

Advanced Practice and the Orthopaedic Nurse: An Interpretive Study

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Abstract

Advanced nursing practice is a broad topic that is often misunderstood. Related terms are used interchangeably, which tends to engender a degree of confusion over what constitutes advanced practice. The relationship of advanced practice to expert and specialty practice is unclear. Health care is increasingly becoming more complex. There are greater expectations placed upon the nurse practising in this context. Therefore the role of the nurse must reflect the increasing complexity that exists within a contemporary health system. Advanced practice provides an opportunity to debate and acknowledge how nursing practice must reflect modern trends. This study will assist in conceptualising advanced practice in terms of the nature and scope of advanced orthopaedic nurse practice.

This study aimed to uncover the meaning of the lived experiences of advanced orthopaedic nurse practitioners, thereby engaging orthopaedic nurses within the debate. The methodology employed in this study was Hermeneutic Phenomenology, informed by Heidegger and van Manen. Seven expert orthopaedic nurse practitioners were asked to describe an experience in which they believed they performed at an advanced level. Concepts and themes emerged from the narratives. Themes included: *having knowledge, being in and outside the role, being an advocate and being in control.*

Controversy and confusion dominates the debate over what constitutes advanced practice, both here and overseas. This study highlighted that advanced practice is part of a continuum that describes specialist, expert and advanced practice. It is also an important concept in contemporary nursing practice. However ongoing clarification and consistency in terminology would assist immeasurably in identifying standards of advanced practice. Once this is achieved, the impact of advanced practice on patient care can be ascertained.

Statement

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

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Anita Taylor

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To the seven orthopaedic nurses, a special thanks. I hope this makes a difference. Your stories made a difference to me.

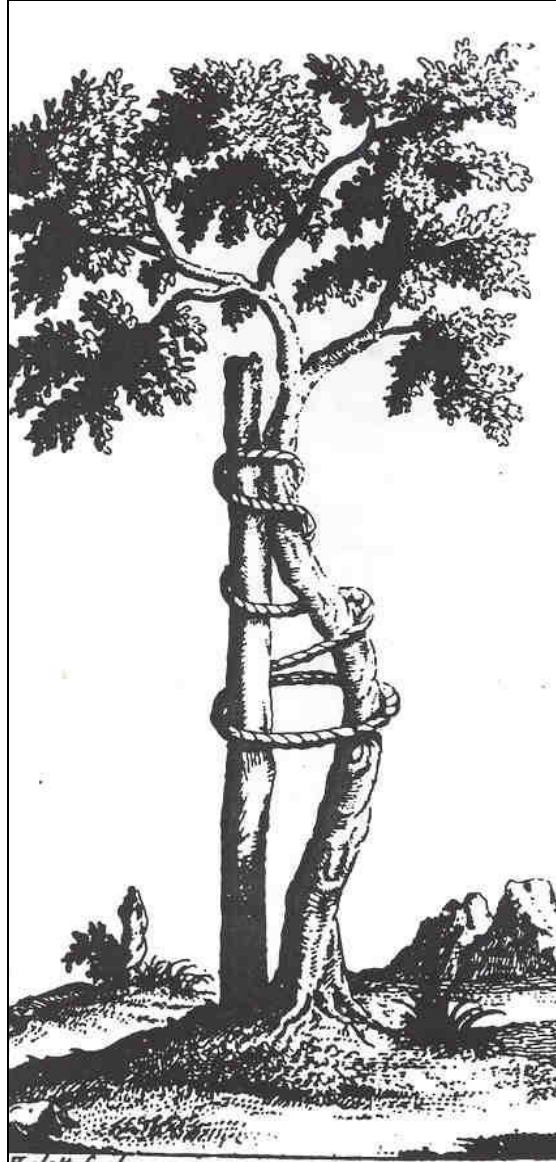
To friends and colleagues who have inquired, listened, encouraged and assisted, thank you.

Finally and most importantly my family...

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Prologue



A certain symmetry exists on one level of this thesis. The orthopaedic tree symbolises the study context. The tree of life symbolises the experiences of the participants contained in their descriptions. The tree of knowledge represents my journey and the quote from Murray Bail's Eucalyptus, which opens chapter three, alludes to the study's methodology.

Chapter 1

Introduction

What began as a notion, became a personal journey ... This thesis represents my journey. Like Homer's character, Odysseus in search of the meaning of life, I sought an explanation of the world of the advanced orthopaedic nurse. I wanted to know what advanced practice meant to expert orthopaedic nurse practitioners, because it was my world too. I had a sense of this phenomenon called advanced practice. Did others share my view?

Not content with a mere description, I sought the 'meaning' of advanced practice. Hermeneutics offered a means to explicate the phenomenon; to give it meaning by interpretation. My journey began with a personal reflection on an incident in which I drew on what I considered advanced practice skills. This exercise served several purposes, one of which was to reveal my orientation towards the phenomenon in question, or my 'pre-understandings' (van Manen, 1990:46). Secondly I wanted to recreate the conditions under which the participants would be interviewed; to know how it might feel, after all I was a participant in the dialogue. It oriented me towards developing a rapport with the participants and therefore by extension, the text to follow which was to become the focus of the research purpose.

My self-interview also established a baseline as it were. My appreciation of advanced practice changed throughout the study period as my understanding became more informed. It was therefore important to capture my initial thoughts.

This thesis has attempted to embrace the complexity of the hermeneutic phenomenological endeavour. That is to represent the many levels on which the methodology is applied. At a personal level, as researcher, this work has meaning. At a participant level there is the narrative which after analysis, transformed the participant's experience into a new meaning. I sought interpretive agreement from the participants, which was confirmed when the participants verified their transcript. At its broadest level this project represents a contribution to the debate on advanced practice at large, both in a professional and theoretical sense. Such complexity identifies with the methodological, philosophical imperative of 'parts and whole' of hermeneutic phenomenological inquiry (van Manen, 1990:33-4).

The purpose of this investigation is to describe and understand the nature of advanced orthopaedic nurse practice. The research question therefore asks '*What is the meaning of advanced practice for the expert orthopaedic nurse practitioner?*' The area of interest for this study becomes the advanced practice of the expert orthopaedic nurse.

The research question required the investigator to pool together a rich description of what advanced practice actually means to the expert orthopaedic nurse. In order to achieve this one must return to the source, as it were. That is, obtain a description from the expert

orthopaedic nurse of the subtleties of their (advanced) practice. The research question is premised on the belief that theory is embedded in practice (Benner, 1984), therefore one is able to extract from description, a definition of advanced practice. The research question aims to apply the theory of advanced practice to the evidence demonstrated in practice, as revealed by the data collected.

It is hoped the information gained from the study will contribute to the debate on advanced practice. This study aimed to engage orthopaedic nurses in the debate, and in so doing, put an orthopaedic perspective on advanced practice. Furthermore the study aimed to make a difference to the nursing profession by seeking to understand advanced practice in the context of orthopaedic nursing.

Implications for the Nursing Profession

This study will provide an interpretation of the advanced practice of the expert orthopaedic nurse practitioner, ensuring that these nurses are represented in the debate. It will contribute to the collective knowledge of the nursing profession as this emerging, contemporary professional issue takes its place in the consciousness of 'ordinary' nurses (Taylor, 1994). Further this study could serve as a basis for assessing the effect, advanced practice has on patient care and health outcomes in general; an area where more research is required.

Some Early Thoughts

My journey began with an ‘abiding interest’ in advanced practice that evolved from an interest in the debate on advanced practice that was taking place within the nursing profession. I had a passion for orthopaedic nursing. I wanted to know how the concept of advanced practice translated to orthopaedic nursing. What was the status of the generic advanced practice competencies in orthopaedic nursing practice? How were orthopaedic nurses engaged in this debate on advanced practice? This was my starting point.

The use of personal experiences as a starting point in researching lived experience is recommended by van Manen (1990:54-8):

...the extent that my experiences could be our experiences that the phenomenologist wants to be reflectively aware of certain experiential meanings. To be aware of the structure of one’s own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all other stages of phenomenological research. (van Manen, 1990:57)

My own experiences as an ‘advanced orthopaedic practitioner’ were therefore worthy of investigation. My underlying assumptions about advanced practice, or pre-understandings (van Manen, 1990:46) were revealed in a taped, self-interview. The qualities I emphasised in my self-interview had little to do with specialist knowledge. I recalled an awareness of the entire (ward) situation and a desire to manage and know this situation. I described ‘juggling’ the patient care needs at the same time as dealing with an episode of inter-professional conflict. I had a strong sense of my role, my professionalism and my patients (fieldnote:35). This introductory chapter has so far described *my* context, at the

outset of the research process. The remainder of this chapter will summarise the thesis framework.

Summary of the Thesis

This is a hermeneutic phenomenological study of the experiences of seven expert orthopaedic nurses who each described an incident of advanced nursing practice. Their personal descriptions, whilst unique, shared commonalities and differences with each other. A dialogue with the narrative texts via the hermeneutic circle, revealed emerging concepts that culminated in the development of themes. The themes represented the meaning of advanced practice for these orthopaedic nurses.

Introduction

The introductory chapter will firstly expand upon how the research process began by describing the researcher's context. This contributed to the formulation of the research question - *'what is the meaning of advanced practice for the expert orthopaedic nurse?'* The research question emanates from an abiding interest the researcher has in advanced practice and orthopaedic nursing. Experiential meaning was pivotal to this inquiry and therefore understanding will be generated through the use of hermeneutic phenomenology.

The Study Context

Chapter two situates the study by describing the context in which advanced practice takes place. The term ‘advanced practice’ is misunderstood largely because of the inappropriate use of it and other related terms. This chapter describes related terms, such as ‘expert’ and ‘specialist’ practice, and situates the debate on advanced practice in a national and international context.

Methodology

This chapter explores the philosophical foundation of hermeneutic phenomenology, a methodology situated in the interpretive paradigm. This chapter advances Benner’s (1984) premise that theory is embedded in nursing practice by interpreting the everyday lived experience of seven expert orthopaedic nurses.

Phenomenological inquiry will be informed by Heidegger (1962) in which the interpretation of lived experience is context related. In order to explicate interpretive phenomenology, it is necessary to discuss the preceding school of thought within the phenomenological movement, that belonging to Husserl. Oiler’s (1982) four foundational features of interpretive phenomenology will be elucidated. Hermeneutical interpretation will follow the method described by van Manen (1990). The application of these methodological principles will be discussed in the context of nursing practice.

Method

Chapter four will describe the methodical process undertaken in this study. This study is informed by the method designed by van Manen (1990). The discussion will elaborate upon the study context in terms of orthopaedic nurse practice, the participants, and how their descriptions of advanced practice were captured. This chapter will incorporate within the discussion an explanation of the role of language, the process of interpretive analysis and how a dialogue with the text was established via the hermeneutic circle.

The Narrative Text

The process of hermeneutic interpretation began with an introduction and summary of the 'personal life stories' or incidents, of the participants: Di, Gina, Ellen, Ben, Anne, Carol and Fay. Through immersion in the participant's narratives, preliminary concepts emerged in the form of impressive words and phrases. A description of these preliminary concepts followed as a beginning to interpretation.

An Interpretation

The interpretation comprised of themes that exemplified commonalities and differences from amongst the participant's descriptions. The themes were: having knowledge, being in the role and outside the role, being an advocate and being in control.

Denouement

Denouement was chosen as the title for this chapter as opposed to conclusion that infers reaching an end point (Jones, 1996:80), which is anathema to interpretive research. Whilst the themes were dealt with as discrete entities in this chapter, the reality is they are inter-dependent. The significance and implications of this study will be discussed along with possibilities for the future. An evaluation of the research process, informed by Madison (1990:29-30) is presented. By way of closure, I will review my original thoughts on advanced practice.

Chapter 2

The Study Context

The “Orthopaedic Tree” originated from the eighteenth century book Orthopaedia: Or the Art of Correcting and Preventing Deformities in Children by Professor Nicolas Andry, in which it has become the international symbol of orthopaedic surgery. It illustrates the concept that a crooked young tree - like a deformed child - can be helped to grow straight by the application of appropriate forces.

(Salter, 1999:2)

Introduction

This chapter will begin to situate the study. The literature demonstrates that advanced practice is a broad topic that is often misunderstood. Related terms are used interchangeably, which tends to engender a degree of confusion in regards to what constitutes advanced nursing practice. International progress on the issue is well ahead that of Australia. However, Australia must consider its own context, and critique the overseas experience in order to progress the national and international debate. This chapter will describe international developments on the issue of advanced practice whilst considering the implications for Australian nursing practice.

The relationship of advanced practice to expert and specialty practice is misunderstood. This chapter will attempt to clarify the association. There are only a small number of specialty nurse interest groups, nationally, which have contemplated the notion of advanced practice, let alone integrated the concept into practice. Orthopaedic nurses are

yet to embrace this idea into practice.

Competency Assessment

The movement towards advanced practice began with the concept of competency assessment. The development of the Australian Nursing Council Incorporated (ANCI) entry to practice competencies for nurses evolved out of a competency based movement dominant in Australian industry at the time. The beginning practitioner competencies built upon the concepts of novice to expert competence, embodied in the work of Benner (1984), but representative of the literature on competency-based education and competency evaluation emerging from America in the 1980's.

The definition of '*competence*' remains confused, contradictory and elusive (Giro, 1993:83; Chambers, 1998:207). Confusion reigns because of the problems associated with assessment of clinical practice. In nursing practice the 'tool' used for clinical assessment must ideally assess practitioners in the 'real world' of practice and in all aspects of nursing knowledge (Giro, 1993:89). Criticism of competency assessment surrounds the risk of reductionist measurement of nursing practice, subjective assessment, and a focus on the performance of tasks (Giro, 1993:88). Both Giro (1993) and Chambers (1998) suggest reflective practice may overcome the problems of assessment of clinical nursing practice, although its application requires caution (Heath, 1998:291-3). Critical reflection of practice is one way of assessing intuitive knowledge and analytical reasoning that characterises expert or advanced practice (Giro, 1993:87).

Expert Practice

The notion of expert practice was first explored through phenomenological research in Benner's seminal text *From Novice to Expert* (1984), in which Benner established five levels of competence: novice, advanced beginner, competent, proficient and expert and seven domains of nursing. Benner examined, phenomenologically, the critical incident accounts of 130 critical care nurses to reveal knowledge embedded in nursing practice. Storytelling preserved 'the language of the familiar, everyday, narrative discourse about their everyday practice' (Benner, Tanner & Chelsa, 1992:15-6). Benner believed 'clinical exemplars', or stories that describe nursing practice, would capture the true nature of nursing (Harvey & Tveit, 1994:45). Furthermore, particularly powerful experiences of nursing practice, were accorded the status of 'paradigm cases' and enabled a better understanding of what was being described (Benner, 1984:8-9). The use of exemplars was augmented through the use of interview and direct observation. Adams et al (1997:221) claims 'Benner's account of the expert practitioner has been the starting point for research and discussion on expertise in practice'; the 'industry benchmark' or 'gold standard' if you will, the influence of which is found in the pages of this study.

The definition of *expert practice*, as purported by Benner (1984:32), incorporated a 'deep understanding' (sourced in a breadth of background experience) and an 'intuitive grasp' on the totality of any given situation and has served as one of the most 'influential perspectives' on expert practice (Sutton & Smith, 1995:1038). However the debate on expert practice has evolved further. A review of expert practice within the literature revealed that the characteristics of expert practice may also include intuition, superior

skills and competencies, specific role functions and an interest in clinical outcomes (Adams, Pelletier, Duffield, Nagy, Crisp & Mitten-Lewis, 1997:220).

Jasper recognises the definition of expert practice as ‘ambiguous and difficult to clarify’ (Jasper, 1994:775). She suggests the concept of expert might be:

A nurse who has developed the capacity for pattern recognition through high level knowledge and skill, and extensive experience in a specialist field, and who is identified as such by her peers.

(Jasper, 1994: 774-5)

In this definition the concept of ‘pattern recognition’ is pivotal, and implies harnessing both knowledge (specialised, practical and theoretical) and experience to think and act intuitively with a sense of the ‘whole’. Further, that such expertise is recognised and validated by qualified others (Jasper, 1994:771-773). Sutton and Smith (1995) advance a similar view that the concept of ‘expert’ has a number of meanings, however they delineate expert from specialist and advanced nursing practice. They believe expert practice embraces the practical, technical and situational aspects of nursing practice. Both knowledge and skill hail from experience that then develops into a particular form of knowledge that is then applied directly into patient care. Their emphasis of the expert is in the ‘doing’ of nursing or an ‘immersion in practice’, as opposed to advanced practice which they believe is ‘qualitatively more than expert practice’, however they contend that expert practice is integral to an understanding of advanced practice (Sutton & Smith, 1995a:138-9 and Sutton & Smith, 1995b:1038-9).

Borbasi (1999:22) uses the terms of expert and advanced practice interchangeably in her study to ‘... gain insight into the human experience of specialty bedside nursing and the meaning specialty nurses ascribe to their world’. Hermeneutic phenomenology was the methodology employed in this study, actualised by the use of interviewing, journalling and participant observation. Borbasi identified that more research was needed to appreciate the contribution ‘senior’ nurses make to the cost and outcome of their care.

Advanced Practice

A broad definition of advanced practice is that it is ‘... more developed and presumably better than ordinary practice’ (Pearson, 1984:16). Pearson adds that advanced practice is essentially ‘being there’ with the patient. He suggests generalists and specialist nurses can both practice as advanced practitioners. Advanced practice is not dependent upon specialist nursing skill, however advanced nurse practitioners often have developed specialist skills in a particular area of interest.

The relationship between specialist, expert and advanced nurse has been investigated, in detail by Sutton and Smith (1995). They investigated the concept of advanced practice by directly observing registered nurses interacting with patients, by discussions with students enrolled in Masters of Nursing (Advanced Practice) programmes and through a review of the literature (1995b: 1040). Their work has been referred to extensively in this study because of its contextual relevance and detail. They have provided detail on the individual terms of expert, specialist and advanced nurse not previously attempted.

Furthermore their observations have occurred in an Australian context, which acknowledges the peculiarities of our health system. They conclude that more 'data' is needed to interpret and extrapolate the meaning of advanced practice before the nursing profession can acknowledge the contribution of these practitioners.

Sutton & Smith recognise the value of experience-based intuition in Benner's work, as this concept leads nurses to challenge their own 'preconceived notions and theories' when confronted with 'actual situations' in practice (McMillan, 1997:54). They don't rely on intuition alone however, as they have the ability to stand back from a situation and assess the overall impact, as it relates to the patient. It is the way the advanced practitioner thinks about, sees and experiences nursing that delineates them from the expert or specialist nurse. An advanced practitioner uses different ways of knowing a whole experience to guide their practice, and continue to constantly critique their practice. Their practice incorporates both practical and theoretical knowledge. They seek excellence and positive outcomes for their patients, and nursing practice is characterised by clarity of purpose and pragmatic endeavour (Sutton & Smith, 1995b:1040).

A distinguishing feature of Sutton & Smith's theory on advanced practice is the advanced practitioner is located 'in the personal' (1995b:1038). The personal attributes of the individual nurse, enhance their advanced practice, by bringing their personal qualities and humanity to the patient-nurse relationship. Furthermore the advanced practitioner is 'located in the immediacy of client situations', which implies an emphasis on the 'personal' aspects of the patient-nurse relationship (Sutton & Smith, 1995b:1040).

