NURSE PERCEPTIONS OF EXEMPLARY NURSING PRACTICE IN THE CONTEXT OF STRESSED WORKPLACES

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Abstract

The aim of this study was to discover how registered nurses identify and define exemplary nursing practice within the context of stressed workplaces. A qualitative study of peer nominated registered nurses within Southern Alberta was conducted to enhance understanding of exemplary nursing practice from the perspective of nurse peers and the nurse nominees themselves. Purposeful, judgement sampling by peer nomination was used to accrue the study sample. Person centered interviews (N=17) provided rich data and understanding of the phenomenon of interest. Being, Knowing, Doing, Giving and Receiving, (Stiles, 1990) served as the conceptual framework.

This research revealed contextual factors that fostered and challenged exemplary nursing practice. Participants identified similar characteristics of exemplary nursing practice, such as love of nursing, deep knowing, high standards of care, and demanding of self. Undermining factors of exemplary nursing such as lack of time, fragmented care, and lack of respect were identified.

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Chapter One

Introduction

Nurses are the structural glue of health care system, although they are not always recognized as such. Indeed full scope of nursing practice is not always visible. Nurses deliver the majority of primary patient care in a variety of practice settings even though nurses often must overcome taxing work environments to provide care to individuals who are at their most vulnerable.

The role and responsibilities of nurses has changed greatly in the last several decades. Increased demands have been placed on the bedside nurse because of many contextual factors including: changing political climates requiring institutional, economic, and organizational reform; new approaches to delivering care; and, advanced technologies. New treatments and greater acuity of patients also challenge the provision of nursing care. The daily difficulty of staff shortages, bed shortages, ever reducing resources, and the sheer number of patients needing care in a single shift all serve to undermine ideal nursing care (Benner, 1984; DeCola & Riggins, 2010; Enns & Gregory, 2007; Fagerström, 2006; O'Brien-Pallus, Duffield & Hayes, 2006). The public expectations of what an ideal nurse is, or should be, add even more pressure in these challenging times (Jensen, Bäck-Pettersson & Segesten, 1995). These factors can undermine the quality of nursing practice and are similar across patient care units. They include for example, high patient to nurse ratios, increased patient acuity, high rates of illness, increase in non-nursing duties, and lack of support from colleagues (Canadian Federation of Nurses Unions 2007; Canadian Nursing Advisory Committee 2002; Davis & Thorburn, 1999; Domm et al., 2007; O'Brien-Pallas, Bauman, Villeneuve, 1994).

In light of these issues, quality of work-life and practice settings have been repeatedly studied and consensus has been reached; nursing is a “stressful profession” (Canadian Federation of Nurses Unions 2007; Canadian Nursing Advisory Committee 2002; Davis & Thorburn, 1999; Fagerström, 2006; O’Brien-Pallas, Duffield & Hayes, 2006). The reality for today’s nurses is that they are working at maximum capacity, facing innumerable challenges and complexities, both physical and emotional, on a daily basis. This often results in exhaustion and burnout especially when they are not valued or recognized for their role or contribution within the healthcare system. Enns and Gregory (2007) identify the “lamentation” of nurses who are unable to perform their nursing duties in the manner they wish, given the demands placed upon them. Andrew Jameton (1994) (as cited in Austin et al, 2008) recognized moral distress and described it as distress arising “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Austin et al, 2008, p.4). Data show this distress directly relates to job satisfaction. In coping with moral distress nurses have sought out better working conditions, reduced their work hours, blamed others, and have left nursing altogether (Kelly, 1998; Zuzelo, 2007). “Stress of conscience” or “ethical caring” is recognized as a significant factor in burnout. These depleted nurses who take stress leaves impact not only those who suffer, but the unit as well. Their leaving affects the emotional well being of other nurses on the unit, staff morale, and increase economic costs to the unit as a whole (Enns & Gregory, 2007; Ericson-Lidman, Strandberg, 2007; Fagerström, 2006).

Chaos, Stressed Workplaces, and Exemplary Nursing

Nurses must continually refine or even redefine their roles in patient care as they face dynamic forces that continually contribute to stressful workplaces and result in chaos. It is impossible to eliminate elements of the unexpected within the human health experience. A 'butterfly effect', one small event or change to a system may have wide spread consequences to the balance of the unit. (Lorenz, 1994) A stressed workplace is certainly a disharmonious and undesirable state for the nursing unit. Chaos is confirmed when nurses sense "that their own capacity is not sufficient and that the situation is not under control" (Fagerström, 2006, p.626). Chaos undermines the nurse's ability to provide quality nursing care, and increases her/his stress and anxiety. This definition of chaos seems to describe what today's hectic and demanding nursing units present for the bedside nurse. Yet, there are exemplary nurses who are undaunted by the daily chaos and continue to deliver exceptional nursing care and maintain control despite the practice environment.

Faced with the reality of these challenges, some nurses "stand out" above the rest as being exemplary, surpassing all others. They are able not only to function within a chaotic and stressed healthcare system, but also to excel in their nursing practice. These registered nurses achieve excellence in the provision of care. They are duly admired by their peers and are regarded as role models. They are nurses who go beyond the usual scope of practice; who are worthy of imitation, commendation, and who serve as role models. Exemplary is synonymous with terms such as excellence, superior, commendable and the finest of the profession.

Perry (2008b) explored how exemplary oncology nurses avoided compassion fatigue and continued to provide exemplary nursing care. Exemplary nurses provided evidence

of moments of connection with the patient, and made moments matter within the context of the nurse-patient relationship. These nurses displayed a positive attitude, a sense of humor, playful spirit, self-confidence and self-awareness. Perry suggests controlling how one responds to difficult situations "results in better outcomes all around" (Perry, 2008b, p. 90). As identified in her findings this surely builds a more amiable workplace and sense of personal well-being. Noble-Adams refers to the phrase 'work excitement' originally introduced by Simms, Erbin-Rosemann, Darga and Coeling in 1990, where they described this as "personal enthusiasm and commitment to work evidenced by creativity, receptivity to learning, and the ability to see opportunity in everyday situations" (Noble-Adams, 2001, p.29). Are these the keys to exemplary practice or are they components? When facing chaos in every aspect of work life, are these traits alone the answer to consistently maintaining exemplary nursing practice or does the unrelenting nature of stressed workplaces impact exemplary practice in deeper ways that nurses must overcome?

"Employers are also beginning to realize that the twenty-first century-workforce will inevitably be different from the workforce of the twentieth century" (Pitt-Catsouphes, 2007; Stewart, 2006). Generational differences may also influence nurse's perceptions when identifying exemplary nursing practice as well as years in nursing practice.

Earlier articles depict an exemplary nurse as possessing certain task-orientated qualities (Bjørk, 1995, p.7). However, there is a blurring of the line between experts and exemplary; often authors use these terms interchangeably making a clear definition difficult. Furthermore, the many facets of all that blends to make an exemplary nurse have not been fully identified (Chiarella, 1990; Coulon, Mok, Krause, Anderson, 1996; Noble-Adams, 2001; Peden-McAlpine, 2000; Thomson, 1990). Research at times has

taken a negative slant as to what a nurse should not be, or pointing out obstacles that interfere with being an exemplary nurse.

There are at least two kinds of nursing that must be clearly understood before fully embracing exemplary nursing practice. These include the 'good' and 'expert nurse'. Recognition must be given to the dynamic nature of nursing and the part it plays in the changing ideation of the 'good' nurse over time.

Good Nurse

The discussion and perceptions of what makes a good nurse has ensued since Florence Nightingale first reformed nursing into a profession of respect and skill, based on science and compassion (Nightingale, 1860; Rush & Cook 2006). Nightingale strongly believed that a good nurse was the "product of moral rectitude, maturity, and a deep understanding of the character traits needed to care for the sick and vulnerable people. While Nightingale acknowledged scientific training, she was concerned that science alone would not produce good nurses" (Kitson, 1996, p.1648). Miller (2006) is in agreement with Nightingale in her definition of good work in nursing. Good work is "work that is technically and scientifically effective as well as morally and socially responsible" (p.471). This is a shift from the 1952 study of 3000 nurses by Shields, (as cited in Bjørk, 1995), who found the most important factor was the nurse's ability as she "performs the technical, manipulative aspects of nursing procedures smoothly and skillfully" (Bjørk, 1995, p.6). From the same study (Shields, 1952), nursing "skills in interpersonal relations, patient teaching and leadership were rated fourth, fifth and sixth respectively" (Bjørk, 1995, p.7).

More recently, opinions and expectations of nurses have been expressed by administrators, educators and patients. A good nurse must possess “sound judgement, a compassionate heart, critical thinking skills, problem solving skills and quite possibly the most important traits of honesty and integrity” (Hicks 2003, p.19). Rush and Cook (2006) simplified the qualities of a ‘good nurse’ to three main requirements by administering a questionnaire to 96 participants, caregivers and patients. They found that attitudes, skills, and knowledge were consistently the most agreed upon indicators recognized by participants as the composite of a good nurse. Research indicates that patients value the nurse as a person: his or “her personal qualities, attitude, manner, personality, and her [sic] presence – being with the patient and being readily available” (Kitson, 1996, p.1649). Although patients are certain of what they see as the making of a good nurse, these qualities may differ from what a nurse views as his/her role (Häggman-Laitila & Åstedt-Kurki, 1994; Lynn & McMillen, 1999; Rush and Cook, 2006).

