FROM THE EDITOR - Dr. Jackie Jones, RN, PhD

NURSING OLDER PEOPLE IN THE ACUTE CARE SYSTEM: A CLASH OF CULTURES OR A TIME FOR NURSING INNOVATION?

In recent weeks, I have been unfortunate enough to experience the loss of an older relative who had required care in an acute hospital.

Reflecting on the way the system took care of him, I could see how older people are at great risk of losing out in the professional nursing divide.

Little things, such as the provision of mouth care, are essential features of comfort for an older person who is hospitalised (Tutton and Seers 2004).[1] Yet as Tutton and Seers (2004, p387) and Jones, Bonner and Pratt (2005) confirm, while nurses value them highly in principle, getting access to them in practice is difficult.[2] Older people are also moved from one clinical silo to the next, under the current medical model evident in acute care.

And this led me to question: Who is providing the basics? Who has the time for them? Is it the role of the registered nurse in this highly technological and fast paced environment? What is the role of enrolled nurses, and increasingly, assistants in nursing, in acute care?

The aim of our work as nurses is to enhance dignity and value a person's individuality, while limiting functional decline – all at a time when the system itself seems to threaten our capacity to do so. In fact, some would argue that aspiring to holistic care provision is becoming unrealistic and unachievable in the current acute care climate.

It is time to acknowledge that older people are the growing population demographic we need to be aware of, but are we ready?

Work in Australia has progressed regarding the management of older people in the health service environment. The Australian Health Ministers' Advisory Council (AHMAC) Care of Older Australians Working group has developed *Age friendly principles and practices* (2004).[3] These principles and practices will be used as benchmarks in future hospital accreditation processes. Principle 1 states: *'Health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life, and is supported through the practice of 'an holistic approach [being] adopted in caring for the older person, which takes into consideration their overall physical, psychological and social needs, despite the person having presented with an acute condition'* (p6). Principle 6 adds that 'care of older people is a primary focus for all health services' (p11).

The latter point is important; older people are the primary focus and their complex care requirements are very much the domain of nursing work. This focus means many nurses will also need to reorient their thinking about the way in which they deliver nursing care. The challenge for all nurses, but particularly those in acute care, is how to remain person focussed and incorporate the values that are important to an older person who finds themself in hospital.

Innovation and leadership are the key to unravelling this issue, and we already have an incredibly knowledgeable and informed group of nursing experts to turn to: aged care nurses. Gerontological nursing has been defined not only by nurses working in this area, but also by older people themselves as: 'a person centred approach to promoting healthy ageing and the achievement of wellbeing, enabling the person and their carers to adapt to health and life changes and to face ongoing health challenges'.[4]

Nurses are practising in a time of great change, yet great constraint. The time is ripe for nurses to show what they are capable of and what it is they value. As the major providers of clinical education and the transfer of practice knowledge to the next generation of nurses, acute care nurses need to push the boundaries of practice once more, and ensure best practice in the provision of nursing to older people.

Our guest editorial by the National Institute of Clinical Studies identifies how nurses have taken leadership in practice development and the uptake of evidence into practice. The paper by Jackson, MacDonald, Mannix, Faga, and Firtko is a good example of why nurses need to focus on individuals in context. It describes a qualitative study undertaken to develop understandings into the views of a group of mothers with an overweight or obese child. The authors found participants were very concerned about their child's weight problems, and their immediate concerns focussed on social problems associated with obesity/overweight. They conclude that understanding parental views about their children's overweight and obesity is a key step in forming effective liaisons between health professionals and parents.

Duffield and colleagues explore the role of clinical nurse specialists and registered nurses through an examination of the use of their time. Adjustments to skill mix usually involve using more plentiful but less-skilled workers, and there is a growing body of overseas research in this field. This unique Australian work sampling study enables employers to begin to answer the question:

Are skilled nursing personnel being used effectively and efficiently?

Wilson and colleagues explore contemporary collaborative experiences of nurse practitioners in providing care with general practitioners and allied health care professionals. Their research shows most nurse practitioners report dissatisfaction due to ineffective collaborative relationships with doctors and allied health care professionals. The authors argue that sustainable collaborative partnerships should be developed with all heath care providers through the acknowledgement of the unique and valuable contribution each is able to make.

In their survey of 346 registered nurses who have completed either a three-year nursing diploma or a degree course and were working in hospitals at the time of the study, Takase, Maude and Manias examine how nurses' professional needs are met in nursing practice. Their findings suggest there is a mismatch between nurses' professional needs and the intrinsic/extrinsic rewards they receive for their performance. The authors argue that because this mismatch has a negative impact on nurses' work behaviour, it is important to reduce the gap between professional needs and the experience of actual nursing practice.

The final two papers focus on workplace learning and/or transition for nurses. Gibb, Forsyth and Anderson provide a theoretical analysis of culture and power in nursing to understand the determinants of social divisiveness that occurs between different levels of the nursing workforce. They describe indications of a move towards greater cultural coherency and support for learning within the nursing team in this study.

Levett-Jones and Fitzgerald, having reviewed the available literature, argue there is little evidence on the effectiveness of transition programs as interventions to enhance the transition from nursing student to professional practitioner. They challenge what constitutes best practice in transition for graduate nurses, and question whether primacy should be given to formal transition programs or to the development of educationally supportive clinical learning environments.

Together, these papers advocate a re-thinking of the work of nurses, and promote the need to explore the value of understanding the people we provide nursing care to.

Festive greetings to you all and good health for 2006.

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GUEST EDITORIAL - Sue Daly, RN, MN, FRCNA, and Margaret Ferma, RN, Grad Dip Emerg, MN (Emerg)

THE UNIQUE ROLE OF NURSES IN BRIDGING EVIDENCE-PRACTICE GAPS

Health care professionals face enormous challenges in grappling with very complex systems to provide patients with clinical care that is supported by credible evidence.

Over the past twenty years, there has been an increasing emphasis of the importance of research in nursing, with an abundance of information and new evidence emerging every day. However, the use of research in everyday practice presents enormous challenges.

Consider the perennial issues associated with the simple technical process of 'hand washing'. Medline listed 69 articles on this topic in 1984, 103 in 1994 and 263 in 2004. Despite the knowledge underpinning this growing evidence base, hand washing remains a major issue across the health care system.

Nurses, working in collaboration with other professional groups, have a pivotal role in shaping and influencing clinical practice, and therefore share responsibility for the quality of care provided within their local environment. However, recent research suggests that nurses are not well enough supported to ensure the quality of care provided draws on the best available evidence.[1]

A recent USA study published in the *American Journal of Nursing*[1] revealed nurses face a range of difficulties in establishing clinical care processes based on the best available evidence.

This study concluded that nurses' ability to use the latest evidence to inform their clinical practice is hampered by unmet learning needs in the use of computers; poor access to information technology; and a lack of education on the relationship between research and patient care.

From a review of the literature, Melnyk and colleagues identified the major barriers to adopting evidence in clinical practice include:

- perceived lack of time, busy clinical workloads;
- misconceptions about the value of research;
- inadequate education and training;
- lack of control over one's practice;
- inadequate administrative support; and
- insufficient resources.[2]

Establishing networks for sharing knowledge encourages the dissemination of ideas and strategies that can help nurses become more involved in the implementation of evidence-based practice.

The National Institute of Clinical Studies (NICS) is Australia's national agency for improving health care by helping close important gaps between best available evidence and current clinical practice. NICS works to raise awareness of the gaps in clinical practice, and through a number of programs and initiatives, guide's individuals and health care organisations to implement and sustain the required changes to improve clinical practice.

One such program, the Emergency Department Collaborative (2000), involved 47 emergency departments across Australia. The clinicians who participated in this initiative worked together to develop new strategies and protocols to improve clinical practice using the best available evidence. The aim of the Collaborative was to reduce time to analgesia for people presenting to the emergency department in pain. Collaborative teams also had the opportunity to undertake other improvements from a selection of 15 key emergency care priorities.

Staff culture surveys undertaken as part of the evaluation of the Collaborative identified nurses as key change agents, driving the evidence implementation process. Nurses took on a leadership role among the individual project teams, and generated momentum in their organisations to bring about changes that improved patient outcomes. This was demonstrated by a 19% improvement across 41 hospitals in time to analgesia for patients who presented to emergency departments. This improvement was equivalent to a 20 minute reduction in the median time for analgesia delivery.[3]

This collaboration has been followed by the formation of an Emergency Care Community of Practice, which provides nurses and their professional colleagues with opportunities to be involved in the uptake and implementation of evidence-based emergency care.[4] The Emergency Care Community of Practice enables clinicians to share resources, test ideas, and be involved in regular activities and projects that support evidence-based practice and implementation.

From our experience, opinion leaders who promote nursing and the profession's capacity to create change can have a very positive influence in changing the attitudes of busy clinicians, who at times have been reluctant to become involved due to lack of confidence.

Six nurses are actively engaged as clinical leaders in the Community of Practice, working to develop nursing leadership in evidence implementation within the emergency care setting. This involvement is giving them the opportunity to learn from local and international experts in the field of evidence implementation.

Individual nurses can also become involved and contribute to NICS programs and activities. As clinical leaders, nurses are encouraged to identify areas of clinical care that have demonstrated evidence-practice gaps and contribute to discussions and projects to help close those gaps.

The needs of nurses at both undergraduate and postgraduate levels should be addressed in order to equip nurses to understand and routinely adopt evidence implementation activities. NICS is working toward establishing strong partnerships with the nursing colleges to continue to support and encourage nurses in this important area.

Acknowledging the unique role of nurses as key professionals in achieving evidence-based care is a critical step in establishing care processes that are supported by the best available evidence.

Equipping nurses to undertake evidence-based practice has the potential to provide enormous benefits in patient care, with progressive reductions in the time taken for research findings to make a real difference.

Further information on NICS can be found at www.nicsl.com.au.

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MOTHERS' PERCEPTIONS OF OVERWEIGHT AND OBESITY IN THEIR CHILDREN

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ABSTRACT

Background:

Childhood obesity is a growing health concern and the literature implicates parents, particularly mothers.

Aim:

To develop understandings into the views of a group of mothers with an overweight or obese child, about their child's overweight or obesity.

Method:

A qualitative design informed by feminist insights. Eleven English speaking mothers of at least one overweight or obese child were drawn from a large urban community in metropolitan Australia to participate in this study.

Results:

Participants attributed their child's obesity to factors such as slow metabolism, sedentary lifestyle, familial or cultural factors, genetics, eating habits such as not drinking enough water, or not chewing food adequately. Participants were very concerned about their child's weight problems and their immediate concerns focussed on social problems associated with obesity/overweight.

Conclusion:

Understanding parental views about their children's overweight and obesity is a key step in forming effective liaisons between health professionals and parents.

BACKGROUND

Childhood obesity is a major international public health concern. Evidence from the United Kingdom (Reilly et al 2004), the United States (Hodges 2003), Canada (Anderson 2000; LeBlanc 2003), Australia (NHMRC 2003) and New Zealand (Gordon et al 2003) all raise concerns about childhood obesity in local populations.

Despite these global concerns, obesity in childhood is poorly defined, although most definitions do relate to measurements of body mass index (BMI). As Reilly et al (2003) point out, childhood obesity is regularly defined as a BMI exceeding the 85th or the 95th percentiles.

Childhood obesity occurs within a context of family life, and parents, especially mothers, have been implicated in the rapid growth of prevalence in childhood obesity (Golan and Crow 2004). Parental style is identified as influential in establishing children's eating patterns, with both over-controlling and under-controlling parental attitudes linked with undesirable child outcomes (Gable and Lutz 2000; Golan and Crow 2004).

A subtext of blame aimed at mothers is evident in the discourses around childhood obesity, particularly in the media (Mitchell 2002; Teutsch 2002). Mothers usually influence the nature, variety and quantity of food available to their young children (Baughcum et al 2000). They are instrumental in moulding the food related attitudes and behaviours children form; they create the family mealtime environment and influence rituals around eating (Gable and Lutz 2000; Golan and Crow 2004; Hodges 2003).

Hodges (2003) notes that parental recognition of obesity in children is a key factor in effecting change. Yet evidence suggests parents may have difficulties in

recognising weight problems in their own children (Myers and Vargas 2000). Myers and Vargas (2000) found that 35% of 200 socially disadvantaged parents of pre-school children did not recognise obesity in their own children. Baughcum et al (2000) found similarly, with only one in five (or 20%) of sampled mothers able to recognise overweight/obesity in their pre-school aged children. Furthermore, evidence also suggests that even where mothers recognise excessive weight, it may be viewed in a positive rather than a negative light. In a study involving mothers of infants aged 12-36 months Baughcum et al (1998) revealed maternal views suggesting that a large infant was a healthy infant and was therefore an indication of successful mothering.

Parental involvement is identified as crucial in obtaining favourable outcomes from interventions aimed at achieving sustained weight management in children (Golan and Crow 2004; Myers and Vargus 2000). Hodges (2003) highlights the importance of clarifying parental understandings and perceptions related to recognition of the problem. Given that obesity is an outcome of lifestyle factors over a period of time and not a sudden occurrence (Gable and Lutz 2000), it is also important to clarify factors that raise maternal concerns about obesity. In addition, maternal views and beliefs about causation are important because they will influence whether mothers feel they can do anything to resolve the problem, and will shape the actions they will take in response to the problem.

The aim of this study was to develop understandings into the views of a group of mothers with an overweight or obese child about their child's overweight or obesity. Specific aims were to: ascertain the length of time the mothers had perceived their child as having a weight problem; identify the catalyst for their concerns; and, discover mothers' perceptions of causative factors.

METHODS

Philosophical underpinnings of the study

Because of its concern with the insights and views of a group of women a feminist approach was selected as appropriate to inform this study. Feminist research principles identified by Cook and Fonow (1986) guided the project. These principles identify the need for continuous recognition of gender as basic to all social life; recognise consciousness-raising as an integral aspect of methodology; accept inter-subjectivity and personal knowing as legitimate sources of knowledge; acknowledge ethical responsibilities in research; and, understand the transformative and empowering aspects of feminist research (Cook and Fonow 1986).

Recruitment and procedure

Information about the study appeared in the media and women meeting the inclusion criteria were invited to contact the research team. Inclusion criteria were that women: were mothers of at least one overweight or obese child currently residing with them; could speak and understand English; and, were willing to participate. The inclusion criteria did not include any reference to age of the child as it was not specifically relevant to the aims of the study. Upon contact with the research team, further information was given to the women and appointments made to meet.

Where mothers had more than one child who was overweight or obese they were asked to focus on one child only and this child was referred to as the 'focus child'.

This study recruited parents rather than children themselves and though we could have asked parents to record the weight of their children this procedure could have been distressing to children who may already be sensitive about their weight. Furthermore, potential problems related to inter-rater reliability would render such information meaningless. Therefore, participants were asked to provide a recent photograph and information about the height and clothing size of the focus child. Clothing size worn by the focus child was sought by the researchers as an objective measure of the child's size in relation to their age. This information enabled researchers to establish each focus child as being either overweight or obese without needing to have any direct contact with the child.

Following recruitment into the study and procedures of informed consent, women participated in in-depth conversations about their perceptions of their child's obesity. During the conversations, three trigger questions were asked:

- How long have you perceived your focus child as having a weight problem?

- What initially raised your concerns?

- What do you consider to be causative factors to your focus child's weight problems?

Each of the conversations lasted for between one to two hours. Conversations were audio-taped and transcribed, with silences, periods of tearfulness, or other notable events indicated in text. Following transcription narratives were analysed taking an approach that involved using the research questions as a guide to question the text (Jackson et al 2003). The narrative was then clustered into key points that addressed the research questions (Mannix 1998).

Ethics approval

The relevant institutional ethics committee granted ethics approval. Pseudonyms are used to ensure participant confidentiality.

Participants

Eleven women meeting the inclusion criteria participated in the study. See table 1 for information about

the age and clothing size of the focus child, and family type of each participant.