Advanced practitioners are mindful of nursing's future direction, and contribute to the development of nursing practice and scholarship within the discipline of nursing by virtue of remaining primarily focussed on patient care and passionate about providing 'hands on care'. Sutton and Smith (1995a:145) claim advanced practitioners demonstrate a 'reluctance to move away from the direct provision of care to the client'. They claim it is possible to be both expert and advanced practitioner, whilst expert is the 'precursor' to advanced practice. Most notably, advanced practice is 'qualitatively more' than expert practice (Sutton & Smith, 1995a:139). The characteristics of advanced and expert practice tend to be more generic in orientation, as opposed to specialist practice that refers to specific skills applied in a specialised field of nursing.

Specialty Practice

Nurse specialties, incrementally and haphazardly, have contributed to the discussion of advanced nursing practice. Critical care nursing is one of the few specialties to adapt this theoretical concept into practice, with the development of their Competency Standards for Specialist Critical Care Nurses (CACCN, 1995). CACCN (1995:v) declares the competencies are 'the gold standard' of the critical care nurse specialist, acknowledging that a continuum exists amongst critical care nurse specialists, and that not all nurses will necessarily achieve this standard. The research methodology undertaken to identify specialist competencies of critical care nurses, was interpretive in nature. Data was collected by way of observation, documentary analysis and interview. Themes emerged from direct observation of specialist level and expert nurses, and by review of critical

incidents. Inferences about performance were made and professional judgement about competence was determined (CACCN, 1995:8-17).

A discussion of advanced competencies is occurring within specialty groups, however this tends to be in the context of the development of specialist competencies. The Australian and New Zealand College of Mental Health Nurses (ANZMHN) have designed Standards of Practice (1995) in which they have specified how mental health nurses will demonstrate advanced practice by incorporating the six standards within the areas of: clinical skills, leadership, management, research and education areas, at a level of excellence. Midwives tend to be focussed on establishing themselves as separate from nursing; indeed they already consider themselves to be advanced practitioners (Clinton, Pearson, Dunn, Cheek & McCutcheon, 1999:29-32). The concept of indicators of 'continuing' competence has been received by the nursing profession with trepidation; this is because the original proposal linked ongoing licensure to practise as contingent upon successful assessment. The intention being that practice would be assessed against the competencies (Wilkinson, 1998:9). The debate on the issue of continuing competence is ongoing.

A nursing specialty is a section of the nursing profession that 'focuses on the health needs of a defined population' (Love, 1996:19). The concept of specialisation is applied in a specific sense to nurse practice, that is specialist nursing knowledge and specialist nursing practice (Sutton & Smith, 1995).

The International Council Of Nurses (ICN, 1992) defined specialisation as a process that 'deepened and refined nursing practice', identified by a 'level of knowledge and skill in a particular aspect of nursing which is greater than that acquired during the course of basic nursing education'. ICN called for an orderly development of specialisation by adoption of a systematic means of determining and designating nurse specialties, setting minimum standards, establishing regulatory mechanisms and nurse resource planning (Scott, 1998:555-6).

The debate in Australia accelerated after the visit of Dr Margretta Styles in November 1991. Dr Styles advised Australian nurses to aim for an orderly and integrated development of specialties that would ultimately empower nurses (Parkes, 1994:25). Specialty practice has been described as located in a field of practice, as a result of formal education and/or accompanied by experience (Sutton & Smith 1995b:1038). The history of specialisation is associated with aspects of medical knowledge and skills - those discarded by medicos. Therefore, specialisation amounts to a maturation process as a result of an expanding knowledge base. Given that nursing is only now defining its 'true essence' in terms of the accumulation of knowledge, we need to rethink our concept of specialist nursing practice (Sutton & Smith, 1995a:140-1).

Concern has been raised regarding the risks of deskilling generalist nurses at the hands of increased specialism in nursing. Risks include the fragmentation of patient care and the emergence of specialist nurse practice becoming too narrowly focussed (Marshall & Luffingham, 1998:658-662).

Contentious debate also surrounds the issue of credentialling specialist nurses. Credentialling is defined as the conferring of a credential on an individual nurse by a process of peer review, in which the highest level of competence is achieved, in contrast to licensure, which is the minimum standard. Another definition holds that credentialling is the 'process by which an individual nurse is designated as having established professional practice standards, at a specified time, by an agent or body generally recognised to do so' (Grealish, 1998:18). This notion raises a number of issues for consideration in regards to who might gain a credential, the cost, possible over-regulation of nursing, the method of assessment and the qualification of the assessor (Grealish, 1998:18-9 & Coulthard, 1998:24-5). The issue is far from resolved.

Further controversy surrounds the role of the 'nurse practitioner' (NP), who is defined as a registered nurse educated for advanced practice, the characteristics of which would be determined by the context in which they practice' (NSW Nurse Practitioner Review Stage 2, 1993: 3-5). A statement by the National Nursing Organisation believes the NP assesses and manages particular clinical presentations. The NP is able to do this because of their 'advanced education' and specific experience. Their role is context specific and designed to 'advance autonomous nursing practice' across a number of settings (NNO,1998).

Argument emanates from outside the nursing profession mainly because NP's, in some contexts, are required to perform tasks formally within the domain of doctors. However the focus of the nursing role is philosophically different from the medical role (Chiarella, 1998: 30-2). Nurse Practitioners practise in epilepsy management, palliation and cervix

screening to name only a few practice settings. Trials are under way to evaluate the effectiveness of the NP role in suturing wounds and treating uncomplicated fractures for instance. The results of which will be of relevance to orthopaedic nursing in the future (Serghis, 1998:7).

Clarification of the role specialty status bears to advanced practice is unclear, and the literature is divided. Sutton and Smith (1995b: 1040) are quite clear that a distinction exists between the two levels of practice; not least of which is its ideological premise. In the case of specialist nurse practice, knowledge generation is limited to a specific area of practice and has evolved from the medical model, as opposed to advanced practice that generates knowledge nursologically, with a general application to nursing practice. Pearson (1984:16) contends that specialism is not necessary for advanced practice, but often occurs simultaneously. This study will attempt to examine the relationship of specialty nursing to advanced nursing, by virtue of the perspective the research has taken, that is an examination of orthopaedic nurse practice, which is of itself a specialty branch of nursing.

Orthopaedic Nursing Practice

Reference to the American literature is necessary to explicate the role of the orthopaedic nurse practitioner because little explanation of orthopaedic advanced practice is available in the Australian literature. Orthopaedic nurses both in the United Kingdom (UK) and the United States of America (USA) have had their specialty status questioned (Salmond,

1996:6). The American experience was in response to ‘downsizing’ of orthopaedic nursing services. This meant that patients hospitalised with orthopaedic conditions were found on general medical-surgical areas, which infers the specialty status of orthopaedic nursing is no longer required. In response to this trend, a study by Love (1996) examined orthopaedic nursing’s specialty status through the use of a self-administered questionnaire, which identified seventy six nursing activities. Thirty-six of those nursing activities were identified as ‘highly orthopaedic’ skills. Nine activities were considered borderline orthopaedic nursing activities, four of which related to orthopaedic professional status apparently confusing to the orthopaedic nurses themselves. Eleven generic activities were identified. Orthopaedic nursing, like any other branch of specialty nursing, uses an holistic approach to patient care from which the generic activities emerged (Love, 1996:24). The study recommended results be considered in the design of orthopaedic nurse education programmes. Salmond (1996) in critiquing Love’s study called for more research, both empirical and interpretive to overcome the absence of orthopaedic research in the field, she suggests ‘a log book of critical incidents’ in order to legitimise the role of specialty orthopaedic nurses. Furthermore she believes research is needed to ‘... quantify [the] differences in patient care outcomes when cared for by specialty registered nurses’ (Salmond, 1996:6-7). Similarly Brunner (1998:5) when considering what is special about orthopaedic nursing recommends the continued use of clinical exemplars or ‘stories’ as a means to demonstrate the ‘good’ work orthopaedic nurses do. Harvey and Tveit (1994:45-53) put a strong case for the use of clinical exemplars to recognise excellence in clinical practice, claiming they define, describe, validate, preserve, and explain nursing practice in both a professional and personal sense.

This study employed clinical exemplars as a means to capture the true nature of advanced orthopaedic nursing.

One Australian study examining the clinical reasoning of expert and novice orthopaedic nurses, used verbal protocols and protocol analysis (Greenwood & King, 1995b:907-913). The study raised some searching issues for orthopaedic nurses and nurses in general. The study method whilst complex, identified the importance of patient-focussed care and noted the tendency of specialist areas of nursing to adopt a medical model of care (Greenwood & King, 1995a:325). Their study's methodology used observation and interview techniques, in addition to 'think aloud' techniques to examine expert knowledge and skill (Greenwood & King, 1995b:908-10). Transcription and analysis of speech provided the material to confirm that the experts in this study knew more than the novice nurses and therefore could access their knowledge more easily (Greenwood & King, 1995a:315).

In the USA certification is the credentialing mechanism for the advanced practice nurse (APN). An APN is a nurse practitioner. They deliver primary and acute care in different settings. They diagnose and treat medical and surgical conditions and have prescribing privileges. Certification as a nurse practitioner may require masters degree preparation, depending on the state, and registering authority concerned. 30% of National Association of Orthopaedic Nurses (NAON) members are certified (Brunner, 1998:5). Orthopaedic nurse practitioners have a range of roles and practices, and are found in a number of settings. Nurses can work from home, ambulatory care settings or in the acute care sector.

In orthopaedics specifically, nurses case manage total joint arthroplasty patients pre-operatively, and manage patients referred with acute musculo-skeletal injuries and long term orthopaedic problems. Patients are privately referred, self referred or referred via an emergency department (Pastorino, 1998:68).

Another role is that of orthopaedic trauma coordinator who is associated with a particular team of orthopaedic surgeons, and oversees their patient's post operative care including referral to other specialty clinics. Triage is another aspect of the role, which is undertaken by phone. Advice is given on fracture management, and management of orthopaedic problems. Nurse practitioners (NP) are also associated with managing localised musculo-skeletal problems such as back pain. The NP provides diagnosis and treatment of acute and chronic musculo-skeletal conditions (Pastorino, 1998:68).

Another example of an orthopaedic nurse clinician (NP), is via the combination of two areas of nursing practice, orthopaedic knowledge and emergency nursing. Care is provided for emergency patients presenting with acute orthopaedic problems. The NP provides care in fracture management, complicated hand injuries, tendon lacerations, interprets x-rays, applies splints and casts, and removes casts. The NP monitors sedated patients undergoing fracture reduction, insertion of skeletal traction pins, application of cervical halo traction or joint aspiration. The NP also provides patient education, mobility education (eg. crutches) and discharge education and planning. Follow up care is provided by phone or by out patient visit (Wiseman, 1996:544-5). These descriptions of orthopaedic nursing roles in America, demonstrate the scope of practice for the

orthopaedic nurse practitioner is vast and caters to local needs.

International Experience

Much debate on advanced practice has occurred within the international arena. The role of the advanced practice nurse has been recognised in the USA for the past 30 years where a certification process has been in place since 1973. In the USA advanced practice nurses (APN) work in one of four areas: as clinical nurse specialist, certified nurse midwife, certified registered nurse anaesthetist or nurse practitioner. Each classification of nurse must have met the relevant educational and clinical requirements. The American Nurses' Association has designed criteria for advanced practice.

They [advanced nurses] conduct comprehensive health assessment, demonstrate a high level of autonomy and expert skill in the diagnosis and treatment of complex responses of individual, families and communities to actual or potential problems. They formulate clinical decisions to manage acute and chronic illness and promote wellness. Nurses in advanced practice integrate education, research, management, leadership and consultation into their clinical role and function in collegial relationships with nursing peers, physicians and others who interface with the health environment

(Ball, 1997 cited by Marshall & Luffingham, 1998:659)

Currently American nurses are considering reducing the number of practitioner roles into a more simplified structure (Castledine, 1998:682). An interstate agreement has been reached in America that recognises the term Advanced Practitioner Registered Nurse (APRN) as representing the four categories of Advanced Practice Nurses that currently exist (Havens, 1999:1). In the United Kingdom significant debate is taking place in

response to the emergence of a plethora of roles, however titled, adding to the general confusion over advanced nursing practice. Nursing practice is divided into three stages according to the United Kingdom Central Council (UKCC). Professional practice immediately follows registration. Specialist practice occurs when expertise is gained in a wide range of settings with specialised knowledge and skills in one or more areas. Advanced practice is specialised practice in direct patient care, in addition to masters degree education, clinical skills, research, consultancy and leadership skills. Advanced practice is currently under review by the UKCC and the nursing profession at large. The pressure to articulate practice outcomes, to clarify the relationship between varying spheres of practice, academic levels and professional competence, to clarify the role of competency assessment in practice, and ascertain the impact of educational arrangements on future developments, the notion of ‘advanced practice’ and how it is ‘operationalized’ is currently under scrutiny (Scott, 1998:560). Suffice it to say the United Kingdom Central Council (1994) defines advanced practice as:

Adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and, with advancing clinical practice, research, and education, to enrich professional practice as a whole.

(cited in Marshall & Luffingham, 1998:659)

However the UKCC are moving away from this definition of advanced practice, preferring to concentrate on the concept of ‘higher level roles in nursing practice’ (Maclaine, 1998:159-163). The latest conceptual statement refers to high level practice in terms of ‘appropriate knowledge and skill requirements for particular areas of practice (UKCC, 1998). UK nurses are demanding greater leadership on the issue of what

constitutes advanced or 'high' level practice.

Compared with our American counterparts, Australia has made little progress towards defining advanced practice. The debate has progressed to the point whereby a generic form of advanced competencies exists in addition to the Australian Nursing Council Incorporated (ANCI) Entry to Practice competencies (1990). The document, Competency Standards for the Advanced Nurse (McMillan, 1997), published under the auspices of the Australian Nursing Federation (ANF), in consultation with the National Nursing Organisations (NNO's) have developed twelve (12) standards which reflect the practice of the advanced nurse in its totality. The standards project aimed to analyse Benner's (1984) levels of nursing practice in the form of competency standards. The project was mindful of recognising nurses working in specialist and generalist practice settings. This study confirmed the use of context and narrative as a means to reveal knowledge about nursing practice, and 'discriminating amongst different levels of practice' (McMillan, 1997:55). Through written 'stories' and/or exemplars, twelve generic competency standards were developed during national workshops to assist in analysing the exemplars. Ongoing clarification of specialist and advanced practice roles is still required, however McMillan's work is important to this study because it is contextually Australian, recognising the peculiarities of Australian nursing practice within the Australian health system. Interestingly the term 'advanced clinical practice' has been enshrined in a recent industrial agreement. This infers tripartite acceptance of the concept has been reached. The role is described as being increasingly complex, differentiated by advanced problem solving and the context in which practice takes place (1998:16). The theoretical work of

Benner (1984) largely informed this study, whilst the work of McMillan (1997) heavily influenced this study.

Summary

Controversy and confusion dominates what constitutes advanced practice. The nurse practitioner role articulates with the advanced nurse practitioner role (Chiarella, 1998:30). An advanced nurse practitioner can be either an expert or specialist, although advanced nursing practice is aligned more closely with expert practice because it incorporates expert practice more readily. The nurse practitioner appears to ‘evolve’ from expert practice (Sutton & Smith, 1998:1038). Expert clinical judgement is the result of complex reasoning and analytical, intellectual processes. ICN recently considered at the Centennial Conference in London (1999), an international definition of advanced nursing practice which encompass other classifications of nursing practice including nurse practitioner. It was agreed the term ‘advanced practice’ become the ‘umbrella term’ under which all other classifications of nursing practice relate (Havens, 1999:1). Advanced nurse practice is the ‘essence of nursing’, which this study will attempt to describe and understand.

Conclusion

Modern health care is becoming increasingly more complex. This complexity is characterised by factors such as new health technologies, increased patient complexity (due to medical, technical and social change) and increased consumer demand. There are a greater number of legal and ethical dilemmas emerging. A wider range of professional practice models (case management, primary and team nursing) are being introduced into health care settings. The nursing profession itself is being placed under greater demand to overcome such issues as skill shortages and other workforce issues (Scott, 1998; Grealish, 1998; Serghi, 1998). There are greater expectations placed upon the nurse practising in this context. Therefore the role of the nurse must reflect the increasing complexity that exists within the health system. Identifying standards of advanced practice is an issue the nursing profession is in the process of addressing. Once this is done the impact advanced practice, however termed, has on patient care can be ascertained. The debate on advanced practice provides an opportunity to acknowledge how nursing practice can reflect the ever-increasing complexity within the health system. This study will attempt to contribute to this debate.

This study will assist in conceptualising advanced practice, particularly in terms of the nature and scope of advanced orthopaedic nurse practice. I consider conceptualisation a necessary step before the nursing profession can seriously debate such issues as regulation of advanced practice, or measure the impact, advanced practice has on patient care. Consistency in understanding associated terminology would assist immeasurably with this objective.

Chapter 3

Methodology

...It is this chaotic diversity that has attracted men to the world of eucalypts. For here was a maze of tentative half-words and part-descriptions, constantly expanding and contracting, almost out of control – a world within the world, but too loosely contained. It cried out for a ‘system’ of some kind, where order could be imposed on a region of nature’s unruly endlessness.

This attempt to ‘humanise’ nature by naming its parts has a long and distinguished history. Once a given subject is broken down into parts, each one identified, named and placed into groups – the periodic table, strata of minerals, weight divisions of prizefighters – the whole is given limits and becomes acceptable, or digestible, almost...

(Murray Bail, Eucalyptus)

Introduction

The methodology used in this study was situated in the interpretive paradigm. Hermeneutic phenomenology was selected because it allowed the meanings of the phenomenon under investigation that are concealed in everyday actions to be revealed. It was through thematic analysis and hermeneutic interpretation of subjects' descriptions that an improved understanding was offered. The phenomenological inquiry undertaken in this study was informed by the philosophical contemplation of Heidegger (1962) who acknowledges that the interpretation of lived experience is inseparable from context. Hermeneutic interpretation followed the method described by van Manen (1990) and a meaningful understanding of advanced practice was generated.

Heideggerian phenomenology was employed as the methodological philosophy in this study in order to reveal the *meaning* of being an advanced orthopaedic nurse practitioner; whilst hermeneutics provided a philosophical framework in which to *interpret* the meaning of being an advanced orthopaedic nurse.

Initially this chapter will provide a working definition of hermeneutic phenomenology. It is beyond the scope of this thesis to describe the methodological minutiae, given the breadth of philosophical thought associated with the phenomenological movement, however, this chapter will attempt to capture the methodological imperatives relevant to the research question.

This chapter will explore, what Oiler (1982: 178-181) considers the four foundational features of the phenomenological approach: namely phenomena, reality, subjectivity and truth. These four perspectives encapsulate why hermeneutic phenomenology was chosen to pursue the research question. Therefore by way of situating the research question, this methodological discussion will refer to certain characteristics of Heideggerian phenomenology which relate to Oiler's foundational features. The discussion will cover the essential concepts of Heideggerian phenomenology: of '*being*' and '*lifeworld*'. A brief discussion will follow describing the phenomenological differences the literature alludes to between '*knowing*' and '*being*'. The discussion will address Heidegger's ideas surrounding '*historicality of understanding*' (Koch, 1995:831). Many of the concepts discussed in this chapter are inter-related and it is therefore difficult to deal with each in a discrete sense. Nevertheless this chapter will provide a general overview of Heideggerian

Phenomenology and Hermeneutics and conclude with a brief discussion that links hermeneutic phenomenology and theory generation.

