. An expected outcome, on the other hand, is more specific, describing the methods by which the goal will be achieved. Goals and expected outcomes are measurable (able to be quantified). The client demonstrates a certain action within a certain time frame and these actions and time frames are the yardsticks that allow the goal or expected outcome to be measured. After the goal has been stated, the expected outcomes are identified. Expected outcomes are measurable steps indicating the progress toward goal achievement. For each nursing diagnosis and overall goal, there may be several expected outcomes.

Goals and expected outcomes should have the following components: subject, behaviour, performance criteria and time frame.

Activity 3

For each nursing diagnosis that was identified for Ms Botha write an appropriate goal and

expected outcomes. Ensure that the identified goals and expected outcomes have all the necessary components.

The following are the goals and expected outcomes that you could have considered for Ms Botha:

- Hyperthermia related to inflammatory process as evidenced by temperature of 38.6 degrees Celsius.

  - Goal: The patient (subject) regains (action) normal body temperature of 37,5 ℃ within 72 hours (time frame).

  ➢ Expected outcomes:

    ⇨ Nursing staff promotes surface cooling by removal of clothing and use of fans.

    ⇨ Patient drinks 8 glasses of oral fluids per mouth.

    ⇨ Nursing staff administers antibiotics as prescribed.

    ⇨ Nursing staff monitor and record body temperature 4 hourly.

- Pain (alteration in comfort) related to inflammation of the pelvic structures as evidenced by verbalisation of pain, facial expression and rebound tenderness on abdominal palpation.

  - Goal: The patient (subject) achieves (action) comfort level within next 24 hours (time frame).

  ➢ Expected outcomes:

    ⇨ The patient does not demonstrate guarding behaviour with abdominal

palpation.

⇨ The patient uses appropriate pain control strategies continuously.

⇨ The patient verbalises increased control over pain until comfort is achieved after 24 hours

- Nausea related to gastrointestinal irritation as evidenced by spells of nausea.

  - Goal: The patient (subject) verbalises (action) relief of nausea within the next 24 hours (time frame).

    ⇨ The patient reports no nausea or aversion to food.

- Skin breakdown of perineal area related to vaginal discharge and pruritis as evidenced by red excoriated perineal skin.

  - Goal: The patient (subject) regains (action) perineal skin integrity within the next 72 hours (time frame).

  ➢ Expected outcomes:

    ⇨ Patient demonstrates self-care in keeping perineum clean and dry.

    ⇨ The perineal skin area returns to a healthy colour with intact skin.

- Anxiety related to unknown cause of inflammation as evidenced by anxious facial expression.

  - Goal: The patient (subject) reports (action) a reduction in anxiety at the time of discharge (time frame).

  ➢ Expected outcomes:

⇨ The patient uses strategies to cope with anxiety.

⇨ The patient develops insight into the causes of the disease.

- Knowledge deficit related to unfamiliarity of condition as evidenced by frequent questions.

  - Goal: The patient (subject) acquires and uses (actions) adequate knowledge at the time of discharge (time frame).

  ➢ Expected outcomes:

  ⇨ The patient has adequate knowledge to carry out the health care regimen at the time of discharge.

  ⇨ The patient verbalises accurate expectations of likely outcomes of health care actions.

 Activity 4

Now repeat activity 3 with the patient that you have worked on since activity 5 of the assessment. Registered nurses form a group and discuss the different results obtained with each case study. Did you acquire new knowledge?

 Did you remember to motivate each other?

- **Planning nursing interventions**

After prioritising problems and setting goals and expected outcomes, nurses use problem-solving and decision-making skills to determine actions that will aid problem resolution.

Appropriate interventions are selected using guiding principles provided by the Nursing Board of Namibia such as the scope of practice of the registered nurse and midwife. Nurses must practise within the legal framework and boundaries of the profession. There are existing nursing care standards, such as the JCAHO standards for nursing care, that assist the registered nurse in setting realistic goals for the clients. The criteria for these standards were tested and measured in practice by nurse professionals and adopted as valid interventions for different nursing diagnoses.

Nursing interventions are classified according to three categories, namely independent, interdependent and dependent. Independent nursing interventions are nursing actions that are initiated by the nurse that do not require direction from another health care professional. They are actions related to all the aspects of the nursing process, namely assessment, diagnosis, treatment and care, and are the normal prescriptive and organisational functions of the registered nurse. The registered nurse is totally responsible and accountable for her actions and she is the only one who can decide whether she has the knowledge and competence to carry out her actions.

The interdependent functions are those functions that are carried out in cooperation with another health professional such as a physician, dietician, physiotherapist, social worker and occupational therapist. The dependent function of the registered nurse relates to the law that authorises her to practice.

Activity 5

Reflect on your different obligations as a registered nurse and identify nursing interventions for the different nursing diagnoses.

Make an effort to get hold of existing nursing care standards to assist you with this exercise.

If your care plan is similar to the one that follows, you did well:

Nursing diagnosis	Goals and expected outcomes	Nursing interventions
Hyperthermia related to inflammatory process as evidenced by temperature of 38.6ºC.	Goal: The patient regains normal body temperature of 37,5ºC within 72 hours. ➢ Expected outcomes: ⇨ Nursing staff promotes surface cooling by removal of clothing and use of fans ⇨ Patient drinks 8 glasses of oral fluids per mouth ⇨ Nursing staff administer	Independent functions Monitor temperature and report an increase above 38,6ºC Cover lightly with bed covers Wear light pyjamas Encourage patient to drink 8 glasses of clear fluid over 24 hours unless

	antibiotics as prescribed • Nursing staff monitor and record body temperature 4 hourly	contra-indicated <u>Interdependent functions</u> Administer antibiotics as prescribed
Pain (alteration in comfort) related to inflammation of the pelvic structures as evidenced by verbalisation of pain, facial expression and rebound tenderness on abdominal palpation	Goal: The patient achieves comfort level within next 24 hours ➢ Expected outcomes: ⇨ The patient does not demonstrate guarding behaviour with abdominal palpation ⇨ The patient uses pain control strategies continuously appropriately ⇨ The patient verbalises increased control over pain until comfort is achieved after 24 hours	<u>Independent functions</u> Provide comfort measures: backrub, non-stimulating environment, heat to lower abdomen, warm shower; Maintain complete bed rest; semi-Fowler's position is desirable to prevent pus from pelvis moving to upper abdomen Assist patient in planning periods of activity and rest, which will enable her to accomplish activities of daily living and recreational activities.

