

THE NATURE OF THE "NURSING PROCESS" AS A CENTRAL CONCEPT
IN THE CURRENT EDUCATION OF NURSES

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ABSTRACT

This thesis is concerned with a conceptual analysis and an empirical investigation of how the nursing process approach is construed by nurse teachers and clinical nurses.

The conceptual analysis is made by a review of the relevant literature. The empirical work is in two phases. Phase one comprises an United Kingdom wide survey using a questionnaire specially developed to ascertain the extent that the nursing process approach is regarded and used. In the second phase hierarchically focused interviews are used to determine how the nursing process is construed.

The thesis concludes by identifying aspects associated with the nursing process label. The aspects are rather diffuse in nature. A weak classification exists as far as nursing process knowledge is concerned. There are some grounds for including individualised, assessment, planning, implementation, evaluation, holistic, humanistic, systematic and patient-centred as commonly construed aspects. Decision-making, scientific, professional status, improved patient care and job satisfaction on the part of nurses received little support as characteristics of the nursing process.

Two-and-five-group typologies emerged when aspects of the interview data were analysed using a cluster analysis technique, confirming the varied nature of the nursing process construals held by the interviewees.

Implications for the teaching and learning of nursing are discussed. The issues investigated in the thesis are pertinent to the reform of nursing education which is currently proposed.

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CHAPTER ONE

THE "NURSING PROCESS" APPROACH

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CHAPTER ONE

THE "NURSING PROCESS" APPROACH

INTRODUCTION

It is intended that this chapter will focus on four things. Namely: a statement of the problem to be investigated; the background to the introduction of the nursing process approach to nursing; the theoretical considerations related to the approach and finally account will be taken of the practical considerations in its implementation.

A STATEMENT OF THE PROBLEM

The delivery of nursing care in the United Kingdom has undergone a major change in recent years. It has changed from the traditional or task-centred approach to one based on the nursing process approach.

At a theoretical level features which characterise the nursing process approach include holistic, humanistic, systematic, scientific and problem-solving, though all these features may not necessarily be found in any single formulation of the nursing process approach. At a practical level the nursing process approach generally involves assessment, planning, implementation and evaluation. By implication it also involves decision making.

The general purpose of this study is to study how the nursing process approach is actually understood in nursing. To this end it is proposed to review critically a good spread of the relevant literature in order to establish the state of existing knowledge on the subject. It is also proposed to carry out an empirical investigation with the object of collecting and interpreting data and possibly advancing the knowledge base relating to the nursing process approach. Since it is becoming increasingly common in practice to use nursing

models in conjunction with the nursing process approach the nature of this relationship will be explored also.

This study will have a conceptual focus and will aim to elicit how nurse teachers and clinical nurses construe the "Nursing Process".

BACKGROUND

a. The origins of the nursing process approach

The nursing process approach has had a longer history in North America than in the United Kingdom. There is a measure of agreement that the expression "Nursing Process" was coined by Orlando (1961). However, as far as British nursing is concerned the nursing process is an innovation of the 1970s. In the mid 1970s, Hargreaves (1975) commented on how little had been written about the nursing process in this country and of the 14 references cited in his article only one was British. The Nursing Times noted in 1977 that as yet relatively few nurses in this country were conversant with the term "Nursing Process".

An event in 1977, however, forced nurses to become more conversant with the nursing process notion. In this year the General Nursing Council circular 77/19 was issued and has this to say about the nursing process

"When defining the overall aims and the learning objectives for the course it will be important to identify the common core of the curriculum and the expected outcomes of the whole course: the synthesis of nursing knowledge, nursing skills and the body of beliefs and values which support a code of professional practice. The stages of the nursing process, as described by Professor Jean McFarlane, and others, are helpful in offering a theoretical framework for practice.

The use of this method commits all concerned in the various caring/learning situations to a shared approach and a common purpose".

At face value the phrase "helpful in offering a theoretical framework for practice" does not sound very prescriptive. However, people on the ground felt they did not have the freedom implied in GNC circular 77/19. Gibbons, Bowmaker and Brewer (1983), for example, pointed out that the General Nursing Council was applying a great deal of pressure by way of restructuring examination/assessments and syllabuses to bring about the implementation of the nursing process approach. Any consideration of the nursing process in a British context must take account of its relatively short history in this country. A related factor concerns the issue of change.

"Change is not made without inconvenience, even from worse to better". Richard Hooker (1554 - 1600). The introduction of the nursing process approach involved considerable change and peoples reaction to change varies a great deal. Chinn (1980, p21) identifies a number of factors which may impinge on the process of change and these include resistance, defense mechanisms, adaptation, adjustment, maladjustment, disintegration, growth, development, maturation and deterioration. Chinn (1980, p21) goes on to identify some conflicts associated with change. He states on the one hand that it's only human nature to resist change. On the other hand "every organisation is always trying to improve its way of working".

Chinn (1980) was dealing generally with the issue of change, but Milne (1985) dealt with change in a nursing context. Milne (1985) suggests that institutional variables may exert more control over the use of the nursing process than the personal characteristics of individual nurses.

The introduction of change may be viewed as progress, advancement and personal and professional growth. Conversely, change may evoke reactions of hostility and alienation. These reactions to change are important for two reasons. First, personal reactions to change may influence how the object of change is construed. Whether it is a good thing or a bad thing, or whatever. Second there is the preparation for change. Milne (1985), for example, suggests that the preparation of individuals through an educational programme in itself may not be enough since institutional variables are also a powerful determinant of reactions to change.

There were a number of sources of impetus to change to the nursing process approach for the delivery of nursing care, but a very significant factor was the GNC circular 77/19. Though the language of the circular was relatively mild, there were feelings at grass-roots level that the nursing process line was being forced upon nurses. It is true that there had been numerous study days, conferences and the like, presumably to win the hearts and the minds of the nurses. But the question remains, if the introduction of the nursing process approach is something which ought to take place, whether enough had been done in this respect. A related question is what is the effect of coercion which some nurses feel: it is unlikely to create a climate of goodwill towards the nursing process. Moreover, many nurses will be unhappy that pilot studies were not done before the nursing process was introduced generally.

It is important to seek reasons for accepting the nursing process approach, for there are many people who are enthusiastic about it, as it is to seek reasons why some people reject it. Some nurses, no doubt, will have examined the nursing process in a critical, analytical manner and will have convinced themselves, or at least given it the benefit of the doubt, about its value, usefulness

and applicability. Examples of people in this category would be Hargreaves (1975), McFarlane (1973), Altschul (1978), Darcy (1980), Webb (1981), McCarthy (1981), Lauri (1982), Barnett (1982), Roper, Logan and Tierney (1983 a, b, c, d, e and f) and Bellamy (1983). The writings of these people may, in some instances at least, have a ripple effect and thus influence the thinking of others in relation to the issue of the nursing process.

There is, however, an alternative explanation as to why nurses may feel favourably disposed towards the nursing process approach and this is the "bandwagon effect". Senicle (1983) writes that the Nursing Process follows a long line of 'nursingisms', the examples she gives are total patient care, team nursing and patient assignment. All of these, of course, have more or less vanished from the scene. Why have they vanished? There is probably no single answer to that question, but it may be that these approaches to nursing, because they were new and had some measure of support, were accepted uncritically and were later found wanting in practice. Or it may be that the resistance to change which existed was greater than the bandwagon effect; hence the reason for fizzling out. The Nursing Process appears to occupy a more entrenched position than these other approaches to nursing which have disappeared from the scene. However, if it is thought desirable to retain, develop and base practices on the nursing process approach, it must be subject to critical examination if it is to go the way of other so-called nursingisms.

b. The need for the nursing process approach

Apart from the issues raised so far there are many more important points to be considered in relation to the nursing process approach, such as why it was introduced in the first place. It is

true that there was dissatisfaction with the task-centred approach to nursing. Menzies (1970, p12) describes a kind of depersonalization or an elimination of individual distinctiveness in both nurse and patient. She goes on to say that nurses often talk about patients not by name, but by bed number or by their disease or diseased organ, 'the liver in bed 10' or 'the pneumonia in bed 15'. Altschul (1978) comments that awareness of past shortcomings has resulted in a search for a more rational approach to nursing practice.

Why do we need the nursing process? In three related articles different authors give their answers to this question. Neilson (1978) deals with the legal reasons and makes the point that proper records are essential where litigation is concerned. Clark (1978) deals with the practical reasons and these are related mostly to manpower matters and communication. Davis (1978) deals with the professional reasons for the nursing process and concludes that the documentation of the process of nursing is what can make nursing a profession.

The former General Nursing Council has never been explicit about the reasons for introducing the nursing process. It would have been aware of the dissatisfaction with task-centred nursing. Through the reports of its inspectors it would probably have had a great deal of data to draw on.

THEORETICAL CONSIDERATIONS

a. Conceptual and Cognitive Aspects

Central to an examination of the matter ought to be the nature of the nursing process as a concept, i.e. the actual meaning of the verbal label "nursing process". The most that can be said at this

stage is that there are a diversity of views relating to the issue. Those of Daws (1982) and Wainwright (1983) are poles apart. Others, from less polarised stances, have expressed concern about the conceptions of the nursing process. Both Boylan (1982) and Hillier (1982) contend that a good deal of confusion exists about the nature of the nursing process. Similarly, Brooking (1983) found that different people often mean different things when they talk about the nursing process. On the basis of the evidence considered so far it appears that there is confusion about the meaning of the nursing process and that a clarification of the nature of the concept is badly needed.

The adoption of the nursing process approach to nursing has conceptual implications but it also appears that it calls for a different style of thinking. McGlynn (1983) suggests that the medical model, which is frequently taken as an alternative description for traditional or task-centred nursing, takes the patient as a collection of specific signs and symptoms which can be brought together and a diagnostic label applied through the process of induction. The patient's disease is induced from the available specifics. McGlynn (1983) goes on to make the point that nursing models take the patient as a holistic entity through the application of several theories borrowed from the life sciences. In this context the patient is at the onset a vague generalization. And from this vague generalization through the process of deduction, the actual specific needs of each patient are arrived at.

A number of questions arise in relation to this issue. Is it fair to characterize the medical model as more or less exclusively involving the process of induction? By contrast, can the nursing process be described as involving deductive reasoning? Does it

have to be a case of induction versus deduction or top-down versus bottom-up dichotomies, or is there a case for an eclectic approach?

b. Defining Nursing

The nursing process approach may be seen as a development in nursing and for this research it ought to be considered in the context of how nursing itself is defined.

The definition of nursing which is now most commonly used or referred to is that by Henderson (1966). Reference to it has been found in the writings of, for example, Grant (1975), Hargreaves (1975), Luker (1979), Long (1981), McFarlane (1981), Lauri (1982), Mackie and Welsh (1982), Roper, Logan and Tierney (1983) and Farmer (1983).

The definition given by Henderson (1966) is as follows

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, in this part of her function, she is master. In addition she helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of a medical team, helps other members as they in turn help her, to plan and carry out the total programme whether it be for the improvement of health, or the recovery from illness or support in death".

Henderson (1966) goes on to state that the nurse is

1. "The consciousness for the unconscious;
2. the love of life for the suicidal;
3. the leg of the amputee;
4. the eyes of the newly blinded;
5. the knowledge and confidence for the young mother;
6. the 'mouthpiece' for those too weak or withdrawn to speak"

The Henderson (1966) definition is of interest for a number of reasons. For one thing, as already indicated, it is perhaps the most widely used and the most frequently quoted definition of nursing. It is used and quoted in the context of the nursing process which is also interesting because Henderson appears to have reservations about the nursing process, or the title at least. A title of one of her papers (Henderson, 1982) is "The Nursing Process - is the title right?" She argues that on purely semantic grounds the nursing process is a debatable term. 'The' makes it so specific that activities outside those in the problem-solving steps of the process cannot be peculiar to or characteristic of nursing. She later concludes that while the nursing process recognises the purpose of the problem-solving aspects of the nurse's work, a habit of inquiry and the use of investigative techniques in developing the scientific basis for nursing, it ignores the subjective aspect of nursing and the role of experience, logic and expert opinion as bases for nursing practice. Henderson makes the further point that in stressing a dominant and independent function for the nurse, the nursing process fails to stress the value of collaboration of health professionals and particularly the importance of developing the self-reliance of clients.

c. Defining the nursing process approach

Writers on the nursing process approach the subject from radically different standpoints. Normark and Rohweder (1975) emphasise decision-making and problem solving. Saxton and Hyland (1975) focus on the concept of stress as the theoretical basis for nursing intervention. They define stress as any factor that requires some responses or result in some change within an individual. These stresses, they assert, may be categorized as

physical, chemical, microbiological, developmental and emotional.

They go on to give examples within each category as follows

Physical - temperature, sound, pressure, light, motion, gravity
and electricity.

Microbiological - viruses, bacteria, molds and parasites.

Physiological - hyperfunction, or hypofunction of an organ,
immunity, neoplasms, atrophy, and hypertrophy.

Developmental - genetic endowment, prematurity, immaturity,
growth, maturation, and aging.

Emotional - cultural/interpersonal pressures.

Saxton and Hyland (1975) there are seven objectives to nursing
intervention and these are set out in two categories as follows

"Those objectives related to stress include

1. Reduce or limit the extent and intensity of the present
stress;
2. Prevent additional stress;

The following objectives are related to the individual's level of
adaptation

1. Support the individual's first level adaptations to
assist in sustaining and maintaining the defensive
responses;
2. Limit and support the individual's second level of
adaptations to confine and restrict the compensatory
responses;
3. Alter, limit, and support the individual's third level
adaptations to modify and adjust the symptoms of
response;

4. Interrupt, alter, limit, and support the individual's fourth level adaptations to discontinue or stop the responses that have become stresses.
5. Supplement, interrupt, alter, limit, and support the individual's fifth level adaptations to complement or replace the responses that are failing to control stress".

These authors go on to relate the relationship between the levels of adaptation and nursing intervention. They assert that the individual's level of physiological adaptation can be related to the five objectives of nursing intervention that are concerned with adaptation. And they go on to maintain that this relationship can be used to develop a plan or care that will be individualized to meet a specific patient's needs.

There are, however, criticisms which need to be made. The Saxton and Hyland (1975) approach is presented as an approach for all seasons. It is questionable whether it is wise to put all the eggs in one basket. Hardy (1982) makes the point that blind acceptance of an approach is to be questioned. The use of this approach must be accompanied by discussion, explanation, and adaptation. And she adds no one approach provides a true picture for all situations.

Another criticism concerns the concept of stress. Selye (1956, p274) describes stress as the rate of wear and tear in the body, or the sum of all non specific changes caused by function or damage. That the human body is subject to wear and tear seems like a statement of the obvious. Equally, that some changes will

result in damage of or change of function seems like an acceptable proposition. The main point is the concept of stress is not generally accepted and the medical profession in particular tends to regard it with a certain amount of suspicion.

In another context Kuhn (1970, p210) asserted that "scientific knowledge, like language, is intrinsically common property of a group or else nothing at all. To understand it we shall need to know the special characteristics of the groups that create and use it". To paraphrase Kuhn (1970) it might be said that nursing knowledge is the common property of the group or else it is nothing at all. This is the crux of the matter in relation to a formulation of nursing based on stress. Since some will reject the concept of stress it is hard to see how it could become the common property of the group.

Murray (1976) suggests that the nursing process is a specific method for organizing nursing actions. It is claimed that it is similar to the scientific method but with less strict control of variables. It is depicted as a series of orderly and disciplined steps, the nursing process is not static and changes constantly in accordance with different situations.

The nursing process is characterised by this source as a combination of intellectual and physical activities. It is a systematic means of analysing the patient's problems, determining how to solve them, carrying out a plan of action, and then evaluating its effectiveness.

Murray (1976) asserts that the nursing process combines the

attitude of sharing oneself with a patient in a knowledgeable service to him. Neither quality alone is enough. Kindness and consideration are essential, but they cannot substitute for sound scientific knowledge. Someone who is abrupt with patients is not following the nursing process, no matter what her scientific or technical expertise.

A number of matters arise from Murray's (1976) definition of the nursing process. One concerns how little this definition has in common with that of Hyland and Saxton (1975) just considered; they appear to be poles apart. The phrase 'similar to the scientific' appears to be unfortunate; to what extent does the scientific method have to be watered down? Is it perhaps better to talk of a scientific perspective rather than an attenuated scientific approach?

Murray does have a humane dimension to her definition for she mentions sharing oneself, kindness and consideration. She also mentions physical activities. Many definitions of the nursing process emphasise the cognitive and affective aspects; some putting more emphasis on one aspect than the other. It must not, of course, be forgotten that there is also a psychomotor aspect; to this could be added social, moral and experiential aspects.

Yura and Walsh (1978, p1) state that the nursing process is the core and essence of nursing: it is central to all nursing actions, applicable in any setting, within any frame or reference, any concept, theory or philosophy. These authors claim that it is flexible and adaptable, adjustable to a number of variables, yet sufficiently structured so as to provide a base from which all

systematic nursing actions can proceed.

These authors go on to offer a more formal definition of nursing and assert that a conscious awareness of one's personal philosophy and due consideration for human values, ethics, and beliefs are essential if one wishes to develop his or her own definition of nursing. Yura and Walsh (1978, p13) offer their definition of nursing which is as follows

"Nursing is an encounter with a client and his family in which the nurse observes, supports, communicates, ministers, and teaches. She contributes to the maintenance of optimum health, and provides care during illness until the client is able to assume responsibility for the fulfilment of his own basic human needs. When necessary, she provides compassionate assistance with dying".

These authors go on to state that philosophy, theory, concept and process are components of nursing on and around which nursing is built. They assert that a sound philosophy with clearly expressed values and beliefs provides a foundation for nursing. They go on to say that the identification of theories and the pursuit of those having significance for nursing are continuing activities as the scientific foundations are established. It is suggested that theories from various disciplines are utilized and adopted as the development of a nursing science is pursued and as nurses rely on already established data as a base for their actions. These authors add that newly identified concepts add to the knowledge and use of theories, and the process of nursing relies on all these firm bases to assure sound practice. And they conclude that intellectual, interpersonal, and technical skills are used in the application of the nursing process by the nurse as she performs actions for the client based on identified theories and concepts.

The Yura and Walsh (1978) contribution raises the discussion on to a higher intellectual plane. Nursing is depicted as an interactive activity and as having cognitive, affective and psychomotor aspects. It is concerned with health and disease; it is also a humane and a compassionate activity. These features share some common ground with other definitions which have been considered. The extra dimension is that philosophy, theory, concept and process are the four components on and around which nursing is built.

It might be argued that a philosophy is fundamental to every human activity and to state that nursing should be based on a philosophy is in no way extraordinary. However, philosophy is seen by some as an unworldly activity or concerned with nut picking or hair splitting. Whichever is the view taken it is possible to dismiss it as being irrelevant to what many see as the essentially practical activity of nursing.

The same objections will be raised in relation to theorizing. This will be regarded as an activity to be conducted in ivory towers and thus well away from the site of nursing activity. Because theory does have, in some minds at least, this ivory tower image it can be readily dismissed. The argument that there is nothing as practical as a good theory does not always hold sway.

It is not argued that there should not be philosophical and theoretical foundations for the nursing process. It is believed that the inclusion of both in a nursing context can be justified and defended. The argument centres on whether this formulation of nursing will be seen as too high falutin and will be discounted.

How well will it be understood in the wards, sluices, treatment rooms and common rooms and the other places where the great mass of ordinary nurses are to be found? Kuhn (1970) as already mentioned, talks of knowledge as the common property of the group. Will these philosophical and theoretical dimensions be regarded as common property? As ever, an open minded approach to the issue is probably the most appropriate stance to take.

Different sources tend to focus on different aspects when characterising the nursing process approach. Chinn and Jacobs (1983) depict the nursing process as being similar to both the problem-solving and the research process. They posit the view that the nursing process has provided an important framework for viewing nursing as a deliberate thoughtful, and self correcting system. These authors go on to write

"The nursing process developed from a skeleton description of actions that were intended to replace the rule-oriented and principle-oriented approach to nursing with a more detailed discription of the components of thought and action that constitute effective practice. The components of the nursing process have become increasingly recognized as a vehicle for developing inquiry skills and nursing knowledge."

(Chinn and Jacobs 1983, p29)

This formulation of the nursing process approach has a strong cognitive element in that it includes problem-solving and the research process. However, these are not seen as an end in themselves; the end seems to be effective practice. A secondary end appears to be the use of inquiry skills and the development of nursing knowledge. A characteristic of this formulation of the nursing process approach is the lack of emphasis on the affective domain and on the humanistic aspects compared to other writers.

Griffith-Kenney and Christensen (1986, p11) construe the nursing process in a similar way to Chinn and Jacobs (1983) for they see it as a deliberate logical, and rational activity whereby the practice of nursing is performed systematically. They go on to write

"Throughout the nursing process the nurse uses a comprehensive knowledge base to assess the client's health status, make judgements and diagnoses, and plan, implement, and evaluate appropriate nursing actions. As the core of nursing practice, the nursing process provides the structure for nursing care. Five interacting components with various steps comprise the nursing process."

The five components are: assessment, which includes data collection; diagnosis which includes analysis/synthesis of data and diagnostic statements; planning which subsumes priorities, goals and objectives, strategies, nursing orders and the scientific rationale. The remaining two elements are implementation and evaluation.

Assessment, planning, implementation and evaluation appear in many formulations of the nursing process approach. The element in the Griffith-Kenney and Christensen (1986) construal of the nursing process, which is not mentioned or highlighted to the same extent by others, concerns diagnosis. Associated with this emphasis is Chinn and Jacob's (1983, p.11) assertion that there is a substantial literature concerning the nature of the nursing diagnosis process, concerning the development of a taxonomy of nursing diagnosis labels, and testing the validity of nursing diagnosis.

According to Griffith-Kenney and Christensen (1986, p12) the diagnosis phase of the nursing process is in two parts. The first part concerns the analysis of the data collected in the assessment phase. This analysis takes place within an appropriate theoretical framework which takes account of standards, norms, health concerns, strengths and resources. With regard to the second part, the

authors write

"... the nursing diagnostic statements are written in clear, concise language. Each diagnosis should be client centred, specific, and accurate and in the form of an aetiological or descriptive statement".

Words used by Griffith-Kenney and Christensen (1986) include deliberate logical, rational and systematic. The emphasis appears to be on the science rather than on the art of nursing. A source to be considered shortly, McFarlane (1981), appears to put equal emphasis on the art and science aspects of nursing. Without arguing for either, it may be noted that these sources demonstrate some variation in emphasis in conceptions of the nursing process approach even in the formal literature.

The final contribution to be considered as far as definitions are concerned will be that by McFarlane and Castledine (1982). They write

"The current emphasis on systematic planning is an attempt to improve the quality of planning, to place decision making on a more scientific basis, and to evaluate the outcomes more effectively. By contrast with previous approaches to planning, use of the nursing process attempts to

1. assess patient needs on an individual rather than a routinised basis.
2. provide a basis for analysis of the cause of patient needs so that the nursing actions planned can be related more closely to the problems.
3. provide a system for analysing the individual's or the family's ability to sustain self-care and to review the professional intervention needed.
4. document or write down the plan and record of treatment as a means of staff communication.
5. make explicit the nursing actions planned to meet particular patient problems so that their effectiveness can be reviewed.
6. provide a method of evaluating nursing care"

One of the authors above, McFarlane (1981), posited the view that nursing practice is a unique synthesis of the art of caring and the principles of science. Without science, the art is sheer sentimentality or, worse, thoughtless routine. Without art, the science is dehumanised and dehumanising. It is a professional tightrope that nurses must walk and find a balance. Maintaining equilibrium between science and art can only be achieved by remaining critically aware and testing the nursing practice against established scientific facts and human principles. In other words this could be described as an open-critical approach, Tomlinson (1981).

The thinking offered by McFarlane (1981) is also reflected by McFarlane and Castledine (1982). In fact the 1982 contribution is a synthesis of much of what has been said about the nursing process. It is depicted as systematic, scientific and concerned with problem-solving or decision-making to use their terms. It is concerned with analysis and actions and it is individualised though it also takes account of the family and by implication the community.

Since the McFarlane and Castledine (1982) formulation represents a synthesis of much of what has been said by others, since it is a reasonable formulation which draws on science and art and since it might be described as an open-critical approach, there would appear to be a case for letting the matter rest there. However, a major problem arises concerning how the concept is construed. Is it an idiosyncratic construal or is it one which would command a wider acceptance? There is as yet no empirical evidence relating to this point.

d. Holistic Aspects

The nursing process is described as systematic (McFarlane and Castledine (1982), Mayers (1978), and Burgess and Lazare (1973). It is also described as holistic (McFarlane and Castledine (1982), Bower (1982) and Carter (1979), for example. Systematic and holistic, while not synonymous terms, imply that the nursing process concept provides a framework within which the elements of the contributory disciplines of nursing can become a unified whole.

It is the case, of course, that there exists such a unifying framework in the form of general systems theory which is generally attributed to Bertalanffy (1968). A system is that which provides a structure whereby unconnected parts may be integrated into an organised whole. According to Bertalanffy (1968) the key terms associated with his general systems theory are equilibrium, homeostasis, steady state adaptation, adjustment, regulating and control mechanisms, the phenomena of change, differentiation, evolution, entropy and negentropy. Mention is also made of open and closed systems, the processes of growth, development, creation and cybernetics. The scope and the range of the concepts subsumed within the general systems theory provides evidence to support the notion that it is a "general" theory.

Chinn (1980, p23) writes of systems theory as follows

".... the systems model is regarded by some system theorists as universally applicable to physical and social events, and to human relationships in small or large units".

This author identifies boundary, stress or tension, equilibrium and feedback as the central elements of general systems theory. Griffith-Kenney and Christensen (1986, p51) deal with general systems theory in the context of the nursing process thus

"Systems theory is applicable in the nursing process of the individual, family, and community client. It is the most frequently used approach to assess and analyse a community. However, because it is so broad, supplemental approaches are often required to delineate input, throughout, and output."

A number of writers on the nursing process use or make reference to general systems theory, for instance Altschul (1978), Mitchell (1973), Kraegel, Moussman, Goldsmith and Aora (1974), Yura and Walsh (1978), Hunt and Marks-Marano (1980) and Bower (1982).

However, it appears that general systems theory has made little impact on nurses. The mention of it leaves most nurses, otherwise well informed, nonplussed. Not one of several groups of nurse tutors with whom I raised the matter had ever heard of the term but thought it might have something to do with engineering, which of course it has. But general systems theory is not confined to engineering; in fact it claimed to have very wide application in the humanities, life sciences and the social sciences as well as engineering.

A number of questions arise at this point. The first concerns the nature of nursing knowledge; it appears from a preliminary analysis that there exists some fundamental epistemological questions which need to be answered. At another level there is the question of the relationship between the nursing process and general systems theory. To what extent is an understanding of the nursing process dependent on a knowledge of general systems theory? If the nursing process

is not founded on general systems theory, or some similar unifying principle, it is difficult to defend the use of the description 'holistic'.

e. Individualised Aspects

The nursing process approach, in contrast to the traditional approach, is described as being based on the needs of patients. A nurse is allocated a patient or a small group of patients and then performs for them all the nursing care that is required. In this way the contact with individual patients is greater so that a nurse has opportunities to get to know patients better. The nursing process is described as a systematic approach to nursing and generally includes four phases which are assessment, planning, implementation, and evaluation. Other descriptions of the nursing process which appear are that it is a humanistic, an individualised and a scientific approach to nursing.

f. Humanistic Aspects

A humanistic approach to nursing may be taken as aiming towards greater individual self-awareness as well as a mutual understanding among patients and nurses. In practice this may be characterised as the difference between doing things for a patient and doing things with a patient. It means greater involvement by the patient in his treatment. If a humanistic approach is adopted, it seems to follow that it will be individualised as well. It might be questioned whether it is necessary to use both terms, however, they do appear as separate characterisations of the nursing process approach.

g. Systematic Aspects

Bower (1982, p10) describes the process of planning nursing care

as a systematic dialectic method of assessing and planning to reach a desired goal. It includes both cognitive and activity components. This source goes on to suggest that the goal of planned nursing care is to help the individual or the family (the client) reach a state of optimum functioning.

The novel element here is the word dialectic. It is not made clear who is to be involved in the dialectic process, but if patients are to be involved then nursing conducted in such a manner would be a very different enterprise from the depersonalization of task-centred nursing which was discussed earlier. However, this should not be accepted at face value. It would be necessary to know how dialectic is defined in this context. Is it a case of finding a new word to define something which has been defined so often before?

h. Scientific Aspects

The scientific approach to solving problems typically involves four phases and these are: 1. recognising and defining the problem; 2. collecting data from observation or experiment; 3. formulating and implementing a solution; 4. evaluating the solution.

The terms scientific and systematic are of key importance in differentiating between problem-solving and haphazard trial-and-error attempts to meet the nursing needs of patients. The phases in the nursing process (assessment, planning, implementation and evaluation) are similar to the phases in the scientific approach set out above. It might, therefore, be said that the nursing process approach provides a framework for a scientific approach to nursing.

However, important questions arise at this stage. The nursing process approach as characterised so far has had humanistic and scientific perspectives. There is the humanistic perspective with concern for the individual. Humanistic data are sometimes described as 'soft' because the concepts are not well defined or less rigorous methods of data collection are used. Those who defend the humanistic position would argue that it offers rich insights into the human condition which ought to be taken into account. By contrast, scientific data are described as 'hard' since the concepts are more precisely defined and data are collected in a rigorous manner. An additional strength of the scientific approach is its concern with verification and its ability to make generalisations.

An issue which arises concerns the dichotomy between a humanistic and a scientific approach, is it asking the impossible to be humanistic and scientific at the same time? Is it possible to have a scientific approach with a humane face? Does the adoption of a scientific framework make the activity scientific?

Among the writers to use the term scientific are Saxton and Hyland (1975), McFarlane and Castledine (1982), Murray (1976) and Yura and Walsh (1978). There are also texts dealing specifically with the scientific basis of nursing and examples of these are Normark and Rohweder (1975) and Cragg and Rees (1974).

There are however, sources which take a contrary view about the scientific basis of nursing. Orr (1979) asserts that the concept of scientific inquiry in nursing is alien or unknown to many nurses. According to this source the student nurse, in Britain at any rate, has rarely found herself faced with basic epistemological

problems in her practice or education and she goes on to assert that the philosophy of the social sciences and the sociology of knowledge are not concepts that arise in any recognizable form within training. Johnson (1980) comes to a similar conclusion to Orr when he states that much nursing practice is unscientific at present.

The question which arises is where is the truth of the matter to be found. Is the nursing process a scientific approach to nursing? If it is, what are the consequences of planting it in ground as barren as Orr (1979) suggests. Is describing the nursing process approach as scientific blowing it up into something which it is not?

i. Problem-solving Aspects

The nursing process, according to Hargreaves (1979) is basically a problem-solving approach to nursing that involves interaction with the patient, making decisions and carrying out nursing actions based on an assessment of an individual patient's situation. It is followed by an evaluation of the effectiveness of our actions.

The nursing process is seen by some, but not by all, as a problem-solving approach to nursing. Roper, Logan and Tierney (1983a) pose the question 'Problems or Needs?'. They write that the nursing process is often described as a problem-solving activity and, because of this, it has tended to direct nurses to consider patient's problems. But these authors go on to state that some nurses do not like this emphasis, preferring patient's needs.

Duncker (1972, p1) defines problem-solving as follows

"A problem arises when a living creature has a goal but does not know how this goal is to be reached. Whenever one cannot go from the given situation to the desired situation simply by action, then there has to be recourse to thinking (By action we here understand the performance of obvious operations). Such thinking has the task of devising some action which may mediate between the existing and the desired situations. Thus the 'solution' of a practical problem must fulfill two demands; in the first place its realization must bring about the goal situation, and in the second place one must be able to arrive at it from the given situation through action."

Problem-solving is a cognitive activity and it might be argued that while this is a necessary condition within the context of the nursing process it is not a sufficient condition to characterize all that is involved. The cognitive/affective dichotomy might be more imagined than real. However, the nursing process approach based on problem-solving approach does appear to have limitations. Tomlinson (1981, p74) for example, talks of levels of problem-solving; this is something which is not mentioned in the context of the nursing process approach.

PRACTICAL CONSIDERATIONS

a. Basic Elements

A formulation of the nursing process was put forward by Burgess and Lazare (1973) who saw it as follows

"The systematic ordering of cognitive steps that provide the basis of nursing practice. It is a method of careful perception and observation, critical thinking and analysis which leads to a plan of action with a client or patient. This includes the assessment of the patient's status, the plan of nursing actions, the implementation of the plan and the evaluation. For optimal care these sequential steps are used concurrently and recurrently in nursing practice".

Cragg and Rees (1974) view nursing as a desirable human service in that it is a way of assisting persons who are sick, aged, or otherwise incapacitated to cope with their needs in illness and, within existing potential, to regain or attain responsibility of self-care. Self-care is the responsibility of the individual to care for himself in order to maintain his mental and physical health, if self-care is not maintained, illness or death is inevitable. The nurse may guide and instruct other persons to maintain wellness through self-care.

The same authors depict the nursing process as a framework through which the nurse functions to meet specific responsibilities in the provision of patient care. They set out the phases of the nursing process as follows

1. "Assess the needs of patients who have potential and/or actual health problems;
2. collecting information about patient's identified problems, which the nurse uses in stating the objectives to be achieved;
3. developing an appropriate nursing care plan in terms of the data collected and the relevant nursing principles;
4. exercising judgement in implementing the nursing care plan to provide optimum quality of nursing care;
5. evaluating the success of the nursing care plan in meeting the patient's individual needs, adjusting the plan accordingly to assist the patient in restoring and/or maintaining health, and achieving his potential for independence".

When compared with the definition of Burgess and Lazare (1973) given earlier a difference of emphasis is apparent. Burgess and Lazare (1973) emphasise cognitive aspects such as perception, observation, critical thinking and analysis. These are missing from the Cragg and Rees (1974) definition, at least in overt form. However, Cragg and Rees (1974) does take account of 'caring'

aspects and individual needs and could therefore be described as somewhat more humane than the Burgess and Lazare (1973) formulation. Cragg and Rees (1974) do place emphasis on health rather than on just disease. They discuss the notion of self care and the responsibility of the individual to care for himself. They also discuss the teaching component in the nurse's role when they say "the nurse may guide and instruct persons to maintain wellness through self care".

It has been noted in passing that some formulations of the nursing process puts more emphasis on disease than on health. An exception is the book by Murray and Zenter (1975, p76) for it contains a chapter entitled "The Nursing Process: a method to promote health". This source defines the nursing process as follows

"The steps of the nursing process are assessment (identifying needs), intervention (ministering to needs) and evaluation (validating the effectiveness of the help given). In this sequence of operations, using the scientific method, your knowledge plus available resources, will combine with your personality, compassion, and commitment to produce an effective art of nurturing. Thus the nursing process is unique and creative. Understanding this circular process is the key to the formulation of a nursing care plan".

A number of interesting points arise from this definition. The first relates to the hoary argument about whether nursing is an art or a science. The above definition implies that the nursing process is both an art and a science since it includes the terms scientific method and the art of nurturing. Words not met before such as commitment and compassion are used. The nursing process as depicted here would at face value meet the criteria of an open-critical approach, drawing on the scientific and

intuitive as it does as postulated by Tomlinson (1981).

Another point concerns the personality of the nurse. Reference was made earlier to the work of Menzies (1970) in relation to the depersonalisation of patients and nurses which was alleged to have occurred in the task-centred mode of nursing. Whether as a reaction to this state of affairs or not, Hardy (1982) talks of the push for comprehensive patient-centred nursing care. In Hardy's view this could result in a lop-sided approach to nursing since she argues that nursing has to do with interaction between patient and nurse with the ultimate goal of caring helpfully. The definition by Murray and Zenter (1975) does take account of the interactive nature of the nurse-patient relationship. Potential problems, however, remain. What about personality clashes which unfortunately do occur? Perhaps the notion of matching models formulated by Hunt (1971) in an educational context might be worth exploring in a nursing process context.

According to Nordmark and Rohwedder (1975) the nurse is constantly called upon to make independent decisions in the solution of such problems as those concerning patient care, safety for herself and others and interpersonal relationships. Increasingly, she is expected not only to make wise decisions for herself but to guide auxiliary personnel who perform nursing functions. In the process of executing nursing activities, the nurse cannot always find a policy, a "rule of thumb" or a person in authority to assist her when a problem arises. These writers suggest that even if a comprehensive set of rules were available, the habitual use of such rules would be potentially dangerous, in that they could very

likely lead to unthinking and harmful actions because of failure to understand the reasons behind the rule. And they posit the view that as demands for nursing services increase, the professional nurse will become more and more the diagnostician of nursing care problems, expected to devise creative nursing interventions; less and less will she function primarily as a follower of medical orders and an overseer of routine procedures. These writers conclude that it would seem vital that the professional nurse be equipped to solve problems in a wise and resourceful manner.

Nursing as depicted by Nordmark and Rohweder (1975) is a dynamic activity which constantly involves independent decisions. Routine and ritual has no place in this approach and every new problem is considered with renewed interest. Although not specifically mentioned, a scientific perspective appears to be implicated and so do the intuitive aspects because the nurse is expected to devise creative nursing interventions.

However, the formulation is not without its weaknesses. While it puts emphasis on the clinical and managerial role of the nurse, the teaching role is more or less neglected. Another question is whether too much independence is ascribed to the nurse since it might be argued that the delivery of health care ought to be an interdisciplinary enterprise involving teamwork.

b. Views of Practitioners

Theoretical analyses are a necessary but not a sufficient condition when it comes to attempting to understand the impact of the nursing process; account also needs to be taken of the views

of nursing practitioners. In this context it is asserted by Daws (1982) that the nursing process is the most revolutionary and positive thing that has happened to nursing and gives the impression of an opportunity to get out of the slough of despondency and go forward into a new and exciting era of nursing practice.

Rawlins (1983) states that her overall impression of the nursing process in action is the development of a mass of complicated and repetitive paperwork designed more to tie the nurse to the desk than to improve patient care or nurse-patient relationships. Senicle (1982) sees the nursing process as a double-ended weapon and she urges that care should be exercised so that it does not become a rigid framework for nursing. Kirwin (1980) comments that many nurses seem to be so preoccupied with the documentation process that they forget to stand back and consider the quality of nursing care that they are providing. He also expressed the view that the General Nursing Council acted most prematurely by incorporating, without adequate validation, the nursing process as part of the syllabus of training. Gibbons, Bowmaker and Brewer (1983) asks the question whether a pilot study relating to the nursing process was done before its widespread implementation was recommended. These writers were probably fully aware that there was no such pilot study, and they went on to state that it would be ironic indeed if a system which stresses the importance of assessment, planning, implementation and evaluation had not itself been completely evaluated.

c. Implication for Practice

The adoption of the nursing process approach has many implications

for nursing practice but the notion of change is a fundamental issue. The paper by Webb (1981) deals with this matter. According to this source in the previous task-centred approach to nursing theory was not explicit and nursing was taught via practice. In the nursing process mode theory should be explicit and formally taught. Task allocation, hierarchy of tasks, brief visits to patients, little interaction with them and a fixed timetable which are associated with the task-centred mode are contrasted with patient allocation, total patient care, extended periods with patients, greater interaction and a flexible timetable are posited as features of the nursing process.

In the task centred mode the patients and family are ascribed a passive role, little knowledge is shared, there is a fixed ward routine and relationships are seen as undesirable. By contrast, the nursing process mode proposes involvement of the patients and family, much sharing of knowledge, the routine is personalized and relationships are seen as necessary.

On the organisation and pacing of work in the task-centred mode, the sister plans the timetable, the nurse has little control over what she does, the patient is not involved in planning his care and workbooks are ticked. In the nursing process mode nurses are said to plan their own timetables, the patient is supposed to be involved in planning his care.

The nature of the relations between sister and student is different. In the task-centred mode rank is important, there is an explicit hierarchy, sister checks and she is a manager, whereas in the

nursing process mode rank is de-emphasised, hierarchy becomes merely implicit, sister advises and teaches and is seen as a colleague. In the task-centred mode there is said to be privacy of information, with much information being of a verbal type, and stereotyped reports. This is contrasted with the nursing process mode where taking a full history is recommended, where the emphasis is on written information and on personalized reports.

The final point in Webb's (1981) list of comparisons concerns power and communication. In both modes medicine dominates. Vertical communication, and brief reports are seen as characteristic of the task-centred mode; whereas horizontal communication, discussing and teaching, and increased written communication are associated with the nursing process mode.

The comparative analysis by Webb (1981) of task-centred nursing and the nursing process is useful since it brings to our attention a great number of points which are relevant and ought to be taken into account in any discussion of current issues in nursing.

However, this analysis cannot be accepted uncritically. Is this an idiosyncratic analysis of the issue or is it one which would command wide support? Are the dichotomies as clear cut as Webb suggests? One can only agree with Webb when she asserts that the questions raised can only be answered by empirical research.

The fundamental implication for nursing practice is its effect on the standard of nursing care. Hayward (1986) reported that "as yet it is not possible to say with any conviction that implementation of the nursing process has improved the lot of patients".

Richards and Lambert (1987) compared the effect of the nursing process and traditional care with two patient groups and they concluded that patients in the nursing process group did not feel nurses were significantly more therapeutic nor were they more satisfied with their care. However, Miller (1985) showed that when the nursing process was used with long stay patients it had beneficial effects, but the same was not found with short stay patients.

This evidence is not encouraging but more data would be needed before it would be possible to come to any conclusion relating to the implications of the nursing process approach for patients.

d. Management Aspects

The nursing process approach is currently the focus of attention in nursing circles, but before the nursing process appeared management issues held the ring for quite a time. The Salmon Report (1966) led to changes in the career structure, work methods and responsibilities of senior nurses in management, but it is arguable how much impact the management movement had on nursing at the level of the hospital ward. It is interesting to note that planning, an element of functional management, is also one of the phases of the nursing process. (Assessment, planning, implementation and evaluation). It therefore appears to be necessary to consider the management implications of the nursing process. Blake and Towell (1982) talk of the management cycle which is fundamental to ensuring individualized patient care at ward level. Pembrey (1980) found that individualized patient care was dependent on the quality of the management. Where ward sisters were not effective managers, it was also the case that the nursing process was either poorly implemented or not implemented at all. Despite all the education

of nurses in management which has taken place Clarke (1978) makes the point that planning is not included on the job descriptions of the ward sister/charge nurse. These, of course, are key people since they are the most senior nurses working at a clinical level.

There is some evidence that a dependency relationship exists between the nursing process and the management process. Nevertheless, some questions remain. Is management an integral part of the nursing process and should it be included in the nursing curriculum? What is the nature of the management skills which are necessary in order to ensure the successful implementation of the nursing process. There has been criticism that the management education offered to nurses is frequently based on industrial and business practices and that these are not wholly appropriate in a nursing setting.

e. Teaching and Learning Aspects

A number of writers have addressed themselves to the teaching and learning aspects of the nursing process approach. These include Alexander (1979), Crow (1979), Daws (1988), Docking (1980), Goodall (1988), Greenwood (1988), Grubb (1979), Henderson (1982), Hollingworth (1979 and 1986), Kershaw (1979), Lewis (1981), Luker (1979), Moss (1988), Roper (1981), Smith (1987), Webb (1979) and Whitfield (1983).

The points raised by these sources in relation to the nursing process are of a varied nature. Carter (1979) asserts that many nurse educators today seem caught in a tug between two philosophical schools of thought, humanism and behaviourism, and give

evidence of this in their teaching. This source goes on to say that nurse teachers espouse a humanistic philosophy as a basis for clinical practice, for example, advocating to students that a patient be a partner in planning his care. At the same time, they use strategies derived from behaviourism, for example, expecting students to learn through programmed instruction and to measure up to standardised behavioural objectives. Martin and Sheehan (1985) dealt with the issue of behavioural objectives and the attitudes of nurse tutor students towards them.

Crow (1979) based her approach on Henderson's (1966) list of 14 points which were intended to provide a framework for nursing care. (1. breathe normally, 2. eat and drink adequately, 3. eliminate by all avenues of elimination, 4. move and maintain desirable posture, 5. sleep and rest, 6. select suitable clothing, dress and undress, 7. maintain body temperature within normal range by adjusting clothing and by modifying the environment, 8. keep body clean and well groomed and protect the integument, 9. avoid dangers in the environment and avoid injuring others, 10. communicate with others in expressing emotion, needs and fears. 11. worship according to faith, 12. work at something that provides a sense of accomplishment, 13. play or participate in various forms of recreation, and 14. learn, discover or satisfy the curiosity that leads to 'normal' development and health.) Crow (1979) then formulates objectives in the manner depicted by Carter (1979). She goes on to state that the nursing process is a good teaching tool as it requires a nurse to acquire and apply knowledge of both the natural and social sciences.

Heath and Marson (1979) offer what they call a nursing process taxonomy. What they have done is to take the four components of the nursing process (assessment, planning, implementing and evaluating) and related them to the taxonomy of educational objectives in the affective domain after Krathwohl, Bloom and Masia (1964).

Alexander (1979) found that the nursing process was a valuable tool in the planning and delivery of patient care. She does, however, make the point that it demanded patience and determination as well as a flexible critical approach.

Dealing with the issue of relating theory to practice Grubb (1979) states, and many would probably agree with her, that nurse learners used to believe that theory was for the classroom and practice for the wards. She asserts that the concept of the nursing process is changing this view and learners now appreciate the value of intergrating theoretical and practical skills and assessing actual and potential nursing problems in meeting the needs of patients. Is this change is taking place it is to be welcomed. However, Mallick (1977) claimed that there is a huge gap between nurses understanding of nursing process theory, on the one hand, and their ability to apply it in practice, on the other.

Thompson (1979) puts forward the view in relation to the nursing process that it is not just the introduction of new forms to be completed. It should be a revolutionary way of thinking about patients. Is it a revolutionary way of thinking about the patient and has nursing education adjusted accordingly?

Much of what has been said so far about the educational aspects of the nursing process has been based on the experience of practitioners rather than on a formal study of the subject. An exception is the paper by Missenger and Munjas (1981) which deals with the nursing process, student attributes and teaching methodologies. The approach adopted in this study, although no mention is made of it, has similarities with Hunt's (1971) matching models approach. It was found, perhaps not surprisingly, that the most used teaching methodology was teacher-dominated presentation: the least used was what is described as individual conference. It was also found that a significant predictive relationship existed between the ability to use the nursing process, and inference ability, locus of control and minimal time spent in small group discussion. Too much cannot be read into one study, but it is useful to have evidence based on studies of this nature.

Many of the sources dealing with the teaching of the nursing process seem to adapt the approach of grafting it on to the existing framework with perhaps minor adjustments to take account of the novel feature in the nursing process. An exception is McFarlane (1983). She advocates nothing less than a reform of nursing education. She asserts that this is needed to provide a knowledge base for the assessment of nursing needs and the prescription of nursing care. McFarlane (1983) goes on to make the point that the content of knowledge is not the major requirement in the reform of nursing education and argues that if the nurse is to use a decision making process, is to use knowledge as a basis for nursing, if she is to exercise autonomy and be accountable, then she will need equipping with different skills and thought

mechanisms. The inductive/deductive dichotomy was mentioned earlier (McGlynn 1983), perhaps this is what is meant by new thought mechanisms, perhaps it is something else).

McFarlane (1983) goes on to suggest that there is a need for a major move from expository learning towards insightful (Gestalt) learning and autonomous learning strategies. And she argues that some of the characteristics and competencies we are looking for in are those of the self-actualizing individual. The United Kingdom Central Council - UKCC (1986) has proposed a reform of nursing education and these are currently being considered by the Department of Health. Whether the timing of this reform is apt from the point of the nursing process is another matter.

Thompson (1979) spoke of the nursing process as a revolutionary way of thinking about the patient. If this is so then perhaps the educational system ought to be reformed to take account of what appears to be a far reaching change in nursing. Perhaps the reform of nursing education could address itself to the dichotomy, already mentioned, of humanistic nursing care and behaviouristic nursing education. Such an interpretation would be possible in the case of the UKCCs 'Project 2000'.

One group of people who have not been much studied in the context of the nursing process is the nurse teachers. It is true that nurse teachers have written about the nursing process but there has been few formal studies of this group. How is the nursing process construed by nurse teachers? This is a potentially important question since in another context Barker-Lunn (1970)

showed that teachers were very significant when it came to change in educational practice. Streaming in primary schools, the subject of Barker-Lunn's (1970) study and the reform of nursing education may not appear to have much in common since the contexts are so different. However, since Barker Lunn showed how important the views of the teachers are, it would be unwise not to take them into account in the context of the nursing process.

f. Professional Aspects

Is nursing a profession? Views are very divided in relation to this question. The Briggs Report (1972) was unequivocal about the issue when it described nursing as 'the major caring profession'. Perusal of the literature reveals a good number of sources who more or less come down on the side that nursing is a profession. These include Altschul (1977a, b), Jacobi (1977), Austin (1978), Rule (1978), Smith (1978), Wyatt (1978), Auld (1979), McCloskey (1981), and Jones (1983). Those holding the view that nursing is not a profession include Katz (1969), Dingwall (1974), Chapman (1977), Bowling (1979), Cox (1979), and Salvage (1979). There is, therefore, a good deal of conflict in relation to this issue. And, inevitably, the question of the professionalism and the nursing process has been raised.

Blake and Towell (1982), for example, write of the significant professional impetus towards revitalizing nursing practice through the widespread implementation of the nursing process. Webb (1981) makes the claim that nurses should derive greater satisfaction through relationships with patients, and a rise in their professional status which comes from more autonomy in their work.

Dickinson (1982) takes a rather different view of the issue. She accepts that the nursing process is offered to nurses as a means of furthering their professional status and autonomy; but she doubts the nursing process will help to achieve these objectives because analysis suggests that features of the nursing process designed to improve the quality of service may not be compatible with the achievement of professional status and autonomy. She also states that such autonomy would be likely to be resisted by the medical profession, which is probably true.

RESEARCH IMPLICATIONS REGARDING THE NURSING PROCESS APPROACH

The introduction of the nursing process approach to the world of nursing in the United Kingdom has generated a great deal of discussion and debate. The testimony for this assertion is the considerable volume of literature relating to the subject.

The rationale for the empirical research which it is proposed to undertake for this study is based on four reasons.