Defining Phenomenology

In its simplest form, phenomenology is the study of a particular phenomenon. Merleau-Ponty (1964) asserted that phenomenology attempts to describe human experience as lived (in Oiler, 1982:178). Therefore, phenomenology is the study of lived experience (Wilkes, 1991:232). According to Gelven, Heideggerian phenomenology is defined as an

...analysis by which the meaning of various ways in which we exist can be translated from the vague language of everyday existence into the understandable and explicit language of ontology without destroying the way in which these meanings manifest themselves to us in our everyday lives... (Gelven 1989 cited by Walters 1994:137)

Interpretive Phenomenology

The expanded definition of Gelven's provides the methodological premise upon which this study is based. Heidegger's definition refers to hermeneutic phenomenology that seeks meaning originating from culture: specifically language, practice and the everyday lived experience (Sorrell & Redmond, 1995:1120). In revealing practices and meanings one is able to better understand culture. It is the "culture" of the advanced orthopaedic nurse that this study has investigated. Language, as a mode of expression, acted as a conduit to the world of the orthopaedic nurse in which certain practices, traditions and rituals took place. Exploration of the participants' experiences revealed insights into their

world. Similarities and differences within those descriptions, volunteered by the advanced nurse, conveyed a 'snapshot' view of their culture. Consistent with hermeneutic phenomenology, meanings were extracted that make explicit and attempt to understand those hidden meanings behind everyday experience and contributes to an appreciation of what it means to be an advanced orthopaedic nurse. Heideggerian phenomenology provided an interpretive process that made possible an understanding that emanated from personal descriptions. Furthermore, interpretive phenomenology provided a philosophical framework in which to consider the significance of the deeper meaning that the narrative presented.

Historical Origins

Edmund Husserl (1859 – 1938) is credited as being the founder of the phenomenological movement. A mathematician by training, he developed a phenomenology that he anticipated could equally apply to philosophy and science (Cohen, 1987:32). He was concerned with exploring the phenomena of consciousness. His focus was how the essence and experience of phenomena 'appeared'. To Husserl experience was the font of all knowledge. Husserl believed, in order to study phenomena it was necessary to isolate them, then subject them to logical inquiry. This style of reductionism included 'suspending one's attitude' toward the phenomenon; that is, completely disconnecting the phenomenon from its surroundings. The ability to objectify the phenomenon was an extension of the dominant Cartesian tradition of the 'mind-body' dualism. Furthermore Husserl believed this form of philosophical inquiry could be subject to rigour in the same

way the scientific method applied rigour (Cohen, 1987:32; Walker, 1994:136-7). Husserlian phenomenology described a transcendental phenomenology with an epistemological inclination, characterised by an 'immediacy' of experience. Immediacy in the sense that the experience was scrutinised at a certain point in time, removed from its context.

Martin Heidegger (1889 – 1976), a student of Husserl, rejected some of the premises of Husserlian phenomenology. Heidegger believed it was impossible to separate phenomena from surroundings. Heidegger focussed on what a phenomenon means in daily existence. This form of phenomenology described an 'existential phenomenology' with an ontological inclination whereby understanding comes from '*being*' in the world (Koch, 1995:831). It sought to understand the state of '*being*' and all the relationships associated with '*being*'. It was characterised by a more contemplative approach. Contemplative in the sense that reflection of the phenomenon took place cognisant of its relationship(s) to context.

Heideggerian phenomenology differed from Husserl's through what Heidegger referred to as '*being-in-the-world*'. Heidegger argued that the individual is situated and self-interpreting, that is, he believed that the individual cannot be separated from the context in which they exist (Leonard, 1989:44 & 7). This was distinct from Husserl, who by following the Cartesian tradition, attempted to view the individual objectively; that is disconnected from one's surroundings (Koch, 1995: 828-9). Neither Husserl nor Heidegger provided a methodological process per se, but described an approach or school

of philosophical thought. As Heidegger (1962:50) stated ‘...phenomenology signifies primarily a methodological conception...’.

Defining Hermeneutics

Hermeneutics is concerned with understanding and interpretation (Geanellos, 1998:154). There is a view within the literature that asserts Heideggerian phenomenology is hermeneutical by virtue of belonging in the world. Heidegger suggests that belonging in the world is interpretive by its very nature (Ricoeur 1981, cited by Ray in Morse, 1994:121). Heidegger claimed people make sense of their everyday lives, by simply trying to understand the reason why certain things happen (Walker, 1994:137). Through textual analysis of actual experience, Chadderton (1997:402) claimed, hermeneutic philosophy is the way we come to ‘*understand*’ human existence. ‘*Understanding*’ is constituted from our historical, social and cultural domains, therefore it was envisaged hermeneutic phenomenology would best reveal ‘...the shared practices and common meanings of the everyday lived experience...’ (Gullickson cited by Crotty, 1997:88). In order to examine the practice and meaning of everyday life, this study embraced certain characteristics of hermeneutics suggested by Leonard; with a view to specifically

...understand[ing] everyday skills, practices, and experiences; to find commonalities in meanings, skills, practices and embodied experiences...
(Leonard, 1989:51)

were applied to the practice of the expert orthopaedic nurse. Consequently this study is informed by Heideggerian phenomenology (1962) and hermeneutics as espoused by van

Manen (1990) with the specific purpose of interpreting the concealed meanings in the phenomena of the advanced orthopaedic nurse practitioner (Sorrell & Redmond, 1995:1120).

'Foundational Features'

Phenomena – the '*things themselves*'

Oiler (1982) refers to phenomena in terms of the appearance of objects and events within the social world. This is an important concept in terms of this study because of the social nature of nursing. Husserl (1911:80 cited by van Manen 1990:31) and Heidegger (1962) believed phenomenology meant turning 'to the things themselves'. Phenomenology is interested in the daily experiences of people. Impacting upon experience is the social context in which the experience takes place. Therefore when searching for the meaning ascribed to the experience of the expert orthopaedic nurse practitioner it was necessary to consider the location or context in which the phenomenon appeared.

'Lifeworld' – the world of lived experience

Phenomenologically, the person is inextricably linked to the world. Our world is imbued with culture. A synergistic relationship exists between the self and the world (Leonard, 1989:43). The '*lifeworld*' of the participant refers to the situated experience of the person, in its totality, (Ashworth, 1997:219) as opposed to how one might perceive it (Jasper,

1994: 311). Heidegger (1962) believed that ‘...our primary relationship with *‘things’* is...through lived experience...’ that is, one is *‘engaged’* in some sense (Ashworth, 1997:221). When turning to the *‘things themselves’*, one does so in the expectation that the individual is linked in a rich and complex sense. When *‘lifeworld’* is viewed in this way it places meaning as contextual and forever changing (Dahlberg & Drew, 1997:311).

Reality

Research paradigms differ according to their view on reality (Jasper, 1994:314). Husserl searched for reality in the *‘things themselves’* (Crotty, 1996:30); hence Koch claims *‘...reality is the lifeworld...’* (Koch, 1995:828). The reality found within the *‘lifeworld’* is a concept that influenced Heidegger greatly, and is integral to phenomenology. In phenomenology it is the *appearance* of reality that is important; reality is subjective and affected by individual perspective (Oiler,1982:178-9). It is the participant’s perspective that the phenomenologist is interested in, particularly if there is a degree of commonality within a number of distinct and unique perspectives. Oiler (1982:179) states *‘...reality is dependent on individual perspective...’*. Rose, Beeby and Parker (1995:1126) claim phenomenology is an extension of the world-view (or *‘lifeworld’*) where reality and individual experience are inseparable, therefore the *‘inner or subjective reality’* becomes the phenomenon of interest. It was the perceived reality of each individual advanced orthopaedic nurse practitioner that this project pursued.

Subjectivity

'Being-in the-world' refers to experience that becomes meaningful by knowing and existing in the world. It is this contact with the world that shapes our experience of it. To reiterate, '...knowing shapes experience....' (Oiler, 1981:179). Heidegger's discourse *Being and Time* (1962) presented the argument that phenomenology is ontological, as opposed to epistemological. That is to say Heidegger explored *'understanding'* as a way of being, not as a way of knowing (Koch, 1995:831). The subjective *'being'* is pivotal to this study because the related experiences of advanced practitioners, came from their subjective reality.

The subjective is further expanded upon by way of background. *'Historicality'* is a combination of a person's background, their *'preunderstandings'* or perspectives on life which they have developed through the experience of their life, and the synergistic relationship of person-world which lends itself to the interpretive nature of human existence (Koch, 1995:831). Heidegger's *'historicality of understanding'* is an aggregation of the structures and concepts that characterise this specific form of phenomenology. Nonetheless Heidegger's *'hermeneutic circle'* seeks to examine the relationship these structures and concepts bear to the whole, and vice versa (Chadderton, 1997:402), which will be discussed in the next chapter.

Phenomenology: A Critique

'Credibility'

Credibility is important to the research endeavour. Credibility is perceived in several ways in qualitative research. In the first instance there is the credibility associated with the phenomenological text. Cohen and Omery (1994) claim Heidegger believes credibility is found in '*being*' (in Morse et al,1994:145). Ashworth (1997:219) supports a reality whereby essential truths of the human, social world are described. Oiler (1982:179) states truth is a 'composite of realities', implying that each participant's reality offers a plausible view. Cohen & Omery (1994), Oiler (1982) and Ashworth (1997) believe there is a credibility or plausability that emerges from the study of the trivialities of life, which is in contrast to how positivists would appreciate truth.

The second approach to credibility is associated with the research method. In support of the notion of credibility in interpretive research, Avis claimed credibility is achieved by maintaining objectivity (1998:142). For Sandelkowski (1986:27-37) credibility is associated with 'rigour'. The positivistic construct of objectivity may not be applicable to qualitative research, as it imposes restrictions on complex social phenomena, that don't abide by such rules. The overall aim of qualitative research ought to be the application of sound methodological principles, and in this sense objectivity and rigour have merit, if those principles are followed.

In phenomenology the quest to understand meaning not truth is paramount (Bailey,1997:21). Therefore for the purposes of this study ‘credible’ qualitative research is associated with all of the above. Credibility for the participants in this study, as expressed by them, was captured in the text and secondly credibility was also achieved with the application of a credible method. Arguably credibility in interpretive research is associated with the participants agreeing with the interpretation and understanding generated by the researcher (Sandelkowski, 1986:35). Consequently credibility was achieved when the orthopaedic nurses were able to agree and identify with the constructed meaning. Finally credibility is demonstrated when the reader clearly follows the research process from examples contained within the participant’s text, to the interpretive understanding reached by the researcher.

‘Rigour’

The positivistic notion of ‘rigour’ is contentiously applied to qualitative research, however, it is not a concept dismissed altogether. Truth and rigour have been reinterpreted in phenomenological research. Faithfully or honestly representing the participant’s experience, or their ‘truth’, is a means of achieving rigour in qualitative research. Being faithful to the description occurs when the individual participant acknowledges the researcher’s representation as ‘credible’; a term used by Sandelkowski (1986:30). Credibility or truth is again achieved when others reading the text ‘identify’ with it, as being an experience that resonates, or one they have personally known or experienced (van Manen, 1990:27).

The researcher must be honest and ethical in their approach to the research endeavour. In phenomenology the researcher must be aware of his/her own 'pre-understandings' or preconceived thoughts towards the phenomenon. It is necessary for the researcher to acknowledge their own experiences and pre-understandings if they effect the discussion in some way. Appropriate referencing to the narrative indicates the researcher is being true to the text. This implies using the participant's text to support the study's findings or themes and arriving at well supported understandings (Koch, 1995:834). Furthermore, a consistency must exist between the research methodology and the research method and be obvious enough to enable the reader to critique such a claim (Bailey, 1997:21). The above has demonstrated there is a place for truth in qualitative research, which rejects positivistic constructs, on the basis that the research imperative in a human science paradigm is quite different.

'Universality'

Dahlberg and Drew (1997: 310-1) refer to the tension between the objectives of 'uniqueness and sameness' in phenomenological research. The contradiction emerges as a result of preserving the 'uniqueness' of an individual's description, yet searching for the 'sameness' amongst descriptions of the phenomena under investigation. Ray (1994:124) poses that theory generation is possible, despite the narrative applying in an isolated sense to the participants of any one study. Notwithstanding, it is the '...unity of meaning of belongingness and the interconnectedness to the whole of the human condition both historically and universally...', (evidenced as essences or themes), which justifies the use

of phenomenological description in qualitative research and enriches our knowledge of human existence.

Methodological Application

The value of phenomenology to nursing knowledge, is its ability to bring certain experiences to light, and therefore through being enlightened, nurses can question or bring about change in nursing practice. This study is premised in the belief nursing knowledge is embedded in practice (Benner, 1984). Given the power of phenomenology to describe the 'essential meaning of human experience' (Ray in Morse, 1994:122), the emergence of theoretical concepts as a result of studying lived experience is possible (Adam 1987 cited in Rose, et al 1995:1128). Leonard (1989:52) believes the role of theory in hermeneutics is to identify meaning contained in lived experience. However van Manen (1990) believes theorising in phenomenology is 'antithetical' unless it occurs in a context of interpretation (Morse, 1994:123&4). Moreover phenomenon can only demonstrate how and under what circumstances theory is applied, that is phenomenology guides understanding which is the first step towards development of a theoretical base for nursing practice. This study will contribute to the collective knowledge of nursing by presenting a descriptive analysis of nursing knowledge embedded in orthopaedic nursing practice.

Nursing and Phenomenology

The literature resonates with the suitability of phenomenology to nursing. Nursing is essentially a social practice by virtue of the social interaction that takes place within the patient–nurse relationship. Taylor states “...nursing occurs in the ‘real world of practice’...” (1993:171) characterised by holistic and caring practices; practices difficult to objectively quantify. Nursing is constructed through language (Walsh, 1996: 234) and our understanding of the world is revealed through the use of language (Mitchell, 1994:227). Social practices, which contribute to our understanding of the world, contain interpretations and meanings. Given that the focus of this study is to reveal the meaning and human dimension of experience, traditional scientific methods are poorly equipped to fully capture and explain this phenomena. Phenomenologists and nurses alike, recognise and value the importance of ‘...observation, interviews, interaction and interpersonal relationships...’, in what they do (Rose et al, 1995:1127).

The use of interpretive phenomenology for this study will preserve the uniqueness of the experience and provide an ontological understanding of what it means to be an advanced orthopaedic nurse practitioner. This study will therefore concentrate on the ‘meaning and significance’ of advanced orthopaedic nurse practice. This personal perspective is important to fully appreciate advanced practice. The research approach of interpretive phenomenology is particularly focused on making visible an interpretation of experience as it is lived in everyday nursing practice. Phenomenologists believe meanings and interpretation are contained within social practice. Phenomenologists are interested in understanding meanings of human action (Avis, 1998:143). The phenomenon of interest

in nursing is the daily life of the people they care for. The practical domain of the nurse is multi-dimensional and complex. Advanced nurses perform in a particular way within this environment. To what extent this occurs is not immediately apparent. This study aims to uncover elements of advanced practice that would otherwise be hidden, and therefore identify the significant impact advanced practice has on the nurse-patient relationship. This study utilised a methodology sensitive to revealing meaning and experience from a personal perspective so that the study findings make a difference in the lives of the participants, orthopaedic nurses, advanced practitioners, other interested nurses and most importantly their patients.

Chapter 4

Method

Introduction

This chapter will describe the actual method and process undertaken in this study. The phenomenological method, per se, was not articulated by the early philosophers. It is the philosophical premise that guides the research method. The task of prescribing the detail of method was taken up by the likes of Colaizzi (1978), Giorgi (1975&9), van Kaam (1966) and Crotty (1996:158-9). This project is informed by the method designed by Max van Manen (1990). van Manen's approach allows the researcher to modify the method to suit the research question. This chapter will begin by elaborating upon his six steps in making an hermeneutical phenomenological interpretation and expand upon those methods chosen for this study. The discussion will elaborate upon the study context in terms of orthopaedic nurse practice; the nurse participants and how their descriptions of advanced practice were captured. This chapter will incorporate within the discussion an explanation of the role of language; the process of interpretive analysis and how a dialogue with the text was established via the hermeneutic circle.

Van Manen's Method

1. Turning to the Phenomenon of Lived Experience

According to van Manen the first stage in conducting human science research is to turn to the phenomenon. For him phenomenological research focuses absolutely on lived experience. The phenomenological endeavour aims to transform the lived experience into its essential structure, and in this way the lived experience gains renewed meaning. Van Manen notes a researcher is already oriented or connected to the phenomenon by possessing a certain interest in the phenomenon (van Manen, 1990:31, 35-41).

In this study I am oriented to the phenomenon by virtue of being a nurse with a passion for orthopaedic nursing, an advanced practitioner, and a student of nursing. The study participants were asked to recall an experience in which they considered they performed as advanced orthopaedic practitioners, and as the researcher I acknowledged it was their interpretation of the experience. The role of the researcher was to tease out the meaningful aspects of the experience in such a way that using the following steps in van Manen's method could '...construct a possible interpretation of the nature of a certain human experience...' (van Manen, 1990:41). In this instance creating the researcher's interpretation of advanced orthopaedic nursing practice.

2. Investigating Experience as We Live It

Our recollection of an experience can alter from the way in which it was originally perceived; by virtue of its 'transformation' into the spoken form (van Manen, 1990:54). This is the distinction van Manen makes when addressing the 'nature of data'. Collecting data or 'lived experience material' is achieved by either interview/conversation, in writing or by observation. The aim of the investigation is to become '...full of the world, full of lived experience...' (van Manen, 1990:32).

Through the act of conveying the experience, the lived experience has already been filtered, and constitutes an 'interpretation' of the original experience as lived. van Manen comments that the 'personal lived description' does not equate to a phenomenological description however. This occurs after a period of reflection when the special meaning of the experience is known. The phenomenologist is interested in the potential for universality, contained within the phenomenon (van Manen, 1990:53-8). The source of phenomenological experiential description can include: written description, interview/'personal life stories', observation, literature, biographies, diaries, journals and art. Importantly the overriding goal of obtaining interpretive meaning of the experience must remain paramount, regardless of the source.

I asked the orthopaedic nurses to describe an experience, whereupon they drew on advanced practice skills. The collection of 'personal life stories' retold through the interview/conversation with the researcher, provided an entrée into their world and enabled me to derive interpretive meaning from a previously lived experience.

3. Hermeneutical Phenomenological Reflection

This step of van Manen's method follows contemplation of and making apparent the essential themes or meanings of the phenomenon. van Manen (1990:77) claims this requires reflection, clarification and an explanation of the structure of the meaning of the lived experience. Total immersion in the data is the process of the researcher becoming intimately familiar with the experience as lived. Through familiarity, the phenomenological themes will become apparent as the 'structure of experience' (van Manen, 1990:79). '(O)pening up' to the deeper meaning of the experiential account, leads the researcher to thematic development. Articulation of themes serves as the stepping stones to deeper meaning. Themes encapsulate the core of the notion and give meaning and understanding to the phenomenon of interest (van Manen, 1990:88).

van Manen suggests thematic discovery occurs as a result of either 'sentencing', 'highlighting' or 'detailing' the text. These techniques are aimed at uncovering or isolating aspects of the phenomenon within the text. When using the 'sententious approach' the aim is to capture the meaning of the phenomenon as a whole. The detailed or line-by-line approach' examines each line of the text to identify what each sentence reveals about the phenomenon of interest (van Manen, 1990:93). In this study selective highlighting was chosen as a means to identify themes. During initial and subsequent reading and listening, I identified significant words or phrases within the written texts. As concepts emerged, I re-read the descriptions searching for examples of phenomenological meaning.