		Interdependent functions
		Administer analgesics and antibiotics as prescribed
Nausea related to gastrointestinal irritation as evidenced by spells of nausea.	Goal: The patient verbalises relief of nausea within the next 24 hours. ⇨ The patient reports no nausea or aversion to food	Independent function Encourage patient to take in small quantities of food and fluid at more frequent intervals Prevent foods and drinks that promote nausea Interdependent functions Administer anti-emetics as prescribed
Skin breakdown of perineal area related to vaginal discharge and pruritis as evidenced by red excoriated perineal skin.	Goal: The patient regains perineal skin integrity within the next 72 hours: ➤ Expected outcomes: ⇨ Patient demonstrates self-care in keeping perineum clean and dry ⇨ The perineal skin area returns to a healthy colour	Independent function Provide and teach gentle perineal cleansing technique 3 to 4 hourly. Blot perineum dry, do not rub Teach patient to change sanitary towels with each perineal toilet; observe

	with intact skin	quantity and quality of vaginal discharge
		Avoid excessive warmth from bed linen or clothing
		Teach front to back wiping technique
		Provide patient with information on wearing underclothing with cotton inner lining
		Nurse does perineal check and observes the status of the perineum
		Explain cause of vaginal discharge and pruritus
Anxiety related to unknown cause of inflammation as evidenced by anxious facial expression	Goal: The patient reports a reduction in anxiety at the time of discharge: ➢ Expected outcomes: ⇨ The patient uses strategies to cope with anxiety ⇨ The patient develops	Independent functions Encourage patient to air feelings of anxiety and to ask questions The patient is encouraged to use coping strategies used successfully with

	insight into the causes of the disease	past experiences The nurse answers patient's questions clearly and uses language that is best understood by the patient Interdependent functions The physician explains questions that are outside the field of the registered nurse
Knowledge deficit related to unfamiliarity of condition as evidenced by frequent questions.	Goal: The patient acquires and uses adequate knowledge at the time of Discharge: ➢ Expected outcomes: ⇨ The patient has adequate knowledge to carry out the health care regimen at the time of discharge ⇨ The patient verbalises accurate expectations of likely outcomes of health	Independent functions Emphasise the need to maintain perineal hygiene Explain the importance of drinking large quantities of water if not contra-indicated Emphasise the importance of having talks with her sexual partner about safe sex practices

		care actions.	Patient has to complete the course of medication prescribed as well as come for follow-up in case of recurrence of the disease
			Ask patient to give verbal feedback to ensure that a good understanding of the causes, management and signs of PID exists
Potential fluid volume deficit related to hyperthermia	Goal: Hydration and body temperature are normal. ➢ Expected outcomes: ⇨ Intake and output are within normal limits		<u>Independent function</u> Explain need for increased fluid intake during infectious process Encourage fluid intake of 3000 ml daily unless contra-indicated Monitor intake and output and report urinary output of < 30 ml/hour Provide lukewarm sponges for increased

		temperature
		Monitor temperature 4 hourly
		Cover lightly in case of fever.
		Interdependent functions
		Administer intravenous fluid as prescribed

Phase 5: Implementation

Standard 5: The registered nurse implements the plan identified (Seaback 2006:75)

Implementation is the fourth phase of the nursing process and requires activities such as executing nursing interventions, performing an ongoing assessment of the client and determining the patient's response to the interventions carried out.

Learning outcomes

When you have studied the information on this phase you should be able to

- implement the plan of care in a safe and timely manner

- document implementation
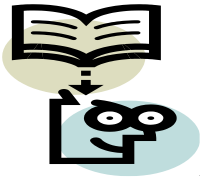
All nursing actions are now recorded. Seaback (2006:78) cites the following guidelines that should be considered with regard to documentation:

- Ensure that the patient record is correct. The patient's name should be reflected on each page.

- Record the client encounter as soon as it is concluded to ensure that data have been accurately recalled.

- Add the date and time to each entry.

- Sign each entry with your full name and professional credentials.

- Do not leave spaces between your entries.

- If an error is made, use a single line to cross out the error, then date, time and sign the correction.

- Never change another person's entry even if it is incorrect.

- Use quotation marks to indicate direct client responses.

- Write legibly.

- Document in a complete but concise manner using phrases and abbreviations as per policy.

- Document all telephone calls that you make or receive that are related to the client's case.

Activity 1

Select a number of patients and carry out a retrospective evaluation of the records that were kept over a period of time, for example the past two days.

Identify the positive aspects as well as the shortcomings in the personnel's recording.

Arrange in-service training and use the examples of the evaluation to correct weaknesses and praise those personnel who do record correctly.

Activity 2

Observe while personnel are busy recording and use on-the-spot teaching to rectify incorrect methods of recording. Make use of praise when correct recording is done.

Reporting includes all verbal communication of facts regarding the client's health status and ongoing care.

Activity 3

Give examples of instances that require verbal reports and state what information should be included in a verbal report.

The following instances require verbal reports:

- oncoming shifts with walking rounds

- a superior who does ward rounds

- any member of the multidisciplinary team who needs to be informed about a patient

Information to be included:

- Essential information about the patient: name, age, admission medical diagnosis, and pertinent historical data.

- Condition: current condition, such as diet, nothing per mouth, response to administered medication, Foley catheter, intravenous solution and site, orientation, prescribed activity level, fluid restriction, assistance needed by patient, current teaching and patient response.

- Care-related information: upcoming procedures, diagnostic tests completed and results if known.

- Values, such as last blood glucose level, vital sign parameters, intake and output amounts.

Activity 4

Observe while a colleague is on ward rounds. Discuss the information or lack thereof

with the colleague after the round.

Activity 5

Arrange a group discussion with the personnel on the ward and discuss how confidentiality has to be maintained.

The following points need to be discussed:

- Patients have a legal and ethical right to privacy.

- The nurse has a legal and ethical responsibility for protecting patient confidentiality.

- Nurses should not disclose information about a patient to another patient or to staff not involved in the patient's care.

- Nurses should not discuss any patient's condition in inappropriate settings, such as at the nurses' station or in lifts.

- Nurses must obtain the patient's permission before disclosing any information regarding the patient, going through the patient's personal belongings, performing procedures, or photographing a patient.

Phase 6: Evaluation

Standard 6: The registered nurse evaluates progress towards attainment of outcomes (Seaback 2006: 87)

Evaluation is the fifth phase of the nursing process. This step takes a critical look at the results of the nursing interventions that have been implemented. Like assessment, evaluation is continuous and ongoing. The question that needs to be answered critically here is whether the patient is progressing towards goal resolution. Have goals been met? Is this part of the plan complete and no longer a problem for the patient? When the client is not progressing as expected, answers are sought to determine why.

Learning outcomes

When you have studied the information on this phase you should be able to

- conduct a systematic, ongoing, and criterion-based evaluation of the outcomes

- evaluate the effectiveness of the planned strategies

- use ongoing assessment data to revise the diagnosis, outcomes and plan

 Activity 1

Pause and reflect on the care plan on page 187-193 of this research report. Consider the following situations with regard to Ms Botha's progress 20 hours after the implementation of the plan:

- Patient reports that she still has episodes of abdominal pain but that is not as severe as with admission.