Table 1: Pseudonym, age, clothing size and family composition

Pseudonym of participant	Age of focus child	Child's clothing size	Family composition
Barbara	14 months	1-2	F1
Kathy	5 yrs	8-10	F3
Fiona	5 yrs	8-10	F3
Donna	6 yrs	12-14	F1
Vicki	7 yrs	12	F1
Rose	7 yrs	14 (children) 10 (ladies)	F1
Julie	9 yrs	12-14	F2
Anne	9 yrs	10-12	F1
Sheryl	11 yrs	12-14	F1
Trish	12 yrs	16	F1
Wendy	15 yrs	22 (ladies)	F3

Key: F1 = mother and father of focus child (traditional married couple);
F2 = mother of focus child with new partner; F3 = sole parent family
(focus child lives with mother)

FINDINGS

Participants expressed great concerns about their child's weight problems. They reported experiencing difficulties obtaining age-appropriate clothing for their focus children. Mothers were anxious about their children experiencing social problems related to their weight, and all but one of the participants described various forms of social rejection experienced by their children. These included uninvited remarks by strangers or family members, mockery, bullying, unkind nicknames, and for some children, exclusion from certain social activities. The findings of the study are presented to reflect responses to the research questions.

How long had they perceived the problem?

None of the participants viewed their children's overweight or obesity as a short-term problem. All participants described having concerns about their child's weight for considerable periods. Most reported concerns for between two to five years, with one mother of a 15-year-old daughter having concerns for 10 years, and the mother of a 14-month-old son being concerned for approximately one year.

Factors that raised maternal concerns about obesity

Various factors were identified as raising maternal concerns. For some mothers, concerns became more intense when their children could no longer fit into age appropriate clothing:

'It never worried me for about the first three years. When he was about four, I think, then I started to worry because he wasn't fitting in clothes that my daughter would fit into, you know, she was quite consistent with her development… So now he's six and he's in clothes size 14, and that worries me.' (Donna)

'When she started school she was already a big girl. We had to get uniforms made for her, she just kept getting bigger. And in high school, we had to try to find uniforms that fitted her.' (Wendy)

Other events that triggered concerns were events such as negative comments from friends and relatives, and seeing their child in a class photo and noticing their child was larger than peers were, or being told that their child was outside centile charts by a health professional. Two participants could not link their concerns with any particular event. Rather, they described a gradual realisation that the focus child's weight was a matter for concern.

Maternal perceptions of causative factors

All participants could identify factors that they viewed as contributing to the problem and these included slow metabolism, sedentary lifestyle, familial or cultural factors, genetics, eating habits such as not drinking enough water, not chewing food adequately, or a combination of these factors. Sheryl took a fatalistic approach in that she felt that 'this is how God made' her daughter. Kathy did not consider her daughter's weight problems had anything to do with her diet. Rather, she considered lack of exercise was the main problem:

'I know good nutrition. I know what causes obesity and I don't think that has happened to my daughter. I think she doesn't do enough activity. I don't think it's her diet. It's her metabolism, it needs to be increased. I feel that is what the problem is with her, so I never even look at it from another perspective.' (Kathy)

And later Kathy commented that:

'She doesn't get much opportunity to exercise. Personally I don't think she overeats.' (Kathy)

Lifestyle and environmental factors were identified as impacting on the activities of their children. Participants reported a feeling that the focus children had a tendency to be naturally sedentary, with preferences for sedentary activities such as drawing or craftwork:

'She tends to come home, sit down, put on a video or watch television and unless I closely supervise her and say "television's going off, go outside and play" she's quite happy just to sit and do nothing… I've noticed her very slow movement to even just get dressed.' (Fiona)

'Since she was a toddler, she has been a fairly sedentary child, she loved being inside doing craft with me or watching a bit of telly, she's never been an outside person, so that's always been a struggle with us to try to get her outdoors more.' (Vicki)

Participants reported that they had to be very inventive and continually encourage their children to move about more. Mothers discussed the tensions between wanting to encourage their children to be more active, and issues around child safety.

A number of mothers felt that walking to and from school would be good exercise for their children, however, felt it wasn't safe for their child to do this alone, and due to other commitments were not able to accompany their children. Therefore, they put child safety first and arranged for their children to be driven or bussed to school:

'It's close enough to walk but there's no footpath and it's too dangerous, so we actually drive to and from school' (Sheryl)

Several participants commented that the focus child seemed to have a different relationship to food than other family members. They felt the focus children enjoyed food and loved to eat more than their other children. Where this was the case, mothers felt there was a need to monitor the dietary intake of the focus child, whereas their other children were able to self monitor food intake. Rose and Sheryl felt that their focus children had a lack of self-control where food was concerned. Other participants also noticed that their focus children ate more than their siblings and peers and would hover around food when it was available:

'She will just eat. We notice a lot when she goes to parties or there's lots of food around. If there's food around she can't not eat it, even if it's nibble food or whatever, she's got to be eating it all the time. You know, other kids might be off running around but she would be sitting eating. Probably not so much now but when she was little bit younger, I'd notice that when I'd stay at the parties.' (Vicki)

'If there's a plate of biscuits, she will have three whereas my other daughter would only have the one, and that daughter is always on the go, where she (focus child) is a bit more slow.' (Sheryl)

Wendy attributed her daughter's longstanding weight problem to a genetic predisposition, and commented that the extended family are a 'big' family. Other participants also linked their current concerns about the weight of the focus child to family issues describing longstanding and entrenched intergenerational obesity among grandparents, parents, aunts, uncles and cousins:

'I look at her dad and his side of the family and they are all naturally as wide as they are tall! They're like squares. Because the grandmother is obese isn't she.' (Julie)

'He was born big, he was 4.7 kgs born, and a lot of people say he's like my mother, and if you look at genes, you know, she's very broad.' (Barbara)

Participants from some minority groups identified cultural heritage as an issue that contributed to their child's weight problem, both because of the feeling that to be large was viewed positively in some cultures, or because of the role of food in family gatherings.

Donna felt that her son's cultural minority background had an effect on his weight and his relationship with food. However, though Donna viewed the role of culture and heritage as contributing to her son's weight problems, she felt that other factors also played a part. Donna's focus child is the youngest child and Donna thinks he may have been 'spoilt' and fussed over by his much older siblings. She felt that his position in the family meant that he was subject to lower parental expectations in general, and she acknowledged that he had been permitted to eat certain 'junk' type foods, which her older children had not been permitted to eat. Donna attributed her child's initial obesity to feeding practices as a baby in that he was given extra bottles to comfort him when he was distressed or unsettled:

'I think the way he was fed up until he was four years old. Not that he wasn't fed healthily, but maybe over-indulged. I think that was the cause, not just genetic. He was predisposed to it definitely, but I think we helped him along the way too.' (Donna)

DISCUSSION

The findings of this study give insights into the views of a group of mothers of overweight or obese children about their child's overweight or obesity. Findings reveal participants were greatly concerned about their children's weight and expressed awareness of the social ramifications of excessive weight for their children. There was less of an awareness of the physical ramifications of obesity.

Parents had been concerned about the weight of their children for considerable periods of time, and with the exception of Barbara who was mother of an infant, children had entrenched weight problems before their mothers became concerned. Prior to specific events that triggered their concerns mothers indicated that they did not feel particularly concerned about their children's weight.

Parents are not the only ones who have difficulties in recognising obesity in children. Myers and Vargas (2000) found that 18.7% of health centre staff did not recognise obesity in children who were clinically obese and they cite other research evidence to suggest that only 20% of obese children are recognised and offered treatment for their obesity (Myers and Vargas 2000). Paradoxically, Story et al (2002) conducted a mailed survey to ascertain paediatric health professionals' attitudes and knowledge about childhood obesity and found that up to 93% of respondents were concerned about childhood obesity, viewed it as a threat to health and well-being, and felt intervention was warranted (Story et al 2002).

Despite mounting concern about childhood obesity in the health community, much about this phenomenon remains unresolved in the professional discourses. Even defining and measuring obesity in children is contested (Fruhbeck 2000; Kimm and Obarzanek 2002), though common measures currently available include body fat distribution measures, BMI, and weight-height indices (Hodges 2003). Kimm and Obarzanek (2002) highlight a need to re-examine definitions of obesity in relation to children. They assert that the accepted BMI measures are arbitrary and are not linked to known adverse outcomes (Kimm and Obarzanek 2002). Ideas about causation held by health professionals (Blasi 2003; Kimm and Obarzanek 2002; Myers and Vargus 2000; Reilly et al 2004) were similar to those held by the participants in this current study.

In this current study, participants also linked eating habits such as not drinking enough water and not chewing food adequately to their children's weight problems. It is important to understand parental beliefs about causation of obesity and overweight because it influenced whether the women felt that they could do anything to resolve the problem, and what actions they could take. For example, where parents perceived the problem was primarily linked to sedentary lifestyle; efforts were made to provide opportunities and encouragement to participate in physical activity.

To be effective, any intervention designed to either prevent or manage overweight or obesity in young children is dependent on the involvement and support of parents (Anderson 2000; Baughcum et al 2000; Golan and Crow 2004). Parents tread a fine line between being over controlling and too laid back when it comes to monitoring their children's food intake. Some participants noted differences between their obese/overweight child and other children in that some children seemed better able to self-monitor their intake. Parental over-control of food and mealtimes is linked to children being unable to self monitor food intake as are overly lassez-faire parents (Gable and Lutz 2000).

IMPLICATIONS FOR PRACTICE

Nurses are ideally placed to support parents and families who are trying to manage overweight or obesity in their children. The literature provides guidance on the needs of parents of children with long-term health challenges and these include a requirement for information, and, a need to form caring partnerships with health professionals (Fisher 2001). However, the evidence suggests that health professionals themselves have difficulties in recognising childhood obesity (Myers and Vargus 2000), and this is an area to be addressed if mothers and families are to be assisted effectively. Studies looking at parental involvement identify the importance of ensuring shared perceptions and views of a situation (Simons et al 2001).

A key step in forming effective liaisons between health professionals and parents is ensuring shared perceptions - that is, both parents and professionals understand what childhood obesity is and understand its full social, emotional and health ramifications.

Mothers and their children are frequent users of health services and though a child's weight may not be a primary reason for the presentation to a health professional, recording weight and height are normal and routine aspects of paediatric health assessment. However, despite collecting height/weight information, it may not be fed back to mothers in such a way that they can fully understand where their child sits in relation to ideal height/weight ratio.

Effectively communicating with parents about growth concerns means that any presentation for health care can provide opportunities to give mothers timely information about child's weight and general health regardless of the catalyst for the contact. Notwithstanding the current debates about the applicability of common measures (Fruhbeck 2000; Kimm and Obarzanek 2002), working with mothers and families to help them start to have an awareness of their children's weight patterns, and how they develop in relation to general growth could be a good beginning in helping families to develop a heightened awareness of weight related issues.

Though participants attributed their children's weight problem to a range of factors, there was acknowledgement that a sedentary lifestyle had contributed to the situation. Mothers described children who were reluctant to exercise, and also described feeling unable to let children walk to school or play outside because of safety concerns. Nurses in the community have a role in working with parents, schools and other agencies to promote child and family health and acting to ensure safe places for children to play and participate in a whole range of physical activity.

LIMITATIONS TO THE STUDY

The self selected nature of the group of participants means that respondents already had awareness of and concern about the weight problems of the focus child.

CONCLUSION

The involvement and support of parents is essential to the success of any intervention aimed at the prevention and management of overweight or obesity in young children. A window of opportunity exists for nurses to recognise childhood overweight or obesity as a preventable chronic health problem. By doing so nurses can work on preventative strategies in partnership with families to manage this major health problem. While findings are not able to be generalised, they provide insights that can help guide the development of preventative strategies and practice initiatives.

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NURSING SKILL MIX AND NURSING TIME: THE ROLES OF REGISTERED NURSES AND CLINICAL NURSE SPECIALISTS

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ABSTRACT

Objective:

The roles of clinical nurse specialists (CNS) and registered nurses, while similar, should also be quite different, with the CNS functioning as an advanced practice nurse. Differences in roles can be partially explained and understood by examining the use of their time. Adjustments to skill mix usually involve using more plentiful but less-skilled workers, and there is a growing body of overseas research in this field. In contrast, little research has examined and compared the use of nursing time for the RN and CNS role, particularly in an Australian context. Comparing work activities enables employers to begin to answer the question: Are skilled nursing personnel being used effectively and efficiently?

Design:

A work-sampling study conducted over eight weeks. Data were analysed descriptively using SPSS, v.9.

Setting:

Six wards in a large private not-for-profit hospital.

Main outcome measure:

To determine whether there is a differentiation in the roles of CNS and RN by examining the percentage of time spent in 25 specific activities.

Results:

In some activities it is not possible to distinguish differences in the amount of time spent by RNs and CNSs. In other activities such as clerical, meetings and administration, CNSs are spending more time than anticipated. Consideration needs to be given to employing clerical staff to relieve the CNS of these non-clinical aspects.

Conclusion:

The study extends the understanding of the roles of registered nurses and clinical nurse specialists and provides a basis on which to begin to understand similarities and differences in their roles.

INTRODUCTION

In Australia, as in most industrialised countries, there is an acute shortage of skilled registered nurses (RN) and this is likely to be exacerbated by the looming shortage of medical staff. While there are many reasons for this, it is acknowledged that there will continue to be insufficient nurses to meet demand, with a projected shortfall of 40,000 to 44,520 nurses (Access Economics 2004; Karmel and Li 2002). It is opportune therefore to examine the activities in which nurses are involved. In particular, an examination of advanced practice roles such as clinical nurse specialists (CNS) is most timely, as medical staff shortages may expand their scope of practice. This in turn is likely to exacerbate nursing shortages, resulting in the replacement of skilled registered nurse and clinical nurse specialist positions with less qualified staff.

This paper presents findings from a work sampling study conducted in a large not-for-profit hospital in Sydney, New South Wales, Australia. Results are presented on selected activities undertaken by registered

nurses (RNs) and clinical nurse specialists (CNSs) in five medical-surgical units and an intensive care unit. The purpose of the study was to determine whether there were differences in their roles through analysis of the work activities in which they were involved. As well as outlining clearly the proportion of time spent in various work activities, the data also highlight the usefulness of this type of information in examining an institution's skill mix, a critical aspect of workforce planning and utilisation.

Skill mix and the use of nursing time

It is quite likely that with increased acuity and shortened lengths of stay, the work undertaken by nurses has changed. More acutely ill patients requiring more complex interventions and treatment regimens in shorter periods of time are likely to have a significant impact on nurses' workloads, and furthermore, require more rather than less skilled employees (Aiken et al. 2002; Duffield and O'Brien-Pallas 2002). As yet there are no Australian data to support this contention. Given workforce shortages and financial constraints, it is timely to examine the activities in which nurses are involved and the best mix of staff to provide the safest care possible.

Adjustments to skill mix (sometimes referred to as staff mix) are a component of health human resource planning used to achieve the most flexible and cost effective use of health care personnel (Lookinland, Tiedeman, and Crosson 2005; Spilsbury and Meyer 2001; O'Brien-Pallas, Thomson et al. 2001; Needleman et al. 2002; Aiken, Clarke, Sloane, Sochalski et al. 2001; McGillis-Hall 1998, 1997). Skill mix models might comprise an all registered nurse (RN) staff, including clinical nurse specialists (CNSs), the focus of this paper. Another model is a combination of RNs, enrolled nurses (ENs) or other categories of unlicensed personnel such as ward assistants (WAs), assistants in nursing (AINs) or personal care assistants (PCAs).

There are several 'drivers' for adjusting skill mix, but the most prevalent influence has been financial. Registered nurses comprise the largest labour force in hospitals and, as such, are often perceived as costly rather than cost-effective (O'Brien-Pallas et al. 1997). This factor, combined with the shortage of qualified nurses and 'multiskilling', has shaped the debate around skill mix. Downsizing of organisations in the corporate world encouraged more skilled staff to expand their roles, providing opportunities for less skilled workers to take over routine tasks. Advocates of multiskilling in nursing argued it would release RNs to spend more time in direct care of patients, while less skilled workers such as AINs, WAs, and PCAs, functioning under the direction of an RN, perform not only basic activities such as routine nursing care (hygiene, changing dressings, ambulating patients, etc) but in some instances, more complex and responsible tasks when so instructed. Their scope of practice may now include tasks that were once the exclusive domain of qualified nursing staff, for example,

wound dressings, physiotherapy and the administration of medications (Fagin 2001; Wansbrough 1998; Bernreuter and Cardona 1997; Friesen 1996). As less skilled employees undertake more complex routine tasks, RNs are in theory released to spend more time in the direct care of patients, but in practice, all too often spend significant amounts of time in communication, conflict management and supervising the work of these employees (Lookinland, Tiedeman, and Crosson 2005).