Nursing professional bodies have developed their own visions of a good nurse through publishing Nursing Practice Standards and Code of Ethics (Canadian Nursing Association, 2008; College and Association of Registered Nurses of Alberta, 2009). These “standards” address acceptable baseline practice that is safe, ethical, and competent.

In a descriptive qualitative study, 53 Registered Nurses were asked to complete the sentence “a good nurse is one who…” (Smith & Godfrey, 2002). From the responses obtained, seven categories were identified accounting for a ‘good nurse’; personal characteristics, professional characteristics, knowledge base, patient centeredness, advocacy, critical thinking, and patient care.

Expert Nurse

Adams et al. (1997, p. 217) comment, “A clear picture of the practice of expert nurses is necessary so that those in the profession can know and articulate expert practice and direct it to the community”. Benner (2001) claims “nurses tend to become “expert” after approximately 5 or more years of practical experience in similar clinical settings”, (p.31) having moved through the five stages of novice, advanced beginner, competent, proficient, to expert. Benner (1984) explains this is not just a passage of time but a gathering and development of skill, knowledge and intuitiveness. In describing the expert nurse, Benner (1984) compares beginner and expert, the beginner “must rely on detached, deliberate considerations of as many variables as possible” (p.215). “As nurses begin their careers, they may be dependent on colleagues and others for guidance, encouragement and support in order to do their work” (Perry, 2005 p.20). In comparison, Benner (1984) asserts: “The expert rapidly grasps the problem by seeing it in relation to past similar and dissimilar situations and rapidly hones in on the correct region of the problem” (p.215). The expert nurse has developed the ability to be attuned to a personal sense of “vague feeling, hunches, or a sense that something is not right” and appropriately act upon them (Benner, 1984, p.215). “Descriptions of expert performance are difficult, because the expert operates from a deep understanding of the total situation” (Benner, 1984, p. 32), and is not always able to verbalize how they know.

Hardy et al (2002) “propose that practice evidence of clinical nursing expertise develops from a practitioner’s ability to ‘see beyond’ what is evident and capture a ‘deeper understanding’ of the impact of clinical situations, clinical decision-making and

clinical outcomes" (p. 201). Experienced nurses use their knowledge, skills and experience in assisting positive patient outcomes.

Exemplary Nurse

Keeping the definitions of a good nurse and an expert nurse in mind, can we as nurses provide exemplary care without understanding or defining for ourselves what constitutes an exemplary nurse within the chaos of today's nursing units? Just what are the qualities of a nurse that makes him/her exemplary in the eyes of nursing colleagues? Is it compassion, education, skill, ability to follow a set code of conduct, respect, communication, a positive outlook in general or a blend of all that allows for that 'extra something' which holds them above the rest? Can this be taught or is it an innate trait possessed by only a few? For Thomson (1990), excellence in nursing practice is one that "upholds the highest standards". For others excellence is skill focused (Chiarella, 1990). Coulon, Mok, Krause, and Anderson (1996) found that excellence in nursing care meant "that at all times the patient was the centre of the nurses' concern" (p. 819), providing professional, competent and holistic care. Respondents in the Coulon et al study identified four personal qualities: professionalism; holistic care; practice – successfully planned nursing intervention; and humanism, as possessed by those delivering excellent nursing care. Noble-Adams' (2001, p.24) research on the phenomenon of exemplary nursing observes that exemplary nurses "are not only clinical experts, but also have other special qualities which make them stand out". She goes on to surmise "it could be possible that "exemplary" nurses are those who want to help others and that is what drives them to provide expert care in the best way they can" (Noble-Adams, 2001, p.25).

Kendall (1999) describes the outstanding or exemplary nurse in terms of a 'star'. She contends, "a 'star' nurse must be a 'good' nurse but a 'good' nurse may not be or become a 'star' nurse" (p.113). Therefore, these terms of "good", "expert", and "exemplary", are likely not interchangeable. According to Kendall's definition,

> The star is a nurse who, for whatever reason, stands above the rest. The 'star' is capable and competent but is much more. The 'star' is the one who others admire; the one that often fills colleagues with pride. The star is a nurse whose caring achieves excellence. She or he is the one whom people say, "I'd really like to be like them'' (Kendall, 1999, p. 113).

The American Nurses Credentialing Center (2009) speaks of the excellent nurse as one who excels in the provision of care, one who stands out in function at a higher level above and beyond her/his peers. These nurses are models and they act as exemplars to assist others in their journey toward excellence.

It is a complex thing to identify all that encompasses exemplary nursing practice. However, without this identification, how will we know when it has been achieved? It is nurses who work alongside other nurses who can best see and understand the full scope of nursing practice and identify the qualities of exemplary nursing practice within a challenging work environment.

What makes this research unique is using the perception or judgement of peers to identify these qualities. In addition, seeking exemplary nurses from varied nursing units as opposed to one specific unit and observing for commonalities of exemplary nursing practice will also enhance our understanding. Nurses face and cope with the challenges of the nursing unit on a daily basis, they are the ones with the inside knowledge to judge and identify exemplary nurses within their midst.

Research Questions

The intent of this descriptive research was to explore exemplary nursing practice by Registered Nurses who are nominated by their peers as being exemplary in their practice. Through person centered interviews (Levy & Hollan, 1998) the nature and characteristics of exemplary nursing practice was explored. By recognizing the intimate knowledge of the bedside nurse, 'peer nomination' revealed how Registered Nurses observe, identify and define what they see as exemplary nurses. Furthermore, these peer nominated nurses were invited to reflect on their practice and articulate their perspective regarding exemplary nursing care. The following questions directed this research.

1. How do peer nominators define, observe, and identify, their colleagues as exemplary nurses?
2. How do peer- nominated nurses describe and reveal their own exemplary practice?

Significance

"To be able to explain expert nursing and describe what makes some nurses exemplary will help in articulating the full nature and significance of nursing to both the lay public and colleagues" (Nobel-Adams, 2001, p. 24). Identifying these exceptional qualities will be potentially significant to educators, employers, managers, patients, and ultimately nurses themselves. Once identified, these qualities may be used to build educational programs, encourage personal growth, and foster job satisfaction for nurses. "Nurses that perceive themselves as respected professionals have higher job satisfaction and are recognized by peers" (Coshow, Davis, Wolosin, 2009; Harris et al 2007).

“Management exists to organize and support expert practice, it cannot substitute it” (Stiles, 1985, p.73). If management could readily identify these expert qualities in present employees by observation, or understanding, policies, and programs could be developed to preserve and enhance them. Managers must also recognize the need for sufficient staff to support nurses through chaotic times, thus maintaining the nurses’ ability to continue providing exemplary nursing care. Peden-McAlpine (2000) supports the importance of time spent with the client or patient as integral to exemplary nursing practice. “The exemplary clinician must be able to continually collect and interpret information to understand the meaning in the patient situation as it changes over time” (p.218).

The average age of a Registered Nurse in Alberta is 56 or older, which is 18% of the Province’s 32,000 nurses (CARNA, 2009). As the first of the baby boomers reach age 65 around 2010, it is probable their healthcare needs will increase just as the number of registered nurses will begin to retire in large numbers (Guglielmo, 2009). With the anticipated large number of nurses reaching retirement, mentoring those newer to the profession by nurses recognized for their exemplary nursing practice, would aid in preparation for the expected attrition. Mentoring implies a sharing of experience and skills in decision making as well as attitudes and values. It is important that the exemplary nurse is recognized and encouraged to share these positive attributes so others may emulate such exemplary characteristics in their professional development. Recognition and job satisfaction are major factors in “staff retention, patient satisfaction, and quality of care” (Perry, 2008a, p.17), all of these factors are desirable in any nursing unit.

With identifiable exemplary traits, management would be able to refine nursing practice and build a mentoring program utilizing the exemplary nurse as a model to the less experienced staff, offering knowledge, skills, education and experience. The unit would benefit by nurturing these ideal qualities among nursing staff. Recognition of the stages in acquisition of skills would provide a tool for career advancement and efficient utilization of nursing within the unit (Benner, 1984). As Kendall (1999) comments; although "not all nurses are or will be 'stars', other nurses may be able to incorporate some of the aspects of the performance of the 'star' nurse into their practice which would contribute to quality care" (p. 116). Patients would be at the forefront of a caring and skillful environment.