- Last temperature reading recorded on the temperature flow record was 38,2ºC. Patient reports that she took in 8 glasses of clear fluid.

- With a pad check the nurse notices that there is still a vaginal discharge but that there is no increase in the quantity. Her perineal skin has not deteriorated. Patient verbalises that the perineal skin is washed and dried after each elimination and that sanitary towels are changed as prescribed. She no longer experiences vulva pruritus.

- The patient verbalises that she eats small portions of food and that no spells of nausea have occurred for the last four hours.

- There is no evidence of a fluid volume deficit. The skin turgor is satisfactory and the urinary output exceeds 30 ml per hour.

- The patient demonstrates a clear understanding of pelvic inflammatory disease and has managed to have an open discussion with her sexual partner. He, however, verbalised anger and blamed her for the situation.

- She expresses feelings of spiritual guilt because of her sexual relationship with her partner and the disease as a potential complication.

- The patient still appears to be anxious and frightened.

Now write an evaluation report using the goals and expected outcomes of the care plan. Answer the following questions on the nursing care interventions that the patient has been provided with:

- What is the purpose of evaluation?

- Is there any nursing diagnosis that you can discontinue at this stage?

- Is there a new nursing diagnosis? If yes, how would you go about drawing up new a nursing diagnosis, goal and expected outcomes and nursing interventions.

The following would be the correct diagnosis:

- Impaired social interaction with her friend related to communication and understanding barriers as evidenced by inability of friend to receive or communicate a satisfying sense of caring and understanding.

- Spiritual distress related to guilt feelings about sexual relationship as evidenced by verbalisation of inner conflict about spiritual beliefs.

You can now finish the assignment by stating goals, expected outcomes and nursing interventions.

5.4.10.4 Session 4: Effective utilisation of the nursing process

5.4.10.4 a   Aim and process outcomes

The aim of this session is to determine the outcome of your learning experiences with the programme pertaining to the internalisation and operationalisation of the nursing process. The process outcome is a completed reflective practice profile that will indicate the

extent to which internalisation and operationalisation has resulted on completion of the programme.

5.4.10.4 b Learning outcomes

At the end of this phase the personnel who have completed the programme should

- be able to identify learning experiences

- have attained learning outcomes

- be able to identify the difference in professional growth between prior knowledge and skills and existing knowledge and skills on completion of the programme

- be able to identify gaps in knowledge and skills on completion of the programme

- be able to identify areas that need to be explored and to read to enable a better understanding

- have evaluated the programme

- mail the profile to Ms M van der Vyver, University of Namibia, Private Bag 13301, Windhoek, Namibia

5.4.10.4 c Framework for reflection

 A practice profile may be described as a reflection on past events, in this case on your nursing practice with regard to the operationalisation of the nursing process

on completion of the programme. The length of this practice profile should be between 1000 and 1200 words.

Croghan (2005:74) advises that you consider the following points when writing your practice profile:

- What have you learnt from this programme and how does it relate to your practice?

- To what extent were learning outcomes met?

- What do you know now that you did not know before the programme?

- What can you do now what you could not do before the programme?

- What can you apply immediately to your practice?

- Is there anything that you did not understand, need to explore or read about further, to clarify your understanding?

- What else do you need to know or do to extend your professional development in this area?

- What other needs have you identified in relation to the internalisation and operationalisation of the nursing process?

- How might you achieve the above?

- How would you evaluate the educational programme with regard to the importance of all the sessions, the layout and aspects that were not addressed and that could have been addressed?

5.5   SUMMARY

In this chapter the programme for internalising and operationalising the nursing process was discussed. The educational programme was based on the results obtained from the data analysis. From the results it became evident that in order for the registered nurses to internalise and operationalise the nursing process, belief systems and attitudes had to be reframed, registered nurses had to work smarter not harder and that effective nursing care was dependant on the operationalisation of the nursing process. The end result of any programme to address shortcomings in the nursing process should be the internalisation and operationalisation of the nursing process in the gynaecology wards.

The programme that was developed consists of four sessions:

Session 1: Reframing belief systems and attitudes. In this session aspects of professional conduct, professional values and emotional intelligence were addressed.

Session 2: Work smarter not harder. In this session aspects of organisation of the self and time management were addressed.

Session 3: Nursing process a prerequisite for effective nursing care. In this session cognitive knowledge of the phases of the nursing process was included to enable registered nurses to provide effective nursing care.

Session 4: The internalisation and operationalisation of the nursing process. In this session registered nurses had to write a reflective practice profile. This would enable them to reflect on the knowledge that they acquired in the programme and on their own reading. It also included self-activities and reflection.

In the next chapter guidelines for the implementation of the programme are discussed.

CHAPTER 6

GUIDELINES FOR THE IMPLEMENTATIONOF THE EDUCATIONAL
PROGRAMME

6.1 INTRODUCTION

In the previous chapter the development of the programme was discussed. The purpose of this chapter is to draw up some guidelines for internalising and operationalising the nursing process. The guidelines were drawn up on the basis of the results of the data analysis of the study and therefore on the sessions presented in the programme.

6.2 DEVELOPMENT OF GUIDELINES

Data gathered and analysed during the first phase of the research clearly indicated a need for the internalisation and operationalisation of the nursing process. A programme and guidelines were therefore developed for this purpose. Guidelines are an important tool in the quest for evidence-based practice, and their implementation involves activities that turn the guidelines into action (Richens 2004:33; Puffer & Rashidian 2004: 501; Newson 2006:1).

The format of these guidelines includes goal formulation and rationale, the overall outcome of a guideline, education and training, clinical audit and other influencing factors.

6.2.1   FORMAT OF GUIDELINES

The format of the guidelines includes goal formulation, the overall outcome of each guideline, education and training, recommendations for each guideline, clinical audit and other influencing factors.

6.2.1.1 Goal formulation

Each guideline starts with a clear goal. The rationale for the goals is that the registered nurses who have to implement the guidelines know exactly what they have to achieve (Richens 2004:33; Green, Holloway & Fleming 2001:659; Garber 2005:176).

6.2.1.2 Overall outcome of each guideline

The overall outcome for each guideline was formulated, as the consequences of each guideline implementation was an important factor.

6.2.1.3 Education and training

The registered nurses first had to experience changes in their knowledge, attitudes and behaviour; and for this purpose the programme described in chapter 5 was formulated. The programme was designed in such a way that it actively involved the registered nurses,

since one of the key aims of educational interventions in adult education is to change knowledge, attitudes and behaviour (Richens 2004:35).

It is recommended that these guidelines be incorporated as part of staff induction of registered nurses in the gynaecology wards, since programme implementation guidelines have at their core the compliance of registered nurses' behaviour with evidence-based practice and the improvement of quality care (Richens 2004:36).