In turn, the role of registered nurses has moved beyond that traditionally practised (O'Brien-Pallas, Baumann et al. 2001; Duffield and Franks 2001; Aiken, Clarke, Sloane, and Sochalski 2001). The 'flow-on' effect is that the role of clinical nurse specialists may also have changed during that time to reflect the advanced practice required for more complex and acute patients, but there is little evaluative evidence thus far. As more sophisticated technology, treatments and procedures are introduced, it is often the CNS who is called upon to become most familiar with these and to be the resource person for the ward, assisting the rest of the staff to upgrade their skills and knowledge.

The perception that replacing RNs with unregulated workers can provide cost savings remains contentious, with evidence emerging that there is a negative impact on patient and staff outcomes (Blegen, Goode, and Reed 1998; Buerhaus and Needleman 2000; Needleman et al. 2001; Aiken, Clarke, Sloane, Sochalski et al. 2001). A growing body of research from overseas highlights the nexus between registered nurses (number and skill level) and patient outcomes (Aiken, Clarke, Sloane, Sochalski et al. 2001; Needleman et al. 2002; Buerhaus and Needleman 2000; Bernreuter and Cardona 1997). These large scale multi-site and multinational projects have placed the issue not only on the research agenda, but have also raised the awareness of policy makers, consumers and registered nurses themselves about the impact of using fewer RNs. The long term shortage of RNs is now pressuring health care administrators to reconsider the viability of adjusting skill mix (using less skilled workers) as a means of decreasing costs given the negative consequences for nurses (inability to retain staff) and patients (increased adverse events) (Aiken, Clarke, Sloane, Sochalski et al. 2001; Buerhaus and Needleman 2000; Baumann et al. 2001; McClung 2000; McGillis-Hall et al. 2001; O'Brien-Pallas and Baumann 2000).

What has received less attention, particularly in Australia, is the use of nursing time. Nursing shortages stem in part from the ineffective and inefficient use of nursing personnel (Prescott et al. 1991). Kovner and Harrington (Kovner and Harrington 2002) found that for every hour emergency department nurses were involved in direct care, an equal amount of time was spent on paperwork. They questioned whether time spent documenting was competing with patient care. More recently in the United States, it has been reported that 34.3% of nurses were performing housekeeping duties,

42.5% delivered and retrieved food trays, and 45.7% transported patients (Institute of Medicine 2004). These are clearly activities in which less skilled employees could and should be involved. Furthermore, 27.9% reported leaving patient/family education undone and 12.7% left discharge planning undone, both significant activities in which nursing expertise is required to ensure patients return home quickly and safely. In another study, Tucker and Edmondson (Tucker and Edmondson 2002, 2003) reported that 33-minutes in every 8 hour shift were lost as a result of coping with work system failures. Of these, 39% caused on average a 90 minute delay in patient care from causes such as missing or incorrect information, missing or broken equipment, simultaneous demands on time, waiting for a human or material resource, and missing or incorrect supplies.

To date, there is no study reported in Australia that examines the work activities in which registered nurses and advanced practice nurses (CNS) are involved. Nor is there work examining the impact that skill mix has on patients, staff and organisations, although work is under way in NSW with results expected in 2006. With shortages of skilled nurses it is timely to consider the work undertaken by registered nurses and clinical nurse specialists.

Work sampling

Work sampling is a validated method for measuring the activities of staff to determine what it is that various classifications of staff do in the work environment (Urden and Roode 1997; Hagerty, Chang and Spengler 1985). Its use involves the observation of multiple workers at random intervals by trained independent observers who record the observed activities into predetermined categories during a sample of hours, shifts or days (Prescott et al. 1991). Work sampling is premised on the laws of probability: that a sample of observations of staff activities can be generalised into a larger snapshot of how staff spend their working days over a longer time frame, without these observed activities being underestimated by more mundane or repetitive activities (McNiven, Hodnett, and O'Brien-Pallas 1992; McNiven, O'Brien-Pallas and Hodnett 1993; Guarisco, Oddone and Simel 1994). The actual activity is recorded, not the time spent in activities (Urden and Roode 1997).

STUDY AND METHOD

The study was conducted over eight weeks (two weeks of data collection per ward randomised over eight weeks). There were 19 data collectors provided by the study hospital, while university staff provided training in the use of the tool and determined inter-rater reliability. The instrument (Urden and Roode 1997 used with permission) and its validation in the Australian context, have been described elsewhere (Duffield et al. 2001). However, in summary, there are four major categories (McNiven, O'Brien-Pallas, and Hodnett 1993; Prescott et al. 1991; Urden and Roode 1997) in which 25 activities are measured at ten-minute intervals. Only one activity is recorded per staff member per observation, and that is the activity that brought the nurse to the patient's bedside. The staff member may well have been undertaking additional activities, but these are not recorded. The activities for each of the four categories: Direct Care, Indirect Care, Unit Related and Personal Time are shown in table 1. A specific activity schedule that outlined each of the 25 activities was given to each data collector.

Table 1. Activity codes by category (direct care, indirect care, unit-related activities and personal time)

DIRECT CARE	INDIRECT CARE	UNIT-RELATED	
• Admission/Assessment	• Co-ordination of Care: Care Planning/Critical Pathways	• Clerical	• Personal Time
• Assisting with Procedures	• Co-ordination of Care: Rounds, Team Meetings	• Errands Off-Unit	
• Hygiene	• Communication/Information	• Environmental Cleaning	
• Medication/IV Administration	• Computer: Data Entry/Retrieval	• Meetings & Administration	
• Nutrition/Elimination	• Medication/IV Preparation	• Supplies, Check, Re-stock	
• Patient Mobility	• Progress Notes/Discharge Notes	• Teaching/In-service	
• Patient/ Family Interaction	• Room/ Equipment Setup/ Cleaning		
• Procedures	• Verbal Report/Handover		
• Specimen Collection/ Testing			
• Transporting Patient			

Results reported here include: General Surgery; Cardiac; Orthopaedic; Urology; Haematology Oncology with a bone marrow transplant (BMT) unit within the ward; and an Intensive Care Unit (ICU). Staff working between 0700 and 1900, Monday to Friday, on randomly selected days were asked to participate. These days and times were chosen as they provided the most cost-effective data and represented most activity. At the time of this study, there were no enrolled nurses (ENs). Most RNs and CNSs consented to participate, the few exceptions being agency/casual staff. Data were collected at ten-minute intervals on each unit in two-hour blocks. There were 53,240 observations, which provided a robust sample for data analysis.

Data were analysed descriptively using the Statistical Package for the Social Sciences, version 9. The activities for each type of nurse are expressed as the percentage of the total number of observations of that staff type. When there is a large number of observations taken at repeated random intervals, the resulting data will have the same distribution as observations taken continuously (Urden & Roode 1997). Thus observations of specific activities, represented as percentages of specific activities represent percentages of time spent in actual activities. Selected activities are presented for discussion.

RESULTS

A major activity in the Direct Care category is Admission and Assessment, which includes activities such as TPR, pulse oximetry, weight, monitoring equipment and alarms. The amount of time spent here by RNs ranged from 6.5% to just over 10%, and for CNSs, 5% to just over 10% of observed activities which is considerable. In a study several years ago only 1.88% of observations were recorded in this activity (Hovenga 1996). Differences in the current study may reflect the increased acuity, rapid turnover of patients with shortened lengths of stay and intensive post-surgical periods that have occurred in the intervening years as the demand for beds increases. The percentage of time spent is slightly less for the CNS than the RN, except on Haematology and ICU, which may be explained by the higher acuity of patients in these units requiring more ongoing monitoring. The CNSs in ICU and the Haematology/BMT unit may well be called upon to assist and teach RNs specific admission and assessment procedures, which may also account for the higher CNS involvement here.

Also in Direct Care is the Patient Hygiene category (activities such as baths or showering, oral care, dressing and shaving are included here). There were less observed activities across the majority of the wards, with the CNS role spending more time (1-5%) doing so on some wards than RNs (1-3%). There is less time in this activity in ICU, which probably reflects the staffing levels of 1:1. The percentage of time spent in hygiene activities is slightly less than previous results of 4.66% (Hovenga 1996). Haematology incorporates a BMT Unit (with

isolation rooms) which may account for the higher level of patient hygiene provided by the CNSs on this ward (5%). While it is the activity that took the nurse to the bedside that is recorded, once in the isolation room, a greater range of activities is likely to have been undertaken by the CNS in the interests of efficiency. For example, this time might have been used to good effect to communicate with the patient on issues such as their recovery process, educational needs and discharge/home support requirements.

**Figure 1: Communication and Information**
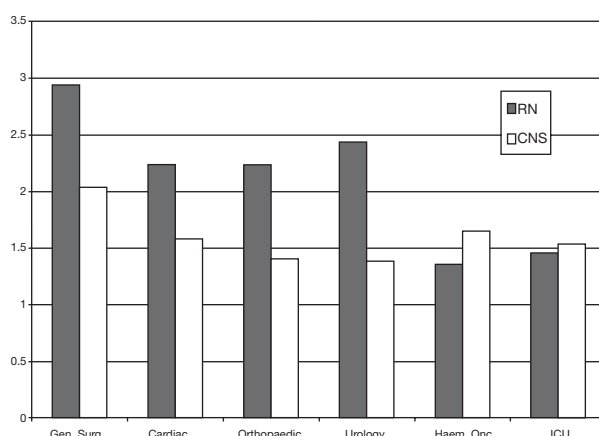
Communication and Information (Figure 1) in the Indirect Care category includes activities such as interaction with other departments related to coordination of patient care and patient advocacy, providing information and direction to support or ancillary staff with aspects of patient care, bed management and referencing written resource materials (eg. textbooks, phone lists, procedure manuals). Again, this activity does not consume a large part of the RN or CNS role, perhaps reflecting stability in staffing and bed management. Permanency in staffing means staff are more likely to be familiar with the patients, the work and hospital routines as does limited bed/room/ward changes for patients. However, the RNs were observed to be involved in this activity more frequently than were CNSs (except on Haematology and ICU where there was little difference), indicating perhaps more involvement in the patient management role than for CNSs.

The results may reflect a common practice of using the CNS role as the manager or shift coordinator in the absence of the Nursing Unit Manager, taking the CNS away from more direct patient care. The limited amount of time spent by CNSs in this activity is consistent with earlier work (Duffield, Donoghue, and Pelletier 1995). The CNS is more likely to engage in communication and information away from the patient's bedside, teaching less experienced staff in in-service sessions.

The Verbal Report and Patient Hand-Over activity (Figure 2) recorded one of the highest percentages of observed activities. It is undertaken more frequently by RNs than CNSs on every unit and in some cases, such as Cardiac, almost twice as often. This result compares with Hovenga's (1996) result of 19.75-minutes/patient day. There are two possible explanations. It may indicate that more patient care is provided by RNs than CNSs and as a consequence, they spend more time in this activity.

Figure 2: Verbal Report and Handover
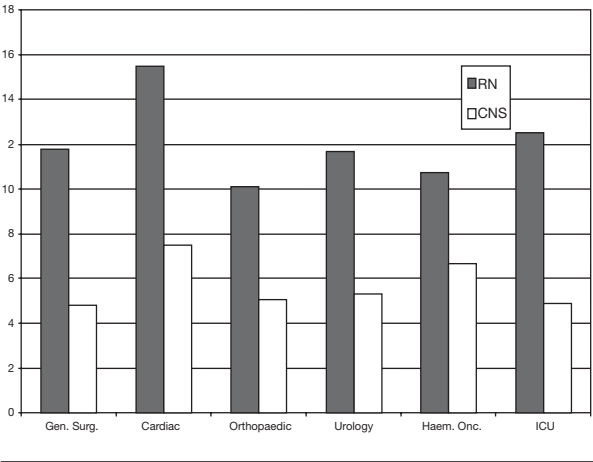
Alternatively, as indicated earlier, CNSs act in charge in the absence of the Nursing Unit Manager and on evening shifts, which may not allow much time for CNS participation in the exchange of clinical information. The complexity of patients' care following Cardiac Artery Bypass Grafts (CAGs), particularly on day one and two after transfer from ICU, would account for the much higher time spent by RNs on Cardiac.

Nevertheless, it would be expected that the CNS role would be equally as involved in handover as RNs. The

interaction between clinical staff during this process is paramount if patients are to receive 'seamless care' and if accurate and timely information is to be communicated. This activity provides nursing staff with an avenue to discuss not only patient care requirements, but also provides an arena to interact professionally through sharing knowledge and experiences. The CNS should use this professional forum to educate other nurses and set standards for patient care using their expert knowledge (Duffield, Donoghue, and Pelletier 1995).

The activity Coordination of Care: Rounds and Team Meetings (Figure 3) includes communication with doctors, allied health workers and other nurses regarding care, including on the phone, planning for admission or discharge and debriefing. Again, as with the results in the verbal report/handover observations (Figure 2), more RNs were observed in this activity than were CNSs, particularly in ICU, and to a lesser extent in Orthopaedics. Again, this result most probably reflects the model of care where the nurse responsible for the patient attends the medical rounds for their patient and more RNs are involved in care than are CNSs. However, an argument could be made that all nurses should attend rounds in order to ensure patients' care is coordinated and continuous through meal breaks and other staff changes. The results might also reflect the amount of medical attention given to patients. More doctors are likely to spend more time with patients in ICU and because of the 1:1 nursing ratio, the RN would tend to be present when the doctor attended the patient. In fact, the RN may well initiate the doctor's visit following an observed change in the patient's condition. Interestingly, the Orthopaedic ward, along with ICU, indicates a higher time by both RNs and CNSs being spent in rounds and team meetings. This could be explained by the need to organise ongoing care for elderly orthopaedic patients who need follow up care, for example following a Total Hip Replacement (THR).

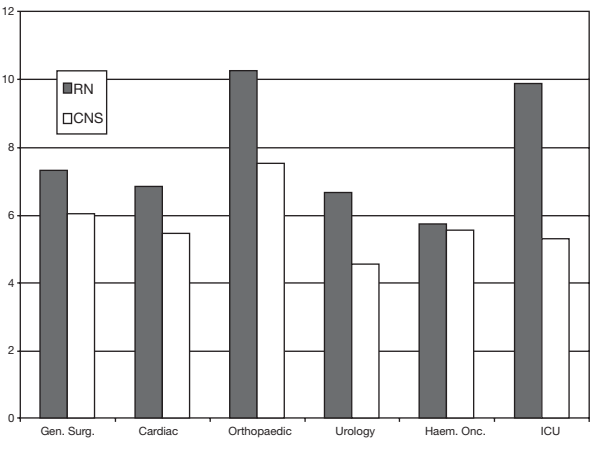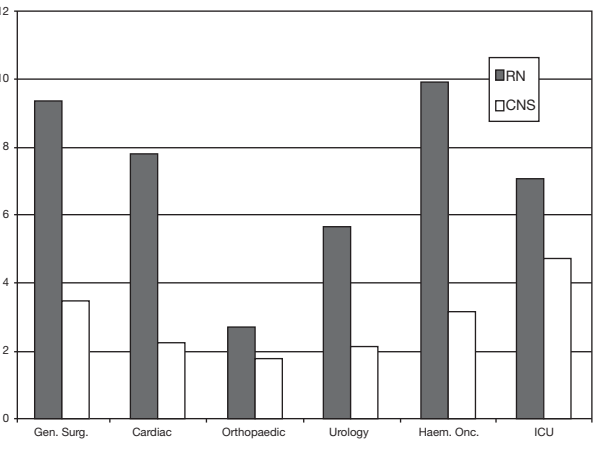**Figure 3: Rounds and Team Meetings**

Figure 4: Care Planning and Critical Pathways

The activity of Coordination of Care: Care Planning and Critical Pathways (Figure 4) which includes evaluating care, completing, revising or changing patient care plans and other patient documents giving direction to the provision of care, involves more RN than CNS observed time. In fact, on Haematology, the RN undertook almost 10% of observed activities in this category. It would be expected that the role of an advanced practice nurse (CNS) should be more heavily involved in this activity than was evident. This is not to say that the amount of RN time spent in this activity is excessive, but that the amount of CNS time seems to be disproportionately low. Hovenga (1996) reported a total of 17.72 minutes/patient on this activity.