In the first place, the evidence emanating from the review of the literature so far indicates that there are varying construals of the nursing process approach amongst the formal writings encountered. It seems to mean different things to different writers.

Second, this diversity of the nature of these formal construals point to a need for a study aimed at establishing the nature and possibly similar variation in conceptions of the nursing process approach held by members of the profession generally, and in particular nurse teachers. Moreover, previous research by, for example, Crow (1977), Pembrey (1978), De La Cuesta (1979), Hollingworth (1982), Rhodes (1984) and Pearson (1986) have not been formally concerned with such

everyday working conceptions of the nursing process approach. Brooking (1986 & 1988) might be thought a possible exception, but she was concerned with developing a measuring instrument relating to the use of the nursing process rather with the concepts held by respondents. The need for a study of conceptions of the nursing process approach is reinforced by Walton's (1986) study. This was a review of the literature relating to the nursing process and in it over 600 sources are cited. Perusal of the titles reveals no explicit indication of empirical attention held by participants.

The third reason concerns the fundamental nature of concepts. Modern psychologists such as Tomlinson (1981, p66) assert that our knowledge and understanding are basically conceptual, for we use concepts to include things or exclude things with respect to particular classes or categories. An analysis of the concept and an empirical investigation of the nursing process approach appears to be a potentially worthwhile area of study.

Fourth the writers interests are in nursing education, particularly the education of teachers of nursing. For these reasons it is proposed to investigate the nature of the nursing process concept with particular reference to teachers of nursing but with comparisons with clinical nurses.

CHAPTER TWO

MODELS OF NURSING

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CHAPTER TWO

MODELS OF NURSING

INTRODUCTION

The conceptual nature of the nursing process is the principal concern of this study. However, it is the case the nursing process approach is commonly used in conjunction with models of nursing. It is therefore necessary to consider models of nursing in order to provide the context for using the nursing process. It is proposed to consider the background, theoretical and practical aspects of some models of nursing.

BACKGROUND

a. The Origins of Models Generally

According to Lippett (1973) conceptual models have existed since people began to think about themselves and their surroundings. He identified examples of models in the early Egyptian and Chinese civilizations and in disciplines such as physics, medicine, mathematics, chemistry and biology. Lippett (1973) made the point that models were influential in shaping the world. Examples given in this context were Marx and Engels (1968). Einstein (1950) and Sigmund Freud (1914). Marx's model related to political, philosophical, social and economic matters and provided a framework for communist ideology. Einstein's model of relativity paved the way to the atomic era. Freud's model provided a structure for the understanding of man in the context of psychoanalysis.

b. The Origins of Nursing Models

An early British paper on nursing models is that by Roper (1976).

The model described is based on the activities of living. A lot was claimed for this model, though in a tentative manner. The author asserts that use of the model could help to produce research-minded nurses, could give value and prestige to helping patients with their activity of daily living and so on. The tentativeness of the proposal is shown by the repeated use of the word could.

Roper (1976) dealt with one model, that is, the one she formulated herself. However, Jones (1977) takes a more eclectic approach and mentions half a dozen models which might be used such as Abdellah et al (1960), Henderson (1966), King (1981), Newman (1971) and Riehl and Roy (1974). Jones (1977) asserts that the function of a model is to ensure a complete assessment for a client's needs for care. As well as the models mentioned Jones (1977) also suggests that a nurse might develop her own model.

Craig (1980) was concerned with theory development in nursing and made the point that nursing models are being used more to guide practice. Examples she cited are Roger's (1970) life process system model; Johnson's (1980) behavioural systems model; Peplau's (1952) developmental model and Orlando's (1961) interactional model. The proliferation of nursing models is highlighted by the fact that the four models named by Craig (1980) does not include any of the six named by Jones (1977).

Do some models present a restricting view? This was the question posed by Hardy (1982). Later on in the article the assertion is made that existing models appear to encourage an elitist pre-occupation with higher thoughts on research for the sake of

knowledge rather than the reality of practice. This source does not pour cold water on the idea of models but asks nurses to examine them with discerning eyes because blind acceptance of any nursing model is questioned. The point is also made that no one model provides a true picture for all nursing situations.

An article by Ross (1983) on the activities of living acted as a curtain raiser for a series of articles by Roper, Logan and Tierney (1983 a, b, c, d, e, f). These articles deal with the Roper (1976) model already mentioned. In the first article the authors link the nursing process and nursing models as follows.

"What makes the 'process' a process of nursing?
The answer is when it is used with an explicit
framework which is unique to nursing - a nursing
model."

This is a useful link to make because in some peoples minds it is not clear why the nursing process and a nursing model need to be used together.

Aggleton and Chalmers (1984 a, b, c, d and 1985 a, b, c, d) deal with nursing models in an eight part series of articles. The first articles was devoted to defining the terms and then the Roy (1980) adaptation model; the Riehl (1980) interaction model; the Rogers (1970) unitary field model; the Orem. (1971 & 1980) self care model; Roper's (1976) activities of living model, and Henderson's (1966) model. In the final articles in the series these authors attempted to put the nursing process and nursing models in perspective.

They make the point that models of care are likely to have something to say about the following aspects of patient or client care:

1. The nature of the person receiving (or about to receive care).
2. The causes of the problems which are likely to require care - related intervention.
3. The nature of the assessment process.
4. The nature of the planning and goal setting process.
5. The focus of intervention during the implementation of the care plan.
6. The nature of the process of evaluating the quality and effects of the care given.

When considering nursing models it is right to put the clients/ patients first; but how they related to nurses learning about nursing is also a legitimate matter for concern. Green (1985) looked at nursing models from the point of view of their value in relation to education and she concluded that nursing models provide a wide vista of insight into the nature of nursing which education-ists should not neglect.

c. The Need for Nursing Models

The nursing process approach is the means of currently delivering nursing care. However, the stages of the nursing process (assessing, planning, implementation and evaluation) are in no way specific to nursing and may be applied to any human activity. Smith (1987) put it bluntly when discussing the nursing process for she wrote "It is a simplistic process".

A number of writers have dealt with the relationship between the nursing process approach and nursing models. Ross (1983) makes the point that in order to make an assessment of a patient we need to know what to assess. The function of a nursing model is to provide a framework for assessment.

Ross and Bourbonnais (1985) suggest that the adoption of a nursing model for practice involves an "exploration of one's personal philosophy about the essential units of nursing and their relationships". These authors suggests that these units ought to include the person, the environment health and nursing as put forward by Fawcett (1978).

Jones (1977) sees models as a framework for ensuring that the needs of patients are properly assessed. A similar point is made by Stephenson (1987) when in the conclusion of her article she writes "The use of models of nursing as a guide to care in the 1980's is simply a development and a creative way of re-examining assessment, care planning, delivery and evaluation...."

Nursing models are needed for a number of reasons. The first being the non specific nature of the nursing process approach whose stages may be applied to any activity. Models therefore provide a framework for the assessment of patients. At the most basic level this framework embodies concepts about the person, the environment, health and nursing, though particular formulations of models, take account of much more than this. As well as providing a framework for assessment nursing models also embody a value system relating to views about man. One model, Orem (1980), makes self-care the ideal to strive for. Another, Roy (1980) makes adaptation to threats to the integrity of the individual the principal concern. To the extent that nurses identify with these values, they are a potentially powerful force.

THEORETICAL CONSIDERATIONS

a. Defining the Term Nursing Models

Before considering models of nursing, it is necessary to consider what is meant by the term model. Page and Thomas (1977 p223) define model as a means of transferring a relationship from its actual setting to one in which it can be more conveniently studied. The key elements of this definition are that a model is an abstraction from reality and that it is concerned with relationships. However, models need to be considered in relation to nursing to determine the meaning ascribed to them in that context.

According to Riehl and Roy (1974) models are constructs related to theory. A model is not really itself, but an abstract and a reconstructed form of reality. A construct is taken to be something that cannot itself be directly observed. A model, according to Jacox (1974), can be a visual, verbal or symbolic representation such that a theory in one field may be used as a model in another. According to Fawcett (1984) the concepts of a conceptual model are highly abstract and generalised. They are not directly observed in the real world nor are they limited to any specific individual, group, situation or event. Adaptation is given as an example of a conceptual model. The writer asserts that it can refer to all types of individuals and groups, in a wide variety of situations. It is also asserted that models are usually defined loosely, if at all. The point is made that adaptation might be defined as the ability to adjust to changing situations.

b. Models and Paradigms

McKay (1969) makes a distinction between entities (models) used in symbolic representation of reality and concepts (paradigms) used as symbolic representations of reality. It is posited that the

model describes structures, while the paradigm describes process. It is asserted that the usefulness of either of these symbolic representations in helping a better understanding of complex phenomena is dependent upon the degree of congruence between the model paradigm and the reality it represents; the greater the degree of congruence, the greater the usefulness.

Jacox (1974) states that a theory on one field may be a model in another. Dickoff and James (1968) define a theory as a conceptual system or framework invented to some purpose, McGlynn (1983) claims that the term model is a much broader concept than the term theory. The former is an image of the whole thing, while the latter refers to the principles and propositions operating within the model.

Other sources to pick up the different uses of the term model include Johnson (1983) for he writes "... nurses used differing definitions of theory and use words like model, conceptual framework, theoretical basis and concept loosely". When dealing with models Crow (1981) described it as "term which we use far too loosely".

Why so many definitions? Why so many meanings of words like theory, model, conceptual framework, concept and so on? Is it the case that the nature of nursing is so complicated that no single definition will suffice; or is it the case that nursing can accommodate a variety of individual interpretations about its nature without serious damage being done to the practice of nursing? Alternatively, is the vagueness over terminology which has been shown to exist the result of sloppy thinking in the first

place? It is proposed to keep an open mind in relation to these questions. However, it will be necessary to keep in mind that terms may have different meanings when it comes to considering models of nursing. Hayward (1986) used the term conceptual quagmires in relation to conceptual frameworks and models.

c. The Theoretical Basis of Some Nursing Models

A search of the literature has resulted in finding several models of nursing. Examples of sources consulted include Clark and Bishop (1988), Chinn and Jacobs (1983), Crow (1982), Griffith-Kenney and Christensen (1986), Luker (1985 and 1988), McKenna (1989), Riehl and Roy (1980) and Uys (1987).

Chinn and Jacobs (1983) compare eleven models of nursing. Griffith-Kenney and Christensen discuss 21 nursing models in some detail. McKenna (1989) makes the assertion that at present there are some 40 nursing models. He does not, however, list these models. Riehl and Roy (1980) include and discuss ten models in their book. There thus appears to be a large range of nursing models in existence.

It is now proposed to attempt to identify the theoretical bases of a representative sample of nursing models. Some of the sources make reference to explicit bases for example, systems theory so that those present little difficulty when it comes to classifying them. Others make no overt reference to any theory; the classification arrived at is therefore that of the writer and it is based on interpreting the written work of the sources concerned. It should be stressed, however, as has been indicated in the comments, it is very much a case of more or less in relation to where a model is

placed. Models described as behaviouristic or humanistic were not always overwhelmingly so. The classification of models is set out in Figure 1. The classification of nursing models by others such as Riehl and Roy (1980), Griffith-Kenney and Christensen (1986) and Chinn and Jacobs (1983) is acknowledged. No claim is made for the supremacy of the present classification over that of any others, the intention is that it should be considered along with them.

Putting theory first in Figure 1 and the model second raises some questions in relation to the view expressed earlier by McGlynn (1983) who considered that the term model is much broader than the term theory. If that view were accepted then model should come first and theory second, since more than one theory may be involved. However, if we consider the nature of nursing, it involves interaction between at least two people (the patient and the nurse). It might, therefore, be argued that it would be appropriate to base the model on a theory which is concerned with explaining this type of interaction. This would not mean losing sight of the other perspectives: they would be subsumed within the approach.

d. Systems Theory

Bertalanffy (1968 p540) already cited in the previous chapter writes "The meaning of the somewhat mystical expression 'the whole is more than the sum of the parts' is that constitutive characteristics are not explainable from the characteristics of isolated parts". An aim of general systems theory is to integrate the various sciences, natural and social through the basic and very general notion of a system. This uses the general notions of elements which have dynamic interplay both with other elements within the system and

THEORY	CONCEPTUAL MODEL OF NURSING PROCESS	MAJOR REPRESENTATIVES	COMMENTS
BEHAVIOURISTIC	Adaptation to stress	Saxton and Hyland	While the model has behavioural features, it also has features which would enable it to be categorised under systems theory.
COGNITIVE	Problem-solving	Cormack Weed	While the model is based on a problem-solving approach, it also has features which would allow it to be considered within systems theory.
HUMANISTIC	Human needs	Henderson	<ol style="list-style-type: none"> 1. Henderson's model is strongly but not exclusively humanistic. 2. Maslow's hierarchy of human needs is implicated in most models of nursing, but is not exclusive to any one model.
SYSTEMS	Holism	Abdellah, patient-centred Johnson, behavioural systems King, transactional Neuman, total patient Orem, self-care Orlando, interactional Replau, interpersonal Rogers, life process Roper, activities of living Roy, adaptation Yura and Walsh, health care.	All the representatives in this section adopt a holistic approach, but within this framework each is associated with a particular emphasis as indicated.

Figure 1. A Classification of Nursing Models.

with other element sets systems, the combination of such interactions having continuing implication for the nature of the system (feedback and self-regulation).

Nursing draws on knowledge from the natural and social sciences so that there would seem to be a need for a unifying theory such as general systems theory. There might in fact be a case for considering all nursing models within the framework of general systems theory. This would provide a theoretical basis for nursing with sufficient scope to account for the constituent elements. Such a step might help to clear some of the confusion surrounding the matter about whether a theory has greater scope than a model, or conversely; since the notion of the sum of the whole being greater than the sum of the parts might help to guide thinking in relation to the issue.

e. A Framework for Analysing and Evaluating Nursing Models

When dealing with nursing models Fawcett (1984 p38) differentiates between analysis and evaluation. According to this source analysis is an objective breakdown of statements into their component elements. It is done to identify concepts, relationships between concepts, and any hierarchy of ideas contained in the model. The intention of analysis is to clarify statements and to indicate their organisation.

Evaluation involves judgements about the value and logical structure of the conceptual model. Such judgements are made by determining the extent to which the model satisfies external criteria and meets certain standards. The evaluation of a model enables conclusions to be made about its validity.

Fawcett (1984) sets out a number of analytical questions as follows:

1. What is the historical evolution of the conceptual model?
2. What approach to the development of nursing knowledge does the money exemplify?
3. How are nursing's four metaparadigm concepts explained in the model?
 - a. How is the person defined and described?
 - b. How is environment defined and described?
 - c. How is health defined? How are wellness and illness differentiated?
 - d. How is nursing defined? What is the goal of nursing? How is the Nursing Process described?
4. What statements are made about the relationships among the four metaparadigm concepts?
5. What areas of concern are identified by the conception model?
6. What is the source of these concerns?

Fawcett (1984) also sets out an equally comprehensive set of evaluation questions as follows:

1. Are the assumptions underlying the conceptual model made explicit?
2. Does the conceptual model provide complete descriptions of all of nursing's metaparadigms?
3. Do the propositions of the conceptual model completely link the four metaparadigm concepts?
4. Is the internal structures of the conceptual model logically congruent?
 - a. Does the model reflect more than one contrasting world view?

- b. Does the model reflect characteristics of more than one category of models?
- c. Do the components of the model reflect logical translation of diverse perspectives?
- 5. Is the conceptual model socially congruent?
 - a. Does the conceptual model lead to nursing activities that meet social expectations, or do the expectations created by the conceptual model require societal changes?
- 6. Is the conceptual model socially significant?
 - a. Does the conceptual model lead to nursing actions that make important differences in the client's health status?
- 7. Is the conceptual model socially useful?
 - a. Is the conceptual model comprehensive enough to provide for practice, education, administration, and research?
 - b. Does the conceptual model generate empirically testable theories?
- 8. Do tests of derived theories yield evidence in support of the model?
- 9. What is the overall contribution of the conceptual model to nursing knowledge?

f. The Elements of Nursing Models

When it came to defining the nursing process a large number of factors were included and it seems, therefore, that virtually nothing can be excluded. A similar state of affairs seems to exist in relation to nursing models, in that a great variety of elements are

involved. These include, for example, the activities of living, the concept of adaptation and the activity of assisting. Communication skills, competence, compassion, and cognitive skills are implicated, though the degree of emphasis varies. Some models stress the dignity of the individual while others bring economic and emotional aspects into play. Empathy is seen by many as important. Some models take account of the family as well as the individual; others focus on health and health care. The interactive nature of nursing is reflected by most models. Some models focus on human needs, even though this is not a well defined concept. There is varying degrees of emphasis on the prevention of illness and the promotion of health, but the phases in the process of nursing are mostly, but not exclusively, given as assessment, planning, implementation and evaluation. Psychomotor skills are given varying degrees of prominence. Most models include or imply that nursing knowledge is drawn from the physical, biological, social and behavioural sciences, though the emphasis given to these does vary. Self care and independence is included in some models, others mention the concepts of service responsibility for patient/clients. The spiritual and social aspects appear with varying degrees of emphasis; understanding, worth and worthwhileness crop up fairly frequently, particularly in models having a humanitarian orientation.

What is included in a model of nursing seems to be rather like what is included in a cake. Many of the ingredients are common to all models but the actual mix in a particular model puts more emphasis on one ingredient or group of ingredients than another. It may, however, be said there are more similarities than differences between models. The similarities are those of substance and the

differences are those of emphasis and semantics.

The theoretical underpinning of most models of nursing is provided by systems theory, although this is not always stated explicitly. But Altschul (1978) states that while nurses have not used systems language, nor on the whole, have they consciously appropriated techniques and knowledge from systems analysis, it seems inevitable that systems theory will sooner or later affect their thinking.

It has been necessary to consider models of nursing since the study aims to find out how the nursing process is construed; and it would be a matter of interest to know whether or not these construals relate to the models depicted in the literature. Are models of nursing the result of acts of cerebration by theoreticians in ivory towers and of interest mainly to other theorists; or have they been assimilated into, for example, the construals of teachers of nursing? Empirical evidence would be needed to answer that question, and it is hoped that the empirical part of this study may provide such evidence.

PRACTICAL CONSIDERATIONS

a. The Place of Nursing Models in Assessing Patients

There is evidence that nursing models have succeeded in establishing a place in nursing practice as the following examples from the literature show. Those who write about nursing models at a practical level include Brooker and Simmons (1985), Chavasse (1987), Jones (1988), Lister (1987), Moir (1986), Ross and Bourbonnais (1985), Walsh and Judd (1989), Wilding, Wells and Wilson (1988), and Wilson (1988). Nursing models are most frequently implicated in the assessment phase of the nursing process approach to nursing.

How a nurse assesses a patient will depend on the ideas about nursing which underpins her actions. Each model of nursing has a different set of values and thus embodies a different concept of the person. This may be illustrated by examining the focus of the Orem (1980) and the Roy (1980) models.

According to Orem (1980) the patient is seen as an individual situated somewhere on a continuum between dependency and self-care. The nurse's aim is to assist the patient to achieve self care. This is done by identifying deficits in functioning and giving help to overcome these functional deficits when the Orem (1980) model is used to guide the assessment of a patient; the assessment is concerned with identifying self-care requisites, demands, deficits and capabilities.

In the context of the Roy (1980) model the patient is viewed as comprising biological, social and psychological components. The key concepts are imbalance and adaptation. When functional imbalance occurs, there is adaptation to the imbalance. This role of the nurse comprises helping the patient to adapt to the internal or external changes which have occurred. Adaptation involves recognising the imbalances and using coping mechanisms to adapt. In the assessment of a patient using the Roy (1980) model revolves around four modes of adaptation: physiological, psycho-social, interdependence and the self concept.

It is now proposed to examine examples of nursing models which appear in the literature in order to appreciate the different approaches embodied in each.

b. King

The approach model proposed by King (1971) is to assist man to attain, maintain or restore health by assisting man to meet his basic needs. Transactions, the provision of service, giving care, guiding and counselling, are central to this model. The nursing process is perceived as a series of acts involving action, reaction, interaction and transaction. The model takes account of the patient's perception, goals, values, needs and expectations on the one hand and those of the nurse on the other. Man is considered as being at the centre of three general systems namely social interpersonal and personal.

c. Rogers

The aim of the model proposed by Rogers (1970) is intended to assist man to achieve maximum health potential by promoting interaction between man and his environment. Through the use of intellectual skills, technical skills, manual skills and human relations the appropriate care is provided. The nurse is regarded as a factor in the patient's environment, provides services and promotes interaction. The response of the patient is a key factor in the process. The nursing process comprises gathering data, making a nursing diagnosis, setting goals and nursing intervention. The dynamics in relation to the nurse are knowledge, technical skills and human relations; those relating to the patient concerning his position with regard to his human and environmental fields. The process is terminated when the potential or real problem in the life process is solved.

d. Roper

The activities of daily living form a foundation for Roper's (1976)

model. This model has a lifetime span from conception to death. In this model the living person required help with or takes part in four groups of activities, namely 'daily living', 'preventing', 'comforting', and 'seeking' activities. According to Roper (1976) the term activities of daily living was chosen in preference to basic human needs because the word 'need' has a negative connotation while the word 'activities' has a positive connotation, even when a person requires help with his activities of daily living.

Roper (1976) itemised 12 activities of living as follows: breathing, feeding, eliminating, personal cleansing, dressing, mobilizing, talking, socializing, working, playing, relaxing and sleeping. The preventing activities are concerned with matters of health education such as taking measures to prevent, for example, such things as accidents, infections, obesity and unwanted pregnancy. Comforting activities are seen as supporting the activities of daily living mentioned above. Seeking activities might, for example, relate to information about matters of diagnosis, prognosis and the need to plan for the future. As with comforting, seeking is also a supporting activity.

According to Roper (1976) to perform the activities of living components a nurse requires well developed cognitive, affective and psychomotor skills. She argues that if cognitive skills are not used a nurse is merely fulfilling her mothering need as, for example, when she dresses a patient where the appropriate activity would be to withhold physical help and give psychological support while the patient fastens the buttons, thus fulfilling his need to regain his independence. Roper (1976) goes on to state that the

acquisition and restoration of independence involves a nurse's perception of the patient's level of ability and the delineation of attainable objectives for nurse and patient in relation to time: it is often necessary to state short-term and long-term objectives.

e. Yura and Walsh

Yura and Walsh (1978) relate their model of nursing explicitly to general systems theory. When discussing the theoretical framework for nursing they write "General systems theory seems to be applicable in a broad way" (p42). These authors go on to suggest that their model is appropriate for the well person or the family or for the acutely ill or for the chronically ill according to the situation. They assert that it can be used by nurse practitioners in whatever setting the client or family is in.

RESEARCH IMPLICATIONS REGARDING NURSING MODELS

Nursing models have a relatively short history in the United Kingdom. The nursing process approach entered the field of nursing with a high profile. Nursing models have had a much lower profile, but they are becoming steadily established in the language, literature and practice of nursing.

Nursing models have been the subject of some criticism. Grahame (1987) writes that nurses are beginning to revolt against the jargon and time wasting of nursing models. Examples of jargon given by this source are "disruptive wellness" "repatterned energy fields" and "significant life crises". Grahame goes on to state that "wellness", a word associated with models (Fawcett 1984), does not appear in the Oxford Dictionary, for example.

Another ground for criticism concerns the use of the term framework. A framework may be seen as providing guidance for an activity. But a rigid framework may be seen as a strait jacket and therefore not desirable. A framework ought to be flexible enough to allow for growth and development as well as providing for the generation of creative theories and the basis for innovative and imaginative practices. As models develop, these are the criteria by which they ought to be judged.

A positive viewpoint has been set out by Aggleton and Chalmers (1987) who wrote ... "models of nursing can act as useful organising devices around which care can be planned and delivered". A more or less similar point was made by Field (1987) when she wrote "Nursing models give shape to the components, begin to define nursing, and direct the goals of nursing care". Aggleton and Chalmers (1986) is a source which is relevant to this context.

There appears to be two implications for research in this area. First, since the nursing process and nursing models are meant to be used in tandem it seems appropriate to investigate the extent that this is seen to be sacred by nurses themselves. Second, since the nursing process approach and nursing models are used together, the nature of the the relationship perceived between them is a matter of interest. Is the relationship one of compatibility, incompatibility, or is it found problematic? It is true that there are some sources dealing with the nature of this relationship, but it is contended that there seems to be a need to investigate the matter further and it is proposed to do this in the empirical part of the study.

CHAPTER THREE

CONCEPTS

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CHAPTER THREE

CONCEPTS

INTRODUCTION

Do we understand the nursing process? This was the question posed by Ride (1983) and the answer seems to be no. He writes that "As nurses we have written widely about the nursing process, our statutory bodies have determined that nursing should be taught on the basis of the nursing process, whether or not the teachers understand what that means....". There is likely to be more than one answer to the question why the nursing process concept is not understood, but it is probable that the issue of concepts will be involved. One problem is likely to be the variety of intensional meanings attached to the label "nursing process". A second issue relates to the nature of the past experience of nurses. Task-centred nursing and the nursing process approach are radically different approaches to nursing.

Another important point has been raised by Ride (1983) concerning whether or not the teachers understand what the nursing process means. Tomlinson (1981 p66) makes the point that our knowledge and understanding are basically conceptual. Now if it is the case that the nursing process is not well understood by teachers of nursing; this would, perhaps, explain why it is not well understood by nurses generally. It is hoped that the present research may throw some light on how the concept of the nursing process is construed by teachers of nursing and clinical nurses also.

In this chapter it is proposed to examine the nature of concepts generally and concepts in a nursing context.

THE NATURE OF CONCEPTS

a. Defining the term concept

When it comes to defining the term concept Drever (1964 p47) simply writes 'see conceptions'. He then defines conception as "That type of cognitive process which is characterized by the thinking, aspects and relations of objects at which therefore comparison, generalization, abstraction and reasoning becomes possible, of which language is the great instrument, and the product the concept - normally represented by a word". However, Page and Thomas (1977 p91) do not hesitate to define the term concept which they do in the following manner: "General mental notion of things or events arrived at by processes of perceptual classification and discrimination, used as a basis for thought and expressed through symbolic language. Concepts can be thought of as lower or higher order, or as from the easily imagined to the highly abstract".

Vinacke (1952) summarised the meaning of the term concept. According to this source a concept is basically a system of learned responses the purpose of which is to organise and interpret the data provided by sense perception. It is asserted that past experience is automatically applied to present contingencies through the use of concepts. Vinacke (1952) suggests the following criteria for defining concepts:

1. Concepts are not themselves sensory data but systems which are products of our past responses to characteristic situations.
2. Using concepts is simply applying past learning to a present situation.
3. Concepts relate discrete sensory data.
4. In human beings words or other symbols are the means of lining discrete items of experience.

5. Concepts have at least two ways of functioning; the extensional use and the intensional use.

Bolton (1977 p23) defines a concept as follows: "A concept may be defined, then, as a stable organisation in the experience of reality which is achieved through the utilization of rules of relation and which can be given a name".

Despite the varying terms and emphases in these definitions, they share the idea that concepts involve individuals using internal criteria (intensions). What would count as the instances (or reference) of the class in question. Our question, then, is whether "the Nursing Process" indicates a concept or stable organisation of experience that is shared amongst nurses, or whether the phrase labels different concepts/meanings for different nurses, and what the context is of any of these.

b. Concept Formation

Concept formation as a process of development from childhood to adolescence takes place by way of "qualitative new acquisitions" (Vygotsky, 1962). Vygotsky (1962) describes three phases in concept formation: a. The child unites diverse concrete objects in groups under a common "family name" and on the basis of external relationship. b. He forms "potential concepts" by establishing objective relationships and connections "uniting and generalising single objects", "singling out certain common attributes". This is objective and connective thinking. c. He considers the element "outside the actually existing bond" between objects, "detached", "abstracts" and "isolates" the individual elements. He then attains to the formation of genuine concepts. Words are integral

to the first two developing processes and maintain a guiding function in the third.

Bruner and his colleagues (Bruner, Goodnow and Austin, 1956, and Bruner 1966) investigated adult concept formation. He sought to discover routes used by people attempting to expand, modify and adapt existing concepts to meet new demands. This is the case with the subjects of the present study who have to adapt from a task centred approach to the delivery of nursing care to one based on the nursing process.

Bruner's strategies comprise plans of action used in concept formation and these are called scanning and focusing. In scanning a person works out hypotheses from given information either simultaneously or successively. In focusing, the individual proceeds one attribute at a time and does not test hypotheses and is therefore rather time consuming.

Wetherick (1966) carried out a study on Bruner's concept of strategy and concluded that the majority of intelligent subjects were found to be scanners rather than focusers. The strategy used also depends on the context. Wetherick found that whether a subject scans or focuses in experimental conditions will depend on how he sees the task rather than on his intelligence. If he sees the task as a model of real life, he may use the procedure he would use in real life: that is, he may scan. He may, however, see that laboratory task as a game in which the object is to play the game as efficiently as possible. If so he will be more likely to focus, since focusing is the most efficient way to play a game in the laboratory.

c. Levels of Conceptual Attainment

A variety of different degrees of conceptual grasp appear possible, as articulated by Klausmeier, Ghatala and Frayer's (1974) four levels of conceptual attainment. These are as follows:

Concrete level

Identity level

Classificatory level

Formal level

For the formal level, though not the other levels, language is held necessary. The levels of conceptual attainment apply most clearly to concepts of a physical-sensory nature, but they may have relevance to other types such as that of the Nursing Process. For concepts may be classified in terms of types and Tomlinson (1981 p68) has set them out in the following manner.

1. Physical-sensory concepts. These involve the sense receptors (sight, hearing, smell, touch and so on) and include, for example, length, loudness, colour and so on.
2. Action-functional concepts. Sitting down is given as an example of an action, and a seat is a functional object since it is defined as something to sit on.
3. Evaluative concepts. These are concerned with positive/negative evaluation. Senicle (1982) described the nursing process as a double-edged weapon and discussed the positive and negative aspects of it. Rawlins (1983) wrote that the nursing process creates so much paperwork that genuine patient care is in danger of being swamped. Chiarella (1983) posits the view that if the documents really are hindering the administration of patient care, then surely the documents themselves are the problem. These are examples of evaluative concepts coming into play in relation to the nursing process.

4. Qualitative Concepts. When it comes to forming a basis for discriminating between things or events this may be done in qualitative terms which operate on an all-or-none basis. Is it the nursing process or isn't it? The nursing process presents some problems in this context since, as we have seen, there are so many definitions of it. In addition the intensional use of the term seems to be variable.
5. Quantitative concepts. An alternative basis for discriminating between things or events is to use quantitative criteria. These concepts operate on a more-or-less basis. It is difficult to see how this could be applied to the nursing process since it would be difficult to describe something as a process if only some of the phases were used. However, Pembrey (1980) did show that the successful implementation of the nursing process depended on good management, particularly on accountability by individual nurses. This would be an example of more-or-less aspect of the nursing process, but it does not characterise the whole concept of the nursing process itself.
6. Concreteness-abstractness. This seems to involve simplicity-complexity and physical immediacy versus indirectness or subtlety, thus concepts of a physical-sensory nature are considered more concrete than functional and evaluative concepts. Various degrees of concreteness of concept are applicable in nursing. Take, for example, a pressure sore; something nurses are at pains to avoid. However, if one occurs it can be seen and is therefore of a physical-sensory nature. To explain pressure sores involves, for example, the general health of the person with the bedsore: it also involves changes of the hydrostatic pressure in the capillaries, cellular nutrition and, if infected,

microbiological concepts. The concepts involved range from the concrete to the abstract.

7. Conjunctive concepts. These incorporate a combination of attributes. The nursing process approach involves at least a conjunctive nature in that there is a sequence of operations, all required for the whole. Also, we have seen earlier that the nursing process draws on concepts from the physical, biological, social and the behavioural sciences.
8. Disjunctive concepts. These are concerned with alternative defining attributes. Is there one single version of the nursing process which is realised in all circumstances? Or are there variants applicable, for example, to general, psychiatric, mental handicap and sick children's nursing? A disjunctive concept would be one which would define the particular attributes in the varying contexts set out above.
9. Interrelationship. Concepts make it possible to classify such things as objects, behaviour, and phenomena. To conceptualise is to abstract common elements from many separate facts or events. It allows us to talk with others who also know these commonalities without having to describe the whole structure or range of events. It is inevitable that the process of concept formation involves interrelationships.

d. Individual Differences

Another relevant factor raised by Bolton (1977 p113) is the notion of individual differences in relation to concept formation. One of these differences concerns the width of attention of the individual. In some instances everything is included with the result that poor discrimination takes place. According to Bolton (1977 p119) a

second major dimension of individual differences that may be derived from a theory of concept formation has to do with the subject's capacity to make meanings explicit by recourse to abstract conceptual analysis. Bolton urges caution in dealing with this dichotomy and makes the point that all objects are simultaneously concrete and abstract, for each has the character of a 'thing' with physical reality and each may be classified, however intuitively or pragmatically, into some abstract scheme. Difficulty only arises when abstract analysis is required and the individual remains on the level of concrete reasoning or when persistence in abstract conceptualization prevents the taking up and using the meaning of a situation.

Later (p123) Bolton suggests that the bipolar dimension which comes closer to an integration of the two dimensions of attention development and concreteness/abstractness is the dimension of abilities first proposed by Guildford (1967). The cognitive style of convergent thinking is viewed as embodying narrow attention deployment together with an abstract attitude, whilst divergent thinking involves broad attention deployment and concreteness. Bolton (1977) suggests that each of these abilities may be relevant at some stage of concept formation; the difficulty arises if there is over emphasis on one rather than the other, or if the modes are used in an inappropriate manner:

e. Classification and Framing

A further point raised by Bolton (1977 p144) in relation to concepts concerns the notion of classification and framing which draws on the work of Bernstein (1971). Classification denotes the degree to

which subjects and subject matter are distinguished from one another. Strong classification exists when boundaries between disciplines are adhered to. Conversely, weak classification exists when attempts are made to integrate across disciplines. Framing refers to the strength of the boundary between what may and may not be transmitted in a teaching context.

Nursing knowledge is of an interdisciplinary nature involving the physical, medical and behavioural sciences. A weak classification would seem to exist. Perhaps this is something which ought to be taken into account in a consideration of the nature of the nursing process as a concept.

f. Organization of Experience

Some of the complexities which Bolton (1977) brings to our attention concerns the organization of experience and the openness, or otherwise, to new experience. This openness is important when it comes to adding new dimensions to individual conceptual schemes. A concept is stable organisation in the experience of reality; but is there one or more realities. People do seem to utilise difference views of what, for them, is reality. Individual differences need to be taken into account in the context of concepts. Factors which seem to be important are the width of attention, concreteness/abstractness, and convergent/divergent pattern of thinking. Matters of particular interest to teachers are those of classification and framing. Perhaps it might be that weak classification and framing would be appropriate in the context of the teaching and learning of nursing.

While it is the case that concepts are complex, it also appears to be

the case that they are fundamental to our understanding of the world for it is asserted by Lovell (1980 p57) that the key to understanding a subject is to understand its concepts. These concepts are identified by words. Lovell posits the view that if all the words that are connected with any chemistry or history or theology could be removed from the language then it would not be too far fetched to say that chemistry, history and theology could no longer exist. To know a subject is to know the meanings attached to the words that represent its concepts.

A source already cited, Bolton (1977 p16) emphasises the importance of language in relation to concepts for he writes "If language did not possess the power of communicating agreed meaning, then our concepts would remain idiosyncratic and incommunicable. Concepts are the expression of shared meaning and, in this sense, they are socially construed. Social cooperation and conventions stabilize concepts because an agreed name can be given to the same experience". It is proposed to examine next some sources in order to determine how the term concept is used in a nursing context.

CONCEPTS IN A NURSING CONTEXT

a. The Concept of Nursing

Wald and Leonard (1964) stated that the problems encountered in any search for the basic concepts of nursing were linked to the difficulty in answering the question what is nursing? This problem remains because there are still a great many definitions of nursing.

Henderson (1978) deals with the problem of delineating the concept of nursing. She suggests that a reason why nurses find the concept of nursing a subject of perennial interest is that their self-image

is often at odds with the public's image and what they do is at odds with what nurses and the public think they should do. Henderson (1978) goes on to assert that there are so many facets to the concept of nursing that it is hard to choose the most important. She gives the example of an American study (California State Nurses Association, 1953) which identified 450 activities carried out by hospital nursing staff.

Both of these sources serve as a reminder about the complex nature of the task of determining the nature of the concepts of nursing. Difficulties existed about defining nursing before the introduction of the nursing process. Superimposing a new way of doing things in a field where there was already a lack of clarity about the nature of the enterprise cannot but compound the existing lack of clarity. Henderson (1978) also reminds us of the need to consider nursing concepts in their social context.

What emerged from the review of the literature is that there exists a wide variety of definitions of the nursing process. Since so much is included in these definitions a problem arises about what may be excluded from them. There is evidence of loose usage of terms such as theory, model and conceptual framework. There is also some variation in the way the term concept is used. The study of concepts is a complex matter, but it is also a worthwhile activity since concepts are fundamental to understanding the nature of a subject. Two important elements relating to concepts are the use of language and the social context in which concepts are used.

There appears to be two particular problems in relation to the concept of the nursing process. In the first place nursing is a

field of knowledge rather than a discipline in its own right. This means that concepts are drawn from a variety of disciplines, so that the nursing process as a concept must be of an interdisciplinary nature: thus adding to the complexity of the problem. The other problem relates to the nature of nursing knowledge. It is difficult to identify nursing knowledge which seems to be inextricably bound with its various contributory disciplines.

There is a considerable body of literature relating to nursing concepts and examples which may be cited are Dickoff, James and Weidenback (1968), Rogers (1970), King(1971), Bevis (1973), Hardy (1973), Nursing Development Conference Group (1973), Riehl and Roy (1976). In fact the majority of these sources have been considered in this thesis in relation to nursing models and the nursing process.

Important points arise out of the work of Yura and Walsh (1978). The complex nature of concepts is recognised: the second point concerns the considerable amount of work already on nursing concepts.

However, it is the case that all the work is American. It was George Bernard Shaw who said that the British and the Americans are "divided by a common language". Bolton (1977) has stressed the importance of language and the social context in relation to how concepts are construed. If the social context is very difficult and there are differences in how the English language is used, then it would appear to be the case that American literature is likely to be of limited value in clarifying the concept of the nursing process in a British context.

The third point relates to teachers of nursing and the nursing process. These are a more or less neglected group when it comes to

studying the nursing process as a concept.

McFarlane (1980) relates theories and concepts in the following way. It is asserted that theories lend themselves to the structuring of a scientific body of knowledge and the formulation of laws by providing a framework in which relevant concepts can be identified and hypotheses generated. Concepts are seen as the basic elements of a theory. They are essential to the understanding of the theory in which they are used.

McGlynn (1983) also relates theory and concepts. It is posited that deductive and inductive theories start with a set of concepts which attempt to define that which is under consideration. Concepts are usually verbal forms standing for ideas and although there are many individual concepts they may be divided into two main classes which are: categorical and dimensional.

b. Health and Illness

Mitchell (1973 p3) argues that differentiation between concepts of health and illness is not purely a question of semantics or an attempt to keep intellectual discourse logical. Rather, definitions of these concepts help the nurse clarify her thinking, which in turn, gives direction to her professional attitudes and behaviour.

Later on (p96) Mitchell illustrates the importance of conceptual knowledge in nursing and she asserts that it is not enough to know the facts about a disease or the nursing care directly related to the medical treatment of that disease. It is claimed that nursing seeks to help the person who has the disease, a person whose reaction

to crises rarely fits any textbook description of pathological change.

An example cited is that of a woman with newly diagnosed diabetes. The social conditions are such that hers is a one parent family and that she has six children and she is in very difficult circumstances.

At a factual level, the woman will need to follow a diet, and may require oral or injectable drugs. Other facts involved are will she follow the diet? Will she be able to afford it? Will she understand the need for it? Mitchell suggests that nursing this woman involves concepts of poverty, of motivation, and of learning to help diagnose her potential coping problems and to design a plan which has some possibility of success.

c. Holistic

Murray and Zenter (1975) claim that a conceptual approach to nursing is essential in order to care for a diverse population in a complex society. According to this source the conceptual approach is the uniting, combining, modifying and utilizing of many theories or ideas from various disciplines into a new form: it is a holistic, dynamic approach. It is suggested that nursing draws upon the methods or approaches of medicine, religion, education, psychology, sociology or business. The conceptual approach fits together, for example, aspects of nursing with a health promotion emphasis, using whatever knowledge is applicable, such as human needs, and levels of wellness, stress adaptation.

Under the heading of 'Basic Concepts' Murray and Zenter (1975 p75) write

"Man is part of all that is within and around him - whether it be cell, organ, system, family, or society. He is more than the sum of his parts. This view, called holistic or total, will provide a foundation for considering all the areas that affect health".

These authors continue by examining man's various needs. Starting with physiological needs, they make the point that man must maintain an optimal level of oxygen-carbon dioxide exchange, fluid and food intake, rest and activity, elimination of waste products, temperature regulation and participation in sex in order to guarantee the survival of the species. The next set of needs concern the need for safety, belonging and love, self-esteem and self actualisation. Nursing helps the person meet the basic needs that he is unable to meet himself. These authors later state that the scientific method must also be an integral part of nursing if the goals of health care are to be met effectively.

d. Self Pacing

As far as the identification of nursing needs are concerned, Murray and Zenter (1975 p79) mention the approaches of eminent people in the field. Mention is made of the 21 problems suggested by Abdellah et al (1960), the functional abilities tool devised by McCain (1965) and Henderson (1966) activities of daily living.

The work of Geitgey (1969) is also mentioned which describes a guide that makes use of the acronym SELF-PACING to identify needs and to emphasise the patient's right to be as self-directing as possible.

The letters stand for:

S = socialization and the special senses.

E = elimination and exercise.

L = liquids and factors influencing fluid balance.

F = foods and dietary modification.

P = pain, personal hygiene, and posture.

A = aeration.

C = circulation.

I = integument.

N = neuromuscular.

G = general condition.

Murray and Zenter (1975) depict nursing as a synthesis of a variety of knowledge of man occupying a central position. Nursing is seen as an interdisciplinary activity and the approach is holistic with implicit reference to general systems theory. It draws heavily on the concept of human needs and on the work of Maslow (1954). It is also scientific and includes the notion of patient involvement in the process and independence for the patient.

RESEARCH IMPLICATIONS REGARDING CONCEPTS

For meaningful learning to take place the learner must have relevant concepts available within his existing cognitive structure. A concept is a system of learned responses which facilitate the organisation and interpretation of data. Concepts are usually associated with specific words or phrases, but it is possible to have concepts without verbal labels. Words are not concepts, they only stand for concepts. It is possible to know many words without any understanding of the concepts that they stand for. This point is relevant to the present study.

Words associated with the nursing process approach include holistic, humanistic, individualised, systematic, scientific, problem-solving and so on. The present study will seek to find out how these terms are understood by people using them in both clinical and educational settings.

There are two principal reasons for attempting such a study, investigating the nature of the nursing process concept as a central element in nurse educators' outlooks. First, a concept is that which a person has when she/he understands or is able to use some part of his language. Concepts thus occupy a basic position in the educational process. Second, teachers are significant people in the educational process (Barker Lunn, 1970). It is the case that teachers of nursing are an under-researched group, since no studies concerning their conceptions of the nursing process or nursing models were found in the literature. There is therefore a need for such a study. The present study, since it is breaking new ground, must therefore be exploratory in nature.

CHAPTER FOUR

INVESTIGATING THE PROBLEM

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CHAPTER FOUR

INVESTIGATING THE PROBLEM

INTRODUCTION

"In the search for the truth of things method is indispensable"
Descartes (1637).

In this chapter it is proposed to consider research methodology before subsequently considering the methods used in relation to this study.

The aim of research methodology according to Kaplan (1973) is

"to describe and analyse these methods, throwing light on their limitations and resources, clarifying the presuppositions and consequences, relating their potentialities to the twilight zone at the frontiers of knowledge. It is to venture generalisations from the success of particular techniques, suggesting new applications, and to unfold the specific bearings of logical and metaphysical principles on concrete problems suggesting new formulations".

Kaplan (1973) goes on to conclude that the aim of research methodology is to help us understand the process of scientific inquiry rather than just the product alone.

Research methodology falls into one of two broad classifications according to the nature of the underlying assumptions, and these are normative and interpretive.

RESEARCH METHODOLOGY

a. The Normative Approach to Research

The normative approach to research methodology is characterised by focusing its attentions on society and the social system, by objectivity, by explaining behaviour and by concern for macro-concepts such as society, institutions, norms, positions, roles, and expectations. (Cohen and Manion, 1985). The term structuralists is used in relation to researchers of the normative mode.

b. The Interpretive Approach To Research

In contrast, the interpretive approach focuses on the individual. It is characterised by subjectivity, understanding actions, and by concern for micro-concepts such as the individual, personal constructs, negotiated meanings and definitions of situations. Exponents of the interpretive approach to research are variously known as symbolic interactionists, phenomenologists and ethnomethodologists.

c. Quantitative and Qualitative Data

A state of tension sometimes exists between the protagonists of these approaches to research. However, it is also possible to see them in a complementary light as expressed by Merton and Kendall (1946) who wrote

"Social scientists have come to abandon the spurious choice between qualitative and quantitative data; they are concerned rather with that combination of both which makes use of the most valuable features of each. The problem becomes one of determining at which points they should adopt the one, and at which the other, approach".

d. Paradigms

While it is possible to look at normative and interpretive approaches to research methodology in a complementary light, it is necessary to take account of their underlying assumptions. In this context the term paradigm is sometimes used. A paradigm consists of a set of assumptions: the normative and the interpretive approaches embody contrasting assumptions. But before dealing with these the concept of paradigm ought to be covered more fully. Gelwick (1977) set out his thoughts relating to the concept of paradigm as follows

"A paradigm expresses the configuration of beliefs, values, and techniques by which normal science is pursued. It represents the outlook and methods by which a discipline of study conducts its routine life, interpreting data and does research. A paradigm provides metaphors, analogies, explanations, and standards for solutions of puzzles. Paradigms are adopted because they both win adherence of followers and are sufficiently open-minded to allow

focus upon further research. The breakdown of old paradigms and the emergence of new ones is a case of major revolution, usually involving preceding periods of crisis and the search for new directions. The establishment of new paradigms is a moment of synthesis and of originality".

e. Attitudes To Data

Cohen and Manion (1985) describe the data gathered by the normative approach as objective, external, quantifiable, explanatory, publically verifiable and replicable. These authors go on to describe data gathered by the interpretive researcher as subjective, internal, qualitative, interpretative, unique and negotiable. And they conclude that at the root of the differences between normative and interpretive approaches to research lies in the attitude to the data. The normative researcher who is seeking universal laws uses data to check out his hunches about objective reality or truth. The interpretive researcher searches out modes of explanation from the data, be they descriptive, analytical or conceptual. The views of the interpretive researcher are in line with Filstead (1970) who wrote

"Knowledge needed to understand human behaviour is embedded in the complex network of social interaction. To assume what is without attempting to tap it; to refuse to tap it on the grounds of scientific objectivity; or to define this knowledge with constructing operational definition, is to do grave injustice to the character and nature of the empirical social world that sociologists seek to know and understand".

f. Hypotheses

According to Kaplan (1973), in the case of normative studies, data are always data for testing some hypothesis or other. The researcher must have hypotheses to be able to deal with the data. By contrast, data from interpretive studies are the source of hypotheses.

The normative researcher would approach his research with attitudes, values, skills and objectives of the positivistic model. He is concerned with the outer social world and, as far as it is possible to do so, adopts a detached and a neutral role. He is thus free to stand apart and apply whatever conceptual scheme he chooses to the phenomena he has selected for investigation.

In the case of a researcher adopting an interpretive approach he favours an inner view of social reality and is therefore much more involved with the subject/subjects he is studying. It may be much more difficult for him to remain neutral.

Cohen and Manion (1985) assert that the traditionalist, which means normative, approaches social reality with preconceptions and hypotheses, manifest in his choice of questionnaires, attitude-scales and structured interview schedules. By contrast, the interpretive researcher starts with the social world as it is and, almost in the spirit of an eavesdropper, will tune in to it on its terms with unstructured interviews, natural conversation and the like.

g. Scientific Observation

Selltiz, Jahoda, Deutsch and Cook (1962) make the point that observation becomes a scientific technique to the extent that it:

1. Serves a formulated research purpose.
2. Is planned systematically.
3. Is recorded systematically.
4. Is subject to checks and controls on validity and reliability.

However the data are collected, whether it be the use of critical incidents, participant or non-participant observation, surveys, interviews or experiments; the issues of validity and reliability needs to be taken into account if a claim is made that the process is scientific.

h. Validity

The validity of a measure is the extent to which it actually assesses what it was intended to measure (Open University, 1979).

There are a number of aspects to validity. Two "theoretical" aspects are construct validity, which is the extent to which the conceptualisation of a particular quality is reflected in the way it is measured and content validity, a term used to describe the extent to which the measure fully samples the domain intended by the concept. Thus, for instance, an examination would have content validity insofar as the questions adequately sampled the whole syllabus. There are then "empirical indication" aspects of validity. These include what has typically been called face validity, the apparent closeness of the test to the intended concept, concurrent validity, referring to the extent to which a test corresponds with other validated tests, ratings or observations of the same thing, and predictive validity, the correspondence of a measure with some future variable, such as the predictive power of school examinations to indicate future success in higher education.

In addition to these aspects there are also the notions of internal and external validity of research procedures, in particular experimental procedure (Open University, 1979, p.40). Internal validity has to do with whether the causal inferences in a piece of research are vindicated by the logic and execution of the procedure. External validity is a matter of the extent to which the results of a study can be generalised to other people and contexts. Internal validity is a logical prerequisite of external generalisation.

i. Reliability

Reliability refers to the extent to which a test is dependable, stable

and consistent when given to different people and/or administered on different occasions. A reliability coefficient is a measure whose purpose is to quantify reliability in a test. Together with validity, reliability is a fundamental property which test constructors hope to achieve.