6.2.1.4 Recommendations

The researcher developed a number of recommendations for implementing each guideline. The focus of these recommendations was to give the registered nurses clear instructions on how to implement the programme. These recommendations also form the basis of the clinical audit instrument, which has been developed to give each registered nurse a clear idea of what is expected from him or her individually so that the terminus of the programme, the internalisation and operationalisation of the nursing process, could be reached.

6.2.1.5 Clinical audit

For the implementation of these guidelines, the researcher developed clinical audit instruments for each. The end product of the clinical audit should be a systematic review of the implementation of each guideline against criteria that were developed in relation

with the guideline recommendations. Clinical guidelines are influential in the improvement of quality care (Richens 2004:37; Kraszewski 2005:1; Morrow-Frost 2006:32).

6.2.1.6 Other influencing factors

In order for this programme to be implemented successfully, the professionals who will be implementing the proposed guidelines, namely the agent (guideline developer) the recipients (registered nurses) and the nurse managers, should form a close relationship. The more the professionals are involved in the implementation of guidelines, the greater the chances of success.

According to Richens (2004:38) permissiveness in nursing management adds to the success of guideline implementation and the right people should be requested to participate.

6.3.1   GUIDELINES   FOR   THE   INTERNALISATION   AND OPERATIONALISATION OF THE NURSING PROCESS

6.3.1.1   Guideline 1: Reframing of the belief system

6.3.1.1 a i   Goal and rationale

The goal of this guideline is to reframe the recipients' (registered nurses in the gynaecology wards) belief systems about the nursing process. The rationale of this guideline is for the registered nurse to obtain knowledge about what is expected from her in order to demonstrate professional accountability, emotional intelligence and professional values that will enable her to reframe her belief system and attitudes pertaining to the internalisation and operationalisation of the nursing process. This guideline furthermore informs the registered nurse about the role of the researcher in this regard.

6.3.1.1 a ii   Overall outcome

The outcome of this guideline is to internalise and operationalise the nursing process by providing knowledge and self-activities involving professional accountability and professional values in order to change registered nurses' belief systems about the utilisation of the nursing process.

6.3.1.1 a iii Education and training

Registered nurses have to utilise the "professional accountability, emotional intelligence and professional values programme" discussed in chapter 5 in the proposed step-by-step manner as presented.

6.3.1.1 a iv Recommendations for the recipient (registered nurse)

The registered nurse

- ➢ has to accept and demonstrate responsibility for her own learning
- ➢ has to assume responsibility for carrying out the activities prescribed in session 1
- ➢ has to negotiate with colleagues for a completion date for the activities
- ➢ has to actively participate in all activities so as to master the skills that accompany each activity
- ➢ has to critically reflect on issues concerning professional accountability and recommend changes for improvement
- ➢ has to verbalise learning needs to a colleague who has reached competency in the specific area, the agent, the nurse manager or the professional development educator
- ➢ has to negotiate with colleagues about group discussions at certain intervals of activity completion or at times such as on a weekly basis
- ➢ has to keep a clear record of the progress of each activity in session 1 of the programme so as to aid in the completion of the clinical audit
- ➢ has to participate in the negotiation for a date for the clinical audit on a quarterly basis

- **Recommendations for the agent**

The researcher

➢ has to actively negotiate a partnership between the University of Namibia and the Ministry of Health and Social Services in the area of professional accountability and related areas

➢ has to assume co-responsibility for collaboration with the registered nurses, the managers, and the professional development educators in the implementation of the programme

➢ has to provide support for the implementation of the programme

➢ has to raise awareness for the introduction of the programme in Ministry and Health and Social Services induction programmes for new staff members on the gynaecology wards

➢ has to establish links with the Ministry of Health and Social services in offering seminars so that recipients (registered nurses) can take on the role of facilitators in the internalisation and operationalisation of the nursing process with regards to professional accountability

➢ has to facilitate educational outreach to the gynaecology wards in areas where behaviour change is needed in professional behaviour

6.3.1.1 a v   Clinical audit

The aim of the clinical audit is to implement the recommendations for clinical guidelines. The clinical audit criteria are therefore developed from these recommendations. Audit and feedback are useful to measure adherence to guideline recommendations and to improve the quality of care pertaining to professional practice.

- **Instructions for completion of audit:**

➢ The clinical audit should be completed by the recipient (registered nurse) or the researcher (agent).

➢ The clinical audit is completed on the basis of records available for the different activities where applicable, as well as for observed behaviour as indicated in the activity.

➢ The audit should be carried out on a date that has been negotiated by all recipients (registered nurses) and the agent on a quarterly basis.

➢ Feedback on the audit needs to be done in a group, on a quarterly basis, at a date that has been negotiated by recipients and agent.

➢ The results of the audit need to be fed back constructively and with the use of motivation such as verbal praise between group members where appropriate.

➢ Each item on the audit list needs to be marked with a x on a scale of 1(never) to 7(in all instances) or NA (not applicable).

Clinical audit: Reframing belief system

Recipient (registered nurse) or agent: _____

Date of audit: _____

Clinical audit criteria	1	2	3	4	4	6	7	NA
Items to be completed by the recipient 1. Please indicate whether you have accepted and demonstrated responsibility for your own learning: • Have you developed your professional conduct and values? • Did you obtain additional reading material on professional conduct? • Are you in possession of the scope of practice of a registered nurse and midwife (Government Gazette 2040); • Have you obtained additional learning material on emotional intelligence?								
2. Have you carried out the activities that were prescribed in session 1? Activity 1 Have you given an example of obligations and said how these were fulfilled?								

Clinical audit criteria	1	2	3	4	4	6	7	NA
Activity 2 Have you completed the activity on reflection on the accountability of the registered nurse with regard to assessment of a patient who has to receive pethidine before receiving an injection?								
Activity 3 • Have you met patients' needs by promoting an environment in the ward where learning for professional development is encouraged?: ➢ If not, have you indicated it as a weakness? ➢ Have you implemented remedial actions to improve on this weakness? • Have you met patients' needs by promoting a practice environment that supports research findings to promote competent nursing practice? If not, have you taken remedial action?								
Activity 4								

• Please indicate whether duties to strengthen the employer's ethical and legal standards were practised. • Please indicate whether you have negotiated with the ward manager/ nursing management shortcomings regarding ethical and legal standards such as an environment conducive to safe, competent care, supplies, manageable workforce, and professional development opportunities.								
Activity 5 Please indicate whether you have exercised independent functions by utilising the nursing process for patients.								
Activity 6 Please indicate whether you have attended and actively contributed to a group discussion on the scope of registered nurses and midwives.								
Activity 7								

Did you participate in a group discussion? Did you apply components of emotional intelligence to the weaknesses and strengths you identified in each other and yourself?								
Activity 8 Please indicate whether you valued "good" practice pertaining to the knowledge and skills required to function optimally in the ward.								
Activity 9 Please indicate whether you valued the characteristics of the nursing.								
Items to be completed by the agent • Please indicate whether you have established a partnership between the University of Namibia and the Ministry of Health and Social Services in the area of professional accountability and related areas. • Please indicate whether you have demonstrated co-responsibility for collaboration with the registered								

nurses, the managers, and the professional development educators in the implementation of the programme.									
• Please indicate whether you assisted with the implementation of the programme.									
• Please indicate whether you have negotiated the introduction of the programme in Ministry and Health and Social Services induction programmes for new staff members on gynaecology wards.									
• Please indicate whether links with the Ministry of Health and Social Services were established by offering seminars that enhance the facilitators' role in internalising and operationalising the nursing process with regard to professional accountability.									