4. Hermeneutic Phenomenological Writing

The next step was to create a 'linguistic transformation' (Van Manen, 1990:96). This continues the process of interpretation via language. Language brings the human experience to life, as it were (van Manen, 1990:38). Hans Georg Gadamer (1975) a student of Heidegger, progressed the notion that human understanding occurs through language and tradition (Walsh, 1996:234). Thompson (1990) believes the link between language and cultural practices, confirms the existential view that a world through language exists (Walker, 1994:139). Heideggerian phenomenology, and therefore language, was used in this study because '...language is sensitive to common human experience...' (Avis, 1998:143). Mitchell adds language reveals different realities; the realities of this study's participants is the source of the hermeneutic phenomenological text. The participant's experiences of advanced orthopaedic nursing practice are summarised in chapter five of this thesis. After thematic analysis certain themes were identified that describe the experience of advanced orthopaedic nurse practice for those nurses. Chapter six will exemplify these themes.

5. Maintaining a Strong and Oriented Relation to the Phenomenon

van Manen cautions the researcher to remain strong and oriented to the phenomena in question and not to become side-tracked or preoccupied with self-interested reflections (van Manen, 1990:33). As a result of appropriate researcher orientation, understandings, interpretations and formulations should be produced that are true to the participants' texts.

I maintained a strong and oriented approach to the phenomenon by declaring my pre-understandings; subjected myself to interview conditions in order to identify with the participants' experience of interview; developed a rapport with each participant; utilised an open interview style, characterised by active listening techniques. Each technique was employed so that the stories came to me in an unadulterated way.

6. Considering Parts and Whole: the Hermeneutic Circle

The hermeneutic circle of understanding is a metaphor to describe the process of moving between the parts (each individual participant's experience) and the whole (made up of all the participants' stories of the phenomenon) during the interpretation process (Walker, 1994:138). It is a continual movement; a constant back and forth motion, that examines the relationship the parts bear to the whole and vice versa. Leonard suggests this systematic analysis of the whole produces deeper understanding, which then assists re-examination of parts, and then re-examination of the whole, in light of the understanding gained. This process continues until the fullest understanding possible, is reached by the researcher (Leonard, 1989:51).

The hermeneutic circle has no true beginning to understanding, and in a way is analogous to the 'chicken and egg' scenario, because of the interdependent relationship between the 'parts and whole' (Geanellos,1998:159). The concept of parts and whole operates on a number of levels. In terms of the study design a balance must be achieved between the parts of the text and the overall textual structure (van Manen, 1990:33). In terms of the

narrative, congruency between the essences and the phenomenon should be achieved and the individual participant and the participant group.

The hermeneutic circle is a combination of a person's background (meanings, skills, practices), co constitution (person-world concept) and pre-understandings (preconceptions/prejudices) where understanding is found. See Diagram 1.

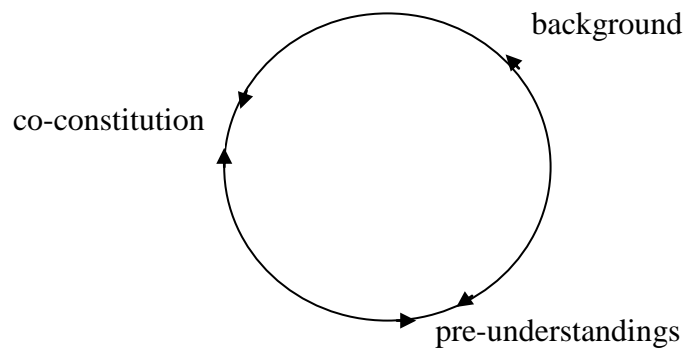


Diagram 1 - The Hermeneutic Circle of Understanding

Imagine viewing this diagram through the lens of a camera. Hermeneutic interpretation occurs through a constant movement of the focus mechanism, back and forth. You may want to focus on separate parts, or the whole. Understanding emerges when the relationship of each part, to the other becomes clear.

A good application of the hermeneutic circle relies on the ability of the researcher to use their own experience and background to develop rapport with the participants (Koch; 1996: 179). Rapport began with the participants well before the study was underway by virtue of a history between the researcher and each participant, established through our working relationship. I respected each participant in a professional sense. Some I had worked with more closely than others, however we all shared orthopaedic nursing in common. It was through the shared experience of collegiality that rapport was established. Moreover it assisted in extending the rapport to the interview process. It was imperative that every participant felt comfortable throughout the interview process, in order to optimise the experience for all concerned.

Study Context

This study was premised by a strong belief in the influence of context; as Leonard (1989:46) attests:

...to understand a person's behaviour or expressions, one has to study the person in context, for it is only there that what a person values and finds significant is visible...

A rich description of context was provided so that the reader could personally reconstruct the research description in their own mind, and live it again, as it were.

The context of this study was the orthopaedic and trauma unit of a busy, metropolitan, public hospital. The unit is divided into four wards. The mission of this unit is the achievement of excellence in musculo-skeletal medicine. The unit's core business is a

combination of elective surgery, trauma management and orthopaedic rehabilitation. The patient population encompasses a broad range of ages. The study participants were all recruited from the orthopaedic service area of this institution.

The Participants

Permission was granted to approach members of the nursing staff by the Director of Nursing. Participant numbers in phenomenological research are typically small as large volumes of data are generated requiring in depth analysis. I therefore invited seven nurses to participate in this study, and all agreed. I believed each nurse participant demonstrated advanced practice in orthopaedic nursing according to Benner's description of 'expert' (1984:31-38). All of the participants, but one, possessed a post basic qualification in orthopaedic nursing, and all had at least five years post basic experience in nursing. The nurse not possessing an orthopaedic certificate had extensive experience in orthopaedic /trauma management and nursing practice. Of those who had formal orthopaedic qualifications, five had obtained hospital certificates, and one had acquired a post graduate diploma. Amongst the participant group, clinical, education and management nursing functions were represented. One male was interviewed the remaining were female.

The researcher and one other participant were not practising nursing at the time of interview. All but two participants were interviewed in the setting in which they practised, however of those nurses, only one was 'on duty' at the time, but interviewed

away from the direct practice setting. The other nurses were interviewed in their own homes, a venue mutually agreed upon by participant and researcher.

The Researcher

The researcher was considered the eighth participant. I am an orthopaedic nurse working in the unit and possess both a hospital certificate and a post graduate qualification in orthopaedic nursing. I would describe myself as possessing a passion for orthopaedic nursing. I have more than five years post basic experience in orthopaedic nursing and had some experience in a promotional position. Moreover I have an ‘abiding’ interest in advanced practice which had evolved from an awareness of the general debate occurring within the profession. The question remained in my mind: How did the concept of advanced practice translate to orthopaedic nursing? What was the formal status of advanced practice competencies in orthopaedic nurse practice? How were orthopaedic nurses engaged in the debate?

Orthopaedic Nursing

Advancement in orthopaedic surgical techniques means the nature of orthopaedic nursing has changed dramatically over the past decade. It could be said orthopaedic nursing is ‘a dying art’. The specialty appears to be experiencing a ‘crisis of confidence’ evidenced by the lack of interest in the orthopaedic nurse special interest group. The state association is currently in a state of abeyance and is run by a passionate few. The national body is

fragmented and the states rarely communicate with each other. Post graduate courses offered by universities in orthopaedic nursing have struggled to attract enrolments in the past. Despite this, you will often hear nurses say of orthopaedic nursing ‘...you either love it or you hate it...’. The nursing work is very physical in nature, by virtue of the patient’s physical disability and impairment to mobility. The overriding aim of orthopaedic nursing is the restoration of musculo-skeletal function. The challenge to nurse this diverse age group, together with the physical nature of orthopaedic nursing, means an atmosphere of camaraderie amongst the nursing staff exists. Teamwork is essential. Good team dynamics rely on each member performing a different role. I was interested in the advanced practice role. I wanted to know how it related to orthopaedic nursing.

Ethics

In this study ethical conduct relied on protecting the rights of participants and respecting their human dignity. Permission to conduct the study was sought from the Director of Nursing. The study was reviewed by the Research and Higher Degrees sub-committee of The University of Adelaide for soundness in approach. Ethical approval was obtained from the hospital’s ethics committee chairperson on the basis of the following: Participants were invited to join the study; inclusion was voluntary. Explanation of the aims of the study was conveyed to each participant, along with the expected level of commitment in a plain language statement (see Appendix 1). Informed consent was obtained prior to each interview (see Appendix 2). A provision for the participant to

withdraw from the study at any time was guaranteed. Where possible, the researcher verified each participant's narrative by returning to the individual concerned, and seeking their approval that the researcher had captured accurately what the participant wanted to say about the phenomenon. The researcher did, as a courtesy, feedback the results of the study to each participant. Privacy, confidentiality, and anonymity were qualities this study embraced by protecting and securing the text by the non identification of participants within the study report. Any references to colleagues and workplace were deleted from the transcript. Security of text (ie. tapes, transcripts and consent forms) was guaranteed by ensuring they are stored in a locked cupboard at the researcher's home. Narrative text will be secured in this manner for at least five (5) years.

Descriptions

A phenomenological interview is more of a conversation aimed at encouraging the participant to tell a story about the phenomena under investigation. The aim of the interview was to elicit a rich description of the phenomenon. The descriptions came forth in response to the question *'Please describe a situation in which you believed you performed at an advanced level. Please disclose all your thoughts, feelings and perceptions until you can think of nothing more to say'*. Throughout the interview the researcher asked questions to seek depth and clarity from the participants. It was important to establish a context to the episode, therefore the participant was asked to think back and recall the time of the experience, who else was present, and the activity level of the ward.

It was important that a vibrant picture of the lived experience was recreated in every detail. At all times, the researcher employed, active listening techniques in order to ‘connect’ with the participant and share their experience anew. The researcher made agreement noises wherever possible, laughed with the participant where appropriate, nodded and actively participated in the recounting of the incident through body language and hand gestures. Participants were made to feel comfortable at the commencement of the interview, by first describing their professional nursing history. By the time the research question was asked, the participants were familiar with the interview conditions and a rapport with the interviewer was established. Each participant was given the chance to think about a situation in private. Some participants required extra time to do so. The remaining participants had an experience that immediately came to mind. The participants retold their experience virtually uninterrupted in the first instance, unless the researcher sought immediate clarification of a particular fact. The researcher then asked questions in order to ‘appreciate’ further the situation being described. The interview therefore:

... evolved as a dialogue in which the nurse and the researcher together focussed and explored the meaning of nurses’ work ...

(Fagermoen, 1997:437)

An unstructured, interview format was adopted. Descriptions were collected by taped, ‘face-to-face’ interviews, conducted by the researcher. One interview exceeded one hour. There was a total of seven hours of interview recorded. Each interview was transcribed verbatim following tape recording. Coding and/or referencing of the text took place by way of firstly identifying the participant with a randomly ascribed name then followed by

the numbered lines from the text. For example two lines of text from Anne's transcript were referenced as (A: 2-3).

Journal

A journal was maintained, by the researcher, throughout the interview process, during the period of transcription and until the last phase of interpretation (writing); that is over a period of ten months. The journal assisted in enriching the context in which the interviews took place (Koch, 1996:178). An entry was made prior to the first interview that discussed the researchers' feelings approaching the initial interview. Following each interview an entry summarising the process of both participant and researcher interaction was made. This began the process of reflection that was to follow (Koch, 1994:977). Similarly fieldnotes were coded to facilitate referencing to the text. Fieldnote references took the form of (fldnte:1), meaning: fieldnote, page 1.

Interpretive Analysis

The verbatim transcripts formed the basis for textual and thematic analysis. Additionally, journal entries provided another source of text. Interpretation emanated from the meanings contained within the narrative text. During analysis it was important to remain oriented to the text and not pre-empt interpretation, although, the process of reflection began when I first listened to the tapes for analysis.

Hermeneutic analysis occurred in three stages as suggested by Leonard (1989:54). After checking for accuracy each individual description was read several times to get a broad 'feel' for the text. When each description was read this way, a mechanism of highlighting the themes emerged, beginning with noting significant words or phrases. This method was applied when returning to each description and searching for similar words, phrases and ultimately themes in accordance with van Manen's style of selective highlighting (1990:94). So for the second stage of analysis, and with a sense of the themes, I returned to the descriptions and searched for examples of themes 'in action'; that captured the meaning in a concentrated form and coded them accordingly. The third and final stage of analysis included the search for strong representations or 'patterns of meanings', otherwise referred to as paradigm cases. A paradigm case or exemplar is an experience that stands out sufficiently that it is used as a reference point for subsequent situations the participant, or nurse, may encounter (Benner, 1984:8). These examples served as a means to preserve the integrity of the text. Commonality and differences amongst the participants' descriptions were identified.

'... Interpretation is an attempt to grasp and recreate meaning in order that more complete or different understandings occur; it seeks to bring to light, that which is fragmentary, confused or hidden...' (Taylor 1971 cited by Geanellos 1998:155). The interpretive account describes and explains how the understanding is generated (Geanellos, 1998:155). Organisation of themes and examples that clarified meaning were organised into the study report that served as the phenomenological text.

Interpretation for this study concluded when the study results were written up, however ‘...[h]ermeneutically, interpretation is never final or complete, it is always an approximation...’ (Geanellos, 1998:158). This study provides the best approximation possible at the time. Notwithstanding, the text and the possibility of ongoing interpretation lives on in the reader.

Hermeneutic Circle

The hermeneutic circle began by recognising my own background, preunderstandings and connection to the world and the phenomenon. Initially this was documented in the journal and declared in chapter one. Movement between the parts (the participant’s experience) and whole occurred continually throughout analysis of the descriptions as previously described.

Dialogue with the Text

A dialogue with the text was established through total immersion in the stories told by the participants. By concurrently listening and re-reading the text, I dwelt in the data up to the point that I could hear the participant’s voice in my head when I read their narrative, until meaning and understandings emerged.

Writing

‘...[H]ermeneutic phenomenological research is fundamentally a writing activity...’ (van Manen, 1990:7). The process of writing added another dimension to interpretation by revisiting the incidents over. The creation of a ‘linguistic transformation’ has been described above.

Conclusion

This chapter has described the process undertaken by the researcher to study the phenomenon of advanced orthopaedic nursing practice. As van Manen claims ‘...a real understanding of phenomenology can only be accomplished by *actively doing it*’ (van Manen, 1990:8). This study provides a glimpse into the ‘lifeworld’ of seven orthopaedic nurse practitioners. The incidents described were tape recorded, transcribed and then subject of interpretive analysis. The hermeneutic principle of ‘dialogue with the text’ via the ‘hermeneutic circle’, was applied, and a new understanding of what it means to be an advanced orthopaedic nurse practitioner emerged. Furthermore this study represents my own personal journey wherein I discovered what advanced practice means to me.

Chapter 5

The Narrative Text

...Story: a narration of the events in the life of a person or the existence of a thing, or such events as a subject for narration...
(The Concise Macquarie Dictionary, 1988:1268)

Introduction

Storytelling has been a custom embraced by many societies as a means to convey its history and inform the young of its cultural origins and traditions as they've evolved over time; such as the dreamtime stories of the Australian aborigines. Phenomenology embraces the process of storytelling and elevates it to an art form; in so much as it provides the means to celebrate the ordinariness of everyday life.

Heideggerian phenomenology views text as data (Koch, 1996:78). In this study seven nurses provided a glimpse into the everyday life of advanced orthopaedic practice. The seven incidents described by these nurses comprised the 'narrative text' that forms the body of this thesis.

The participants represented a mixed group of advanced practitioners in terms of years of experience and positions held. The participants involved in this study were expected to capture the breadth of advanced practice that exists in this unit. Each individual participant was asked '*Why did you choose this as an example of advanced practice?*'

The following descriptions provide insights into their beliefs about the world of orthopaedic advanced practice. This chapter will take each interview and create a description of the event each participant chose to share. An appreciation of the uniqueness of these nurses and their orthopaedic nursing practice will therefore emerge as the context of each event is revealed.

Di

Di described an incident that occurred upon her return from leave, in which an elderly woman allocated to the other end of the ward suffered a post-operative, cardiac and respiratory arrest. Di knew the patient and her relatives from a previous admission. During her conversation with the relatives another member of the nursing staff approached Di requesting her urgent attention:

An enrolled [nurse] came and got me [because] they needed a hand in the toilet; And she [the patient in the toilet] had fainted; that had become non responsive and was obstructing her airway. And when I got there the nursing staff member was trying to maintain her airway but without supporting her spinal fusion ... (D: 62-66)

Di, being the most senior nurse on the ward, immediately took charge of the situation. With assistance she moved the patient to the ground whilst maintaining spinal alignment, and noticed the patient ‘... wasn’t breathing and (she) had no carotid pulse ...’ (D:68-69); she instructed someone to ring the emergency number; and ‘screamed’ for the emergency trolley; she then gave the patient ‘a big breath and she responded’ (D: 71-77). Di remained with the patient after she was transferred to bed. She administered oxygen;

made sure her observations were stable; organised an Electrocardiograph (ECG) to be taken; set up an intravenous drip and generally assessed and observed the patient (D:91-93). Meanwhile Di was wondering where the emergency team was. The junior nurse responsible for calling the emergency phone number had not specified ‘cardiac arrest’ when making the emergency call, and subsequently the resuscitation team had not arrived. The medical intern however was present. Di expressed (several times throughout the interview), some concern over the medical intern’s management of the situation:

Like I’d never met this intern before. But within a five second decision I’d have decided that he was incompetent because he wasn’t worried about her venous access, he wanted a postural B/P [blood pressure]. And that wasn’t my primary ... That wasn’t the train of thought that I had ... But I saw her, I knew that she had stopped breathing, I knew that she had no carotid [pulse], because I was the one feeling for it and I couldn’t find it... (D:222-228)

The significant issue for this nurse, from an orthopaedic perspective, was the fact the patient was recovering from surgery to her cervical spine. She was concerned that during the resuscitation process there did not appear to be consideration of the patient’s underlying orthopaedic condition (spinal fusion). Di acknowledged surviving this acute event was the current priority but felt consideration and care for the patient’s underlying condition should not have been forgotten, that is, preserving the integrity of the spinal fusion. The nurse registered surprise that only she seemed to consider the potential damage.

... nobody else around me had any idea of what was going on. Like they just didn’t even think about her orthopaedic injuries, they were

more concerned about her airway which, yeah sure it's her primary concern, but she was breathing and she was responding... (D: 80-83)

The incident required this nurse to draw on many clinical skills. Not only did she attend to the patients physical needs, but made time during the incident to provide reassurance to the family members:

Like I just, in a spare obvious two minutes, [ironic laughter] I went down there and reassured them that she was okay ... I just reassured them that she was alright, and that she was responding. (D234-239)

Di was very much aware of the impact the situation had had on the junior staff members.

She recalled:

I've got to think, (I got), to remember to speak to that enrolled [nurse] about what happened and to the student [nurse]... (D:342-343)

She described in detail the debriefing, support and education she provided to nursing staff throughout the shift. At a later date Di felt it was necessary to report this incident to the Clinical Nurse Consultant (CNC). During this discussion she highlighted issues of concern in relation to a deficit in some staff's knowledge of nursing spinal injury patients and associated bowel care, and the poor skill mix that was occasionally evident on weekends in this ward.

Di displayed in her interview a cognisance of, and an ability to, manage the ward situation. Di attended to the care of this patient and reallocated staff to care for her

patients at the other end of the ward. She had a lot on her mind and was doing, and thinking of several things at once.