Theoretical Framework

The work of Marilyn Stiles (1990) through her research involving hospice nurses, identified five themes in the spiritual nurse-family relationship: nurses' ways of being, nurses' ways of knowing, nurses' ways of doing, giving and receiving, and ways of welcoming a stranger. Kendall (1999) adapted these descriptors in her efforts to "provide a framework for the overall description of the 'star' nurse and allow for readily identifiable components of the whole" (p.118). In identifying outstanding or "Star" oncology nurses she chose to leave aside 'welcoming of a stranger' as not pertaining to her study. Within this proposed study, I will use the initial descriptors of being, knowing, doing, giving, receiving, and welcoming a stranger as a conceptual framework to help identify attributes of exemplary nurses and their practice.

Ways of being.

Stiles (1990) identifies "ways of being" as, "being available, sitting with, holding hands, talking with, being with the family for the duration, sharing similar experiences, truth-telling, answering questions and humor" (Stiles, 1990, p.237). Kendall (1999) refined these descriptors to being present in the moment with the patient: "caring, empathy, trust, security, advocate, professional, and committed" (p.118). Being there "involves entering into the experiences of patients by being present in their lives" (Noble-Adams, 2001, p.24). Being is "moments of connection between nurses and patients that have the potential to leave deep impressions on the nurses, helping to rekindle their passion for nursing" (Hogen & Lovesy, 2007, p. 39).

Ways of knowing.

Generally, this entails what the nurse knows. Here Stiles (1990) is focused specifically towards the hospice nurse with key identifiers being "knowledge of the dying process" and "knowledge of the transcendent". Kendall (1999) resituates these terms more broadly as what and how the nurse knows, "knowledge, assessment, intuition, and experience" (p.120). The nurse is knowledgeable in the practice of nursing, is able to problem solve, anticipate the unexpected, and is prepared for all outcomes.

Ways of doing.

This theme refers to actions taken by the nurse. Stiles (1990) grouped "nursing care skills, pain control, explaining, teaching, reassuring, preparing, helping patients die with dignity" as ways of doing. Similarly, Kendall (1999) placed the same descriptors of providing for the patient; "basic care, clinical and technical skills, competent, organized, prioritizing, patient educator" under the same heading of ways of doing. (p.118)

Ways of giving and receiving.

Stiles (1990) refers to "ways of giving and receiving as a "reciprocal view of the nurse patient relationship" (p.236), subsequently describing giving as: "relieving of patient suffering, providing quality of life, sharing of self, making a difference, being needed, and providing holistic care" (237). Stiles also asserts receiving for the nurse stems from the patient or situation: the nurse gains "personal growth, learning to confront own mortality, learning about self … realistic expectations, personal responsibilities, coping with others grief" (p.237). Kendal (1999) agrees that "'ways of giving and receiving' are associated with social interaction" (p.120) either between the nurse and patient or the nurse and other staff members. She maintains "the strength of the nurse-client relationship influences the perceptions of quality of care" (p.120).

Ways of welcoming a stranger.

Welcoming of a stranger, in Stiles study of hospice nurses, refers to the way families welcome a nurse into their lives and family during the preparation for the death of a loved one. In Stiles' study she refers to this as the nurse-family spiritual relationship, teaching or guiding patient and family along the way toward death. Nurses are often given the privilege of being entrusted with the well-being of families loved ones, and the sharing of intimate experiences. Kendall chose to omit this last finding of Stiles, as not pertaining to her study. In this study ways of welcoming a stranger will be given a broader meaning, it will refer to the nurse relationship in being entrusted with the care of loved ones and the sharing of intimate experiences with patients and their families.

Summary

The nurse is pivotal to health care. Roles and responsibilities vary and nurses' full scope of practice may not be readily visible to the observer. Constant change has increased demands whereby nurses deal with changing political climates requiring institutional, economic and organizational modifications. The provision of patient care has become more stressful to the bedside nurse who encounters the daily difficulties of staff and bed shortages, reduced resources and the great acuity of patients in his/her care.

The inability to meet these daily nursing challenges can result in exhaustion and burnout. Moral distress and lamentation in being unable to care for their patients as they would wish, affects the emotional well being of these nurses which in turn affects unit functioning and staff morale.

In examining exemplary nursing, the definition of good nurse, expert nurse, and exemplary nurse held differing definitions and were often used interchangeably. In reality there are differences associated with these terms and their respective concepts. Despite the reality of these challenges, some nurses stand out above the rest and are able to excel in their nursing practice.

Styles, framework (1990) was chosen to help reveal the complexity of exemplary nursing practice, as it appears to include frequently identified dimensions of nursing practice: behaviours, personal qualities, personal experiences, attitudes, knowledge and skill. In using these general headings as a guide, qualitative data will provide an opportunity to discover not only exemplary nursing practice, but to further discern contextual factors that foster exemplary nursing care.

Chapter Two

Related Literature

In an effort to identify current understanding of exemplary nursing practice, a review of the nursing literature was undertaken. Little research was available in identifying what qualities nurses possess that enables them to maintain an exemplary nursing practice within today's chaotic nursing units. Many studies have identified exemplary nursing care from the patients' perception but few identify exemplary nursing care from a peer nominated perspective. Specialization and advanced technologies have also introduced uniqueness to individual nursing units. Several studies were located that compared the perception of 'star' or exemplary nursing practice among specialty units; that being oncology/palliative care. The difficulty arises in the varied and often interchangeable references used in describing exemplary nursing practice. Expert, exemplary, excellent or experienced have all been used interchangeably in many of the articles.

A Good Nurse: Patient and Nurse Perspectives

Cody and Squire (1998) set out to discover "Nurses' perceptions of good nursing care" and provide a definition of good care as perceived by nurses in a variety of settings. A narrative approach was used allowing participants to tell their own story. A group of eight nurses (two men and five women) were recruited to take part; their clinical experience ranged from three to 28 years. The nurses were asked to relate a story that depicted good nursing care. Seven stories were used in the final analysis. From the seven stories the phenomenon of good nursing included good communication, caring or 'being with' the patient and offering reassurance. Technical care was not

considered as a distinct part of good nursing care. The ability to cope was identified, especially with inadequate staffing levels and differing levels of skill. Building a relationship with patients rather than simply performing physical tasks was also noted as important in providing good care. The authors felt that nursing is caring, and that caring has different levels. "To give care that is specific to each patient's unique needs will mean that the presence of the nurse will be required at different levels, these being determined by the patient" (p.581). This study focused on the nurses' perceptions of good care without input from the patient perspective.

"What makes a good nurse?" Rush and Cook (2006) asked this question to 96 patients, service users and carers. Because knowledge of the subject was limited, qualitative research using narrative interviews was conducted. The intent of the study was to help assist a diploma nursing program in Nottingham to enhance its curriculum. The authors observed that the results were relevant across the nursing profession. Focus groups were used to obtain their view about nurses and nursing by considering their own good and negative hospital-based experiences. Five hundred and twenty-five comments were recorded on the requirements of a good nurse and findings revealed: "attitudes 50%, skills 28%, and knowledge 22%" (p.383). References to good communication crossed over into all categories. It was not clear as to the exact nature of the sample, and what information was extracted from "website searches of voluntary and charity organizations" (Rush & Cook 2006, p. 382).

In their descriptive, qualitative study, Smith and Godfrey asked 53 nurses to respond to two open-ended statements: A good nurse is one who...; and How does a nurse go about doing the right thing? Three hundred and thirty one meaningful data units were collected which included the answers to both statements. From these

meaningful words and phrases seven themes emerged; personal characteristics, professional characteristics, knowledge base, patient centeredness, advocacy, critical thinking, and patient care.

Smith and Godfrey (2002) recognized that some bias may have occurred in the selection of participants. Participants were recruited by convenience sample during a conference on ethical nursing practice. Attending this conference may have had some bearing on the participants' responses. The questions were also biased toward the positive. Collecting data from anonymous participants made it impossible to clarify answers. Smith and Godfrey (2002) acknowledge that the ideal of the 'good nurse' is recognized, with the exact meaning still in question. They suggest more research is needed to provide a suitable definition.

Quality Nursing Care

Miller (2006) conducted a study using semi-structured interviews to uncover goals, practices, values and supports, as well as "obstacles" and strategies to overcome them to provide "good work". Interviews were conducted with 24 nurses; eight at the entry level of professional bedside practice (1-5 years experience) and who were nominated by their supervisors, former faculty, or peers. Fellow colleagues or the investigator also selected sixteen experienced nurses based on national or international distinction. These experienced nurses held administrative roles in hospital or universities. Taped interviews and a 30 item Q-Sort ranking of 30 professional values generated the data set. A phenomenological approach was used in the analysis of interview transcripts. Entering professional nurses identified that "providing quality care for patients was the primary mission of their work" (p.474). Quality care included

treating others with respect and honesty, providing support for patients and being present to patients. Experienced nurses also identified quality care as a primary mission as well as indirect ways in which they promote good care such as “promoting excellence”, advocating for others, modeling excellence, empowering others and promoting quality education. A working definition was not given for “promoting excellence in nursing” (p.475). This research provided opinions from extreme ends of the nursing spectrum; beginning bedside nurses and at the other end, administrative nurses with recognized distinction nationally and internationally. Four obstacles to good work were identified: 1) nursing shortage; 2) demands on time; 3) conflicting values among peers; 4) and lack of autonomy. To overcome obstacles new nurses reported using strategies such as teamwork and prioritization of their care. These nurses chose to avoid conflict with peers rather than address it. Experienced nurses in this study cited financial constraints and diminishing resources as major obstacles in providing quality care. (p.483) In facilitating good work, both new nurses and experienced nurses identified the importance of role models and mentors. The author suggests further study into the concept of good work in nursing. (Miller, 2006)

In another effort to measure patients’ and nurses’ perceptions of quality of services and satisfaction, a Korean study used a questionnaire survey administered to 272 patients and 282 nurses to compare nursing service quality and satisfaction. Nurses’ expectations and performance were higher than those of the patients. Patients expressed a greater satisfaction with nursing and medical care than was expressed by the nurses. It was identified that “quality consists of two interdependent parts: quality in fact and quality in perception. Quality in fact means confronting [sic] to standards and meeting

one's own expectation, while quality in perception refers to meeting the customer's expectations" (Lee & Yom, 2006, p.546).