Kitwood (1977) deals with the issue of reliability in relation to interview data and he writes:

"In proportion to the extent to which 'reliability' is enhanced by rationalisation, 'validity' would decrease. For the main purpose of using an interview in research is that it is believed that in an inter-personal encounter people are more likely to disclose aspects of themselves, their thoughts, their feelings and values, than they would in a less human situation. At least for some purposes it is necessary to generate a kind of conversation in which the respondent feels at ease. In other words, the distinctively human element in the interview is necessary to its 'validity'. The more the interview becomes rational, calculating, and detached, the less likely the interview is to be perceived as a friendly transaction, and the more calculated the response also is likely to be".

THE SURVEY METHOD OF INQUIRY

a. Methods of Inquiry

When dealing with the methods of inquiry used in education Galfo and Miller (1970 p13) make the following points:

"Although educational research studies may not always lend themselves to a rigid system of classification, it is usually possible and desirable to put them into one of three general categories. The reason for using some means of classification stems from the fact that criteria for evaluating research studies become clearer when they are related to that specific methodology of each category."

These authors go on to list the three broad categories of research generally recognised by educators as follows:

1. Historical studies.
2. Descriptive studies.
3. Experimental studies.

They go on to describe studies (p15) as 'depicting the present', in comparison with historical studies which 'describe past conditions'.

Nisbet and Entwistle (1970 pp8-9), when dealing with methods of inquiry, have differentiated between surveys, or descriptive research and experimental studies. They write

"The term survey is used here for a wide range of studies which involve observation of a situation as it is, without setting up experimental conditions or allocating groups to different treatments".

These authors go on to point out that surveys may include the use of tests, examining the distribution of scores or the application of sophisticated techniques of measurement.

The survey method of inquiry according to Oppenheim (1966 p8) is sometimes called 'the poor man's experiment'. Another source, Roiser (1974) entitles a chapter in his book 'Asking Silly Questions' and, as might be guessed from the title, he is highly critical of the use of questionnaires on the grounds that, among other things, they are too deterministic in nature and are therefore unlikely to elicit the truth relating to a matter being investigated.

b. Practices and Opinion

With regard to surveys Evans (1984) differentiates between a survey of the literature and a survey of practices or opinion. She makes the point that a survey of the literature requires the use of printed sources and can be carried out without the aid of other people. A survey of practices or opinions involves finding out what other people are thinking or doing and asking them for information.

The survey part of the present study is in the second category in that it is concerned with finding out about practices and opinions relating to the nursing process.

Evans (1984) when dealing with questionnaire design summarises the key points as follows

1. Define clearly the purpose of the questionnaire.
2. Decide exactly what information is required.
3. Analyse it into its component parts.
4. Frame a series of questions to elicit it.

Evans (1984) goes on to assert that the only qualifications needed are the ability to think clearly and to ask plain questions in simple, unambiguous terms.

c. Four Phases of a Survey

When dealing with surveys Davison (1970) sets out a more elaborate plan than Evans (1984) when dealing with the survey method of inquiry. However, Davidson's (1970) approach comprises four phases. The first phase concerns stating the problems and reviewing the relevant literature. The second phase is concerned with the theoretical planning of the study which takes account of, for example, obtaining permission to carry out the study; choosing the subjects and deciding on the method of sampling and formulating hypotheses. Next is the practical phase which involves the construction of the instrument to be used and carrying out a pilot study. Finally, there is the analysis of the data, the testing of hypotheses and reporting on the findings.

d. Sampling

Cohen and Manion (1985) stress the importance of sampling and they distinguish between the two methods of sampling. First, there are probability samples in which the probability of selection of each

respondent is known. Second, there are non-probability samples in which the probability of selection is unknown. In the present study it is proposed to use the probability sampling in the survey part of the study since the respondents, the directors of nurse education, will be known.

e. Questionnaire Construction

Cohen and Manion (1985) set out what they consider to be the pitfalls in questionnaire construction and they set out a number of questions which ought to be avoided.

1. Avoid leading questions.
2. Avoid highbrow questions.
3. Avoid complex questions.
4. Avoid irritating questions or instructions.
5. Avoid questions that use negatives.
6. Avoid open-ended questions on self-completion questionnaires.

The reason posited for this is that it is not possible to probe the respondent to find what he means by a particular response, therefore, the open-ended question is less satisfactory in that context.

f. Characteristics of a Survey

The Open University (1979) summarises the characteristics of the survey method of inquiry as follows

1. The survey method requires a sample of respondents to reply to a number of fixed questions under comparable conditions.
2. The survey may be administered by an interviewer who completes a form for each respondent by asking him or her the survey questions or a form on which the questions are printed is sent to each respondent for self-completion.
3. The respondents in the survey represent a defined population. If all the members of a population are interviewed or fill in a self completion form, then a census (or 100 per cent sample survey) has been taken. If only a fraction of the population is covered, then

a sample survey has been conducted.

4. A survey sample should be representative of its population. If it is, then we can generalise the results from the sample to the population.
5. By using the same questions for a sample of respondents, comparisons of individuals within the sample may be made.

According to the Open University (1979), the chief advantage of the survey method of inquiry is the ability to collect a great deal of data quickly and cheaply. The chief disadvantage of the survey method of inquiry is the superficial nature of the data. A survey may leave behind as much, or perhaps more, data untouched as that elicited. Data from surveys therefore need to be interpreted in this light.

g. Osgood's Semantic Differential

Osgood (1952, 1954) was concerned with the relationship between symbols and their meanings. The problem of meaning would not be very difficult if all symbols pointed only to specific things or actions, such as names of objects (table, spoon) or specific directions (turn left, stop). Such meanings are called denotative; they specify something to which you can point and are alike to all who comprehend them. But there are other kinds of meaning, called connotative meanings, which accompany the denotative meanings of many words; for Osgood connotations are emotional, usually expressing some kind of evaluation or preference and varying from one person to another.

In order to pin down connotative meanings more precisely Osgood (1952, 1954) developed a measurement that he called the semantic differential. He called it 'semantic' because it had to do with meaning and 'differential' because the method provides several different dimensions of meaning.

To go about finding the connotations of a word, Osgood asked the subject to rate the word according to a number of bipolar adjective pairs; an example is the pair 'strong-weak'. One member of the adjective pair was placed at one end of a seven-point scale, the other at the opposite end. Then the subject indicated the direction and intensity of his judgement by rating the word under study at some point along this scale.

In attempting to find out about the connotative meanings ascribed to the nursing process, the use of the Osgood semantic differential approach seemed appropriate as a first step. For this reason a number of semantic differential items were included on the questionnaire used.

THE INTERVIEW METHOD OF INQUIRY

a. Definition

The research interview has been defined by Cannell and Kahen (1968) "as a two person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information, and focused by him on content specified by research objectives of systematic description, prediction and explanation".

Brenner (1980 p213) asserts that the research interview is not just employed for the purposes of information gathering, "it has to do with that particular quantitative form of information getting called measurement". Brenner (1980) goes on to make the point that measurement in the research interview implies a stimulus-response model of the question and answer process. It is suggested that each question is thus seen as involving just one particular set of stimulus material which must be used uniformly in all interviews included in a data collection programme.

b. Bias

Later, Brenner (1980) states that in practice it is often difficult to

meet the conditions for adequate measurement in the research interview. A major problem is that of bias and sources who have dealt with this include Hyman (1954), Cannell and Kahn (1968), Phillips (1971) and (1973), Deutcher (1973) and Sudman and Bradburn (1974).

There are two sources of bias and the first is the presence of the interviewer. Characteristics of the interviewer such as gender, colour, mode of speech and bodily communication can under certain circumstances, bias responses.

The second source of bias concerns the respondent. Bias may arise, for example, because of problems of recall, lack of understanding of the questions or because of motivational barriers such as an unwillingness to respond accurately.

Brenner (1980 p214) stresses the importance of social skills training for interviewers. And he identifies three areas of social skills competence which ought to receive attention. He suggests that the social skills should be identified. Once identified, the interviewer should be trained in those skills. Lastly, an assessment format should be devised in order to determine the degree to which interviewers succeed or fail in the use of interviewing skills.

c. The Interview Process

According to Brenner (1980 p216) an interview is designed for the purpose of adequate measurement. The actions to be performed by the interviewer rely on particular rules which have been developed to enable reliability and accuracy of the information gathering. The rules which relate to asking questions are:

1. Questions must be read exactly as they are worded on the schedule.
2. Every question that applies to the respondent must be asked.
3. Prompt cards should be used when required. The rules which apply for dealing with the respondents are:

1. When probing is required it must be done non-directively, that is without implying a particular answer.
2. Answers should be recorded verbatim.
3. When the respondent requires an action of the interviewer to be repeated, this should be done.
4. When a respondent asks for clarification, this should be given in a non-directive manner.
5. When a respondent gives an inadequate answer, the interviewer should probe non-directively towards an adequate answer.
6. When a respondent refuses to answer a question, the refusal should be accepted if it is definite. Otherwise non-directive probing may be used to elicit an answer.
7. Questions unrelated to the interview questions should be avoided.

d. Conceptions of the Interview

According to Kitwood (1977) three conceptions of the research interview exist. The first is that of a transfer of information. Kitwood (1977) writes:

"If the interviewer does his job well (establishes rapport, asks questions in an acceptable manner etc.) and if the respondent is sincere and well motivated, accurate data may be obtained. Of course all kinds of bias are liable to creep in, but with skill these can largely be eliminated. In its fullest expression, this view accords closely with that of the psychometricians, who apparently believe that there is a relatively permanent consistent 'core' to the personality, about which a person will give information under certain conditions. Such features as lying, or the tendency to give a socially desirable response, are to be eliminated where possible."

Secondly, the interview is seen as a transaction which inevitably has bias, which has to be recognised and controlled. Kitwood (1977) takes the view that rather than regarding the realities of the research interview as 'potential obstacles to sound research, and therefore to be removed or controlled' they should be taken into account and harnessed.

In Kitwood's (1977) view the third conception of the interview sees it as an encounter necessarily sharing many of the features of everyday life. Kitwood takes the view that what is required is not a technique for dealing with bias, but a theory of everyday life that takes account of the relevant features of interviews.

Cicourel (1964) lists five features of the research interview as follows:

1. There are many factors which inevitably differ from one interview to another, such as mutual trust, social distance and the interviewers control.
2. The respondent may well feel uneasy and adopt avoidance tactics if the questioning is too deep.
3. Both the interviewer and respondent are bound to hold back part of what it is in their power to state.
4. Many of the meanings which are clear to one will be relatively opaque to the other, even when the intention is genuine communication.
5. It is impossible, just as in everyday life, to bring every aspect of the encounter within rational control.

When dealing with the problems surrounding the research interview Kitwood (1977) concludes as follows "The solution is to have as explicit a theory as possible to take the various factors into account. For those who hold this view, there are not good interviews and bad in the conventional sense. There are simply social encounters; goodness and badness are predicates applicable, rather to the theories within which the phenomena are explained."

e. The Validity and Reliability of Interview Data

As a data gathering technique, the interview has its strengths and its weaknesses. Its strength is the potentially rich data which can emerge.

If research is a pursuit of truth then, assuming an effective interview technique, the interview has the potential to elicit the whole truth of matter better than the use of questionnaires and similar instruments.

The weakness of the interview concerns the issues of validity and reliability and consequently the scientific standing of research based on interviews. This is particularly the case when qualitative data resulting from interviews has to be accommodated within a framework of validity and reliability which have been developed to take account of quantitative data. Kitwood (1977) deals with the issues of validity and reliability as follows. He suggests that when either of the first two conceptions of the interview apply, as outlined earlier, the solution might be a 'judicious compromise'. When the third conception of the interview applies Kitwood (1977) asserts that validity and reliability become 'redundant notions'. He goes on to state that "every interpersonal situation may be said to be valid, as such, whether or not it conforms to expectations, whether or not it involves a high degree of communication, and whether or not the participants emerge exhilarated or depressed".

To regard every interview as an unique social encounter which is valid in its own right helps to extricate the interview from the strictures of an inappropriate quantitative framework. However, the criteria for data gathering by interview needs to be explicit and so must the data analysing techniques in order that the process may be described as scientific.

f. Types of Interview

According to Cohen and Manion (1985 p293) there are four types of interview that may be used in a research context: the structured interview; the unstructured interview; the non-directive interview; and the focused interview.

Cohen and Manion (1985) depict the principal features of the non-directive interview as minimal direction or control exhibited by the interviewer and freedom for the respondent to express himself as fully and as spontaneously as possible. Moser and Kalton (1977) discuss the non-directive interview as follows:

"The informant is encouraged to talk about the subject under investigation (usually himself) and the course of the interview is mainly guided by him. There are no set questions, and usually no pre-determined framework for recorded answers. The interviewer confines himself to elucidating doubtful points, to rephrasing the respondents answers and to probing generally. It is an approach especially to be recommended when complex attitudes are involved and when one's knowledge of them is still in a vague and unstructured form".

The non-directive interview as a research method was introduced into the present study as a means of opening up the inquiry to the fullest extent and to allow the subjects to express themselves freely regarding the nursing process. Having studied the various types of research interview, the non-directive interview seemed to have much to commend it. The object was to elicit the construals of the nursing process from those interviewed. In the process of interviews, the interviewees respond to the interviewer's questions and cues so that the responses are to some extent influenced by the interviewer. In one sense this gives structure to an interview. In another sense the interviewer may unduly influence the nature of the construals which emerge. An analogy might be drilling for water or oil. The object is to get out the water or the oil without debris. The presence of debris contaminates the water or the oil; similarly, the interviewer's questions may contaminate the responses given and thus influence the nature of the construals elicited.

However, the use of non-directive interviews proved to be too idealistic and unproductive and were abandoned at the pilot stage. They were abandoned because the interviewees found them stressful and because the data emerging was variable in quantity and quality.

g. The Focused Interview

The focused interview developed by Merton and Kendall (1946) appeared to be worth exploring since it offered a better focus for the interview, as its name implies, and also allows for openness which is essential in the elicitation of construals. Cohen and Manion (1985 p310) summarise the characteristics of a focused interview as follows:

1. The persons interviewed are known to have been involved in a particular situation: they may, for example, have watched a TV programme; or seen a film; or read a book or article; or have been a participant in a social situation. In the present research all the participants have had some experience of the nursing process so that this formed the focus for interviews.
2. By means of the technique of content analysis, elements in the situation deemed significant have been previously identified. He has thus arrived at a set of hypotheses relating to the meaning and effects of the specified elements. A content analysis was undertaken. First a vocabulary was derived from the literature reviewed. Secondly, the most commonly used words were identified. The point at which the present research departs from the account set out above concerns hypotheses. The approach here is exploration rather than hypotheses testing after Kitwood (1977 p192).
3. Using this analysis as a basis, the investigator constructs an interview guide. This identifies the major areas of inquiry and the hypotheses which determine the relevant data to be obtained in the interview. An interview guide was constructed and hierarchised (Tomlinson 1987). Appendix 1.
4. The actual interview is focused on the subjective experiences of the persons who have been exposed to the situation. Their responses enable the researcher:
 - a. to test the validity of his hypotheses;
 - b. to ascertain unanticipated responses to the situation thus giving

rise to further hypotheses. In the present research the subjects did have experience of the nursing process which provided the focus for the interview.

Merton and Kendall (1946) write about the focused interview in the following terms

"Fore-knowledge of the situation obviously reduces the task confronting the investigator, since the interview need not be devoted to discovering the objective nature of the situation. Equipped in advance with a content analysis, the interviewer can readily distinguish the objective facts of the case from the subjective definitions of the situation. He thus becomes alert to the field of 'selective response'. When the interviewer, through his familiarity with the objective situation, is able to recognise symbolic or functional silences, distortions, avoidances, or blockings, he is more prepared to explore their implications".

The design of the interview guide for the present study aimed to incorporate the following points. A content analysis of the literature relating to the nursing process was carried out. The number of questions on the guide was kept to a minimum, though subsidiary points were included on the guide (Appendix 1). Aspects introduced spontaneously by the subjects were ticked. If an aspect was mentioned briefly then a return mark was made on the guide. When an aspect on the interview guide was not forthcoming then a prompt was introduced. Questions were kept open and general. The approach was to allow the interviewees talk to flow, irrespective of the logic of the interview and to prompt only when absolutely necessary. The justification for the approach was that whatever emerged would be the construals of the interviewees in relation to the nursing process, rather than a strongly directed interviewer version.

ETHICAL ASPECTS

a. Dignity and Privacy of the Individual

Data collection techniques, whether they be interviews or whatever,

ought to be logical and systematic in order that a claim may be made to call them scientific. They ought to take account of the dignity and privacy of the individual whether he be a subject, an interviewee, or a respondent or whatever, to be able to call them ethical.

The Royal College of Nursing (1977) published the following guidelines relating to nursing research.

1. The research must be necessary and must contribute to further knowledge.
2. The subjects must receive full explanations of what their participation might entail and must be told that they have the right to refuse.
3. Consent must be obtained, if necessary, from a relative or legal guardian.
4. Subjects must be protected against physical, emotional, mental or social injury.
5. Confidentiality must be assured and maintained.
6. The researcher must be qualified to carry out the investigation, must make public the results of the inquiry and must attempt to prevent their misuse.
7. The contract between the sponsor of the research and the researcher must make explicit their mutual obligations and must state clearly the remit for the work to be undertaken.
8. Clear arrangements must be made as to the researchers' duties and responsibilities in the place where the research is carried out.

The various points set out in the RCN (1977) document were kept in mind during the process of the present research. A study of the nursing process was considered timely, since it had been in use for ten years. Moreover, construals of the nursing process approach had not previously been studied. It was the firm intention that the study would contribute to further knowledge.

The subjects were fully informed and participation was entirely voluntary. In the case of schools of nursing, permission was obtained at an institutional level to carry out the research. Many respondents said how much they enjoyed the challenge of the interview, so the question of injury did not arise. Confidentiality was assured; at the start of each interview assurance was given that no individual or institution would be identified.

With regard to being qualified to carry out the research, I was, of course, a student working for a higher degree and therefore a learner. However, every stage of the process was closely supervised by an experienced supervisor. The results will be made public in the form of a thesis.

The question of a sponsor did not arise. The responsibilities in relation to where the researches were carried out were seen as establishing and maintaining good human relations.

b. Respect for Persons

In summary, it may be said that ethical considerations impinge on all research whatever data collection methods are used. An important principle is incorporated in the title of a book by Downie and Telfer (1968): the title is "Respect for Persons". Respect for persons means, among other things, respect for a person's individuality, integrity, privacy, rights such as the right to refuse and so on. Downie and Telfer (1969) were concerned with human relations generally; but it does seem that respect for persons is an appropriate guiding principle in relation to the conduct of research.

SUMMARY

It is the attention paid to the methodology that characterises the quality of a piece of research. The normative and the interpretive approaches to research have their strengths and weaknesses. It

therefore seems to follow that a combination of approaches is more likely to produce a better answer to a problem than could be the case if only one approach were used. For this reason both normative and interpretive approaches are used in this study.

CHAPTER FIVE

DEVELOPING RESEARCH STRATEGIES

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CHAPTER FIVE

DEVELOPING RESEARCH STRATEGIES

Introduction

"The aim of our studies should be that of so guiding our mental powers that they are made capable of passing sound and true judgements on all that present itself to us".

Descartes (1629)

This chapter deals with the development of the methods used in the study to collect data. Two strategies are used: a postal survey by questionnaire and focused interviews.

QUANTITATIVE ASPECTS

a. The Survey

The aim of the survey was to find out about practices and opinions relating to the nursing process and nursing models. As Evans (1984) suggested a survey of practices or opinions involves finding out what other people are thinking or doing and asking them for information and this is what was done. In addition semantic differential items were included in order to determine the meaning attached to the nursing process by the respondents.

b. The Questionnaire

In developing the questionnaire used it was considered that the semantic differential items should be included in the context of other developments relating to the nursing process. Items about the state of implementation of the nursing process and problems encountered in implementing it were posed. Opportunity was also provided to respond to the advantages related to the introduction of the nursing process.

It is becoming more or less generally accepted that the elements of the nursing process - assessment, planning, implementation and evaluation are in no way peculiar to nursing and could apply to

agriculture, chemistry, engineering and so on and that the nursing process should be used in conjunction with a nursing model. It seemed essential therefore to find out to what extent nursing models are used in conjunction with the nursing process, and which models are used in particular clinical settings.

The writer produced a first draft of the questionnaire to be used. The principles outlined by Selltiz, Wrightsman and Cook (1976) were borne in mind in the construction of the questionnaire. The points which these authors put forward relate to decisions about content. Is the question necessary? How will it be useful?

Selltiz, Wrightsman and Cook (1976) deal with the matter of wording. Can the question be misunderstood? Clearly, an ambiguous question will not yield useful data. Is the wording biased? Biased questions are to be avoided since it would be impossible to get to the truth of a matter using such questions.

The authors cited above deal with the matter of the form of response. Is the form of response easy, definite, uniform and adequate for the purpose? The form of response used in the questionnaire was straightforward. Respondents were asked to circle responses rather than tick them, since respondents are sometimes haphazard about ticking and sometimes tick in a position which is not clear what response is meant. For example, a big tick might cover more than one response making it difficult to decide the actual response the respondent intended.

Selltiz, Wrightsman and Cook (1976) deal with the matter of question sequence. In constructing the questionnaire used, it was decided to start off with factual items such as the type of course offered on the grounds that these would be non-threatening. The problems relating to the advantages emanating from the implementation of the nursing process were also matters of common concern for the respondents. Semantic differential items were likely to be the least familiar part of the questionnaire and were included after the more factual items on the grounds that the respondents thought processes would be more receptive at this point, than if these items were introduced earlier. The nursing process arrived on the scene before nursing models so that it seemed on logical grounds the items relating to models should appear after those relating to the nursing process.

c. Pilot Study

The draft questionnaire was shown to seven teachers of nurses who were familiar with the subject matter and related issues. Three of these were involved in advanced studies themselves and were familiar with research methods.

At the pilot stage most discussion revolved around the semantic differential items. These items were based on the content derived from a review of the literature on the nursing process. The arguments centred on two points. The first was: was the range of items correct. A vocabulary derived from the literature was available to those helping with the pilot work and contained 87 words such as holistic, humanistic, scientific, individualised problem-solving and so on. The first draft of the semantic differential contained ten words in a bipolar form. Following discussion, some of the items originally included were taken out

and others were added. At the fourth and final draft 16 bipolar items were adopted as the final version. (Appendix 2).

A second matter which provoked much discussion at the pilot stage was the wording of the bipolar items. Some of the items used had straightforward antonyms and presented no problems. Others were not so easy. When it was a choice between an obscure antonym and a longer but a more down-to-earth term the pilot respondents were in no doubt that the more common terms should be used. A consequence is that in some instances three or four words had to be used where it was intended to use one.

d. Sample

In order to obtain as wide a spread of data as possible it was decided to survey all the directors of nurse education and senior tutors in charge of schools of nursing in the United Kingdom. Probability sampling, that is, the probability of selection of each respondent is known, was used (Cohen and Manion, 1985 p98). This method of sampling was adopted as the means most likely to elicit a representative response. Alexander (1983) was used as a source of addresses and 217 schools of nursing were identified and circulated with questionnaires.

The directors of nurse education and the senior tutors in charge were chosen for two reasons. First, they are a readily identifiable target audience and mail would be more likely to reach them than it would if addressed to say 'nurse tutor', or 'senior tutor' since there would be many people in these categories but there would be only one head of school.

The second reason for surveying the heads of schools concerned the role they occupied. As heads they could be expected to provide lead-

ership. They might therefore be expected to be in a better position to provide data relating to the nursing process than other members of the staff in schools of nursing.

e. Instrument

A 64 item questionnaire, whose development was described in the pilot stage of the study, was used to collect data relating to the nursing process and nursing models. Semantic differential items were included as nos. 35 - 50. The questionnaire contained both open and closed questions and the respondents were invited to write in comments in spaces provided (Appendix 2).

f. Procedure

The questionnaires, an explanatory letter, and a stamped addressed envelope for return of the questionnaires were posted in January, 1986. The questionnaires were coded in order to follow up non-respondents.

Within a month 67 per cent of the questionnaires had been returned completed. At this point non-respondents were followed up and this was worthwhile because within another month 82 per cent of the questionnaires were returned, which was the final figure for the response.

When dealing with the response to postal questionnaires Oppenheim (1966 p.34) asserts that for respondents who have no special interest in the subject matter of the questionnaire, figures of 40 per cent are typical; even in studies of interested groups, 80 per cent is seldom exceeded. According to Oppenheim's statement, the respondents to the present survey may be regarded as being in the interested category.

Analysis

The data were analysed by computer using 'Genstats' which is a descriptive statistics package which includes the mean, variance and standard deviation. The results of the survey are presented in the next chapter.

QUALITATIVE ASPECTS

a. The Interview

"The aim of the research interview, therefore, is to get truthful information from people on a subject about which they are under no obligation to tell, if they do not wish to"

Stacey (1969 p72)

The aim of the interview in this study is to elicit the nature of the construals of the respondents relating to the nursing process and nursing models. According to Madge (1965 p150) "The principal application of the interview in social science is its use for the purpose of making people talk about themselves". The intention of the present research was to get a specific group of people, that is teachers of nursing and clinical nurses to speak about a current issue in nursing, namely the nursing process and nursing models.

The theoretical support for the interview part of the study came from Kelly (1963) who states that man looks at his world through patterns or templates. Kelly (1963 p9) calls these patterns "constructs" and he goes on to make the point (p43) that different people construe this world in different ways. The process of construing (p50) involves 'placing an interpretation': a person places interpretation upon what is construed. Kelly (1963 p69) relates concepts and constructs as follows:

"While we have not said so before, it is probably apparent by now that we use the term construct in a manner which is somewhat parallel to the common usage of 'concept'."

Kelly's preference for this term construct is that it has emerged from within the context of experimental psychology rather than within the context of mentalistic psychology or of formal logic. He also held that constructs are essentially bipolar dimensions, a view which one may reject whilst agreeing with the interpretive nature of constructing and the possibility of many constructs being bipolar

A point pertinent to the present study is raised by Kelly (1963 p136) when he asks "Can a construct be communicated from one person to another without losing its reality? Kelly suggests such communication is possible and states "A construct does not change its allegiance when someone else gets a version of it". There are grounds for expecting that it ought to be possible to elicit how senior nurses construe the nursing process assuming a competent interview technique.

The initial decision was to use non-directive interviews so that whatever emerged would be the respondent's own construals rather than responses framed through interaction with the interviewer. However, at the pilot stage the non-directive approach to the interviews proved to be heavy going and stressful for the respondents and was more or less universally disliked. It was therefore abandoned, following six pilot interviews, and it was decided to adopt the focused interview approach. The focused interview was developed by Merton and Kendall (1946) as a means of using the principle of non-direction, while at the same time giving the researcher more control over the interview. This was developed into a hierarchically focused interview (Tomlinson 1987, see Appendix 1).

At a face value level the focused interview seemed appropriate for the study because all the proposed interviewees met an important criterion in that they could all be expected to have been involved in a particular situation, that is, all would have some experience

of the nursing process and also nursing models.

b. The Interview Guide

In developing the interview guide (Appendix 1) a number of principles were kept in mind and these were openness, non-directiveness and comprehensive coverage of the subject area. This proved to be easier said than done. Early attempts emphasised adequate coverage too strongly and what emerged was a question and answer agenda. In opening up the process, the interviews tended to lose their focus and could not be described as focused interviews.

To achieve openness, non-directiveness and comprehensive coverage proved to be a demanding skill. To remain too open, as happened in the first attempt at interviewing, using unstructured interviews, was unsatisfactory. One respondent commented that it was most disconcerting for an interviewer to sit there like a tailor's dummy. The non-directiveness is also a tricky one. Interviewees constantly 'fish' for signals about how they are doing. To keep the interviewees comfortable and thus to keep the interviews flowing, then feedback needs to be given. The skill is to provide feedback which does not point the interviewee in any particular direction and yet is friendly and helpful. In this context, there is also the matter of the individual differences of the interviewees. The dynamics of interviews vary so that it is difficult to prescribe how such interviews ought to be conducted. It is, however, possible to identify three elements which appear to be fundamental and these are the ability to listen carefully, the ability to think and react on one's feet and lots of practice, which includes a review of and a reflection on the process.

In a nutshell, the skill involved in interviewing is sensitivity in human relations. As with any skill practice is crucial, but it is

also important to reflect and review. Interviews which are recorded in writing or by tape recorder provide material to review and reflect on. Strengths and weaknesses can be identified and lessons learned in the process. This review and reflection takes time but it is essential in the development of interview skills.

Non-directiveness and comprehensive coverage of a subject area is an equally challenging proposition. In fact at first sight they might appear to be mutually exclusive. However, non-directiveness does not preclude questions which are both open and general. In the interview guide that was developed, five other versions were produced and discarded on the way, contained only three main questions (Appendix 1) and these were of a general nature, for example, "What is the nature of the nursing process as far as you are concerned?" Each question had a number of subsidiary questions derived from the literature relating to the nursing process and nursing models. The responses given by the interviewees were ticked on the interview guide and brief answers were followed up by say "You mentioned so and so, do you want to add anything to what you said?" If an aspect on the guides was not mentioned by the interviewee, then a prompt was used "Would you say it involved X?" In this way comprehensive coverage was achieved and non-directiveness was maintained by the use of general and open questions.

c. Pilot Study

As with the draft questionnaire, the draft interview guide was shown to the same teachers of nursing who helped to pilot the questionnaire. Having covered the ground once, the development of the interview guide posed no problems at first. The problems arose when it came to be used in practice.

At first the questioning and the conduct of the interview were too open and the quality of the data was variable. A change of tactic resulted in over reaction and the interviews were too closed and little more than a question and answer session.

Because of these difficulties the pilot stage was rather protracted and comprised 16 interviews of approximately 40 minutes each. Gradually a position was reached when the interviews flowed well and embodied a good balance between openness and comprehensive coverage of the field.

As part of the pilot stage those taking part in the interviews were invited to comment on how they found the experience. This proved helpful. It emerged that many experienced nurses get nervous when interviewed. There is a strong case for helping people to settle down. Friendliness came across as an important attribute of an interviewer. Feedback is also seen as important, though care has to be taken to ensure that it is non-directive. A view was expressed a number of times that researchers are frequently unduly mysterious about the nature of their research and that this tends to arouse suspicion among those interviewed. In the present research an open approach was adopted in that full explanations were given and this seemed to be appreciated. The interviewees felt that they had the opportunity to express themselves fully in relation to the issues raised in the interview. Some, apart from initial nervousness, said they actually enjoyed being interviewed.

d. Sample

It is important in both quantitative and qualitative approaches to data gathering to choose a sample which is representative of the population being investigated (Field and Morse, 1985). All the schools of nursing were included in the survey part of the research.

When it came to sampling for the interviews the scale of the study had to be considerably reduced because of the need for face to face contact for the interviews and thus the time and costs involved.

Instead of interviewing a representative sample of directors, it was decided to interview other grades of nurse teachers such as nurse tutors and senior tutors and clinical nurses in an attempt to achieve some sampling of the range of personnel involved in nursing and nurse education. A non-random selection was made of two Regional Health Authorities in England. From these regions four schools of nursing were selected at random from each. Tutorial and clinical staff were selected on a non-random basis from each school of nursing making 40 subjects in all (Appendix 3). Individual teachers and clinical staff were selected on a non-random basis in that participation was voluntary and all interviewees were given the opportunity to withdraw. The schools of nursing prepared students for all parts of the Register of Nurses, and representatives of the various specialities were included. All the participants had clinical experience as a ward sister or charge nurse and at least one years teaching experience; though many had much more than this (Appendix 3).

e. Instrument

An interview guide, whose development was described in the pilot stage of the study, was used to collect the interview data relating to the nursing process and nursing models. The guide was designed so that it was possible to record spontaneous comments and those where a prompt was necessary (Appendix 1).

f. Procedure

Permission to conduct the interviews was first obtained at an institutional level: this was always forthcoming. A quiet room was

used for the interviews. Every interview began with a settling down period in order to create a friendly and an unhurried atmosphere. The interviewees were assured of anonymity and confidentiality and asked if they would allow taperecording, with an option to wipe sections of tape afterwards if deemed necessary. The interview guide was followed flexibly, so that all aspects were eventually covered. The approach was to encourage a free flow of comment and to interject only when the person dried up or was spending a long time on one aspect to the exclusion of others. The length of the interviews was between 30 and 40 minutes and all were in fact tape recorded.

g. Analysis

First, the interviews were transcribed verbatim. Six representative transcripts are presented as Appendices 4, 5, 6, 7, 8 and 9. The transcripts were read several times and key words or phrases were highlighted using a highlighting pen. The next step was to develop a content analysis guide. The saturation principle was used in developing this guide, that is, it was continued to be developed until no new words or phrases appeared. The content analysis guide (Appendix 10) was validated by six people familiar with the area and with research. Each person was sent a content analysis guide and seven transcripts. Their responses were compared and a 90 per cent agreement was achieved using the guide.

The analysis of the transcripts took two forms. In the first place each individual transcript was perused and aspects mentioned were tabulated with reference to the content analysis guide developed (Appendix 10). These tables are presented in Chapter 8. The next step was to formulate a synthesis from the data analysed.

Using the content analysis guide (Appendix 10) and the analysis tables for the individual interviewees, the rates of mention for the various aspects such as assessment, planning, implementation, evaluation, scientific and so on were tabulated thus providing an overview for each aspect for the interview sample as a whole. The rates of mention tables are also presented in Chapter 8.

h. Cluster Analysis

The study is concerned with investigating how "the nursing process" is construed by teachers of nurses and clinical nurses. A central question concerns the extent to which the construals are similar or dissimilar. Cluster analysis is a technique which orders data in this manner. For this reason cluster analysis was used with the intention of identifying typologies which may exist.

i. Defining Cluster Analysis

Everitt (1974 p.1) states "The most commonly used term for techniques which seek to separate data into constituent groups is cluster analysis". Bennett (1976 p.41) states simply that cluster techniques group people together who share common characteristics. Cluster analysis has a relatively short history, indeed, Youngman (1979 p.125) wrote that since the process of classification is so fundamental to human behaviour it is perhaps surprising that a similar interest has not been apparent in statistical methodology until quite recently. He goes on to say that cluster analysis, or numerical taxonomy as it is otherwise known, enables entities to be classified on the basis of a large number of measures. He writes "More recently the methods have achieved greater popularity, particularly in social research where the complexity of the domain of relevant variables is ideally suited to cluster analysis".

Everitt (1974 p.43) reminds us that there are problems with defining the term cluster analysis and he writes "The most common feature of most proposed definitions is their vague and circular nature, in the sense that terms such as similarity, distance, alike etc. are used in the definition, but are themselves undefined". He goes on to state that it is probably true that no single definition is sufficient.

j. Reasons for Choosing Cluster Analysis

Whilst not overlooking the problems of defining cluster analysis, there were a number of reasons for choosing it as an analytic technique to use on the data. An important reason is that cluster analysis deals with individual people rather than variables which is the case in most other analytic techniques, for example, factor analysis. Individual people can thus be grouped together in cluster according to the characteristics they exhibit. If it emerges that a number of clusters can be identified, this provides the basis for typology formation.

The fact that cluster analysis deals with individuals rather than variables makes it appropriate for qualitative research where there is a concern not to lose sight of individual subjects. It might be argued also that the analytic techniques ought to be consonant with the approach to research. Youngman (1979) suggests that cluster analysis is suited to social science research and it has been used in studies which share some common features with the present study. For example, Bennett (1979) used cluster analysis to produce a typology of teaching styles. Similarly, Youngman (1974) used it to produce a typology of engineers.

Everitt (1974 p.4) notes that in many fields the research worker is faced with a great bulk of observations which are quite

intractable unless classified into manageable groups. He goes on to say that clustering techniques can be used to perform this data reduction. "In this way it may be possible to give a more concise and understandable account of the observations under consideration".

k. Measuring Similarity

Everitt (1974 p.51) states that a similarity coefficient measures the relationship between two individuals, given the values of a set of p variables common to both. He goes on to state that similarity coefficients take values in the range of 0 to 1. "In many cases where similarity coefficients are to be used, the variates are of the 'presence' and 'absence' type which may be arranged in the familiar two way association table in which the presence of a variable is denoted by a + sign and its absence by a - sign." A two-way association table for two individuals would be as follows:

		Individual i		
		+	-	
Individual j	+	a	b	a + b
	-	c	d	c + d
		a + c	b + d	p

Where $p = a + b + c + d$.

l. Measuring Distance

Distance measures are dealt with by Everitt (1974 p.56) as follows. He asserts that a numerical function $d(x, y)$ of pairs of points of a set E is said to be metric for E if it satisfies the following conditions:

- (i) $d(x, y) \geq 0$; $d(x, y) = 0$ if $x = y$;
- (ii) $d(x, y) = d(y, x)$;
- (iii) $d(x, z) + d(y, z) \geq d(x, y)$.

It is claimed that it is the third condition above which differ-

entiates most between distance measures and similarity measures.

Everitt (1974 p.56) claims that the most commonly used distance measure is the Euclidean metric. For this measure the distance between point i and j denoted by d_{ij} is defined as:

$$d_{ij} = \left\{ \sum_k^p (x_{ik} - x_{jk})^2 \right\}^{\frac{1}{2}},$$

where X is the value of the k th variable for the i th entity.

m. Ward's Method of Cluster Analysis

Everitt (1974) and Youngman (1979) remind us that there is a great variety of clustering techniques to choose from. For the present study Ward's (1963) method was chosen because it is one of the most commonly used methods and was therefore a 'safe' choice. Secondly, as Youngman (1979) reminds us, Ward's method starts with individual cases and therefore no decision is required from the analyst. Youngman goes on to make the point that the alternative centroid method demands an initial classification on the part of the analyst.

Youngman (1979 p.221) describes Ward's method as an hierarchical agglomerative grouping method. According to Everitt (1974 p.7) hierarchical techniques are those in which the classes themselves are classified into groups, the process being repeated at different levels to form a tree, a tree being defined as a connected graph with no circuits and a circuit being defined as a closed path.

Everitt (1974 p.8) states that agglomerative methods begin with the computation of a similarity or distance matrix between entities, the product moment correlation coefficient being used as a measure of similarity and the common measure of distance being that of Euclidean distance. Everitt (1974 p.8) goes on to

say that the end-product of the method is a dendrogram showing the successive fusions of individuals which culminates at the stage where all the individuals are in one group.

Youngman (1979 p.226) summarises the seven steps in Ward's method as follows:

1. Compare each individual with every other using the distance formula.
2. Combine the two cases with the smallest distance.
3. Compare the error potential increases associated with combining the new cluster with each of the rest.
4. Combine the two clusters with the smallest error increase.
5. Repeat step 3 and 4 until all clusters have fused.
6. Select one or more classifications from the complete set.
7. Obtain the characteristics of the clusters comprising the selected classification/s.

n. The Use of Cluster Analysis in the Present Study

The interview data were the raw material for the analysis. The aspects mentioned by each of the interviewees were tabulated. For the cluster analysis only the global views from Section A of Appendix 10 were used. These were the aspects which were mentioned spontaneously at the beginning of each interview. The reason for confining the cluster analysis to the opening part of the interviews is that whatever emerged would represent the interviewees' own constructs of the nursing process rather than a question and answer response.

The data for each of the 40 interviews were analysed on the Amdahl mainframe computer at the University of Leeds using a Clustan 2 programme. The outcome was a clustan plot and this is presented with the results in the next chapter.

SUMMARY

The quality of the instruments used to collect data is a critically important part of the research process. Adequate testing at the pilot stage is absolutely essential and therefore both the quantitative and qualitative instruments used were subjected to a rigorous pilot phase. The interview aspect was more problematic in this respect than the survey by questionnaire. The first stage of the analysis of the data was to read and re-read the interview transcripts. This formed the basis for producing a profile for each individual interviewee. The second stage comprised calculating the rates of mention for the various aspects of the nursing process. Thirdly, the statistical technique of cluster analysis was used in order to identify interviewees with similar and dissimilar construals of the nursing process and thus derive a typology from the resultant clustering. In the following chapters the results of the survey by questionnaire and the interviews will be reported.

CHAPTER SIX

RESULTS OF THE SURVEY

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CHAPTER SIX

RESULTS OF THE SURVEY

INTRODUCTION

"The large-scale survey of a particular institution can provide information of a kind the local study cannot and without which the latter would be hampered. At the same time, a local study can put flesh on the bones of the structural skeleton which the broad survey reveal."

Stacey (1969 p.27)

The results of the survey are presented as tables. These results are based on the analysis of 178 questionnaires, that is, 82 per cent of the total number of schools of nursing in the United Kingdom.

TABLES

Table 1 The range of courses offered by the Schools of Nursing Surveyed.

Designation		Percentage
Registered General Nurse	(1)	94
Enrolled Nurse (General)	(2)	64
Registered Mental Nurse	(3)	65
Enrolled Nurse (Mental)	(4)	26
Registered Nurse for the Mentally Handicapped	(5)	32
Enrolled Nurse (Mental Handicap)	(6)	16
Registered Sick Children's Nurse	(8)	15

Table 2 - Length of time the teaching of nursing has been based on the nursing process

	1986	85	84	83	82	81	80	79	78	77
Years		0-1	2	3	4	5	6	7	8	9
Percentage		0	8	22	24	24	11	5	2	4

Table 3 - How the nursing process is regarded by Directors of Education

	1	2	3	4	5
Regard	Very Unfavourably	Unfavourably	Favourably	Very Favourably	Exceptionally Favourably
Percentage	1	2	26	62	10

Table 4 - How the education staff reacted to the introduction of the nursing process

	1	2	3	4	5
Reaction	Very Unfavourably	Unfavourably	Favourably	Very Favourably	Exceptionally Favourably
Percentage	2	1	39	52	6

Table 5 - How the service staff reacted to the introduction of the nursing process

	1	2	3	4	5
Reaction	Very Unfavourably	Unfavourably	Favourably	Very Favourably	Exceptionally Favourably
Percentage	1	26	70	3	0

Table 6 - Stage of implementation of the nursing process

	1	2	3	4	5
Stage	Not Implemented	Being Implemented	Barely Implemented	Partially Implemented	Fully Implemented
Percentage	0	9	6	68	17

Table 7 - Problems encountered in implementing the nursing process presented in rank order

Problem	Rank Order
Resistance to change by nurses	1
Staff shortage	2
Lack of time	3
Extra paper work	4
Rapid turnover of patients	5
Jargon language	6
Rapid changes in the condition of patients	7
An imported concept	8
Resistance by medical staff	9

Table 8 - Additional problems relating to the implementation of the nursing process as supplied by the respondents

Problem	Number of Times Cited
1 Difficulty in providing staff development courses on the nursing process.	41
2 Problems of defining terms/understanding the concept.	24
3 Lack of understanding/commitment by nurse managers	21
4 Lack of commitment/motivation by senior staff	14
5 Too much stress on documentation/paper work	14
6 Lack of knowledge by trained/clinical staff	13
7 Lack of knowledge about nursing models on which to base care.	7
8 Confusion over what it was all about	6
9 Lack of a nursing process co-ordinator	6

Table 8 Continued

Problem	Number of Time Cited
10 Insufficient qualified staff	4
11 Not seen as relevant	4
12 Taught in school but not practiced on the wards	4
13 Lack of guidance by GNC/ENB or DHSS	3
14 Lack of resources to implement changes	3
15 Poor ability in writing objectives of care	3
16 Rapid turnover of staff	3
17 Change agent seen as school of nursing	2
18 Implementation by dictat	2

Table 8 Continued

Problem	Number of Times Cited
19 Insufficient storage space for bulky documents	2
20 Lack of patient involvement	2
21 Lack of underlying research findings	2
22 Low recognition of need for nursing process	2
23 Staff insecurity	2
24 System introduced before properly understood	2
25 Care plans not reflecting care given	1
26 Change of role of ward sister	1
27 Closed minds	1

Table 8 Continued

Problem	Number of Times Cited
28 Confidentiality concerning care plans	1
29 Day patients	1
30 Duplication of records	1
31 Failure to take account of the changes necessary for implementation	1
32 Imported concept	1
33 Inappropriate goal setting making evaluation impossible	1
34 Inappropriate recordings	1
35 Lack of experience with nursing process	1
36 Learners knowing more than qualified staff	1

Table 8 Continued

Problem	Number of Times Cited
37 Long stay patients	1
38 Lack of teaching aids	1
39 Overcoming myths about nursing process	1
40 Rapid turn over of patients	1
41 Resistance to nursing process in clinical areas	1
42 Restricted understanding of evaluation	1
43 Seen as an academic bandwagon	1
44 Seen as an idea from the school of nursing	1
45 The "panacea for all ills" approach	1

Table 9 - Advantages gained from the implementation of the nursing process presented in rank order

Advantage	Rank Order
More effective patient care	1
A better framework for learning for students and pupils	2
Better communication between nurses and patients	3
Better communication between nurses	4
A better quality of nursing for patients	5
A better framework for teaching by qualified staff	6
Greater job satisfaction on the part of nurses	7
Better documentation	8
Better communication between doctors and nurses	9

Table 10 - Additional advantages relating to the implementation of the nursing process as supplied by the respondents

Advantage	Number of Times Cited
1 Greater/better accountability	8
2 Introduction of a holistic, problem solving approach to nursing	7
3 Better evaluation of nursing	7
4 Better continuity of care	4
5 Involvement of patients/families	4
6 Improved patient satisfaction	4
7 Encouraged nurses to think more analytically about their work	3
8 More awareness of research findings	3
9 The patient is put in a more central position	3

Table 10 Continued

Advantage	Number of Times Cited,
10 Better communication between school and service staff	3
11 Encourages nurses to be more questioning	2
12 Negotiation of care with patient	2
13 Nurses more aware of the individuality of people	2
14 Useful basis for curriculum development	2
15 Better documentation	1
16 Emergence of nursing models	1
17 Improved preparation of patients for discharge	1
18 Improved quality of life	1

Table 10 Continued

Advantage	Number of Times Cited
19 Increased understanding of the change process	1
20 More cost effective care	1
21 More emphasis on communication skills	1
22 Motivation to extend knowledge and skills	1
23 Provides a theoretical construct for care	1
24 Reduces dichotomy between theory and practice	1
25 Staff think more about what they do	1
26 Task allocation eliminated	1
27 Untrained staff have a better work plan	1

Table 11 - Profile of ratings used in arriving at a semantic differential relating to the term "nursing process"

	1	2	3	4	5	6	7	
Important to nursing	X							Unimportant to nursing
Good for nursing	X							Bad for nursing
Holistic	X							Atomistic
Systematic	X							Unsystematic
Humanistic	X							Not humanistic
Individualised	X							Task-centred
Scientific			X					Intuitive
A problem-solving approach	X							A routine-bound approach

Table 11 continued

Theory-based			X					Intuition-based
More family-centred		X						Less family-centred
Enhances communications	X							Impedes communication
Enhances the quality of nursing		X						Detracts from the quality of nursing
Likely to endure				X				Not likely to endure
A clear concept			X					A confused concept
Enhances the autonomy of nurses		X						Detracts from the autonomy of nurses
Patient-centred	X							Not patient-centred

Table 12 - Models taught in schools of nursing

Model	Henderson	Johnson	King	Levine	None of These
Percentage	82	0	2	0	16

Model	Newman	Peplau	Orem	Riehl	None of These
Percentage	13	10	48	1	28

Model	Rogers	Roper	Roy	Yurs & Walsh	None of These
Percentage	20	75	1	1	3

The data on Tables one to eleven provides a perspective on the nursing process approach. It is widely used as the means of delivering nursing care throughout the United Kingdom. At the very least, this suggests that a more detailed study of the matter would be justified. A detailed discussion of the results will be made in the final chapter of the thesis.

Table 13 - List of models plus those which emerged from 'other' section of questionnaire (N = 34)

Abdellah	Johnson	Peplau
Artesian	King	Putt
Berewick	Lancaster	Riehl
Brodtt	Levine	Rogers
Castledine &	Maslow	Roper
Ashworth	McFarlane &	Roy
Clark	Castledine	Saxton &
Eclectic	Newman	Hyland
Goal Planning	Nightingale	SOAP
Gordon	None	Wiedenback
Hall	Orlando	Yura &
Henderson	Orem	Walsh
Interactionist	Own	

Table 14 - Extent to which nursing models are used in clinical areas

Extent	Very Great	Great	Some	Small	Not at all
Percentage	2	10	49	33	6

Table 15 - Extent to which nursing models are seen as useful in the delivery of nursing care.

Extent	Very Great	Great	Some	Small	Not at all
Percentage	3	22	47	24	4

Table 16 - Models relating to children's nursing

Model	Percentage
None	58
Henderson	10
Orem	7
Roper	24
Roy	2

Table 17 - Models relating to community nursing

Model	Percentage
None	58
Henderson	9
Orem	9
Roper	17
Roy	7

Table 18 - Models relating to general nursing

Model	Percentage
None	38
Henderson	22
Roper	37
Roy	3

Table 19 - Models relating to mental handicap nursing

Model	Percentage
None	67
Henderson	7
Orem	9
Roper	13
Roy	4

Table 20 - Models relating to nursing the elderly

Model	Percentage
None	46
Henderson	16
Orem	11
Roper	27

Table 21 - Models relating to obstetric nursing

Model	Percentage
None	70
Henderson	4
Orem	12
Roper	11
Roy	3

Table 22 - Models relating to ophthalmic nursing

Model	Percentage
None	66
Henderson	8
Orem	3
Roper	20
Roy	3

Table 23 - Models relating to orthopaedic nursing

Model	Percentage
None	58
Henderson	9
Orem	8
Roper	22
Roy	3

Table 24 - Models relating to psychiatric nursing

Model	Percentage
None	47
Henderson	3
Newman	3
Replau	7
Orem	16
Riehl	2
Roper	1
Roy	11

Table 25 - An analysis of the additional comments on nursing models made by the respondents on the questionnaires

Model used/comment	Number of Times Cited
Eclectic	17
Impossible to relate model to speciality	10
Roper	7
Henderson & Roper	5
Models should come before process	3
Orem & Roper	3
Too early to say	3
Own	2
Curriculum tool	1
Henderson & Newman	1
Models not of much value	1
None	1
Roy	1
Systems approach	1

The data suggests that there are many nursing models. However, it appears that only the Henderson, Roper and Orem models are used with any degree of frequency. As with the nursing process, discussion of the nursing models will be postponed until the final chapter.