Results by recipient: _____

Results by agent: _____

Recommendations: _____

_____

6.3.1.2   Guideline 2: Work smarter not harder

6.3.1.2 a i   Goal and rationale

The goal of this guideline is for the recipient (registered nurse) to work smarter not harder.

The rationale of this guideline is to provide the registered nurse with knowledge of what is expected of her and the researcher with regard to effective time management through managing the self in order to assist in operationalising the nursing process in the time available.

6.3.1.2 a ii   Overall outcome

The outcome of this guideline is for the registered nurse to make the best use of time by managing the self.

6.3.1.2 a iii Education and training

Registered nurses have to apply the time management programme discussed in chapter 5 in the step-by-step manner proposed.

6.3.1.2 a iv Recommendations for the recipient (registered nurse)

The registered nurse

➢ has to accept and demonstrate responsibility for her own learning

➢ has to assume responsibility for carrying out the activities prescribed in session 2

➢ has to negotiate a completion date for the activities with colleagues

➢ has to actively participate in all the activities so as to master the skills that accompany each activity

➢ has to critically reflect on issues concerning time management and recommend improvements

➢ has to verbalise learning needs to a colleague who is already competent in the specific area, the agent, the nurse manager or the professional development educator

➢ has to negotiate group discussions at certain intervals of activity completion or on a regular basis with colleagues

➢ has to keep clear record of the progress for each activity in session 2 of the programme as to aid to completing the clinical audit

➢ has to participate in negotiating the date for the quarterly clinical audit

- **Recommendations for the agent**

The researcher

➢ has to actively collaborate with the University of Namibia and the Ministry of Health and Social Services in the area of time management and related areas

➢ has to assume co-responsibility for collaboration with the registered nurses, the managers and the professional development educators in the implementation of session 2 of the programme

➢ has to provide support for the implementation of session 2 of the programme

➢ has to raise awareness for the introduction of session 2 of the programme into induction programmes of the Ministry and Health and Social Services for new staff members on gynaecology wards

➢ has to establish links with the Ministry of Health and Social Services by offering seminars so that recipients (registered nurses) can undertake the role of facilitators of internalisation and operationalisation of the nursing process pertaining to time management

➢ has to facilitate educational outreach to the gynaecology wards in areas where behaviour change is needed on time management

6.3.1.2 a v Clinical audit

The aim of the clinical audit is to implement the clinical guideline recommendations on time management. The clinical audit criteria are therefore developed from the guideline recommendations. Audit and feedback are useful for measuring adherence to guideline recommendations and improving the quality of care pertaining to time management.

- **Instructions for completion of audit**

  ➢ The clinical audit should be completed by the recipient (registered nurse) or the researcher (agent).

  ➢ The clinical audit is completed on the basis of available records of the different activities where applicable as well as with observed behaviour as indicated in the activity.

  ➢ The audit needs to be carried out on a date negotiated by all the recipients (registered nurses) and the agent on a quarterly basis.

  ➢ Feedback of the audit should be done in a group on a date negotiated by recipients and agent on a quarterly basis.

  ➢ The results of the audit should be fed back constructively using motivation such as verbal praising between group members where appropriate.

  ➢ On a scale of 1(never) to 7(in all instances) or NA (not applicable) each item on the audit list should be marked with an x.

Clinical audit: Work smarter not harder

Recipient (registered nurse) or agent: _____

Date of audit: _____

Clinical audit criteria	1	2	3	4	4	6	7	NA
The recipient (registered nurse) Please indicate whether you have kept a record of your work pertaining to session 2.								
Please indicate whether you have accepted and demonstrated responsibility for your own learning.								
Please indicate whether you have assumed responsibility in carrying out the activities that were prescribed in session 2..								
Activity 1 Please indicate whether you have participated in a group discussion. Please indicate whether you managed to reflect on your individual functions and determined a focus.								
Activity 2 Indicate to what degree you have organised								

your work for the upcoming week.							
Activity 3 Indicate to what degree you took 20 minutes at the end of each day to prioritise your needs for the next day.							
Activity 4 Please indicate whether you have identified time stealers.							
Activity 5 Please indicate whether you have managed to take ownership of your own behaviour with regard to time management.							
Activity 6 Please indicate whether you used the tips that were given in this activity: • Did you say no and delegate? • Did you surround yourself with "good" staff? • Have you improved your skills where appropriate? • Did you start projects at the right time?							
Indicate whether you negotiated a completion date for the activities with colleagues.							

Indicate whether you verbalised learning needs to a colleague who is already competent in the specific area, the agent, the nurse manager or the professional development educator.							
Please indicate whether you negotiated group discussions at certain intervals of activity completion or on a regular basis with colleagues.							
Please indicate whether you have kept a clear record of progress for each activity in session 2 of the programme as to aid in completing the clinical audit.							
Please indicate whether you participated in negotiating a date for the quarterly clinical audit.							
The agent Please indicate whether you actively collaborated with the University of Namibia and the Ministry of Health and Social Services in the area of time management and related areas.							
Indicate whether you assumed co-							

responsibility for collaboration with the registered nurses, the managers, and the professional development educators in implementing session 2 of the programme.								
Indicate whether you assisted in implementing session 2 of the programme.								
Indicate whether you raised awareness for introducing session 2 of the programme into Ministry and Health and Social Services induction programmes for new staff members on the gynaecology wards.								
Indicate whether you established links with the Ministry of Health and Social services by offering seminars so that recipients(registered nurses) can undertake the role of facilitators of internalisation and operationalisation of the nursing process pertaining to time management.								
Indicate whether you have facilitated educational outreach to the gynaecology wards in areas where behaviour change is needed on time management.								

Results by recipient: _____

Results by agent: _____

Recommendations: _____

_____

6.3.1.3   Guideline 3: Nursing process a prerequisite for effective nursing care

6.3.1.3 a i   Goal and rationale

The goal of this guideline is to empower recipients with knowledge on the nursing process as a prerequisite for quality care in the gynaecology wards.