Using van Manen's hermeneutic phenomenology, Burhans and Alligood (2010) set out to find what the lived meaning of quality nursing care was for practising registered nurses with a baccalaureate degree with at least one-year's experience. Twelve female practising medical–surgical nurses were interviewed. Each of the participants were asked a series of questions and encouraged to answer in their own words. Six themes were uncovered in these interviews and included advocacy, caring, empathy intentionality (intention to deliver quality care), respect and responsibility. From these interviews caring was highly valued and surpassed clinical skill as an indicator of quality nursing care. Four out of the six themes related to quality nursing were found to be related to the art of caring. The researchers suggest further research to "explore if the art of nursing informs a more effective application of the science" (p. 1694).

Concept of the Expert Nurse

Maternity nursing expertise was the focus of a qualitative meta-synthesis study conducted by Downe, Simpson, and Trafford (2006). The purpose was to "undertake a review of a specific attribute ('expertise') from the perspective of individual caregivers themselves" (p.128), by reviewing English language research between the years 1970 – 1976. Seven papers met their preset criteria. Midwifery skills, practices, beliefs and philosophies were examined to offer a basis for a theory of expert intrapartum non-physician maternity care. The researchers found the use of the terms expert, exemplary, excellent, and experienced were all used in the same context and therefore used all those terms in searching the literature. "Participants from all studies included; nurse, nurse-

midwives, and midwives" (p.130). Their findings identified the following characteristics of these expert practitioners: wisdom (education, experience, knowledge); skilled practice; and enacted vocation (personal values, intuition, and connected companionship). Compared to Benner's "expert" model (1996) these researchers found their concept of expert may be a consequence of wisdom, skilled practice and enacted vocation as compared to Benner's five levels of skill acquisition: novice, advanced beginner, competent, proficient and expert (1984).

Concept of the Excellent/Exemplary Nurse

Jensen, Bäck-Pettersson and Segesten (1995) conducted semi-structures interviews with 10 Danish women being treated for breast cancer. These women were considered to be valuable informants in describing essential characteristics of an excellent nurse in relation to the time spent in hospital and while receiving treatment. The participants were asked to describe the characteristics of an excellent nurse and a caring situation in which the nurse was involved.

Four main concepts were found: competence, compassion, courage (faces death together with the patient), and concordant friend (on the same wavelength, acts according to the patients' preferences, connectedness, inspires confidence). The authors found 'concordance' to be a novel finding, one not previously explored, and suggest further study to understand the importance it plays in the excellent nurse. They question that if the demographic and disease were to change would the importance of a concordant relationship change as well.

Qualitative data were collected through an open-ended questionnaire from 156 undergraduate and postgraduate nurses who were asked, "to give an example of what

you mean by excellence in nursing care" (Coulon, Mok, Krause, & Anderson, 1996, p.819). Four themes were identified; professionalism, holistic care, practice; and humanism. From this data, three sub themes were also recognized; enabling personal qualities, nurse patient relationships, and nurse-team members' relationships. From the demographic data, further information was gathered in differences of focus in responses. Undergraduate nurses based their answers on inner qualities and tasks, where as seasoned nurses tended to focus on problem-based and unbiased care. These findings align with Benner (1984), in that there is a progression of stages though which the nurse passes as experience is gained.

Perry (1998) conducted a qualitative study of eight exemplary oncology nurses with the purpose of enhancing the understanding of exemplary nursing care in oncology. Using interpretive research, the researcher gathered information by oral, written and observation methods. Nurses were peer nominated by unit members who answered the question, "Who are the nurses on your unit that you would want to have care for you (or your family member) if you were diagnosed with cancer?" (Perry, 1998, p. 98). Perry found that consistent aspects of the exemplary nurse included;

> a belief that life is precious; a respect for the dignity, worth and autonomy of each person; an awareness of the values of self-understanding; a commitment to helping each patient attain the highest quality of life possible, with quality being defined by the patient; an acceptance that death is a natural part of life; and resolve to act according to their own philosophies (p. 101).

Research has identified outstanding clinical nurses or 'star' nurses, as Kendall (1999) named them. Semi-structured interviews with 12 oncology nurses were conducted. Each nurse was asked to describe an outstanding oncology nurse in terms of clinical practice. Data analysis was done following three steps of symbolic interactionism; humans act toward things based on personal meaning (self); meaning of things is developed from

personal interaction with others (society); and people handle and modify meaning by interpretation (mind). Findings showed outstanding nurses were more than 'good' nurses, and such a nurse was characterized as "professional, committed, and caring; delivers excellent nursing care both basic and technical; is knowledgeable; has advanced communication skills, and establishes strong relationships with clients and peers"(p.116).

Radwin and Alster (1999) collected the views of 22 purposively selected oncology patients during 45-60 minute semi-structured interviews. The focus of this study was to determine health outcomes of patients who felt they had received excellent nursing care. The definition of the quality of care was not defined prior to the study. "The analysis revealed that care was deemed excellent when nurses were knowledgeable, attentive, and caring; established a rapport with patients; provided individualized care, engaged the patients as partners in planning, implementing, and evaluating care" (Radwin & Alster, 1999, p. 329). Patients who felt that nurses had delivered excellent nursing care acknowledged a "sense of well being and increased fortitude" to persevere through treatments (p. 340). Interestingly, Radwin and Alster grouped thematic concepts of excellent nursing care similarly to Styles (1990) and Kendall (1999) as "ways of being, doing, knowing, giving and receiving" to corresponding headings of "*to know*", "*do*", and "*be*" (p. 339).

Perry (2008b) identified seven oncology nurses by peer nomination as being exemplary care givers. Through semi-structured conversations, three themes were identified: moments of connection, making moments matter, and energizing moments. "The data suggested that when nurses recognized similarities between themselves and the care recipients, it assists them in knowing how their patients would like to be

treated" (p. 89). Perry also stated that "exemplary nurses seemed to have discovered, a positive response in a difficult situation often results in better outcomes all around" (Perry, 2008b, p.90).

Perry (2009) continued her research of oncology nurses in this qualitative study. Peer nomination and self-nomination met the criterion of "who they would like to have care for them or their family members if they had cancer" (p.221). Conversations were held with six of the respondents as well as observational field research and narrative exchange on an individual basis. Snapshots of exemplary nursing practice were depicted through a series of anecdotal stories from both researcher and participants. As Perry phrased it "Lessons Learned: Exceptional nursing practice is more than competent performance of procedures, although these exemplary nurses were skilled practitioners" (p.184); personal philosophies of nursing practice gave exemplary nurses direction (p.184); self-awareness – nurses learned about themselves from others; (p.187); care for own physical self (p.188); spiritual self; emotional self – being open to emotional self-awareness (p.189); significance of experiences with death (p.193); moments of growth – some of these moments came when they faced their greatest challenges (p.195); touch, silence, and light heartedness – all shared ways of communicating (p.196); motivation and satisfaction; as the exemplary nurses met patient needs, the exemplary nurses had their own needs met (p.197).

From the literature review the following characteristics and descriptors were identified and placed under their respective headings; good nurse, quality nurse, expert nurse, excellent nurse and exemplary nurse. Many of the qualities are referred to in more than one category reflecting how these descriptors are often used interchangeably and how a finite set of descriptors may not be possible.