Interestingly, considerably less time for both RNs and CNSs was spent in this activity on Orthopaedic than elsewhere. An explanation for this result might relate to the use of established Critical Pathways on the ward. If there was little deviation in patient progress, less time would need to be spent in this activity.


Figure 5: Teaching and In-service
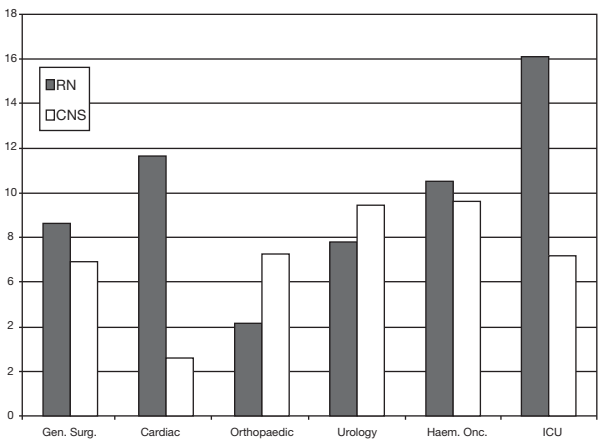
Pleasingly, Teaching and In-service (Figure 5) was an activity in which a great deal of both RN and CNS time was observed. Activities here include participation in teaching and learning activities or acting as a resource to students, or orienting staff redeployed from other wards and other health professionals. Of interest is that more RN time was observed in this activity than CNS time in four of the six units, particularly in ICU and Cardiac. It would be expected that the CNS usually has a significant component of their role related to education, teaching and mentoring of staff and students, which is not reflected in the results, perhaps because the CNS role is often in-charge.

The results for Meetings and Administration (Figure 6), while surprising, are likely to reflect the role of the CNS, meant to be that of an expert clinician, as de facto unit manager. The CNSs on Cardiac spend over 10% of


Figure 6: Meetings and Administration
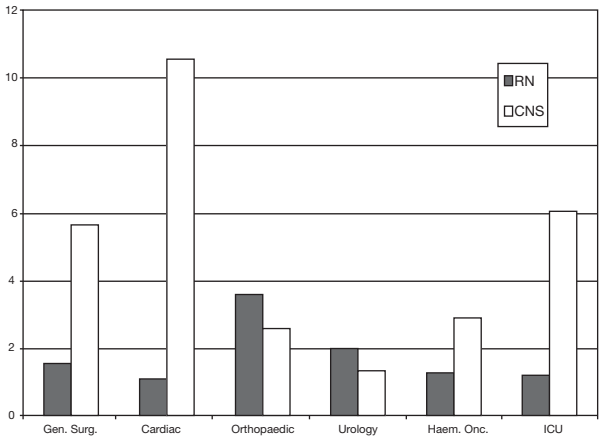
the observed activities in this category, which includes committee work, interviews, communication on non-patient related matters, rostering and quality activities, significantly more than the RN role. In fact, RNs on all units were observed less frequently in this activity. Only on Orthopaedics and Urology did the RN involvement exceed that of the CNS. Again, an explanation might relate to the role of the CNS in management. Additionally, there is limited after-hours medical coverage, thus requiring the CNS to expertly coordinate, administer and evaluate patient care needs and the needs of significant others. It is also possible that the CNSs are more involved in quality activities, which would be an appropriate aspect of their role. Nevertheless this is an area in which further examination of workload and work practices needs to be undertaken.

In a similar vein, the Clerical category of activities (Figure 7) (which includes answering telephones and delivering messages, filing and assembling charts) indicates both RNs and CNSs were observed undertaking this activity very frequently – close to 9% of all observed activities for RNs on General Surgery. One of the most time-consuming clerical activities required by all nurses engaged in patient care is following up medication orders. Phone orders need to be written up within 24 hours and medication and intravenous orders need to be documented accurately and clearly. An inordinate amount of time is spent in this activity. Interestingly the lowest observed activity level is in ICU where there is most often a medical officer available to write up orders. Also as each nurse provides care to only one patient, it is anticipated that less time would be spent in this activity than if the nurse were responsible for more patients.

DISCUSSION

It would appear that the CNSs are spending significant amounts of time in functions not expected in the role, particularly in activities such as clerical, meetings and

Figure 7: Clerical
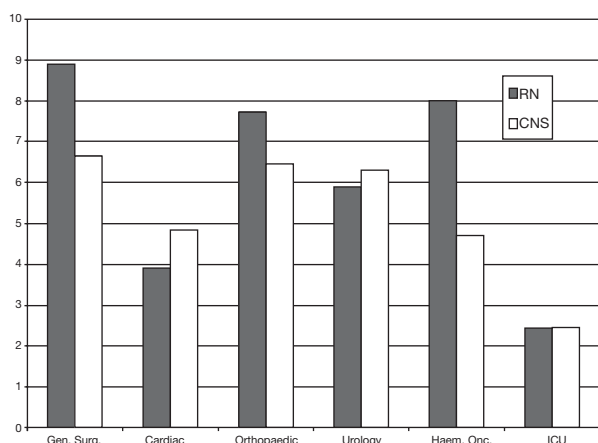
administration. As is customary in many institutions, the advanced practice nurse (CNS) is used as the nurse manager in the absence of the appointed manager – after hours and during periods of leave. Patient activity no longer occurs mainly from 0700-1500. Increasingly, surgical procedures and patients returning to the wards can occur over 24 hours, requiring a senior appointment to coordinate care and staff. However, nursing unit managers are usually employed only during business hours and there is no formal second-in-charge role. Employment of a CNS to undertake this activity may ensure that the standard of care provided during the day was also provided after hours and also overcomes what many in the hospital system see as a deficit in current ward staffing. However, is this best use of an expert clinician?

Nurses who wish to act in the role of advanced practitioners may not wish to be diverted into these managerial activities. There is growing acceptance that there needs to be a different career structure for a managerial position which provides strategic clinical leadership, with the position underpinned by clinical coordinators providing day-to-day coordination and leadership, including weekends and after-hours. Alternatively, the CNSs may be quite happy to undertake aspects of the managerial role, if they believe there are limited career opportunities in a clinical path. Also, expert clinicians are needed when other staff such as doctors, allied health and managers are not around – after hours and on weekends. Use of a CNS for after hours management therefore may well be appropriate and result in positive patient and nurse outcomes.

As indicated earlier, there is evidence from overseas that nurses are spending a great deal of time in non-nursing activities (Institute of Medicine 2004). With no comparative evidence in this country, it is not possible to determine whether scarce nursing time is being taken up by activities that do not 'value-add' to patient care. Using staff for tasks for which they are over-qualified is not

cost-effective and worse, leads to increased turnover. The results indicate that the CNS spends less time in handover than the RN. As expert clinicians, the CNS brings to handover invaluable expertise and knowledge about patients and their care. Not having these staff at the patient bedside and reporting their assessments at the formal handover could result in less than desirable outcomes for patients, other staff and the organisation.

In using these results to consider work redesign, it must be remembered that it is the activity that took staff to the patient's bedside that was recorded, and other tasks could have been undertaken at the same time. Indeed it would be most unlikely that a nurse would perform only one activity when attending the patient. It should not be assumed therefore, that less skilled and cheaper staff than RNs and CNSs should be providing patient care. Nurse dissatisfaction and burnout increase as nurses' capacity to provide the basic nursing care that patients require declines (Aiken, Clarke, Sloane, Sochalski et al. 2001). It is the capacity to be able to provide high quality care to patients that is most likely to result in high nurse retention rates. However, from the results presented here, there are some activities that could more cheaply and effectively be undertaken through the employment of additional clerical support staff, for example.

It is also important to remember that work sampling measures the activities undertaken, not the activities that nurses might have left undone. Future work should examine these two aspects in greater detail – nursing activities left undone and the activities in which nurses are involved that could and should be done by less skilled staff.

CONCLUSION

These results provide some interesting baseline information about what it is that nurses do, but perhaps more importantly, provide a basis on which to begin to understand the roles of registered nurses and clinical nurse specialists, their similarities and differences. These data provide an avenue of discussion between participants about what it is that they do, what should they be doing, and if they are best placed to undertake these activities or should other categories of employee do so. The educational preparation for registered nurses is focused very much on meeting patient needs, the most basic of these are personal hygiene needs and other activities of daily living which from the results, it is clear they are doing. Less clear is whether the role of clinical nurse specialist is truly acting as an advanced practitioner.

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NURSE PRACTITIONERS' EXPERIENCES OF WORKING COLLABORATIVELY WITH GENERAL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS IN NEW SOUTH WALES, AUSTRALIA

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ABSTRACT

Objective:

The study aimed to explore contemporary collaborative experiences of nurse practitioners (NPs) in providing care with general practitioners (GPs) and allied health care professionals.

Design:

A qualitative descriptive, exploratory design was considered the most appropriate to achieve the study objectives. This allowed the researcher at first hand to gain a thorough understanding of the nurse participants' experiences.

Setting:

The study was conducted in urban, rural and remote clinics and hospitals throughout New South Wales, Australia, where the NPs were authorised to care for the community.

Participants:

Nine authorised NPs were the key participants in the study.

Results:

Analysis identified one main theme of *Collaboration* and three sub themes that were named as *Total Collaboration, Partial Collaboration and Non Collaboration*.

Conclusion:

In this study, most NPs reported dissatisfaction from working in ineffective collaborative relationships with medical and allied health care professionals. Total collaboration did not automatically occur and was identified as the exception. Sustainable collaborative partnerships should be developed with all heath care providers by acknowledging each others unique, valuable contribution. Despite this challenging and complex situation, NSW NPs remained determined to provide advanced nursing care for patients and to establish and maintain effective collaboration with all health care professionals.

INTRODUCTION

Previous international researchers indicated that collaborative practice between doctors and nurses resulted in positive outcomes for patient care. According to the Macquarie Dictionary (1989) collaboration is defined as 'to work, one with another, cooperate'; it also connotes teamwork, coaction, consilience and synergy. In this paper, collaboration related to health care is referred to as a joint communicating and decision making process with the expressed goal of satisfying patients' wellness and illness needs whilst respecting the unique qualities and abilities of each professional (Coluccio and Maguire 1983). However, authors such as Chaboyer and Patterson (2001) assert that collaborative practice appears to be the exception, rather than the dominant pattern, within health care. The act and art of effective collaboration appears challenging to health care professionals for a variety of reasons. It requires sharing of information and expertise among disciplines who have typically worked independently.

Traditionally, hierarchical and competitive relationships which typify many nurse-physician interactions, do not exist in a true collaborative environment, where instead, power is shared, and is based

on knowledge and expertise rather than on titles or roles (Henneman 1995). Hallmarks of collaborative practice appear to be based on effective communication and include: mutual trust, respect, use of conflict resolution skills, use of humour and negotiation (Taylor and Seehafer 1998). In the health care arena, doctors in particular tend to see themselves as the leaders of teams and may insist on their views having precedence (Begley 2003).

Examination of existing literature from MEDLINE and CINAHL spanning more than 20 years revealed diverse international perspectives concerning nurse practitioners (NPs) collaborative role and caring experiences, especially between nurses and physicians. While on one hand this partnership has been positively linked to patient outcomes in adult acute care (Curley et al 1998), on the other hand the introduction of NPs into the NSW health care system has been fraught with opposition by some health care professionals, such as doctors (Courtney 2001). Despite such opposition the state government enacted legislation authorising NPs to practice in NSW.

In contrast, authors such as Baggs and colleagues (1992) identified a good correlation between patient outcomes and collaboration as reported by nurses. Other authors have suggested that NP practice can enhance interdisciplinary collaboration (Britton 1997; Sidani and Irvine 1999).

In the NSW context, there are now more than 35 authorised NPs providing care in urban, rural and remote areas of the state. In addition there are over 30 more advanced nurses in transitional positions throughout the state (Henderson and McMinn 2004). However, there has been little contemporary research undertaken concerning collaboration of NSW NPs with GPs and other health care professionals in Australia. Consequently, this study aimed to address this imbalance by identifying collaborative experiences of the NPs providing care for local communities in NSW.

METHOD

The study utilised a qualitative, descriptive exploratory design (LoBiondo-Wood and Haber 1998). This method was considered highly appropriate because it allowed at first hand, and for the first time, valuable description and insights concerning authorised NPs. This day-to-day caring practice with patients was negotiated both with GPs and allied health professionals. Data for this paper was part of a larger study conducted in NSW.

PARTICIPANTS AND SETTING

A purposive sample (Schneider et al 2003) of nine authorised NSW NPs were the key participants in this study. These voluntary participants were from urban, rural and remote clinics and hospitals where the primary goal

was to provide quality care to individuals and local communities.

The NPs were recruited using the following process. Firstly, the researcher obtained a list of authorised NSW NPs from the state health department. Secondly, the researcher telephoned each NP to discuss and provide information about the study and invite them to participate. Finally, the researcher made a follow-up telephone call to each NP to finalise arrangements and answer any questions that may have arisen. In order to maintain confidentiality and anonymity names and urban, rural and remote clinical locations of these study participants, have not been more clearly identified.

DATA COLLECTION

As this was a multi-site study, ethics approval was obtained from the human research ethics committee of the Australian Catholic University and eight area health services across NSW.

Each participant provided written consent for an in-depth interview which typically lasted from one to two hours using a semi-structured format (Minichiello et al 1995).

Examples of questions asked during the interviews included: *What skills and qualities do you believe are essential in order to be a nurse practitioner? How do you provide care to patients in collaboration with other healthcare professionals? From your clinical practice, what barriers have you experienced in your role?*

All interviews were audiotaped and conducted at a mutually convenient time and place, which was usually the clinic where the NP was employed. Criteria for judging the scientific rigour of the research was evidenced by the credibility, auditability, fittingness and confirmability of the findings (Schneider et al 2003).

In order to have confidence in the truth of the findings, the researcher returned the thematic analysis of the data to three of the NPs. When a NP agreed with a statement made by another NP it was assumed the statement was indeed credible (Chenitz and Swanson 1986, p.229; Schneider et al 2003).

DATA ANALYSIS

Interviews were transcribed verbatim. Initial analysis of the data included reading and rereading the data and subsequent sorting of the responses from the data into categories, whilst looking for patterns. Three coders were involved in the analysis process with regular team meetings enabling intercoder reliability and consensus for the development of themes (Coulon et al 1996).

The method of analysis used was line by line coding (Strauss and Corbin 1990). Following the development of codes, themes and sub themes were identified. Once the themes were identified, these provided an overview and

synthesis of the participants' experiences. Systematic review using the constant comparison method of analysis (Strauss and Corbin 1990) enabled the analysis process to reveal new themes embedded within the data that may have been missed during the previous analysis process.

FINDINGS

From an in-depth analysis of NPs day-to-day working patterns, one main theme emerged and was named Collaboration. This theme embraced three sub themes of Collaboration. These were: *Total collaboration; Partial collaboration; and, Non collaboration*.

For the purposes of this study *Total collaboration* was defined as a dynamic transforming process of creating power sharing partnerships for pervasive application in health care practice and organisational settings for the purposeful attention to patients' needs and problems in order to achieve likely successful outcomes (Sullivan 1998).

Partial collaboration was referred to as, professional interactions with GPs and allied health care teams who only supported NPs in select clinical circumstances.

Non collaboration referred to the non-engagement and total rejection of professional health care partnerships and refusal to acknowledge the contribution of NP care.

In this study, only three NPs described their caring practice as being in *Total collaboration* with GPs and allied health care teams. Each study nurse identified that they were autonomous practitioners, and they were part of the local multidisciplinary health care teams. These nurses considered that successful quality health care environments were influenced by collaborative practices among team members.

From the findings, two key characteristics emerged which supported the *total collaborative* process. These were the length of time the NP had worked in the hospital or community, and the rapport established before the NP was authorised by the NSW Nurses' Registration Board. The three NPs who enjoyed *total collaboration* identified that they had an extensive employment history within their health area. For example: all were employed within their local health service for over ten years. This included working in a number of different departments with various health practitioners and local GPs. Also, their authorisations were welcomed and publicly acknowledged by professionals in this area.

Heather said: *I have been working in this area for ten years, everyone knows me* (one year experience as an NP).

Lorraine said: *Because I have been in the area for so long, people know what I am doing, what I can do and what I am capable of* (18 months experience as an NP).