SUMMARY

The aspects presented in the Tables include how the nursing process approach is regarded; what advantages are claimed for it and what problems were encountered with its implementation. A semantic differential relating to the term "Nursing Process" is presented. The models of nursing taught in schools of nursing in the United Kingdom are set out and models are related to clinical nursing specialities.

Interviews were used as well as a survey in order to gather data. The results of the interviews will be presented in the next chapter and the outcome of the survey and the interviews will be discussed in the final chapter.

CHAPTER SEVEN

RESULTS OF THE INTERVIEWS

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Rates of mention for aspects relating to holistic	229
Rates of mention for aspects relating to humanistic	229
Rates of mention for aspects relating to systematic	230
Rates of mention for aspects relating to scientific	230
Rates of mention for aspects relating to individualised	231
Rates of mention for aspects relating to patient-centred	231

Rates of mention for aspects relating to problem-solving	232
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CHAPTER SEVEN

RESULTS OF THE INTERVIEWS

INTRODUCTION

The results of the interview part of the study are presented in this chapter in three forms. In the first instance the content of each interview is analysed with reference to the interview analysis guide (Appendix 10). These results are presented in tabular form and then briefly expanded upon. Next the rates of mention for aspects related to the nursing process are also set out in tabular form. The rates of mention are derived from an analysis of the individual interviews as described above. Aspects of the interview data were analysed using the technique of cluster analysis and this is presented as a dendrogram as related tables.

The composition of the interview sample is set out in Table 26.

Table 26 Some characteristics of the interview sample. N = 40

	Women	Men	Total in each group	average of each group in years
Senior tutors, G	2	2	4	42
Nurse tutors, G	5	5	10	36
Clinical nurses, G	11	-	11	32
Senior tutors, P	-	3	3	43
Nurse tutors, P	3	3	6	37
Clinical nurses, P	1	1	2	34
Senior tutors, M.H.	-	1	1	45
Nurse tutors, M.H.	1	2	3	38
TOTAL	23	17	40	

G = General Nursing, P = Psychiatric Nursing, MH = Mental Handicap Nursing

For the purpose of analysis each interviewee was given a number. The numbers so ascribed, the gender and the status of each interviewee are set out in Appendix 3.

The results for individual interviewees are presented in the following tables.

Table 27 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	2	1	1	1	4	1	2	1	1	6	1	-	4	1	4	1	7	5
1	2	3	7	2	2		4	3	4		7		-	7			6	8	
	3	4	8	5	5		5						-				7		
	4	7	9	6	6		6						-						
	7		10										-						
	8												-						
	10												-						
	11												-						
	12												-						

The initial statement made by this senior tutor comprised several elements. She described the nursing process as problem-solving, individualised, systematic, said it involved negotiation with the patient. She described the nursing process as a systems model and involving planning, implementation and evaluation. Oddly, assessment was not mentioned though it could be inferred from what was said. Early on in the opening statement, she used the term action research. She also included the word holistic (Column A).

A great deal was offered spontaneously and in the course of the interview, these and other aspects were discussed further. For example, the elements subsumed within the label "assessment" included communication, diagnosing and observation. The notion was advanced that assessment is based on a model of nursing. (Column B).

Several elements were subsumed within the label "planning", including negotiation with the patient, the notion of short term and long term planning, the fact that strategy and communication are mentioned. (Column C).

Implementation was seen as the act of carrying out nursing care with patient involvement. To show what was meant she said "..... it involves giving the patient autonomy because after all they are the ones.... that matter most". (Column D).

Evaluation was depicted as being concerned with the success of the care and the reassessment and with a time scale. Measurement is also subsumed within the label evaluation. "You've got to know what you are measuring.... You must be quite specific". (Column E).

As far as this person was concerned, the nursing process is seen as "an interactive process involving the nurse and patient. Decision making was also seen as ideally involving the patient. However, the reality is that it is still prescriptive with the person with the knowledge and skills making the decisions. In many instances medical decisions overturned nursing decisions". (Column G).

The nursing process was characterised as holistic, which was taken to mean taking account of the psychological, biological, social and spiritual needs of the individual. Similarly, the nursing process was seen as humanistic in an ideal sense, but it was not seen as humanistic in practice for she says "we still have the medical model in evidence".

The nursing process was seen as systematic which was taken to mean orderly and logical. The scientific standing of the nursing process is that it is potentially scientific, but in practice it is not. (Column K).

Individualised was seen as a characteristic of the nursing process. With individualised taken to mean "getting away from task-orientated nursing". (Column L).

Problem-solving was seen as a characteristic of the nursing process and was taken to mean looking at things in a logical way and prioritisation. (Column N).

"There needs to be a mechanism.... perhaps.... and the mechanism that I see is the use of a nursing model, I see that as the link.... a means by which the nursing process can be implemented". That was how the relationship between the humanistic/holistic and the systematic/scientific aspects of the nursing process were seen to be related. (Column O).

This nursing process approach is differentiated from other approaches to nursing by a move away from just performing tasks. The documentation was seen as more problematical and the most difficult aspect of the nursing process, but it was also seen as a vital element. (Column Q).

"A model is a representation isn't it.... its an abstract.... its a conceptual thing". Nursing models were also seen as serving a purpose in relation to the assessment part of the nursing process. The relationship between nursing models and the nursing process was seen as a mechanical/abstract one."I see one as the mechanical bit and the other as the abstract bit, so I see the nursing model as the conceptual framework. .. and I see the nursing process as the actual

.... a working tool". (Column R).

Table 28 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3).

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	8	5	1	2	1	3	1	1	1	5	3		3	1	4	1	5	1
2	2		7	2	7	2		2	2	3			4	8		7		8	
			8															9	

This person made a brief opening statement and mentioned only problem-solving and individualized in relation to how she saw the nursing process (Column A). She was similarly brief in dealing with assessment which she saw essentially as problem identification (Column B). Planning incorporated three elements and these are the setting of goals; short term and long term goals (Column C). Implementation was seen as carrying out the care plan with patient involvement (Column D). "Deciding whether you have met the goals", that was how evaluation was seen (Column E). It was also seen as reassessment. To the question who carries out the nursing process the reply was "Hopefully registered nurses.... actually do the assessment.... a registered nurse should carry out the planning and evaluation.... and should be able to delegate some work as appropriate to different people". (Column F).

That it is individually based was seen as the essential characteristic of the nursing process. The nursing process was seen as holistic, which was taken to mean "looking at the patient and his environment and his social setting and his family." (Column H). With regard to humanistic this person said "I consider this to be its main point" (Column I). The nursing process was seen as systematic "there should

be a logical system in having problems assessed." (Column J).

"I don't think it is scientifically based.... it's not a research thing is it? I can't think it has a scientific base". That was how the scientific standing of the nursing process was perceived in this instance. (Column N). With regard to patient-centredness the response was "yes.... if it is done properly...." Patient-centredness being taken to mean that individual patient problems are being considered (Column M).

With regard to problem-solving, this person was of the view that it should be, but went on to say "I prefer individualised patient care ah it sounds as if patients are being processed". (Column N).

"They should all relate shouldn't they if they are done properly.... ah.. just because you are systematic and problem-solving doesn't mean it can't be humanistic." That was how the relationship between the scientific/systematic and the holistic/humanistic aspects were perceived. (Column O).

The essential difference, as perceived by this person, between the nursing process and other approaches to nursing is that it is not task-centred, but it involves more paperwork. She goes on "We had about six types of care plan before we found one that was effective" and later she adds "I have come to the conclusion that it is very difficult to use care plans without having a model of nursing around which to work". (Column P).

Nursing models were perceived as theoretical frameworks, as a guide/check list for making assessments, but they were also seen as confusing "models tend to be confusing and the fact they were introduced after the nursing process... I think the way the nursing process was introduced caused a lot of resentment". This person went

on to say "Nursing models should provide a framework within which you can use the nursing process". It appears that there is a compatible relationship between the two.

Table 29 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	11	6	2	7	2	2	1	2	1	4	2	2	1	5	2	2	1	2
3			13			4	4				5		5				6		

"It is an attempt to individualise care". Essentially, this was all this person offered spontaneously by way of an opening statement (Column A). He saw assessment as a team approach (Column B). Planning was seen as involving making a care plan solving problems (Column C) ".... must be in co-operation with the patient", that was how implementation was perceived (Column D). We have to do a lot more work on our assessments and on our planning.... and making the goals we set reasonable". Evaluation was thus seen as concerned with that attainment of goals (Column E). Junior nurses should have the opportunity to make decisions". With regard to the standing of the nursing decisions he had this to say "If there is conflict the doctor obviously has the ultimate responsibility... he will hold the line". (Column G).

The nursing process was seen as holistic which was taken to mean involving the whole patient (Column H). It was also seen as humanistic because of the involvement of patients in their care (Column I). Systematic was seen as a characteristic of the nursing process, but the reason (Column J) given was tautological because he said "We look at things systematically". This person dealt with the scientific

status of the nursing process as follows (Column K)".... it depends on what you mean by scientific". When asked what he meant by scientific he said "Well.... experimenting to see if it actually works and if we could do better.... um.... in a way I suppose it is scientific". The notion that each patient is treated as an individual was seen as making the nursing process individualised (Column L). The nursing process was also seen as patient centred, at least in theory, but this person went on "It just falls down in hospital.... because of the constraints, because of the hospital routine, therefore it is not totally patient centred". (Column M).

Problem-solving (Column N) was perceived as follows "I think it is developing.... we are not there yet". The relationship between the holistic/humanistic aspects and the systematic/scientific ones presented this person with a problem. Following some thought and a little unease he replied "I can't answer that question." (Column O).

The main difference between the nursing process approach and other approaches to nursing was seen to be better communications with patients. No comment was made whether or not nurses experienced better job satisfaction or whether patient care was improved (Column P). The documentation relating to the nursing process was seen to be time consuming, but good documentation was also seen as important (Column Q).

"If we are looking at models we are looking at the ABC of care". At one point, this was how this person perceived models. However, he had some difficulty in relating nursing models to the nursing process. "I don't think they relate totally.... except in documentation.... actually our care.... don't relate to the nursing models" (Column R).

Table 30 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	8	14	1	3	2	4	3	3	3	5	3	2	4	4	8	2	1	1
4	8																4	8	

The initial statement made by this person was relatively brief. "To me it's a systematic way of planning care" sums up the essence of the opening statement (Column A). The assessment phase was seen as being concerned with problem identification (Column B). Planning was characterised as "sorting out what we are going to do (Column C). Implementation was seen simply as carrying out what was planned (Column D). Evaluation was seen in equally terse terms "to see what is happening (Column E). Decision making was seen as a team affair (Column F).

When asked what features characterised the nursing process, the response was "it is time consuming". With regard to holistic he was not sure that it was (Column H). However, the interactive aspect, made it humanistic (Column I). The nursing process was seen as systematic because "it is an organised way of going about it" (Column J). This person was unsure about the scientific standing of the nursing process "I haven't really looked at it in that way". (Column K). The nursing process was seen as individualised (Column L) "it's made for that person", and it was also seen as patient-centred and a problem-solving approach (Columns M & N).

There were no difficulties in relating the holistic/humanistic aspects

to the systematic/scientific ones. "I think a bit of each", but he added "I don't know whether that is scientific" (Column O). The differences between the nursing process and other approaches to nursing was expressed in terms of the person's own experience and as such was placed in the unclassified category (Column P). With regard to documentation he had this to say "The positive role of the documentation is that it is much more detailed.... the negative side is that it sometimes takes too long to complete". (Column Q).

Nursing models were seen as ways of looking at things and as serving a function in relation to the assessment of patients. The relationship between the nursing process and nursing models was seen as being compatible. "The process is an organised way.... a model is a way of looking at.... how this person can care for himself" (Columns R & S).

Table 31 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3).

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	5	1	1	7	2	1	1	1	2	5	2	6	1	5	1	4		1
5	5					3	2	2	4	5				12		2	7	5	5
	6	6							5							4			
	8															5			

Problem-solving, assessment, decision making and planning were offered spontaneously by this person in her opening statement (Column A). Assessment was seen as involving the determination of needs and the setting of goals (Column B). Planning was seen to be involving the patient (Column C). "Thats actually giving the care" was implementation was depicted (Column D) "I think it's done very badly" was the comment

on evaluation, but essentially it was seen as being concerned with the achievement of goals (Column E). All nurses were seen as carrying out the nursing process, though some nurses may need help especially with assessment (Column F). "It should be an interactive process so that decisions about the nursing care should be made by the patient as well as the nurse". This was how decision making was seen (Column G). However, the person considered that there were too many people making decisions and thus the decision making process was somewhat fragmented.

"I would say that it could be.... it's not always" that was how the holistic standing of the nursing process was perceived (Column H).

"I would say that it should be humanistic, but it isn't always" that was how the humanistic aspect was perceived (Column I).

"I didn't like the use of that word". That was this person's response to the scientific study of the nursing process (Column K).

"I think it all depends on what you mean by scientific". She went on to say "Think what is meant by scientific.... it's experimental and empirical and I don't know that I see this process in that light".

This person could see the humanistic/holistic aspects of the nursing process relating well and she went on to say "I think if you are going to adopt a problem-solving approach.... which is what we say the nursing process is.... You have to be systematic". She was prepared to accept that the nursing process was systematic, but not scientific (Column O).

More job satisfaction for nurses, better relations with patients, no longer task-centred and patients looked at as individuals were seen as the points which differentiated the nursing process from other approaches to nursing (Column P).

"We are recording more information about the patients than we did previously". This was how the documentation was perceived. She added, however, "We are still not doing evaluation well at all whether it should be dates, criteria, measurements or whatever" (Column Q).

Nursing models were seen as frameworks on which you can hang things.

"Some of them I don't understand". A compatible relationship was seen to exist between nursing models and the nursing process

(Columns R and S).

Table 32 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	5	1	1	3	1	2	1	4	2	5	1	2	1	2	1	1	3	2
6	5	6			7	2	5							2	4	7	8	3	
		11			3	6													

"My perception of the nursing process is that it is a systematic way of assessing needs". That is the essence of the opening statement made by this person (Column A).

The assessment part of the nursing process was seen as being concerned with determining needs, setting goals and involving a team approach (Column B). The patient was seen as being involved in the planning of nursing care and again a team approach was emphasised (Column C). "I think the (Column D) student nurse finds this the easiest bit". This was how implementation was viewed and was seen to involve carrying out nursing care. "Evaluation is looking back to see.... what is actually happening.... we said what we would like to happen.... and then we go back to the patient and see what is actually happening". That was how

evaluation was perceived (Column E).

All grades of nursing staff were seen to be involved in carrying out the nursing process (Column F). With regard to making decisions "I feel it should be the person giving the care", but she went on "... really it should be the person most suitable.... to make the decision". The standing of nursing decisions was described as follows. "The nursing decisions are given very little credibility.... they are still medically prescribed" (Column G).

"I would like to think that it was" was how this person regarded the holistic aspect of the nursing process. However, she went on to say it's not always holistic "we just look at a very small part" (Column H). Would you say it is humanistic? "No, I wouldn't.... no... I think it's still authoritarian.... ". She seemed to be in no doubt about the humanistic standing of the nursing process. (Column I).

The nursing process was seen as systematic because there is a format to it (Column J). When asked if the nursing process was scientific the reply was "I am not sure about that"(Column K). The nursing process was seen to be both individualised and patient-centred "if it's done well I think it is patient-centred" (Column M).

This person experienced some difficulty in reconciling the holistic/humanistic and the systematic aspects (she wasn't sure about the scientific standing of the nursing process). She comments "... but when we take it down to the ward.... it's not realistic" (Column O).

Two aspects were seen to differentiate the nursing process from other approaches to nursing and these were more job satisfaction for nurses using the nursing process and getting away from task-centredness (Column P).

"It's a pain!" That was how documentation was described. The documentation was seen as a difficult aspect and an aspect not fully understood, for example, "we are getting our problems mixed up with our outcomes (Column Q).

Nursing models were seen as "... different criteria for implementing the nursing process for individualised care. Regarding the relationship between the nursing process and nursing models she said "I think there is a lot of confusion in that area ...No they are not the same" (Columns R and S).

Table 33 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	2	11	1	8	2	4	2	4	1	2	1	2	3	1	2	2	10	1
7	5	7					7				5					4	7		
	8						7												
	11																		

In her opening statement this person offered systematic, assessment, planning and evaluation as elements comprising the nursing process (Column A). Assessment was seen to be concerned with communication and based on a nursing model (Column B). Planning was essentially concerned with the identification of nursing action (Column C). Implementation was seen as carrying out nursing care (Column D). Evaluation was seen as a combination of assessment, planning and implementation which is true, but this throws little light on the nature of evaluation (Column E).

All ward staff were seen to be carrying out the nursing process and decision making was seen as a team activity, but the primacy of the medical decisions was recognised (Column G).

"It should be" that was how she saw the holistic status of the nursing process. Holism was taken to mean involvement of the psychological and social aspects of the individual (Column H). "I am not quite sure" was how she responded when asked about the humanistic aspect of the nursing process (Column I).

The nursing process was seen as a systematic approach to nursing (Column J), but there was some doubt about its scientific standing (Column K). "I am not sure about science". It was seen as an individualised approach (Column L). But patient-centredness was another matter "It should be but it's not because the patients' opinions are never asked for (Column M). The nursing process was seen as a problem-solving approach, but the answer was tautological since problem-solving was taken to mean problem identification (Column N).

The scientific/systematic and the holistic/humanistic aspects, despite earlier comments about the humanistic and scientific aspects, were seen as relating well (Column O). Better relations and communication with patients and getting away from task-centredness were seen as the features which differentiated the nursing process from other approaches to nursing (Column P). The documentation involved was seen as time-consuming, but although not stated explicitly, the documentation was seen as an improvement on previous approaches (Column Q).

What are nursing models? This question elicited the names of several models, but not a description of a nursing model. The relationship between the nursing process and nursing models was seen as compatible and was expressed succinctly as follows "... the process is just the way of doing it.... the models are just the different ways that the people implement it" (Columns R and S).

Table 34 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	5	1	1	1	2	4	2	2	1	5	1	6	8	5	-	2	3	1
8	9	1	5	2			7										4	8	
		5																	

The key elements in this person's opening statement were individualised patient care and scientific "I see the nursing process as a means of providing the patient with individualised care and that it's concerned with two aspects: 1 the caring element of nursing and 2, the theoretical or scientific component of nursing (Column A).

Assessment was seen as being concerned with collecting information and determining needs (Column B). Planning involves negotiation with the patient and the setting of goals (Column C). Implementation was seen to be carrying out nursing care with patient involvement (Column D). Evaluation was seen as checking the care was successful (Column E).

Decision making was considered to be a team affair. "The doctors make the medical decisions. Doctors sometimes rely on nurses' observations. The doctor will get his way.... the doctors have power. You can discuss with some doctors.... nursing plans can be scuppered at a stroke". That was how nursing decisions were seen in relation to medical decisions (Column G).

The nursing process was characterised as being holistic and humanistic (Columns H and I) though the commitment to humanistic was no stronger than "Yes, I think so". Despite including scientific in her opening

statement she later concluded that the nursing process "is not really scientific" (Column K). The relationship between the humanistic/holistic and the systematic/scientific aspects was unclassified and something the person had not thought about very much (Column O).

The documentation was seen as time consuming, but it was also seen to have a positive aspect resulting in better documentation (Column Q). Nursing models were seen as a way of implementing the nursing process and also as a checklist. "A model is like a checklist but used on an individual basis ensures you don't miss out on any vital stages" (Columns R and S).

Table 35 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	2	4	1	4	-	4	-	1	1	5	1	-	1	1	4	3	10	1
9		12	13													5			

"The nursing process is a way of identifying people as individuals" (Column A). That is the essence of the opening statement made by this person. Assessment was seen to involve communication principally (Column B). Planning was described as sometimes being a paper exercise (Column C). It was also seen to be concerned with making a care plan. "Doing the nursing" was how implementation (Column D) was depicted and "Is the care plan working?" was how evaluation was seen (Column E).

Decision making was seen as a team affair (Column G). However, the primacy of the medical staff was accepted. "Doctors are responsible for the patients the medical decision usually carries ... arrangements are amicable usually. The power lies with the consultant the doctors think the nursing process is a load of rubbish!".

This person passed on the holistic (Column H) aspect of the nursing process, but accepted that it is humanistic (Column I) "Yes, it's humanistic.... it's concerned with the human element...." There was uncertainty about the scientific standing of the nursing process "I am not sure about scientific". (Column K).

It was accepted that the nursing process is a problem-solving approach, but problem-solving was described as solving the problem identified which is not very illuminating (Column N).

The differences between the nursing process and other approaches to nursing was seen as getting away from task-centredness and looking at the patient more as an individual (Column O). Standardized documentation was welcomed because "guidelines are necessary otherwise they don't know where to start (Column Q). The nursing process and nursing models were seen as going well together (Columns R and S).

Table 36 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3).

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	2	1	1	1	2	4	3	4	1	2	2	2	-	4	1	1	5	1
10		4	13													7	2		
		12																	

Individualised was offered spontaneously as this person's notion of the nursing process. "The nursing process aimed to get nurses to look at the person, it is a process of giving care to the whole person" (Column A). Assessment was seen to involve communication, observation and the taking of a history (Column B). "Taking stock of

what you are going to do" was how planning was depicted and the nurse and patient were seen to be involved (Column C). Implementation was succinctly described (Column D) as "the doing bit", the giving of care. "Not always well done" was the comment on evaluation and it was seen as involving reviewing and checking (Column E).

Decision making was seen as a team-affair. However, this person commented that "too many assessments are made". With regard to the standing of the nursing decisions she said "doctors tend to have the power" (Column G).

This person wasn't sure of the holistic (Column H) standing of the nursing process and was somewhat dismissive of it's humanistic standing, "The nursing process is a practical thing" was how it was perceived (Column I). The scientific standing of the nursing process was another matter. "Yes, it has to be..... it's based on knowledge and research.... it"

"I need to think about that" was how she dealt with the relationship between the holistic/humanistic and the systematic/scientific ones (Column O). The principal difference between the nursing process and other approaches to nursing was seen to be more paperwork and more job satisfaction for nurses. Improved patient care was not offered as an example of a difference (Column P).

Documentation was seen as a difficult aspect and also a time consuming one. There was no comment as to whether the information recorded was better or not (Column Q).

Nursing models (Column R) were seen to serve a number of purposes. As a structure to fulfill the nursing process, as a framework to use for planning, and a view of the person. She went on to say models take account of health and illness and the nursing process does not. It

was also mentioned that the nursing process approach could be used in any context while models are people specific (Column S).

Table 37 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3).

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	13	9	1	7	2	4	1	2	1	3	2	5	1	1	8	2	2	1
11							7							6			6	7	

As far as this person was concerned the nursing process comprised assessment, planning, implementation and evaluation. He added that it comprised individualised care (Column A).

"I would like to see it used in conjunction with the patient so that a nurse is assessing.... it's not just her view.... it's also hers and the patient together.... it ought to be patient-centred.... it's not really patient-centred." That was how this person saw the assessment part of the nursing process (Column B). Planning was seen as thinking ahead "... unless there is an aim, it's difficult to evaluate"

(Column C). Implementation was seen as putting plans into action; but this person made the point that "plans are rarely consulted at the implementation stage.... care is done as in the past"(Column D).

Evaluation was seen to be concerned with seeing whether goals are met.

"Evaluation is not well done, not usually written down and is often missed out" (Column E).

Decision making was seen as a team affair which generally works well.

However, the medical decisions were seen as paramount and overriding

all others. "Medics have their way.... patients ought to be involved"

(Column G).

The nursing process was characterised as humanistic, concern for the individual (Column I) and holistic (Column H). "We don't just deal with the physical.... we also deal with the emotional, aesthetic needs". The nursing process was also seen as systematic (Column J) which was defined "as a process which is universally understood and systematized". This is a somewhat tautological definition.

Scientific was a characteristic ascribed to the nursing process and science was seen as being concerned with exact measurement "... there is a certain amount of measurement, and there is a body of knowledge called from medicine, physiology" "Yes, I think it's scientific" (Column K).

"It's not really patient-centred"(Column M) was how the issue of the patient-centred standing of the nursing process was seen. Problem-solving was seen in a similar light (Column N). He made the point that many problems are not solvable and he suggests "the aim ought to be something which is achievable. It's definitely not a problem-solving approach".

The holistic/humanistic and the scientific/systematic aspects were seen to go well together "... its difficult to separate them" (Column O). This person didn't think there was any difference between the nursing process approach and other approaches to nursing "care is done as in the past" (Column P). Views were mixed about the documentation aspect which was seen on the one hand as time consuming, but on the other hand good documentation was seen as essential (Column Q).

Nursing models were seen as embodying a philosophy (Column R) and also embody a value of other people "... seeing everyone as having value". This person went on "There is a sort of mystique around models.... difficult models are no good then language is often too

complicated". The relationship between the nursing process and nursing models was seen as compatible (Column S).

Table 38 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3).

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	2	7	1	7	2	4	1	1	1	2	1	5	6	1	3	2	5	1
12		4	8															5	

"It has basic elements for providing individualised care and I see it as better for the patient and better for the provision of care.... it could also be cost effective.... it's better for the nurse because individualised care is an advantage.... it's also time consuming and involves a lot of paperwork". This is what this person offered spontaneously in his opening statement (Column A).

Assessment was seen essentially as involving listening and observation skills (Column B). Planning was seen to involve short term and long term goals "At the moment the learners do it.... it should involve technical staff, but it doesn't always, the patient is very little involved" (Column C). Implementation was seen as carrying out nursing care and evaluation being concerned with whether the goals were met (Column E).

Decision-making was seen as a team affair and generally there was harmony concerning the decisions made. In the case of conflict ".... the medical decision overrides" (Column G).

"Yes, it can.... we are dealing with human beings and nursing is to do with human relationships it has to be humanistic.... the personal

touches, personal relationships make it humanistic". That was how the humanistic aspect of the nursing process was perceived (Column I). The holistic aspects were viewed in similar terms. "Yes, it is holistic. Looking at the individual as a whole, which.... it makes emphasis on the holistic approach to care". (Column H).

"It's scientific because you can apply scientific method to nursing care.... the process does allow for that". This was how the scientific standing of the nursing process was perceived (Column K). Its standing with regard to patient-centredness was seen in different terms "No it's very much nurse-centred.... nurse gathering, nurse obtaining, nurse doing... there should be more patient and family involvement". (Column M).

"It's supposed to be a problem-solving (Column N) approach" was how he responded to the problem-solving aspect of the nursing process. He went on to say that patients' problems and nursing problems often get mixed up.

The humanistic/holistic and the systematic/scientific aspects were seen to relate well together (Column O). The following aspects were seen as differentiating it from other approaches to nursing: better patient care; a good teaching tool; a scientific orientation and research mindedness (Column P).

"There is a lot of paper work involved in terms of collecting data.... and keeping records of the nursing care.... and then people don't always use the nursing process effectively". That was how the documentation aspect was seen (Column Q).

Nursing models were seen essentially as a way of implementing the nursing process and also framework (Column R). The relationship between the nursing models and the nursing process was put thus:

"Nursing models have to employ the nursing process.... the nursing process is a framework, it's not a model" (Column S).

Table 39 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	2	1	1	4	2	4	3	1	3	5	1	-	1	-	4	1	8	1
13	5	3	5											4	5				
		4	7																

"The nursing process is a concept or a model to assist nurses to solve problems.... to do this they have to assess the patient.... to give individual care.... We are not treating patients in groups any more.... theoretically we shouldn't.... we were given tasks in the past e.g. temperature, pulse, respiration, pressure areas etc..... it was task orientation". That was the opening statement volunteered by this person (Column A.

The assessment part of the nursing process was seen to comprise communication, observation and making diagnoses (Column B). Planning was depicted as follows: a plan is a statement of the problem; an aim is what we want to happen; a goal the achievement of what you wanted to see happen, but in other terms it was making the problem go away or relieving the symptoms (Column D). Implementation was seen as the activity part of the nursing process and was seen to depend on the problems identified (Column D). Evaluation was seen as observation for improvement or otherwise (Column E).

Decision-making was seen as a team affair, though it was admitted that sometimes nurses, physiotherapists and others each go their own way. "Nurses can question decisions.... then doctors have the power to decide.... but there may be consultation with the medics". Again it seems to be a case of medical primacy as far as decision-making is concerned (Column G).

This person was fairly certain about the humanistic standing of the nursing process. "... we're using all we've got to help the patient it's humanistic" (Column I). He wished to reserve his position about holistic - he was not sure (Column H).

The nursing process was considered to be a systematic approach in that it was seen to go through stages (Column I). This person was ambivalent about the scientific status of the nursing process. At first he said "it tends to be science based". Later, however, he said "No, I don't think it is scientific, not in a way that would be acceptable to scientists generally" (Column K).

Problem-solving was seen as a characteristic of the nursing process because it was seen to be concerned with analysing problems and with looking at things logically (Column K). The difference between the nursing process and other approaches to nursing was set out in this person's opening statement and amounted to the fact that nursing is no longer task-centred and that it is individualised (Column P).

With regard to the documentation aspect this person said "Nurses don't like change (a point made in the review of the literature by Menzies, 1970) people get used to routine.... the documentation, not the idea that caused the problem" (Column Q).

"I am wrestling with them", that was his comment on nursing models (Column R). However, models were seen as useful in the assessment

phase of the nursing process. He went on to say that the nursing process and nursing models complement each other (Column S).

Table 40 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10).

Vertical axis = interviewee (Appendix 3).

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	4	1	1	1	2	4	1	1	1	5	1	1	1	-	3	7	2	1
14	2	12	5	2												4			
	5		13													5			
	8																		
	11																		

The elements in this person's opening statement included problems, individualised, assessment, planning and evaluation.... "the most important aspect of identifying the problem is that they are the problems of that individual patient the problems should take into account that patients' perceptions of the problems.... it should be individualised" (Column A).

Assessment was perceived as being concerned with making observations, taking a history, but mention was also made about interpreting the observations made (Column B). Planning was seen as involving the patient, setting goals and making a care plan (Column C). Implementation was seen as giving care and the point was made that the plans may or may not be consulted (Column D). Evaluation was seen as being concerned whether the care was successful or not. Mention was made however that the patients' perceptions ought to be taken into account (Column E).

With regard to decision making the point was made that many people are asking the same questions and that a single assessment would be better.

The standing of nursing decisions was dealt with thus: "The beds belong to the consultant and he has the final say.... however most consultants will listen to nurses.... the power rests with the doctor" (Column G).

"If it's not humanistic, it's not worth having" (Column I). That was how the humanistic aspect of the nursing process was seen, though he was unsure about the holistic aspect (Column H).

The inclusion of the behavioural and the biological sciences was seen as providing the scientific basis for the nursing process. He went on "Some aspects of nursing care have been subjected to scientific study.... as practised in our hospital it's not scientific.... we are half a mile along a ten mile development road" (Column K). The nursing process was perceived as patient centred in that negotiation with the patient was seen as an element of it (Column M).

The difference between the nursing process and other approaches to nursing were seen as better care, individualised and therefore no longer task-centred (Column P).

Documentation was not seen as an issue. What was seen as an issue was that doctors, occupational therapists, physiotherapists, dieticians, nurses and so on were all making assessments and many people were asking the same sort of questions. It was suggested that a single assessment would be better (Column Q).

It was suggested that the nursing process should use nursing language and that nursing models embody the language of nursing science.

Nursing models were seen as incorporating concepts such as health, ill health, nursing and so on. Nursing models were also seen to embody differing views of the patient (Columns R and S).

Table 41 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	4	1	1	1	2	4	1	1	1	2	4	4	1	1	8	7	5	1
15	5	2	3					2	3										
	8	4																	
	11	12																	

Problem-solving, assessment, planning and evaluation were the elements which were offered spontaneously by this person who went on to say "we plan the nursing care or intervention for that patient.... in order to help the patient.... we can work out what we hope to achieve.... we can go out and deliver that care to the patient.... and then look back at what we've done.... reassess the patient.... evaluation" (Column A).

Assessment was seen essentially as involving communication, observation and the taking of a history (Column B). Planning was seen to include negotiation with the patient and intellectual activity. "The nurse actually fulfills the plan...." but she added "the nurse may consult the plans, but may not not as much use made of the plans as might be". Evaluation was seen to be concerned with whether the care was successful or not (Column E).

"All are assessing, all are asking similar questions". The question was raised whether one document would do for all concerned. In the case of conflict over decisions "the power lies with the doctors.... nearly always" (Column G).

"Its got elements of the humanities and science". That was how the knowledge aspect of the nursing process was seen. Dealing with people

and with the effective and emotional components were seen to make it humanistic (Column I). Looking at the total person, the physical, psychological, social and spiritual aspects were seen as supporting a claim for holism (Column H).

The nursing process was seen as scientific because there are elements which can be proven scientifically.... proven by research. "Yes, it's scientific - there has been lots of research" (Column K). The nursing (Column L) process was seen as being both individualised and patient centred (Column M) and a problem-solving approach to nursing (Column O). The scientific/systematic and the humanistic/holistic aspects were seen as going well together because the nursing process was depicted as having elements of the humanities and science (Column O).

The differences between the nursing process and other approaches to nursing were not seen to be very pronounced. It was not seen to be working and the standard of care was thought to be about the same.... "the nursing process has not fulfilled it's expectations"(Column P). The documentation involved was not seen as an issue except that observations were recorded on a standard document. However it was felt that it is possible to individualise a standard document to allow for individual interpretation (Column Q).

Nursing models were seen to embody a whole philosophy of nursing within which the nursing process can be used. The point was made that the nursing process does not deal with, for example, health and illness. Hence the necessity for using a model in conjunction with the nursing process. (Columns R and S).

Table 42 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	5	2	13	1	2	2	4	1	3	1	1	5	5	1	1	8	7	8	1
16	8	4			7		7		5		5			2					
	10																		
	11																		

The elements which this person offered by way of an opening statement (Column A) were assessment, planning, implementation and evaluation.

She defined the nursing process as follows: ".... the not unique to nursing.... business, industry, commerce have used assessment, planning, implementation and evaluation for many years.... it's useless on its own.... it's a tool used by nurses today".

Assessment (Column B) was seen as involving communication and observation and the point was made that "nurses are not good interviewers... not skilled ". Planning (Column C) was seen to be concerned with making a care plan. The point was made that "patients or relatives are not involved as much as they should be".

Implementation (Column E) was seen as nursing intervention and the point was made that "plans are not always consulted at the implementation stage and are sometimes ignored". "The most difficult part of the process to do" that was how evaluation was viewed. It was seen as reassessment and it was noted "that there is confusion about the terms and tools of evaluation. To clarify matters the person said we evaluate with our senses: eyes, nose, ears, touch etc. and we evaluate with instruments: thermometers, blood pressure apparatus, fluid charts and so on".

Decision making (Column G) was seen to be a team affair. The point was made that there was repetition of the same questions to patients and she went on to say "I'd like to think that nurses have become more assertive. It depends on the "bottle" of the sister whether she is prepared to stand up and be counted doctors still carry a lot of clout.... the power lies with the consultant. Nursing staff are under the doctor's thumb".

Holism was readily accepted (Column H) as a characteristic of the nursing process because it was seen to involve the whole patient and family. Humanistic was also accepted as a characteristic of the nursing process (Column I) because its concern with communication and the fact that intuition was seen to be involved. She said "It is humanistic primarily because it involves people, it involves the affective domain and the non-measurable side of life".

The scientific standing of the nursing process (Column K) was somewhat ambivalent. It was seen as scientific in the sense that it follows logical steps and that aspects of evaluation can be measured in certain circumstances. On the other hand it was not considered to be scientific in a sense that would be recognised by the scientific community generally.

There was some doubt about the patient-centred study of the nursing process because the patient is not as involved as much as they should be in their care. Problem-solving was seen as a characteristic of the nursing process because it was described spontaneously as a method of solving problems and creating an order of priorities. Pain, for example, was seen as requiring quick action.

The relationship between the scientific/humanistic and systematic/scientific was seen as compatible "... it encompasses the scientific

method and it's humanistic.

"I believe it's not working properly". This statement had a blurring effect on any differences that might exist between the nursing process and other approaches to nursing.

The documentation was not seen as an issue except that nurses were not good interviewers, the implication being that this would affect the quality of the information gathered.

Nursing models (Column R) were seen as norms for assessment. The nursing models were seen as dealing with health and illness whereas the nursing process was not seen to be concerned with these. The relationship between the nursing process and nursing models was seen as compatible.

Table 43 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	3	9	1	1	1	2	1	6	3	8	1	6	3	1	5	1	1	1
17	3					2													

This person volunteered that the nursing process was an individualised and systematic approach to nursing (Column A). As far as assessment was concerned (Column B) it involves "appraisal of the whole situation and identifying an effective way to achieve your objectives". Planning was seen as ".... involves saying you are going to go from A to B You've got to ensure that everybody looking after that patient knows what the plan is and the best way to implement it". There is no mention about ensuring the patient knows about the plan.

"Putting into practice what you have assessed and planned". That was how implementation was perceived. Evaluation was seen essentially as being concerned about whether the care was successful or not.

Decision making (Column G) was not seen as an issue. Nurses were making decisions and developing their skills in that respect. "It ought to be" was how holistic was seen in relation to the nursing process. Holistic was taken to mean "looking at the whole patient.... the environment....". Humanistic was seen in a similar light "By humanistic I mean having empathy with the patient.... and I think that's about it....". There was an obvious reluctance to go any further. "You've a process to go through.... that must make it systematic". That was how systematic was perceived.

"I don't know what grounds you would actually say it is scientific... I don't know how much research has actually been done". Later on she said "... it's much more scientific than it used to be". This person showed some ambivalence about whether scientific is a characteristic of the nursing process or not (Column K).

Individualised (Column L) and patient-centred (Column N) were seen in a different light. Individualised was accepted as a characteristic of the nursing process, but with regard to patient-centred the view expressed was "It ought to be.... but whether in actual fact it is... is another matter....".

"That's the only way really I can look at the nursing process". That was how the problem-solving status of the nursing process was seen (Column N).

The holistic/humanistic and the scientific/systematic aspects were seen to relate well (Column O). The difference between the nursing

process and other approaches to nursing was seen essentially to be a matter of looking at the patient more as an individual.... "the patient is much more involved". "The documentation is quite horrendous". That was how the documentation was perceived, but there was an unwillingness to pursue the matter further (Column Q).

"Nursing models are ways of approaching care" (Column R). That was how nursing models were viewed. The relationship between the nursing process and nursing models was seen as compatible.

Table 44 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	1	1	2	7	2	1	1	4	1	3	2	5	5	4	4	1	5	1
18	3	9						2			4				5	2			

This person opened up by saying she saw the nursing process as a problem-solving and a systematic approach to nursing care (Column A). Assessment was seen to involve the collection of information and the making of a nursing plan. (Column B). The patient was seen to be involved in the planning stage of the nursing process (Column C). "We both work together, that is, patient and nurse". That was how implementation was perceived (Column D). Evaluation was seen to be concerned with the achievement of goals (Column E).

"They should be joint.... joint between the patient and the nurse". That was how decision-making was perceived. However, the standing of nursing decisions was seen as very limited ".... the doctors are listening. Not all of them".

Holistic (Column H) was seen as involving the physical, psychological, and emotional needs of the person. However, there was some doubt about the holistic standing of the nursing process. "I don't know... I don't really understand the term", was how she responded to the question concerning the humanistic standing of the nursing process (Column I).

Would you say the nursing process is scientific? "I don't think so... it is systematic.... but I don't think it is scientific.... By scientific I mean experiments, measurements.... doing things in a very logical fashion". That was how the scientific standing of the nursing process was perceived (Column K).

Individualised (Column L) and patient-centred (Column M) was seen as characteristics of the nursing process. Problem-solving was also seen as a characteristic of the nursing process ".... setting realistic goals". This person was not sure about the relationship between the holistic/humanistic and the systematic/scientific aspects "that's difficult" (Column O). More individualisation and getting away from task-centredness were seen as the features which differentiated the nursing process from other approaches to nursing (Column P).

"A lot.... an awful lot.... for some documentation is what the nursing process is all about.... All that is needed is very simple documentation". That was how the nursing process was perceived in this case"(Column Q).

".... a framework really". That was the essence of what the person had to say about nursing models (Column R). ".... the nursing process is used in conjunction with nursing models (Column S). The relationship between the nursing process and nursing models was thus seen as compatible.

Table 45 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	2	1	1	1	2	1	1	1	1	5	2	1	3	1	4	1	4	1
19		4	13		2		6						3						
		12																	

As far as this person was concerned the nursing process "is a systematic, logical approach to the care patients are given...." (Column A). Assessment was seen to involve communication, observation and history taking. (Column B). Planning was seen as involving negotiation with the patient and making a care plan.... "devising a plan of care.... a plan of action.... ah as a negotiated thing between you and the patient" (Column C). "Actually doing it" that was how the assessment phase of the nursing process was seen (Column D). "I see evaluation as a different aspect of assessment.... ah see the two very much entwined" (Column E).

Ideally, the nurse and patient together ought to be involved in the decision making process, however, she went on to say the decision making goes on at sister and staff nurse level.... It's very much influenced by the medical input". It was stated ".... nursing decisions tend to be overruled by the medics" (Column G).

"Looking at the person as a person" that was how holistic was depicted. With regard to the holistic standing of the nursing process she said "Yes, it should be holistic.... yes. I don't think I see it in practice very much". The response concerning the humanistic standing of the nursing process was very similar. "Yes, it is (humanistic) but it's not always in practice"(Column I).

Systematic was seen as a characteristic of the nursing process. "... ah.... logical, not random.... it's thought through.... it's not just happening.... ah.... it's conceived before decisions are made" (Column J). The scientific standing of the nursing process was seen in different terms "I don't know, I don't know really" (Column K).

Individualised (Column L) and patient centred (Column M) were seen as characteristics of the nursing process. Patient-centred was seen as "ah.... adjusting, amending, negotiating with the patient.... the care evolving it round the patient". Problem-solving was also seen as a characteristic of the nursing process which was seen essentially as the identification of problems/needs (Column N).

"That's a tough one" that was the initial response concerning the nature of the relationship between the holistic/humanistic and the systematic/scientific aspects of the nursing process. She said later "they should jog along together.... ah.... the main problems with the nursing process are problems with change" (Column O).

The differences between the nursing process and previous approaches to nursing were seen principally as getting away from task-centredness (Column P). "I feel the problem with the nursing process is the fact that there is so much store set by the documentation.... that people think the nursing process is the documentation. People tend to get bogged down with the documentation.... it becomes a task in itself" (Column Q). That was how the person saw the issue of documentation.

Nursing models were seen as a representation of the patient's role and the nurses role. "I think the nursing process is just.... the actual doing of the job.... the nursing models.... is how you see the job.... I don't think you can have one without the other". That was how the relationship between the nursing process and nursing models were perceived.

Table 46 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	4	12	1	7	2	3	2	2	1	2	2	1	5	1	4	7	5	3
20	2	12		2															
	5																		
	8																		
	10																		
	11																		

There were six elements in this person's opening statement including problem-solving, individualised care, assessment, planning, implementation and evaluation. This person's construct of the nursing process subsumed these elements (Column A).

The assessment phase of the nursing process was seen to be with making observations and taking a history. There was no mention that a model of nursing might be used in relation to the assessment phase. The planning phase of the nursing process was seen to be concerned principally with the matter of resources "... You should have a knowledge of resources.... and restraints, because you have to be realistic....". Implementation was depicted thus "This is actually carrying out the nursing care.... of course.... this is really the individual in the bed". Evaluation was seen to be concerned with whether or not the set goals were met (Column E).

All grades of nurses were seen to be carrying out the nursing process. A registered nurse was seen as the person to make decisions concerning nursing care. She went on "we should value ourselves as nurses.... we have 24 hour contact with patients.... I think.... I am tempted to say we are the most important.... because we have so much contact with our patients". This person felt strongly about the standing of

nursing decisions and did not feel overruled by medical staff.

Holistic was seen as a characteristic of the nursing process which was taken to mean involvement of psychological, social, physiological and spiritual needs (Column H). Humanistic was also considered to be a characteristic of the nursing process with the person as the main focus (Column I).

"You have a logical sequence of events" that was how this person depicted systematic, a characteristic she ascribed to the nursing process. She also thought the nursing process was a scientific approach because she considered it to be research based (Column K).

Individualised was seen as a characteristic of the nursing process because of the patient's involvement in his/her care (Column L). "We should let them (patients) have a say in what is going on.... letting the patients tell you what the options are.... the patient is central to what is happening". That was how patient-centredness was seen (Column M). Problem-solving was seen to be principally concerned with setting realistic goals (Column N).

"I think the holistic/humanistic side is far wider.... whereas in the scientific you are coming down to the finer points.... You couldn't be holistic if you didn't consider the science part.... because you wouldn't be looking at every aspect of the patient....". That was how the relationship between the holistic/humanistic and the scientific/ aspects were seen to be related (Column O).

"The nursing process has given us the chance to get to know the patients. We are moving away from lists.... You are encouraged to think.... and be a bit more creative perhaps....". These are the points which were posited as the difference between the nursing process and other approaches to nursing (Column P).

"The early documents were not quite right too restrictive.... we now have a new one which is much better there's less of it we are working towards a blank sheet". That was how the documentation aspect of the nursing process was seen (Column Q).

"Models are a way of visualising how I am going to cope with the situation". She went on to say "... they are not always well related (the nursing process and nursing models) because you we do I don't think we do it very well, but we are trying".

Table 47 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	1	2	3	1	2	2	3	4	3	5	2	2	3	4	8	1	10	1
21		5	7		4														

".... the process is the method by which we decide on the nursing care for a patient, rather than following the medical model, we now make our own decisions concerned with nursing" (Column A). That was what this person volunteered at the beginning of the interview. The assessment part of the nursing process was seen to be concerned with collecting information and determining needs (Column B). "Planning involves the criteria by which you are going to nurse the patient" (Column C). That was how the planning stage was seen. "It actually involves implementing your assessment" (Column D) was how the implementation stage was described. "Evaluation involves looking backwards over the implementation, whether that was successful" (Column E). That was how evaluation was seen.

All grades of nurses were seen to be carrying out the nursing process (Column F) and the nursing process was seen as offering nurses good scope for making decisions. However, the medical decisions were seen to take priority (Column G).

There was some doubt about the holistic and the humanistic standing of the nursing process. "I think everyone is going holistic these days.... ah.... it's the latest thing to do.... I don't think we have arrived yet.... I think we've a long way to go before it becomes holistic" (Column H). Would you say it is humanistic (Column I) ".... ah.... again, much the same as holistic."

Systematic was seen as a characteristic of the nursing process because of following the stages (Column J). However, there was uncertainty about the scientific standing of the nursing process and the response was "I am not sure about scientific" (Column K).

Individualised (Column L) and patient-centred (Column M) were seen as characteristics of the nursing process ".... the patient is the central character, that they are the most important person as opposed to the medical staff and the nursing staff". Problem-solving was also seen as a characteristic of the nursing process (Column N).

The nature of the relationship between the humanistic/holistic and the scientific/systematic was expressed thus: ".... I can see it is systematic ... in fact I think in order to deal with the humanistic/holistic.... we can give more effective nursing care if we are systematic I am not sure where scientific comes in". The person was consistent about the scientific standing of the nursing process (Column O).

"There was a conveyer belt system people were referred to by their

conditions or diseases, as opposed to being actual people ah ... theoretically the nursing process is supposed to make us see a patient as an individual". That was how the nursing process was seen to differ from other approaches to nursing (Column P).

"Ah ... now that has been the biggest headache". That was how the documentation aspect of the nursing process was viewed. She went on to say "it's possibly the biggest stumbling block there is the part that is done most badly is the evaluation (Column Q).

"There are different methods of looking at the process of caring". That was essentially how nursing models were seen. The relationship between the nursing process and nursing models was expressed thus: "We need both the nursing process and nursing models because they are both good guidelines the nursing models assist with the process" (Column S).

Table 48 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	1	5	1	1	2	6	2	1	2	5	1	4	4	4	4	1	5	1
22	8		7 8																

This person opened by saying that she saw the nursing process as an individualised approach to nursing which involved planning (Column A). The assessment phase was seen as involving the collection of information (Column B). Planning was seen to involve setting goals both in the short term and in the long term and implementation was seen to be

concerned with carrying out the nursing care. "Evaluation, it's effect in looking at the caring of people, looking at the results and either improving or probably getting you to examine your care, but you've got to organise time to look at what you have done in a critical ". That was how evaluation was viewed (Column E).

Decision making was seen to be in the province of senior nurses. In her view there was a potential for conflict in relation to medical decisions and she suggested conflict should be approached thus: "it's something which should be talked through and some test of decision come to at the end" (Column G).

Holistic was a characteristic attributed to the nursing process "I mean it takes in the whole person. You look at the whole person. You're looking at the person's physical, mental, emotional and sociological state". (Column H). Humanistic (Column I) was also seen as a characteristic of the nursing process (I mean relating to that person in a very sort of personal way".

The nursing process was seen as a systematic approach to nursing "I mean going through the patient's physical state. Going through for instance a patient's respiration-respiratory state, going through all the different systems of the body (Column J). Systematic appeared to be seen in terms of the systems of the body in this instance. "I don't know that it is scientific because I don't know if any sort of research has been done and if it has been proven" (Column K). That was how the scientific status of the nursing process was seen.

Individualized (Column L) and patient-centred were seen as characteristics of the nursing process. "It is certainly patient-centred, because what we are doing for the patient is what the patient needs"

(Column M). Problem-solving was also seen as a characteristic of the nursing process and problem-solving was taken to mean "identifying the problem and solving it" (Column N). There was uncertainty about how the holistic/humanistic and the systematic/scientific aspects were related. "I can see holistic as humanistic and systematic. I don't know about scientific" (Column O).

"I mean we've said it's holistic, we said it's humanistic and problem-solving. The other system of nursing which we had was staff-orientated we had or what else we used to do, we used to sort of allocate different tasks to patients, it certainly wasn't patient-centred. I mean it wasn't patients' needs at all". That was how the difference between the nursing process and other approaches to nursing was perceived (Column P).

"I mean it's probably one of the things that people tend to complain about when they have to implement the nursing process. But like everything else, I think that once you get into it it would become quite easy". That was how the documentation aspect was viewed (Column Q).