... I was thinking at two hundred miles an hour. I was already thinking of what was going on with the patient. I was thinking about the fact that I'd left twelve patients at my end of the ward unattended, so I was prompting my junior staff to make sure they were okay and to start settling them. (D:325-328)

By the end of the shift Di had everything under control. The patient's condition was stable. She'd checked that the drug rounds had been done, other patients were settled, '*... and I knew everything was up to date, yeah at both ends. Then I took the enrolled [nurse] aside*' (D:314-315) to discuss the situation that had occurred and ascertain how she felt she handled the situation. Despite the unprecedented emergency situation that had occurred, the other patients in the ward had not been neglected and all staff on the ward completed their allotted duties and left on time.

When I asked how she felt about the situation, Di made two points: The first was. '*I umm felt competent and I felt that we'd done a good job*' (D:349); The second point she raised was in relation to her role as a nurse during the cardiopulmonary arrest:

...[pause] I felt a bit guilty.

Anita: *Why's that?*

Because it's always been that nurses are not, not there to call the shots on what happens. They are not the people that make the decisions and the medical staff are responsible for that and that we should answer to them. But in this situation I wasn't answering to anybody. The nursing staff were the ones in control of the situation. (D:355-361).

Di's management of the ward situation was orderly, routine, almost second nature. Thankfully the patient survived the event. Di remarked upon reflection - *'that's good nursing'* (D367). Di felt rewarded when the patient was discharged two days later and commented on the family's reaction to her:

... I'm sure that the family appreciated, like I had no hesitation in thinking that the family appreciated everything we did. And the patient thanked us and kissed our hand as well and was so grateful and that was a rewarding feeling like, a positive feeling and it made you think that's what I'm here for, that feeling. (D:370-374)

The thing Di remembered most about the incident was the possibility that the outcome could have been far worse.

Or just maybe the potential if we didn't have that orthopaedic knowledge, the potential complications is what I thought of afterwards ... we could have done more damage than good. (D: 413-417)

Gina

Gina's nursing role in the orthopaedic nursing service was as a case manager, which incorporated supervision and responsibility for clinical care and broader multi-disciplinary coordination. Usually she was the first health worker, patients awaiting joint reconstructive surgery, would come into contact with. The patient would arrive in pre-admission clinic for examination and education prior to their surgery. At this first, pre-operative appointment, Gina would routinely obtain a medical history, perform an orthopaedic examination and assessment, and initiate discharge planning. Gina recounted

a recent experience of just such an appointment in which she detected a previously undiagnosed, medical condition.

The patient presented with a history, in the last six to eight months, of occasional, nocturnal, central chest pain and shortness of breath during the day (G: 35-38).

I suspected that it could be angina type symptoms. She wasn't complaining of any other sort of symptoms and I thought it was necessary to get this investigated before she was due to come in and have her operation. (G:40-42)

Gina proceeded with the examination but prepared the patient, on the basis of her findings. She informed the patient she would probably be referred to a cardiologist (G:157-158). She advised the operation may be delayed, her recovery may be slower and discharge delayed because of her medical problem (G452-454).

The patient, an elderly woman in her eighties, appeared 'quite healthy'. The orthopaedic assessment revealed the patient had been experiencing severe osteoarthritic pain in the affected knee over the past five years. Her mobility was poor, characterised by a noticeable limp and reliance on a walking stick. She had a noticeable leg length discrepancy and valgus deformity (bow-legged) of her lower leg. There was poor extension and flexion in the knee and limited range of movement (G:52-54; 186-197).

Even when she just stood up onto the one step to get on to the weighing machine, she struggled quite badly with that two or three inch step. So she was pretty limited in what she could do, I think. (G: 212-215)

Based on the medical history, orthopaedic assessment, and investigation of this patient's social situation, Gina predicted this patient's post-operative recovery would progress slowly, requiring an extended length of stay and rehabilitation.

Looking at her, it is amazing how quickly you get to judge people [laughs] You can pick off the head probably nine times out of ten, the ones you think are going to get up out of bed and progress according to plan and go home with minimal supports and that type of thing. And the ones that are probably going to need a little bit longer or extended rehab or you know that they are going to struggle at home.

(G:217-221)

Angina was provisionally diagnosed by the anaesthetist in clinic that day. Afterwards Gina spoke to the orthopaedic registrar who would make the ultimate decision about whether this patient would proceed for joint replacement surgery. In uncomplicated cases Gina would decide '*about the order in which we operate on people*' (G330-331). She considered this a fairly responsible task.

At the interview Gina struggled to find an incident to recount. Eventually she chose something that had happened the previous day. She appeared to be in a reflective mood throughout the interview, preferring to generalise about her duties, rather than providing specific detail. She provided a lot of detail *about* her role emphasising the routine education of patients (fldnte:11-12). In describing her thoughts on advanced practice Gina focussed on education and knowledge:

Not just specific orthopaedic knowledge, but also that higher level of orthopaedic knowledge that I have got as well. On the ward nurses don't necessarily do a complete orthopaedic assessment on range of motion and joint function and I have been taught how to do that in the ortho [paedic] course and also by doing this job.

(G: 585-589)

Furthermore Gina focussed on her ability to make decisions and pointed to the level of interaction she had within the multi-disciplinary team regarding patient care, as something that gave her personal satisfaction:

It [the job] allows me to make decisions above what you'd be doing on the ward. And I really, really find it rewarding to be able to interact with the doctors on such a one-to-one level which you don't necessarily get on the ward as well. (G: 589-592)

Gina mentioned several times during the interview how important the ability to make decisions and act on those decisions was to her. In this recollection, the decision to book the patient in for a cardiology review and follow up the results; the modifying of her pre-operative education in response to the patient's medical history; and the discharge planning she implemented following her inquiries, generally left her feeling satisfied:

... I was pretty confident that we did a thorough assessment of her [the patient] and identified relevant issues with regards to her discharge planning and also her medical needs ... (G:570-572)

I was left with the impression Gina was confident the assessment had gone 'pretty well' (G:582) and that over time, in the position of case manager, her professional confidence had grown.

Ellen

Ellen described a situation which occurred some years ago, where she believed patient care was compromised due to the incorrect application of Hamilton Russell traction. The elderly male patient had suffered a traumatic fractured neck of femur and the purpose of traction in this instance was to provide pain relief from muscle spasm and also apply traction to approximate the fracture fragments. This nurse was compelled to act in a situation she found herself confronted with. It was immediately obvious to Ellen as soon as she arrived on the ward that morning that the patient's traction had not been applied correctly and had become dysfunctional.

... as a quick overview I saw it as a pressing thing that needed to be done and I suppose my concern was knowing the nurse, umm, that I could see that it could really get to the end of the shift, until the lates [afternoon shift] come on before something for this patient's traction [was done] which was another few hours. (E:187-191)

Furthermore Ellen was concerned with the patient's level of discomfort. Her quick assessment of the patient confirmed her original observations. The ward wasn't unduly busy so Ellen turned what she perceived as a problem with nursing care, into an educational opportunity for the nurse responsible for delivering care to this patient. She and the nurse reviewed the traction apparatus. The nurse was unable to demonstrate a working knowledge of the principles of traction and did not detect any problem despite *'the bandages were all slipped down and the weight was resting on the ground'* (E: 82-83). Ellen was *'horrified'* because she knew this nurse had recently attended an introductory educational session on traction and was undertaking studies in orthopaedic

nursing. Ellen was concerned that the transition of knowledge to practice had not occurred (E: 395-396).

Due to the lack of insight on the part of the nurse, Ellen called upon all her skills as an educator, and diplomatically went about reapplying the traction. Ellen felt an overwhelming '*sense of obligation and responsibility as an educator to address the situation ...*' (E:194-195).

... there was a big problem with what was happening in nursing practice there that I needed to address, or that I felt I needed to address. (E: 311-314)

Ellen talked about being annoyed and angry that this patient wasn't receiving the care that he was entitled to, which reflected poorly on the hospital (E:286-291). She therefore had no hesitation in rectifying a situation she felt '*so strongly about*' (E: 274).

... I felt confident and comfortable to, to take those steps because ultimately the patient is paramount ... (E:278-279)

The incident was significant to this participant because traction is recognised as a basic skill in orthopaedic nursing. '*I suppose I see that traction as being a, a skill specific to the orthopaedic nurse, traction application*' (E:377-378). Some orthopaedic nurses would consider the application and care of the patient in traction, as one of those orthopaedic nursing skills, fast becoming 'a dying art'. This is why this incident remained prominent in this nurse's mind. That and the fact it was such a '*blatant*' lack of patient

care. Ellen informed the CNC and the relevant nurse educator of the incident, and she contributed towards the nurse's performance appraisal.

I recall after the interview being equally impressed by Ellen's strong sense of patient focus, and commitment to supporting the nurse (fdnte:3). Indeed I was convinced support and diplomacy were qualities that embodied Ellen's nursing practice, evidenced by her considered responses to my questions.

Interestingly three of the seven participants chose to relate a situation where the application of traction was involved.

Ben

Ben chose an incident related to the application of traction also. He was called upon to assist in the emergency admission to the ward of an elderly woman who had sustained a traumatic intertrochanteric fractured left neck of femur (a fracture between two bony landmarks of the upper femur).

The treatment ordered involved the application of a Thomas splint and traction. Ordinarily the application of a Thomas splint occurs in an emergency department where femoral nerve blocks, or an appropriate form of anaesthetic, can be administered so as to minimise pain during the application of the leg long splint. Reducing a femoral fracture can require a substantial amount of physical force and manipulation. Due to the large

amounts of analgesia and anaesthetic required to facilitate the procedure, and to keep the patient comfortable, close observation of the patient throughout and following the procedure is required, which is usually not available at a ward level.

It was about 3 o'clock on a busy night shift in the unit and there had been several admissions. Ben was relieving on another ward, but as the most senior qualified orthopaedic nurse in the area he was called upon to assist with this admission. The ward staff were relatively junior and unfamiliar with Thomas splint and traction. The patient was a small and frail 86 year old woman who had sustained the fracture in a simple fall. Ben described the injury as '*a bit nasty*' (B:51), because the proximal fragment was observed directly under the skin and could have easily pierced the skin and become a compound wound. The patient was in significant pain because of the grossly unstable fracture. At a glance, Ben observed the patient was frail and suffered from medical problems. Her delicate condition concerned him greatly (B:213).

Ben spoke by phone to the orthopaedic medical registrar who had been delayed in emergency operating theatre for some time. Ben requested his presence to implement the treatment order. It was impossible for the medical registrar to attend. Ben was faced with a dilemma between leaving the patient in severe pain with the risk of compounding her injury and at risk of pressure sores, or intervening and applying the traction himself. Ben discussed this further with a surgical intern and then surgical registrar. He struggled with the decision as to whether he should clinically intervene or not. He had his doubts as to whether the treatment ordered would succeed:

So it was a bit of a tricky decision as to sort of just leave her and, she would end up compounding or being in a lot of pain, being quite sore, or trying to do something. (B:69-71)

Ben proceeded with a treatment he suspected wouldn't work. Ben went about calmly organising the equipment and overseeing the application of the splint; he noted '*no-one else knew how to set up the traction at all or what ... that sort of stuff to do*' (B:116-117). He monitored the patient's condition throughout the one and a half hours it took to set up the traction; he supervised the other Registered Nurse (RN), and reviewed the ward situation from time to time, both this ward and the ward he was relieving on; '*that was another thing that I was thinking about, is making sure the patients were covered*' (B:443-444).

After some time it was clear to the medical team that the traditional form of traction wouldn't reduce the fracture, therefore Ben, by drawing on his knowledge of the principles of traction and fracture management and previous experience (B: 277-278), suggested an alternative way of reducing the fracture. This adapted form of Hamilton Russell traction proved successful on this occasion.

Reflecting back on the situation Ben regretted proceeding under the circumstance, but he felt he had no other choice.

I sort of have the twinge of, like I should have said no, or made the ortho reg come up and see this lady or do something but, I sort of know that that really wasn't a possibility; or not for at least a couple of hours if not longer. So I sort of feel, yeah I feel good about it because it ended up in a positive way, we helped

the lady, and we sort of worked as a team and everything went okay. The outcome was positive ...' (B:560-565)

Ben was annoyed that standards of care had to suffer because of an organisational hitch, however he understood the pressures placed on the institution (B: 613-617). Ben was proud of the team effort and felt he'd '*handled it pretty well*' (B:651). The next night he followed up on the patient's progress to make sure everything was alright.

I guess you see the results and you're a part of that. I guess you know that if you'd gone along a certain track and done nothing and left her in a bad way or a negative way you'd think about it next time you'd practice in this sort of situation. That's all part of - I think experience, is, about looking at the outcome in the end and seeing what you could have done differently, or what you did well. (B:511-516)

When asked what Ben did well he replied:

Umm, [pause] I guess I didn't panic. I drew on a lot of my experience. Umm I think I assessed the situation as a whole. I thought I didn't get too focussed on one little thing. I made suggestions well and if I thought they were umm important, sort of reinforced them ... I was assertive. (B:528-531)

The reason Ben volunteered this as an example of advanced practice was confirmed by the praise for 'handling the situation' and respect of Ben's abilities, the other RN working with Ben, shared with him, afterwards.

Anne

Anne shared a similar incident that involved the application of a Thomas splint and traction in the ward situation. The elderly female patient involved had sustained a spiral fracture to her femur between two prostheses, that is her total hip prosthesis and a total knee replacement on the same leg, following a fall. In this example Anne was required to oversee the application of the Thomas splint in the presence of the patient's medical consultant, junior medical registrar, nursing staff and of course the patient. It drew upon many skills.

The junior registrar approached Anne and reported that the consultant had requested this particular form of traction, but that the registrar didn't know how to set it up and asked her '*what should we do?*' (A: 34). Anne explained the procedure to the registrar, but was also mindful that her nursing staff were going to have to care for this patient. Anne organised for the relevant information to be made available, because she did not want the patient to detect a deficit in the knowledge base of the registrar or nursing staff (A: 47-49). Meanwhile Anne discussed the treatment plan with the consultant over the phone. She described the patient's condition and informed the consultant that she wasn't happy to apply the splint and traction until x-rays were available and he was present (A:141-149). Whilst waiting for the consultant to arrive Anne kept the nursing staff allocated to the patient informed of what was going to happen. Anne reviewed the staffing needs for the next twenty four hours, confident in her nurses' ability to care for the patient.

When the consultant arrived, the team discussed how they planned to proceed. They then entered the patient's room. During the three and a half hour procedure Anne assisted the consultant, observed the patient and supervised the RN. Anne felt it was necessary to diplomatically ask the consultant why he chose to do things in a certain way at times, in order to clarify where his thoughts were heading. Anne was concerned about the amount of intravenous analgesia the patient may require and had previously suggested the registrar consult with the appropriate medical officer, which he did. The procedure was successful.

Reflecting back on her role as a nurse in this situation Anne perceived:

I would probably say I was an advocate for the consultant and registrar and the registered nurse. Probably acting as a leader just directing and making sure that everything was going smoothly, keeping everyone calm and relaxed. Being professional at all times.

(A:252-255)

During the interview Anne stressed the importance of staff education and felt it was important that staff did not appear uncertain in front of the patient. She also emphasised to me the time she spent educating the patient. Throughout the following six weeks the traction was in place, Anne began to take less of a 'hands on' role with the patient, as she observed her staff demonstrating greater competence and confidence in looking after this patient.

When recalling this experience during the interview, Anne appeared confident and sure of herself. She approached the recounting in a concise, methodical and professional manner as reflected in the following words:

As a professional with knowledge, experience in that area. Feeling confident in my interactions with the patient, with my interactions with the other staff, with the consultant and the registrar. I see myself as more of a coordinator; I don't like really to say I am a leader, but more of a coordinator. Just making sure that everything's smooth and runs according to plan. I don't like stress, and I don't like hassle and I don't like people being - "I don't know what I'm doing" - feeling not confident.

Anita: *Do you think you achieved this?*

Mmm, I think so.

(A: 345-352)

Carol

Described a complex ward management issue surrounding the direct admission to the ward of a young man involved in a sporting accident who had sustained a lower limb fracture. This nurse felt strongly about addressing, what she believed was a situation that could potentially compromise this patient's care due to the absence of medical assessment and stabilisation of the injury prior to admission to the ward. Moreover she wanted to prevent this occurrence from happening again.

The young man arrived on the ward screaming in pain. He had been classified as an 'arranged admission' because his General Practitioner (GP) had spoken directly to the

orthopaedic registrar, however briefly, and therefore the patient was 'expected'. He bypassed the emergency department and was sent directly to the ward.

... often [it] is very complicated because the paperwork doesn't come with the patient; because they haven't really been admitted; they haven't gone through admissions and more importantly they haven't been seen by medical staff and stabilised in casualty. And so they are sent up, often in quite a lot of pain, often all their injuries aren't fully assessed and there may be another injury that we are not aware of at the time when they arrive on the ward ... (C:99-104)

Carol welcomed the patient to the ward, quickly found a bed for this patient (by diplomatically asking a patient awaiting discharge to vacate his bed), attempted to calm the patient because he was screaming in pain, placate the parent's anger and arranged an intern to assess the patient. Carol's main concern was the risk that this patient may have sustained a spinal column fracture that had not yet been detected (C:135-137). Carol felt confident he hadn't, because of the degree of trunk control the patient displayed. It was important to Carol that she maintain composure despite feeling 'angry and furious' that this type of admission had occurred again (C:166).

Carol's next task was to get this patient settled into a bed, calm him down, and make him comfortable. She was aware that the patient and his parents may have lost confidence in the hospital system as the admission seemed to be disorganised. Carol delegated the admission of the patient to the ward to an experienced Enrolled Nurse (EN).

Fortunately the consultant arrived on the ward just as she was thinking about contacting him, as Carol had not been successful in contacting any other doctors and she knew the

patient needed to be urgently assessed. Carol appraised him of the situation, and reminded him that she had previously raised the issue of medically unassessed patient admissions direct to the ward, with medical staff only the week before. The consultant organised for an orthopaedic registrar to review the patient. Meanwhile Carol was already preparing to administer pain relief once it was ordered. The patient attended x-ray, was fasted for the operating theatre and settled into the ward.

And in the midst of all that, once I got that under control, as much control as you can, the following up issue dealing with ...and going and talking to [the relevant] CNC about the issue. (C:121-123)

Once the ward had settled down, and Carol made sure all staff had been to lunch, and the afternoon shift staff had arrived, Carol attempted to resolve the issue of unsafe patient admissions to her ward, with the relevant member of the nursing staff. *'And as much as I had tried to use all my conflict resolution skills, nothing was resolved'* (C:126-127). Carol felt frustrated and disappointed that an opportunity for nurse *'colleagues to problem solve and overcome things'* had been lost (C: 720-721; 506-507). The matter encroached upon broader political issues within the hospital and therefore was dealt with by the appropriate personnel, from the relevant disciplines. However Carol felt her efforts had been thwarted because *'the frustrating thing for me in all of this is the patient was being disadvantaged'* (C: 550-551). Her last thought when leaving work that day was for the patient and hoping there wouldn't be a delay in his going to operating theatre:

... his admission had been, you know a stuff up more or less. (That) his admission hadn't run smoothly. It didn't look good for the hospital; it didn't look good for the ward (C: 525-527)

Later on down the track, Carol informed the patient of the patient advisor role (patient support service), and explained to the patient's parents what should have happened during the admission process because she felt '*they have a right to know*' (C: 713). Carol discussed the conflict this occasionally presents:

You're in a really precarious position, because yes you can be a patient advocate to a point, which I really believe should be. But at the same time I am an employee of the hospital and you can't umm, you can't [pause] ... put the hospital down... (C:713-717)

Carol maintained a composed, professional demeanor at all times, particularly throughout her contact with the patient, his family, medical and nursing staff. She demonstrated a concern to protect the reputation of the ward and hospital, and promote the nursing profession.