Table 1: Literature Research Findings

Good Nurse	Quality Nurse	Expert Nurse	Excellence	Exemplary
Good communication Caring Being with the patient Offering reassurance Coping ability Build a relationship with patients Personal characteristics Professional Characteristics Knowledge base Patient centeredness Advocacy Critical thinking	Providing quality care Respect Honesty Patient support Promotes excellence Advocacy Promote quality education Observation of role models & mentors Caring Empathy Intention to deliver quality care Responsibility	Wisdom (education, experience, knowledge) Skilled practice Personal values Intuition Connected companionship	Competence Compassion Courage (when facing death with a patient) Concordant friend Acts according to the patient's wishes Connectedness Inspires confidence Professionalism Holistic care Practice Humanism Personal qualities Nurse/patient relationships Nurse/team relationships knowledgeable, attentive caring established a rapport with patients provided individualized care engaged the patients as partners in planning implementing, and evaluating care	Dignity Individual worth Autonomy of each person Personal values Self-understanding Commitment to each patient Being able to respond to patient need Spend time with the patient Act according to own philosophies Professional Commitment Caring Basic nursing skill Technical skill Knowledgeable Advanced communication skill Open to emotional self awareness Touch Humor Motivation
Cody & Squire,1998; Rush & Cook, 2006; Smith & Godfrey,2002	Burhans & Alligood, 2010; Lee & Yom, 2006; Miller, 2006	Downe, Simpson & Trafford, 2006;	Coulon, Mok, Krause & Anderson, 1996; Jensen, Bäck-Pettersson & Segesten, 1995; Radwin and Alster (1999)	Kendall, 1999; Perry, 1998b, 2009

Stressed Workplaces

Workplace stress has been widely reported from all areas of nursing and all parts of the world. (Literature Search CINAHL, 2011) Increasing demands on health systems, aging populations, chronic diseases, shortages in healthcare professionals and nursing educators were all recognized as stressors (DeCola & Riggins,2010).

A review of literature data bases between 1985 and 2003, undertaken by McVicar, (2003) to answer the research questions 1) Is there commonality of sources of workplace stress for nurses? 2) Are sources of workplace stress for nurses changing? 3) Will recent organizational interventions introduced to reduce the sources of stress for nurses be effective? Participants came from a wide range of practice areas. Main sources of stress were identified as workload, leadership/management style, professional conflict and emotional cost of caring. Inexperienced nurses added low levels of confidence as another source of stress. Three levels of stress responses were identified eustress (good stress which enhances performance), distress and severe distress, which progressively contributes to "consistently observed symptoms of emotional burnout and serious physiological disturbance[s] (p. 634). Pay and shift work schedules are added to the previous list as new sources of stress in the literature. McVicar concluded "stress intervention measures should focus on prevention and organizational issues.

In determining levels of optimal workload, Fagerström (2006) conducted a hermeneutic study. Seven focus groups totalling 29 nurses were conducted. Participants were identified with the aim that they should be representative of the entire population of nursing specialties. Selection of participants was also based on work experience and type of position, such as permanent employment, continuing contract of employment or temporary post for at least one year (Fagerström, 2006). Optimal nursing care intensity

was determined to be one of “being able to respond to patients’ caring needs because the necessary time for nursing care is available. The nurses are able to care in ‘peace and quiet’ and there is time to ‘sit down and listen’ to the patients’ anxieties and worries” (Fagerström, 2006, p.625). “High nursing care intensity level is when the workload is too high and the nurses feel they cannot provide the nursing care the patients require. ‘You are in a hurry and you do what is absolutely necessary for the patient you do what you have to do’.” (p.626). This entails medication administration, treatments, and attending to the basic needs of the patient. The process of interpreting the data was done in six phases, beginning with description and ending with interpretation of the meaning, “What was the underlying message and meaning of the material?” (Fagerström, 2006). From this study, we see the complexity of nursing care.

Domm, Smadu and Eisler surveyed 508 health care workers using a stratified random sample of front-line healthcare workers, board members and CEO’s from Saskatchewan’s regional health authorities. A web based survey, focus groups and workshops were conducted to gather information about workplaces. From those results, barriers to developing high-quality health-care workplaces were identified including: ineffective leadership, poor communication, low morale, lack of respect and trust, too many hierarchical structures, increased size of health regions, lack of information technology, excessive overtime, insufficient budget and excessive workloads (Domm, Smadu, and Eisler, 2007).

A study of workforce issues in nursing in Queensland 2001 and repeated in 2004 was undertaken by Hegney, Eley, Plank, Buikstra and Parker (2006), with the aim to identify the factors having an impact upon nursing work, and to gather data on satisfaction of nurses’ working life to aid in strategic planning. A survey with 77 questions regarding

nursing employment, working conditions, and experience was mailed to 3000 Queensland Nurses Union members, both male and female; 1349 nurses responded. Workloads were believed to be heavy, skills and experience poorly rewarded; work stress was reported as high, and morale was low. Skill mix was reported as being insufficient and time factors prevented nurses from completing their work.

The researchers concluded that in order to retain nurses these factors must be addressed or face large staff turnovers and increased "litigation against employers" who ignore international evidence about registered nurse to patient ratios. (p.1530)

A 2007 study of 300 Western Australia emergency room nurses was conducted to determine which stress-evoking incidents nurses perceived as most significant and whether demographic characteristics affect theses perceptions. Also, respondents were asked to discuss their debriefing experiences after a critical incident. Ross-Adjie, Leslie, and Gillman conducted a cross-sectional descriptive study using non-parametric testing to identify and rank workplace stressors and determine if demographic sub-groups ranked and identified stressors differently. Stressor were identified from literature and participants were asked to rank them. Violence against nurses was ranked number one with workload and skill mix second. Critical incidents, death and sexual abuse of a child was ranked third, fourth and fifth. Most (60%) of that participants reported that critical incident debriefing is not routinely part of their work place. Nurses stated in order to deal with critical incident stressors, debriefing should be mandatory not optional and be conducted by professionals with specific training. (p. 118)

Silén, Tang, Wadensten, Ahlström (2008) acknowledge healthcare systems are undergoing continual change. Qualitative interviews were conducted with 21 neuroscience nurses discussing workplace distress, managing distress and ethical

dilemmas, and quality of nursing care. Workplace distress was identified as demanding and stressful work situations, lack of control over the work situation, shortage of resources, concern for the quality of nursing and lack of co-operation among patient, families and staff all contributed to stressed workplaces. The participants felt that the workload was too heavy in which fatigue, exhaustion and frustration carried over into leisure time. Nurses with less experience felt tension when they started as wished for "adequate introduction to their new workplace" (p.224). Relatives of patients also placed greater demands on the nurses that they were not always able to achieve.

Administrative work was also seen as increasing the burden as was inadequate work space. Reorganization and department changes created uncertainty among the nurses and "required a great deal of energy" (p.224). Inadequate salary was also mentioned and work schedule was also a point of stress. "Lack of communication and lack of cooperation with other healthcare team members lead to stress, nurses felt they were not appreciated by physicians and not respected as professionals". (p.225) Ethical dilemmas concerned decision making about patient treatments and the exclusion of nursing input. In order to manage these stressors tended to turn to each other for support.

Summary

A knowledge gap remains in identifying factors that can be enhanced and encouraged in order to foster exemplary nursing practice. The many descriptors, often used interchangeably by researchers when attempting to define nursing practice, draws attention to overlapping components making it difficult at times to separate good, expert, quality and expertise into separate categories, be they extrinsic and system based or intrinsic and involving personal attributes. However, based on this review, the

exemplary nurse is one who excels in the provision of care, one who stands out in function at a higher level above and beyond her/his peers. These nurses are the role models other nurses admire and strive to emulate. They act as exemplars to assist others in their journey toward excellence filling colleagues with pride (American Nurses Credentialing Center, 2009; Kendall, 1999; Styles, 1990).

This study permitted nurses to voice what they saw as the attributes of an exemplary nurse. A qualitative study of peer nominated registered nurses enhances an understanding of exemplary nursing practice from the perspective of nurse peers and the nurse nominees themselves. In view of the existing data it is important to give registered nurses a voice in determining what factors are present to allow exemplary nursing practice to continue and flourish. This qualitative study privileges the voices of nurses and further contributes understanding and knowledge to the existing literature.

It is well documented that nursing is multi faceted and fraught with demands and stressors. Moral dilemmas and burnout are but two of the recognized deleterious outcomes. These stressors impact not only the individual but the workplace as a whole and cannot help but adversely affect patient care. Literature indicates little progress has been made in dealing with workplace stressors in the past decade. Significant stressors continue to be identified across the nursing spectrum.

Chapter 3

Methodology

Introduction

The research design of this qualitative study was exploratory and descriptive. It was chosen as the best fit to allow nurses to express their perceptions and intimate knowledge of the subject. This design is in keeping with the aim of understanding how registered nurses identify and define exemplary nursing practice within the context of a stressed workplace. Much has been written on the negative aspects hindering nursing care; the aim of this study was to focus on the positive contextual factors that promote exemplary nursing practice. Appreciative Inquiry methodology identifies what is positive, "seeks out the best of 'what is' to help ignite the collective imagination of 'what might be"' and 'what should be' (Cooperrider, Whitney, Stavros, 2008, p. XI; p.16). Cooperrider and Whitney, 1999, state "appreciative inquiry involves the art and practice of asking questions that strengthens a system's capacity to heighten positive potential" (p.10). With this positive focus in mind, the Appreciative Inquiry method of seeking out the positive was applied to the questions posed to the participants in the interview guides and in interpretation of the data collected.

Ethics, purposeful sample selection, person-centered interviewing, inclusion criteria, data analysis, trustworthiness, validity, bias, limitations and dissemination are also addressed within this chapter.