Nursing models were seen as frameworks a sort of framework to help us to plan our care and using the nursing process as well ".... The nursing models it's more of a theoretical business and it's the framework Again I think to help us give more structured care, and um, together with the nursing process". The relationship between the nursing process and nursing models was seen in those terms.

Table 49 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	2	1	1	8	2	4	3	1	1	5	2	2	-	4	4	1	5	1
23		4	5	13														8	

The assessment phase was seen as comprising communication and observation (Column B). Planning was seen to involve negotiation with the patient, the setting of goals and the making of a care plan (Column C). "It's the delivery of care" was how the implementation phase of the nursing process was seen (Column D). "This is an area in which we are not coping as well as we might.... this is an area we need to develop". That was how evaluation was perceived (Column E).

Decision making was seen to involve a lot of people such as doctors, social workers, physiotherapists and so on "Each group needs different information". She went on to say the position of the nursing decisions is improving "... some doctors will listen to the nurse, some won't" (Column G).

"It's not quite there" that was how the holistic standing of the nursing process was seen (Column H). "It has to do with people it's looking at individuals". That was how the humanistic standing of the nursing process was seen. When asked whether humanistic is a characteristic of the nursing process the reply was "Yes, it has to be" (Column I).

"It's a systematic approach to planning care to meet the needs of individuals" (Column J). Systematic was thus seen as a character-

istic of the nursing process "... I don't think it has been researched enough a lot of the care that is delivered has not been researched to call it a science". Scientific was thus not seen as a characteristic of the nursing process. "We are bad scientists"

Individualised, planning care to meet individual needs and patient-centred, involving the patients in her care were seen as characteristics of the nursing process (Columns L and M).

There was some doubt about the relationship between the holistic/humanistic and the systematic/scientific aspects of the nursing process since neither holistic or scientific were perceived as characteristics of the nursing process. (Column O).

"I think the nursing process is very good for nursing because it has made us look at what we are doing and why we are doing it". Apart from getting away from task-centredness, the nursing process was seen as a more thoughtful and reflective approach to nursing than previous approaches (Column P).

Documentation was seen as a difficult aspect of the nursing process (Column Q). "The problem when the nursing process was introduced was there was no pattern and no limit to the information required. A nursing model gives the framework. So the two go together" (Columns R and S). She went on to say "nursing models help with assessment and they deal with concepts such as nursing and health".

Table 50 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1c)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	4	1	1	2	2	1	2	2	1	1	2	5	3	1	4	7	5	1
24	5	5	5		6														
		7																	

The person volunteered that she saw the nursing process as involving individualized care and the assessment of patients (Column A).

Assessment was seen to involve observation, determining needs and the use of a nursing model (Column B). "The plans involve patients sometimes not always told of goals". That was how the planning phase of the nursing process was seen. Implementation was seen to be concerned with carrying out nursing care. "The goals should be written in measurable terms the goals should have a date". That was how evaluation was viewed.

The person said the following concerning the decision making aspect of the nursing process. "I think it should be called the patient process the doctors don't look at the nursing process they don't look at the problems identified by the nurse in case of conflict the doctor has the ultimate responsibility".

"Yes, it's holistic at because you are using the activity of daily living which cover the whole person. That was this person's view of the holistic standing of the nursing process. "Would you say the nursing process is humanistic?" "Yes because of the communication part man in society and how does his illness affect him in society and within his environment". This holistic and

humanistic were seen as characteristics of the nursing process.

The nursing process was seen as systematic approach to nursing because of its logic. "It involves a thinking process and logical steps then it's scientific. That was how systematic and scientific aspects of the nursing process were seen.

Individualization was seen as a characteristic of the nursing process. The patient-centred standing of the nursing process was another matter and she put it like this "In theory it's patient-centred, in practice it is not".

Problem-solving was seen to be concerned with the identification of problems and needs and proceeding to deal with them. The holistic/humanistic and the systematic/scientific aspects were seen to relate as follows " because it follows logical steps you say it is humanistic it's a bit of both. I suppose it is more humanistic than scientific".

Getting away from task-orientation was seen as the main difference between the nursing process and other approaches to nursing. In this instance the documentation was not seen as an issue. The point was made that too much tends to be made of the documentation aspect.

"Models give you a framework to identify problems". That was how nursing models were seen. She went on to say "We need the nursing process because it identifies what the nurse is doing it identified nursing intervention to identify nursing intervention and to do an assessment of a patient you need a model". This was how the relationship between the nursing process and nursing was seen.

Table 51 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	2	2	1	7	2	-	1	4	1	8	2	1	3	1	8	7	2	1
25	2	4	5															8	
	5		7																
	8		8																
	10																		
	11																		

Problem-solving, individualized, assessment, planning, implementation and evaluation were offered by this person at the beginning of the interview (Column A). The assessment part of the nursing process was seen to involve communication and the making of observations (Column B). The elements involved in the planning phase were seen to be putting the problem into a logical sequence, setting goals both in the short term and in the long term (Column C). "Doing the nursing - actually putting into action the plan we set out". That was how the implementation phase of the nursing process was seen (Column D). "Have the targets been met?" In essence, that was how the evaluation phase of the nursing process was seen (Column E).

Holistic was considered to be a characteristic of the nursing process and was defined thus: "the sum of the whole is greater than the sum of the parts all the knowledge areas need to be interrelated". This person was not sure whether humanistic was a characteristic of the nursing process (Columns H and I).

Systematic was accepted as a characteristic of the nursing process (Column J). This person viewed the scientific standing of the nursing

of the nursing process as follows: ".... For me ah . a science is something which attempts to identify facts and laws. I believe there are facts and laws that can be applied to nursing in that sense it is scientific". She added, however, "it is secondary science.... baby science" (Column K).

The nursing process was seen as individualised because of a concern for individual needs". "It involves the patient and family". (Column L). It was also seen as patient-centred because it involved negotiation with the patient (Column M).

Problem-solving was seen as a characteristic of the nursing process because of the emphasis on the identification of needs/problems (Column N). "Yes, there is a science base but it's more than that it's also an art it's holistic". That was how the relationship between the holistic/humanistic and the systematic/scientific aspects were perceived (Column O).

"It is questionable whether the nursing care is better, but nurses are under most stress". That was how the question concerning the difference between the nursing process and other approaches to nursing (Column P) was seen.

"Each ward should have a computer". That was the solution advanced in relation to the documentation aspect of the nursing process (Column Q).

"A model is a roadmap for developing care for the individual models embody concepts of man, models allow for patient involvement and take account of the person". Concerning the relationship between the nursing process and nursing models, she went on to say "a nursing model is the tool that the nurse uses to implement the

nursing process" (Columns R and S).

Table 52 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1C)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	5	1	1	8	2	9	1	2	1	8	2	5	3	1	8	4	8	1
26	5	9																	
	8	12																	
	10																		
	11																		

"I see it as a systematic approach to delivering nursing care systematic is the key word for me". That was the opening statement made by this senior tutor (Column A). He went on to say that the nursing process comprised assessment, planning, implementation and evaluation. Assessment (Column B) was seen to involve determining the needs of a patient, making a nursing plan and taking a history. "The patient should be aware of the plans it doesn't always happen ... in the majority of cases it doesn't happen nurses generally have the view that they know the kind of care a patient ought to receive". That was the view expressed about the planning phase of the nursing process (Column C). "It involves doing things for the patient and with the patient". That was how the implementation phase of the nursing process was seen (Column D). "We should evaluate continuously". That was more or less what was said about the evaluation aspect of the nursing process (Column E).

"A lot of nurses see themselves as subordinate to their medical colleagues a lot of nurses would back off and modify things in case of conflict with the medics medics are consulting more".

That was the view expressed concerning the decision making aspect of the nursing process (Column G).

"Yes, it is holistic the nursing process is like an empty vessel how you look at the person, how you put forward ideas is based on what you perceive about a patient". That is what this person had to say about the holistic standing of the nursing process (Column H). The response concerning the humanistic standing of the nursing process was in a similar vein. "Yes, it's humanistic" (Column I).

The nursing process was seen essentially as a systematic approach to nursing (Column J). Scientific was also seen as a characteristic of the nursing process (Column K). "If based on the life and social sciences, then it would be acceptable to scientists generally. Sciences should be included in nurse training".

Individualised was seen as a characteristic of the nursing process (Column L), but there was a reluctance to describe it as patient-centred (Column M). "If the patient is not involved, it is not truly patient-centred".

The relationship between the holistic/humanistic and the systematic/scientific was seen as compatible (Column O). The difference between the nursing process and other approaches to nursing was expressed as follows: "In the past nurses relied on instinct or gut feeling about the patient's needs. I think the nursing process has taken us a step beyond that so that we have a systematic way of looking at people ". (Column P).

This senior tutor had a positive view about the documentation aspect of the nursing process, maintaining that communication was better and that this gave nurses status (Column Q).

Nursing models (Column R) were seen embodying "the information needed, what kind of things we should be looking at when assessing needs". This person went on to say that the nursing process and nursing models are interdependent "The nursing process is an empty vessel, a nursing model fills the vessel. The nursing process is a systematic way of using a nursing model" (Column S).

Table 53 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	2	1	1	6	2	2	3	3	1	2	2	1	6	4	3	1	5	1
27	5	4	5				7											8	
	8		6																
	10																		
	11																		

This senior tutor opened up by saying he saw the nursing process as an individualised approach to nursing care. He went on to say that it involves assessment, planning, implementation and evaluation (Column A). Assessment was seen to involve communication and observation "it is concerned with overt behaviour, observable behaviours" (Column B). The planning phase of the nursing process was seen to involve negotiation with the patient, the setting of goals and problem-solving (Column C). "This is the nurse doing the nursing". This was how the implementation stage of the nursing process was depicted (Column D). Evaluation depends on the nature of the problem. "Psychiatric problems the time scale is longer, therefore you evaluate less frequently."

With regard to decision making the person had the following to say

"Some problems are nurse related, therefore the nurses decision will be important Eventually it is the doctor's decision. Some doctors will win no matter what doctors have the power" (Column G).

There was uncertainty about the holistic and humanistic standing of the nursing process and an unwillingness to pursue the matter further (Columns H and I).

The nursing process was seen as systematic (Column J). "Nursing is a practical activity, but it must also be a scientific thing research based". That was how the scientific standing of the nursing process was expressed (Column K).

Individualised was seen as a characteristic of the nursing process (Column L) and so was patient-centred (Column M). "The patient is a co-worker it's the nurse using her technical ability"The notion of a co-worker role for the patient is a novel contribution as far as the patient-centred standing of the nursing process is concerned.

There was some reluctance to ascribe problem-solving as a characteristic of the nursing process (Column N). The point was made "Everyone has needs, some have problems".

In view of the fact that there was some doubt about the holistic/humanistic standing of the nursing process, it was inevitable that there would be similar doubts about the nature of the relationship between the holistic/humanistic and the scientific/systematic aspects of the nursing process (Column O).

"If care is negotiated, if it is a two way process, then I would think

that to be better than what went before Yes, nursing care is better". That was how the difference between the nursing process and other approaches to nursing were viewed (Column P). The documentation was seen as a difficult aspect (Column Q).

Nursing models were seen as providing a framework and a basis for making a nursing assessment and the nursing process was seen as actually doing the nursing (Columns R and S).

Table 54 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	2	1	2	1	2	1	1	2	1	3	1	2	1	1	8	1	8	1
28	9						2				4								

"I see it in two dimensions: a. I see it as a more methodical approach to patient carea scientific approach to patient care and b. a new philosophy of care". That was the opening statement made by this senior tutor (Column A). The assessment of the nursing process was seen to be concerned with communication (Column B). "The patient is seen as a responsible individual as having some autonomy some rights some accountability for his own health and care". That was how the planning phase of the nursing process was seen (Column C). The patient was seen as being involved in the implementation phase of the nursing process as a partner rather than a passive recipient of care (Column D). The evaluation phase was seen to involve constant checking and measuring to see if the care given was successful (Column E).

The issue of decision making (Column G) was dealt with thus: "... the nurse is the central agent other members may be more peripheral to the nursing and patient". He put forward the view that the central issue ought to be "what's best for the patient". And he went on to say "Nurses need to be clear about their boundaries Nurses care, doctors treat many doctors are prepared to respect the nurse's expertise".

Holistic was seen as a characteristic of the nursing process (Column H). "... the holistic approach sees all elements as interdependent spiritual, social, psychological all having influence all operating together as a unit". Humanistic was also accepted as a characteristic of the nursing process (Column I). "Man is seen in a totality rather than in little bits and pieces"

Systematic was seen as a characteristic of the nursing process and was depicted "as a logical sequence of steps which a nurse takes" (Column J). Scientific was also seen to be a characteristic of the nursing process (Column I). He commented "The difficulty with the nursing process is developing an appropriate scientific methodology. The social scientists have different problems than the chemists if we wish to be scientific we have to be careful not to adopt the methods of traditional science. We have to find new methods to ah... to inform our observations predictions to test our theories."

The nursing process was seen as an individualised approach to nursing (Column L). "Seeing the individual as a person rather than a disease or a diagnosis" was how the individual aspect was seen. It was also seen as patient-centred "... the individual has responsibility for his own care and actions " (Column M). "Care is problem orientated and we have to question our practices, our beliefs, our

knowledge base, we have to be continually researching". That was how the problem-solving aspect was seen (Column N).

"I think that social science is beginning to emerge with really dynamic methods and the nursing process is going to develop along with the social sciences there is a symbiosis really - a symbiosis between science and the humanities". That was how the humanistic/holistic and the systematic/scientific aspects were seen to relate (Column O).

"There is a different philosophy underlying the nursing process ah ... than other approaches to care more humanistic". That was how the nursing process was seen to differ from other approaches to nursing (Column P). The documentation was seen as a difficult but a necessary aspect and not something which greatly concerned the senior tutor (Column Q).

Nursing models were seen as providing guidelines for the assessment part of the nursing process and were thus seen as linking well with the nursing process (Columns R and S).

Table 55 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	5	13	1	1	2	2	2	1	5	3	2	4	3	1	2	4	5	8
29	3	11		5			5							7	3		8		

"It is a systematic approach, the biggest thing for me is the individualization of care for patients putting the patients central". That was the opening statement made by this nurse tutor in psychiatric nursing (Column A). Assessment was seen to be concerned with determining needs and involving a team approach (Column B).

"Planning is planning your care" was the somewhat tautological way that the planning phase was depicted (Column C). Implementation was also depicted in cryptic terms "It is what a nurse is going to do" (Column D). "You see whether you have achieved what you set out to achieve". That was how the evaluation phase was seen (Column E).

"The nurses make the decisions overall the sister/charge nurse on the ward". The standing of nursing decisions was depicted thus "... nurses tend to devalue themselves and they are reluctant to assert themselves nursing decisions tend to be overridden". (Column G).

Holistic and humanistic were seen as characteristics of the nursing process (Columns H and I). Holistic was seen as taking all the systems of a person into account "... the physical, the spiritual, the emotional etc." "Treating people as individuals souls, feelings, emotions" was the meaning ascribed to humanistic.

The use of the stages assessment, planning, implementation and evaluation was seen to make the nursing process systematic "Would you say it is scientific?" "I don't think it is I don't think the nursing process is scientific" (Column K).

Individualisation, as mentioned at the beginning, was seen as the central characteristic of the nursing process (Column L). It may also be seen as a patient-centred approach because "the focus is on

As far as this person was concerned the nursing process involved individualized care and assessment, planning, implementation and evaluation (Column A). The assessment phase was seen as involving communication, observation and history taking.(Column B). The implementation phase was seen as being concerned with the making of a care plan. (Column C). Implementation was seen as carrying out the nursing care (Column D). "Stopping and asking patients how they are is evaluating if the information is used, that is evaluation if it is not used it is not evaluation" (Column E).

"Nurses make more decisions than anyone else some less important not life threatening ..." However, in the case of conflict, the power rests with the doctors (Column G).

"I would go for humanistic rather than holistic humanistic rather than holistic" (Columns H and I). There was some doubt about the scientific standing of the nursing process it is a combination of art and science more art than science, but some science" (Column K).

Individualized was seen as a characteristic of the nursing process, but there was some doubt about patient-centred "planning takes place away from the patient" (Columns L and M).

Problem-solving? "So we are told the emphasis is on problem identification rather than on problem-solving." That was how the problem-solving aspect of the nursing process was perceived (Column N).

"It is seen as an added responsibility, something on top of the existing job care is no better more difficult for the learners".

The conclusion was that the nursing process is not working and the differences between the nursing process and other approaches to nursing are therefore difficult to identify (Column P). The documentation aspect was seen as difficult (Column Q).

"Nursing models are a way of identifying problems they make problem identification easier". Nursing models make it possible to implement the nursing process (Columns R and S). That was how nursing models were seen and the relationship between the nursing process and nursing models.

Table 57 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1c)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	13	1	1	1	2	1	2	1	1	5	2	1	1	4	1	4	2	1
31	2		1				7									3			
	5		13																
	8																		
	10																		
	11																		

This nurse tutor in psychiatric nursing opened the interview by saying that she saw the nursing process as involving problem-solving, individualized care, assessment, planning, implementation and evaluation (Column A). Assessment was seen as not being done properly "When patients come to hospital they are anxious and if you assess them then, that is not a true assessment" (Column B). Planning was seen as involving negotiation with the patient and with the making of a care plan (Column C). The implementation phase of the nursing process was

seen to be concerned with the giving of care (Column Q). " A crucial aspect unless you evaluate you might as well throw everything away you evaluate to see if the care has worked" (Column E). That was how evaluation was seen.

The view expressed was that the patients ought to be involved in the decision making process. In the case of conflict "The decision of the medical staff stands (Column G).

The nursing process was seen as holistic and this meant taking into account the psychological, social and spiritual aspects of the person "... the person as a whole not fragmented" (Column H). Humanistic was also seen as a characteristic of the nursing process ".... because we are human beings" (Column I).

Systematic was seen as a characteristic of the nursing process because it is logical (Column J). However, the scientific standing of the nursing process was viewed quite differently. "I don't believe in it the nursing process is a process of care I don't think it's scientific" (Column K).

Individualised was a characteristic ascribed to the nursing process (Column L), and so was patient-centred "Oh, yes, always it couldn't be any other way (Column M).

Problem-identification, rather than problem-solving was seen as a characteristic of the nursing process (Column N). "It's more humanistic than scientific". That was how the relationship between holistic/humanistic and the systematic/scientific of the nursing process were seen (Column O).

"More job satisfaction, better morale, more accountable, everything is now set out clearly better patient care. It's absolutely wonderful. I spread the good word I teach the good word" This person was enthusiastic about the nursing process and considered it was better than any form of nursing which went before (Column P).

This person was also enthusiastic about the documentation aspect describing it as very good, more concise, more precise, much more clear, more realistic (Column Q).

She considered that nursing models were confusing. However, she saw models as providing a view man and considered that a nursing model was necessary in conjunction with the nursing process.

Table 58 Analysis of interview transcripts

Horizontal axis - items from interview analysis guide (Appendix 10)

Vertical axis - interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	1	1	1	1	2	2	2	1	1	5	2	2	1	4	5		-	-
32	3	5	5	2	2		7								3				
	5	12																	
	8																		
	10																		
	11																		

This male nurse tutor in psychiatric nursing opened up by saying he saw the nursing process as being an individualized and a systematic approach to care. He also saw it as comprising assessment, planning, implementation and evaluation. (Column A). The assessment phase was seen to involve the collection of information and the determination of problems (Column B). Planning was seen to involve the patient in

his care and the setting of goals (Column C). The implementation phase was seen to be concerned with carrying out nursing care (Column D). The evaluation phase was seen to be concerned with whether the care was successful; it was seen as reassessment (Column E).

All staff were seen to be involved in the decision making process, but with the power resting with the doctor. "What the doctor says goes" (Column G). The concern for people was seen to make the nursing process holistic (Column H). "We look at the patient as an individual a person who has individuality as opposed to a ruptured appendix etc." That was how the humanistic aspect was seen (Column I).

Systematic (Column J) was seen as a characteristic of the nursing process, but not scientific (Column K). "... people don't have science or research skills. Hypotheses are not tested therefore it is not scientific" He went on to say "if you ask 100 different people about the nursing process, it wouldn't surprise me if you get 100 different definitions".

"It should be individualised Yes, it is individualised" (Column L). The patient was seen as being involved in the planning of nursing care, making the nursing process patient-centred (Column M). The problem-solving aspect was seen to be more concerned with problem identification than actually solving problems (Column N). The relationship between the systematic/scientific and the holistic/humanistic aspects was seen to be problematic since the nursing process was not seen to be scientific (Column O). The individualization of nursing care was seen as the principal difference between the nursing process and other approaches to nursing (Column P). Standard documents used to collect information were not seen as a good thing. "Ticks in

boxes are not a good idea documents should be individualized". That was how the documentation aspect of the nursing process was seen (Column Q).

Table 59 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	1	1	1	1	2	2	3	6	1	5	2	1	-	3	8	7	2	1
33	5						7												
	8																		
	10																		
	11																		

This male nurse tutor in psychiatric nursing saw the nursing process as a systematic approach to nursing which comprised four phases: assessment, planning, implementation and evaluation (Column A). The assessment phase was seen to be concerned with the collection of information (Column B). Planning was seen to involve negotiation with the patient (Column C). Implementation was described as "What has to be done" (Column D). "A review of progress and plan was it successful was how evaluation was seen (Column E).

"Nurses, doctors and paramedical staff all make separate assessments why not one assessment?". The point made was that too many were making decisions concerning the patient. However, in the case of conflict "Most of the power rests with the medics but it's changing (Column G).

"The nursing process per se is not holistic it is just a tool the nursing process can be used to implement other kinds of philosophies". That was how the holistic standing of the nursing

process was seen (Column H). "Yes, it's humanistic, that's the philosophy behind the nursing process" (Column I).

"It is a systematic way of going through a series of steps". Systematic was thus seen as a characteristic of the nursing process (Column J). The scientific standing of the nursing process was seen quite differently. "No it's not scientific because it is a reasonable logical tool for nursing. logical is better than scientific". The nursing process is thus seen as a logical rather than a scientific process (Column K).

Individualised was seen as a characteristic of the nursing process (Column L). "Joint planning with the patient with a contract implied was seen as making it patient-centred (Column M).

The relationship between the holistic/humanistic and the systematic/scientific was seen as problematic since scientific was not considered to be a characteristic of the nursing process.

"It has now been recognised as a better way of giving nurse care, people are now changing their ideas about what nursing is" That was how the nursing process was seen to differ from other approaches to nursing (Column P).

The nursing process was in danger of becoming a "paper process". The point was made that a piece of blank paper was the best type of nursing process form (Column Q).

"Nursing models are a representation of a philosophy. a belief in what a person is Nursing models should have come before the nursing process. Nursing models give something the nursing process does not, that is, a view of health, illness, the person etc." Those

were the views expressed concerning nursing models (Columns R and S).

Table 60 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	5	1	1	1	1	2	1	1	1	1	5	2	2	3	3	5	4	6	4
34	8	5	11		2		7							8					
	10																		
	11																		

"Something we have done for years". That was the opening comment made by this male nurse tutor in psychiatric nursing. The element of the nursing process were seen to be assessment, planning, implementation and evaluation (Column A). The assessment phase was seen to be concerned with the collection of information and with determining needs (Column B). Patients were seen to be involved in the planning of their care. Planning was also seen to be concerned with the identification of nursing action (Column C). Carrying out the care plan was how the implementation phase of the nursing process was depicted (Column D). "Looking back and seeing what the other three stages had achieved was it successful?" Evaluation was also seen as reassessment (Column E).

Nurses, doctors and paramedical staff were seen to be involved in the decision making process. However, there was no doubt about the primacy of the medical decisions. "The doctors are a law unto themselves the doctors have power nursing decisions are overridden" (Column G).

"It's humanistic rather than scientific it's also holistic it's the individuality of the individual my own feelings my feelings about people and the quality of life". That was how the holistic and humanistic aspects of the nursing process were perceived (Columns H and I).

Systematic (Column J) was seen as a characteristic of the nursing process; but the standing of science was different. "I am not sure about science" (Column K).

"Finding out about the patient, gaining knowledge, discovering what is best for the individual." That was how the individualized aspect was seen (Column L). Patient-centred was also seen as a characteristic of the nursing process because of the individual's involvement in the planning of his care (Column M).

"Patients come into hospital for a reason that a problem for them therefore the nursing process should help to solve the problem". Problem-solving was seen to involve identifying the problem and "working out a way of solving the problem" (Column N).

The relationship between the holistic/humanistic and the systematic/scientific aspects was problematic since there was uncertainty about the scientific aspect (Column O).

"Looking at the patient as an individual treating the patient with respect and as a whole person doing what is best for the patient patient involvement". That was how the nursing process was seen to differ from other approaches to nursing (Column P).

The documentation was seen as a positive aspect of the nursing process. The point was made that it should be for the benefit of the patient and that the information is better now (Column Q).

"I don't know much about nursing models I don't go into nursing models to be able to talk about them" (Columns R and S).

Table 61 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	1	5	1	7	5	9	3	4	1	5	3	6	9	1	1	1	5	3
35	5	12														3	7		
	8																		
	10																		
	11																		

"As far as I am concerned it's a way of giving patients individual care". That was how this ward sister in psychiatric nursing opened the interview. She went on to say that the elements of the nursing process were assessment, planning, implementation and evaluation (Column A). Assessment was seen as being concerned with collecting information through taking a history (Column B). "Planning involves using your skills to formulate objectives which must be obtainable." That was how the planning stage of the nursing process was seen (Column C). "Doing the job doing whatever is in the care plan". That was how the implementation stage was depicted (Column D). "Evaluation completes the cycle you check the care plan and see if the goals have been attained" That was view taken about the evaluation phase of the nursing process (Column E).

"That's another thing that eases problems nurses don't like to take responsibility for their actions". She went on to say "all their peers say the nursing process is rubbish and they feel they must conform". That was how the decision making aspect was viewed (Column G).

"It's supposed to be I wouldn't say it was in my hospital (holistic) it should be humanistic but it isn't because one don't do it right I can't be anything but cynical about it"(humanistic). That was how the holistic and the humanistic aspects of the nursing process were seen (Columns H and I).

Systematic was seen as a characteristic of the nursing process (Column J). "Would you say it is scientific?" "No because I know a lot of people say the nursing process is research based I don't know how much has been proved". That was how the scientific standing of the nursing process was seen (Column K).

The nursing process was seen as an individualized way of giving nursing care (Column L), but patient-centredness was another matter ".... it's not in my hospital patients don't have care plans" (Column M).

"Would you say it was a problem-solving approach?" "Yes then psychiatric nursing has always used a problem-solving approach". The problem-solving aspect of the nursing process was seen in those terms (Column N).

The holistic/humanistic and the systematic/scientific aspects were seen to relate well despite earlier comments made about these aspects as characteristics of the nursing process (Column O).

"I think it's better for the patients and it's better for the nurses if we can get them to accept it Nobody could fail to benefit from the nursing process. This was how this ward sister expressed the differences between the nursing process and other approaches to nursing (Column P).

Documentation was seen as a difficult aspect of the nursing process. The reason advanced for this was "I think most nurses have decided

they don't like the nursing process and that includes the document-
ation"(Column Q).

"Um, um they are frameworks lots of models are far too
complex they are futile exercises. I think there are too many
models I think people devise models for M.A. theses or something".
This was the view expressed concerning nursing models (Columns R and S).

Table 62 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	1	5	1	1	-	4	1	2	3	4	2	2	3	2	5	2	3	1
36	5	5	12	6	5		6	4	5		5			8	3	7	4		
9											6								
12																			

This male charge nurse in psychiatric nursing made an opening state-
ment that he saw the nursing process as comprising individualization,
assessment, and evaluation. He also mentioned scientific. "The
nursing process is a method of delivering individual care to patients
.... um, um, in a scientific a way as possible" (Column A).

"Data collection that's the assessment bit". That was how the
assessment phase of the nursing process was seen (Column B). The
planning phase was seen to involve the setting of goals and using
resources (Column C). "It's actually putting the plans into operation
.... again, the resources you have". That was how the evaluation
phase was seen (Column E). "You've got to set a date and you've
actually got to do it on that date scrutinising the way things
are going". That was how the evaluation phase was seen (Column E).

Decision-making was seen as a team affair, but with the power resting with the consultants "... some consultants really have no time for the nursing process they see it I think as a way of nursing trying to assert themselves above their role in life as it were and accordingly reject it or keep it very much in control" (Column G).

Holistic was a characteristic ascribed to the nursing process. " I mean by holistic as looking at every aspect of the person" (Column H). "Looking at the person as an individual and caring for him in the best possible way". That was how the humanistic aspect of the nursing process was seen (Column I).

Systematic was seen as a characteristic of the nursing process and was taken to mean "... a grading of events to reach an outcome" (Column J). "I don't believe the nursing process is as scientific as it's made out to be I feel I certainly it comes over as being very scientific, but but in reality I am not too sure it is" That was the view expressed concerning the scientific standing of the nursing process (Column K).

"It means looking at a patient as a person". That was what individualized was taken to mean (Column L). "Again, you are looking at the person's problems and formulating care". That was how patient-centred was perceived (Column M). Individualized and patient-centred were seen as characteristics of the nursing process. "Identification of an individual's problems um um, and working with them towards a solution". That was how problem-solving was seen (Column N).

"I don't think the holistic/humanistic and the systematic/scientific aspects fit well together, it depends on the problems you have on balance they are not totally compatible". That was how the

relationship between the holistic/humanistic and the systematic/scientific aspects of the nursing process was seen (Column O).

Looking at the patient more as an individual and more paperwork were seen as the principal differences between the nursing process and other approaches to nursing (Column P). On the debit side the documentation aspect of the nursing process was seen to be time consuming, but on the credit side more and better information results (Column Q).

"Some appear in my mind to have far more basis in reality than others the process is the delivery of care as far as I see it the models are a structure on which that care a framework from which that care can be delivered" (Columns R and S). That was how nursing models were seen and the relationship between them and the nursing process.

Table 63 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	2	8	1	7	1	2	3	2	1	3	3	2	6	7	1	8	6	5	6
37	5		5				7		2										
	9																		
	11																		

This senior tutor in mental handicap nursing opened up by saying the nursing process involved individualized care, assessment, and evaluation. It was also seen as being scientific. "It is a scientific tool for measuring the effectiveness of care" (Column A). The

assessment phase of the nursing process was seen as being concerned with the identification of problems. "What kinds of problems the patients might have" (Column B). Planning was seen to be concerned with negotiation with the patient and with the setting of goals. "I want nurses to say how things are implemented in a language they can understand that's very important. Anybody coming into that particular area will be able to see what is to be done who is to do it and so on". That was how the implementation stage of the nursing process was seen (Column D). "I think evaluation is the \$64,000 question. Have I been successful?" Those were the views expressed concerning the evaluation stage of the nursing process (Column E).

As far as who carries out the nursing process, a multidisciplinary approach was seen as desirable (Column F). Similarly, decision making was seen as a team effort. On the issue of conflict concerning decisions he went on to say "Our plan should be one that would have the doctors' support but if not there should be a mechanism for nurses to seek a resolution to the conflict (Column G).

Holistic was seen as a characteristic of the nursing process. "It has a biological perspective, a psychological perspective, a sociological perspective and a spiritual perspective the spiritual perspective tends to be neglected" (Column H). The nursing process was also seen as humanistic. "By humanistic I mean that the person's psychological and spiritual welfare are taken into account" (Column I).

Systematic was seen as a characteristic of the nursing process and the hope was expressed that "it's not too mechanical" (Column J).

"A measurement of ones own effectiveness that scientific. Scientific to me means you can measure it you can measure the

care" That was how the scientific standing of the nursing process was seen (Column K).

"I mean caring for the particular individual". That was how individualized was defined (Column L). "The nursing care is prescribed round identified needs. That was how patient-centred was seen (Column M).

Problem-solving was seen as a characteristic of the nursing process and was defined as "A problem-solving approach to me is deciding on what is the most dominant problem the most pressing problem and there work out ways to try to tackle these problems" (Column N).

"They go hand in hand I don't see it as a particular problem". That was how the relationship between the holistic/humanistic aspects and the systematic/scientific aspects were seen (Column O). The differences between the nursing process and other approaches to nursing were enumerated as follows: "Client involvement, problem-solving, documentation, professionalism and on going these are the main ones" (Column P).

"The documentation is important reports are personalised now I am encouraged about how personalised they have become". That was the view taken of the documentation aspect of the nursing process (Column Q).

"A framework for ones thoughts regarding assessing a patient ... they also look at levels of dependency". That was how nursing models were seen by this senior tutor (Column R). "I feel the nursing process is the proper way to set about nursing I view models with less enthusiasm" (Column S).

Table 64 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 10)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	3	12	1	1	1	3	1	1	1	1	5	2	2	3	-	3	7	6	1
38	5			2			7	2								4			
	8																		
	10																		
	11																		

For this nurse tutor in mental handicap nursing the nursing process is "a systematic approach to nursing using APIE (assessment, planning, implementation and evaluation)"(Column A). The assessment stage was seen to be concerned with taking a history including physical, social and psychological aspects (Column B). The patient was seen to be involved in the planning stage (Column C) and implementation was seen as to be carrying out the nursing care with patient involvement (Column D). "Seeing how well the care has been carried out". That was how the evaluation aspect of the nursing process was perceived (Column E).

Learner nurses were seen as carrying out the nursing but she went on to say "Ideally it should be registered nurses" (Column F). As far as decision making was concerned it was seen as involving patients, nurses and the doctors. However the point was made that in cases of conflict "the consultants get their way" (Column G).

Holistic was seen as a characteristic of the nursing process ".... taking account of his physical, social and psychological aspects" (Column H). "Would you say it is humanistic?" "Yes, I think so it's an individual approach". That was how the humanistic aspects were seen (Column I).

Individualized, systematic, assessment, planning, implementation and evaluation were offered by the nurse tutor in mental handicap nursing by way of an opening statement (Column A). Assessment was seen as collecting information (Column B). Planning was seen to be concerned with negotiation with the patient (Column C) and implementation was seen to be concerned with carrying out nursing care (Column D). "You are constantly evaluating to see if the care is successful". That was the comment made about evaluation (Column E).

All grades of nurses were seen to be carrying out the nursing process (Column F) and decision making was seen as a team affair (Column G).

Holistic was seen as a characteristic of the nursing process and holistic was seen to embody problem-solving, individualized and systematic (Column H). "Yes, it is humanistic in the sense that you are operating in the best interests of the patient" (Column I).

"Science does little more than investigate what is already there.... I don't like calling it a scientific approach". That was the view expressed concerning the scientific standing of the nursing process (Column K).

Individualized was seen as a characteristic of the nursing process "..... it's a systematic way of dealing with patients as human beings" (Column L). "The individual is more than a disease the individual is a person". That was how patient-centredness was perceived. (Column M). Problem-solving was perceived to be concerned with the identification of problems and was considered to be an attribute of the nursing process (Column N).

The main difference between the nursing process and other approaches to nursing is that it is humanistic. ".... humanistic is the sense that you would not use a single word to describe a person You

stop labelling what is important is that it has made people look at what they are doing in terms of individualized care" (Column P).

The documentation was seen as the most difficult aspect of the process (Column Q). Nursing models were seen to embody a particular view of man. The example given was an action view of man versus a passive view of man. (Column R). The relationship between the nursing process and nursing models was set out thus: "The nursing process is only a method; it is the form or the way. Nursing models embody the content as well as a view of man" (Columns R and S).

Table 66 Analysis of interview transcripts

Horizontal axis = items from interview analysis guide (Appendix 1)

Vertical axis = interviewee (Appendix 3)

LETTER	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
NUMBER	1	5	14	1	8	2	7	3	4	1	3	2	4	3	5	3	4	5	1
40	2	9																	

Problem-solving and individualized care were the two points offered at the opening of the interview (Column A). Assessment was seen to be concerned with determining needs and with the formulation of a nursing plan (Column B). "It includes all people who have care of the patient nurses, social workers, occupational therapists all observations interviews and things like that". That was how the planning phase of the nursing process was seen (Column C). "Carrying out the care that is planned" (Column D). That was the view taken of the implementation aspect of the nursing process. "I like to evaluate the problems daily it's concerned with the continuity of care". That was the view taken of evaluation (Column E).

Everybody in contact with the patient was seen to be carrying out the nursing process (Column F). "The major decisions are made by the consultants they are in charge, they discharge, change medication and things like that" (Column G).

"Ah unfortunately no not the way it is practised". That was how the holistic aspects of the nursing process were seen (Column H).

"I don't know I don't know quite honestly". That was the view taken of the humanistic standing of the nursing process (Column I).

Systematic was seen as a characteristic of the nursing process (Column J) and so was scientific which was taken to mean "Something that is measurable" (Column K).

Individualized was seen as a characteristic of the nursing process (Column L) and so was patient-centred which was taken to mean "letting the individual have a say instead of telling the patient what to do" (Column M).

"Crumbs what a question! I can't answer that question". That was the response concerning the nature of the relationship between the holistic/humanistic and the systematic/scientific aspects of the nursing process (Column O). The main difference between the nursing process and other approaches to nursing were seen to be improved patient care through individualized care. The nursing process has created this individualized approach" (Column P).

The documentation aspect of the nursing process was seen in a positive light "the observations are more specific the documentation is also more specific (Column Q). Nursing models were seen as nursing theories "I think self-care is something we should encourage

(Column R). "I think the nursing process and nursing models go hand in hand but they are separate things they go hand in hand." That was how the relationship between the nursing process and nursing models was seen (Column S).

RATES OF MENTION FOR ASPECTS RELATED TO THE NURSING PROCESS AND NURSING MODELS

It is now proposed to analyse the range of responses in order to present an overview of the whole interview sample relating to the aspects associated with the nursing process and nursing models. This analysis is presented in rates of mention tables which follow. These rates refer to the number individuals mentioning particular aspects such as assessment, planning, implementation, evaluation and so on in their explanations. The actual number of people citing each aspect is given in the tables and so is the percentage value. These are percentages of 40 which was the size of the interview sample.

Table 67 Rates of mention for aspects offered spontaneously at the opening of the interviews. N = 40

Aspect	N	%	Aspect	N	%
Problem-solving	11	27.5	Planning	20	50.0
Individualised Care	25	62.5	Scientific	4	10.0
A systematic approach	15	37.5	Implementation	14	35.0
Negotiation	1	2.5	Evaluation	18	45.0
Assessment	22	55.0	Action Research	2	5.0
Decision-Making	1	2.5	Holistic	1	2.5
Systems Model	1	2.5	Unclassified	-	-

What is the nature of the nursing process as far as you are concerned? Interviews opened with this question. The responses are presented in

Table 67. Aspects receiving 50 per cent of the mentions or more are individualized care, assessment and planning, with individualized care mentioned more often. A systematic approach, implementation and evaluation received over a third of the mentions. Problem-solving received just over a quarter of the mentions, with scientific and holistic being mentioned infrequently.

Table 68 Rates of mention for aspects offered relating to assessment
N = 40

Aspect	N	%	Aspect	N	%
Collecting information	11	27.5	Problem identification	3	7.5
Communication	13	32.5	Nursing Plan	4	10.0
Making a diagnosis	2	5.0	Team Approach	2	5.0
Observation	13	32.5	Taking a history	11	27.5
Determining needs/ problems	12	30.5	Unclassified	3	7.5
Setting goals	3	7.5			
Based on a model	3	7.5			

The aspects which were mentioned with more or less equal frequency in relation to assessment were communication, observation and determining needs/problems. Collecting information and taking a history were mentioned with equal frequency. The remaining eight aspects relating to assessment received mentions in single figures with the exception of nursing plan.

Table 69 Rates of mention for aspects offered relating to
planning N = 40

Aspect	N	%	Aspect	N	%
Negotiation with patient	22	55.0	Short term	4	10.0
Putting problem in logical sequence	2	5.0	Strategy	4	10.0
A cognitive process	1	2.5	Communication	1	2.5
Paper exercise	1	2.5	Identifying nursing action	2	5.0
Setting goals/targets/objectives	13	32.5	Resources	2	5.0
Problem-solving	2	5.0	Making a care plan	10	25.0
Long term	6	15.0	Unclassified	2	5.0

The aspects mentioned relating to planning were rather diffuse in nature. Only three were mentioned frequently and these are negotiation with the patient, setting goals/targets/objectives and making a care plan. The last finding is perhaps surprising in that only ten people mentioned the making of a care plan as an aspect of the planning stage of the nursing process.

Table 70 Rates of mention for aspects offered relating to
implementation N = 40

Aspects	N	%	Aspects	N	%
Carrying out nursing care/plan	35	87.5	Goals	2	5.0
Patient involvement/participation	11	27.5	Dependence/independence	2	5.0
Implementing the assessment	1	2.5	Unclassified	1	2.5
The doing part of the process	1	2.5			

A relatively small number of aspects were offered concerning the implementation aspect of the nursing process. Two aspects, carrying

out nursing care/plan and patient involvement/participation were the only aspects mentioned with any degree of frequency. Perhaps surprisingly, implementing the assessment was mentioned only once.

Table 71 Rates of mention for aspects offered relating to evaluation N = 40

Aspect	N	%	Aspect	N	%
Was the care successful?	19	47.5	Time scale	2	2.5
It is reassessment	7	17.5	Measurement	2	2.5
It is a process of reflection and reassessment	2	5.0	Were the goals/objectives met?	11	27.5
Is it working?	3	7.5	Unclassified	6	15.0

Was the care successful? Were the goals/objectives met? These were the only aspects which were mentioned frequently in relation to the evaluation stage of the nursing process. Measurement, for example, was mentioned by two people only..

Table 72 Rates of mention for aspects offered relating to who carries out the nursing process N = 40

Aspect	N	%	Aspect	N	%
Registered nurses	3	7.5	Nurse and patient	2	5.0
All grades of nurses	34	85.0	Unclassified	1	2.5
Learner nurses	3	7.5			

A limited range of aspects were offered relating to who carries out the nursing process. That it was carried out by all grades of nurses had the support of 34 of the interviewees. It is interesting that only two people saw it as involving the nurse and patient since

patient-centredness is sometimes ascribed as a characteristic of the nursing process.

Table 73 Rates of mention for aspects relating to decision-making
N = 40

Aspect	N	%	Aspect	N	%
Patient should be involved	9	22.5	Ward sister/charge nurse	5	12.5
The nursing giving care	12	30.0	Medical staff	12	30.0
A registered nurse	3	7.5	Prescriptive	1	2.5
A team approach	15	37.5	Unclassified	2	5.0
Person with knowledge and skills	3	7.5			

A team approach was mentioned most frequently when it came to the decision-making and the nursing process. Second, was the nurse giving the care. The medical staff were mentioned by 12 people. Although not involved in the making nursing decisions, the decisions made by the medical staff were seen as sometimes overturning the nursing decisions. Only 9 people mentioned that the patient should be involved. Patient-centredness is thus not strongly featured when it comes to decision-making. It is also worthy of note that the nurse giving the care is seen to be involved in decision-making to a much greater extent than ward sisters/charge nurses.

Table 74 Rates of mention for aspects relating to holistic
 N = 40

Aspect	N	%	Aspect	N	%
Involves the whole patient	18	45.0	No sure	12	30.0
Involves psychological, social, physiological biological and spiritual needs	15	37.5	Unclassified	3	7.5

Very few aspects were offered relating to the holistic standing of the nursing process. That it involves the whole patient received the most mentions. That it involves psychological, social, physiological, biological and spiritual needs was the next aspect mentioned most frequently. Twelve of the interviewees were in the not sure category.

Table 75 Rates of mention for aspects relating to humanistic
 N = 40

Aspects	N	%	Aspects	N	%
Concerned with human/individual needs	17	42.5	Not sure	10	25.0
Person is the main focus	10	25.0	Intuition	3	7.5
Concerned with communication	4	10.0	Unclassified	4	10.0

A small range of aspects were offered relating to the humanistic standing of the nursing process. Nearly half have mentioned that humanistic was concerned with human/individual needs. The person is the main focus and not sure was mentioned equally. Intuition was mentioned by three people.

Table 76 Rates of mention for aspects relating to systematic
 N = 40

Aspects	N	%	Aspects	N	%
Orderly/logical	30	75.0	Not sure	-	-
There is a format to it	3	7.5	Unclassified	1	2.5
Follows stages/steps	8	20.0			

Orderly/logical was the biggest category of aspects offered relating to the systematic standing of the nursing process. Follows stages/steps were the aspects next mentioned most frequently.

Table 77 Rates of mention for aspects relating to scientific
 N = 40

Aspects	N	%	Aspects	N	%
Follows logical steps	4	10.0	Not sure	25	62.5
Research based	6	15.0	Potentially, yes	2	5.0
Involves measurement	6	15.0	Practically, no	1	2.5
Involves experiments/ empirical work	4	10.0	Unclassified	3	7.5

The most striking finding relating to scientific is that 25 (62.5 %) of the interviewees mentioned not sure in relation to the scientific standing of the nursing process. On the basis of the evidence there are little grounds for ascribing scientific as a perceived characteristic of the nursing process.

Table 78 Rates of mention for aspects relating to individualized
 N = 40

Aspect	N	%	Aspect	N	%
One patient to one nurse	11	27.5	Total patient care	1	2.5
You look at the patient as an individual	24	60.0	Not sure	1	2.5
Individually defined problems	3	7.5	Unclassified	-	--

Only five different aspects were offered relating to the individualized standing of the nursing process. Looking at the patient as an individual was the aspect mentioned most frequently. On the basis of this evidence there are grounds for saying that individualized is perceived as a characteristic of the nursing process.

Table 79 Rates of mention for aspects relating to patient-centred
 N = 40

Aspect	N	%	Aspect	N	%
Negotiating with the patient	7	17.5	Person considered and not just the illness	6	15.0
Involving the patient in his/her care	11	27.5	Not sure	9	22.5
Allowing the patients to have a say	3	7.5	Unclassified	4	10.0

The range of aspects offered relating to the patient-centredness standing of the nursing process was small. The aspect mentioned most frequently was involving the patient in his/her care. The next aspect most mentioned was in the not sure category.

Table 80 Rates of mention for aspects relating to problem-solving

N = 40

Aspect	N	%	Aspect	N	%
Analysing the problem/ taking a history	13	32.5	Setting realistic goals	2	5.0
Setting goals	2	5.0	Not sure	4	10.0
Identification of problems/needs	14	35.0	Prioritization	3	7.5
Looks at things logically	4	10.0	Working out a way of solving the problem	4	10.0
			Unclassified	2	5.0

Problem-solving elicited a good range of aspects. Heading these was the identification of problems/needs. Next was analysing the problem/taking a history. Goal setting and prioritization were mentioned in only a few cases. Solving the problem as an aspect of problem-solving seems tautological.

Table 81 Rates of mention for aspects relating the holistic/
humanistic aspects to systematic/scientific ones

N = 40

Aspect	N	%	Aspect	N	%
Compatible/interlock	18	45.0	Not sure	10	25.0
Incompatible/contra- dictory	3	7.5	Unclassified	5	12.5
Problematic	4	10.0			

Nearly half (45 %) the sample saw the relationship between the holistic/humanistic aspects and the systematic/scientific aspects of the nursing process as being compatible. However 25% of the sample were in the not sure category. A small number (10%) saw the relationship as problematic.

Table 82 Rates of mention for aspects relating to the differences between the nursing process and other approaches to nursing N = 40

Aspect	N	%	Aspect	N	%
More job satisfaction using the nursing process approach	5	12-5	No longer task-centred	15	37-5
Better relations/communications with patients	4	10-0	Looking at the patient more as an individual	9	22-5
Improved patient care	8	20-0	Not sure	1	2-5
			More paperwork	3	7-5
			Unclassified	11	27-5

No longer task-centred was the aspect most frequently mentioned concerning the difference between the nursing process and other approaches to nursing. More job satisfaction, better communication with patients and improved patient care were mentioned relatively infrequently.

Table 83 Rates of mention for aspects relating to documentation
N = 40

Aspect	N	%	Aspect	N	%
A difficult aspect	16	40-0	More and better information is recorded now	10	25-0
Time consuming	9	22-5	Not sure	2	5-0
Standardised documents and individualized care do not go well together	3	7-5	Documentation is vital	4	10-0
			Unclassified	10	25-0

Only a small number of aspects were elicited relating to the documentation aspects of the nursing process. Sixteen interviewees were of the view that it is a difficult aspect. A further nine thought it

was time consuming. This means that over half the sample saw the documentation aspect as problematic. However, a quarter of the sample were of the view that more and better information is recorded now.

Table 84 Rates of mention for aspects relating to nursing models
N = 40

Aspect	N	%		N	%
A way of looking at things/care	3	7-5	A theoretical framework	15	37-5
A construal based on a particular view of man	6	15-0	Not sure	2	5-0
A way of implementing the nursing process	5	12-5	Abstract/conceptual	2	5-0
A representation of reality	1	2-5	Guide/checklist for assessment	13	32-5
			Confusing	1	2-5
			Unclassified	3	7-5

A theoretical framework was the aspect most frequently mentioned in relation to nursing models. Secondly, nursing models were seen as a guide/checklist for the assessment part of the nursing process. This represents a nice balance between the theoretical and the practical aspects. Models are sometimes criticised because they are confusing. This does not appear to be the case as far as the interviewees in the present study are concerned.

Table 85 Rates of mention for aspects concerning the relation between the nursing process and nursing models N = 40

Aspect	N	%	Aspect	N	%
Compatible/interlock	30	75-0	Not sure	1	2-5
Incompatible/contradictory	2	5-0	Mechanical/abstract	2	5-0
Problematic	3	7-5	Unclassified	3	7-5

The overwhelming response concerning the relationship between the nursing process and nursing models was that they were compatible. Few saw the relationship as being either incompatible or problematic.

A CLUSTER ANALYSIS OF SPONTANEOUSLY SUPPLIED CONSTRUALS OF THE NURSING PROCESS.

It is now proposed to present the results of the cluster analysis of the data from the opening part of the interviews using Ward's (1963) technique. This analysis is presented in the first instance as a dendrogram, which is followed by tables characterising the clusters which emerged.

Table 87. Dendrogram of cluster analysis of aspects of the nursing process.