The rationale for this guideline is to provide the registered nurse with information about what is expected from her and the researcher with regard to operationalising all phases of the nursing process in everyday practice.

6.3.1.3 a ii Overall outcome

The outcome of this guideline is to internalise and operationalise the nursing process by providing knowledge on and self-activities for all phases of the nursing process.

6.3.1.3 a iii Education and training

Registered nurses have to work through session 3 of the programme discussed in chapter 5 in the step-by-step manner proposed.

6.3.1.3 a iv Recommendations for the recipient (registered nurse)

The registered nurse

- ➢ has to accept and demonstrate responsibility for her own learning
- ➢ has to assume responsibility for carrying out the activities prescribed in session 3
- ➢ has to negotiate a completion date for the activities with colleagues
- ➢ has to actively participate in all the activities so as to master the skills that accompany each activity
- ➢ has to critically reflect on issues concerning the phases of the nursing process and recommend improvements
- ➢ has to verbalise learning needs to a colleague who is already competent in the specific area, the agent, the nurse manager or the professional development educator
- ➢ has to negotiate group discussions at certain intervals of activity completion or on a regular basis with colleagues
- ➢ has to keep clear record of progress for each activity in session 3 of the programme as to aid to completing the clinical audit
- ➢ has to participate in negotiating a date for the quarterly clinical audit

- **Recommendations for the agent**

The researcher

- ➢ has to actively collaborate with the University of Namibia and the Ministry of Health and Social Services in operationalising all phases of the nursing process
- ➢ has to assume co-responsibility for collaboration with the registered nurses, the managers, and the professional development educators in implementing session 3 of the programme
- ➢ has to provide support for implementing session 3 of the programme
- ➢ has to establish links with the Ministry of Health and Social Services by offering seminars so that recipients (registered nurses) can undertake the role of facilitators of the internalisation and operationalisation of the nursing process with regard to phases of the nursing process
- ➢ has to facilitate educational outreach to the gynaecology wards in areas where behaviour change is needed in the operationalisation of the nursing process
- ➢ has to negotiate with the Ministry of Health and Social Services to include these guidelines in the quality assurance system of the service

6.3.1.3 a v   Clinical audit

The aim of the clinical audit is to implement the recommendations of the clinical guidelines. The clinical audit criteria are therefore developed from these recommendations. Audit and feedback are useful for measuring adherence to guideline recommendations and improving the quality of care pertaining to operationalisation of all phases of the nursing process.

- **Instructions for completion of audit**

➢ The clinical audit should be completed by the recipient (registered nurse) or the researcher (agent).

➢ The clinical audit is completed on the basis of available records of the different activities where applicable as well as with observed behaviour as indicated in the activity.

➢ The audit should be done at a date negotiated by all the recipients (registered nurses) and the agent on a quarterly basis.

➢ Feedback from the audit needs to be given on a quarterly basis, in a group at a date negotiated by recipients and agent.

➢ The results of the audit should be fed back constructively using motivation such as verbal praising between group members where appropriate.

➢ On a scale of 1(never) to 7 (in all instances) or NA (not applicable) each item on the audit list needs to be marked with a x.

➢ In this audit, the standards that were set by the American Nursing Association (Seaback 2006) will be used as audit criteria for the different phases of the nursing process.

Clinical audit: Nursing process as pre-requisite for effective nursing care

Recipient (registered nurse) or agent: _____

Date of audit: _____

Clinical audit criteria	1	2	3	4	4	6	7	NA
Completion by recipient Please indicate whether you have accepted and demonstrated responsibility for your own learning.								
Please indicate whether you have assumed responsibility for carrying out the activities prescribed in session 3.								
Activity 1 Please indicate on what level you utilised the nursing process at this stage.								
Activity 2 Phase 1 of nursing process: Assessment Please indicate whether you have collected comprehensive data pertinent to the patient's health need.								
Activity 3 Please indicate whether you managed to								

analyse, interpret and cluster data.								
Activity 4 Please indicate whether you managed to write the progress report with regard to the admission data correctly. Please indicate whether you wrote the correct data when required to supply subjective data. Please indicate whether you entered the data under objective assessment correctly. Please indicate whether you participated in a group discussion with colleagues.								
Activity 5 Please indicate whether you participated in a group discussion to reflect on the pathophysiology of pelvic inflammatory disease.								
Activity 6 Please indicate whether you selected a patient in the ward on whom you could apply your knowledge on the nursing process up to this point of assessment, analysis and interpretation of data.								
Phase 2 of nursing process: Nursing diagnosis								

Please indicate whether you analysed the data and determined the nursing diagnosis.								
Activity 1 Please indicate whether you have formulated a nursing diagnosis from the data given in the programme. Please indicate whether you participated in a group discussion where critique was used to assist one another.								
Activity 2 Please indicate whether you have studied the NANDA list of nursing diagnosis and labelled the data.								
Activity 3 Please indicate whether you have studied the list of nursing diagnosis of NANDA and managed to formulate a nursing diagnosis correctly.								
Activity 4 Please indicate whether you have identified at least fluid volume deficit as a potential problem for Ms Botha.								

Activity 5 Please indicate whether you have formulated a nursing diagnosis for the patient that you studied individually. Please indicate whether you have participated in a group discussion to discuss your findings for activity 4. Please indicate whether you have used critique and praise as group interaction methods.									
Phase 3: Planning Please indicate whether you have identified expected outcomes for an individualised plan for the patient or the situation.									
Activity 1 Please indicate whether you have reflected on prior knowledge when prioritising patient problems. Please indicate whether you could identify a model for hierarchy of needs.									
Activity 2 Please indicate whether you prioritised Ms Botha's problems correctly.									

Activity 3 Please indicate whether you identified goals for each problem. Please indicate whether you identified expected outcomes correctly. Please indicate whether you indicated a subject at all times. Please indicate whether you indicated an action at all times. Please indicate whether you indicated a time frame at all times.								
Activity 4 Please indicate whether you could repeat activity 3 with regard to the patient that you worked on individually. Please indicate whether you gained new knowledge with the formulation of goals and expected outcomes activities. Please indicate whether you used motivation as a group technique.								
Activity 5 Please indicate whether you identified								

independent nursing interventions for each nursing diagnosis. Please indicate whether you identified interdependent nursing interventions for all nursing diagnosis.							
Phase 4: Implementation Please indicate whether you met the standard for implementing an individualised plan.							
Activity 1 Please indicate whether you did a retrospective evaluation of a patient's record based on the guidelines for documentation. Please indicate whether you identified positive aspects pertaining to the implementation of the plan of care. Please indicate whether you identified shortcomings in the record. Please indicate whether you arranged an in-service education session for personnel.							
Activity 2 Please indicate whether you observed personnel while doing record keeping. Please indicate whether you applied on-the-							