Personal Philosophical Stance

Nurses are best able to identify exemplary nursing in their peers and on specific units. This approach was different from much of the existing research, which tends to focus on the perception of the patient or views of nursing supervisors. To further explore exemplary nursing practice, it was important to extend this insight by adding the perspective of nurses and their peers to deepen and augment our understanding of the phenomenon. “Good” nursing care has been constructed for nurses throughout their nursing education in a task orientated way. I also come from a nursing education perspective focused on the right and wrong way to do things; there are rules that must be followed. As a nursing clinical educator, I recognize that along with competent decision-making and skill level, there is a necessary human component. I do believe that nursing is not solely an art or purely a science but something much more when the two dimensions are combined. Exemplary nursing practice moves past “good” to a higher level whereby nursing practice is emulated.

Ethics

The proposal was submitted for ethical review to the University of Lethbridge Human Subject Research Committee and also to the Chinook Health Research Committee to ensure that ethical principles and standards were met and the rights of the participants protected (Appendix A, B).

The following are the main ethical considerations within the proposal. Permission was sought from Chinook Health Research Committee to recruit participant nurses within the workplace. A copy of the information letter for both nominators and nominees was provided to the research committee. Confidentiality and anonymity of

participants was maintained by assigning each participant a number code when referencing the data. Transcripts were coded with a numeric identifier, assigned at the time of consent to replace a name to assure anonymity of the respondent. Raw data in the form of transcripts, and tapes were kept under lock and key in my home office in Lethbridge, Alberta for the duration of the project. The transcripts will be securely stored for five years, and at the end of five years all data will be shredded and destroyed as confidential waste.

The interviews were conducted in the summer and fall of 2010. All participants received a full explanation of the research study. The purpose and procedures of the study was explained by myself to each participant prior to interviewing her. At this time the participant was reassured regarding steps taken to maintain confidentiality, anonymity, and security of information gathered. The participant was made aware that engagement in the study was voluntary, and each interview lasting approximately one hour at a mutually agreed upon location. The interview was audio recorded (with permission) for accuracy and transcribed exactly as spoken. Participants were made aware when agreeing to participate, and again when they signed the consent form, that they had the option to withdraw from the study at anytime without negative consequences and all data collected would be destroyed as confidential waste. As well, the offer to stop the audio recorder at any time during the interview was made. Verbal and written consent (Appendix C) was obtained prior to each interview and consent obtained for audio recording of the interview as well. The participant was again reassured regarding steps taken to maintain confidentiality, anonymity, and security of information gathered. Thorne (2004) describes informed consent as "consent which is *knowledgeable*, exercised in a situation of *voluntary* choice, made by individuals who

are *competent* or able to choose freely" (Thorne 2004, p.161). Participants were made aware of the researcher's identity and nursing experience. This provided the base for building trust between researcher and participants. Bowling, (as cited in Darra, 2008) identifies that "it is now generally accepted that if the interviewers are to practice ethically, then they must reveal their identity and something of themselves…in order to obtain true informed consent and the required in-depth, qualitative data" (Darra, 2008, p.253).

McCormack (2003) is direct in stating when using person-centered approaches, disengagement needs to be planned. "The 'hit and run' approach to research participants is not person-centred but is instead one of abuse of another person's humanity as it reduces them to a level of object that serves to meet another's (the researcher) end" (p.185). To aid in the disengagement process, participants were offered the choice to receive copies of their transcripts and/or an executive summary of the findings by ticking a box on the bottom of the consent form.

Method

To allow nurses to express their perceptions and intimate knowledge of the subject, an exploratory, descriptive, qualitative design was chosen as the best fit for this study. "Qualitative research is being increasingly recognized as an essential way through which to understand experiences of health care and address gaps in current knowledge" (Banner et al., 2008, p.24). Qualitative interviewing allows a view of individual perceptions and reactions known only to those to whom they occurred (Weiss, 1994). The goal of qualitative study is to understand rather than measure, as is the case with quantitative methods. Sandelowski (2010) feels qualitative analysis is the least

interpretive as data is presented in the voice of the participants, rather than being represented using different language, vocabulary or meaning by the researcher (p.78).

The research questions directing this research were:

1. How do peer nominators define, observe, and identify, their colleagues as exemplary nurses?
2. How do peer nominated nurses describe and reveal their own exemplary practice?

The study focused on an actively working nurse population within Southern Alberta. Two purposeful, judgement samples were sought: One of peer nominators, who were asked to identify by nomination, the study population of exemplary nurses. The second purposeful, judgement sample was the exemplary nursing practice nominees.

Judgement samples are used when a "person in the sample is judged to have the right knowledge or information" pertaining to the study (Procter & Allan, 2006, p. 186). "Judgement samples can be derived purposively to access specific expertise" (Procter & Allan, 2006, p.186). Weiss (1998) agrees that the researcher "would do best to interview people who are especially knowledgeable or experienced" (p.17) in the area of study.

To distinguish and recruit participants the use of a letter of introduction and request for nominations (Appendix D) was personally given out by this researcher to N=20 Registered Nurses with five or more years of nursing experience working within hospital units in Southern Alberta. If these Registered Nurses expressed an interest in participating in this study, they were asked to nominate their peers whom they identified as being exemplary nurses. From these twenty Registered Nurses, nine nurses agreed to

participate in the study as nominators. An attempt was made to involve both male and female nurses; nurses from diverse clinical units; and nurses with varying years of experience, to more fully understand the phenomenon and particularly if any of these factors are reflected in the participants view of exemplary nursing practice. The aim, research questions, and details of the study were thoroughly explained to the nominators by a letter of invitation, in person by this researcher and all questions were answered. The nominators were then asked to directly contact prospective participants and present their nominee with a written invitation (Appendix E) to participate in the study. Use of referrals or a snowball effect was encouraged, aiding in the recruitment of nominators and nominees who could speak to the phenomenon of exemplary nurses and enlarge the scope of participants beyond those known to the researcher. Those nominees interested in participating in the study were then asked to contact this researcher by phone or e-mail for further explanation of the project, purpose of the research, what would be required of each participant during the study and to set up an interview appointment. In advance of the interview, research questions were given to the participants either in hard copy or in e-mail format to allow them time to reflect on exemplary nursing practice.

To provide richness and greater understanding of the topic, the nominators were also asked to participate in a person-centered interview to enable understanding of what identifiers they saw in their peer that distinguished them as an exemplary nurse compared to other colleagues. By hearing the views of both nominator and nominee greater understanding was achieved to comprehend the experiences described by the participant and as well as observer (Weiss, 1994).

The person-centered interview is a valuable method of gaining insight and understanding of the personal experiences of the interviewee as they relate to the

phenomenon. Levy and Hollan (1998) state the interviewee can be both an informant on the topic in which he or she describes a phenomenon, as well as acting as a respondent in providing personal experience of the phenomenon.

Following the interview, both nominators and nominees were asked to fill out a short demographic information sheet (Appendix E) addressing; gender, age, education, type of nursing unit, and years of nursing practice. This revealed any overlapping or common features of the participants as well as identified dissimilarities. One question from the original demographic questions "What unit do you work on?" was removed at the request of Chinook Regional Research Committee. "Presentation of contextual background material, such as demographics and study setting, is necessary if the reader is to be able to ascertain for which situations the findings might provide valid information" (Malterud, 2001, p.485-486). Weiss (1994), maintains that requesting demographic data at the beginning sets the wrong tone for the interview, one of question and answer; 'just the facts'. This makes it harder for the interviewer to establish a relaxed atmosphere and a "full, detailed account of the phenomenon (p.51).

In order to ensure comprehensiveness and trustworthiness, peer nomination, person-centered interviews, audio recording of interviews, and observation documentation were used to gather data. In addition, verbatim transcription of interviews by an accurate and experienced transcriptionist and member checking for accuracy was meticulously carried out. Participants were contacted by phone or e-mail one week following the interview to give them an opportunity to voice any further recollections or comments if they wished. Member checking was carried out by phone or in person, with those whose responses required further confirmation or understanding. Documentation of the data analysis process and findings was carried out in detail (Harvey-Jordan & Long, 2001).

Selection and Interview Process

"An in-depth study of a particular phenomenon involves an intensive and detailed exploration of a relatively small sample" (Forman, Creswell, Damschroder, Kowalski & Krein, 2008; p.767), as opposed to the large sample size needed to generalize findings to a population in quantitative studies. "Because sample-size is not an intrinsic feature of the analysis in qualitative research there is very little guidance on the size of samples. In most cases the resources available and the feasibility of obtaining the sample combine to determine the size" (Procter & Allan, 2006). Saturation of findings, when no new information emerges, can also guide the final size of the sample (Corbin & Strauss, 2008; Creswell, 1998; Weiss, 1994).

Purposeful judgement sampling of N=17 practicing Registered Nurses provided rich data and understanding of the phenomenon of exemplary nursing practice. Nine peer nominators (N=9) were interviewed individually to determine what they viewed as exemplary nursing practice. Eight nominated nurses (N=8) were also interviewed separately to acquire understanding as to the nature of their practice and provided a wide range of perceptions and practices. A ninth nurse was nominated but did not respond to the invitation to participate in an interview.