Heather remembered: *The CEO came and congratulated me on my authorisation* (one year experience as an NP).

Lorraine: *The rapport I have with the local GPs allows me to phone them up and request a script for Erythromycin for this person without the GP having to see them* (18 months experience as an NP).

Total collaboration was also demonstrated through diverse forms of professional support. For example, various members of the multidisciplinary team were sometimes involved in the development of the NP position and provided ongoing encouragement. Two NPs reported that colleagues were concerned there was not enough support available for them in their role. Some local doctors advocated for adequate support for the local NP. According to Lorraine: *The main concern of the doctors was I was not going to get enough support and backup. They were looking at it from a caring attitude as opposed to how can we get rid of her attitude* (18 months experience as an NP).

About half the NPs identified that they worked in Partial collaboration with a variety of doctors and allied health care professionals and reported that some doctors shared their clinical work on a day to day basis. However, their professional respect for NPs was not always evident. This lack of respect may have resulted from a poor understanding of the role, or a personal belief that NPs were not essential to the health care delivery system. Clare stated that from her experience, educating other health care professionals did not always result in total collaboration, but rather partial collaboration with some support.

She pointed out that: *Once the GPs understand the role and can see what we are trying to do and it's a supportive role and that we do need collaboration, they are fairly supportive* (two years experience as an NP).

One NP who reported experiencing partial collaboration worked in a community where one of the local GPs was very active in that community. This GP was known to have expressed grave concerns in the community about the advent of NPs.

Olma explained: *We have a very community active medico in town who is wary of the whole nurse practitioner thing and who is really concerned about prescribing and test ordering, he has expressed concerns* (13 months experience as an NP).

According to Olma, this situation forced her to rely heavily on scientific knowledge and extensive clinical experience when treating patients. Her advanced care for patients had to be delivered in alternate ways to avoid GPs raising further concerns about the NPs' extended skills.

Olma later explained: *I have avoided confrontation by getting things done in other ways. I am still doing the prescribing and ordering tests when I need to and making*

it up with good rationale and working within guidelines (13 months experience as an NP).

Some GPs were concerned that these NPs would take patients away from the doctor's practice.

Olma's example highlighted this issue: *I am very careful not to be seen to take patients that would be patients accessing the surgery and that is an issue we have identified… I have got three doctors surgery's open, it means I have to access another population so that means another time of day until I establish nurse clinics then I can pick the times for those clinics* (13 months experience as a NP).

Although there was open disapproval expressed by some local doctors with collaboration remaining minimal, there was one time when a local GP chose to collaborate with the NP. This occurred when a patient required emergency care at the local hospital.

Clare illustrated this in the following example: *If I ring any of the doctors and I don't get them straight away the receptionists know that if I am ringing and I say its about a clinical issue I don't give names or anything, within two minutes the doctors are back on the phone, they know there is a problem, a significant problem* (two years experience as an NP).

According to Olma, one of the GPs main concerns was the loss of income as a direct result of patients accessing the NP instead of the doctor. This possibly fuelled the doctors' refusal to collaborate in a professional and effective manner.

Olma said: *With the extended primary health care and incentives that general practitioners have got in their practices….there is quite a significant financial remuneration for general practitioners…All the doctors see me in terms of pinching the Medicare stuff,* [and] *that I am pinching their patients* (13 months experience as an NP).

A third sub theme was identified as *Non-collaboration*. According to two NPs, Sarah and Jenny, collaboration with health care professionals such as doctors in their local area was non-existent. This disappointing situation arose from battles with local GPs and resulted in the doctors' refusal to have any professional relationship or dealings with the nurses, which led to a policy of *Non-collaboration*.

Sarah received a letter from the local doctors which outlined: *We feel were a nurse practitioner to practice at …. We would have no option but to withdraw from … as the definition of roles and responsibilities, mindful of the conditions that prevail at the moment, would be impossibly complicated and unworkable from our point of view.*

Threats from the local doctors to withdraw their services from the local community, where Sarah had provided care for many years, made her feel responsible for the reduction in medical services available to the community.

This experience forced Sarah and Jenny to reconsider whether they should have an NP position in their respective community. An integral part of their experience included personal examination and reflection of this volatile situation. They explained this during their interviews with the researcher and indicated they knew the fight would be tough. To their professional credit, they remained committed to providing advanced care for their patients.

Sarah's final correspondence from the local GPs was a letter stating: *We wish to advise you, that if you wish to discuss a patient with us for whatever reason, or if you are in doubt about the best management of a patient, do not contact us, always refer them directly to the base hospital'.*

Sarah and Jenny approached the state government clearly stating that their local community should have authorised NPs available. They informed the NSW Health Department about their professional problems with the local GPs. The issue became deadlocked, with the local GPs giving the NSW health department the ultimatum of choosing either NPs or GPs. The health department supported the NPs.

According to Jenny, the essence of the conversation between the doctors and NSW Health was as follows: *Their trump card then of course was, well if you put this nurse practitioner position in then we will leave, we won't come out to this community once a fortnight or once a week, we will leave if you put this in and New South Wales Health said, you are a private practitioner you can do what you like* (One years experience as an NP).

Without regular community consultation with a GP, Sarah and Jenny were forced to establish nurse led clinics without medical assistance. The area health service allocated funding to give Sarah and Jenny the best opportunity to establish their clinic.

Sarah explained: *I think if we work within appropriate guidelines and we are ethical and we are courteous in our dealings with our colleagues, if they don't like it, well, it's law now, and we're able to practise, we're able to provide care, if they want to be unscrupulous and unethical in the way they relate to us, well, that's their problem. I am not going to let it worry me* (11 months experience as an NP).

DISCUSSION

Findings from this study identified three different models of clinical collaboration engaged in by the study nurses with local healthcare professionals: *Total collaboration, Partial collaboration* and *Non collaboration*. Despite state legislation authorising NPs to practice, only three NPs were described as being engaged in Total collaboration with medical and allied health care professionals.

However, there were two factors which clearly facilitated the establishment of total collaboration. These were the length of time the NP was employed in that hospital or local community. For instance, the longer the time working in the area, the more it enabled a sense of trust and respect to be built with the local health care professionals. Further, the degree of rapport built up and established with allied members of the health care team prior to the NPs authorisation made a difference to their on-going relationship and the resulting model of collaboration.

Lorraine conceded that her success in collaboration as a NP was: *because I have been in the area for so long, people know what I am doing* [and] *what I can do and what I am capable of.*

It is postulated that the employment of a nurse who had an extensive history of working in the local area was more successful in gaining acceptance as an NP than the appointment of a nurse new to the area, who had not developed a network of professional health colleagues.

Consequently, it may be more prudent to appoint a nurse who has successfully achieved an advanced practice role over a period of time and who has developed an appropriate level of collegiality. All three NPs who identified they were engaged in total collaboration had a previous extensive employment history where they were appointed. Each reported establishing excellent rapport with other health practitioners, managers and patients. It is recognised that there were a few GPs who openly supported these three NPs, and that not all local doctors opposed the concept of NPs. Winson and Fox (1995) considered that American NPs were successful in becoming established in health care teams. However, this required effective communication and negotiation with other health care professionals in order to initially determine the NPs' agreed scope of practice. This suggests that establishing collaboration requires effective communication as an on-going dynamic process mutually and consistently undertaken across multidisciplinary health care teams.

Most NPs in this study explained their experience of working in *Partial collaboration* with other health care professionals. A major contributing factor to this limited professional relationship was the resistance expressed by some doctors. According to these NPs, the doctors were concerned that they may lose their patients to the NP. In effect, they were concerned about a reduction in their income.

This was pointed out by one participant Olma who said: *all the doctors see me in terms of pinching the Medicare stuff, that I am pinching their patients.*

This suggests that the inception of NPs has the capacity to reduce country doctors' income. However, most NSW NPs provided extended nursing care with only four or five approved clinical practice guidelines. Thus, it is a questionable assumption that the introduction of NPs would greatly reduce GPs incomes. In addition, the Medicare Benefits Scheme (MBS) in Australia does not have a fee structure that includes independent nursing services in general practice. Only fees that are medically initiated attract a rebate as part of the overall medical consultation (Patterson and McMurray 2003). Furthermore, from these nurses' accounts, it is worth noting that many NPs in rural and remote NSW provide advanced care to patients, where there were no doctors for hundreds of kilometres.

In NSW, NPs have been subjected to political attack, which, only serves to remind the wider community that for some NPs they will most likely remain engaged working in the often stressful situation of partial collaboration. While the concept and role of NPs was never going to be welcomed by all involved, it remains concerning that professional respect for health colleagues is not forthcoming or indeed valued by some members of health care teams.

The urban NPs reported that from the start they had total support for their role. In contrast, most NPs in rural and remote areas reported that barriers existed from the beginning. This may have been the result of inappropriate education strategies which failed to inform the wider health care community about this new nursing role. In addition, it is suggested that underlying political, environment and economic influences played a part in the poor reception of the NP positions. For example one area health service collapsed two registered nurse positions classified as eighth year and thereafter to fund the new NP role. This decision by management had the potential to put further pressure on the individual NP and the health care facility where the nurse was employed.

This study's findings concurred with those of Chaboyer and Patterson (2001) who indicated that a collaborative relationship cannot evolve if individuals do not value and respect each others competencies. This was evident in the reflections of two NPs who were forced into a non-collaborative relationship because the local doctors showed disregard for the NP positions.

Although some doctors openly questioned the role of NPs, all the withdrawal of medical services would achieve is to disadvantage isolated communities where access to health care remains limited. It is recognised that by expanding the traditional nursing role it may be viewed by some community groups as medical substitution, or role encroachment, or alternately they may consider it a rightful claim of the nursing profession. As Professor Judy Lumby (2000) explained, 'they will not be working as GPs, but as expert nurses'.

As illustrated in this study and supported by Patterson and McMurray's research (2003), a particular barrier to nurse-medical collaborative practice has been a lack of understanding on the part of medical practitioners and nurses concerning each other's roles and responsibilities. With improved innovative educational strategies and effective communication, specifically targeted toward

doctors and allied health care professionals, this issue of non collaboration may be overcome and consensus reached with most health care industry professionals.

CONCLUSION

This study identified that total collaboration between NPs, GPs and allied health care professionals remains complex and does not automatically occur. The process of effective collaboration needs to be, consciously constructed, learned and once established protected.

In contemporary health care, it is now time to set aside differences and work harmoniously with colleagues from all disciplines toward the common goal of quality care, which will provide the necessary shared identity (Begley 2003). This opportunity may increase in Australia once there are more NPs appointed and authorised to provide effective care.

It is recommended that a national study be undertaken to explore the contemporary challenges embedded in health care partnerships and the forces that facilitate or negate collaboration. Findings from such studies may provide a clearer understanding of the dynamic complex collaborative relationships existing in urban, rural and remote areas. In the future, sustainable collaborative partnerships need to be developed with more health care providers recognising the valuable contribution that can be made by NPs in improving patients' health outcomes.

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COMPARISON BETWEEN NURSES' PROFESSIONAL NEEDS AND THEIR PERCEPTIONS OF THEIR JOB

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ABSTRACT

Objective:

The aim of this study was to examine how nurses' professional needs were met in nursing practice.

Design:

A survey design was used in this study.

Setting:

Data were collected from one metropolitan public hospital, one rural public hospital, and from postgraduate students in diploma/certificate course at a university in Victoria.

Subjects:

Participants consisted of 346 registered nurses (RNs), who had completed either a three-year nursing diploma or a degree course, and were working in hospitals at the time of the study.

Main outcome measures:

Nurses' need to obtain professional rewards, challenges and support for their performance were compared with their perception of how their work environment actually reinforced those needs. In addition, desired nursing roles were compared with perceptions of actual roles carried out in practice.

Results:

The findings suggest there is a mismatch between nurses' professional needs and the intrinsic/extrinsic rewards they receive for their performance. There is also a mismatch between their desired nursing role and actual roles in practice. These mismatches are prominent in areas such as participation in policy decision-making, professional recognition and opportunity to earn a higher income.

Conclusion:

The findings suggest there is a mismatch between nurses' professional needs and their actual nursing practice. As these mismatches may negatively impact upon nurses' work behaviour, it is important to reduce the gap between professional needs and the experience of actual nursing practice.

INTRODUCTION

Nurses work within a unique context of practice, which determines the occupational characteristics of their practice. Many aspects can influence practice. This paper considers two influential aspects of occupational characteristics: nursing roles and environmental attributes. Examples of nursing roles are: provision of patient education and emotional support, and development of patient care-plans. With examples of environmental attributes being: a reward structure for nurses (eg career advancement opportunities, recognition, remuneration and autonomy/power provided to nurses) and the organisational policies in which nurses work (eg protocols and policies to follow).

This paper also examines how nurses' perceptions of their occupational characteristics could impact upon their work behaviour.

Much empirical research has suggested a link between unpleasant occupational characteristics and psychological strain of nurses such as burnout, job dissatisfaction (Laschinger and Havens 1996; Tummers et al 2001; Budge et al 2003) and turnover intention (Dolan et al 1992). However, these studies tend to conceptualise occupational characteristics as being responsible for various work behaviours of nurses, and assume nurses as passive agents who respond reactively to their roles and environment. Thus, how nurses perceive their occupational characteristics in the context of their professional needs, and how they respond to their work based on the relationship between their needs and their perception of the occupational characteristics have been largely overlooked (Takase et al 2005).

To provide a better understanding of nurses' work behaviour, we sought to examine and compare nurses' professional needs and their perceptions of their occupational characteristics. The person-environment fit theory, which is concerned with the relationship between personal and environmental factors and the employee's work behaviour, was adopted as the theoretical framework.

THEORETICAL FRAMEWORK

The person-environment fit refers to a perceived compatibility or correspondence between employees' occupational needs and the characteristics of the environment where their job occurs (Dawis and Lofquist 1984; Mitchell et al 2001). Thus, the person-environment fit theory shifts the focus of investigation from occupational characteristics to the *relationship* between employee's needs and his/her environment, and is concerned with how employees' perceived compatibility with their job affects their work behaviour.

Over the past two decades, many types of the person-environment fit theories have been developed to examine specific aspects of the relationship between the person and his/her environment. In reviewing these theories, Law et al (1996) classified the relationship into two concepts: the person-environment relationship and the person-occupation relationship.

In the context of nursing, the person-environment relationship refers to nurses' perceived compatibility between their work values and their perception of the environmental attributes. Work values are defined as desired outcomes employees like to or ought to be able to achieve through their work (Nord et al 1990). These work values include nurses' need for recognition, fair remuneration, respect, career opportunities, and autonomous practice. Thus, when nurses perceive their work values (ie professional needs) are met by what their organisation offers them, they will experience a person-environment fit.

While the person-environment relationship involves an interaction between nurses and the organisation, the person-occupation relationship concerns an association between nurses and their job. In the context of nursing, the latter involves a compatibility between nurses' desire (and expectation) to engage in particular roles and the actual opportunities they have in conducting such roles; and between nurses' knowledge and skills to conduct their roles and the actual abilities required to complete their job.

The outcomes of the person-environment-occupation fit are reflected in employees' work behaviour including improved occupational performance, greater job satisfaction and reduced intention to quit a job (Walsh and Holland 1992; Law et al 1996; Dawis 2000). These outcomes are achieved because employees' needs are satisfied by their environment and job, leading to a greater physiological and psychological wellbeing.

On the other hand, a misfit causes a burden such as frustration and dissatisfaction to employees and adversely influences their occupational behaviour (French and Kahn 1962). To avoid such a burden, employees attempt to maintain the person-environment-occupation relationship by adjusting their needs to their occupational characteristics or by attempting to modify their job and environment. The ultimate solution to avoiding this burden is to leave an organisation or the occupation itself and to look for a more compatible environment or job (French and Kahn 1962; Dawis and Lofquist 1984). Thus, the person-environment fit theory is important for examining how nurses' professional needs influence their evaluation of the occupational characteristics and how their evaluation influences their work behaviour.

While many aspects of the person-environment-occupation relationship can be investigated, the present study examines two relationships. The first relationship is between nurses' role conception, which is defined as the roles nurses desire (Corwin 1961), and their perception of the actual roles (the person-occupation relationship). The second relationship is between nurses' work values and their perception of the environmental attributes (the person-environment relationship).