Upon reflection Carol stated '*I don't think advanced practice is just clinical skills*' (C:733). She believed it's about how an institution works, policy development, conflict resolution and delegation, which was the focus of her story (fldnte:10).

Fay

By far the longest interview, Fay described a complex ward situation like Carol, which involved the transfer of a young male victim of a fork lift accident from a Queensland hospital. This patient had sustained multiple bilateral leg fractures and presented with a large necrotic pressure sore to one heel.

Not only were there the complicated logistics of patient transfer, and negotiating a treatment plan for this patient at a time of bed closures and winding down of hospital wide services, there was also the issue of a complex family dynamic. This nurse had a dramatic impact on the coordination of this patient's care and the direction the hospital admission took, over a relatively short period of time. Her suggestions considered every aspect of holistic care.

Fay arrived on duty one morning to find the young male patient had arrived unexpectedly during the night. Fay had alerted the casualty department and the other orthopaedic wards to this possible transfer (F:335-337). She thought there was a chance this patient would arrive unannounced, after being disappointed with the lack of information the nurse at the Queensland hospital was willing to impart to Fay about this patient; *'I got the feeling she wasn't telling me everything'* (F: 362-363). Fay read his notes and *'... started having a bit of a chat with him before the ward round'* (F: 374-375). Fay discovered the patient *'had had enough'* and *'got the impression it was important to keep them [the family] fully informed'* (F:387). So before the doctors left the ward, Fay insisted they inform him of the treatment plan (F:132-134).

The team established he was non-weight bearing (NWB) on both legs due to an unreimed (unsecured) nail inserted into the femur. Fay suggested they replace the non-weight bearing nail with a weight bearing nail *'... 'cos I'd seen it before'* (F:314). Her suggestion was well received and relayed to the consultants (F:487). When the orthopaedic team were reviewing the patient's ankle Fay suggested perhaps the patient should be referred

to the orthopaedic foot specialist. The medical team responded favourably to this suggestion. Although the heel wound did not concern the doctors, Fay was most concerned: ‘...looking at it I can assure you that it wasn’t going to [heal]...’ (F: 125).

I just felt that, that was important to get them [plastic surgeons] involved. It was a huge necrotic area, really sloughy, and that was... I looked at it and it just reminded me so much of this other case of ten years ago; that required skin grafting with muscle flaps. Didn’t want to go on and just dressing it for weeks on end, and we were about to send him home, to then decide they wanted to do grafting and muscle flaps on it. May as well get it all done now in the acute phase. ‘Cos I also suggested to them, you know if you’re going to get plastics involved and they want to do some grafting or anything, if they were considering doing the nail, then they did it all at the same time with one anaesthetic
(F:704-713)

Fay was very much aware that the patient didn’t want any further surgery (F:402).

Fay considered the input from other members of the multi-disciplinary team, that could possibly assist this patient’s healing and recovery. She therefore notified the dietician and explained to the patient, who was of slight build, the benefits involved of a good nutritional state (F:440-447). Fay also arranged for orthotics to modify his splint (F:470). When asked, Fay said she felt ‘empowered’ by making suggestions and having them taken seriously (F:491). She made a point of educating and involving the patient in the decisions about his care, which she would do for any patient, but more so in this case based on her impression formed after her initial assessment.

... “no-one’s ever spoken to me about any of these sort of things before”. I think it was a whole new experience for him. I mean I must admit I don’t know whether he took in everything I said. Umm, but I

think he seemed happy that we actually were providing him with some information and I just left him with “if you’ve got any questions, or you want to know what’s going on, just ask, you know we’re not going to bite your head off. I’m not going to profess I know all the answers”. I said “we can certainly try and find the answers”. He seemed to be happy with that. (F:551-558)

Fay kept the nursing staff caring for the patient informed, and began to take less of a direct role in his care, as she concentrated on managing the ward. The patient was handed over in detail to the CNC covering the Christmas period, at which she emphasised her *‘main concern to everyone was the heel wound’* (F:690).

An issue Fay felt strongly about following up was the communication issue with the CNC in Queensland, and after consulting her colleagues she did take some action and reported the incident to this CNC’s line manager. *‘I felt very strongly about it at this point in time because I just felt all I was trying to do was be an advocate for the patient and try umm, look out for his best interests’* (F:223-225) and maintain continuity of care.

At the end of the day, when asked to reflect upon her actions, Fay felt *‘she hadn’t done enough for the patient’* (F:960). But she felt *‘good’* that her suggestions were taken up and she was able to *‘initiate’* holistic care for this patient (F: 939).

My impression of Fay as she reflected several times upon her actions, that she seemed to take her professional growth very seriously. Her answers to my questions were comprehensive but considered.

Emergence of Preliminary Concepts

Di's story described an extraordinary event but at the same time highlighted skills that she would use in her everyday practice. She had **specific knowledge** of the patient's diagnosis and the implications for nursing care this knowledge afforded. However, Di **intuitively** knew, having not received handover, at what point in the post-operative recovery the patient had reached because she knew *'she must have been day two because she was able to walk'* (D: 121). Upon confronting the emergency situation Di incorporated her **orthopaedic knowledge** into her assessment of the patient. Using her **superior assessment skills**, she quickly identified the need to maintain the patient's airway whilst supporting the spinal fusion.

Di used her underlying knowledge to **support** and **educate** the junior staff. After checking on the patient in the toilet, Di had mentioned the importance of bowel care to both patient and staff. Di was aware of the manner in which junior staff reacted to the cardiopulmonary arrest situation. It was important to her that the enrolled and student nurses were **debriefed** as soon as the situation allowed. Di reassured the other RN that she would *'go through what happens in the event of an arrest'* with the EN (D:345).

Di demonstrated knowledge of a different sort in her assessment of the entire situation. In the middle of the emergency Di took **control** and **directed** staff to perform certain tasks. Di knew the **background** of each staff member, which therefore enabled her to **delegate** appropriately. She had **prioritised** this patient's care above other patients on the ward as

needing her care and remained with the patient whilst the situation warranted it. At the appropriate time, Di withdrew from the patient's direct care to **re-assess** the ward situation. Di's **management of a complex situation** involved analysing the ability of all staff members, including medical staff. This presented Di with a **conflict** when she found herself questioning the competence of the medical intern. As a result Di felt the need to go **outside of her role** as the nurse and **control** what emergency care was given. Di felt she had engaged in **good nursing** and felt **rewarded** when the patient expressed her gratitude on discharge, which made Di think *'that's what I'm here for'*.

Reward for Gina came in her ability to draw on all her **education and knowledge**, *'not just specific orthopaedic knowledge but that higher level of orthopaedic knowledge'* (G: 585-586). Gina used this knowledge to **make decisions** about her patient's care. Furthermore Gina was **professionally stimulated** by her ability to **interact** with medical staff at a higher level. The patient Gina saw in clinic that day, reported symptoms of the type which alerted Gina to the patient's need for further assessment. Gina passed this information on to the appropriate medical staff. In her **assessment** of the patient Gina exercised **professional judgement**. She identified a medical problem that had the potential to impact on the decision as to the timing of surgery. She was **confident** she could predict how long it would take this patient to recover from her surgery, therefore impacting on their length of stay.

The other concept that began to emerge from Gina's story was the issue of her **role**. Gina talked about her role in general terms but also the association her role had in relation to

other medical personnel. This relationship needed to work well for the smooth running of the arthroplasty clinic. At times Gina felt she had to take on the role of the registrar, and this left her with **mixed feelings**. Notwithstanding, Gina welcomed the **responsibility** the role carried.

Ellen also took on the responsibility of **patient advocate** and **educator** without question. She was motivated by an overwhelming **concern** about the standard of patient care and the implications for nursing practice. Ellen could **sense** the patient's discomfort and having **assessed** the ward's activity Ellen decided to approach the situation as a learning opportunity for the nurse concerned. Ellen was familiar with this nurse's **background**, so she was **prepared** to draw on her skills as an educator and rectify the situation. Ellen referred to the '*inner conflict*' associated with balancing competing demands of her **role** (E:317-22). Like the other participants, Ellen talked about a **strength of feeling** which compelled her to act and of **feeling good** once a positive outcome for the patient was achieved.

Ben felt **conflicted** from the start of his incident, but had an understanding of the **organisational demands** that were impacting upon his ability to **make a decision** about this patient's care. He was confident in the **knowledge** he had gathered from **previous experience** and undertaking **education**, that he could **manage the situation**, but **concerned** and **annoyed** that the patient was in this predicament (B: 251-253). Ben **coordinated** the team through the application of the Thomas splint. He knew the **background** of the members of the team and was pleased with the overall **team effort**

but felt **fortunate** the outcome was positive. Ben **organised** all the equipment and **anticipated** some needs. Ben demonstrated an ability to **critically analyse** and **reflect** upon the situation, as evidenced by the misgivings he still harbours.

Anne shared an experience that involved the application of Thomas splint and traction as well. She approached this situation in a calm and **organised** manner and considered the full impact nursing a patient in a Thomas splint would present. Anne had **anticipated** what was required for the procedure, prior to the consultant arriving (fldnte:14). After ensuring the application of the splint went smoothly, much of Anne's effort was spent in **educating** the patient and her staff, in order that the care the patient received was of the highest standard. Anne remained a strong **patient advocate** throughout. She endeavoured to project as a **competent professional**, certain of her convictions (A:154) and philosophy of care.

Professionalism was a concept that emerged strongly from Carol's story. When the patient arrived on the ward, she welcomed him warmly and didn't allude to the extraordinary circumstances surrounding his admission. As a **priority** she efficiently attended to his clinical needs. She **delegated** his care to a nurse she knew would deal with the situation appropriately.

Confident that the ward was under **control**, Carol attempted to discuss the inappropriate admission with the relevant nursing personnel in the hope of resolving the matter. It disappointed Carol that she wasn't able to advance the cause of nursing in this instance.

She was however, resigned to the hierarchical politics that exists in a large institution that had an impact on this circumstance. She demonstrated professionalism in her relations with patients and colleagues (C: 622-623) and professional maturity in reflecting personally on how to act in situations such as this (C:634-639). Carol demonstrated a **breadth** and **complexity** of her **role** as she described her performance at a ward level and then at an organisational level. She mentioned the tension in her **role** between **patient advocate** and the need for diplomacy, versus her role as an employee which implied a need to **juggle** or **balance** competing demands, a concept alluded to by some of the other participants.

Finally, Fay described a **complex situation** that required the sensitive handling of a situation outside the ward environment. Fay drew on her **assessment** ability and **orthopaedic knowledge** to firstly sum up the situation, then suggest and determine **priorities** for care. Fay conveyed to the team her impression of the patient's physical and emotional condition. She **felt strongly** about acting as a **patient advocate** and went to every effort to involve the patient in his care and explain the possible treatment plan. She showed evidence of **reflection** on her performance and anticipated she would '*grow*' as a result of this incident (F:903). Fay referred to previous **exemplars** in her practice that affected the way she delivered **holistic** care.

Preliminary concepts began to emerge from the participant's descriptions as words or phrases that occurred and reoccurred throughout repeated reading and listening of the text. It was not clear the significance these words might have in the interpretive process.

In summarising the stories of these nurses I have highlighted words or phrases that may prove to be of significance during thematic analysis.

Conclusion

This chapter has summarised the participant interviews and presented preliminary concepts that began to emerge from the descriptions that were verified as accurate by all but one participant who had moved interstate.

I have attempted to preserve the uniqueness of the text in this chapter by directly quoting from the nurses' narratives. The incidents the nurses described focused on the individual actions and interactions with others in a particular situation. The nurse's choice of incident revealed much of how they wished to be seen as a nurse and an advanced orthopaedic practitioner (Fagermoen, 1997:437). Their self representations formed the basis of the interpretation that was to follow.

Chapter 6

An Interpretation

Introduction

This chapter will thematically deconstruct the participant descriptions summarised in the previous chapter. A feature of the phenomenological method is to ‘get at’ the narrative or ‘dwell with the data (Fitzgerald, 1998). This is the aim of textual analysis. A contemplation of the data will uncover the meaning of the lived experience of advanced orthopaedic practice. Hence the researcher listened, read and re-read the texts. Thoughts, concepts and patterns of meaning emerged as I familiarised myself with the data. Eventually the meanings behind the phenomenon revealed themselves and themes were developed. Themes were evidenced by examples from the data. In hermeneutics the role of the researcher is to thoroughly understand the text by constant reference from the parts (each participant) to the whole (emerging concepts and themes). Therefore, I would ask myself, *What does the word ‘knowledge’ mean for this nurse as an advanced orthopaedic practitioner?* To link an emerging concept with the theme I would ask, *How does knowledge relate to the experience of being an advanced orthopaedic nurse?* Finally I referred to theoretical frameworks and extant nursing literature in the field to expand upon the themes. Interpretation is completed when creating the phenomenological text, that is the writing up of the study report. Analysis occurred using the principles of hermeneutics as described by van Manen (1990).

Interpretation requires the researcher to establish a dialogue with the text. This was achieved by asking questions of the text, *What does this word or phrase mean in the context of this part of the story?* or, *What does this passage reveal about the whole experience being described?* The text began to ask questions of myself such as, *What do I understand these feelings to mean?* By constant questioning and movement between the different perspectives of the hermeneutic circle, emerging concepts developed into the following themes: *having knowledge; being in the role and outside the role; being an advocate* and *being in control*. Themes will be exemplified by reference to representations from within the text.

Having knowledge

Knowledge and its relationship to nursing practice has been the subject of much discussion within the nursing literature. Similarly, the theme *having knowledge* was strong amongst the participants, maintaining a pervasive presence in each story. Di's specific orthopaedic knowledge had an immense impact on the outcome for her patient, because it underpinned her every action. She reflected:

*... if we hadn't been lateral thinkers with her orthopaedic knowledge...
we could have done more damage than good.* (D:415-417)

This was contrasted by the lack of knowledge of junior nursing staff, which was of concern to Di:

... possibly they don't have a lot of spinal knowledge, about maintaining alignment and that's not their fault but inexperience and if you haven't been given the opportunity to experience nursing spinal injury patients, or nursing just patients post spinal surgery, which we don't get a lot of, you know they just haven't got that experience.

(D:263-268)

This example demonstrates the knowledge gained from experience, and as Sutton and Smith posit '...the knowledge derived from experience is a particular type of knowing ... the knowing how' (Sutton & Smith, 1995a:138 and Jasper, 1994:771), which contributes to expert knowledge. Gina differentiates between the 'knowing that' and the 'knowing how' (Kuhn 1970 and Polyani 1958 cited by Benner, 1984:2). She refers to 'specific orthopaedic knowledge' and 'that higher level of orthopaedic knowledge' (G: 585-590), which supports the notion of a higher level of nursing practice (Humphries, 1998:10-13 & Maclaine, 1998:159-630). She explained the assessment on range of movement and joint function that she performs is more advanced than the assessment an ordinary ward nurse would perform, if at all. This infers it is one thing to perform an assessment but another to know what the outcome of the assessment means and then be able to apply it to practice. Gina would assesses the patient's pre-operative status, and use this information to exercise clinical judgement in determining discharge needs. For example, the patient described her nocturnal chest pain. Gina recalls:

... just thinking back to university about angina symptoms and things umm, made me think that it could be something along those lines because I can remember specifically with chest pain at night was related to angina ... Yeah it's amazing how quickly you whip through with it in university, you think you're never going to retain all of this information. It's amazing, when you see it in practice how often you put two-and-two together, and it just clicks in your mind and yes I

remember this and that and other things you are supposed to be looking out for, and it all came back to me. (G:73-83)

The transition of knowledge to practice features in Ellen's story. The lack of knowledge the nurse possesses is juxtaposed against Ellen's educational role.

[The nurse caring for the patient had attended] ... *an introduction to traction [education session] and we had demonstrated Hamilton Russell traction, which was the traction application here. And that umm, they were involved in an orthopaedic nursing course and had covered lectures on traction as well, so there was more umm, times that education had been given to that person in traction application and some practical sessions within those as well. That the actual personal umm - transferring of, or transition of knowledge to practice just wasn't happening.* (E:390-396)

This example suggests knowledge is more than formal education alone. The example also emphasises that nursing is both an art and a science. Praxis is the combination of practical and theoretical knowledge (Sutton and Smith, 1995a:144); a concept embodied in Benner's claim that knowledge is embedded in practice (1984:2-3), however there needs to be a dialectic between the two forms of knowledge.

Ben drew on his '*knowledge and skills*' (B:141), a previous experience (exemplar) and education (B:277-278), in order to feel confident managing the application of the Thomas splint and traction on the ward, despite his misgivings. Ben also drew on his knowledge of similar experiences:

... I mean the nuts and bolts of what happened is different to what I have ever been through before but it's a situation that has the same sort of stressors, the same sort of concerns and the same way of

approaching it I've done quite a few times so I guess yeah ... yeah I probably learned a bit. (B:549-552)

Not only does this example typify the complexity and breadth of knowledge required for expert/advanced nursing practice, it does show evidence of reflection, another aspect of nursing knowledge which aids knowledge development. Ben reviewed his patient's progress on his next shift:

... to make sure everything was alright. I guess you see the results and you're a part of that. I guess you know that if you'd gone along in a certain track and done nothing and left [the patient] in a bad way or a negative way you'd think about it next time you'd practice in this sort of situation. That's all part of I think experience, is about looking at the outcome in the end and seeing what you could have done differently, or what you did well. (B:511-516)

Reflective practice is an important notion in the achievement of advanced practice. Sutton and Smith (1995a:144) state '... critical reflection on practice and integration of the outcomes with what they [advanced nurse practitioners] know in order to further develop, [where] the unification of theory and practice provide[s] ... distinctive ways of thinking about practice. Gina talks about '*trusting my own judgement a bit more*' (G:477). Ben reflects:

... you'd think about it next time you'd practise in this sort of situation. That's all part of I think experience, is, looking at the outcome in the end and seeing what you could have done differently, or what you did well. (B:513-516)

Anne also recognised the value of her '*knowledge and background experience of how to assist with the setting up of traction*' (A:71-72). Benner states it is '... an enormous

background of experience...’, which distinguishes expert performance (1984:31-32). Fay’s experience, education and knowledge enabled her to make suggestions about her patient’s care. She also drew on exemplars to inform her practice, to justify her suggestions and nursing interventions. Fay’s suggestion to *‘change the nail over so at least he had a weight bearing leg’* (F:315-316) emanated from a previous incident. Similarly her concern over the heel wound reminded her of a case she had seen ten years ago (F: 706). The use of clinical exemplars was pioneered by Benner and is well established within interpretive nursing research (Harvey & Tveit, 1994:45-53).

Benner (1984:37) refers to ‘multi-faceted knowledge with referents’. Sutton and Smith contend the nature of knowledge is complex and multi-faceted (Sutton & Smith, 1995a:138). They suggest advanced practitioners subsume intuition within their perception of the totality of the situation (Sutton & Smith, 1995a:145). The best example of this from amongst the participants is Carol. Carol recognised the complexity of the situation before her when the patient arrived unexpectedly on the ward. She welcomed him to the ward, found him a bed when there previously had been none, assessed that the patient did not appear to have a spinal column fracture, and allocated a staff member to his care. She organised for a medical officer to assess him as a priority, and knew she must follow the issue up with the relevant staff, as a matter of urgency because she was acutely aware of the risks of having a patient arrive to the ward not assessed by a doctor. Carol did not want this scenario to be repeated. She therefore followed the issue up with the relevant members of the nursing and medical staff.