Inclusion Criteria

Inclusion criteria: Nominators were selected who had five or more years nursing experience. There was no restriction in the number of years worked by the nominees, their age, gender, specific nursing unit, or limitation to full or part time status. Part-time nurses may be exposed to the stressed workplace less than full-time nurses by nature of their part-time hours. Participants were practicing Registered Nurses, they spoke and understood English thereby ensuring accuracy regarding the phenomenon of interest.

Interviews were conducted at a mutually agreeable time between researcher and participant. The location was one of the participant's choosing, as long as privacy could be maintained to ensure confidentiality and the freedom for the participant to be as candid and open as possible. The interviews occurred outside of the hospital environment and not during the participant's regular workday, which encouraged a more relaxed atmosphere.

"An interview is a conversation that has a structure and a purpose" (Kvale, 1996, p.6). The interview is "an event-taking place between two people with one attempting to elicit something of the other's perceptions, experiences, beliefs, knowledge or story" (Darra, 2008). Tod (2006) describes interviews as having "the capacity to describe, explain and explore issues from the perspective of participants" (p.338). Kvale (1996) states "the research interview is not a conversation between equal partners, because the researcher defines and controls the situation", by posing the topic, questioning, and attentive listening (p.6).

The interview guide is less structured than an interview schedule which contains preset questions that all participants respond to (Ryan, Coughlan & Cronin, 2009, p. 310). Using a less formal, more relaxed, semi-structured interview format was undertaken. The semi-structured approach was preferable as the aim was to allow the participants to express their own individual feelings and practices. The interview guide served as a base to build from, and revealed areas that required coverage (Weiss, 1994). These questions were not necessarily asked in the same order for each interview, but were asked of all participants to obtain consistency of basic information. This structure also allowed probing for more information or explanations as the conversation unfolded (Endacott, 2005; McCance et al., 2001, Weiss, 1994). An interview guide for

nominators (Appendix G) and one for nominees (Appendix H) was prepared as a starting point to focus the interview. These interview guides comprised broad open-ended questions to allow the participant the opportunity to give voice to her experiences of exemplary nursing practice (Tod, 2006; Ryan et al., 2009).

To establish content validity of the interview guide, three Registered Nurses, not participating in the study, were asked to review the questions before administering it to participants. Feedback from these Registered Nurses suggested questions related to being, knowing and doing be added to the interview guide. These were added to the guide as reference points and the participants were asked to reminisce about a situation in their practice that revealed being, knowing and doing.

The first open-ended question for the nominators was, 'Can you describe a situation when you felt exemplary nursing occurred?' This guided the participant toward narrative examples and personal descriptors of the phenomenon without influence from the interviewer while still allowing flexibility to clarify and pursue comments for further understanding. Nominees were also asked an opening question: 'Would you please describe a situation where you felt exemplary nursing practice occurred?'

In order to help the participants reach a common understanding of 'exemplary', and focus on the phenomenon of interest, guidelines were included in the invitation to participate for both nominators and nominees.

> You are invited to nominate a nurse who goes above and beyond:
> A nurse who is an example of exemplary nursing practice,
> the nurse who serves as a role model to other nurses (see Appendix D).
>
> You have been nominated by a nursing peer as being an exemplary nurse!
> A nurse who goes above and beyond: a nurse who is an example of
> exemplary nursing practice; one who serves as a role model (see Appendix E).

This broad definition was repeated at the beginning of each interview to set the focus of the interview and to establish common understanding of the phenomenon of exemplary nursing practice.

Member checking was carried out on all data during the interview process and at the end of the interview to confirm accuracy of the content. This allowed the participant to correct or elaborate on points made during the interview. “Clarifying the meanings of expressions used during the interview will facilitate later analysis” and understanding (Kvale, 1996, p.100). Participants were contacted by phone, or e-mail, or in person one week following the interview to give them an opportunity to voice any further recollections or comments if they wished. Purposeful sampling of three members whose responses required further confirmation and understanding was also carried out. Copies of individual transcripts were shared with the participants and they reviewed them for accuracy. Final member checking was conducted by telephone contact and in person to ensure accuracy in the collection, recording, and interpretation of data. Member checking is an important part of data interpretation thus preventing any misrepresentation of the participants’ stories, or undue influence by the researcher in the interpretation. The three participants contacted confirmed accuracy of the transcription process and interpretation. The three participants were asked to read their transcripts containing content groupings to ensure interpretation coincided with what they were saying. These three participants were selected from early interviews to ensure research questions and analysis were capturing accurate data. None of the participants wished to receive a copy of their transcript but did wish to receive an executive summary on completion of the thesis defence.

Data Analysis

In order to maintain accuracy, develop meaning and understanding from the raw data, audio recording of the interviews was undertaken with consent of the participant. Transcription of the full audio recording was be done verbatim by a reliable transcriptionist within 24 – 72 hours after the interview, to capture not only the interviewees' thoughts, but my own observations as well (Liamputtong, 2009).

"Progressive subjectivity describes the process of the researcher scrutinizing and contemplating his or her prior and emerging assumptions and interpretations in relation to the project" (Coleman, 2001, p.ш). To recognize and minimize potential bias, my observations or field notes were recorded during and following the interview in order to capture my observations and feelings as they occurred during the interview. These field notes were added to the corresponding interview transcripts.

Repeatedly reviewing the recording refreshed recollection of the data and gave a more holistic understanding of the interview in the context it was conducted. Listening to the audio recordings and comparing them the transcripts gave a better sense of accuracy and understanding to the whole interview. This also identified any 'directing' or 'leading' on the part of this researcher requiring refinement of the interview process. Transcripts were read many times to ensure as complete an understanding as possible.

Thematic data analysis was applied to the data set. Burnard (1994) offers a "systematic method in analysing textual data" (p.112). He suggests that "by breaking down [textual data] into meaning units, developing a category system and grouping together ideas of a similar sort" meaning can be identified and accuracy maintained (Burnard, 1994, p. 112). Burnard (1994) refers to Mostyn (1985), who defines meaning units as "a discrete phrase, sentence or series of sentences which conveys one idea or

one related set of perceptions" (p.113). These meaning units are then categorized to identify patterns, similarities, and differences, which are grouped accordingly under a descriptive heading or category title (Burnard, 1994).

Analysing the data was done manually. A line-by-line content analysis was performed on the transcripts to ensure all the meaning units were identified from within the data. These units of meaning were then aggregated into categories as they emerged from the data. Categories were then grouped again to form major themes based on recurrence and repetition. By making connections between main categories, it is suggested that themes can be readily identified (Greenhalgh, 2006; Liamputtong, 2009; Shin, Kim & Chung, 2009). These themes were then reviewed for their association with the conceptual framework and to form explanations for the findings. Unique findings, categories, or contradictions that did not readily fit within the major themes were reviewed for accuracy. Specific questions were added to the interview as relevance emerged from the data. The phenomenon of false praise was added to later interviews in the form of a question regarding recognition and its importance; this question was asked of both nominators and nominees. Analysis of each interview was undertaken as soon as possible to its completion to assist in accuracy of content interpretation. Overlapping of interviewing and analysis stages "allows the analysis to guide subsequent data collection, whether through theoretical sampling … or through amending interview/observation instruments to ensure emerging areas are explored" (Endacott, 2005, 126). "The new data collected by the modified interviewing then produces new analysis" (Weiss, 1994). The opinion and insight of my supervisor and eventually my committee members was sought throughout the data analysis process to ensure that focus was accurately maintained in categorization of the data.

Trustworthiness / Validity

Guba and Lincoln (1989) outline criteria for ensuring trustworthiness and validity in qualitative research. To establish credibility, participants were invited to review their transcripts and analysis as a member check for accuracy. Providing thick description and sufficient data to allow for transferability, will enable readers to evaluate if the findings are applicable from one context to other similar contexts. To ensure dependability, note taking or tracking of any changes in the way the study was conducted and consistency in the data analysis was undertaken. Guba and Lincoln (1989) maintain, "changes and shifts are hallmarks of a maturing – and successful – inquiry" (p.242). Confirmability and objectivity of data was maintained by assigning an identifying number to ensure data could be traced back to the original source, and interpretation verified using peer checking to review analysis while maintaining anonymity of the participants.

Validity is used to determine "whether the findings are accurate from the standpoint of the researcher, the participant, or the reader's account" (Creswell, 2003, p.195).

Creswell (2003) outlines strategies to check accuracy of findings and ensuring trustworthiness. I followed the strategies presented throughout this study.

- Triangulation – using several different data sources, using multiple data analysts or multiple data collection sources to justify themes. Both nominators and nominees were invited to share their knowledge of the phenomenon. Nurses from a number of hospital units were approached for recruitment of participants. Data analysis was reviewed by my supervisor and committee members.