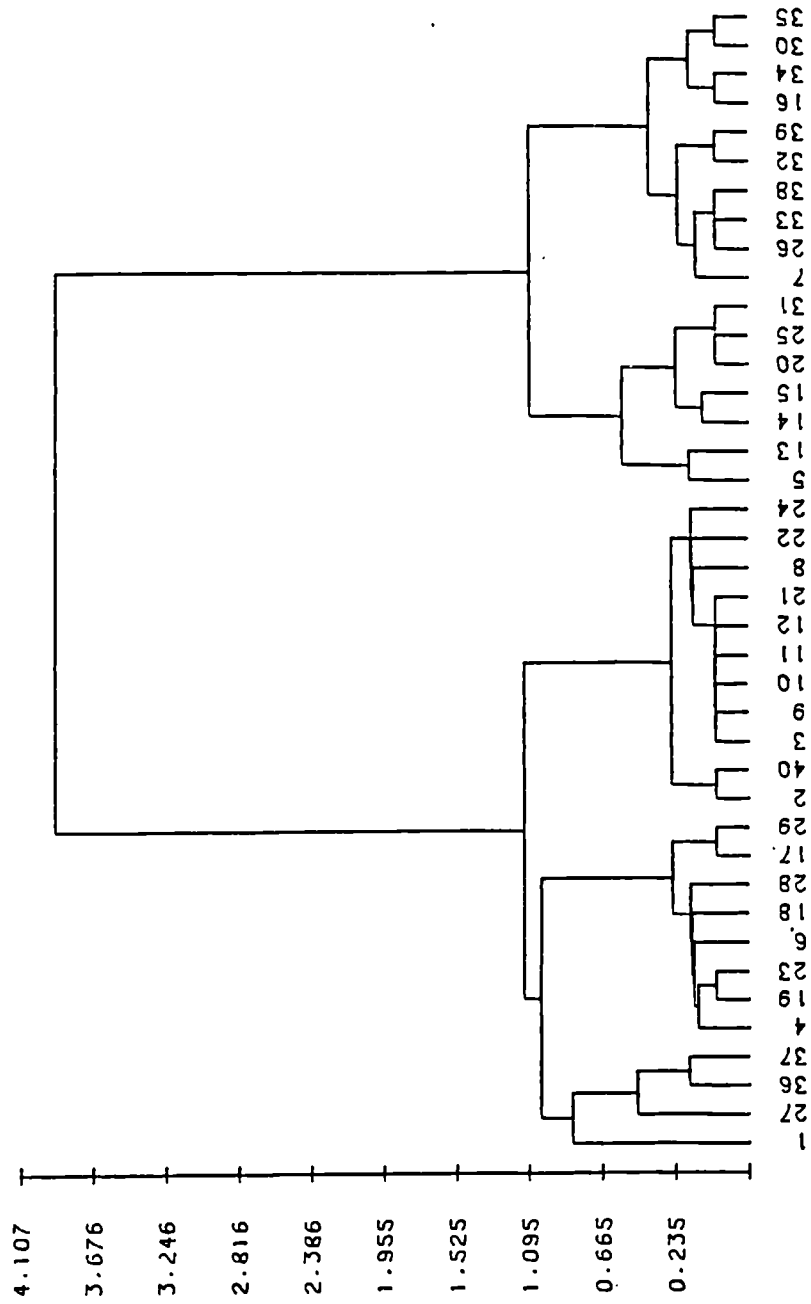


Table 89 The composition of clusters one and two of the two cluster solution

CLUSTER 1 (N = 23)			CLUSTER 2 (N = 17)		
CASE	GENDER	STATUS	CASE	GENDER	STATUS
1	F	Senior tutor, G	5	F	Nurse tutor, G
2	F	Senior tutor, G	7	F	Nurse tutor, G
3	M	Senior tutor, G	13	M	Nurse tutor, G
4	M	Senior tutor, G	14	M	Nurse tutor, G
6	F	Nurse tutor, G	15	F	Ward sister, G
8	F	Nurse tutor, G	16	F	Ward sister, G
9	F	Nurse tutor, G	20	F	Ward sister, G
10	M	Nurse tutor, G	25	F	Ward sister, G
11	M	Nurse tutor, G	26	M	Senior tutor, P
12	M	Nurse tutor, G	30	F	Nurse tutor, P
17	F	Ward sister, G	31	F	Nurse tutor, P
18	F	Ward sister, G	32	M	Nurse tutor, P
19	F	Ward sister, G	33	M	Nurse tutor, P
21	F	Ward sister, G	34	M	Nurse tutor, P
22	F	Ward sister, G	35	F	Ward sister, P
23	F	Ward sister, G	38	F	Nurse tutor, M.H.
24	F	Ward sister, G	39	M	Nurse tutor, M.H.
27	M	Senior tutor, P			
28	M	Senior tutor, P			G = General Nursing
29	F	Nurse tutor, P			P = Psychiatric Nursing
36	M	Chargenurse, P			MH = Mental Handicap Nursing
37	M	Senior tutor, M.H.			
40	M	Nurse tutor, M.H.			

Table 90 The composition of clusters one to five of a five cluster solution

CLUSTER ONE (N = 4)			CLUSTER TWO (N = 8)			CLUSTER THREE (N = 11)			CLUSTER FOUR (N = 7)			CLUSTER FIVE (N = 10)		
CASE	GENDER	STATUS	CASE	GENDER	STATUS	CASE	GENDER	STATUS	CASE	GENDER	STATUS	CASE	GENDER	STATUS
1	F	Senior Tutor, G	4	M	Senior Tutor, G	2	F	Senior Tutor, G	5	F	Nurse Tutor, G	7	F	Nurse Tutor, G
27	M	Senior Tutor, P	6	F	Nurse Tutor, G	3	M	Senior Tutor, G	13	M	Nurse Tutor, G	16	F	Ward Sister, G
36	M	Charge Nurse, P	17	F	Ward Sister, G	8	F	Nurse Tutor, G	14	M	Nurse Tutor, G	26	M	Senior Tutor, P
37	M	Senior Tutor, MH	18	F	Ward Sister, G	9	F	Nurse Tutor, G	15	F	Ward Sister, G	30	F	Nurse Tutor, P
			19	F	Ward Sister, G	10	M	Nurse Tutor, G	20	F	Ward Sister, G	32	M	Nurse Tutor, P
			23	F	Ward Sister, G	11	M	Nurse Tutor, G	25	F	Ward Sister, G	33	M	Nurse Tutor, P
			28	M	Senior Tutor, P	12	M	Nurse Tutor, G	31	F	Nurse Tutor, P	34	M	Nurse Tutor, P
			29	F	Nurse Tutor, P	21	F	Ward Sister, G				35	F	Ward Sister, P
						22	F	Ward Sister, G				38	F	Nurse Tutor, MH
						24	F	Ward Sister, G				39	M	Nurse Tutor, MH
						40	M	Nurse Tutor, MH						

G = General Nursing
P = Psychiatric Nursing
MH = Mental Handicap Nursing

Visual inspection of the dendrogram suggests a two cluster solution (Table 87). Cases (along the horizontal at the base) fuse into two distinct clusters at 1:095 on the vertical dissimilarity scale at the left. Fusion at this relatively low level indicates that the composition of each cluster is homogenous. At the other end the two clusters fuse only at a point beyond 3:676 on the scale. This means that, while each cluster is relatively homogenous, the fact that the clusters fuse at a high point on the scale also makes them dissimilar to each other.

Clusters one and two of the two cluster solution are presented in Table 88. Diagnosis of cluster types requires a characterisation in terms of those features (i.e. variables) which set the members apart from those of other clusters. For dichotomous or binary variables as in the present case this requires attention both to the percentage occurrence of such features in a cluster and to the binary frequency ratio, that is, the ratio of the percentage of cluster members possessing a quality to the percentage of members of the overall sample possessing it. Using this approach cluster one seems to be characterised by one variable, this being the variable with a high percentage occurrence. The percentage occurrence for "individualised care" was 69.6 per cent and the binary frequency ratio was 1.16.

The composition of cluster one of the two cluster solution is set out in Table 89. Perusal of Table 89 reveals that 57 per cent are females, 74 per cent are in general nursing and 65 per cent are nurse teachers and it is perhaps noteworthy that seven out of the total of eight senior tutors were in this cluster.

Cluster two of the cluster solution is characterised by a wider spread of binary variables than cluster one. These are: "assessment", "planning", "evaluation", "implementation", and "problem-solving", which all achieve quite high and distinctive rates of mention. Although less so than in Cluster 1, "systematic", and "individualised" also feature clearly. All members of the cluster have "assessment" among the aspects they mentioned and the binary frequency ratio for this was 1.90. The percentages and ratios for the other components of this cluster were: "planning" 94 per cent and 2.09; "evaluation" 88 per cent and 1.96; "implementation" 70.6 per cent and 2.17; "problem-solving" 41.2 per cent and 1.50; "systematic" 38 per cent and 0.88 and "individualised care" 47.1 and 0.78.

The composition of cluster two of the two cluster solution is set out in Table 89. In summary it comprised mostly female nurse tutors, more or less evenly spread in general and psychiatric nursing.

Perusal of Table 88 reveals a number of major contrasts between cluster one and cluster two of the two cluster solution. In the case of cluster one of the two cluster solution the percentage and ratio for assessment were 17.4 per cent and 0.33. For cluster two the figures were 100.0 per cent and 1.90. The values for cluster one for "planning" were 8.7 per cent and 0.19. For cluster two the values were 94.1 per cent and 2.09. Another contrast was found concerning "implementation". The values for cluster one were 4.3 per cent and 0.13; those for cluster two were 70.6 per cent and 2.17. A contrast is also evident relating to "evaluation".

For cluster one the values were 13.0 per cent and 0.13; those for cluster two were 70.6 and 2.17.

Cluster two seems to involve a high percentage of the "orthodox" formal features of the nursing process (assessment, planning, implementation and evaluation). Cluster one seems to be characterised by the absence of most of these things (note the low percentage occurrence/low ratios in cluster one). Cluster two seems to be a group with a much more differentiated, multi-aspect grasp of the concept, whilst cluster one has an 'individualised only' idea. We noted earlier (Table 89) that seven out of eight of the senior tutors in the sample were in cluster one. Since the cluster comprises a group of experienced people it may be that they construe the nursing process approach as individualised by contrast with traditional and task-centredness, rather than seeing it more fully in its own terms.

Further inspection of the dendrogram (Table 87) reveals a five sub-cluster solution which fuses at the level of 1.095 on the scale. Although this is a relatively low level of dissimilarity, the similarity is due to the common absence of certain variables. These clusters nevertheless show some interesting contrasts in what they do possess, and are therefore worth examination.

Cluster one of the five cluster solution is a small cluster comprising only four cases, but it is strongly characterised in terms of high percentage of occurrence and high binary frequency ratios.

"Scientific" had a percentage occurrence of 75 per cent and a binary frequency ratio of 6.0; "evaluation" was 75 per cent and 1.67; "action research" 75 per cent and 10.00; "individualised" 75 per cent and 1.25; "assessment" 50 per cent and 0.95 and "systematic" 50 per cent and 1.25. "Planning" received no mention (Table 88).

The composition of cluster one of the five cluster solution is set out in Table 90. It is made up mostly of male teachers with equal numbers coming from psychiatric and mental handicap nursing.

Cluster two of the five cluster solution is set out in Table 88. This cluster contrasts strongly with the cluster just described in that it is characterised by "a systematic approach". This variable had a percentage occurrence of 100 per cent and a binary frequency ratio of 2.50. All the other binary variables occurred infrequently and several such as "negotiation", "decision-making", "systems model", "implementation", "action research" and "holistic" received no mention at all.

Cluster two of the five cluster solution is also a small cluster comprising eight cases. Reference to Table 90 shows that these are mostly female general nurses with equal numbers of teachers and clinical staff.

Cluster three of the five cluster solution, like cluster two, is also characterised by a single binary variable (Table 88). The binary variable concerned is "individualised". This was present in 100 per cent of the cases and the binary frequency ratio was 1.67. As with cluster two above, it is notable that a number of binary frequencies such as "systematic", "negotiation", "decision-making", "systems model", "implementation", "evaluation", "action research" and "holistic" were not mentioned.

Cluster three of the five cluster solution comprised eleven cases (Table 90). It was made up mostly of nurse teachers in general nursing with a more or less even spread of males and females.

Cluster four of the five cluster solution comprises seven cases (Table 90). Unlike the two previous clusters, which were characterised by single binary variables, cluster four is characterised by six binary variables (Table 90). These variables, their percentage occurrence and binary ratio frequency are as follows: "problem-solving" 100 per cent and 3.64; "assessment" 100 per cent and 1.90; "planning" 85.7 per cent and 1.90; "evaluation" 71.4 per cent and 1.59; "individualised" 57.1 per cent and 0.95 and "implementation" 42.9 per cent and 1.32. It is notable that a number of binary variables such as "systematic", "negotiation", "systems model", "scientific", "action research" and "holistic" were not involved in the composition of the cluster.

The cases in the cluster (Table 90) were characterised by being mostly females in general nursing with nurse teachers slightly outnumbering clinical nurses.

Six binary variables go to make up cluster five of the five cluster solution (Table 88). The variables, their percentage occurrence and their binary frequency ratios are as follows: "assessment" 100 per cent and 1.90; "planning" 100 per cent and 2.2; "evaluation" 100 per cent and 2.2; "implementation" 90 per cent and 2.77; "systematic" 60 per cent and 1.50 and "individualised" 40 per cent and 0.67. Binary variables not contributing to the cluster include "problem-solving", "negotiation", "decision-making", "systems model", "scientific", "action research" and "holistic".

Examination of Table 90 shows that there are ten cases in the cluster. It also shows that it is comprised mainly of teachers

in psychiatric nursing with equal numbers of males and females. When the two nurse teachers in mental handicap nursing are included, the cluster members could be said to have a strong psychiatric orientation.

Perusal of Table 88 reveals a number of contrasts relating to the five cluster solution. These contrasts will be considered in the order they appear on Table 88.

The first binary variable is "problem-solving". This appears to a significant extent in cluster four of the five cluster solution where the values were 100 per cent and 3-64. In the remaining clusters the percentages and ratios were low. "Problem-solving" was not mentioned in cluster five of the five cluster solution.

"Individualised care" is a characteristic common to a considerable extent to all clusters except cluster two of the five cluster solution. In the case of cluster two the values for this variable were 25 per cent and 0-42.

The third binary variable, "a systematic approach", evoked contrasting responses. The variable was a characteristic of cluster one (50 per cent and 1-25), cluster two (100-0 per cent and 2-50), and cluster five (60 per cent and 1-50). This variable received no mention in clusters three and four of the three cluster solution.

The next binary variable, "negotiation", was mentioned by cluster one only, and here the percentage value, 25 per cent, was low and the ratio was 10-00. We have seen that "individualised care" is a fairly persuasive characteristic of most of the clusters which

emerged. "Negotiation" is generally accepted as an aspect of "individualised care". Yet "negotiation" received a very low rate of mention by the interviewees which suggests that for them at least it is not incorporated in their construal of the nursing process.

"Assessment" was the next binary variable on the list. Perusal of Table 88 shows that it is present to a significant extent in clusters one, four and five of the five cluster solution. It is present, but to a lesser extent, in clusters two and three. In fact clusters two and three contrast strongly with clusters four and five in this respect. The values for cluster two were 12.5 per cent and 0-24, for cluster three they were 9.1 per cent and 0-17; whereas for cluster four the values were 100 per cent and 1-90 and the values for cluster five were also 100 per cent and 1-90.

The noteworthy thing about variable six "decision-making" is how infrequently it features. It is present to a small extent in clusters one and four, but is missing from clusters two, three and five. It seems that "decision-making" is not perceived to be a characteristic of the nursing process by these interviewees at least only to a very limited extent.

Variable seven, "systems model", was also notable for its absence in the majority of the clusters in the five cluster solution. It was present in cluster one and the values were 25 per cent and 10.90. It was absent from clusters two, three, four and five.

Strong contrasts are evident in relation to variable eight which was

"planning". Perusal of Table 88 shows that it is present to a significant extent in clusters four and five of the five cluster solution. It is present to a small extent in clusters two and three of the five cluster solution and, surprisingly, it was not mentioned by cluster one. At a basic level the nursing process is often characterised by the abbreviation APIE (assessment, planning, implementation and evaluation). Since that is the case, it might be expected that planning would be a more pervasive characteristic of the nursing process than proved to be the case in the present study.

Variable nine, "scientific", produced some strong contrasts. In cluster one of the five cluster solution, the values were 75 per cent and 6-00. It received a low rate of mention in clusters two and three, and no mention in clusters four and five of the five cluster solution. It seems that "scientific" is not a very pervasive characteristic of the nursing process.

"Implementation" was variable ten on the list and it turned out that this was not an all pervasive characteristic of the clusters. It was present to a significant extent in cluster five of the five cluster solution (90 per cent and 2-77), to a lesser extent in cluster four (42.9 per cent and 1-32) and to a still lesser extent in cluster one (25 per cent and 0-77). It was absent from clusters two and three of the five cluster solution. As with "planning", "implementation" is an integral element of APIE and might therefore be expected to be a more pervasive characteristic of the nursing process.

"Evaluation", another element of APIE, was the subject of variable eleven. This provided some sharp contrasts. It was present to a significant extent in clusters one, four and five of the five cluster solution. It was absent from clusters two and three of the five cluster solution. Again, if APIE are to be taken as the basic

elements of the nursing process approach, it might be expected that "evaluation" would be a more universal characteristic than it turned out to be.

The penultimate variable on the list was "action research". This was present to a significant extent in cluster one of the five cluster solution and it was absent from clusters two, three, four and five. "Action research" is thus a characteristic of only one cluster in the five cluster solution.

The final variable on the list was "holistic". This was present only in cluster one of the five cluster solution and it was absent from clusters two, three, four and five. "Holistic" was offered spontaneously as a characteristic of the nursing process by only a very small number of the interviewees. Reference to Table 90 shows that cluster one of the five cluster solution comprised four people only. It seems from this data that "holistic" is not a very pervasive characteristic of the nursing process.

SUMMARY

In this chapter the results of the interview part of the study have been presented in three forms. In the first case results are presented for individual interviewees with reference to the items on the interview guide (Appendix 1). In the second case results are presented for the rates of mention for aspects on the interview guide. Thirdly, the aspects mentioned spontaneously at the beginning of the interviews were analysed using the technique of cluster analysis. The cluster formations resulting from this analysis are presented as a dendrogram and in tabular form. These results will be discussed in the next chapter.

CHAPTER EIGHT

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DISCUSSION AND CONCLUSION

INTRODUCTION

The aim of the study, as stated earlier, was to investigate the meaning of the nursing process as construed by members of the nursing profession. The study has a conceptual focus because as Tomlinson (1981 p.66), already cited, reminds us" our knowledge and understanding are basically conceptual, for we use concepts to include or exclude things with respect to particular classes or categories." A conceptual analysis is therefore of fundamental importance concerning how a subject is understood and taught. A conceptual analysis would be a worthy pursuit in its own right, but it seems particularly relevant as far as the nursing process approach is concerned because this is a relatively new innovation in the field of nursing and therefore ought to be studied systematically. Moreover, some of the sources reviewed such as Boylan (1982), Hillier (1982) and Brooking (1983) suggested there was confusion about the nature of the nursing process.

In this chapter the survey will be discussed first and this will be followed by a discussion of the interview part of the study.

Typologies resulting from a cluster analysis of part of the interview data are set out. Finally the implications of the study for teaching and learning are discussed.

THE SURVEY

a. The Nursing Process in Perspective

The types of training courses offered by the schools of nursing in the survey are set out in Table 1. This reflects the current organisation of nursing education, with the majority of schools offering Registered General Nurse training.

Table 2, concerning the length of time the teaching of nursing has been based on the nursing process, is of interest. As mentioned earlier, the GNC issued its circular concerning the central place of the nursing process in the teaching and learning of nursing in 1977. Examination of Table 2 shows that at that time and for a number of years to follow only a handful of schools of nursing were basing their teaching on the nursing process. According to the data presented here only 22 per cent of the schools of nursing based their teaching on the nursing process by 1980. By 1981 the figure stood at 46 per cent. The take off point appears to be 1982 since by then 70 per cent of the schools of nursing claimed to be basing their teaching on the nursing process.

How the nursing process is regarded by directors of nurse education is presented in Table 3. The majority of the response cluster around favourably (26 per cent) and very favourably (62 per cent). From this data it may be inferred that this group of potentially influential people are favourably disposed towards the nursing process.

The teaching staff in schools of nursing are said to be marginally more in favour of the nursing process than their bosses. Table 4 shows 39 per cent viewing it favourably and 52 per cent very favourably. There appears to be the condition at this level to get the innovation off the ground.

A somewhat different picture, however, emerges with respect to service staff in the hospitals concerned. Table 5 shows that the directors of nurse education report nearly a third of this group as viewing the nursing process unfavourably. While 70 per cent of this group are said to view it favourably, only a small number are very favourably disposed to it. It is being suggested that learner nurses are faced with teachers who are generally enthusiastic about the nursing process and ward staff who are noticeably less enthusiastic about it. What is the effect on the learners? Is this a prescription for dissonance?

Partially implemented seems to represent the state of implementation of the nursing process in the schools of nursing surveyed; 68 per cent of the responses being in this category. Table 6.

The respondents were next asked to place in rank order a number of problems encountered in implementing the nursing process. The problems were derived from the literature relating to the implementation of the nursing process. The results are presented in Table 7, which are based on the averages of the total response scores.

b. Change

It is perhaps no surprise that resistance to change by nurses was ranked number one in the problems encountered in implementing the nursing process. Menzies (1970 p22) wrote

"It is understandable that the nursing service, whose tasks stimulate such primitive and intense anxieties, should anticipate change with unusually severe anxiety. In order to avoid this anxiety, the service tries to avoid change wherever possible, almost, one might say, at all costs, and tends to cling to the familiar even when the familiar has obviously ceased to be appropriate or relevant. Changes tend to be initiated only at the point of crises".

It is possible to criticise the GNC for the manner in which the nursing process was introduced, schools of nursing were not given a choice in the matter. But, given a choice in the matter, given that such a change was both necessary and desirable, and given the resistance to change described above by Menzies (1970); would anything

have happened without the force of the statutory body in the form of the GNC? Not to implement the nursing process would have meant possible withdrawal of approval for training by the GNC. Withdrawal of approval would have meant a staff crisis for the hospital concerned. We are therefore back to Menzies' change only at the point of crisis.

c. Problems

Staff shortage, lack of time, extra paperwork and a rapid turnover of patients are all ranked highly as problems encountered in implementing the nursing process. Medical staff generally have little time for the nursing process, but in this instance resistance by medical staff was ranked bottom in the list of problems associated with introducing the nursing process.

In the next section of the questionnaire the respondents were asked to write down additional problems relating to the implementation of the nursing process. These are set out in Table 8.

There were responses, sometimes one and sometimes up to five, on 60 per cent of the questionnaires returned. Further analysis revealed a total of 112 individual items relating to problems encountered in implementing the nursing process. This represented 64 per cent of all the items (problems as well as advantages) on this section of the questionnaire. The items relating to problems are presented in Table 8, together with the frequency in which they appeared.

The first thing to note about Table 8 is that it contains a very long list of problems. However, to take account of the problems which occur in double figures, this reduced the problems to four main themes.

d. Staff Development

Heading the list is difficulty in providing staff development courses on the nursing process. If the sixth problem on the list, lack of knowledge by trained/clinical staff, is taken to be an aspect of the provision of courses; then it may be said that the major problem associated with the implementation of the nursing process was education, or more precisely lack of education.

e. Understanding The Concept

Second on the list is the problem of understanding the nature of the concept. This may be explained in terms of resistance to change and the nursing process being arbitrarily dismissed as being unnecessarily complex. Another explanation might be the lack of educational opportunity already mentioned.

Third and fourth on the list (lack of understanding/commitment by nurse managers and lack of commitment/motivation by senior staff) are concerned with goodwill, or more precisely lack of goodwill. Many nurses tend to be very self conscious about the professional standing of nursing, and there are many, as mentioned in the review of the literature earlier, who regard nursing as a profession: there are others who do not regard it so. If a professional is a person who examines his practices from time to time and modifies and adjusts if they are found wanting, then the present findings which reflect a lack of goodwill do not advance the case that nursing is a profession. However, it might be argued that the nursing process was thrust upon nurses who were ill prepared to take it on board, and without any evidence about its worth. It might also be argued that a healthy scepticism would be a perfectly proper and even a prudent stance to take in the circumstances.

f. Paperwork

In any discussion about the nursing process the issue of the amount of paperwork involved nearly always crops up. It is interesting that it occupies fifth place in the list of problems here and that staff development is seen as a problem which is three times greater. It may be that the paperwork was a convenient scapegoat while more fundamental problems were not discussed. On the other hand, it may be that the directors of nurse education are not closely in touch with such details. It might also be the case of course that people are getting used to the new form of documentation and are becoming more tolerant towards it.

g. Diverse Views

What inference may be drawn from the remaining data on Table 8? An obvious comment is that there is a great deal of it. Perhaps this is what might be expected if one considers that these are the problems posited by over 100 directors of nurse education, or their equivalents, and gathered from all parts of the United Kingdom. The diversity of views is also explicable when the wide range of nursing specialities covered in the survey is taken into account and these are set out in Table 1.

One inference which may be made was that the implementation of the nursing process caused considerable upheaval. Whether it was worth all this upheaval is another question. Another inference which might be made is that all is not well with the implementation of the nursing process, given the nature and range of problems which have emerged. However, some caution is needed in relation to this matter. The question asked for problems encountered in implementing the nursing process and account has to be taken of the state of implementation. Table 6 shows the state of implementation of the nursing process as

elicited by this study. Given that 'partially implemented' represents the biggest category of responses, it may be inferred that the implementation of the nursing process continues to give rise to problems.

Perusal of Table 7 reveals that many of the problems were cited on only once or twice and may therefore not be of much significance, While it would be possible to support such an argument, it might also be argued that since the respondents took the trouble to write the problems on the questionnaires, it may be assumed that these were perceived as real problems for the respondents. If this is so and if it is intended to attempt to understand the problems relating to the implementation of the nursing process in their totality, then individual responses ought to be taken into account.

h. Advantages

What advantages have been gained following the implementation of the nursing process? The respondents ranked the nine items on the questionnaire as set out in Table 9. More effective patient care emerged at the top of the list. This is followed by a better framework for learning for student and pupil nurses. Communication between nurses and patients and between nurses follow close behind. It is interesting to note that extra paperwork was ranked four among the problems of implementation (Table 7. Better documentation is ranked eight among the advantages gained from implementing the nursing process. A criticism of nursing before the introduction of the nursing process was the poor quality and varied nature of nursing documents. Care plans were meant to change all that. It is interesting therefore that documentation is nearly at the bottom of the list of advantages claimed to be related to the introduction of the nursing process. Once again, the doctors appear at the bottom of the pile. What is the explanation for this? Medical indifference as perceived by the respondents or a

failure of nurses to get their case across concerning the nursing process?

As with problems associated with the implementation of the nursing process, the respondents were asked to write in additional advantages relating to the implementation of the nursing process which occurred to them. These are set out in Table 10.

When the problems relating to the implementation of the nursing process were considered, a total of 112 individual items were written on the questionnaires accounting for 64 per cent of the total items. In the case of advantages relating to the implementation of the nursing process, 64 items were written on the questionnaire or 36 per cent of all the items.

An inference which may be made is that the problems outweigh the advantages in relation to implementing the nursing process in a ratio of almost 2:1. Perhaps this is what might be expected when an innovation is introduced in a setting which, as Menzies (1970) contends, is resistant to change.

When the problems were considered only those in double figures were picked out for mention. In the case of advantages, the same principle cannot apply since none of the items are in double figures. While bearing in mind the relative size of the numbers involved three categories of advantages have risen to the top of the list.

i. Managerialism

Greater/better accountability heads the list of advantages. Third on the list is better evaluation of nursing. Together these form a category which may be described as managerialism since it is concerned with aspects generally, but not exclusively, associated with management.

There is currently much concern throughout the National Health Service with management and it is interesting that this aspect should head the league of reported advantages.

J. Progressivism

The second advantage on Table 10 concerns the introduction of a holistic, problem-solving approach to nursing. As far as nursing is concerned, these are progressive ideas and this category of advantages may therefore be described as progressivism.

k. Patiency

Items four, five and six on Table 10, that is, better continuity of care, involvement of patients/families, improved satisfaction are concerned with patients. This category may be described as patiency. Dickoff, James and Wiedenbach (1968) used the term patiency in relation to who or what is the recipient of the nursing activity. While this is an imported term which sometimes jars on British ears, it does seem to be an appropriate collective term for the advantages included in this category.

l. Priorities

The order of priority given to the advantages relating to the implementation of the nursing process is a matter of interest. Nurses frequently talk about patients first. But this is not well reflected on Table 10. Managerialism is a clear leader and progressivism is following closely on its heels. Matters relating to patients are a poor third because it is only by putting three different sets of items together that it is possible to make a sizeable category. It seems that the imperatives of managerialism outweigh human concerns for patients. Is this a question of values or is it the case that managerialism is in a stronger

position than patients and therefore can command greater attention? It might be argued that good management is essential for good patient care and therefore no conflict exists. This argument has a certain validity, but a question which arises is: why should the tail wag the dog?

The points made in relation to the problem associated with the implementation of the nursing process equally apply to its advantages. Items cited only once or twice could be written off as the idiosyncratic contributions of isolated individuals. But if we are interested in attempting to understand the nature of the problem in its entirety, then account ought to be taken of all relevant evidence.

Reference to Table 6 shows that the nursing process is only partially implemented in the schools of nursing in the survey. Given the problems encountered with its implementation it may well be too soon for its advantages, if any, to begin to appear in a significant way. The shorter list of advantages for the nursing process ought to be interpreted with those facts in mind.

SEMANTIC DIFFERENTIAL

a. The Profile

The next section of the questionnaire comprised 16 semantic differential items and the results are presented in Table 11. The points on the profile were derived from the averages of the total response scores. Examination of Table 1 shows that the majority of the ratings in the profile are found within a range of 1.5 and 2.5 on the seven point scale. The nursing process is rated as holistic, systematic, humanistic, individualised, problem-solving and a patient-centred. The bipolar items given the highest score were; scientific-intuitive (2.9), likely to endure-not endure (3.0) and a clear-a confused concept (2.9). These scores are still nearer to the positive than

the negative end of the scale. However, they are worthy of comment.

b. Scientific-Intuitive

The fact that the scientific-intuitive item scored nearer to the mid-point might indicate a desire to draw on scientific knowledge and intuition when nursing. It is interesting that the item relating to the durability of the nursing process received the highest score of all. The respondents would be mature people and would therefore have seen a number of nursing band wagons disappear into oblivion. This might account for the mild degree of scepticism concerning the durability of the nursing process.

c. Nature of Concept

A clear or a confused concept? The rating suggests a move away from the clear end of the scale. This might be seen as a reaction to the fact that the nursing process was imported from across the Atlantic and was sometimes presented in unfamiliar terms. This reaction might also be explicable in terms of resistance to change. The respondents would have trained before the nursing process arrived on the scene and may, in some cases, be inclined to dismiss it rather than come to terms with it.

NURSING MODELS

a. Nursing Models in Perspective

It is now thought desirable to use a nursing model in conjunction with the nursing process. The argument being that the stages of the nursing process (assessment, planning, implementation and evaluation) are in no way peculiar to nursing and could, as already mentioned, equally apply to agriculture, chemical, engineering processes and so on. While the stages of the process provide a systematic basis for

setting about a task, they should be used in a nursing setting in conjunction with a nursing model which embodies assumptions about the nature of man, health, the environment and nursing intervention.

A study of the nursing process therefore ought to take account of nursing models. Table 12 shows the models of nursing which are taught in schools of nursing. It emerged that three models: Henderson, Roper and Orem are the models most commonly taught. Only the models set out in Table 12 appeared on the questionnaire, but the respondents were invited to write in others taught in the space provided. Table 13 is the outcome. This comprises the models listed on Table 12 and the additional ones which were written in so as to give a comprehensive list. Many of those written in appeared only once, nonetheless the list is a long one.

To what extent are nursing models used in clinical areas? Table 14 shows that 49 per cent of the responses are in the 'some extent' category, with a few at either extremes of the scale. The response relating to the usefulness of models in the delivery of care presents a very similar picture. 47% of the responses are in the 'some extent' category and the numbers at both ends of the scale are similar to the responses concerning usage. Table 15.

In the final section of the questionnaire the respondents were asked to relate nursing models to nursing specialities. The results are set out in Tables 16 to 24. Perusal of Tables 16 to 24 shows that in six out of the nine nursing specialities cited, the non-responses exceeded 50 per cent. The exceptions are general nursing, nursing the elderly and psychiatric nursing. General nursing had the lowest percentage of non-response (36 per cent) and consequently the highest relation of models to a speciality (approximately 60 per cent).

b. Models Taught

Perusal of Tables 16 to 24 reflects the findings set out in Table 12 regarding models taught in schools of nursing. The three most commonly taught were Henderson, Roper and Orem. It is also the case that those most frequently related to the nursing specialities were those same models, an exception being psychiatric nursing. In this case the Henderson model figured in only two per cent of the responses. The Orem and Roper models featured fairly significantly in psychiatric nursing, but two models: Peplau (six per cent) and Roy (eleven per cent) featured to a greater extent in this than in any other speciality.

Was it a fair task to ask the respondents to relate nursing models to nursing specialities? Many would argue that it is not appropriate to attempt to relate nursing models to nursing specialities since the model used ought to relate to the needs or problems of individual patients. It is also argued that a different model might be appropriate at different stages of patient's illness. However, these considerations did not deter many respondents to this survey from attempting to answer this question; though some did question the wisdom of relating nursing models to clinical specialities. The question was answered by 146 or 82 per cent of the respondents.

c. Respondents Comments

There was space on the questionnaire for additional comment and 57 or 32 per cent of the respondents made use of this space to relate nursing models to clinical specialities. Five respondents or approximately 3 per cent commented that they were unable to relate nursing models to nursing specialities.

The additional comments on nursing models as written by the respondents are set out in Appendix 11. These are reproduced verbatim

except in cases where the comments were very long: in these cases the essence of what was being said was extracted.

These additional comments have yielded a wealth of data which is rather diverse in nature. However, it is possible to categorise the points made and these are presented as Table 25.

d. Eclectic

Eclectic heads the list. These respondents are of the view that a variety of models ought to be used when nursing patients. Another sizeable group is saying much the same thing when it says that it is impossible to relate a nursing model to a clinical speciality. Yet an almost equal number of respondents have opted for Roper's model. These are followed by another sizeable group who opt for a combination of Henderson and Roper's models. Another group opted for a combination of Orem and Roper's model. Yet another is saying that nursing models should come before the nursing process. Three respondents felt they hadn't enough experience with models to comment on them. This may be taken as a good sign since these respondents wished to make a considered judgement on the issue rather than automatic acceptance or rejection. Two respondents made up their own model which is a perfectly proper stance to take, except one would be interested in their experience and competence in model building. Only one person admitted to using no models and only one person concluded that models are not of much value.

e. Conflict

Is it possible to relate a nursing model to a clinical speciality? Some say yes and some say no. Is it possible for a school of

nursing to opt for one nursing model? Some say yes and some say no. Is there any consensus among the respondents concerning nursing models? The empirical evidence from this study suggests the answer is no. The state of nursing models is like that of a centipede. The problem is that the organism's many feet striking out in different and often different and opposing directions. Such a set up is likely to make progress difficult, if not impossible. However, perhaps some confusion is to be expected since it is early days yet as far as nursing models are concerned. It may be that with time and with a good deal of effort, nursing models will actually provide a framework for the practice of nursing.

f. Consensus

The teaching of nursing throughout the United Kingdom is based on the nursing process; at least the respondents to this survey claim this to be so. It is well regarded by the directors of nurse education and their staff, but is perceived to be less well regarded by service staff. The data from the survey shows that it is partially implemented throughout the United Kingdom. When asked to rank a number of potential problems relating to the implementation of the nursing process, resistance to change emerged at the top of the list. But when the respondents wrote on the problems they encountered, then lack of staff development was most frequently cited. The respondents were asked to rank a list of potential advantages relating to the implementation of the nursing process, then more effective patient care was ranked number one. Again, when respondents were asked to write in the advantages which they perceived, then managerial aspects such as accountability headed the list of problems relating to the implementation of the nursing process far outweigh the other perceived advantages. However, it is early days yet and it might be prudent to

reserve judgement on this issue. The semantic differential profile which emerged presented a very consistent set of responses at the positive side of the profile. There was less certainty however concerning three items and these were the scientific standing of the nursing process, its durability and its clarity as a concept.

g. The basis of Choice

The nursing process and nursing models tend to be used in tandem these days and the respondents were therefore asked about nursing models. It emerged that the Henderson, Roper and Orem models are those most commonly used. Nursing models are used only to some extent and similarly they are seen to be useful only to some extent. Opinions about models were very mixed. Some schools of nursing had elected to adopt one model but many had opted for an eclectic approach. Some respondents commented that they had had little experience with models or that it was too early to comment. It is perhaps too early to comment on the place of nursing models within nursing for they are at a rudimentary state of development in relation to nursing in the United Kingdom, hence the rather shaky basis for choosing a model/models.

h. The Survey in Perspective

The survey aimed to find out about practices and opinions relating to the nursing process and nursing models. This aim could be said to have been achieved since the response rate was at the upper end of expected responses for postal surveys. However, this can be considered to be no more than a first look at the issues involved. Stacey (1969 p27) spoke of 'the structural skeleton which surveys reveal' and the present study may be considered in this light. This is particularly the case regarding how the nursing process is construed by teachers of nursing. The semantic differential items yielded data about the

meaning of the nursing process as far as the respondents were concerned. This provided a clear cut picture, but this is what might be expected from the forced format used. It is likely that the empirical reality is more complex than the semantic differential results imply. The additional comments made by the respondents on the questionnaire proved interesting and provided insights which would not otherwise have been available. There is a strong case for asking people to comment on their own way.

The limitations associated with the forced format of the semantic differential are accepted. However, the fact that there was a lack of certainty concerning the scientific standing of the nursing process approach, its durability and its clarity as a concept suggests that these aspects warrant further study.

Data were collected in a systematic way, yet allowing people to express themselves in their own way. As the following discussion will indicate, the interview findings tend to corroborate the directors of nurse education characterisation of the nursing process as a confused concept.

THE INTERVIEWS

a. Opening Statement

An analysis of the opening statements made by the interviewees is presented in Table 67. A range of aspects were offered and the aspect mentioned most frequently was individualised care. A number of the sources reviewed such as McFarlane and Castledine (1982), Blake and Towell (1982) and Pembrey (1980) use the term individualised in relation to the nursing process. The present finding is therefore in keeping with views expressed by others.

A number of sources such as Hargreaves (1979), Burgess and Lazare (1973), Murray and Zenter (1975) and Heath and Marson (1979) include the elements assessment, planning, implementation and evaluation in their definitions or descriptions of the nursing process approach. These aspects were mentioned frequently in the opening statements by the interviewees. The empirical evidence from the present study provides support for the notion that assessment, planning, implementation and evaluation are widely accepted as elements of the nursing process.

A wide range of aspects (Table 68) were offered relating to assessment and only two, communication and observation, getting more than 30 per cent of the mentions. There appears to be little consensus about the aspects which the assessment phase of the nursing process subsumes.

Negotiation with the patient received 55 per cent of the mentions relating to the planning stage of the nursing process (Table 69). Other two aspects, setting goals/targets/objectives and making a care plan, were mentioned with any degree of frequency. Apart from negotiation with the patient there is very little consensus about what is mentioned relating to the planning stage of the nursing process.

A small number of aspects were mentioned relating to the implementation stage of the nursing process (Table 70). Carrying out nursing care/plan came out as a clear leader and received over 80 per cent of the mentions. Patient involvement/participation was the next biggest category of responses (27.5 per cent). This accounted for less than a third of the mentions. One of the

claims made for the nursing process approach is that it is patient-centred, meaning that the patient is more actively involved in his care (Webb 1981). Evidence from the present study offers only a very small degree of support for this claim.

Few aspects were mentioned in relation to the evaluation stage of the nursing process (Table 71). Was the care successful? This evoked the biggest and the only sizeable category of response apart from where the goals/objectives met? A number of sources such as Murray (1976), Yura and Walsh (1978), McFarlane and Castledine (1982), Saxton and Hyland (1975), Rohweder (1978), Cragg and Rees (1974) and Murray and Zenter (1975) use the term scientific in relation to the nursing process approach. Measurement is a characteristic of the scientific approach to the study of problems. Only two people mentioned measurement as an aspect of evaluation. The conclusion seems to be that measurement and thus scientific method did not feature largely as an aspect of the nursing process approach where, if scientific is included as a characteristic, it might be expected to feature.

b. Decision-Making

A number of sources such as Nordmark and Rohweder (1975), McFarlane and Castledine (1982), Hargreaves (1979) and Rhodes (1984) mention decision-making as a feature of the nursing process approach.

Rhodes (1984) claimed that the model he used demonstrated that the "nursing process model is a decision-making model synonymous with the accepted definition of autonomous professional activity".

Who should make the decisions relating to the nursing process?

The responses are set out in Table 73. The biggest category of mentions (37.5 per cent) saw decision-making as a team approach. Next two categories tied for each place. The nurse given the care was seen as the person who ought to be making decisions. Medical was mentioned equally frequently.

Decision-making is perceived as an aspect of the nursing process approach, though the rate of mention for the various aspects was low with none achieving 40 per cent of the responses. The decision-making aspect is not as well supported as Rhodes (1984) study seems to suggest. There is, however, common ground concerning the role of medical staff and decision-making. Many of the interviewees in this study, as the transcripts show, were pessimistic about the decision-making aspect of the nursing process because the reality is that nursing decisions can be and are overturned by medical staff decisions. Medical staff do not make nursing decisions per se but they do make decisions concerning patients which run counter to nursing decisions. Rhodes (1984) argues that the utility of the model as a strategy of professionalisation is found questionable. Rhodes (1984) went on to contend that the adoption of the nursing process will not confer the status of the profession. He further argues that fundamental to this issue is the lack of role-support for a professional role-identity from a majority of medical practitioners. What Rhodes (1984) refers to as autonomous professional activity is not a reality for many as far as the present study is concerned.

Individualized has been cited as a characteristic of the nursing process in sources such as McFarlane and Castledine (1982), Blake and Towell (1982) and Pembrey (1980). Patient-centred has been

cited as a characteristic of the nursing process by, for example, Webb (1981). If the nursing process were to be described as either individualised or patient-centred then involvement in the decisions relating to him or her ought to take place. That the patients should be involved in the decision-making process received a low rate of mention suggesting that, as far as the present study is concerned, patient-centredness was given a low priority by the interviewees.

c. Holistic

Holistic is mentioned as a characteristic of the nursing process by sources such as McFarlane and Castledine (1982), Bower (1982) and Carter (1979). Holistic was taken to mean involving the whole patient (Table 74), this aspect receiving most mentions. The next aspect mentioned most frequently was that holistic meant involving psychological, social, physiological, biological and spiritual needs. Thirty per cent of the mentions were in the not sure category.

It may be said that there is a measure of support for the notion that the nursing process approach is holistic, though some interviewees were very sceptical about this and some more definitely of the view that it was not holistic.

In the review of the literature the work of Bertalanffy (1968) and general systems theory was mentioned. The argument was that general systems theory provides a unifying principle where fields of knowledge are involved, as is the case relating to the nursing process. General systems theory was not mentioned by the interviewees so a question mark remains concerning the unifying principle, if any, used.

d. Humanistic

"Nursing practice is an unique sythesis of the art of caring and the principles of science. Without science, the art of sheer sentimentality, or worse thoughtless routine. Without one art, the science is dehumanized and dehumanising" (McFarlane, 1981). Thus a humanistic perspective is seen by this source as a crucial element of the nursing process. Other sources to use or to imply the term humanistic in relation to the nursing process include Bellamy (1983), Cragg and Rees (1974), Murray and Zenter (1975) and Carter (1979).

In the present study few aspects were mentioned relating to humanistic. Concern with human/individual needs was the aspect mentioned most frequently (Table 75). The person is the main focus and not sure were mentioned with equal frequency. The rates of mention for aspects set out in Table 75 provide evidence of a measure of support for the notion that humanistic is seen as a characteristic of the nursing process approach. However, some of the interviewees were of the view that it is not humanistic. "I should say that it should be humanistic, but it isn't always (Interviewee five). "No, I wouldn't No, I think it's still authoritarian (Interviewee six). "The nursing process is a practical thing (Interviewee ten). This person didn't see that the label humanistic applied to the nursing process at all.

e. Systematic

"A systematic approach to the Nursing Care Plan" was the title of Mayer's (1978) book. Systematic was thus clearly part of her thinking on the subject. Other sources to include systematic into their descriptions of the nursing process approach were McFarlane and Castledine (1982) and Burgess and Lazare (1973).

The responses evoked by this aspect are set out in Table 76. The majority of the interviewees mentioned orderly/logical in relation to systematic. Follows stages/steps was the next biggest category of aspects mentioned. When both sets of responses are taken together it may be said that there is a good measure of support for the notion that systematic is a characteristic of the nursing process approach.

f. Scientific

The term scientific is sometimes advanced as a characteristic of the nursing process approach. It has been used by, for example, Murray (1976), Yura and Walsh (1978), McFarlane and Castledine (1982), Saxton and Hyland (1975), Rohweder (1975), Cragg and Rees (1974) and Murray and Zenter (1975).

Perusal of Table 77 shows that the rudiments of the scientific approach are to be found among the aspects mentioned by the interviewees, but not to any significant extent. A systematic approach to the study of phenomena, measurement, experiments and empirical work are present but the rate of mention is also in all cases low.

Measurement as an aspect of scientific was mentioned by six out of the 40 people interviewed. Similarly experiments/empirical work was mentioned by four people. The most striking finding of this aspect of the study was that 62.5% of the mentions were in the not sure category. The interviewees were not sure of the scientific standing of the nursing process approach.

"The nursing process is potentially scientific, but in practice it is not" (Interviewee one). "I don't think it has a scientific base" (Interviewee two). "I don't like the use of that word"... I don't see the nursing process in that light" (Interviewee five). I don't think so it is systematic but I don't think it is

scientific. "It is a secondary science a baby science" (Interviewee twentyfive). "The difficulty with the nursing process is developing an appropriate scientific methodology" (Interviewee twenty-eight). "No, it's not scientific because it is a reasonable logical tool for nursing logical is better than scientific" (Interviewee thirtythree). "Ah I would say it's half scientific (Interviewee thirtyeight).

The low rates of mention for aspects of the scientific method as depicted on Table 77 and the quotations cited above leads to the conclusion that there is very little justification for saying that the nursing process approach is in practice seen as scientific. The term is not subsumed to any extent within the interviewees' understanding of the elements that go to make up the label nursing process.

A question arises as to how the term scientific entered into the language of the nursing process to the extent that it appears in the literature? Writers on the subject have had no relevant empirical research to draw on to help them with their formulations of the nursing process. Evidence, of course, may also be of a logical nature which is in the province of philosophy. The writers on the subject would probably not claim to be philosophers, but it does seem to have arisen from their ideas and proposals regarding a new approach in nursing. Thus, how the term scientific came to be used in relation to the nursing process approach is not clear, but there appears to be a case to be more circumspect concerning its use in the future.

The professional standing of practitioners using the nursing process approach also arises in view of what has been said about the scientific nature of the nursing process. Page and Thomas (1977) for instance, view occupations as professions if they carry out an

essential social service, are founded on systematic knowledge, require lengthy academic and practical training, have high autonomy, a code of ethics and generate in-service growth.

The present study provides evidence regarding the professional status on two dimensions. The issue of autonomy was raised in relation to decision-making and a number of the interviewees did not feel they were autonomous with regard to decision-making because their decisions could and were overridden by medical staff.

The second issue concerns the systematic knowledge aspect. McFarlane (1981), for example, wrote about the art of caring and the principles of science.

The evidence from the present study suggests that the claim to scientific status for the nursing process approach is not one that is widely made by nursing practitioners. Other things equal this means that any claim to professional status by practitioners using the nursing process approach is consequently weakened. The professional standing of nursing has been a contentious issue. Sources who ascribe professional status to nursing are Altschul (1977 a and b), Jacobi (1977), Austin (1981) and Smith (1978). Those who take a contrary view include Kratz (1969), Dingwall (1974), Chapman (1977) and Cox (1979). On the dimension that the nursing approach is founded on scientific knowledge the present study offers virtually no support to a claim for professional status for nursing process practitioners.

g. Individualized

Individualized is posited as a characteristic of the nursing process approach. Sources to use the term of McFarlane and Castledine (1982), Blake and Towell (1982) and Pembrey (1980). The present study

provides evidence that individualized is perceived as a characteristic of the nursing process approach in that 60 per cent of the mentions related to looking at the patient as an individual, and a further 27.5 per cent related to one nurse to one patient. Only one person was not sure about the individualized standing of the nursing process approach. "..... the patient is the central character of the nursing process, they are the most important person as opposed to the medical staff and the nursing staff" (Interviewee twentyone). "Yes, it should be individualized" (Interviewee thirtytwo). "It means looking at a patient as a person (Interviewee thirtysix). These quotations from a selection of interviewees also support and articulate the notion that the nursing process approach is perceived as being individualized.

h. Patient-Centred

Sources such as Yura and Walsh (1978) and Webb (1981), for example, state or imply that the nursing process is a patient-centred approach to nursing. The present study offers some support that this is so (Table 79). Among the aspects mentioned none received 30 per cent of the mentions. Involving the patient in his/her care was the aspect mentioned most frequently (27.5 per cent). Not sure was the next biggest category (22.5 per cent).

Comments made on the patient-centredness of the nursing process include, "It should be but it's not because the patient's opinions are never asked for". (Interviewee seven). "It's not really patient-centred" (Interviewee eleven). "No, it's very much nurse-centred nurse gathering, nurse obtaining, nurse doing, there should be more patient and family involvement". (Interviewee

twelve). "If the patient is not involved, it is not truly patient-centred" (Interviewee twentysix).