Fay also demonstrated an ability to hone in on the more salient aspects of her situation, then work through her priorities one-by-one. Upon realising the patient was on the ward, Fay made a point of reading his notes then having a ‘*chat*’ with him (F: 369-375). Fay used the information gained from this assessment to determine the patient’s priorities of care. Her language made evident the perception, impressions and intuition that existed in her practice. This was highlighted in some of her phrases ‘... *I got the impression that information was very important ...*’ (F:387); ‘... *I really sensed all this ...*’ (F:394) and ‘... *I just felt that...*’ (F:704). Fay was clear about how the orthopaedic team should manage the care of this patient. Fay was also aware of the constraints operating within the hospital at the time of ward closure and Christmas holidays, and she therefore liaised with the appropriate personnel in a timely manner.

All of the other participants demonstrated an ability to intuitively assess a situation. Di ‘s actions were second nature as is important in emergency situations. Gina assessed her patient in a precise manner:

... even when she just came around the corner toward my office I thought “ ooh, she’s not real mobile”. (G:234-235)

Ellen performed ‘*a quick overview*’ of the ward situation and determined this patient was a priority (E: 187-188). Ben ‘s first impression of his patient was that:

... she was a frail old lady who was quite small and she was quite with it. But she’d obviously had medical problems you could tell that by looking at her. And umm, you could see her hip...And I also noticed

that her upper leg was deformed, it wasn't natural alignment. Umm, and I noticed that she was in pain... (B:188-203)

Whilst he may not have predicted the outcome, he knew intervention was warranted. Anne knew she had to remain calm and in control of the situation with the patient, her nursing staff, the registrar and consultant in her story (A:252-255). The ability to ignore extraneous information and 'zero in on the accurate region of the problem' is synonymous with expert practice and subsequently draws on expert knowledge (Benner, 1984:32). Therefore *having knowledge*, in whatever form is integral to the concept of advanced practice, as the participants demonstrated to some extent or another.

Being in the role and outside the role

The theme of *being in the role and outside the role* emerged from each description, however the concept differed according to the participant's context. The role of the registered nurse is regulated by legislation, organisational policies, procedures and protocols, which are designed to eliminate confusion over role boundaries. The traditional role of the nurse however, has displayed deference to the medical profession.

Di felt frustrated and guilty about the medical intern's seeming incompetence. She was frustrated that his priority of care during the emergency did not accord with hers:

And I just said it's [a postural blood pressure] totally inappropriate. It's just not warranted and if you're not competent enough to assess this patient I'll get someone else to do it. (D:195-197)

She felt *'a bit guilty'* (D: 3550) about telling him what to do but she took control of the situation regardless. She felt compelled to go *outside the role* of the nurse however. It was not until Di reflected on the situation that she acknowledged her feelings:

And I thought I'll let, I'll just let it go because it's a lesson learnt that sometimes you can't trust the medical staff. As much as they're medical staff they're novices in their own profession, they're only beginners.
(D:361-363)

Gina mentioned the interface her role had with the orthopaedic registrar. She expressed *'mixed emotions'* and *'frustration'* about taking on the role of the registrar, that is in terms of *'extra responsibilities'* and tasks. But she certainly enjoyed the responsibility and high level of interaction with the multi-disciplinary team (G:126 & G:591-592). Ben also knew he was challenging role boundaries when they applied the Thomas splint, in the absence of an orthopaedic registrar.

I felt confident in a way, I mean I knew we were doing stuff that, we weren't really [slight pause] qualified or whatever – for want of a better word, to do but I knew sort of, I had the knowledge and skills so hopefully we could fix it in the end...
(B:139-142)

Ben was uncomfortable about his *being outside the role*, but he was able to reconcile this and determine a course of action for the patient. Di, Gina and Ben experience some discomfort being outside the traditional role of the nurse, which is in contrast to Ellen, Anne, Fay and Carol.

Ellen experiences '*inner conflict*' when attempting to reconcile competing demands on her role (E:322). When she encountered the situation of inappropriate traction application however, she had no qualms about acting. '*I felt a strong sense of obligation and responsibility ... to address the situation*' (E:194-195). Ellen acknowledged she had stepped out of the role but felt '*confident and comfortable to, to take those steps because ultimately the patient is paramount*' (E:278-279).

In her story Anne is confronted with an orthopaedic registrar who, because of a lack of knowledge, is unable to implement the treatment recommended by the consultant. Anne assumed the defacto role of registrar and assisted the consultant in the application of the Thomas splint and traction. In contrast to Ben she feels entirely confident *being outside the role*:

I was confident in what I was doing. I felt happy that he [the consultant] felt confident in me to assist him (A: 320-321)

Whilst Fay did not go *outside the role*, the suggestions she made to the doctors would not be typically made by the ordinary nurse, and yet were quite consistent with her role as a nurse. She felt empowered being able to make suggestions about patient care:

... you can make suggestions without being - oh them biting back and saying it's none of your business. Umm, I think too it's all to do with your own confidence and where you are within nursing and within yourself... I suppose in this role you have to do ... if you don't say anything nothing ever happens... (F: 491-496)

Fay's sense of professional pride was shared with Carol. Carol refers to a desire to '*maintain my composure*' despite feelings to the contrary, when the patient first arrived on the ward, and when she discussed the admission with the other nurse (C:171 & C:453). Carol believed the consultants had '*respect for me and my practice*' (C:603) and talked about '*maintain[ing] a professional front with my colleagues*' (C:622-623). There was a strong sense of self and professional maturity that emerged from Carol's story, evidenced by her commitment to her principles (C:498-499) and a desire to promote the interests of nursing (C: 503-511). Sutton and Smith (1995a:144) suggest advanced nurse practitioners see the 'potential future situations' and 'stretch the boundaries of nursing practice'.

My impression of Ellen, Anne and Carol is a strong sense of professionalism. Perhaps this is because they were comfortable *being in the role and outside the role* of the Registered Nurse.

Emerging from the participant's descriptions was a sense of the complexity of *being in the* [advanced practice] *role*. In addition to clinical skills, these nurses were expected to be an organiser, overseer, initiator, co-ordinator, manager and consultant, to name but a few of the different aspects of their roles, as evidenced in the narrative text. Professional stimulation and satisfaction was important to them. Perhaps the concept of advanced practice remains elusive because of the challenge to accommodate all of these needs and the ever-changing health care environment. However, my impression of each participant is that they felt strongly (in both a positive and negative sense) about *being in the role*

and outside the role, and were primarily motivated by doing what's best for the patient. Sutton and Smith (1995a:143) suggest when the patient is considered central to care, advanced practitioners are 'willing to bend the rules'.

Being an advocate

The theme of *being an advocate* is pivotal to the role of the advanced nurse practitioner. Commonality across the participants was clearly evident. The sense of patient advocacy tended to be communicated by the words '*my concern*'. Di was concerned that the patient had been left in the toilet for too long. She was concerned that bowel care had not been attended to, and she was concerned about maintaining the patient's dignity:

I was speaking to her daughters and they pointed out that she'd been in the toilet for fifteen minutes and they wanted to see if she was alright. And instead of them walking up [to] their Mum attending to her activities of daily living, I thought, maintaining her privacy and respect I'll just go in there...
(D:125-128)

Ellen's primary concern was for the patient.

I was concerned to see that this person [patient] had been – obviously for some period of time – with their traction apparatus not being applied correctly ... [and] something needed to be done about it straight away.
(E:73-77)

She was '*concerned about the standard of care that wasn't happening for that patient*' (E:100-101). Her strong feelings of annoyance and anger related to the patient not receiving the care he deserved.

I was annoyed. Umm, that here was a patient who was in someone's care and they weren't receiving the care that they were entitled to ... I suppose some of that annoyance was also anger as well. And it reflects not only ... the person that's missing out on the care, ... it reflects on nursing care that's being provided, really by the hospital. (E:286-291)

Ellen was being an advocate for the patient, the nurse and the hospital:

I felt good about - like what had happened - in that things had been picked up for the patient. Some things had been addressed with the nurse in the situation. (E: 347-349)

Ben was strongly motivated by the best interests of the patient, but protecting his patient's interests presented him with a dilemma. There were obvious risks applying the Thomas splint on the ward '*with not a lot of support*' (B:65), but equally there were the risks to the patient if nothing was done. Ben was '*concerned*' about the patient's frail condition (B:188-190). Ben decided to proceed, because of his desire to assist the patient. Ben was frustrated that the patient was in this predicament, and that '*standards [of patient care] went down a bit...*' (B:616-617).

Anne was a strong advocate in her story:

I would probably say I was an advocate for the patient, an advocate for the consultant and [orthopaedic] registrar and the registered nurse (A:252-253)

Being an advocate manifested consistently throughout Anne's story.

We kept the patient reassured all the time. We explained that it was a very delicate procedure; we were waiting for x-rays, waiting for the consultant and also making sure that the knowledge base of either the registrar or the junior staff was such that they weren't able to care for here once it was in place. (A:45-49)

Throughout the procedure Anne's abiding concern was for the patient:

You have just got to be very careful in front of the patient as to make sure they are completely at ease. That you really know what you are doing ... (A:56-57)

[and]

I was feeling strongly for the patient to make sure that her pain was controlled. (A:52-53)

Had the procedure been too uncomfortable for the patient Anne was prepared to stop the procedure and ensure the patient received the appropriate analgesia (A:243-246). Anne's abiding concern motivated her to educate the nursing staff and ensure adequate staffing levels so that care was provided for this patient.

Carol too shared an abiding concern for the welfare of her patient and prospective patients. She was '*frustrated*' that the patient was being '*disadvantaged*' over an organisational conflict (C:550-551). Her concern for the patient motivated her to speak with the relevant Clinical Nurse Consultant, her Nursing Director and the orthopaedic consultants. She also advised the patient of his right to access the patient advocate (the hospital's patient support service), and informed the patient's parents that there had been an irregularity with their son's admission to the ward.

Fay's overriding concern for the patient was to determine his treatment plan and involve him in his care. She was concerned from the outset with the lack of information forthcoming from the Queensland hospital. *'I felt I was doing the right thing for the patient, for continuity of care'* (F:837-838). Fay had assessed how important information was to this patient so she went to every effort to involve him in his care, and start to generate some positive outcomes for this patient. Advocacy as an expression of caring is considered to be a function of expert nurses (Copp cited by Adams et al, 1997:219). Furthermore advocacy is highly regarded by expert nurses and is an extension of a nurse's self esteem and professional identity (Adams et al, 1997:220). Sutton and Smith (1995a:143) describe advanced practitioners as being patient-focussed, that is 'the client is the centre of that world [of practice]'

Being an advocate also manifested itself in achievement of patient outcomes of care. Di believed they had provided 'good nursing', Di didn't feel rewarded until the patient was discharged.

... the patient thanked us and kissed our hand as well and was so grateful, and that was a rewarding feeling like, a positive feeling and it made you think that's what I'm here for, that feeling (D:371-374)

When discussing how 'fantastic' she felt the next day, a nursing colleague of Di's said 'that's what it's all about' (D:428). This notion was identified in some of the other narratives. Gina had received positive feedback from some of her patients:

It's really nice feedback to get that. Like I had two yesterday out of four patients I saw. One was coming back for a revision of his hip [prosthesis] and this lady was coming for the second knee [replacement] and who said exactly the same thing. They found it was a lot more beneficial to have the pre-admission education the first time round ... It makes you feel good, and it makes you feel that there must be something good in the system at the moment (G:415-424)

Ben received '*profuse thanks*' from the patient (B: 505) and he felt '*good*' because the outcome was positive (B563-565). The reward these nurses described I referred to as *completion brings reward*. Fay explained the reason why she was asking the nurse in Queensland, questions about the patient, was because '*that's what we're here for*' (F:858). Although, at the end of the day, Fay felt she hadn't done enough for the patient (F:957). '*I suppose I really don't feel that sense of achievement 'cos I never saw anything through*' (F: 938-939). I interpreted this slightly differently as *completion brings the 'greatest' reward*; and what I mean is, achievement of patient outcomes was important to the participants. However, Fay said she '*felt good, 'I felt really good that – you feel you can achie[ve], you can provide something to the patient*' (F:960-961). The re-occurrence of '*feeling good*' provides the means to celebrate nursing practice. The '*good feeling*' described in the stories is a feeling of professional pride (Harvey & Tveit, 1994:53; Brunner, 1998:5).

Being in control

This theme of *being in control* was uniquely evident in all of the stories. Each individual participant brought unique personality traits to their situation, which affected their *being*

in control. Naturally the context of the incident determined what degree of *control* the participant assumed.

Di *took control* of the emergency situation, after being called upon to assist. The impressive words that suggested Di was *in control* were ‘*directing*’, ‘*instructed*’, ‘*organised*’. She felt guilty after the event, having *taken control* of the situation from the medical intern: ‘*...the nursing staff were the ones in control of the situation ...*’ (D:360-361). Di did not hesitate in making the decision to *take control*, however. *Being in control* also meant dealing with the situation as a whole, and in this sense Di prioritised patient care, provided reassurance to family members, ensured ward activity and patient care ran smoothly after the emergency, supported, educated and debriefed nursing staff. Di reported the incident to her Clinical Nurse Consultant (CNC), in which she raised issues of concern. *Being in control* meant managing the ward, often attending to several tasks at once. By the end of the shift, Di was assured all nursing duties had been attended to:

... once the patients had settled, visitors gone, things were under control, drug rounds had been done and I knew everything was up to date. Yeah at both ends... (D:313-315)

When Di was certain everything was *under control*, she discussed the emergency with the enrolled nurse. Di ensured staff left work on time, which stands testament to her ability to manage the ward, which was very much second nature for her. Di equated feeling competent (under these circumstances), with ‘good nursing’. ‘*I umm felt competent and I*

felt we'd done a good job' (D:349). *Being in control* and being seen as a competent nurse was important to Di, which is why she chose her particular story.

For Gina *being in control* meant having the authority to make decisions and taking responsibility for organising whatever was necessary for her patient's care. The ability to work autonomously within the orthopaedic team left Gina feel valued and rewarded. Her decision making '*above what you'd be doing on the ward*' (G:589-590) and the higher level of interaction with the medical team allowed Gina to feel *in control*. She stressed this several times throughout our conversation, and I sensed it was very important to her.

Ellen *took control* of a situation she discovered when visiting the ward. On immediately visualising the slipped traction, Ellen knew '*... something needed to be done about it straight away*' (E:77). Indeed once the patient's traction had been reapplied correctly, control had effectively been restored. Ellen's ability *to control* and organise the situation contrasted markedly with the registered nurses inability to control the end of the ward to which she was working that shift.

She wasn't the most organised person...she hadn't prioritised the [patients'] needs in order of priority of need. (E: 182-184)

Ellen refers to the registered nurses lack of prioritisation and organisational skills, and *inability to control* the situation, which implies these are characteristics Ellen would expect of this nurse, and consider necessary in a senior nursing position.

Ben, like Di, was called upon to *take control* of a situation because he was the most senior orthopaedic nurse working that shift. Ben *took control* of the situation because

... no-one else had any idea about the sort of traction, especially Thomas splints, no-one had even heard of Thomas splint let alone knew how to put one on...
(B:80-82)

Ben organised the traction equipment, and co-ordinated application of the splint and traction. Concurrently Ben was expected to monitor the patient, supervise the other registered nurse in accordance with and,

...abiding by the (the) guidelines of hospital policies and procedures and all those other things, and by the Acts and all that sort of stuff...
(B:352-353)

He reviewed the ward situation from time to time as well. Ben also arranged the patient's transfer off the ward, to a ward where the patient could be more closely observed. Like Di, *being in control* meant directing and managing the team under what would be considered as extraordinary ward circumstances. Ben found humour assisted in this task, and he thought afterwards they worked well as a team (B:564). Ben's example of managing a complex situation demonstrates the multi-dimensional aspects of *being in control*.

Anne quietly and calmly *assumed control*. To Anne *being in control* meant being a co-ordinator. By virtue of her position as Clinical Nurse Consultant, she already was *in*

control of the ward. So this incident required Anne to *maintain control*. This was achieved by leading by example:

... acting as a leader just directing and making sure that everything was going smoothly; keeping everyone calm and relaxed. (A:253-254)

Anne monitored the patient, assisted the consultant, supervised the registered nurse, ensured the procedure went smoothly, and afterwards ensured the documentation was in order, that nursing staff were educationally prepared to care for this patient and there was adequate staffing for the next twenty four hours or so. For Anne *being in control* required little effort.

Carol was in charge of the ward and responsible for overall ward management when the patient unexpectedly arrived on the ward. Carol *took control* of the admission because she considered it to be the most natural thing to do. This type of admission tended to be ‘*... very complicated because the paper work doesn’t come up with the patient; because they haven’t really been admitted ...*’ (C:99-100) and because of the potential for this sort of admission to re-occur. Carol dealt with the immediate matter of getting the patient comfortable and medically assessed. Then she delegated the patient to a member of her nursing staff. Once control had been resumed ‘*... once I got that under control, as much control as you can ...*’ (C:121-122), Carol followed the matter up further. Carol was disappointed the admission ‘*hadn’t run smoothly*’ (C:526), therefore it was important to her to do what she had to do, to ensure the ward did run smoothly and remain *under control*. Furthermore, Carol believed control was related to advanced practice.

I think it's [advanced practice] is also about, ahh, being aware of how an institution functions, how a hierarchy functions. The way things are supposed to go correctly, and the channels to follow if they don't

(C: 734-736)

This implies Carol believes organisational control, or *managing control* within an organisation, is consistent with the role of advanced nurse practitioner.

Not only did Carol's story highlight *being in control* of the ward situation, but also *being in control of herself*. Carol mentioned her efforts to maintain her own composure; her *self-control* related to her professionalism. I was impressed by Carol's strong sense of professional identity.

Fay also had responsibility for ward management. Fay was *in control* throughout the twenty-four hours she was involved with this patient's care. She attended to the different aspects of managing the situation in a way similar to the other participants, by prioritising, organising, liaising and initiating. However what impressed me most about Fay's *being in control* was in her *giving control* back to the patient. The patient wanted to go outside the ward and have a cigarette. Fay explained to the patient the effect smoking has on the body's ability to heal, but she surmised,

... [smoking] seems to be like a crutch that they [patients] need it, so they've got some control in their lives. I think he felt very out of control.

(F:547-548)

Fay's actions were oriented toward the patient *regaining control* which was an extension of her *being in control*. Sutton and Smith (1995a:144) suggest advanced practitioners

adopt the role of patient advocate until the patient 'is able to do this for themselves'. Fay enabled the patient to achieve this.

Decision making

The ability to *make decisions* is related to *being in control*. I have attempted to describe how each participant did this. Di *made decisions* in an emergency, which were second nature. Gina *makes decisions* based on her assessment of the patient, such as a referral to a cardiologist, and discharge planning needs. She says she has to make some very *responsible decisions* when booking patients into the operating theatre. She *makes decisions* above what an ordinary nurse on the ward would make. She enjoys the responsibility *making decisions* brings. Ellen *decides* to turn the situation around in to a learning opportunity for the nurse concerned. Ben has to make '*a tricky decision*' to clinically intervene or not. He struggles to *make this decision* to some extent, but does so. He is then quite clear about what this *decision* will mean. Ben is certain of his *decision* to transfer the patient from the ward. Anne makes decisions that are orderly and unequivocal. She was certain that '*I shouldn't proceed with a procedure that I wasn't comfortable with*' (A:151-152). Carol was very clear about her priorities and following the matter up: '*It was something I would of made myself go and do because I felt strongly about it and I like to follow my principles*' (C:497-499). These examples demonstrate that *decision making*, is essential in *being in control* and managing complex situations.