METHODS

Sample and data collection procedures

The target population in this study were RNs, who had completed a three-year nursing diploma or degree course, and who were currently working in Australian health care institutions. Nurses working in midwifery, perioperative nursing, outpatient departments and aged care homes were, however, excluded from this study, because their specific roles and the characteristics of their working environment could be considered quite specialised.

The study sample comprised nurses who were working in a metropolitan public hospital and a rural public hospital in Victoria, Australia, at the time of the study. In addition, RNs who were completing a postgraduate diploma or certificate in a university in Victoria were also invited to participate in the study.

After ethics approval from the three participating institutions was granted, questionnaires were administered to a total of 943 nurses. For the hospital sample, questionnaires were distributed by nurse unit managers or charge nurses at the request of the researchers. Completed questionnaires were returned using a self-addressed reply-paid envelope. For the university sample, the researchers visited classrooms with the permission of subject coordinators and distributed the questionnaires to students. The students were given opportunities to complete the questionnaires either in the classroom or at home.

Instruments

A questionnaire, containing demographic questions, a modified nurses' role conception scale (Hojat et al 1999; Taunton and Otteman 1986) and a modified work value scale (Manhardt 1972), was administered. The latter two scales were modified in accordance with the study purpose and through a validation process using the following procedures. Before data collection, the content of each of the modified scales was examined by six nursing experts using the Index of Content Validity. The Index of Content Validity was designed to measure the level of agreement on relevance of each scale item to the study purposes (Waltz et al 1984). The questionnaire was then administered to 16 post-registration students in one university as a pilot study to further refine the questionnaire. Based on comments provided by pilot study participants, minor rewording of the questions was undertaken. The data findings of the pilot study were not included in the main study. The refined questionnaires were administered to the main study sample with the permission of the copyright holder of each original scale. A factor analysis was conducted to establish the construct validity of the scales. Chronbach's alpha was calculated to examine the internal consistency of the scales. A 6-point Likert scale was used to measure nurses' needs and their perception of actual roles and environmental attributes with larger scores indicating more positive responses.

Modified nurses' role conception scale

This scale was created from 10 selected items from the *Jefferson Survey of Attitudes Toward Physician-Nurse Inventory* (Hojat et al 1999) and the *Staff Nurse Role Conception Inventory* (Taunton 1986). Eight items measured nurses' desire to use their nursing skills such as patient education and decision-making on patient discharge and hospital policy. The other two items measured nurses' desire to delegate basic tasks, which included assisting with the patient's daily activities of living. This scale was also used to measure nurses'

perception of their actual nursing roles. Reliability of the overall scale was 0.62 for measuring nurses' desired roles and 0.73 for measuring the actual roles.

Modified work value scale

The original Work Value Scale was developed by Manhardt (1972), in the discipline of organisational psychology, to measure 25 dimensions of work values. In this study, 21 items were selected and modified in accordance with the study purpose and the scale validation process. This modified scale was used to measure nurses' work values and their perception of the environmental attributes. The scale consisted of three factors. The first factor included 13 items related to professional rewards such as reward with recognition and career advancement opportunities. The second factor consisted of four items concerned with professional challenges such as intellectual stimulation and use of knowledge. The third factor encompassed four items associated with organisational support such as job security and working for respectable superiors. Reliability of the scale measuring both nurses' work values and their perception of environmental attributes was 0.89.

Data analysis

A paired t-test was used to compare the scores reflecting nurses' needs with those reflecting nurses' perceptions of their actual roles and environmental attributes. Given the increased statistical power resulting from a large sample size and multiple comparisons, the likelihood of encountering a Type I error exists (Cohen et al 2003). Therefore, the significance level was set at $p < 0.01$ (two-tailed). Cases with missing values were not included in the analysis.

RESULTS

A total of 346 questionnaires were returned, accounting for a 36.7% response rate. The majority of the respondents were female (92.7%), and the mean age of the respondents was 33.6. More than half of the participants (58.9%) were working over 35 hours per week. The majority of the respondents were working as clinical staff (90.4%) and the rest as managers, educators or research nurses. The practice areas of the participants were: medical/surgical care (27.8%); critical care including intensive care and emergency (27.8%); mental health (6.6%); cardiothoracic/cardiology (6.1%); paediatrics (5.8%); palliative care (5.5%); oncology (5.2%); and, other clinical areas including rehabilitation, gerontology, orthopaedics and day surgery.

At the time of the study, 45.5% of the participants were completing a postgraduate course, 19.9% had already completed a postgraduate course, and 30.9% were without a postgraduate qualification. Of the participants, 3.7% did not respond to the question regarding their educational qualification.

Figure 1. A comparison between nurses' role conception and their actual roles.

Note. The vertical axis represents the scores for nurses' role conception and their perceptions of their actual roles. The scores range from 1 = strongly disagree to 6 = strongly agree. The horizontal axis represents the summary statements of items used in the modified nurses' role conception scale.

Figure 2. A comparison between nurses' work values and the environmental attributes

Note. The vertical axis represents the scores for nurses' work values and their perceptions of environmental attributes. The scores range from 1 = strongly disagree to 6 = strongly agree. The horizontal axis represents the summary statements of items used in the modified work value scale.
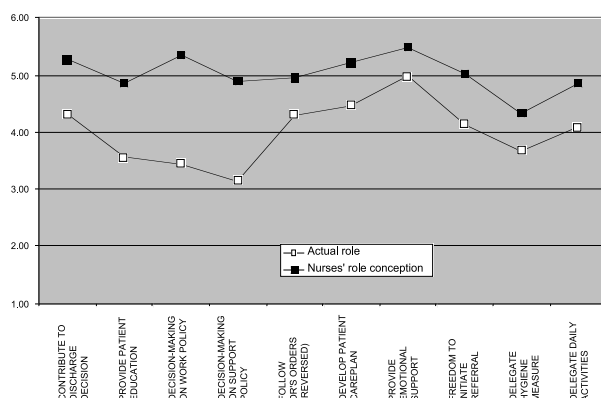

Figure 1 presents the comparison between nurses' role conception and their perception of their actual roles.

The mean score of the overall nurses' role conception was 5.03, which indicates nurses' strong desire to engage in their professional roles including decision-making and patient care. Compared with nurses' role conception, the mean score of their actual roles was moderately positive (M=4.01). The t-test showed that the difference between nurses' overall role conception and their perception of the actual roles was significant, $t(314)$=21.33, p<0.01. The first eight items on the left in figure 1 measure 'the use of nursing skills'. Nurses' desire to use their skills was high across all the items (M=5.13), while perceptions of their actual roles tend to fluctuate according to their roles (M=4.03).

In particular, nurses saw opportunities to participate in the decision-making on hospital policies as being restricted, resulting in large discrepancies between their desires and their actual roles. Figure 1 also shows that nurses had limited opportunities to provide patient education compared with their desire to do so. The result of analysis using a t-test suggests that nurses' desire to use their skills was not congruent with their practice, $t(320)$=22.35, p<0.01.

The next two items in figure 1 shows nurses' desire to delegate basic tasks and their actual task delegation practice. Nurses' desire to delegate patient hygiene care was relatively low, compared with their desire to delegate care for patients' daily activities. Nurses also perceived they delegated fewer tasks concerning hygiene care than those concerning care for patient daily activities. The mean score of nurses' role conception in this factor was 4.62, and that of actual practice was 3.89. The t-test shows that the difference between nurses' task delegation needs and actual practice was significant, $t(328)$= 8.26, p<0.01.
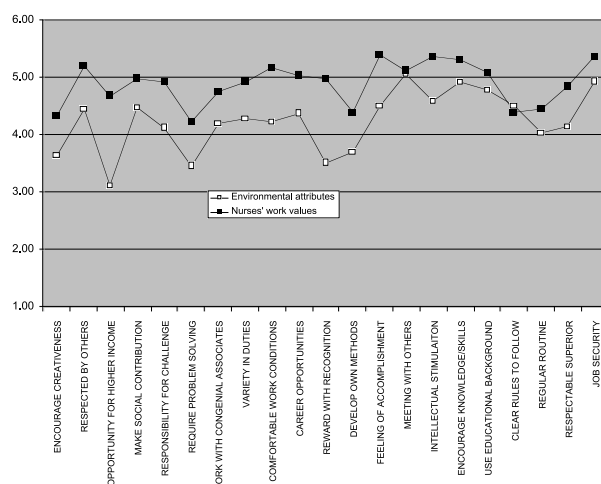
Figure 2 presents the comparison between nurses' work values and their perception of the environmental attributes.

Overall, nurses rated their work values (M=4.89) significantly higher than their perceptions of the environmental attributes (M=4.01), $t(313)$=16.29, p<0.01. The first 13 items from the left in figure 2 show the scores on 'professional rewards'. The figure shows that there were large discrepancies between nurses' needs and the actual rewards they received in terms of opportunity for higher income and reward with recognition.

Figure 2 also shows that nurses' needs to be creative and problem-solving were relatively low compared with their other needs. Apparently, nurses' low need for creativity and problem-solving contributed to smaller discrepancies with their perception of the environment, which was also perceived as providing low opportunities for creativity and problem-solving.

The t-test shows that nurses' needs for professional rewards were significantly higher compared with their perception of the environmental rewards, $t(322)$=17.226, p<0.01.

The next four items in figure 2 show the scores on 'professional challenges'. Although the result of the t-test shows that nurses' needs for professional challenges (M=5.21) and the actual challenges they had (M=4.83) were significantly different, $t(340)$=9.36, p<0.01, the difference was much smaller compared with that for professional rewards. In particular, nurses' need for meeting with others is met by their actual practice. Nurses also perceived that the current organisational climate encouraged skill utilisation and this met their needs.

Slightly different results were observed in the 'organisational support' factor represented by the last four items in figure 2. There was a smaller discrepancy between nurses' needs (*M*=4.75) and the actual support they perceived they received from their hospitals (*M*=4.39), *t*(337)=7.76, *p*<0.01, compared with the difference in the professional rewards factor. However, this moderate discrepancy emanated from nurses not wanting organisational rules and routines to follow. In particular, nurses' need for rules to follow was low, and this is the only factor where actual opportunity exceeded nurses' needs.

DISCUSSION

Overall, the findings show that nurses' professional needs are not met by their occupational characteristics. In particular, nurses reported that opportunities to participate in organisational decision-making, to have a higher income, and to receive professional recognition are limited and incongruent with their professional needs.

The person-environment fit theory maintains that the misfit will lead to employee job dissatisfaction and turnover (Walsh and Holland 1992; Law et al 1996; Dawis 2000). Previous studies have shown nurses' strong dissatisfaction with organisational policy (Finn 2001; Takase et al 2001) and pay (Takase et al 2001). In addition, lack of recognition was identified as a reason for nurses, who were out of the nursing workforce, not returning to nursing practice (Victorian Government Department of Human Services 2001).

The results of this study show that nurses saw themselves as being encouraged to utilise their skills and knowledge by their environment (eg organisation), thus experiencing a relative fit with their needs for professional challenge. On the other hand, they tended to see their need to use their skills as not being met by actual nursing practice, leading to person-occupation misfit. These seemingly contrasting results may occur because health care organisations encourage nurses to engage in continuous professional development by funding post-registration courses. At the same time, nurses' capacity to conduct their roles, such as patient education, may be reduced due to increased workload as a result of cost-containment coupled with the current nursing shortage (Buchanan and Considine 2002). In addition, nurses perceiving little opportunity to be involved in the decision-making process signified their experience of the person-occupational misfit. Having adequate knowledge and skills to care for patients and making decisions while being provided with inadequate opportunities to do so could be quite stressful for nurses. It is possible that their frustration eventually leads to job dissatisfaction with nursing and, therefore, to increased turnover.

Nurses utilise adjustment strategies to avoid the burden caused by the person-environment-occupation misfit. One of these strategies is to change their needs in accordance with their job characteristics. Research shows that the types of roles and rewards employees receive from their environment influence their needs and self-beliefs (Johnson 2001a, 2001b; Kirchmeyer 2002). For example, a lack of environmental rewards could reduce an employee's need to obtain such rewards. Alternatively, an employee's needs could be shifted to other aspects of environmental rewards that are more accessible to them (Johnson 2001a, 2001b).

These findings could be applied to interpret some of the present study findings. For instance, nurses rated their needs for being creative and problem-solving relatively low. Nurses also rated their environment low in terms of encouraging creativity and problem-solving. The findings by Johnson (2001a and 2001b) may, therefore, suggest a lack of opportunity for nurses to be creative and problem-solvers has lowered their need to engage in these activities. These studies may also suggest that limited opportunities to have professional recognition and fair remuneration would have shifted nurses' values to more accessible rewards such as 'job security' and 'meeting others'.

Changing one's needs may lead to a successful adjustment to an environment. However, if nurses do not actively seek creativity and problem-solving opportunities in their practice, quality of nursing care will not improve. It is important for nurse managers to encourage staff nurses to pursue problem-solving opportunities. In addition, it is necessary to facilitate nurses' adjustment to their environment by improving the environment in a way that encourages them to be creative and to have fewer rules imposed on them.

It is also important to reduce the misfit itself. For example, improving the salary package for nurses is one solution to filling the gap between nurses' needs for better pay and the actual reward system. This strategy also seems to be effective in reducing incongruence between nurses' need for recognition and the actual recognition they perceive they receive. This is because nurses view pay as the most important parameter of recognition (Cronin and Becherer 1999). Under current financial constraints, however, this strategy may not be possible.

An alternative approach to alleviate the recognition incongruence could be opening a feedback channel between nurses, patients and managers, as private verbal feedback and written acknowledgement from patients, co-workers and managers are important sources for nurses to obtain recognition for their performance (Cronin and Becherer 1999).

As for the misfit between nurses' needs for participating in policy decision-making and the actual opportunities available, it may be difficult for managers to increase each individual's opportunities at the organisational level. It could be more feasible to increase their participatory opportunities in ward level decision

making, which may have a more immediate impact on their practice.

Finally, it is important to maintain the relationships that are identified as congruent. This is because employees, occupation and organisations go through constant change and development, which may subsequently alter the relationship between nurses, their roles and the environment (Law et al 1996).

LIMITATIONS

A limitation of the study is attributable to the relative low reliability of the modified nurses' role conception scale that measures nurses' desired roles. Although the scale has been validated using the Index of Content Validity and factor analysis, the low internal consistency of the scale may reduce the accuracy of the study findings. Another limitation arises from the sample characteristics. A large proportion of the participants were represented by nurses with postgraduate qualifications and those undertaking postgraduate courses. Thus, the study sample may not reflect the characteristics of the nurse labour force in Australia, which could reduce the generalisability of the findings. On these grounds, the findings of this study should be interpreted cautiously.

CONCLUSION

This study examined the relationships between nurses' professional needs and their perceptions of occupational characteristics. The findings show that there was incongruence between nurses' needs and actual nursing practice.

While these results may provide explanations for why nurses are dissatisfied with their jobs and leaving the profession, more empirical research is necessary to investigate the effect of the person-environment-occupation fit on nurses' work behaviours including job performance, job satisfaction, organisational commitment, and turnover.

The results of future studies could provide nurse researchers and managers with ideas for possible interventions to enhance nursing practice and to improve the retention rates of nurses in the workforce.

The innovative aspect of the person-environment fit theory is that it allows nurse researchers to shift their focus from environmental factors or nurses' needs in isolation to the relationship between environmental factors and nurses' needs. Such an approach would enable a more mutual approach to be developed for nurses and their environment.

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CULTURE OF RURAL NURSING PRACTICE: A CRITICAL THEORETICAL ANALYSIS OF DETERMINANTS OF POWER IN NURSING

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ABSTRACT

Objective:

This paper investigates the culture of workplace learning within a study of eight small hospitals in rural New South Wales (NSW), Australia.

Design:

The study used a focus group method of data collection, undertaken before then after a series of interventions designed to nurture a culture that supports learning within the rural health care setting.

Participants:

student AINs, AINs, ENs and RNs from any of the eight hospitals.

Conclusion:

Framed within a critical social perspective it applies a theory of culture to understand the determinants of social divisiveness that was occurring between different levels of the nursing workforce. These results are further analysed within a theoretical discussion of culture and power in nursing.