spot teaching where appropriate. Please indicate whether you made use of praise to reinforce positive behaviour.							
Activity 3 Please indicate whether you gave examples of instances that require a verbal report.							
Activity 4 Please indicate whether you observed a colleague doing ward rounds and discussed the information or lack thereof after the round.							
Activity 5 Please indicate whether you participated in a group discussion on the maintenance of confidentiality of the patients in the ward.							
Phase 5: evaluation Please indicate whether you managed to maintain the standard for evaluating patient's progress towards the attainment of outcomes.							
Activity 1 Please indicate whether you have written a evaluation report for Ms Botha. Please indicate whether you identified a							

nursing diagnosis that could be discontinued. Please indicate whether you identified a new nursing diagnosis. Please indicate whether you finished the assignment by stating goals, expected outcomes and nursing interventions.							
Completion by agent Please indicate to what extent you actively collaborated with the University of Namibia and the Ministry of Health and Social Services in operationalising all phases of the nursing process.							
Please indicate whether you assumed co-responsibility for collaboration with registered nurses, managers, and professional development educators in the implementation of session 3 of the programme.							
Please indicate to what extent you provided support for the implementation of session 3 of the programme.							
Please indicate whether links with the Ministry of Health and Social Services were established by offering seminars so that							

recipients (registered nurses) can undertake the role of facilitators in internalisation and operationalisation of the nursing process with regard to the all phases of the nursing process.								
Please indicate to what extent you facilitated educational outreach to the gynaecology wards in areas where behaviour change is needed in oprationalising the nursing process.								
Please indicate whether you negotiated with the Ministry of Health and Social Services to include these guidelines in the quality assurance system of the service.								

Results by recipient: _____

Results by agent: _____

Recommendations: _____

_____

6.3.1.4   Guideline 4: Effective utilisation of the nursing process

6.3.1.4 a i   Goal and rationale

The goal of this guideline is to determine the outcome of your learning experience in the programme.

The rationale for this guideline is to provide the registered nurse with information about what is expected of her and the researcher with regard to writing the reflective practice profile and the outcome thereof, namely the degree to which the educational programme and the guidelines resulted in the internalisation and operationalisation of the nursing process in gynaecology wards of Namibian training hospitals.

6.3.1.4 a ii Overall outcome

The outcome of this guideline is a completed and returned reflective practice profile indicating the extent to which the nursing process has been internalised and operationalised during the application of the programme.

6.3.1.4 a iii Education and training

Information and experience in writing a practice profile.

6.3.1.4 a iv Recommendations for the recipient (registered nurse)

The registered nurse

➢ has to accept and demonstrate responsibility for writing her own practice profile

➢ has to follow the steps involved in writing a practice profile

➢ has to negotiate a completion date for the practice profile with colleagues

➢ has to critically reflect on issues pertaining to each session and discuss them with colleagues, seniors or educators

➢ has to negotiate group discussions at certain intervals of activity completion or on a regular basis with colleagues

➢ has to keep a clear record of the progress of the practice profile

- **Recommendations for the agent**

The researcher

➢ has to provide support for the writing of a practice profile

➢ has to provide recipients with feedback at a predetermined time on the outcome of the practice profile

6.3.1.4 a v Clinical audit

The aim of the clinical audit is to implement the recommendations for the clinical guidelines. The clinical audit criteria are therefore developed from these recommendations. Audit and feedback are useful to measure adherence to guideline recommendations and to improve the quality of care pertaining to professional practice.

- **Instructions for completion of audit**

➢ The clinical audit should be completed by the recipient (registered nurse) and the researcher (agent).

➢ The clinical audit is completed on the basis of available records of the different activities where applicable as well as observed behaviour as indicated in the activity.

➢ The audit should be carried out on a date negotiated by all the recipients (registered nurses) and the agent on a quarterly basis.

➢ Feedback on the audit should be given on a quarterly basis in a group on a date, negotiated by recipients and agent.

➢ The results of the audit should be fed back constructively using motivation such as verbal praising between members of the group where appropriate.

➢ On a scale of 1(never) to 7(in all instances) or NA (not applicable) each item on the audit list should be marked with an x.

Clinical audit: Practice profile

Recipient (registered nurse) or agent: _____

Date of audit: _____

Clinical audit criteria	1	2	3	4	4	6	7	NA
Completion by recipient Please indicate whether you participated in negotiating a date for this clinical audit.								
Please indicate whether you wrote your practice profile on the basis of the following points: • What you learned from the programme and how it relates to your practice.								
• To what extent learning outcomes were met.								
• What you know now that you did not know before.								
• What you can do now that you could not do before.								
• What you can apply immediately in your practice.								
• Anything that you need to explore								

further before you can introduce it in your practice.								
• Any other need that you identified during the application of the programme for internalising and operationalising the nursing process.								
• How you can meet the above needs.								
Completion by agent • Please indicate to what extent you provided support with the writing of a practice profile. • Indicate whether a date for feedback was determined with the recipients.								

Results by recipient: _____

Results by agent: _____

Recommendations: _____

_____

6.4 SUMMARY

In this chapter guidelines for the application of the programme were discussed. These guidelines were based on the sessions that had been formulated for the programme:

Guideline 1: Guideline for implementing session 1 of the programme on the topic: "Reframing belief systems and attitudes".

Guideline 2: Guideline for implement session 2 of the programme on the topic: "Working smarter not harder".

Guideline 3: Guideline for implementing session 3 of the programme on the topic: "Utilising the nursing process as a prerequisite for effective nursing care".

Guideline 4: Guideline for implementing session 4 of the programme on the topic: "Writing a reflective practice profile of the internalisation and operationalisation of the nursing process".

The guidelines for internalising and operationalising the nursing process were based on aspects of a cognitive learning theory and Knowles' andragogical learning theory. The format of the guidelines include goal formulation and rationale, an overall outcome for each guideline, education and training, recommendations for each guideline, a clinical audit and other influencing factors.

In chapter 7 the study will be evaluated, limitations will be discussed, and concluding remarks and recommendations will be made.

CHAPTER 7

EVALUATION, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

OF THE STUDY

7.1   INTRODUCTION

This research concludes with chapter 7. This chapter contains the evaluation of the research, conclusions, limitations and recommendations.

7.2   EVALUATION OF RESEARCH

The study is evaluated on the basis of the purpose and objectives, the justification of the original contribution to the knowledge base in nursing science, the limitations of the study and the recommendations made with regard to nursing practice, nursing education and nursing research.

7.2.1   THE PURPOSE OF THE STUDY

The purpose of the study was to explore the content of a programme for internalising and operationalising the nursing process and to develop guidelines for implementing the programme. In-depth focused interviews were used to explore the experiences of registered nurses and from the analysis of the data collected from these interviews it was clear that the nursing process was not being utilised effectively.