There is only moderate support for the notion that patient-centredness is a characteristic of the nursing process approach. Indeed, there is some evidence, as evidenced by the quotations above, that points in the opposite direction.

i. Problem-Solving

Problem-solving is a characteristic sometimes ascribed to the nursing process. Sources who have used the term include Normark and Rohweder (1975) and Hargreaves (1979). A number of aspects were mentioned by the interviewees in this study. The aspect mentioned most frequently was the identification of problems/needs (Table 80). The aspect mentioned next most frequently was analysing the problem/taking a history. These two aspects together make up a significant number of the aspects mentioned. However, they do not include the action element in Dunker's (1972) definition of problem-solving which has been cited already. Only four people mentioned working out a way of solving the problem as an aspect of problem-solving. There are therefore grounds for questioning how well the problem-solving process was understood by the interviewees. "That's the only way really I can look at the nursing process" (Interviewee seventeen). "Identifying the problem and solving it" (Interviewee twentytwo). "Care is problem orientated and we have to question our practices, our beliefs, our knowledge base, we have to be continually researching (Interviewee twentyeight). "Patients come into hospital for a reason that is a problem, for them

.... therefore the nursing process should help to solve the problem"
(Interviewee thirtyfour).

The evidence from this study supports the notion that problem-solving is seen as characteristic of the nursing process. It has to be said however that a question mark surrounds how well the nature of problem-solving is understood.

j. The Nature of the Relationship between Holistic/Humanistic aspects to the Systematic/Scientific Ones.

Characteristics of the nursing process which are to be found in the literature include holistic, humanistic, systematic and scientific. The level of support for these characteristics have been discussed in relation to the present study. However, the relationship between the holistic/humanistic aspects on the one hand and the systematic/scientific on the other is a matter of interest, since the two approaches appear to be based on different sets of assumptions. Cohen and Manion (1985) depict the scientific approach as being objective, external, exploratory, publically verifiable and replicable. The holistic/humanistic approach is depicted as being subjective, internal, qualitative, interpretative, unique and negotiable. Carter (1979), for example, discussed the tensions which she observed in nursing education. She depicted nursing education as being based on behavioural objectives and thus embodying assumptions associated with the normative approach to the creation of knowledge. Carter (1979) depicted the nursing process as being based on humanistic considerations and concern for the individual. The present study sought the views of the interviewees relating to this matter.

Perusal of Table 81 shows a limited range of mentions relating to

this aspect. The aspect mentioned most frequently regarding the holistic/humanistic and the systematic/scientific was that these very different approaches were compatible or interlocked. However, 25 per cent of the mentions were in the not sure category.

The following are comments made by the interviewees concerning the nature of the relationship between the systematic/scientific and the holistic/humanistic aspects of the nursing process approach. "They should all relate shouldn't they if they are done properly ah first because you are systematic and problem-solving doesn't mean you can't be humanistic" (Interviewee two). "I think a bit of each I don't know whether that is scientific (Interviewee four). "It encompasses the scientific method and it's humanistic. (Interviewee sixteen). "They should jog along together ah the main problem with the nursing process are problems with change" (Interviewee nineteen). "You couldn't be holistic if you didn't consider the science part because you wouldn't be looking at every aspect of the patient" (Interviewee twenty). "I can see it is systematic in fact I think in order to deal with the holistic/humanistic we can give more effective care if we are systematic I am not sure where scientific comes in" (Interviewee twentyone). "It is a combination of art and science more art than science, but some science" (Interviewee thirty).

The present study provides evidence that the relationship between the systematic/scientific and the holistic/humanistic aspects are perceived as being compatible. However, a quarter of the sample were not sure about the nature of the relationship. The quotations

cited provide evidence of compatibility, but they also provide evidence about the scientific standing of the nursing process. This is in keeping with what emerged when the scientific aspect was discussed per se.

k. Differences Between the Nursing Process and Other Approaches to Nursing.

A number of sources have dealt with the differences between the nursing process and previous approaches to nursing. McFarlane and Castledine (1982) set out six points in this context. The differences they identified are individualised versus routine assessments; nursing actions more closely related to the problems; better analysis of the need for professional intervention; better documentation and better staff communication; nursing actions made explicit; better evaluation of nursing care. According to Webb (1981) previous approaches to nursing were task-centred, while the nursing process approach is patient-centred.

The present study sought to establish how the nursing process approach was seen to be different, if at all, from previous approaches and the results are set out in Table 82. No longer task-centred was the largest category of responses and accounted for 37.5 per cent of the mentions. Next in order of magnitude was looking more at the patient as an individual. Thus McFarlane and Castledine's (1982) point concerning individualisation and Webb's (1981) point about patient-centredness are reflected, though to not an overwhelming extent, in the results of the present study.

Nursing exists to provide nursing care for patients who need it. The quality of patient care is therefore of fundamental importance.

Improved patient care accounted for 20 per cent of the mentions in the present study concerning the differences between the nursing process and other approaches to nursing. This may be said to be a rather low rate of mention for such a fundamental issue given the upheaval which the introduction of the nursing process caused.

However, this finding of the present study is in line with other findings relating to the quality of care and the nursing process approach. Hayward (1986) commented that it was not possible to say with any conviction that the implementation of the nursing process has improved the lot of patients. Similarly Richards and Lambert (1987) came to the conclusion that use of the nursing process approach did not make any significant difference to the quality of patient care.

Webb (1981) ascribed greater autonomy on the part of nurses and better communication between staff and patients as features of the nursing process approach. Although not mentioned specifically, these conditions imply more job satisfaction on the part of nurses using the nursing process approach. The present study offers very little support for the notion that nurses experience more satisfaction since this accounted for only 12.5 per cent of the aspects mentioned. "Care is done as in the past" (Interviewee eleven). "The nursing process has not fulfilled its expectations the standard of care is about the same" (Interviewee fifteen). "I believe it's not working properly" (Interviewee sixteen). "The patient is much more involved the documentation is horrendous" (Interviewee seventeen). "There was a conveyor belt system.... people were referred to by their conditions or diseases,

as opposed to being actual people ah theoretically the nursing process is supposed to make us see a patient as an individual" (Interviewee twentyone). "It is questionable whether the nursing care is better, but nurses are under more stress" (Interviewee twentyfive). ".... it is seen as an added responsibility, something on top of the exciting job care is no better more difficult for the learners" (Interviewee thirty).

This study provides evidence that the nursing process approach is perceived to be different from other approaches to nursing. The principal difference is that it is not task-centred as other approaches have been depicted to be. However, the overall rate of mentions or the quotations cited above do not support the notion of improved patient care. This important aspect does not feature to any extent as a characteristic of the nursing process approach. Neither does job satisfaction on the part of nurses.

1. Documentation

A number of sources have commented on the documentation aspect of the nursing process approach including McFarlane and Castledine (1982), Cragg and Rees (1974), Rawlins (1983) and Kirwin (1980). Opinions about the documentation aspects tend to be mixed. McFarlane and Castledine (1982) see better documentation as a positive aspect of the nursing process approach. Rawlins (1983) and Kirwin (1980) see the documentation aspect of the nursing process approach as being time-consuming and cumbersome.

The present study offers support for the latter view because 40 per cent of the sample saw the documentation as a difficult aspect and 22.5 per cent of the sample saw it as time consuming.

However, 25 per cent of the sample related to the fact that more and better information is recorded now.

Quotations by the interviewees include: "The positive side of the documentation is that it is much more detailed the negative side is that it sometimes takes too long to complete" (Interviewee four). "There is a lot of paper work involved in terms of collecting data and keeping records of the nursing care and then people don't always use the nursing process effectively" (Interviewee twelve). "People don't like change people get used to routine the documentation, not the idea that causes the problem" (Interviewee thirteen). "The documentation is quite horrendous" (Interviewee seventeen). "A lot an awful lot for some documentation is what the nursing process is all about all that is needed is very simple documentation" (Interviewee eighteen). "I feel the problem with the nursing process is the fact that there is so much store set by the documentation" (Interviewee nineteen). "Ah now that has been the biggest headache" (Interviewee twentyone). "I mean it's probably one of the things that people tend to complain about when they have to implement the nursing process. But like everything else, I think that once you get into it it would become quite easy" (Interviewee twentyone). "There is more documentation more than previously, but it's probably better" (Interviewee twentynine). "Ticks in boxes are not a good idea documents should be individualised" (Interviewee thirtytwo). "The nursing process is in danger of becoming a paper process (Interviewee thirtythree).

The evidence from the present study suggests that all is not well with the documentation aspect of the nursing process. This is an aspect which needs and would probably benefit from developmental work in order to resolve a fairly major difficulty.

m. Nursing Models

Nursing models have not had as high a profile as the nursing process as far as entry into the field of nursing is concerned. However, since they are gaining a foothold and they are being used in conjunction with the nursing process it was felt that while the thesis focuses principally on the nursing process, nursing models ought to be considered, if briefly, in that context.

A number of aspects were mentioned relating to nursing models (Table 84). That models were seen as theoretical frameworks accounted for 35.5 per cent of the mentions. A guide/check list for assessment accounted for 32.5 per cent of the mentions. A construct based on a particular view of man accounted for 15.0 per cent of the mentions.

The comments made by the interviewees about nursing models included: "A model is a representation isn't it it's an abstract it's a conceptual thing" (Interviewee one). "Models tend to be confusing" (Interviewee two). "If we are looking at models we are looking at the ABC of care" (Interviewee three). "There is a lot of mystique around models difficult models are no good the language is often too complicated" (Interviewee 11). "There are different methods of looking at caring" (Interviewee twentyone). "Models give you a framework to identify problems" (Interviewee twentyfour). "I think models are guidelines for assessment planning etc. they provide guidelines to work from" (Interviewee twentynine). "Nursing models are a representation a belief in what a person is nursing models should have come before the nursing process. Nursing models give something the nursing process does not, that is, a view of health, illness, the person etc." (Interviewee thirty).

The present study provides evidence that the interviewees have, with

some exceptions, a limited knowledge of the nature of nursing models. Fawcett (1984 p.38) has set out a framework for analysing and evaluating models of nursing. Fawcett (1984) sets out what she calls nursing's four metaparadigms which are: a. how the person is described; b. how the environment is described and defined; c. how is health defined; d. what is the good of nursing? That nursing models are a construct based on a particular view of man accounted for 15.0 per cent of the aspects mentioned. This cannot be taken to be a very pervasive aspect of nursing models. Aspects such as the environment and health, mentioned by Fawcett (1984) did not feature in the aspects mentioned at all. The absence of any mention of health is perhaps surprising, given that nursing curricula are now meant to be based on health rather than illness.

n. The Nature of the Relationship Between the Nursing Process and Nursing Models.

How do the nursing process and nursing models relate? According to Roper, Logan and Tierney (1983a) what makes the process a process of nursing is when it is used with an explicit framework which is unique to nursing - a nursing model. Ross (1983) asserts that the function of a nursing model is to provide a framework for the assessment phase of the nursing process approach. The literature thus gives an indication of the nature of the relationship between the nursing process approach and nursing models. However, it was felt that the nature of the relationship ought to be investigated empirically in order to see whether or not the claims made in the literature hold.

The results of the investigation relating to this aspect of the study are set out in Table 85. A compatible relation receive 75 per cent of the mentions. The remainder of the mentions were in single figures and were therefore not very significant. Only one person was

not sure about the nature of the relationship.

Examples of quotations by the interviewees follow. "I see one as the mechanical bit and the other as the abstract bit, so I see the nursing model as the conceptual framework and I see the nursing process as the actual tool a working tool." (Interviewee one). Nursing models have to employ the nursing process the nursing process is a framework, it's not a model" (Interviewee twelve). "I think the nursing process is just the actual doing of the job the nursing models is how you see the job I don't think you can have one without the other" (Interviewee nineteen). "We need both the nursing process and nursing models because they are both good guidelines the nursing models assist with the process" (Interviewee twentyone). We need the nursing process because it identifies what the nurse is doing it identifies nursing intervention to identify nursing intervention and to do an assessment of a patient you need a model" (Interviewee twentyfour). "Nursing models give something the nursing process does not, that is, a view of health, illness, the person etc." (Interviewee thirtythree). "I don't know much about nursing models I haven't got into nursing models to be able to talk about them" (Interviewee thirtyfour). "I feel the nursing process is the proper way to set about nursing I view models with less enthusiasm" (Interviewee thirtyseven).

There was an admission of a lack of knowledge and a lack of enthusiasm relating to nursing models; but generally the relation-

ship between the nursing process approach and nursing models was seen as compatible and complimentary.

o. Cluster Analysis

The cluster analysis of the data was deliberately confined to aspects mentioned spontaneously at the beginning of the interviews in order to obtain unprompted responses. The rationale being that whatever emerged would be the interviewee's own concepts relating to the nature of the nursing process approach.

A question underpinning the research was how the nursing process is construed by nursing teachers and clinical nurses. To what extent do these construals vary? The interview data suggested that the construals of the interviewees do vary in nature. The differences will be set out now as conceptual typologies.

p. Conceptual Typologies

It is possible to identify two broad typologies which come from the two cluster solution, which is set out on Table 86. Further examination of Table 86 shows that the two broad clusters each give rise to sub clusters. Cluster one of the two cluster solution gives rise to three sub clusters. Sub cluster one of the broad cluster one comprises cases 1, 27, 36 and 37; sub cluster two comprises cases 4, 19, 23, 6, 18, 28, 17, and 29; sub cluster three comprises cases 2, 40, 3, 9, 10, 11, 12, 21, 8, 22 and 24. Cluster two of the broad two cluster solution gives rise to two sub clusters. Sub cluster one of the broad cluster two comprises cases, 5, 13, 14, 15, 20, 25 and 31; and cluster

two comprises cases 7, 26, 33, 38, 32, 39, 16, 34, 30 and 35. In the typologies to be presented broad cluster one and two become typologies one and two. The five sub clusters are presented as sub typologies one to five.

Type 1

The defining binary variable was "individualised". The people in the cluster were mostly female teachers in general nursing. This is a one dimensional construal of the nursing process approach.

Type 2

This cluster was defined by the following binary variables "assessment", "planning", "implementation", "problem-solving" and "systematic". The cluster comprised mostly female teachers with a more or less even spread of general and psychiatric nurses. This is a multi dimensional construal of the nursing process approach.

Examination of the dendrogram (Table 87) suggests a two cluster solution because of the length of the branches. The fact the clusters fuse at a high level is indicative of dissimilarity. In spite of the dendrogram indicating a relation of similarity between the three sub types in Type 1 and between the two sub types under Type 2, an examination of the actual responses and defining features make the sub types' classification of considerable interest. The five sub types were characterised as follows.

Sub Type 1

The defining binary variables for this cluster were "scientific", "evaluation", "action research", "individualised", "assessment"

and "systematic". This cluster was composed mostly of male teachers in psychiatric and mental handicap nursing. This was the only sub type in the study to include "scientific" as a characteristic of the nursing process approach.

Sub Type 2

"Systematic" was the only binary variable involved in defining this cluster. It comprised mostly female general nurses and equal numbers of teachers and clinical staff. The members of this sub type appear to have a limited conception of the nursing process approach.

Sub Type 3

Again only one binary variable was involved in defining this cluster and that was "individualised". The cluster comprised mostly teachers in general nursing with an even spread of males and females. Again, this sub type appear to have a limited conception of the nursing process approach.

Sub Type 4

Six binary variables including "problem-solving", "assessment", "planning", "evaluation", "individualised" and "implementation" defined this cluster. The people in the cluster were mostly females in general nursing with more teachers than clinical nurses. It is notable that problem-solving was a strongly significant characteristic as far as this sub type was concerned.

Sub Type 5

The defining binary variables for cluster seven were "assessment"

"planning", "evaluation", "implementation", "systematic" and "individualised". It comprised mostly teachers in psychiatric nursing with equal numbers of males and females. The notable thing about this sub type is that it brings together the psychiatric nurses in sample.

The fact that as many as five types of construals emerged indicates considerable dissimilarity in how the nursing process is construed by the interviewees. The number of defining binary variables also varies greatly. Clusters one, four and five were defined by a single variable in each case. The remaining four clusters are each defined by six binary variables. This is evidence of dissimilarity in how the nursing process is construed.

When each type is examined with regard to the contributing binary variables it emerged that the most pervasive binary variable was individualised which was present in six of the seven types which emerged. Next was systematic which appeared in five of the types. Planning and implementation each appeared in three of the types. Problem-solving appeared in two of the types. The commonly used APIE (assessment, planning, implementation and evaluation) appeared in its entirety in one of the types. Scientific appeared in one type only.

The composition of the interview sample is set out in Table 26. It comprised men and women, two grades of nurse teacher (senior tutors and nurse tutors) and general, psychiatric and mental handicap nurses are represented. These various interests are represented to some extent in the types but not strongly so. Type

one was made up mostly of female teachers in general nursing. Type two comprised mostly teachers by spread across general and psychiatric nursing. Sub type one was made up mostly of male teachers in psychiatric and mental handicap nursing. Sub type two involved mostly females with equal numbers of teachers and clinical staff. It is notable that while the differences in numbers between teachers and clinical staff are not great, the clinical staff have not formed a type in their own right. Sub type three related to general nursing with a more or less even spread of males and females. Sub type four involved mostly females with a mixture of teachers and clinical nurses. The composition of sub type seven was mostly teachers in psychiatric nursing with equal representation of males and females.

The composition of the types which emerged are somewhat mixed with respect to gender and clinical speciality. The most distinctive types to emerge are type one (mostly female nurses in general nursing); and sub type five (mostly teachers in psychiatric nursing with equal numbers of males and females).

The cluster analysis of the data provides further evidence of the elements which go to make up the nursing process label. If there was consensus about what constituted the nursing process label then few, if any, typologies would have emerged. Instead two principal typologies and five sub typologies emerged, though in some instances the number of people involved was small.

The elements that go to make up the nursing process label seems to depend on who you ask. Some interviewees offered only one word

spontaneously. These being systematic in one cluster and individualised in another. It might be argued that these interviewees have a very clear idea about the nature of the nursing process and are able to pin it down to one or two words. Conversely, it might be argued that such people have a very limited view of the nursing process and thus have a poor understanding of it.

Four of the clusters were made up of six elements each. This could be taken to mean that the interviewees were either more articulate or had a better understanding of the elements that constitute the nursing process label. Whichever is the case the evidence seems to lead to the conclusion that the nursing process is not a clear conception in the sense of the same aspects being associated with it by everyone investigated.

As far as student nurses learning about nursing is concerned, it appears they are likely to get different versions concerning the nature of the nursing process. It might be argued, of course, that this is not a bad thing and that at the end of the day the students arrive at their own synthesis concerning the nursing process. However, reference has been made a number of times in this thesis about the importance of concepts in relation to learning. If the concepts are not clear, as seems to be the case in relation to the nursing process, then it might be argued that this places undue difficulties in the paths of students who are attempting to arrive at a synthesis relating to the composition of the nursing process label.

q. The Implications for Teaching and Learning

The implications arising from the present study for teaching and learning the nursing process approach are twofold. In the first place the General Nursing Council committed nursing education to the use

of the nursing process approach in GNC Circular 77/19. The General Nursing Council no longer exists but the statutory organizations that have replaced it have retained the commitment to base the teaching and learning of nursing on the nursing process approach. Teachers of nursing must heed the edicts of their statutory bodies or risk getting into all sorts of trouble. Given the existence of a powerful determinant relating to the use of the nursing process approach, then the conceptual nature of the approach becomes a matter of some interest, since concepts are of fundamental importance as far as the teaching and learning process is concerned.

Tomlinson (1981 p.66) asserts that we use concepts to include or exclude things with respect to particular classes or categories. It is now proposed to identify the aspects which have emerged from the present study which comprise the "label" called the "nursing process".

It emerged that individualized is an aspect which was mentioned frequently and it may be said that there is empirical justification for using this term as a characteristic of the nursing process approach as construed in the field.

Assessment, planning, implementation and evaluation, sometimes abbreviated to APIE, emerged as aspects of the nursing process label. However, the picture is not as clear as it might be. When the interviewees were asked "What does assessment, planning and so on involve?": a wide range of aspects emerged. It therefore cannot be said that these aspects, which are sometimes considered to be the cornerstones of the nursing process approach, are widely shared in conceptions of it.

There was a measure of support for including both holistic and

humanistic as aspects of the nursing process label. It also emerged in both cases that a sizeable number of the interviewees were not sure about either the humanistic or the holistic standing of the nursing process, or of the meaning of these terms.

There was strong support that the nursing process approach is characterised by being systematic, with no uncertainties as to this. The support was less strong when it came to problem-solving. In particular, the aspects mentioned were concerned with analysing problems and identifying problems; there were few mentions that problem-solving was concerned with working out a way of solving the problem.

The nursing process approach was perceived to be different from other approaches to nursing and the thing that differentiated it was getting away from task-centredness. Looking at the patient more as an individual was also mentioned as a differentiating feature.

Documentation was perceived to be an aspect of the nursing process approach. While some interviewees mentioned that more and better information is now recorded; over half thought the documentation aspect was either difficult or time consuming. With such a level of dissatisfaction there would seem to be a case for making a special study of the documentation aspect of the nursing process approach.

As far as this study is concerned these are the aspects which go to make the nursing process label. The interview part of the study is based on a non-random sample and therefore it is not possible to generalise from it. However, it is hoped that the findings may act as food for thought for those involved in nursing education.

In the chapter dealing with concepts, the mention was made by

Bolton (1977) of classification and framing, this being based on the work of Bernstein (1971). We have seen that the elements which go to make the aspects of the nursing process approach such as assessment, planning and so on are rather diffuse in nature. The conclusion seems to be that a weak classification exists as far as nursing process knowledge is concerned.

A number of aspects have emerged from the study which have little or no claim for inclusion within the nursing process label. The decision-making aspect is one of these. The lack of autonomy which was perceived makes it difficult to ascribe decision-making as a characteristic of the nursing process approach in practice.

It emerged that a large number of the interviewees were not sure about whether the term scientific applied to the nursing process approach. For them it therefore cannot be said that scientific is an aspect of their conception of the nursing process. This has consequences for the professional standing of the nursing process approach. In the review of the literature a sizeable number of sources considered nursing to be a profession and an equally sizeable number did not. As far as the study is concerned there is no justification for including the term professional within the nursing process label.

The scientific and professional standing of the nursing process approach does have implications for teaching. If teachers put forward scientific and professional as aspects of the nursing process approach then sooner or later their credibility is likely to be called into question. In the meantime students are likely to experience dissonance and frustration trying to accommodate aspects which are illusory, or at least, not shared by many in practice, whether clinical nurses or teachers.

Improved patient care was mentioned so infrequently by the interviewees that it cannot be taken as a consequence of the nursing process approach. Similarly, better job satisfaction on the part of nurses was also mentioned so infrequently that it cannot be regarded as an advantage of the nursing process. In fact, there was a suggestion, though not widely supported, that nurses found the nursing approach stressful. The chastening conclusion seems to be that neither the patients nor the nurses are perceived to be reaping great benefits from the introduction of the nursing process approach.

As mentioned earlier, the generalisability of these findings is somewhat open. However, it does provide evidence that at least five aspects from this study would warrant further study in their own right. These are the documentation aspect, this badly needs attention, the decision-making aspect; the quality of patient care and the job satisfaction for nurses and the scientific aspect.

r. An Overview

When it comes to evaluating a piece of research there are many criteria which may be used such as the theoretical foundations of the study; the research design; the method of sampling used; the data collection methods; the validity and reliability of the observations made; the analytical techniques used; the ethical aspects and the applicability or otherwise of the findings.

For the survey part of the present study, schools and colleges throughout the United Kingdom were surveyed and there was an above average response for a postal survey. There are therefore grounds for thinking that it is representative of how the nursing process approach is perceived throughout the United Kingdom. Although the questionnaire used was piloted, it did use a fixed format for responding. Such a format has

limitations when it comes to studying complex issues, because it limits the freedom of expression. While additional free hand comments were welcomed, the majority of the data was from the fixed formal part of the questionnaire and ought to be evaluated in that light.

The interview part of the present study was based on a less representative sample than the survey since it involved only 40 interviewees. This was inevitable for two reasons. The collection and analysis of the interview data is much more time consuming than conducting a survey by questionnaire. Second, there is the requirement that a higher research degree should be the student's own work. This limits the scope of what it is possible to do without extending unduly the time taken for the research. While the interview sample comprises a spread of nurse teachers and clinical nurses, it is the case that a better interview sample would be desirable. This is a factor which ought to be taken into account in evaluating this study.

The concepts of validity and reliability are crucial when it comes to evaluating a piece of research. These are matters which were of constant concern throughout the study. A small team was involved at every stage to ensure the observations made were valid and reliable. However, the problem concerning the reliability and validity of data based on interviews are fully acknowledged and ought to be kept in mind when evaluating this study.

As well as the methods of sampling used and the problems concerning validity and reliability any valuation of the present study ought to take account of the fact that the nursing process approach is a fairly recent innovation as far as the world of nursing is concerned.

Like any innovation it will have had to contend with the resistance to change which is a fairly pervasive attribute among people generally and among nurses too (Menzies 1970).

While bearing these caveats in mind, the evidence seems to suggest that the nursing process approach is variously construed by the interviewees in this study. This state of affairs is well depicted on Table 88. For cluster one of the two cluster solution, the nursing process approach is a one dimensional concept involving only individualised care. In the case of cluster two of the two cluster solution, the nursing process approach is a multi-dimensional concept involving assessment, planning, implementation and evaluation.

The sub clusters also provide evidence that the nursing process approach is variously construed. Problem-solving is a characteristic which is present in 100 per cent of the cases in cluster four, but is absent from cluster five of the five cluster solution. Perusal of Table 88 reveals that many characteristics are present to varying degrees, but are absent in many cases as evidenced by the number of noughts on the table. The most striking illustration of this concerns action research and holistic. Both of these aspects are mentioned as characteristics by cluster one of the two cluster solution and cluster one of the five cluster solution. They are absent from the remaining clusters on the table.

The survey part of the present study provides evidence of the extent the nursing process approach is used. The interview part of the study provides evidence as to how it is characterised by the interviewees. The nature of the construals is varied making for a lack of clarity. There appears to be a lack of shared views about the

nature of the nursing process approach.

Reference was made earlier in this thesis to the work of Kuhn (1970, p210) who posited the view that scientific knowledge, like language, is the common property of the group or else it is nothing at all. The evidence from the present study, especially the interview part of the study, suggests that the lack of conceptual clarity and the lack of shared views concerning the nursing process approach make it difficult to see how it could be considered in Kuhn's terms to be the common property of the group.

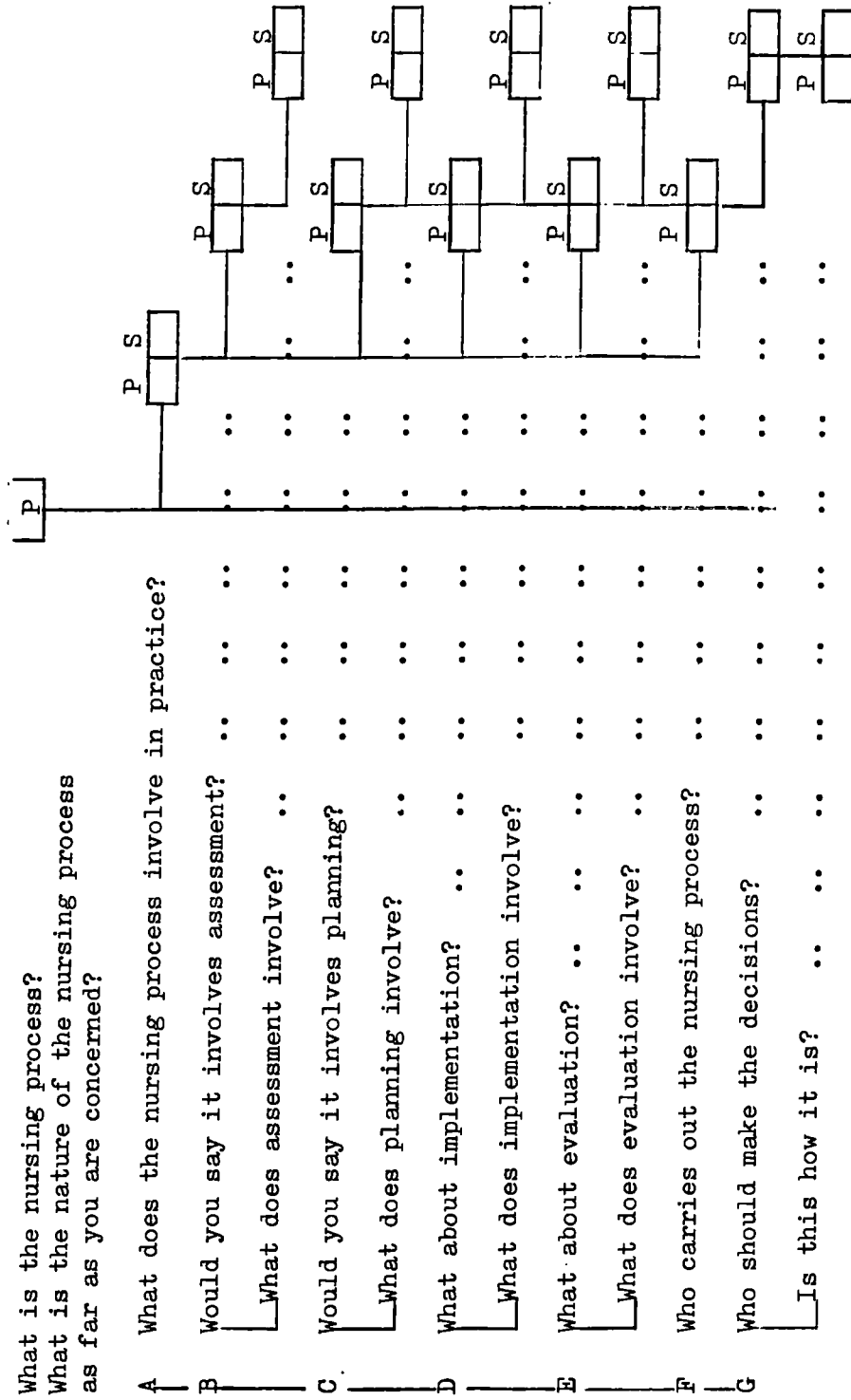
It would be imprudent to claim too much for one study. However, if it is desired that the nursing process approach is to be continued as the accepted approach for the delivery of nursing care and is to continue to be developed, then the quest for conceptual clarity will continue to be a dominant issue. In this context the present study may be said to be a contribution in that direction. It also offers a methodology which seems promising and it raises many questions which could be well worth further investigation.

APPENDIX 1

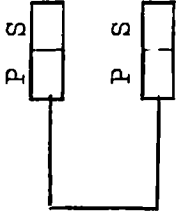
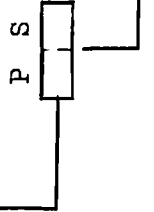


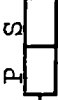
NURSING PROCESS INTERVIEW GUIDE

INTRODUCTION: My research is concerned with how the nursing process is understood by teachers of nursing such as yourself.

1. What is the nursing process?
What is the nature of the nursing process as far as you are concerned?



APPENDIX 1 continued

2. O How do you see the holistic/humanistic aspects
 relating to the systematic/scientific ones? 
- P How does the nursing process differ from other
 approaches to nursing? 
- Q What documentation is involved?

3. R What for you are nursing models?

- S How, if at all, are the nursing process and
 nursing models related? 

APPENDIX 2

THE POLYTECHNIC, HUDDERSFIELD - FACULTY OF EDUCATION

A Survey of Schools of Nursing in the United Kingdom Relating to the Nursing Process and Nursing Models Used in Basic Nurse Training

CODE

PLEASE RESPOND BY CIRCLING (O) THE APPROPRIATE NUMBER/NUMBERS BELOW.

PARTS OF THE REGISTER FOR WHICH TRAINING IS OFFERED

DESIGNATION	PART OF REGISTER	ABBREVIATION
1. Registered General Nurse	1	RGN
Enrolled Nurse (General)	2	EN(G)
Registered Mental Nurse	3	RMN
Enrolled Nurse (Mental)	4	EN(M)
Registered Nurse for the Mentally Handicapped	5	RNMH
Enrolled Nurse (Mental Handicap)	6	EN(MH)
Enrolled Nurse	7	EN
Registered Sick Children's Nurse	8	RSCN

IN THE NEXT SECTION PLEASE RESPOND BY CIRCLING THE APPROPRIATE NUMBER ABOVE THE ITEMS IN BOXES

2. How long, in years, has the teaching in your school been based on the nursing process?

1	2	3	4	5	6	7	8	9
0-1	2	3	4	5	6	7	8	8+

3. How do you regard the nursing process?

1	2	3	4	5
Very Unfavourably	Unfavourably	Favourably	Very Favourably	Exceptionally Favourably

4. How have the education staff reacted to the introduction of the nursing process?

1	2	3	4	5
Very Unfavourably	Unfavourably	Favourably	Very Favourably	Exceptionally Favourably

5. How have the service staff reacted to the introduction of the nursing process?

1	2	3	4	5
Very Unfavourably	Unfavourably	Favourably	Very Favourably	Exceptionally Favourably

6. How would you describe the stage of implementation of the nursing process in your school?

1	2	3	4	6
Not Implemented	Being Implemented	Barely Implemented	Partially Implemented	Fully Implemented

IN THE NEXT SECTION PLEASE RESPOND BY WRITING IN A NUMBER IN THE BOXES ON THE LEFT OF THE STATEMENT. THE BIGGEST PROBLEM SHOULD BE RANKED 1, THE NEXT BIGGEST PROBLEM SHOULD BE RANKED 2 AND SO ON UNTIL THE LIST IS COMPLETE. PLEASE FOLLOW THE SAME PROCEDURE FOR THE QUESTION ON ADVANTAGES.

What problems have you encountered implementing the nursing process?

WRITE NUMBERS IN ORDER OF IMPORTANCE IN BOXES.

- 7. Staff shortage
- 8. Lack of time
- 9. Extra paper work
- 10. Resistance to change by nurses
- 11. Resistance to medical staff
- 12. Jargon language
- 13. An imported concept
- 14. Rapid turnover of patients
- 15. Rapid changes in the condition of patients

PLEASE WRITE ADDITIONAL ITEMS BELOW WHICH YOU FEEL OUGHT TO BE INCLUDED AND RANK THEM SEPARATELY i.e. BEGIN WITH NUMBER ONE AGAIN.

16.	
17.	
18.	
19.	
20.	

What advantages have been gained following the implementation of the nursing process?

- | | | |
|-----|--|---|
| 21. | | More effective care. |
| 22. | | Better communication between nurses. |
| 23. | | Better communication between doctors and nurses. |
| 24. | | Better communication between nurses and patients. |
| 25. | | Better documentation. |
| 26. | | A better framework for teaching by qualified staff. |
| 27. | | A better framework for learning by students and pupils. |
| 28. | | Greater job satisfaction on the part of nurses. |
| 29. | | A better quality of nursing for patients. |

PLEASE WRITE IN ADDITIONAL ITEMS BELOW WHICH YOU FEEL OUGHT TO BE INCLUDED AND RANK THEM SEPARATELY, BEGINNING WITH NUMBER ONE.

30.	
31.	
32.	
33.	
34.	

THE NEXT SECTION CONTAINS A NUMBER OF BIPOLAR STATEMENTS RELATING TO THE NURSING PROCESS. PLEASE RESPOND BY CIRCLING THE APPROPRIATE NUMBER ON THE SCALE BETWEEN THE STATEMENTS.

THE NURSING PROCESS IS/IT:

35. IMPORTANT TO NURSING 1 2 3 4 5 6 7 UNIMPORTANT TO NURSING

- | | | | | | | | | |
|-------------------------------------|---|---|---|---|---|---|---|--------------------------------------|
| 36. GOOD FOR NURSING | 1 | 2 | 3 | 4 | 5 | 6 | 7 | BAD FOR NURSING |
| 37. HOLISTIC | 1 | 2 | 3 | 4 | 5 | 6 | 7 | ATOMISTIC |
| 38. SYSTEMATIC | 1 | 2 | 3 | 4 | 5 | 6 | 7 | UNSYSTEMATIC |
| 39. HUMANISTIC | 1 | 2 | 3 | 4 | 5 | 6 | 7 | NOT HUMANISTIC |
| 40. INDIVIDUALISED | 1 | 2 | 3 | 4 | 5 | 6 | 7 | TASK-CENTRED |
| 41. SCIENTIFIC | 1 | 2 | 3 | 4 | 5 | 6 | 7 | INTUITIVE |
| 42. A PROBLEM-SOLVING APPROACH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | A ROUTINE-BOUND APPROACH |
| 43. THEORY-BASED | 1 | 2 | 3 | 4 | 5 | 6 | 7 | INTUITION-BASED |
| 44. MORE FAMILY CENTRED | 1 | 2 | 3 | 4 | 5 | 6 | 7 | LESS FAMILY CENTRED |
| 45. ENHANCES COMMUNICATION | 1 | 2 | 3 | 4 | 5 | 6 | 7 | IMPEDES COMMUNICATION |
| 46. ENHANCES THE QUALITY OF NURSING | 1 | 2 | 3 | 4 | 5 | 6 | 7 | DETRACTS FROM THE QUALITY OF NURSING |
| 47. LIKELY TO ENDURE | 1 | 2 | 3 | 4 | 5 | 6 | 7 | NOT LIKELY TO ENDURE |
| 48. A CLEAR CONCEPT | 1 | 2 | 3 | 4 | 5 | 6 | 7 | A CONFUSED CONCEPT |
| 49. ENHANCES THE AUTONOMY OF NURSES | 1 | 2 | 3 | 4 | 5 | 6 | 7 | DETRACTS FROM THE AUTONOMY OF NURSES |
| 50. PATIENT CENTRED | 1 | 2 | 3 | 4 | 5 | 6 | 7 | NOT PATIENT CENTRED |

THE NEXT SECTION IS ABOUT THE USE OF NURSING MODELS. PLEASE RESPOND BY CIRCLING THE APPROPRIATE NUMBER ABOVE THE MODEL/ MODELS USED.

Which of the following models are taught in your school?

- | | | | | | |
|---------------|---|---------|------|----------------|---------------|
| | 1 | 2 | 3 | 4 | 5 |
| 51. Henderson | | Johnson | King | Levine | None of these |
| | 1 | 2 | 3 | 4 | 5 |
| 52. Neuman | | Peplau | Orem | Riehl | None of these |
| | 1 | 2 | 3 | 4 | 5 |
| 53. Rogers | | Roper | Roy | Yura and Walsh | None of these |

Others, please specify

.....

.....

TO WHAT EXTENT ARE NURSING MODELS USED IN THE CLINICAL AREAS OF YOUR HEALTH DISTRICT?

	1	2	3	4	5
54.	A VERY GREAT EXTENT	A GREAT EXTENT	SOME EXTENT	TO A SMALL EXTENT	NOT AT ALL

TO WHAT EXTENT ARE NURSING MODELS SEEN AS USEFUL WHEN IT COMES TO THE DELIVERY OF NURSING CARE?

	1	2	3	4	5
55.	A VERY GREAT EXTENT	A GREAT EXTENT	SOME EXTENT	TO A SMALL EXTENT	NOT AT ALL

PLEASE RELATE NURSING MODELS TO NURSING SPECIALISMS BY WRITING IN THE NAME OF THE MOST APPROPRIATE MODEL/MODELS OPPOSITE THE SPECIALISM.

SPECIALISM	
56.Children's nursing	
57.Community nursing	
58.General nursing	
59.Mental handicap nursing	
60.Nursing the elderly	
61.Obstetric nursing	
62.Ophthalmic nursing	
63.Orthopaedic nursing	
64.Psychiatric nursing	
OTHER, please specify	
.....	
.....	
.....	

Thank you very much for your help with the survey. Any additional comments you may wish to make would be most welcome

APPENDIX 3 The organisation of the interview sample for the purpose of analysis

For the purposes of analysis each interviewee was given a number. The numbers so ascribed, the gender and the status of each interviewee are set out in Table 86.

Table 86 The organisation of the interview sample for the purpose of analysis.

NO.	GENDER	STATUS	NO.	GENDER	STATUS
1	F	Senior tutor, G	21	F	Ward sister, G
2	F	Senior tutor, G	22	F	Ward sister, G
3	M	Senior tutor, G	23	F	Ward sister, G
4	M	Senior tutor, G	24	F	Ward sister, G
5	F	Nurse tutor, G	25	F	Ward sister, G
6	F	Nurse tutor, G	26	M	Senior tutor, P
7	F	Nurse tutor, G	27	M	Senior tutor, P
8	F	Nurse tutor, G	28	M	Senior tutor, P
9	F	Nurse tutor, G	29	F	Nurse tutor, P
10	M	Nurse tutor, G	30	F	Nurse tutor, P
11	M	Nurse tutor, G	31	F	Nurse tutor, P
12	M	Nurse tutor, G	32	M	Nurse tutor, P
13	M	Nurse tutor, G	33	M	Nurse tutor, P
14	M	Nurse tutor, G	34	M	Nurse tutor, P
15	F	Ward sister, G	35	F	Ward sister, P
16	F	Ward sister, G	36	M	Charge nurse, P
17	F	Ward sister, G	37	M	Senior tutor, M.H.
18	F	Ward sister, G	38	F	Nurse tutor, M.H.
19	F	Ward sister, G	39	M	Nurse tutor, M.H.
20	F	Ward sister, G	40	M	Nurse tutor, M.H.

G = General Nursing
P = Psychiatric Nursing
MH = Mental Handicap Nursing

APPENDIX 4 The transcript of an interview with a senior tutor in
general nursing. (Interview 1)

I = Interviewer

R = Respondent

INTRODUCTION

Counter
Number

- 00 My research is concerned with how the nursing process is understood by teachers of nursing/clinical nurses such as yourself.
What is the nursing process?
What is the nature of the nursing process as far as you are concerned?
- 108 R I see the nursing process as a problem-solving approach... to nursing ... it is a way ... a form of action research ... in one way ... in identifying problems ... and planning individualised care ... answers to that problem ... you then get on to implement them ... and change them in the light of experience ... and ... if it's done in a holistic ... rather than if it's done taking... the patient as a whole ... and not compartmentalising the patient ... into a systems model um, um if you are looking at the total needs of the patient ... um, um ... hopefully you will be able to deliver the goals ... You will be able to deliver what the patient wants ... and what you want ... I think there should be an element of negotiation in it ... the patient should be involved ... from the start really ... I think it should be a shared thing ... an interactive process ... for all client groups you should identify problems with the patient and share in the planning and in the implementation and in the evaluation ... um, um and as far as possible the patient is taking responsibility ...

022 I You mentioned assessment. What does assessment involve?

R Assessment involves making a diagnosis... a diagnosis of need.... is there a need? Is it a patient's need or is it the nurse's need... assessment involves a lot of things... a ... it involves observation... communication... ah... feelings, experiences... ah... emotions.... it is a very wide thing is assessment... I was thinking of an assessment based on a model really... I was thinking of Neuman's systems model... I was thinking of how she uses assessment... and the various levels that she looks at... from the patient's point of view and then she looks at it from the nurse's point of view... and then she tries to get the two to match up... um, um. It is a very wide ranging... thing...

038 I You mentioned planning. What does planning involve?

R Planning involves a clear identification of what the situation is ... um, and looking at ways of... dealing with the situation... um, ah... planning can be long term or it can be short term... it's a strategy really... designing a strategy... um, um of how you are going to deal with the goal you have in mind... you can have a long term plan or a short term plan... it involves co-operation... between patient and nurse... um, it involves communication... and negotiation u,, um... and it involves giving the patient autonomy because after all they are the ones ... that matters most...

050 I You mentioned implementation. What does implementation involve?

R That involves actually carrying out the plan... actually doing what you decided to do... um, um, so that part of the planning must be to make realistic goals... it's no good having plans if the patient can't actually implement it... so implementation

from my point of view is carried out with patient participation... and ... they need to have the motivation to do it... and the knowledge to do it... and they need to have the skills to do it... first there is dependency in the nurse and then a growing independence...

060 I You mentioned evaluation. What does evaluation involve?

R It involves seeing what you decided to do... and the way you have done it is the right way... whether it is successful... and ... you must have a clear cut idea... perhaps a time scale... because you can go on and on doing something in the hope that eventually it will be effective... so you must have sort of a boundary... um ... and if things are not going the way you planned, then your evaluation shows it's not, then you're back to assessment... you go back and you reassess... the whole process starts again, but I don't think it's in clear cut stages, I think it goes on and on... you are evaluating and you are reassessing... and you are replanning... etc.... We need criteria for evaluating... criteria and specific items... at... they form part of your plan... that you can measure and you can say... right I wanted so and so to happen... and it hasn't... You've got to know what it is you're measuring... you must be quite specific.

076 I Who carries out the nursing process?

R I think... I see it as an interactive process involving the nurse and patient... I don't see it as the nurse diagnosing what is happening and carrying out the plan... and saying, oh I did a good job... I think it must be patient-centred... even though initially the client may not see the need...

083 I Who should make the decisions?

R The patient should...

084 I Is this how it is?

R No, but I think you mustn't be put off by that... you must aim... for the very best you can... How it is still is prescriptive... meaning that the person with knowledge and the skills does the deciding... um, um... I would like to believe that the change is towards... how do you see things... how would you like it to happen... how would you like to do it... and I believe that has to be based on trust... and respect for each other... I think it is achievable... there are obviously many constraints on the nursing profession... there are things like the public image and public expectation... and then our expectations of the employers ... All these constraints are operating... and the nurse has to adjust and adapt and try to do the best she can... I would say it depends very much on the context in which decisions are made. ... I am sure many times the nursing decision does not stand... because we have to work with Doc particularly in hospital...

118 I You said earlier that it was holistic. By holistic you mean?

R Holistic means an all round view of the patient, psychological, social, biological... need of the patient and not breaking the patient down into a series of parts... A person is more than the sum total of his parts... I think it's becoming rather hackneyed ... a cliché at the moment... it's been around... for a while... I am not sure that people always understand it... When they are doing an assessment they write down the list of needs that the patient has... they think they are giving holistic care... I am not sure we do really...

134 I Are there any other features of the nursing process?

R The word process suggests that it is a dynamic thing... not static... it's ongoing, it changes... it develops... ah...

135 I Would you say it is humanistic?

R It depends on how you define that word...

137 I By humanistic you mean?

R Having regard for people... ah... having regard for the emotional ... and the psychological and the social part of the human being and not just... the physical entity... that's how I see humanistic...

141 I So is the nursing process humanistic?

R ... Not fully... I have this concern that we use these terms and we talk about them... and yet we don't really fully know where we are at... So no, I would say totally... but I think we are getting there... because I still think in nursing... even that we tend to look in nursing not... we still have the medical model in evidence ... and I think until we start looking at things from a health model - ah, and having respect for the person... as being responsible for himself... then I think... we will not be looking at the patient in a humanistic way...

156 I Would you say it is systematic?

R Yes, I think it is...

156 I By systematic you mean?

R By systematic I mean orderly... and logical... it's just a way of doing something... it's a perspective, it's a ... it's an approach...

162 I Would you say it is scientific?

R ... It can be ...

163 I By scientific you mean?

R By scientific I mean that it can be said... that it can be used as a tool... for further development... um, based on what's happened and evaluating what has happened, documenting it, reviewing it, um, um, and trying to reach a conclusion... Yes, it can be scientific but it isn't because... I am afraid that it isn't done... we get people who think the nursing process is just... writing things down um, um... You can write anything down... but it's more than just writing things down... but I think documentation is important... I wouldn't dismiss it, but I think the documentation... can deflect from what you are trying to do...

179 I Would you say it is individualised?

R Yes...

180 I By individualised you mean?

R By individualised I mean getting away from task-oriented working ... ah... that person does a certain task and another does another sort of task... individualised is like primary nursing ... one person carries out all the nursing...

184 I And primary nursing is?

R Primary is one person - it can't just be one - 24 hours a day. One person who cares - for the patient um, um, and like I said sharing interaction ... with the client ... the key worker ... or the mentor, or the advocate... whatever word you like... that is the primary nurse...

191 I You mentioned earlier that it was problem-solving. By problem-solving you mean?

R A system whereby a problem is approached logically... and aspects are taken into consideration... you prioritise... and then organise...

198 I How do you see the holistic/humanistic aspects relating to the scientific/systematic ones?

R Yes... there needs to be a mechanism... perhaps... and the mechanism that I see is the use of a nursing model... um. I see that as the link... a means by which the nursing process... can be implemented... by having a conceptual framework... whichever one you choose... you can get a holistic/humanistic view of the nursing process is the means by which you deliver the care ...

213 I Do you see the holistic/humanistic and the scientific/systematic aspects as comfortable bedfellows?

R No, not really... holism and humanism conjures up in my mind emotional and psychological and affective concepts... and scientific nursing process conjures up objective... and calculated ... ah... so they have to be married up somehow... I don't think they go well together... if nursing is to be truly professional and autonomous in the long run... then we must make an attempt

to be scientific... and objective...

226 I How does the nursing process differ from other approaches to nursing?

R The main dichotomy is the traditional task-orientated approach to nursing where the person is split into... his needs are split into... little jobs which can be done by a junior nurse... things like clean his teeth... and give him a bedpan... and don't get to know the patient... there is a distance or a barrier... I think that is the main difference... At the other end of the continuum one nurse is becoming involved with the total aspects of that patient... his psychological, his emotional... his physical and that in a partnership... I see it as two ends of a continuum, um... in some places they are fairly near to one another and in some they are polarised... um.

240 I What documentation is involved?

R I think the documentation has been one of the most difficult... ah... things to overcome in trying to implement the nursing process because trying to get people to change... and to realise the value of the nursing process initially that is what they throw back at you... it's more work, it's more paperwork... we have been doing this for years... all you want us to do is write it down. I think the documentation is vital... if... we are to use our knowledge... and to store our knowledge and to build on our knowledge... I think the documentation is being seen as the be all and end all... I am a believer in the importance of good documentation for a lot of reasons... from the body of knowledge we must develop and the legal aspects we must be seen to.... be accountable for what we do... and not

afraid to write it down... Um, documentation allows peer group review... peer group evaluation... and I don't think we should be afraid of that... also I think we should be showing this documentation to the patients... I am a documenter, yes...

264 I What are nursing models?

R A model is a representation isn't it... it's an abstract... it's a conceptual thing... and... they are also checklists... so that when you are doing an assessment... it helps you to remember... ah... perhaps it's more than that... if it was just a checklist you could have a list and tick it off. ... I think it should be opening up, widening... the view of the patient... but I don't think you should stick stringently to one model... because I think it can be constructing... I have tried various models in practice and I have not found the perfect one yet... So, yes, I do see the value of nursing models... I do think they help to structure your thoughts, I think they also act as a blockage...