Anticipation

The theme of *anticipation* is related to *being in control* and *maintaining control*. Di insists the medical intern secure intravenous access in the event of the patient having a second cardio-pulmonary arrest. Gina *anticipates* her patient's surgical operation may be delayed, she therefore prepares the patient for this eventuality. It's Gina's job to predict and plan for discharge. Gina *anticipates* this patient may take longer to recover from her knee surgery. Ben *anticipates* his patient's bone may pierce through the skin, so he prepares the skin with an antiseptic lotion. Ellen *anticipates* problems, knowing that this particular nurse is on duty. Anne looks ahead at the staffing arrangements because she *anticipates* the need for senior staff having to look after this unusual method of treatment. Carol *anticipates* this patient will need more space around his bed during his recovery, she therefore places him in a bed by the window. She follows up the issue of inappropriate ward admissions, to prevent it from happening again. Fay *anticipates* the patient may arrive unannounced, so she notifies the casualty department and the other orthopaedic wards. She *anticipates* the need for plastic surgeon's intervention, so she suggests they be involved in her patient's care. The role of *anticipation* in the participant's nursing practice is best represented by Fay:

... you start thinking on your feet. You start thinking ahead of what things can go wrong and then trying to fix them before they actually occur, or intervening before they occur... (F:980-982)

Managing a complex situation was demonstrated by the participants in one way or another by *being in control*, *making decisions and anticipation* of needs. *Being in control*

is contextually driven and comprises several attributes. Each participant demonstrated 'perception in skilled performance' which Benner (1984:37) identified as evidence of masterful performance. Benner (1984:109-10) identified seven domains of nursing practice, amongst which was the 'effective management of rapidly changing situations' exemplified by an ability to quickly problem solve, intervene, seek assistance if required. Benner suggests (1984:119) managing the situation which includes preventing crises as well. The participants demonstrated an ability to do this, evidenced in the themes of *being in control*, *decision making* and *anticipation*

Summary

This chapter has expanded upon the concepts that began to emerge from the participant's stories in chapter five and developed the following themes that describe advanced orthopaedic nurse practice for the participants interviewed in this study. They are: *having knowledge*, *being in the role and outside the role*, *being an advocate* and *being in control*. These themes have been woven into a linguistic transformation that comprised the phenomenological text.

Seven orthopaedic nurses described to me a situation in which they believed they performed at an advanced level. Through thematic analysis of these seven descriptions, concepts emerged which were developed into themes through a process of hermeneutic interpretation. A constant movement between the parts (each participant's story) and

whole (the emerging themes) of the hermeneutic circle revealed a possible understanding of what it means to be an advanced orthopaedic nurse practitioner.

Having knowledge emerged as a strong theme amongst the participants. Specific orthopaedic knowledge underpinned the actions of these nurses but it wasn't the only form of knowledge highlighted. Knowledge was comprised of experience, education, intuition, perceptions and impressions. Knowledge was developed through reflection and operationalised through the use of prior examples in practice, or exemplars.

Being in the role and outside the role was exemplified by professionalism, a sense of responsibility and obligation, and evidenced, as the participants described, by being an initiator, co-ordinator, organiser, educator or leader. Role definition was sometimes blurred and this led to conflict in some instances. *Being outside the role*, stretched the boundaries of collegial and collaborative practice at times and was sometimes associated with feelings of guilt, misgiving or inner conflict. Equally however *being in the role and outside the role* engendered clarity, commitment and a strong sense of self.

Being an advocate held a strong presence in each description and was expressed in the context of 'my concern'. This abiding concern underpinned the nurses every action. Feelings of reward for the participants originated in the achievement of patient outcomes. A relationship between patient advocacy and a sense of completion emerged from the descriptions, exemplified in *'that's what we're here for'*. Furthermore advocacy manifested as staff advocacy too.

The last theme identified was *being in control* or managing complex situations. *Being in control* was related to individual participant characteristics as much as contextually related. *Being in control* was viewed as a desirable ability to have in the context of advanced practice. *Making decisions* and *anticipation* were related to the theme of *being in control* and were clearly demonstrated by the participants in the management of their sometimes, complex situations.

This chapter has explicated the themes that emerged from the descriptions of seven orthopaedic nurses. To what extent these themes represent advanced practice this study will now turn, as the meaning and understanding evolves.

Chapter 7

Denouement

... it's funny when you talk about it, some stuff you just do, you don't even think about it, it's weird ... (B: 454-455)

Introduction

This chapter will summarise my interpretation of advanced practice of the orthopaedic nurse. This interpretation was made possible by analysing the personal experiences of seven orthopaedic nurses. Their stories focussed on making visible an interpretation of experience, as it is lived, in everyday orthopaedic nurse practice. My interpretation therefore highlights the meaning and understanding of advanced orthopaedic nurse practice. It is only one interpretation however. An enduring interpretation is made possible through repeated readings of the phenomenological text. I therefore 'hand over' the prospect of future interpretations of my work to you, the reader.

It was important for me to engage orthopaedic nurses in this contemporary debate over what constitutes advanced practice. This study has attempted to conceptualise advanced practice through examination of the descriptions of seven advanced orthopaedic nurses. This study attempted to understand not only the meaning but also the significance of advanced orthopaedic nurse practice.

Original Thoughts

This study has demonstrated the meaningful aspects of advanced orthopaedic nurse practice. As the researcher, I recognised I was involved in the world of my participants (Oiler, 82:179). I therefore revisited my taped self-interview of an incident I was involved in as an advanced nurse. I listened again to my original thoughts and feelings on advanced nursing, with a new perspective of the knowledge gained from this study. It was heartening to discover that the findings of this study confirmed my initial thoughts on advanced practice and those thoughts I had developed before commencing interpretive analysis (fldnte:15). I found the impressive words and phrases from the participant's descriptions were revealed in my own interview. *My* experiences were the *collective* experiences (van Manen, 1990:57). As part of 'sharing the experience' I found myself at times 'debriefing' the incidents with the participants. This was performed willingly and sensitively.

Perhaps I gravitated to my pre-understandings in the texts of the participants? I prefer to believe my pre-understandings enriched the interpretation. Perhaps I could have added more substance to this study, by directly observing advanced nurses in practice; time prevented this. Providing clinical reasoning occurs in the context of 'real practice', as this study has established, then the findings have relevance (Greenwood & King, 1995:908).

This study did not address the issue of orthopaedic nursing's specialty status. It remains an issue of significance to me however, and a commitment has been given to the South Australian Orthopaedic Nurses (SAON) association to share the knowledge I have gained

from this study and assist resolution of the perceived 'crisis in confidence' the specialty is experiencing.

Significance and Implications for Practice

The seven nurses involved in this study described an incident in which they believed they performed at an advanced level. Interestingly five of the seven nurses described what would be considered as 'extraordinary events' in the otherwise ordinary activities of the orthopaedic nurse. This is consistent with Benner's (1984) notion that critical incident analysis uncovers the knowledge embedded in practice. It is claimed knowledge is operationalised in these 'memorable or outstanding' clinical events (Greenwood & King, 1995:908).

The participants attributed *having knowledge* as being an essential component to practice at an advanced level. Certainly, each participant drew on specialist orthopaedic knowledge, however a breadth of knowledge was evident in the stories. *Having knowledge* comprised different types of knowledges, of which specialty nursing knowledge was only one aspect, not necessarily considered integral to advanced practice (Pearson, 1984:16). Retention and development of unique orthopaedic knowledge is necessary to ensure the nursing specialty does not become 'a dying art'. The pursuit of a theoretical base for nursing has increasingly become evident within the literature, to which this study will contribute in part by highlighting the need for further investigation into the areas of specialist/expert/advanced nursing knowledge. When the concept of

advanced nursing practice is clearer, and this can only be achieved through further investigation, development of 'advanced knowledge' can be encouraged.

Commonalities and differences were exemplified in the theme *being in the role and outside the role*. The participants expressed mixed emotions regarding being *outside the role*. It appeared the more senior the advanced practitioners, the more comfortable they felt *being outside the role* when compared to their inexperienced colleagues. It appears advanced practice is a matter of perspective. However the 'value' of expert/advanced nursing practice has not been adequately quantified in the extant literature (Borbasi, 1999:22 & 28).

This study suggested the role of the advanced practice nurse is many and varied. The challenge to define advanced practice is complicated by the different interpretations of, and contexts in which advanced practitioners are found. From the discussions surrounding the nurse practitioner role for example, a renewed interest in delineating the nursing role has emerged. It has been characterised as possessing an 'intimacy, flexibility and constancy', which will continue to evolve in response to the increasing demands placed upon it (Chiarella, 1998:31). The effort to define advanced practice must reflect the uniqueness and diversity within modern nursing practice. The value in clarifying the role of advanced practice should not be underestimated. It is necessary therefore, for the nursing profession to recognise the resource or 'wealth of knowledge' that advanced practitioners possess. Identification of the breadth of the advanced nursing role should be promoted so that all health professionals can benefit. Furthermore the nursing profession

must seriously consider how it prepares its expert nurses for advanced practice. Mentoring and forums that discuss and validate feelings associated with *being outside the role* should be encouraged

One role the participants of this study were unequivocal about, was that of *being an advocate*. Patient advocacy in particular, maintained a powerful presence in each of the descriptions. It was a strong, unifying theme throughout the narrative that explained the motivations and actions of each participant, embodied in the phrase '*that's what I'm here for*' (D:373 & F:858). Nurses take their patient advocacy role extremely seriously. The advanced nurse considers patient advocacy as central to their practice. (Sutton & Smith, 1995a:144-5). Holistic thinking becomes the province of the expert/advanced nurse (Jasper, 1994:772). A strong sense of self is often required to be an effective advocate:

The need for and the capacity to care have been described as universal requirements reflecting an important aspect of our human nature, affecting our perceptions of ourselves and our relations with others.
(Heidegger 1962 cited by Kitson, 1987:324)

It is important to celebrate the role of patient advocate that nurses enact. Through the sharing of clinical exemplars, the uniqueness of our practice is realised (Harvey & Tveit, 1994:53). We must also recognise that sometimes the nurse advocate comes into conflict in their role as an employee, sharing these experiences amongst nursing colleagues will guide future practice.

The ability to manage complex situations was demonstrated by the participants in each description. *Being in control*, maintaining control, restoring control is expected from advanced nurses, either of themselves or by their colleagues. It is about the smooth resumption of a manageable situation. *Making decisions* and *anticipation* were activities synonymous with *being in control*. The advanced nurse's ability to do this is imperative. How does the advanced nurse do this? It is not something easily taught. Encouraging reflective practice however, and further research will clarify what is involved in managing complex situations.

The meaning of advanced practice for the expert orthopaedic nurse is, I suspect, not unlike the practice of any other advanced practice nurse. Whilst orthopaedic nurses possess unique knowledge, the focus and the characteristics of the nursing role is universal. The participant's described 'extraordinary' orthopaedic experiences, yet managed these situations in an 'ordinary' and advanced way. The development of generic competency standards of advanced practice, both in Australia and in the United Kingdom, supports the notion that commonality in performance exists amongst advanced practitioners. Furthermore, a continuum of expert to advanced practice exists (much like Benner's (1984) novice to expert sequential acquisition of skills). The participants in this study demonstrated a breadth of advanced nursing performance. Some were expert, that is their knowledge gained from experience, meant that they cared for their patient in an expert way. Their advanced practice was in a state of emergence however. The subtle transition to advanced practice occurs in the context of the patient – nurse relationship. There is a qualitative difference in how the advanced nurse practitioner thinks, sees and

experiences nursing practice (Sutton & Smith 1995b:1040). This was evident in the comprehensive descriptions of nursing practice from Anne, Carol and Fay. Their perspective effortlessly conveyed a knowledge of the fullest extent of a situation. If the nursing profession is serious about advanced nurse practice, then the onus is on it to develop and prepare advanced nurse practitioners. This must be done in an orderly and coordinated way, so as to avoid any further confusion. I believe the application of generic competency standards for the advanced nurse will assist in this transition. My desire is to see the acceptance of generic competency standards for the advanced nurse, into the practice of orthopaedic nurse practitioners.

Sutton and Smith (1995a:145) suggest advanced nursing practice is the essence of nursing. But what benefit is this claim to ordinary nurses? The claim that 'all practitioners have value in the delivery of health service' must not be lost in this debate on advanced practice (Humphries, 1998:13). Benner (1984:35) believed the study of proficient and expert performance developed knowledge that would form the basis of excellence in nursing practice. This notion can be extended to expert and advanced practice. An understanding of advanced nursing practice contextualises remaining nursing practice. Similarly an understanding of advanced nursing practice contextualises orthopaedic nursing practice, that is provides a measuring stick if you like. In this way this study has attempted to make a difference to all nurses. The extent to which the patient benefits from advanced nursing practice, is an area worthy of further investigation.

Potential Ramifications

The nature and scope of advanced practice has yet to be agreed on in any definitive sense (Clinton et al, 1999:18). Genuine progress appears to have been taken in reaching this objective. How a nurse achieves advanced status is not known. Revealing the subtleties of advanced practice will provide meaning and understanding of this complex concept. This study has attempted to reveal the meaning of advanced orthopaedic nurse practice by:

...presenting a description which is in some ways clearer and more open to understanding than the individuals would have been able to provide unassisted. (Ashworth, 1997:221)

In this way a contribution toward a general understanding of advanced practice was generated.

As the debate on advanced practice continues, future possibilities will evolve. Benner (1984) claimed ‘... there is a wealth of untapped knowledge embedded in the know-how practice of expert nurse clinicians ...’. A promising future awaits, as the wealth of knowledge in nursing practice is revealed. However, nurses must apply an hermeneutical approach to their nursing practice; that is, taking new knowledge gained from experience and practice, and reapplying it back into practice (Reed 1998:79 cites Peplau). Nurse practitioner trials are under way in which nurses will be suturing wounds and treating uncomplicated fractures (Serghis, 1998:7). The outcome of these trials heralds exciting possibilities in the context of advanced orthopaedic nurse practice.

Future research efforts need to focus on further clarification of the concept of advanced practice and evaluating the impact advanced nursing practice has on patient care and the achievement of patient outcomes.

Evaluation of the Research Process

In order to determine whether this interpretation is sound, I have chosen to apply the following evaluation ‘methodological principles’ suggested by Maddison (1990:29-30). Interpretive agreement is not necessary, but the process of reaching interpretive agreement is; that a ‘dialogue of understanding’ should emanate from this work (Geanellos, 1998:158-9).

Coherence

The details and parts of the interpretation should be coherent and in harmony with the whole picture depicted in the texts.

Throughout the interpretive process a movement back to the whole story of the participants took place. Emerging concepts were referenced from the original participant’s description and coded accordingly.

Comprehensiveness

The interpretation should relate to the total picture depicted in the texts.

An extension of the above principle, emerging themes were exemplified by reference to ‘patterns of meaning’ or examples from within the participant’s description.

Penetration

The degree to which the interpretation achieves what the researcher set out to do.

This study set out to discover the meaning of advanced practice for the expert orthopaedic nurse practitioner. The thoughts, feelings and perceptions of the seven expert/advanced, orthopaedic nurse practitioners were presented in chapters five and six. These feelings were transformed into the interpretation of this study.

Thoroughness

The interpretation attempts to answer the questions it poses to the text and those posed by the text.

An ongoing dialogue with the text provided an entrée into the questions raised by the text; and questions asked of the text. The interpretation gleaned from this process, was presented in chapter six.

Appropriateness

The interpretation should deal with those questions raised by the text itself.

Chapter six comprises the interpretation, which contained the answer to the questions posed by the text.

Contextuality

The interpretation is in keeping with the historical and contextual nature of the text.

Chapter four explains the participant's background. Chapter five summarises the participant's stories and thereby describes the individual nurse's own context within their description. Paradigm cases were further contextualised by reference to literature-in-the-field. There is a phenomenological tradition associated with this study's research topic, therefore use of this particular methodology adds to the historical context of the research.

Agreement

The interpretation should agree with what the text is saying and not manipulate the meaning of the texts.

From the outset I was sensitive to the need for a 'pure' interpretation. I conducted a self-interview, the purpose of which was to identify with the participants in terms of replicating interview conditions, and to declare my pre-understandings towards the phenomenon. However my original understanding of the phenomenon was transformed

by the process of this study. By accurately referenced excerpts from the participant's narratives in support of concepts and themes, agreement has been possible.

Suggestiveness

The degree to which the interpretation stimulates further research.

In the absence of orthopaedic nursing literature-in-the-field, this study raises questions about the relationship between orthopaedic nursing practice and advanced practice.

Potential

The degree to which the interpretation can be extended in the future.

The question remains as to whether advanced practice makes a difference to the orthopaedic patient, and further does advanced practice make a difference to the experience of the patient and health outcomes generally.

A Final Comment

This study has attempted to reveal the meaning of advanced practice in the context of orthopaedic nursing practice. This study provides *one* perspective. If you have reacted, agreed, disagreed, or identified with the experiences of this study, then I am satisfied the study has accomplished what it set out to do. van Manen (1990:27) refers to the ‘phenomenological nod’; if this describes your reaction, then the study has value as a ‘good’ phenomenological description.

My experience of this study as an orthopaedic nurse, has transformed my understanding of advanced practice, and will inform my future nursing practice. I should like to revisit the opening quote of this chapter ‘... *it’s funny when you talk about it, some stuff you just do, you don’t even think about it, it’s weird ...*’ (B:454-455). Ben’s words are a validation of the ‘... multiple interpretive layers of this research process and practice ...’ (Koch, 1996:182); they carry such resonance that confirms this is not an end; there will always be another possibility.

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Appendix 1

Information Sheet to Participants

Dear

Thank you for considering to take part in my research proposal titled "Advanced Practice and the Orthopaedic Nurse: An Interpretive Study". I am a Registered Nurse working on an orthopaedic ward at the RAH. I am currently undertaking a Masters of Nursing Science. The award requires me to undertake some form of research. I am interested in describing advanced practice of the expert orthopaedic nurse. It is hoped the information gained from the study will contribute to the debate on advanced practice. To date orthopaedic nurse involvement has been minimal, therefore this study aims to engage orthopaedic nurses in the debate and in so doing put an "orthopaedic" perspective on advanced practice.

I envisage your commitment will be as follows:

Up to one (1) hour of your personal time is required to conduct the taped interview, which forms the body of the research. Then a shorter session in which I would like to verify my interpretation of the initial interview with you. Finally a feedback session in which I would like to advise you of the results of the study. This may be conducted in writing if you prefer.

Please be reminded inclusion is entirely voluntary on your part. You may withdraw from the study at any time. Privacy, confidentiality and anonymity is guaranteed.

Should you wish to discuss this proposal please don't hesitate to contact me on 8379 3413. You may also contact the Chairman, Research Ethics Committee on 8222 4139 if you wish to further discuss aspects of the study. If you are still interested in taking part please complete the attached consent form and return in the envelope provided. I shall contact you shortly to arrange an interview time.

Thanking you in anticipation.

Yours sincerely

Anita Taylor

Appendix 2

Consent Form

Project Title: "Advanced Practice and the Orthopaedic Nurse: An Interpretive Study"

Researcher: Anita Taylor

This is to certify that I

(print name)

agree to participate as a volunteer in the above named project. I give permission to be interviewed and for those interviews to be tape recorded.

The nature and purpose of the research project has been explained to me by the researcher. I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

I understand that, while information gained during the study may be published, I will not be identified nor any other persons or institution; and such information shall remain confidential.

I understand that I can withdraw from the study at any stage or refuse to answer any question of my choosing, without penalty.

participant

researcher

date