Although ample literature on the nursing process was found, there was no specific literature on programmes for addressing shortcomings in the utilisation of the nursing process. This subsequently presented the researcher with a major challenge, which made the study unique.

7.2.2   PHASES OF THE STUDY

All the phases of the study were carried out successfully. The first phase of the study entailed carrying out a situational analysis to explore whether and to what extent the nursing process was being utilised in the gynaecology wards of Namibian training hospitals. This objective served to explore practice in the training hospitals that had never been studied before. This phase was implemented by conducting in-depth focused interviews with nine registered nurses in the country's three training hospitals. The interviews proved to be a rich source of data, which were transcribed verbatim using the naturalistic method and analysed using Tesch's (1990)open-coding method. Data were contextualised and a literature study was conducted to validate the findings. The Lincoln and Guba's (1985:290 in Botes in Rossouw 2000:188) model was used to ensure the trustworthiness of the data. From the data it became clear that the nursing process was not being used effectively, as this was the storyline that could be followed through all the transcripts.

The second phase was to describe the experiences of the registered nurses regarding the utilisation of the nursing process. This phase comprised of describing the experiences at the hand of existing literature. To ensure that the meaning of the experiences were maintained, participants' exact words were quoted before literature was described.

The third phase was to develop a programme based on the data analysis conducted in phase 1. It was only through this phase that the programme could be developed exclusively for the registered nurses in this context. During this phase a programme was successfully developed that addressed the results of the data analysis in phase 1; the purpose of this programme being to reframe the belief systems and attitudes of registered nurses, to help them to work smarter not harder, to enable them to utilise the nursing process as a prerequisite for effective nursing care, and to internalise and operationalise the utilisation of the nursing process.

The fourth phase involved developing guidelines for implementing the programme for internalising and operationalising the nursing process in the gynaecology wards. The researcher regarded this as a communication channel, the means by which the research was shared with the rightful owners of practice, that is, the registered nurses on the gynaecology wards. Guidelines were then formulated.

7.2.3   JUSTIFICATION OF THE STUDY AS AN ORIGINAL CONTRIBUTION MADE TO THE BODY OF KNOWLEDGE IN NURSING SCIENCE AND THE UTILISATION OF THE NURSING PROCESS

This research is an original contribution to the body of knowledge in nursing practice; in particular in the context of gynaecology in training hospitals, and in nurse education.

The data were analysed in an orderly fashion, using Tesch's (1990) open coding principles. The results revealed that the nursing process was not internalised effectively. It was therefore clear that a programme and guidelines were needed for the internalisation and operationalisation of the nursing process. The reasoning map that was used in this study was based on the survey list suggested by Dickhoff et al. (1968). This survey list encompasses context, agent, recipient, dynamics, procedure of the activity and terminus.

This study is unique in that, on the basis of results obtained from the data analysis, a programme was developed to internalise and operationalise the nursing. Guidelines were developed exclusively to implement the programme.

7.3   LIMITATIONS OF THE STUDY

The study was limited by certain factors. In a qualitative study such as this it is not appropriate to generalise the results to all clinical areas where patients are treated as in-patients. The use of a small purposeful sample indicates that the findings are contextual,

and are not representative of all registered nurses. Yet the results of this study will be valuable for reference and future research.

7.4   CONCLUSION

From the results of the data analysis carried out on the data obtained from the interviews with the registered nurses, it became clear that the nursing process was not being used effectively in the gynaecology wards of Namibian training hospitals. However, a literature study showed that this situation is not unique to Namibia. In order to internalise and operationalise the nursing process, more emphasis needs to be placed on education and training in order to create a culture in which the nursing process will be utilised; a culture that promotes individualised, holistic nursing care relating to contemporary nursing practice.

The main purpose of the study therefore was the internalisation and operationalisation of the nursing process. Internalisation was achieved through the formulation of a programme and operationalisation was achieved by the development of guidelines for implementing the programme.

7.5   RECOMMENDATIONS

Recommendations of the programme apply to clinical practice, nursing education and nursing research.

The rationale for the study was to internalise and operationalise the nursing process, and in doing so, the consumers of health services would have the benefit of improved accountability and responsiveness of health services. For nursing personnel it would mean improvement in the implementation the nursing process as a tool for clinical practice. This study should assist in maintaining the implementation of the nursing process internationally in clinical nursing as well as in theoretical developments in the nursing process.

7.5.1   NURSING PRACTICE

Although the purpose of the study was not to address factors such as staff shortages and the establishment of an environment conducive to effective and efficient nursing practice, these are important aspects that affect registered nurses' ability to conduct "good" practice. The researcher therefore recommends that these factors be investigated and addressed by the Ministry of Health and Social Services to assist registered nurses in their task of delivering effective nursing care.

7.5.2   NURSING EDUCATION

Lecturers play an immensely important role in preparing students to internalise and operationalise the nursing process effectively. The quality of care given to the health

consumers of this country depends on the quality of education provided by lecturers and registered nurses in the clinical environment.

Since the Faculty of Medical and Health Sciences is in the process of building a curriculum for the implementation of a degree programme for pre-registration students, it is imperative to consider the inclusion of the nursing process as a basis for providing nursing care at all levels of the curriculum.

7.5.3   NURSING RESEARCH

More research on this important issue pertaining to nursing care is necessary. It is recommended that the outcome of the implementation of the guidelines be researched in the future.

7.6   OVERALL SUMMARY

In this chapter the study was evaluated with regards to whether the purpose and objectives that were formulated were met. The purpose of the study was to develop a programme to internalise and operationalise the nursing process and to develop guidelines to implement the programme. The study was performed in phases. Phase 1 consisted of a situational analysis to explore and describe the nature of the content for a programme for internalising and operationalising the nursing process. The content identified as necessary for the programme was that the belief systems and attitudes of registered nurses had to be

reframed, that registered nurses had to work smarter not harder, and that the nursing process is a prerequisite for effective nursing care.

Phase 2 consisted of the development of a conceptual framework from the results of phase 1. The activities from Dickhoff et al.'s (1968:433) situation-producing theory were used to describe the framework for this study. The survey list encompassed the items: context, agent, recipient, dynamics, procedure and terminus.

Phase 3 consisted of the development of a programme for internalising and operationalising the nursing process. The programme was presented in four sessions. Session 1 consisted of reframing the belief systems and attitudes of registered nurses, session 2 entailed working smarter not harder, session 3 comprised the nursing process as a prerequisite for effective nursing care and session 4 consisted of internalising and operationalising the nursing process. Phase 4 consisted of the development of guidelines for implementing the programme.

The study was justified as an original contribution made to the body of knowledge in nursing science and the utilisation of the nursing process. The limitations of the study have described and recommendations pertaining to practice, education and research have been discussed.

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