279 I How, if at all, are the nursing process and nursing models related?

R I see one as the mechanical bit and the other as the abstract bit, so I see the nursing model as the conceptual framework... and I see the nursing process as the actual tool... a working tool... The nursing model is the cognitive bit, the thing that gets you thinking... something to hang your thoughts onto... I think we have been very strongly influenced by American ideology of what nursing should be... and I think we are struggling a bit... I think things will change...

299 I Do we need the nursing process and nursing models?

R I do... because I feel the nursing process is a means of doing

something as a format... but see the nursing models as more than that... I have been used to using the two... I don't think of one without the other...

308 I Would you like to summarise?

R I see a nursing model as a conceptual framework a way of getting a total view of a patient/situation... I see it working at the level of the individual, the community, the society... I think you can have a conceptual model of a village or a country... it doesn't stop at a patient... and I feel models are a way of developing ideas... whereas the nursing process is the actual giving of care... a planned method of delivering the actual goods... that's it...

Thank you very much

APPENDIX 5. The transcript of an interview with a nurse tutor in
general nursing. (Interview 5)

I = Interviewer

R = Respondent

INTRODUCTION

Counter
Number

00 I My research is concerned with how the nursing process is understood by teachers of nursing/clinical nurses such as yourself.
What is the nursing process?
What is the nature of the nursing process as far as you are concerned?

R It is a problem-solving approach to nursing care... ah, which is based on interaction between nurse and patient... and involves the patient... in making decisions... and it involves the nurse in doing things like assessing the patient... taking a nursing history um, um... and getting as much information from the patient... talking to them, interviewing them... and getting information from their relatives... and so... it also involves ability to assess the patient as far as looking at the... using that information to identify problems... and needs that the patient might have... and then using knowledge with the patient again trying to set goals in order to solve the problems... and then identifying the nursing care... and working out a care plan ... and then if the care is not successful to go back again... and start again... um, um...

020 I Would you say it involves assessment?

R Yes, it involves assessment... it involves setting goals... and it involves identifying nursing action... and it involves a

nursing plan.

023 I You said it involves planning. What does planning involve?

R Yes, planning should involve the patient... um... because the patient needs to know what is going on... what you are planning for him... and he should have some say in what those plans are...

027 R That's actually giving the care... the patient should know what is going to happen... and then evaluating it...

029 I You mentioned evaluation. What does evaluation involve?

R I think it's done very badly... ah... it involves setting goals ... and the goals have to be realistic... achievable... um, um ... because you can't want to demoralise the patient... if you set goals that you can't achieve... and it involves looking at the goals to see whether it has been achieved um, um... if set goals that are not achievable, then you countervaluate.

038 I Who carries out the nursing process?

R All nurses should carry it out... although some nurses... student nurses as well as trained nurses... some nurses need supervision ... especially with assessment... it is some important in terms of gathering information... and looking for things the patient doesn't see for himself... It takes a skilled person to collect that information... realistically it should be... done by trained nurses but I think what happens on the ward... is that a lot of it is done by student nurses... and sometimes...

048 I Who should make the decisions?

R It should be an interactive process so that the decisions about the nursing care should be made by the patient as well as the nurse... obviously I think ... everything is forgotten is the medical treatment the patient is to receive as well... it's to be implemented... um, um.

052 I Is this how it is?

R I think a lot of the time student nurses are nursing the patients ... assessing patients... they don't have the experience to do it correctly... I think nursing decisions and medical decisions ought to go together... go alongside one another... there are other decisions made by OTS etc.... and I do think if everyone could use one form of record that record the patients care, um, um... that would make the care so much more whole... At the moment everyone is recording... and writing down their care on their own little bit of paper... and it makes it very fragmented...

062 I What is the standing of the nursing decisions?

R Ah... one has to come to a compromise... because... one has to respect the knowledge of other people involved... Sometimes the standing of the nursing decision isn't high... Like the medical profession... doctors do have respect for our knowledge and for our advice especially. I think some of them have a feeling that
073 they know better... um...

075 I I mentioned earlier that it is a problem solving approach. By problem solving you mean?

R I mean, in order to be able to solve problems you have to be able to assess and therefore identify the problems... from that assessment... and problems or needs... and these problems I think are

identified by the nurse who discusses it with the patient... and once the problems have been identified... I think the patient should be involved... Although sometimes people record problems on a care plan and the patient doesn't know that these problems have been recorded... it is not something we do very well, I don't think we share enough information with the patient... the nursing process is a good way of teaching the patient about his illness or about his problems and try and give him the ability to help himself... and I like the nursing process as a teacher ... it is structured and systematic and planned... um, um.

095 I You said it is systematic. By systematic you mean?

R Well I mean there is a sort of a system that you can follow, sort of a framework... there is a definite structure to it... which is different from when I was doing my training... you were just given tasks to do... it makes you think more... about the care... it makes you more... about the care, it makes you more... ah individualised...

100 I You mentioned individualised. By individualised you mean?

R Well it relates to that particular person... because I think we tend to confuse the person because I think if we have done the assessment properly... and you've taken a nursing history properly.... you would know not only about the person and his illness but you would also know about him as a person and about his normal life style and on the whole you try to make your nursing care to fit in with that patient's life style.

108 I Is that the same as patient-centred?

R Well... yes, I would say it is... patient centred, individualised

... I would say it is similar...

108 I Would you say the nursing process is holistic?

R Ah... I would say that it could be... it's not always... it can, it should be holistic in that it can... it should look at the whole person... which means considering as a person and what he does and what he thinks and so on, what he feels... it should also include the physical aspects of his needs... as well as the psychological... and also the social aspects... it encompasses the patient's whole life... to make him individual... to look at him as a whole person - instead of treating him as an illness.

117 I Would you say it is humanistic?

R I would again say that it can be...

118 I By humanistic you mean?

R By humanistic I mean looking at him as human being... as an individual human being... and not somebody with illness... yes, I would say it should be humanistic... but it isn't always... because I think a lot of the time... a lot of people don't understand... I find that student nurses who have'nt been brought up on anything different to the nursing process that they understand the basic philosophy behind it much better than nurses who have been brought up in the traditional way... and I think sometimes it is very difficult... because we haven't quite got the paperwork... sorted out in that a lot of time can be spent doing ticking and writing and I feel personally that because we haven't sorted out our documentation... um, um, I do feel there is a lot of resistance to the nursing process from people who feel threatened by it because I don't think they understand it...

as a label they can implement in the way that fits in with their environment...

134 I Would you say it is scientific?

R Ah... I don't like to use that word... I think it all depends on what you mean by scientific...

136 I By scientific you mean?

R Well... I think what is meant by scientific... in the wide world sense is that it is... its experimental and empirical... and... I don't know that I see the process in that light... I see it as being systematic... I see it as attempting to be individualised... and also see it as solving problems... and I suppose if you look at it in that way and you say that science is about identifying problems and solving them, then I suppose you could say that it is scientific...

155 I How do you see the holistic/humanistic aspects relating to the systematic/scientific ones?

R Well I think holistic and humanistic... those two seem to me to go together... because if you are looking at human beings... and obviously the whole human being... that to me is humanistic... I think if you are going to adopt a problem solving approach... which is what we say the nursing process is... then obviously... in order to have a problem solving approach... you have to have a system to work by um, um... and the system is going to help you to identify various steps that you can work through as a means of identifying the problems and therefore once having identified problems, trying to solve them... um...

117 I How does the nursing process differ from other approaches to nursing?

R Nursing used to be task-orientated... I think the difference is that it... it's certainly more individualised for the patient... I remember the days when I was... sent to do the input and output charts... and the observations and then I would know exactly what all the patients' B/P were... but I don't know anything else... about their care for that day or anything about them... um I think we have gone a long way towards trying to ah... identify the person as a whole person. It differs from the task orientation in that you look after the whole person and get to know the person... I think it gives much more satisfaction to the person giving the care... because you are not just giving one piece of care... you are giving all of the care and you also get to know the person better... and establishing some sort of rapport... the patient gets to know you better... because there is much more continuity... of care and if the patient gets to know the nurse better... and the nurse gets to know the patient better... that makes for better relationships... nursing is an interaction between patient and nurse...

195 I What about the documentation?

R Our hospital... we are going through constant changes... I think maybe it's a good thing that it is dynamic... that there is a constant change in how people are tending to document things. I don't think we have got it right at all... we are still repeating an awful lot of things... and we are recording information... sometimes three times and we spend a lot of time... I do think the documentation, especially the assessment... we are recording so much more information about the patient... than we did

previously... before we did the nursing process... that certainly is something that is very good... We are still not doing evaluation very well at all... I think nurses are getting good at identifying the problems in such a way that they are understandable ... and not only to us but also to the patient... I don't think we are too bad at actually planning the care... and actually writing down the nursing intervention... evaluation is not good at all... whether it should be dates, criteria, measurements or whatever...

223 I What are nursing models?

R Ah... I see nursing models as a sort of a framework in which to practice the nursing process... ah... there are all sorts of models, some of them I don't understand!!! Some of them seem to... the one I like... is Roper... and... I think the reason I like... is because it makes sense... because it is based on a simplistic view of the individual, but, ah... I think it is something that you can hang on things on... the ADL... I think it's just a framework.

236 I How, if at all, are the nursing process and nursing models related?

R Ah... I think they are related ah... nursing models gives a framework in which to do the nursing process in which to work the nursing process... and I have started using Roper's model... ah... I think the nursing model gives the ah. . gives us a philosophy... in which to base the nursing process... I think they are related... some of them have shortcomings... and others are specifically useful for certain areas. Like the stress adaptation model which I find very difficult to understand... which people tell me it works very well in psychiatry... Orem's model, the self-care model... works very well in certain areas... where patients continually come in and go out again... and come back in for treatment... and

the emphasis is on... teaching them to be able to care for themselves... so we do need a model in order to do the nursing process.

253 I Would you like to summarise?

R Well I think you need a nursing model in order to do the nursing process. I see a nursing model as a philosophy... or a framework, a thing which to do the nursing process. I see the nursing process as a problem solving approach to nursing care which involves interaction with the patient... it's a two way thing and I see the nursing process as a method of assessment which involves taking a nursing history from the patient... it involves using your senses to examine the patient... using your knowledge of nursing... in order to get information from the patient so that you have a basis from which to identify problems or needs... that the patient may have... setting goals... and planning the care and implementing it and evaluating the care based on the goals that we have set previously...

268 I Thank you very much indeed.

APPENDIX 6. The transcript of an interview with a nurse tutor in
general nursing. (Interview 6)

I = Interviewer

R = Respondent

INTRODUCTION

Counter
Number

00 I My research is concerned with how the nursing process is understood by teachers of nursing/clinical nurses such as yourself.

What is the nursing process?

What is the nature of the nursing process as far as you are concerned?

R My perception of the nursing process is that it is a systematic way of assessing needs... um, um. It's a tool... to improve care... it improves care because... it gives us a check list... to work through... so that we meet all the needs... of our patients um, um... It is specifically to meet the nursing needs of the patient... not the medical needs.

012 I What does the nursing process involve in practice?

R In practice it involves four stages APIE um...

015 I What does assessment involve?

R Assessment is... going to the patient... and systematically assessing... what her needs are... um, um... then prioritising ... really... and then providing a realistic goal to meet those needs... planning care... nursing care with a reference to medical prescription... um and evaluating it... the effectiveness of your care... and continually updating... and evaluating

in a circular process... um, um.

024 I What does planning involve?

R It is planning with the patient as a partner... planning the patient's care... how we do it is... we do it with the patient ... a team approach with everybody lending their expertise... um and their level of knowledge...

032 I What does implementation involve?

R Listing quite categorically what that means... um, your care plan is specific... in how you are going to implement your care... um, um... For the student nurse that is probably the easiest... the evaluation is the most difficult... once the criteria for implementing have been established... then I think the student nurse finds that the easiest bit... ah... implementation... ah...

041 I What does evaluation involve?

R Evaluation is looking back to see... what is actually happening... we said what we would like to happen... and then we go back to that patient and see what is actually happening... um, um and then we would re-assess... with a view to re-implementing... and replanning and re-evaluating... It's spiral as well as... No... It's not a spiral... it's a circle... it's a circle of care... with continuous updating.. and ... continually going back to your patient to check out... if in fact what you are prescribing is actually happening... My worries are that we prescribe... the care... and say what we would like and once we have done it and ticked it off... then we don't check out with our patient what is actually happening and we don't check out with them that we are achieving the goals... we know what the goals are... but we

presume because we are doing the right things that we are achieving them... and we don't necessarily achieve them... um, um.

057 I Who carries out the nursing process?

R Ah... it's supposed to be the Registered Nurse... and the student nurse is supposed to be surprised... um, the nursing auxiliary is responsible for contributing in a team approach... and she contributes not to the decision making... but to the supplying of information... necessary to evaluate...

061 I Who should make the decisions?

R Well... I feel it should be the person giving the care... um... and the person giving the care should... have the requirements to make the decision... really it should be the person most suitable... to make the decision...

065 I Is this how it is?

R No, this is not how it is... how it actually is... ah... in theory that's how it is but... working on the wards as I do... the student nurse actually... gives the care... and it is task orientated... um, um, it is still disease orientated... i.e. this lady had a hysterectomy.. and she will want a first day bed bath... and her wound redressing etc.... But in the care plan we've got... such things as emotional support... reassurance ... wound care... but what actually is the sister tells the nurse redress that wound because it's the first day post-op... and you will bed bath the patient... the patient is not a partner in care... she is done too... um, um. The nursing decisions are given very little... credibility... the nursing decision, can this lady get out of bed... could this wound have its sutures

removed... they are still medically prescribed... even though they are nursing decisions... so we are still allowing the medical side to prescribe nursing care... um, um, I feel sad about it... I think unless the ward sister grasps her role and grasps her responsibility... nothing will change um, um, unless she stands for nursing... and says that this is a nursing decision... not a medical decision... things will never change...

085 I What features characterise the nursing process?

R Could you give an example?...

086 I Would you say it is holistic?

R ... I would like to think it was...

087 I By holistic you mean?

R I mean the whole person... not just the disease... it's the whole person... Not just a hysterectomy... Not that this hysterectomy is called Mary Smith... it's very important... we sometimes consider the condition rather than the patient... we look at one person, we don't look at the home or the environment... or any sort of extended part of that person... we just look at a very small part...

096 I Would you say it is humanistic?

R No, I wouldn't... No... I think it's still authoritarian... still ... no... I wouldn't...

098 I By humanistic you mean?

R Ah... it's taking into consideration the cultural needs... the spiritual needs... ah... I am... my mind is blank... Humanistic

is dealing with the person as an individual... humanistic comes with the holistic framework... it comes into the patient deciding for himself what is the best for her... ah... the patient is an equal... um, um... ah... I still think the person is done to ... we certainly do things to the patient.. she is denied... she has her dignity taken away from her... in certain ways...

118 I Would you say it is systematic?

R ... the nursing process is systematic.

119 I By systematic you mean?

R I mean there is a format to it... there is a system to work through... a logical sequence... um, um, that follows on... and I don't mean the nursing model... that you choose to give that care... is really very relevant... I think so long as it encompasses the whole... you can make the model meet the needs that you have... ah... I don't think that it should be dogmatic though ... it shouldn't be dogmatic and rigid... it then spoils the nursing process... because I think it should first al all be concerned with individual needs...

127 I Would you say it is scientific?

R ... I am not sure about that... scientific in as much as it is research based... and educationally sound... I don't know, I'd need to think about that...

134 I You said earlier that it was individualised. By individualised you mean?

R One to one... One patient to one nurse... and one nurse looking at the patient's needs... and fulfilling those needs... um, um.

138 I Is that the same as patient-centred?

R Patient centred... by patient-centred I would mean... a... I think... if it's done well I think it is patient-centred... Yes ... the patient is in charge the whole time of her own affairs ... she is never denied... that inherent... ah... her individuality ... we don't take anything away from her... we don't make her dependent on us... um, um...

157 I Would you say it was a problem-solving approach?

R It is the way I do it...

159 I By problem solving you mean?

R We decide... if this patient... has a problem... then we that is her problem and we try and help her to do something with it... If she doesn't perceive something as a problem... then we don't make it into a problem... we do set nursing goals... ah... like a wound... if we saw a wound was becoming infected... the patient might not say my wound is a problem... but we would see that it was... there are patient goals and nursing goals... which have problems going with them...

169 I How do you see the holistic/humanistic aspects relating to the systematic ones?

R ... I can see the contradiction... and I think we are trying to achieve something in an organisation... which is not moving... there are two things happening... we can see a need but are fulfilling that need in a rigid organisation... we get the rigidity with the systematic bit... and saying we must have some sort of system to... get through this workload... to make it easier... to make it... acceptable um, um... and... also we understand the

philosophy of... patients as people... and the concept of individualised care... and problem solving... but we still work within a very rigid organisation... I think that is where my conflict is coming from... um, um... but the organisation... is demanding these things but putting the constraint on us to prevent us from delivering them... we are modifying everything... along the way... we understand the philosophy of it... but when we take it down to the ward... it's not realistic... we must have some system... to get through the work load... which is only going to make it more rigid...

202 I How does the nursing process differ from other approaches to nursing?

R The empirical process of nursing... on my ward you will do this this way etc. ... completely task orientated... completely mindless... and... as I say... it's very safe... everybody knew their role... and everybody could complete their tasks in a morning and go to sister and say I have done my work... um, with the nursing process you could never say I have done my work... it's perpetual ... I find as a nurse... that I get much more job satisfaction out of using the nursing process... I get to know my patients as people, usually...

217 I What documentation is involved?

R It's a pain... the documentation is difficult... ah... the students don't understand it... we don't understand it... we are getting our problems mixed up with our outcomes... and our evaluation getting mixed up with our goals... and that is where the problem is... the nursing process documentation can be superb and can be simple... and can be easy to follow... it can be but it isn't...

we've got resistance... we've got verbal consent... we've got covert resistance... the management are saying yes, it is wonderful... you implement it... but you do it... I am not going to support you doing it... um, um, and so when a sister goes and complains that this person is getting on my nerves ramming the nursing process down my throat... the manager will say just back off there a little... leave the ward because they are too busy to do it... ah, so you have very weak support... through the management structure...

235 I What are nursing models?

R Ah... different criteria for implementing the nursing process... for individualised care... the nursing models... Orem... and Roper... Castledine and whatever... ah... they are just adaptation models... activities of daily living... a... they are different ways of analysing... the data that you get... the different ways of collecting it... and assessing... ah... the needs of the patient... some do it like Roper et al. ... with individual needs with 12 activities of living... and then there is the problem solving approach... what I am finding is actually happening... is that we are using bits and bobs of all sorts of models to meet the needs of our patients...

250 I How, if at all, are the nursing process and nursing models related?

R ... I would have said ten minutes ago... before I saw the contradiction... I would have said that they giving a systematic method of approach... I think they are a tool or a facilitator... I think they have been used so badly in the past that they are almost taken as synonymous... I think there is a lot of confusion now... nursing models point out quite clearly... where

the nurse's responsibility lies and what is a nursing decision and what is a medical decision the nursing process is tied up with... individualised care... with the patient... So there is a lot of confusion in that area... No they are not the same um,um...

271 I Would you like to summarise?

R ... the nursing process... respect for people... dignity... Not taking anything away from them... allowing them to be in charge of their care... to be aware... to be consenting... ah... I feel very strongly that they shouldn't be made to feel like nincom-poops and idiots... when they come into hospital... they should be partners in care... they should definitely be partners... we should definitely inform them... and respect them... we should respect their views and we should find out what their views are ... and we should do everything we could to meet those needs... um, um...

292 I Thank you very much indeed.

APPENDIX 7. The transcript of an interview with a nurse tutor in
psychiatric nursing. (Interview 29)

I = Interviewer

R = Respondent

INTRODUCTION

Counter
Number

00 I My research is concerned with how the nursing process is understood by teachers of nursing/clinical nurses such as yourself.

What is the nursing process?

What is the nature of the nursing process as far as you are concerned?

R It is a systematic approach, the biggest thing for me... is the individualisation of care for patients... putting the patients central... their needs central... um, um... and really planning their care... on an individual basis... being more accountable for what we do... evaluating what we do... something we have'nt really done before...

011 I Would you say it involves assessment?

R ... It certainly involves assessment of what we are doing... of what nurses are doing... it certainly involves assessment of patients...

013 I What does assessment involve?

R It's taking the patient as a whole person... and assessing their physical, their psychological, their social needs um, um... Not just what the doctor says... determining the patient's problems and needs... assessing what they are doing... it is systematic...

... um, um. I like to have guidelines for assessment... so that I don't miss anything out... um, um, separate headings under the physical, psychological etc...

024 I Would you say it involves planning?

R Yes...

025 I What does planning involve?

R Planning is planning your care for the patients... and with... patients and with relatives, planning goals... for individuals ... ah... that is largely planning... What do you want... to be your end product?... for the patient...

031 I What about implementation?

R It is what a nurse is going to do... for the patient to achieve their goal... the nurse and the patient... to achieve the goals stated in the plans...

036 I What about evaluation? What does evaluation involve?

R You start off by giving yourself a target... APIE... you see whether you have achieved what you set out to achieve... If you are successful fine... if not let's change the approach... and try something else...

043 I Who carries out the nursing process?

R The whole team... different people carry out different parts of it, but on the whole it is the team... one person should coordinate it... there is an input from everybody... OTS, nurses, doctors, physios...

053 I Who should make the decisions?

R ... the nurses make the decisions. Overall the sister/charge nurse on the ward...

057 I Is this how it is?

R No, it's not... ah... I find that most decisions... staff nurses and others make decisions... have responsibility... the nursing decisions tend to be less important... nurses somehow devalue themselves... and they are reluctant to assert themselves... Nursing decisions tend to be overridden...

078 I What features characterise the nursing process?

R It is systematic...

079 I By systematic you mean?

R It's a process of assessment... APIE... individualisation...

082 I By individualised you mean?

R The patients are treated as individuals... and not en block as before... they had to fit into the ward routine... rather than the ward fitting in with them... um, um, ah... there is also accountability... nurses have to sign for what they are doing, um...

087 I Would you say it is holistic?

R It should be holistic, yes...

088 I By holistic you mean?

R That it takes all the systems of the person into account... the physical, the spiritual... the emotional etc.

093 I Would you say it is humanistic?

R It should be... ah... people should be treated as individuals,
as human beings...

097 I By humanistic you mean?

R ... treating people as individuals... souls, feelings...
emotions.

101 I Would you say it is scientific?

R I don't think it is...

102 I By scientific you mean?

R The natural sciences... control... measurement... I don't think
the nursing process is scientific...

112 I Would you say it is patient-centred?

R Yes...

113 I By patient-centred you mean?

R The focus is on the patient and not on the routine of the ward...
and not on the nurses' jobs... it is concerned with dealing with
patients' problems... the patients' needs...

116 I Would you say it is a problem-solving approach?

R Yes...

117 I By problem-solving you mean?

R I suppose... dealing with a patient's problems... financial
problems, emotional problems... their illness... educational
worries... sexual worries... There are nurses' problems and
patients' problems. What's a problem for the patient... there

are relatives' problems... there's often a lot of conflict between the nurses and the relatives...

135 I How do you see the holistic/humanistic aspects relating to the systematic/scientific ones?

R ... I think it can be scientific but I don't think that dehumanises it... Holistic medicine can be scientific... um... although we can't prove it... I think the holistic/humanist and systematic/scientific go quite well together... I see no problems there.

154 I How does the nursing process differ from other approaches to nursing?

R The first thing is patient allocation... the nursing process allows for a better relationship with the patient... we were discouraged from having a relationship with the patient... it should be more efficient was well... it's more caring as far as the patients are concerned... patients are more involved in their care... the patients are more in control...

178 I What documentation is involved?

R The normal admission forms that we have before... but a place for assessment... a place for planning... a space for implementation and a space for evaluation... There is more documentation ... more than previously... on the other hand it gets rid of all those separate things like the bath book etc. ... TPR ... bowel it is centralised documentation... all in one place... initially it is probably more... it varies so much from place to place... um...

201 I What are nursing models?

R They are guidelines in a way... guidelines to the way I think um, um... I don't like them... I think they have been produced to get people Ph.D.s ...'' Models are mostly confusing... to ordinary folks on the ground... I think nurses are practical people... they like bedside nursing and they can't see the use of models? They don't want theoretical models... they are patterns for working by...

225 I How, if at all, are the nursing process and nursing models related?

R I think... models are guidelines for assessment... planning ... etc. they provide guidelines... to work from... ah...

236 I Would you like to summarise?

R I really get frustrated with the nursing process. I like to have a relationship with people I work with... therefore I like to get to know my patients... like the idea that... patient-orientated, patient-centred... it breaks down a lot of rules... I like to work as a team... I like everybody to be involved... I like team spirit... ah... the nursing process doesn't work in psychiatry... if it's general nursing orientated... it's not for psychiatry...

274 I Thank you very much for your help.

APPENDIX 8. The transcript of an interview with a senior tutor in
mental handicap nursing. (Interview 37)

I = Interviewer

R = Respondent

INTRODUCTION

Counter
Number

001 I My research is concerned with how the nursing process is understood by teachers of nursing/clinical nursing such as yourself.

What is the nursing process?

What is the nature of the nursing process as far as you are concerned.

001 R The nursing process is a framework for the delivery of individualised care um, um, ah... it enables the nurse to... I feel to effectively evaluate the type of care I am going to give um, um. It is also a scientific tool... for measuring effectiveness... ah... it is a structured way of increasing patient involvement in care... I feel that is very important um, um... It enables nurses who are working in the field to chart effective progress for many of the assessment forms that I have seen are unrealistic ... there are gaps in the various stages of development... therefore nurses can make realistic objectives... in conjunction with the plans um, um... ah... unfortunately I feel that not many of my colleagues see it that way... ah having used the nursing process... I feel it should be more person-centred in our approach to nursing... and cut out an awful lot of reporting which I feel is irrelevant. For example, slept well etc. um, um ... I feel also that the process unfortunately didn't have the correct public relations exercise it should have had... ah I myself... I think some people don't know exactly what the

nursing process is... and unfortunately they developed negative attitudes towards ah... I often wonder the reasons why the nursing process was introduced... for me it is an effective tool ... for ensuring the quality of care also I think it helps quality assurance... measuring the standard of care, um, um, ah ...

036 I Would you say it involves assessment?

R Yes

037 I What does assessment involve?

R I would say... a holistic assessment... I believe the best assessment forms are a blank piece of paper... many of my colleagues don't believe that... assessment forms and the process... I believe we should be extending beyond that um... I believe the process is a problem-solving exercise... the assessment is obviously a biological, psychological, sociological assessment... I try to get nurses to ask themselves what kinds of problem the patients might have... I find that nurses spend time filling in forms... from my own experiences...

067 I Would you say it involves planning?

R Of course it does.

067 I What does planning involve?

R It involves establishing goals. One must plan care when making all assessment... planning must involve the patient... one must seek to put the plan into action...

075 I What about implementation?

R Oh, implementation is important... the care must be prescribed in... a professional manner... ah... I believe it should be related to evaluation who, why, what, where and when... I believe we should be separating who should be providing what... I am a great believer in separating the stages... um, um and having individual accountability... Also at the implementation stage... I want nurses to say how things are implemented... in a language they can understand... that's very important. Anybody coming onto that particular area will be able to see what is to be done... who is to do it and so on... um, um.

019 I What about evaluation?

What does evaluation involve?

R I think evaluation is \$64,000 question. Have I been successful? If the answer is no, then I must adopt a problem solving approach and go back to the assessment to see... if my objectives were realistic... have I got the right resources? Did I have the correct knowledge? Um, um, um... evaluation should involve all the elements of care... For example, if you are teaching a client a social skill... everybody should be involved in the evaluation... I have mixed feelings about unqualified nurses evaluating prescribed nursing care... Evaluation should be done by someone who knows the reasons why that care is planned...

118 I Who carries out the nursing process?

R As far as I am concerned, the nursing process is not a process in isolation... it is a framework for delivering care... but we should not see it in isolation... we should see it in relation to other professional agencies... but I do believe... that nurses can evaluate medical care quite easily... we can see

whether patients are improving or not. I think we should have a multidisciplinary approach... um, um...

129 I Who should make the decisions?

R Ah... the decisions should be made by a registered nurse... with regard to the actual assessment... she should be acting as a facilitator and co-ordinator... and she should pull in the other people in making the assessment... I think it must be a team effort... because I don't... nursing is a caring profession... We must involve other disciplines... in the decisions making process. For example, if it is a decision about admission and discharge... that's a matter for the medical staff... unfortunately that's the situation... the nursing process is a nursing decision making process... if one has discussions and a plan of action, there shouldn't conflict... but we are professionals in our own right... and it is important what we say, we believe... our plan should be one that would have the doctors' support... but if not there should be some mechanisms for nurses to seek a resolution to the conflict.

159 I You mentioned earlier that the nursing process is holistic. By holistic you mean?

R It has a biological perspective; a psychological perspective and a sociological perspective and a spiritual perspective which is not always the case... the spiritual perspective tends to be neglected um, um... So therefore one is looking at... a man being at the centre... I think also, we get mixed up. I think, with individual care... because of the care being focused down... the person is the centre... and it's important.

171 I By individualised you mean?

R I mean caring for the particular individual. We must start...
what does this patient need? and start asking questions...
and building up individualised care for him... I see the
nursing process...

183 I Would you say it is humanistic?

R I hope so.

185 I By humanistic you mean?

R By humanistic I mean that the person's psychological and
spiritual welfare... are taken into account at all times... all
too often... we do not concern ourselves with the psychological
... so humanistic... it must be kind... and the person must
feel involved... the person must be able to question why some-
thing is being done... I feel it must be a contractual thing as
well... they are entering into a contract with somebody... there
is an element of ethical conduct... Humanistic is to me... it is
philosophy... where the client is uppermost... or should be
upper-most in our minds at all times... it means involving
people...

206 I Would you say the nursing process is systematic?

R It should be.

207 I By systematic you mean?

R By systematic I mean an ongoing process... there are steps to
follow... steps which one cannot jump... they are sequential
steps... ah... APIE if successful. . give a plan of action...
it's got to be systematic... ah... I hope it's not too
mechanical.

218 I You mentioned earlier that it was scientific. By scientific you mean?

R A measurement of one's own effectiveness... that's scientific. Scientific to me means you can measure it... you can measure the care... ah... therefore the process format... gives the nursing staff a tool... to measure their own effectiveness... and that's important because... patients are wanting more and we've got to give that... we've got to base our practices of nursing on scientific research. It is wrong for... that we can carry on doing this as we have been for years... I think it is very important... that we process our thoughts... if it is implemented properly... it will also increase the nursing staff awareness of... research. Here is a tool that will hopefully... tell you that you have not been successful and why... we should critically evaluate our practices.

245 I You said earlier that it was patient centred. By patient centred you mean?

R The nursing care is prescribed round identified... needs...

257 I You mentioned earlier that it was a problem-solving approach. By problem-solving you mean?

R Problem-solving to me is looking at the patient's point of view ... it is a process approach... because if one has a problem one must diagnose the problem... You make a plan of action, um, um, you must implement the plan of action and it must be evaluated, um. um. I don't think we introduce the students early enough to problem-solving... the ones we do we tend to introduce silly abstract problems... A problem-solving approach to me... is deciding on what is the most dominant

problem... the most pressing problem... and from there... work out ways of trying to tackle these problems...

274 I How do you see the holistic/humanistic aspects relating to the systematic and scientific ones?

R That's a very different question... I think the difficulty has been in the past that lip service was paid to holistic... and humanistic... they were jargon words that were used... My feelings are that they are quite simple... It's difficult... people think that scientific means being cold and clinical... and therefore there is no room in this approach. Well I don't see that at all... the scientific approach is a way of improving the practice... of the profession. The humanistic approach ... is a way of improving the standard of care... So I don't see it as a dichotomy at all... they go hand in hand... I don't see it as a particular problem...

295 I How does the nursing process differ from other approaches to nursing?

R ... I will list these as I see them:

- (a) Client-involvement
- (b) Problem-solving
- (c) Documentation
- (d) Professionalism
- (e) Ongoing
- (f) These are the main ones ...

These are the characteristics of the nursing process which did not exist in other approaches to nursing... We now have a more patient-centred approach... previously we had a medical model... where the doctor was the tin god on the ward... nurses looked to

doctors to sort problems out for them...

319 I You mentioned documentation earlier. What documentation is involved?

R Yes, the documentation is important... I always say that care plans should be in a place they are easily accessible... Having read ward reports, they are full of mundane drivel... things like... has had a good day... I think people try to justify their existence... when they write these reports... the documentation is important... also... people write reports away from the clients... reports are personalised now... I am encouraged about how personalised they have become...

343 I What for you are nursing models?

R Nursing models are frameworks... they are trains of thought... do I use an adaptive model for this particular person, or do I use... a model based on life's activities... do I use, for example, models of nursing are philosophers of care... when we can engender discussion amongst colleagues, um, um... of frameworks... the ways we are organising our thought processes... in regard to formulating care...

354 I How if at all are the nursing process and nursing models related?

R They are humanistic... ah... they look at the individual... they are also a framework for delivering care... a way of organising the delivery of care... ah... they normally contain an element of assessment... for example, the Roper model... ah... it's a framework for one's thoughts regarding assessing a patient... they also look at levels of dependency... ah... sometimes they are written by people who are not nurses... and that doesn't give them credibility. I think it is important

with nursing models... it's how we sell them... models tend to become jargonistic, they become trendy... and people don't realise that models are really arguments... academic arguments ... ways of organising your thoughts about how you would approach a problem...

383 I Would you like to summarise?

R I regard the nursing process as a positive thing... I regard it as a quite exciting, actually... I am research minded myself... and I feel that the nursing process is the proper way to set about nursing... I view models with less enthusiasm... I think we need to increase people's awareness of... thoughts and philosophies... of how to develop care. I don't think it's important that one uses a particular model... one looks at what one needs for that patient... we should be aware of the various models... and pick out what is best... for that individual...

401 I Many thanks for your help.

APPENDIX 9. The transcript of an interview with a nurse tutor in
mental handicap nursing. (Interview 38)

I = Interviewer

R = Respondent

INTRODUCTION

Counter
Number

001 I My research is concerned with how the nursing process is understood by teachers of nursing/clinical nurses such as yourself.

What is the nursing process?

What is the nature of the nursing process as far as you are concerned?

R It's a systematic approach to care using assessment, planning, implementation and evaluation...

009 I You mentioned assessment. What does assessment involve?

R Looking at the patient as an individual... whatever condition the patient has and taking a history... the physical, social, psychological... aspects... from there... working out the care ... the patient would need...

013 I What does planning involve?

R Ah... why the assessment it involves the patient um, um... ah...

017 I You mentioned implementation. What does implementation involve?

R Carrying out the nursing care... and the participation of the patient... and the patient being actively involved... in the implementation of care... um...

021 I You mentioned evaluation. What does evaluation involve?

R Looking at the care plans... and seeing how well the care has been carried out... we decide to carry on or change it if need be...

028 I Who carries out the nursing process?

R Ah... mainly learner nurses... the ward team... but ideally it should be registered nurses... but...

035 I Who should make the decisions?

R Ah... again as far as possible it should be the patient... and the nurses... and the doctors...

039 I Is this how it is?

R ... From my experience... it is... the patients should be involved... and they are becoming more aware of their rights... it's a very slow process... and... when there is conflict the status of the nursing decisions is slow... usually the consultants get their way...

058 I What features would you say characterise the nursing process?

R They are the four components, assessment, planning, implementation and evaluation...

063 I Would you say it is holistic?

R Yes...

064 I By holistic you mean?

R Looking at the person as a whole... as a whole person, um, um... ah... taking account of his spiritual, social and psychological aspects...

068 I Would you say it is humanistic?

R Yes, I think so...

069 I By humanistic you mean?

R ... It's an individual approach...

073 I You said earlier that it is systematic. By systematic you mean?

R You've got an order of how you actually do things... um... you approach things in a logical way... um.

078 I Would you say it is scientific?

R Ah... I am not too sure about that one... ah... I would say it's half... half scientific... I am not sure

080 I By scientific you mean?

R Has it been researched... um, um... and personally from what I have read... I wouldn't say it is very well researched... and the outcome of where they did the nursing process before... hasn't been that successful um, um... from the articles I have read...

086 I Would you say it is individualised?

R Yes, it is definitely individualised...

087 I By individualised you mean?

R Looking at the patient individually... I mean treating the patient as an individual... as a person...

091 I Would you say it is patient-centred?

R Yes... it should be

092 I By patient-centred you mean?

R ... the care is there... the patient is involved...

096 I Would you say it is a problem-solving approach?

R Yes... you identify the needs and you try to solve them...

097 I By problem-solving you mean?

R Identifying needs... and then you take it from there... um, um...

101 I How does the nursing process differ from other approaches to nursing?

Ah... in the past people... just carried out treatment and nursing procedures... without looking at what they are doing and without evaluating whether it was working effectively or not... um, um, and again you don't have to set it out in writing... Rather than the Resdex system... um. It does provide continuity of care... Hopefully it will make it more effective... um, um.

113 I What documentation is involved?

R ... Ah... it involves the forms... those are the documents... ah... the documents we are using at the moment... there are a couple of... forms that the staff aren't very happy with... They are in the process of re-devising them... it gives a detailed account of the individual...

125 I What for you are nursing models?

R ... It's first based on how somebody sees the person as a whole and it takes into account all the benefits... physical, psychological, social... and it has a hierarchy... You don't

have to use just one model... you can always take bits from each model... and use it to suit the individual... using one model can be restricting... I know only two or three models very well... because there are so many I get confused... I can't understand some of the models... because of the jargon... it's all right reading about models but putting them into practice is more difficult...

145 I How, if at all, are the nursing process and nursing models related?

R Ah... Well the nursing process is a systematic approach to care and then you can base... your care in a model that you think feel happy and comfortable with or what you believe in... because each model embodies a set of beliefs... It depends very much on what you believe... models are guidelines... ah... the nursing process and nursing models are used in conjunction with each other...

169 I Would you like to summarise?

R Ah... the nursing process is the means by which... one... actually plans care... using APIE... as you evaluate you might have to reassess etc. ... and nurses can actually look objectively at what they are doing and... sitting back and actually seeing whether what is being done is effective... and the nursing process is based on different models of nursing... but I know only a couple of models... I stick to these... and... what we need is more practical help at ward level... rather than all these lectures...

198 I Thank you very much indeed.

APPENDIX 10

GUIDE FOR ANALYSING THE CONTENT OF THE INTERVIEWS RELATING TO THE
NURSING PROCESS AND NURSING MODELS

A. GLOBAL VIEWS

- | | |
|--------------------------|---------------------|
| 1. Problem solving | 8. Planning |
| 2. Individualization | 9. Scientific |
| 3. A systematic approach | 10. Implementation |
| 4. Negotiation | 11. Evaluation |
| 5. Assessment | 12. Action research |
| 6. Decision-making | 13. Holistic |
| 7. Systems model | 14. Unclassified |

B. ASSESSMENT

- | | |
|-------------------------------|---------------------------|
| 1. Collecting information | 8. Problem identification |
| 2. Communication | 9. Nursing plan |
| 3. Making a diagnosis | 10. Prioritising |
| 4. Observation | 11. Team approach |
| 5. Determining Needs/Problems | 12. Taking a history |
| 6. Setting goals | 13. Unclassified |
| 7. Based on a model | |

C. PLANNING

- | | |
|--|--------------------------------|
| 1. Negotiation with the patient | 8. Short term |
| 2. Putting problem into a logical sequence | 9. Strategy |
| 3. A cognitive process | 10. Communication |
| 4. Paper exercise | 11. Identifying nursing action |
| 5. Setting goals/targets/objectives | 12. Resources |
| 6. Problem solving | 13. Making a care plan |
| 7. Long term | 14. Unclassified |

APPENDIX 10 continued

D. IMPLEMENTATION

1. Carrying out nursing care/plan
2. Patient involvement/participation
3. Implementing the assessment
4. The doing part of the process
5. Goals
6. Dependence/independence
7. Unclassified

E. EVALUATION

1. Was the care successful?
2. It is reassessment
3. It is a process of reflection and reassessment
4. Is it working?
5. Time scale
6. Measurement
7. Were the goals/objectives met?
8. Unclassified

F. WHO CARRIES OUT THE NURSING PROCESS?

1. Registered nurses
2. All grades of nurses
3. Learner nurses
4. Nurse and patient
5. Unclassified

APPENDIX 10 continued

G. DECISION MAKING

1. Patient should be involved
2. The nursing giving care
3. A registered nurse
4. A team approach
5. Person with knowledge and skills
6. Ward sister/charge nurse
7. Medical staff
8. Prescriptive
9. Unclassified

H. HOLISTIC

1. Involves the whole patient
2. Involves psychological, social, physiological, biological and spiritual needs
3. Not sure
4. Unclassified

I. HUMANISTIC

1. Concerned with human/individual needs
2. Person is the main focus
3. Concerned with communication
4. Not sure
5. Intuition
6. Unclassified

J. SYSTEMATIC

1. Orderly/logical
2. There is a format to it
3. Follows stages/steps
4. Not sure
5. Unclassified

APPENDIX 10 continued

K. SCIENTIFIC

- | | |
|--|---------------------|
| 1. Follows logical steps | 5. Not sure |
| 2. Research based | 6. Potentially, yes |
| 3. Involves measurement | 7. Practically, no |
| 4. Involves experiments/
empirical work | 8. Unclassified |

L. INDIVIDUALISED

- | | |
|--|-----------------------|
| 1. One patient to one nurse | 4. Total patient care |
| 2. You look at the patient as
an individual | 5. Not sure |
| 3. Individually defined problems | 6. Unclassified |

M. PATIENT-CENTRED

- | | |
|--|--|
| 1. Negotiating with the patient | 4. Person considered and not
just illness |
| 2. Involving the patient in his/
her care | 5. Not sure |
| 3. Allowing patients to have a say | 6. Unclassified |

N. PROBLEM-SOLVING

- | | |
|--|--|
| 1. Analysing the problem/taking
a history | 5. Setting realistic goals |
| 2. Setting goals | 6. Not sure |
| 3. Identification of problems/
needs | 7. Prioritization |
| 4. Looks at things logically | 8. Working out a way of
solving the problem |
| | 9. Unclassified |

APPENDIX 10 continued

O. RELATION OF HOLISTIC/HUMANISTIC ASPECTS TO SYSTEMATIC/SCIENTIFIC ONES

- | | |
|-------------------------------|-----------------|
| 1. Compatible/interlock | 4. Not sure |
| 2. Incompatible/contradictory | 5. Unclassified |
| 3. Problematic | |

P. DIFFERENCES BETWEEN THE NURSING PROCESS AND OTHER APPROACHES TO NURSING

1. More job satisfaction using the nursing process approach.
2. Better relations/communication with patients
3. Improved patient care
4. No longer task-centred
5. Looking at the patient more as an individual
6. Not sure
7. More paperwork
8. Unclassified

Q. DOCUMENTATION

1. A difficult aspect
2. Time consuming
3. Standardised documents and individualised care do not get well together
4. More and better information is recorded now
5. Not sure
6. Documentation is vital
7. Unclassified

APPENDIX 10 continued

R. NURSING MODELS

1. A way of looking at things/care
2. A construct based on a particular view of man
3. A way of implementing the nursing process
4. A representation of reality
5. A theoretical framework
6. Not sure
7. Abstract/conceptual
8. Guide/check list for assessment
9. Confusing
10. Unclassified

S. RELATION BETWEEN THE NURSING PROCESS AND NURSING MODELS

1. Compatible/interlock
2. Incompatible/contradictory
3. Problematic
4. Not sure
5. Mechanical/abstract
6. Unclassified

Appendix II Comments on nursing models written on the questionnaires
by the respondents.

1. "We are at present involved in exploring the application of nursing models, and clinical areas are using a model or models so that evaluation can take place. We do not intend to base the curriculum of this school on any one model but to introduce models relating to practice as the student progresses through the programmes".
2. "There is a danger that nurses will be taught one model and will not be aware of the appropriateness of different models..... There is a tendency for nurses to latch on to Henderson or Roper because they find it easy to identify the needs base of these".
3. "I do not know enough about models other than Roper and Henderson to really answer the question".
4. "The senior managers in this district have made a firm commitment to implement a model - the Roy model has been chosen and has been modified slightly.....".
5. "It is almost impossible to relate models to specialities. If we are to foster the right attitudes it must be the most suitable model for that client/nurse at that time..... Staff are totally bemused by the concept of a model and can't differentiate it from the nursing process".
6. "Implementation of the nursing process is not sufficiently under way for models of care to be considered yet by the nurses managing care at ward level".
7. "No single model of nursing care has been considered as more suitable or otherwise. In general, a combination of Roper and Henderson is used".
8. "We feel that in many cases, an eclectic approach to the application of nursing models in a psychiatric ward is more practicable because of the changing condition of our client group.....".
9. "Our model is based on Orem/Roper and derived and decided by service and education as a broad brush treatment for acute units and community".
10. "Elements of each model on list are appropriate. In other words there is not a best model".

11. "I feel that learners should be aware of a variety of models".
12. "I believe an eclectic approach is necessary. One cannot use Orem's self care model in care for the unconscious patient. Therefore models of care may alter at various times".
13. "At this early stage our understanding of nursing models I find it impossible to state which is the most appropriate for the specialities listed".
14. "This school of nursing believes that Roper's model the most appropriate for British nurses in that it does not have the language problem the American models have and it can be adapted for all the specialisms".
15. "Whilst nursing models are useful in the delivery of care their main use lies in the planning of care".
16. "We do not consider that one specific model is necessarily appropriate for all settings or specialisms. Our philosophy acknowledges that a combination of models may at times be more appropriate across the full spectrum of care".
17. "In the areas where models are being considered more than one is considered and individual ward managers are freely adapting or constructing their own model from components of others according to patient/client/situation".
18. "We tend to use Roper and Orem depending on the dependency of the person".
19. "Present curriculum based on the Henderson model for general nursing. In psychiatry Neuman model is being used".
20. "One model will not fulfill all the needs of one patient during hospitalisation. We hope to teach the nurses to select appropriate models for the daily different needs of the patient".
21. "..... it depends upon the nurse who implements the nursing model rather than on the specialism concerned".
22. "I can give you an idea of the models I might use, but I cannot be rigid, because I believe that in some cases a mix of models may be used within a specialism e.g. Roy/Orem/Roper".

23. "A systems approach type of model such as Artesian could be used in any of the specialisms. The model is merely an aid, a way of perceiving situations and events in a holistic manner".
24. "We have designed our own documentation of profile and care plan following looking at several models".
25. "Models are surely tools/strategies. Surely differing models are needed for differing people not labels".
26. "We are encouraging different specialities to develop models according to client needs".
27. "Henderson's definition of nursing and Roper's activities of daily living can be used in all specialisms".
28. "No one model fits every situation. The most apposite model is that practised by the nurse dealing with the patient, for we all evolve our own models through experience".
29. "I feel students should be introduced to a variety of models although we tend to base the introductory course on Roper".
30. "We decided in our District that trained staff could only deal with one model and we decided on Roper. The staff found greater difficulty in constructing various models and logically thinking them out".
31. "I believe that some models are suitable for certain specific patient/client groups. There appears to be a danger in assigning a particular group. There will always be a patient who does not 'fit' the model and I am concerned that the patient who will be seen to be at fault".
32. "The learners will be encouraged to develop their own models of care, based on their own experience as individuals and as carers".
33. "We teach a range of models from which to choose according to the individual patient".
34. "A model of nursing should apply whenever people require care..... current models are not of great value, it would be of more value to concentrate on developing skills using the nursing process".

35. "I consider Roper and Orem and Henderson to be the models of choice for each specialism. As they are macro-models each needs adapting to the specialism".
36. "I see nursing models in the curriculum as tools to assist nurses to utilise different approaches to thinking about nursing and to compare and contrast alternative approaches".
37. "The concept of models is a difficult one to sell to trained staff - in consequence, the delivery of care is presently confined to those seen as least complex and most readily applied - Henderson, Roper and Orem".
38. "We have used the Roper model for a number of years but are now considering other models. We will probably find that no one model fills the needs of our patients and we will devise one of our own".
39. "I feel the nursing process requires the framework of a nursing model for effective use and therefore models of a nursing should be established first".
40. "Not appropriate to state specific model against client care group. The model should be determined by the specific needs of individuals client/patient".
41. "I do not feel we have sufficient work on the use of models to comment on their use in specialisms".
42. "From my limited knowledge of models, I am led to understand that the appropriate model should be chosen to help plan the needs of a specific patient, not be used indiscriminately across the range of patients simply as a result of their age or medical condition".
43. "The question on models were difficult to answer as they challenged my own knowledge base and the School of Nursing's resources!".
44. "We are not sufficiently experienced in the use of different models to comment".
45. "All models can be made to fit any speciality".
46. "The curriculum is based on Roper. It may be that in the course of time other models will be found to be more appropriate".

47. "An eclectic approach is necessary to meet individual needs/circumstances".
48. "Patient care in every setting is individualised using a problem solving approach and this often necessitates an amalgam of models".
49. "The current emphasis on models will correct some of the misunderstanding of the nursing process".
50. "I don't feel models are necessarily related to client groups, but more to a stage of progress. Different models could be employed for the elderly in acute illness episodes to that on long term adaptation.
51. "I think the problems relating to the nursing process is lack of understanding of models which should have been implemented/discussed/taught first".
52. "Models taught are not stated as specific to any speciality. Individual interpretation encouraged to meet individual needs".
53. "In the clinical setting many nurses use the medical model or the old fashioned Nightingale model because they have not, for various reasons, read or have been introduced to any other".
54. "This school is currently preparing a new curriculum and it has been agreed that one model only should be used so that the students are not confused,.... Roper will be the model upon which the curriculum is based".
55. "Staff tend to adapt the model with which they can most readily relate. There is a tendency also to adapt the model chosen. The most popular model generally is the Roper model".
56. "One model will not fulfill all the needs of one patient during hospitalisation. We hope to teach the nurses to select appropriate models for the daily different needs of the patient".
57. "Should be a blend individually adapted to the circumstances".

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