INTRODUCTION

To facilitate preparation of nurses for delivering health care in small rural communities, an educational pathway has been introduced involving a number of small rural hospitals in western NSW (Gibb et al 2002). Applied to areas where nursing staff shortages are threatening hospital closures, rural hospitals work with TAFE (technical colleges) to employ community members within their aged care section as they are undertaking Certificate III in Aged Care. Once the assistant in nursing (AIN) has completed this level of study they are enrolled in the Certificate IV Enrolled Nurse (EN) training.

They are then enrolled in the bachelor of nursing by distance education at Charles Sturt University to become a registered nurse (RN), at the same time being a full-time employee of the rural hospital in the community in which they live. This allows the hospital to provide a range of supports to enable the nursing student to progress successfully (Hamilton and Gibb 2001). The emphasis of the pathway is to allow remote communities to access nursing preparation without the expense and life stress related to leaving their community for protracted periods of time.

An evaluation of the AIN students' experience on the educational pathway in 2002 (Gibb et al 2003) revealed highly variable support and some derision and hostility toward students from other accredited nurses.

The political context for this is that while AINs have been employed in aged care facilities in the region, the recent amalgamation of aged and acute care services within Multipurpose Services (MPS) meant that ENs and

RNs were encountering AINs on their staff roster for the first time.

It was decided by the research team, along with nurse managers, that some form of intervention was needed to build a more supportive environment for students of nursing, who were isolated in their studies – apart from potential support in the workplace by more senior nurses. Funding was obtained to work with staff where the educational pathway was being used. This involved eight sites throughout central west NSW.

The goal of increasing student support went hand-in-hand with the recognised need to develop more cohesiveness among nursing staff generally as the basis for providing support to the students.

The interventions themselves used participatory action research (Kemmis and McTaggart 2000; Waterman 1998) designed to generate cohesive approaches to developing value and support for learning in the workplace. Interventions included investigating different forms of mentoring and workplace educational activities, all designed by nursing staff with the assistance of the research team. Details of these interventions are reported elsewhere (Gibb et al 2004).

This paper reports on findings from two focus groups conducted as a before and after assessment of the effectiveness of the interventions. Specifically, the focus group data allowed for a comparison of understandings and values prevalent among the nursing team about learning in the workplace before then after the interventions.

Because of the rather indeterminate nature of values in relation to learning that could exist in any nursing team, we were unable to specify hypotheses or outline expectations about the kinds of themes that would emerge even in the pre-intervention period. However, we did locate the research inquiry within a theoretical framework of cultural analysis. Culture, in this context, means the beliefs, actions and values shared by the nursing team which are expressed symbolically in nursing language and actions (Minami 2002).

These symbols are more prominent in 'high points' of experience; in the current context these are represented most distinctively in RN designated practices, including advanced practice and decision-making. These practices and the theoretical knowledge underpinning them, constitute symbolic aspects – 'objects' – of nursing culture (Hall 1999). They also forge cultural identity and define social relations of power (who can and cannot legitimately be involved in these practices).

Ideally, the function of culture is to provide cohesiveness within the practices of a community (or organisational team) (Disch and Taranto 2002). It adds to the sense of a single identity, allowing the group to survive and thrive in its environment. However, the underside of cohesiveness is the creation of boundaries that separate the in-group from an identified out-group. Hence, symbols of activity that define the RN role, and to a lesser extent also the EN role, served to exclude other, newer members of the nursing team - AINs and student AINs - as the out-group. From a research perspective we were interested in whether acceptance (or lack of) by ENs and RNs of AINs' involvement in study toward acquiring in-group status, was associated with low understanding and value for learning in the workplace generally.

METHODS

The two focus groups were conducted early in the year (March) then again at the end of the year (October-November).

Participants

Within each of the hospitals potentially all nursing staff (student AINs, AINs, ENs and RNs) were voluntarily involved in the interventions and focus groups. No nurse declined to be involved. Participation was generally determined by who was rostered on duty at the time, although some nurses came in on their days off to be involved. Between four and eight staff members were involved in each site, indicative of the low level of staffing in each rural hospital.

Procedure

The project received ethical clearance to audiotape record accounts of nurses' perspectives on the workplace as a learning environment. We asked nurses to reflect on what they considered learning to entail, whether the health care environment constituted an effective learning environment for nursing, and, what supports they believed nurses needed - and were indeed entitled to - within the workplace.

During the first focus group across the eight sites in March, nursing staff were at first reticent to speak. This perhaps accounted for the fact that many fewer themes came out of this first data set.

The second focus group was conducted in turn across the eight sites in October-November of the same year. Having already participated in the first focus group earlier in the year and having worked with researchers on the interventions, the second focus group was much more animated and yielded a more extensive data set.

ANALYSIS

Tapes were transcribed and subjected to thematic analysis once all the data had been collected. A thematic 'tree' was constructed of baseline themes defined by the data itself, which were then sorted and grouped together under higher order or major themes.

First focus group

Three major themes emerged from the first focus group:

Perception of learning in the workplace: Learning in the hospital was considered to relate only to practical tasks which were learned as a group. By contrast, acquisition of knowledge leading to a greater depth of understanding was considered to be acquired through formal courses that people undertook on their own outside of work.

Dis-enablers: There were perceived to be overwhelming obstacles preventing staff undertaking these formal educational courses, including geographical distance, time, cost and nurses' advancing age.

Organisational environment: The changes in rural health care facilities had imposed major change on RN work practices, in particular. Themes of nostalgia and even grief were identified in reference to former days when people used a range of skills such as midwifery, emergency and surgical nursing skills. By contrast many viewed aged care, now the core business of their facility, as less attractive work requiring less skill and formal training.

In summary, dominant cultural qualities were: a reticence to learn (only something done outside of work), inertia in relation to self-directed learning and a profound sense of imposed change.

Second focus group

Four major themes emerged:

Perception of learning in the workplace: By the second focus group, learning had taken on more elaborate meanings. A broader understanding was reflected in the nurses' discussion, of what learning – and workplace learning in particular – comprised.

Educational literature (eg Welton 1991) describes three kinds of competencies: 1. clinical or skill related competency, 2. learning competency – developing the skills and conceptual knowledge on how to learn, and 3. influence competency – advanced learning that manifests in knowing appropriate ways to influence change and take self responsibility. Descriptions of each kind of competency were identified in the data from the second focus group.

Learning competency and influence competency are considered advanced forms of learning requiring a deeper theoretical understanding of a topic and flexibility in applying the knowledge acquired. An example of learning competency was derived from workplace experience: *'She shows you how to relate to other people and show them what to do. There's a lot of mutual learning'.* An AIN undertaking Certificate III provided an example of influence competency: *'last weekend we had a resident that was very ill, has actually been losing a lot of weight. And I went to the RN last weekend and said I thought he*

had a nutrition problem and you know, give him some yoghurt and pureed veg and she took it on and said "I'm going to look into it" and it was done that day, so I was very happy about that.'

Enablers: Rather than considering the obstacles to their own learning, nurses recognised the personal benefits of change through embracing opportunities to learn. First, one needed to recognise that one has the capacity to change and learn.

The educational pathway was one way to achieve this: *'…I hadn't been to school since year 10… so doing my EN first has a "step up" advantage. Like talking about step up - that is definitely the way to go.'*

Lifelong learning was identified as a value, wherein several staff had reconsidered their view that age was an obstacle to learning. Some were now planning to advance their learning: *'A friend said " you're only 52" and I thought what… a good positive attitude'; 'I am having a bit of a midlife crisis because I really want to learn… I would like to learn something different'.*

Organisational environment: Organisational support was considered critical to learning in both formal and informal ways. Value was placed on teamwork and how each staff member in a small MPS is dependent on one another for the smooth running of the organisation. This was an important statement, considering some of the ancillary staff were AIN students on the educational pathway.

Workplace learning via the new flexible delivery mode for Certificate III, delivered by TAFE, allowed for a more traditional way of learning in the MPS - doing it as a team: *'Some of the staff that have not updated their training like me are a bit reluctant to answer. So if I don't know the answer we look it up together or we look at the medication and see if the medication is affecting the behaviour'.*

Mentoring: Two kinds of mentoring were in evidence across the various nursing teams, minor mentoring and major mentoring. Minor mentoring was confined more to work related skills. Major mentoring was focused on the whole person's development: *'For me the joy of being able to sort of steer, not really steer, but guide someone toward future development for themselves. It's personal development as well as education'.*

Major mentoring extended also to interest in staff members' confidence and wellbeing: *'Mentoring gives you confidence. I enjoy encouraging the girls along. I get a lot of fun out of seeing my staff participating in a learning experience and then coming back with renewed vigour and excitement at work'.*

Summary of differences between 'before' and 'after' focus group discussions

Understandings of learning and the workplace as a site of learning had altered; previously advanced learning was

considered to be something acquired in formal courses outside the workplace. Now various kinds of advanced competency development were being illustrated as integral to routine nursing work.

Rather than focusing on why learning could not be pursued, nurses had identified that the real impediment was their own lack of confidence in studying to update or upgrade their skills. Age was jettisoned as an excuse. Several ENs in their 50s enrolled in university study to become RNs following the project. People had shifted from a state of nostalgia and grief reflected in their discussions, to focusing on how to move ahead and embrace change. Reflection moved to how to support people learning 'on the job' (including greater awareness of different kinds of mentoring). This was an important outcome considering the reference included AIN students in the learning team.

DISCUSSION

This discussion of the shift in meaning around learning between the two focus groups can be broadened within a theoretical discussion of culture and power. Bourdieu's (1979, 1993) cultural model is used to frame this discussion of the cultural shifts that occurred.

Culture and social power

While meanings given to the concept of culture are varied (Waters 1994), it is generally agreed, as we have argued earlier, that culture has an ideological function. According to Hall (1999) cultural ideology can block social groups from creating new meanings, new significations - which would mark the natural evolution of their self-defining values and beliefs. This moment of exercise of power is in controlling the natural evolution of cultural meaning. What is then created is a contest of meaning between social groups.

A sense of control has pervaded small rural hospitals in that AINs and ENs have both experienced lack of validation for their initiative in upgrading their skills. Workplace support to develop clinical nursing competency has often been withheld. Active invalidation has been experienced through challenges to their ability to study or their 'pretensions' to better themselves.

Interventions relating to workplace learning in our project acted as a catalyst to reorganise boundaries between the in-group and out-group within the nursing teams involved in the study. The result was a weakening of the boundary by a shift in team practices associated with the interventions, which then catalysed a shift in patterns of relating within the group. Mentoring in particular took on new importance within the workplace. This drew down boundaries as out-groupers became the focus of mentoring by in-groupers, taking on the role of protégés.

How derision and exclusion constitute cultural practices of ideological control will be discussed using Bourdieu's (1979; 1993) account of cultural power. How cultural intervention can occur to transform disabling power into enabling power is then explored.

Bourdieu's theory: Practices of cultural exclusion

Within Bourdieu's theory, culture is considered a form of capital, a metaphor taken from financial capital but applied to one's social assets. Cultural capital is considered to symbolically reside in things that can be produced, accumulated and traded. These include abstract assets such as knowledge and skills.

These symbols of culture provide markers of membership of powerful social and professional groups. Cultural capital - like financial capital - is unevenly distributed across society, and is linked to educational attainment or professional training. In other words - the capacity to engage in membership of such a group is transmitted through educational opportunity. In rural communities, distance disadvantage links educational dis-opportunity directly to cultural exclusion.

Bourdieu's (1993) theory conceives of the social world as a symbolic space; its shape is formed by superimposed fields. A field is a social space of play of cultural capital, and hence, influence, such as the field of philosophy or the field of nursing. Being marked as a member has certain value stakes that its players are intent on playing for. Each field has its unique identifiers such as its particular knowledge, its developmental history, or its prized methodology for generating knowledge of its discipline or conducting its practice.

In nursing this can range from technical scientific to intuitively informed reason underpinning certain expert practical skills. To enter a field requires rigorous formal training into these methods. This acts as an initiation for new members. It also acts as a field boundary to delineate members from outsiders.

Usually, someone outside the membership of a particular field can have only limited knowledge of these intrinsic principles of knowledge and practices that gives the field its identity. It is the very esoteric nature of this disciplinary field that accords its legitimacy as an authority over some area of social life. Members within the field are naturally conditioned to prevent intrusion into this field by the uninitiated and therefore the undeserving. This defensive manoeuvre is conditioned within cultural members' cultural beliefs and values and expressed through language and behaviour. These discursive actions signal boundary markings and remind the uninitiated of their outsider position.

An individual's position in a field or outside it defines the habitus or living space of a person. Habitus is a predisposition to act out preconscious perceptions about one's 'place' in the world (Bourdieu 1979). Developed from one's earliest experiences, habitus is the limits one sets on one's ability to access cultural capital or social position, achieved by formal educational qualification. An

example of habitus limiting one's entry to a profession is a perception about one's inherent lack of competency.

While habitus sets the limits as to the kind of capital one can aspire to, disciplinary field boundaries set professional entry barriers. To engage in a field of play such as nursing, one needs to occupy a habitus equipped with the self beliefs and awareness about having sufficient capacity to play.

AINs in our study and indeed generally in Australia (Walker 2002) are not defined as nurses. Discursive practices to patrol their outsider status in our study generally took the form of derision. This may be interpreted in Bourdieu's conception as boundary marking behaviour.

Conversely, the habitus of people who were undergoing Certificate III training worked in collusion with these practices of exclusion in as much as most AINs began study with a view that they were 'not up to it', that they were too old. The pervading habitus of the entire nursing team (RNs and ENs) was similar to that of these AINs, giving rise to perceptions that further learning 'was not for the likes of us', being too geographically far, too expensive, took too much time or else 'beyond me at my age'.

Resistance

It would be simplistic to confer victim or underdog status to AINs in this study. Power in a simple Foucaultian (Foucault 1991) reading is multidimensional in complex organisational settings, resistance being a form of power exercised by subjects who cannot access positional or legitimate (professional) power. Resistance was exercised by AINs repeatedly as displays of contempt for RNs who had not studied for many years. The identity of AINs as students on the educational pathway - regardless of its elementary stage - strengthened their cultural identity within the field of nursing. They had scaled the boundary.

An aspect of culture discussed by Hall (1999) is identity. Identity allows a position or location within a culture from which to think and act definitively, with confidence in one's reference point or membership. The educational pathway and the opportunity to gain a TAFE certificate had unwittingly given AINs a nursing identity. It had provided AINs with a new means of negotiating their way over the boundary into nursing cultural space, armed with qualification and new knowledge in nursing.

Resistance also operated amongst RNs and ENs against management expectation to upskill and gain further qualification. Resistance was articulated in the first focus group in accounts of experience of nostalgia and grief. Imposed workplace change had eroded their practice of nursing skills and at the same time failed to enskill them to practice in a more technological (computerised) world.

Working with cultural power

Cesta (2002) has described how people who are in an educational void remain themselves politically naïve. Lack of awareness or understanding of the politics operating in an organisation most often results in behaviours that are the most resistant to change. He argues that educational opportunities tend to reduce resistance and rather increase support for change.

Political naiveté or unawareness provides one explanation for field boundary patrolling by some RNs, many of whom had no post-basic training and had been in their current employment most of their working life.

The choice of learning interventions in this study was inspired by such theorising about political insight as a means to reducing and re-deploying power exercised in the form of resistance. Mentoring, for example, provided the opportunity for all nurses to appreciate the political relativity of their own position and invited them to view other political agendas beyond their own. One such shift was in realising their own workplace learning opportunities increased through supporting others. Another was through recognising that the hospital's viability lay in 'growing' and nurturing their own local staff.

The impact of the mentoring intervention lay in the way it catalysed a restructuring of relationships in the nursing team. Such a shift which necessitated loosening field boundaries was in evidence during the second focus group. Organisational values included the interdependency of all team members, as well as learning together.

Habitus shifts were in evidence in that 'not for the likes of us' was replaced by a hunger to learn, an appreciation of the need for life-long learning as part of practicing nursing and most importantly that the operational site of nursing practice was as appropriate for the learning of advanced skill and knowledge as formal higher educational centres.

CONCLUSION

Focus group work in this project provided the symbolic space for practising nurses to connect with and rework dominant cultural constructions. Changing values were the result, reflected in language and behaviours demonstrating new perspectives on the place of learning in nursing work.

Additionally, the study has excavated a site of tension within the professional field of nursing which may signal ideological blockage, and which therefore requires open debate. The ubiquitous presence of AINs in nursing teams in small rural communities, signals the inevitable proximity of non accredited carers to the field boundaries. Boundary patrolling in larger public or industrial forums may ostensibly have practical political import. However in looking more closely through a cultural frame, discursive

exclusion of AINs from initiate status within nursing, threatens to continually fracture small isolated nursing communities. AINs are not only important to the delivery of basic care in rural health contexts. Our work indicates how the position is an important step toward full nursing accreditation where educational dys-opportunity persists.

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A REVIEW OF GRADUATE NURSE TRANSITION PROGRAMS IN AUSTRALIA

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ABSTRACT

Background:

Despite nearly two decades of experience with graduate transition programs in Australia little evidence exists regarding the effectiveness of these programs as interventions that enhance the transition from nursing student to professional practitioner. There is general acknowledgement that this is a crucial time for people entering the profession and yet there is little agreement on what constitutes best practice for nurses' transition to the workforce.

Aim:

This paper challenges the status quo through a review of current programs and questions whether primacy should be given to formal transition programs or to the development of educationally supportive clinical learning environments.

Conclusion:

There is sufficient doubt in the efficacy of formal transition programs to at least investigate potential alternatives such as concentration on the development of a supportive practice culture conducive to learning. Indeed, the type of learning environment suitable for graduate nurses is likely to be one that will also facilitate the continued development and enhanced job satisfaction of the rest of the nursing team.

INTRODUCTION

Common sense dictates that some form of support for graduate nurses in their first year of health sector employment is essential. In Australia this belief has translated into the provision of graduate transition programs. There is a range of formal and informal programs available that aim to boost the confidence and competence of new graduates, enhance professional adjustment and, improve retention in the nursing workforce. What is not evident is whether transition programs are effective in achieving these goals, or indeed whether they are as effective as a sustained period of practice in a supportive and stimulating clinical environment.

In this paper we explore the arguments that have developed regarding preparation for practice and the apparent dissonance between the views held by universities and health sector organisations, in other words, the theory practice conundrum. In reality these viewpoints are not polemic but are useful points of discussion that may help to clarify the present dilemma. The current state of graduate transition programs throughout Australia is mapped and obvious anomalies highlighted.

The effectiveness of these programs is questioned in relation to their stated goals and, in particular, recruitment and retention. The central question to arise from this paper is whether educationalists should concentrate on the development of formal transition programs or work in collaboration with clinicians to develop educationally supportive clinical cultures in practice settings.

Transition support programs: Current situation

In 1984, after decades of deliberation and intensive political lobbying the watershed decision to transfer nursing education in Australia from the hospital setting to the tertiary sector was finally announced. The difficulties in transition from university to the clinical environment and the apparent lack of graduates' clinical preparedness soon became a contentious issue.

In order to bridge what was described as the theory-practice gap, a plethora of graduate transition programs emerged and have since become accepted as the most appropriate way for registered nurses (RNs) to enter the workforce. However, programs for new graduate employment have continued to develop over the years based on little if any research (FitzGerald et al 2001; Clare et al 1996). Transition programs share three primary goals: (a) to develop competent and confident RNs; (b) to facilitate professional adjustment; and, (c) to develop a commitment to a career in nursing.

In Australia transition programs provide the initial sustained exposure to clinical contexts and an opportunity for the application of the theory learnt in the undergraduate degree. The first three to six months is considered to be the most critical time for professional adjustment and for creating a commitment to a career in nursing (Greenwood 2000).

Evidence suggests, however, that graduate transition to practice continues to be problematic and stressful in Australia as it is internationally (Greenwood 2000; Charnley 1999; Kelly 1998; Fisher and Connelly 1989). Graduate programs have been criticised for being unnecessarily long, expensive and repetitive (Madjar et al 1997; Reid 1994). There is consistent evidence that suggests there is a lack of consensus about the requirements of new graduates as well as an inadequate degree of involvement and support from the higher education sector (Clare et al 1996; Johnson and Preston 2001; Moorhouse 1992; Reid 1994).

Since nursing education transferred from hospitals to the tertiary setting there has been ongoing discussion and debate about the preparedness of new graduates. The Reid Review (1994) undertook an extensive analysis of the related issues, as did the more recent National Review of Nursing Education 2002 (Heath et al 2002).

What is evident is that in the decades since the transfer the contentious issues have changed little. The disparity between the expectations of graduate employers and universities figures as highly on the present agenda as it did nearly 20 years ago. Heath et al (2002) suggest that the current nursing shortages and difficulty in working environments may have in fact exacerbated the tension between employers and universities, at times placing the graduate nurse in an untenable position.

Health care, and therefore the environments that graduates are expected to work within, has become increasingly complex and difficult. As one senior nurse stated in the DETYA (Department of Employment, Training and Youth Affairs) reports:

'The people now in general wards were in intensive care 15 years ago, many people cared for in hospital are now cared for in the community, and the people who are now in intensive care would have died 15 years ago' (Johnson and Preston 2001, p.6).

Nursing is more stressful, intense and technological than ever before and graduates are expected to cope, even as some of their more senior colleagues struggle with contemporary health care.

Current programs in Australia offered to support graduates in their first year of practice are inconsistent across health care organisations with the level of funding provided to support graduate transition varying significantly between states and territories (see table 1).

Johnson and Preston (2001) suggest that some of the funding allocated by Australian state governments for the support of graduate nurse programs is not being s pent for the purpose for which it is intended, questioning the degree of accountability and equity across these programs.

Currently, transition models across Australia differ in duration, structure, financial support and content. The length, number and type of clinical rotations vary as do the range of interventions within the programs. These interventions may include formal or informal preceptorships or mentorships, extensive supernumerary time, study days, and formal orientation programs to name a few.

For many graduates the transition process is difficult and stressful (Goh and Watt 2003) and there remains an unrealistic expectation for graduates to be able to 'hit the decks running'. While surveys reveal that new graduates are acutely aware that they need a high level of support to successfully make the transition from graduate to competent and confident nurse (Kerston and Johnson 1992), Kelly (1998) reports that the real world experience of the new graduate is often unsupportive and extremely traumatic. For many the transition experience is typified by fear of failure, fear of responsibility and fear of making mistakes. Clare et al (2002) report that conflict and bullying of graduates in the workplace remains a national problem, with up to 25% of graduates reporting negative experiences and a lack of support from clinicians. Little wonder then that attrition of new graduates remains a significant problem in Australia.

Recruitment and retention

Successful transition programs are said to encourage new nurses to remain in the workforce and maximise the community's investment in the education and training of nurses (Heath et al 2002). The extent to which this is achieved by existing graduate transition programs is contentious. While the transition from student to RN is

Table 1: Graduate transition program funding, 2003				
State or territory	**Number of graduates employed in 2003**	**Amount of government funding per graduate nurse**	**Stated purpose of funding**	**Program specifics**
New South Wales	1200 (on average)	$900 (for the first period of employment as an RN)	To maximise employment of graduate nurses; To provide a meaningful and supportive period of employment; To encourage retention of graduates; and, To develop an experienced nursing workforce.	Varies between hospitals both public and private. Most programs of 12 months duration.
Australian Capital Territory	30-40	Nil	N/A	
Victoria	1641 in public and private health care facilities, 1250 funded by DOH	$12600	To cover direct and indirect costs associated with the teaching and training of graduate nurses, including a theoretical program of not less than 40 hours coordinated by a nurse educator.	Varies between hospitals. Most programs of 12 months duration.
Tasmania	110	Nil	N/A	12-month program. Standardised program across all government hospitals. Preceptor support is provided. Three paid study days per year as well as in-service sessions. Program provides rotations between clinical practice settings including acute and rural settings.
Northern Territory	80	$4000	To maintain sustainability of program and to ensure that supernumerary weeks and study days continue.	12-month program. Standardised and equitable program across all government and some private hospitals. Three rotations. Four weeks supernumerary time in first placement and one to two weeks in subsequent placements. Offers rural, mental and community health specialised placements, as well as acute. Graduate nurses supported by CNEs and preceptors. Includes mandatory and optional learning packages.
Queensland	600	$1600 – metropolitan hospitals $3000 – rural and remote hospitals	To provide 'backfill' for preceptors and supernumerary time for graduates, particularly in rural areas.	Both structured transition programs and informal support is evident, however, the Queensland Government supports individualised programs claiming that there is no proven benefit from formalised structured programs.
South Australia	250-300 (public sector)	$11000 – public sector		Varies between hospitals.

All information is correct at the time of submission. This information is not available from one source. It was collected for the purpose of this paper from state health department personnel via email correspondence.

reported to be 70-90% (Heath et al 2002), with an average of 4000 graduate nurses currently recruited and employed each year throughout Australia (see table 1), some studies suggest that a significant number will leave the profession within 12 months of employment post registration (Johnson and Preston 2001).

The media also report rates of attrition though they are harder to substantiate. For example, in an interview with Mohamad Khadra, University of Canberra's Pro Vice Chancellor, Lucus (2003) reported that as many as one in five nurses leave the profession in the first year following graduation. Dr Brendan Nelson, Federal Minister for Education, reported that at least one third of nurses leave within the first five years (2003). When these statistics are viewed against the backdrop of a workforce crisis recognised globally as the worst nursing shortage in the last 50 years it is evident that poor retention of graduates is an issue worthy of serious concern.

As the current shortage bites Johnson and Preston (2001) predict that by 2006 Australia will have only 60% of the RNs it needs, and New South Wales less than 50%. This translates to a shortage of 40,000 RNs in Australia by the year 2010. In order to meet future demands the number of new graduates recruited and retained in the workforce would need to increase by 60-120% (Johnson and Preston 2001). In light of these alarming statistics and the dissatisfaction expressed by many new graduates it is imperative that the process of graduate transition is thoroughly researched and its impact on retention rates understood.

Criticism or collaboration

Even 20 years after the decision to transfer nursing education from hospitals to the higher education sector it is common for clinicians to suggest that nurses graduating from universities do not assimilate into the clinical environment as quickly and easily as had their hospital trained counterparts (Burns 2004; Johnson and Preston 2001; Madjar et al 1997), complaining particularly about the perceived lack of graduates' clinical and patient management skills.

The transfer to the tertiary sector, the much-anticipated panacea for the problems of the nursing profession continues to be questioned, particularly by clinicians (Heath 2002). In fact, some venture to suggest that in reacting to the rigid hospital-based training system the pendulum has swung too far in the opposite direction, supporting a system of liberal education that produces poorly prepared nurses who are often unable or unwilling to practice in the clinical setting.

Conversely, universities claim to provide a broad and comprehensive preparatory education that develops 'beginning' rather than competent or expert practitioners who are critically reflective and committed to lifelong learning. Greenwood (2000) suggests a more positive and realistic alternative to both of these strongly held viewpoints, is a collaborative model that views nursing education as a joint 'health sector'-'education sector' enterprise. Greenwood asserts that each sector is primarily, but not exclusively responsible for differing components which occur at differing points in nurses' educational continuum: 'Education' - being primarily responsible for the pre-registration component; and, 'health' - being primarily responsible for the post-registration component which critically includes transition to practice.

A shift to the type of collaborative venture described by Greenwood would require rational debate rather than adversarial argument and the encouragement of nurses from both sectors to contribute to the development and implementation of both pre-registration programs and transition to practice.

As Crookes (2000) suggests, this type of model would encourage the closure of the so-called 'theory-practice' gap by an approximation of the two parts. Unfortunately

there currently exists little collaboration between hospitals and the tertiary sector with regard to graduate transition (Johnson and Preston 2001; Greenwood, 2000) and while Greenwood is perceptive in identifying the problem she is less successful in determining a solution.

Clare et al (2003) suggest that although there are a few excellent examples of collaborative structures where optimum clinical learning environments have resulted, the precise structures and practices in those environments that contribute to their success have not been studied in detail.

The culture of universities and health services, as well as the relationships between all the stakeholders with a vested interest are cited as significant determinants of the success of the clinical partnership and the degree of collaboration that does occur (Chalmers et al 2001; Davies et al 1999), as is the right leadership. Linden (2002) and Waddock (1988) suggest that leaders who have credibility and clout and who make collaboration a high priority will positively influence the partnership between universities and health services. It is hoped that with the growing awareness of the importance of partnership models potential benefits to graduate nurse transition will be realised.

Research

Although a number of researchers (Crowe 1994; Currie 1994; King and Cohen 1997; Madjar et al 1997) suggest that graduate transition programs successfully 'smooth' the transition process, there is minimal evidence to support efficacy, particularly in terms of improved retention. Certainly it is acknowledged that there is at least anecdotal evidence to suggest that formal programs, or more particularly the interventions utilised therein may have a positive impact on graduates' transition to practice. Mentorship and preceptorsip have been described as the most common form of clinical supervision and support. Both interventions are said to have the potential to reduce the reality shock experienced by graduates as they leave the relatively sheltered world of academia and enter the health service environment with all of its contemporary challenges and pressures (FitzGerald et al 2001; Kramer 1985; Pigott 2001; Smith and Camooso-Markus 2002). However, the forces in contemporary practice, such as staffing shortages and increased casualisation of the workforce, mitigate against these supportive relationships being sustained.

What becomes evident in reviewing the literature is the paucity of research data on transition support models (Clare et al 1996; Goh and Watt 2003; Madjar et al 1997). Both the programs as a whole and the various interventions employed within them have not been studied in a systematic, comprehensive or objective manner to determine their efficacy or cost-effectiveness (FitzGerald et al 2001). Certainly there has been little research focused on the Australian context, or on graduates' perceptions of either the value of transition programs or the interventions utilised. FitzGerald et al (2001), in a

systematic review completed for the Queensland Nursing Council, determined that most studies are small scale and descriptive. Although small studies may indeed shed some light on the pertinent issues, conclusive evidence cannot be drawn, thus restricting the validity of the results and the capacity to generalise outcomes. Additionally, most of the studies regarded by FitzGerald et al to be of sufficient quality were between 10 and 20 years old.

The question of whether structured formal transition programs are actually required to facilitate the transition to a competent and confident practitioner or whether a period of supported clinical exposure would suffice has been the subject of a small number of studies. Dear et al (1982) discussed a non-randomised trial in which a group of graduates completing an organised internship in the USA were compared to a group undertaking a traditional orientation and work immersion model. Competency was measured using a validated scale and no statistical difference was identified between either group.

An Australian study by Baker and Liwu (1991) could show no clear difference between graduate groups receiving formal preceptoring and a control group who received none.

Clare et al (2002) in a study commissioned by the Australian Universities Teaching Committee proposed that the key goals to be achieved in the transition year include increased intrinsic motivation, socialisation into the role and job satisfaction. Whilst this study suggests that these goals may be partially realised by a structured transition program, the authors advocate that they are better addressed by creating a supportive work environment.

The question arises, therefore, as to whether or not graduates require a formalised transition program or as Clare et al (2002) propose, a better use of resources that create a warm, cohesive and graduate friendly clinical environment, with access to clinicians that are competent role models willing and able to share their knowledge and expertise with novices. Resources should be directed toward alleviating the tension currently experienced by clinicians to get 'the work done' thus allowing time for experienced nurses to reflect on practice and maximise clinical learning opportunities for their new nursing colleagues.

It is evident there has been a great deal of discussion regarding graduate transition yet little consensus regarding what constitutes best practice. The limited research that does exist suggests that a clinical learning culture that is supportive and nurturing is at least as effective, if not more effective, than formal programs in facilitating the transition process and improving retention (Clare et al 2002; Dear et al 1982). In addition it has become evident that graduates consider the most important aspect of the graduate year to be the level of support they received from the clinical environments

(Clare et al 2002), although the features that define a supportive work environment are complex.

CONCLUSION

This paper has demonstrated that there is enough doubt in the efficacy of formal transition programs to at least investigate potential alternatives such as concentration on the development of a supportive practice culture conducive to learning. We could also envisage that the type of learning environment suitable for graduate nurses is likely to be one that will also facilitate the continued development and enhanced job satisfaction of the rest of the nursing team.

These ideas are ideologically sound and have been expounded since learning environments were first researched in the 1960s and 1970s. The challenge remains to identify and analyse the features that are evident in contemporary practice environments that are recognised as conducive to the transition from student to RN. Moreover, the means to recreate these environments across the health service should become the focus of future research, research that is persuasive because the evidence is grounded in practice exemplars.

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