- Member-checking – taking data and major themes back to selective participants to assure accuracy and that the interpretation is reasonable. Two members who were able to recount situations in a rich and descriptive way were purposefully selected from the, nominators and nominees. The participants contacted did not have anything further to add and confirmed transcripts and interpretation were accurate.
- Use of rich, thick description to set the stage for the reader to engage in the experience.
- Spending prolonged time in the field. In this case frequent reviewing of the recorded interviews and verbatim transcription for familiarity of content and accuracy.
- Peer-debriefing with an advisor to review and ask questions.
- Use of committee members to review and assess throughout the research process.
- Progressive Subjectivity. Use of reflective notes during the interview process to record personal feelings, opinions and observations. These observations were included in the transcripts of corresponding participants.

Bias

Bias is described as, "the systematic influence of factors other than those being investigated" (Gerrish & Lacey Ed., 2006, p.535). Within research it should be minimised. Although interview data may be used as evidence about people's perceptions and understanding, it is pertinent to remember that responses may be shaped by variables such as if and how the interviewer has influenced the interviewee, and the

level of trust and rapport between the two people" (Ryan, Coughlan & Cronin, 2009, p. 309).

Coar and Sim note when interviewing peers, the need by the interviewee "to project a positive professional identity to a colleague may mould the informant's responses, especially when the objectives of the study bear upon professionally sensitive or contentious issues" (p.255). There was the risk for potential bias if the participants answered in a manner they thought was expected rather than how they truly perceived their nursing practice. Every effort was made to establish a relaxed atmosphere and comfortable environment for the interview process. An interview guide was used to define the phenomenon of interest and provide a starting point for the interview. This orientated the interviewee without influencing a particular kind of response. Participants were direct and forthright in their responses, they spoke from their hearts, with a sincere caring for the nursing profession, voicing both good and bad reflections of their nursing practice. They did not give the impression of trying to please me with any particular kind of answer.

Limitations

Limitation of the study by way of judgement sampling prohibits the findings from being widely transferable, as nurses work in many diverse situations and unique conditions and not all situations have been studied. The findings will provide for understanding of the phenomenon as related to this specific group of exemplary nurses and their nominators (Weiss, 1994). In qualitative research, and in relation to transferability of the findings, it is the consumer (or user) of the findings who determines

the “fit” with local contexts. It is also recognized that some conceptual universals were discovered in the findings and that there is relevance beyond this immediate study.

It is acknowledged that nurses do not always have a common language to describe their expertise (Benner, 1984; Hardy et al, 2002). Literature reviewed established this point with the use of good, expert, exemplary, star, being used interchangeable in an effort to articulate nursing care. A baseline definition of exemplary was provided to participants in the letter of invitation and again at the beginning of the interview to provide focus and direction. A concerted effort was made for consistency in the use of words and their meaning; clarification was sought from participants to ensure clear meaning.

By using snowball sampling it is acknowledged that those nurses who have fewer social contacts may be underrepresented as they may be unrecognized as they go about their work (Weiss, 1994).

Dissemination

Dissemination of information was undertaken by sharing preliminary findings with committee members. Following thesis defence, feedback in the form of an executive summary of findings will be sent to participants who indicated they would like to receive one on their consent form. Articles will be submitted for publication to the Canadian Nurse, and Creative Nursing: A Journal of Values, Issues, Experience and Collaboration.

Summary

This research design has been driven by the nature of the research question, and an incomplete understanding of exemplary nursing practice present in the literature. Person-centered interviewing was selected to understand and interpret the everyday experience of the exemplary nurse, using her own words. It is important to position both the nominator and nominee's perspective in order to take advantage of both perspectives; as that of observer and the observed to gain a comprehensive understanding of exemplary nursing practice.

Informed consent was obtained prior to beginning and again before recording of the interviews. Every effort was made to ensure the confidentiality of participants and security of data collected. Participants were sincere and forthright in their comments and concerns regarding exemplary nursing practice.

A concerted effort was made to be consistent in the use of words such as good, expert, excellent and exemplary in order to avoid confusion for participants and readers. A brief definition was given to all participants to give clear meaning to the focus and meaning of the exemplary nurse.

Transcripts were read multiple times to ensure understanding and meaning of the data collected. Member checking was carried out to ensure accuracy in understanding and interpretation of data.

Chapter Four

Findings

Introduction

Findings specific to this study are identified within this chapter as well as the demographics of those who participated in this research. Nurse perceptions of exemplary nursing practice were revealed by person centered interviews with both nurse nominators (N=9) and exemplary nurse nominees (N=8). Nominators identified not only exemplary nursing practice, but also factors that undermined the provision of exemplary care. Nominees revealed personal philosophies and an ability to transcend or overcome undermining factors.

Data were analysed separately for each group of nominator and nominee. Only one difference was noted regarding exemplary nursing practice and barriers undermining it. Nominators raised the issue of fragmented care that was not mentioned by nominees. The consequences of exemplary nursing practice faced by exemplary nurses was noted by both nominee and nominator group of nurses.

Participants felt very strongly about exemplary nursing and the nursing profession as a whole. During the course of the interviews, many became emotional with despair at the factors they saw as undermining exemplary nursing practice. Frustration was palpable as they shared some of the nursing situations that they encountered on a daily basis. Their desire to provide exemplary nursing care was evident. Both nominators and nominees deeply reflected upon the phenomenon of exemplary nursing care.

The Participants

Seventeen female Registered Nurses who work at the bedside providing direct patient care in three Southern Alberta Hospitals were interviewed; nine nominators and eight nominees. All participants [See Table 2] were women, with ages ranging between 30 - 60 years; the mean age was between 51-60 years. Nominators were older than 46 years of age. Nominees ages ranged between 30 and 60+ years. Years of work experience spanned between 21 and 40 years for nominators and between 8 and 40 years experience for nominees. Both full and part-time staff were interviewed, six full-time, 11 part-time. Educational standing which was slightly higher for nominees included nine participants who attended two and three-year nursing diploma programs, five baccalaureate and three Masters prepared nurses. Six participants had additional nursing certifications above those required for employment in their specific area.

Table 2: Participant Demographics

Number of Participants	*N=9*	*N=8*
Characteristics	**Nominator**	**Nominee**
Age		
30-35 years	0	1
36-40 years	0	0
41-45 years	0	1
46-50 years	2	1
51-60 years	7	4
>60 years	0	1
Total	**9**	**8**
Years as RN		
1-10 years	0	1
11-15 years	0	0
16-20 years	0	1
21-25 years	1	1
26-30 years	3	1
31-35 years	4	1
36-40 years	1	3
Total	**9**	**8**
Education		
Nursing Diploma	6	3
Bachelor	2	3
Masters	1	2
PhD	0	0
Additional Certificates	3	3
Full Time	3	3
Part Time	6	5

Findings: Being, Knowing, and Doing

Findings of the study fell naturally into the thematic areas of Being, Knowing and Doing; this became evident when analysing the individual responses. These descriptors were in keeping with the work done by Marilyn Stiles (1990) where she identified the descriptors of being, knowing, doing, giving and receiving, and ways of welcoming of a stranger, in relation to Hospice Nurses and the spiritual nurse-family relationship. Kendall (1999) adapted these descriptors in her efforts to “provide a framework for the

overall description of the ‘star’ nurse within oncology nurses, but also to allow for readily identifiable components of the whole” (p.118).

Nurses in both categories of nominator and nominee had similar ideas of the characteristics and practice qualities of exemplary nurses. The emergent categories were not established apriori; rather when analyzed, the data ‘spoke to’ Being, Knowing and Doing. Being comprised a relational approach to patients including: communication with patients, physicians, and colleagues; touch; mentoring; leadership; and a genuine love of nursing. Deep knowing or intuition involved: anticipating patient care or needs; patient perspectives of knowing; life experience; and knowledge base. Doing, encompassed: nursing practice; nursing skill; teamwork; and acting as an advocate for both patients and colleagues [see Table 3]. Because the sample was women, I refer to the nurses as “she” throughout the findings. Of course, there are exemplary nurses who are men; however, they were not the focus of this study.

Table 3: Thematic Findings: Exemplary Nursing Practice

Being	Knowing	Doing
Communication: patients physicians colleagues Touch: Connecting with Patients Leadership, Mentoring and Respect Genuine love of nursing	Deep knowing or Intuition: Wisdom Knowing from the patient perspective Life experience	Nursing practice Nursing skills Teamwork Advocate

Exemplary nursing practice

Being: Relational approach to patients

An exemplary nurse is one who is genuine, welcoming, and open with patients and their families. This nurse has a genuine love of fellow human beings, uses her heart and her intelligence in sincerely caring for others. This nurse helps patients to allay their fears, and to discover their own strengths. In doing so, the exemplary nurse empowers the patient and fosters hope. The exemplary nurse respects the patient perspective, is kind, and includes family members in care and decision-making.

Fundamentally, exemplary nursing practice is characterized by a relational approach with patients. These nurses entered into authentic relationships with their patients. Participants identified that empathy and compassion were central to exemplary nursing care and were characteristics of authentic relationships.

These nurses also had the ability to create a caring space in which they instilled confidence and trust with the patient. Participants identified that patients felt secure in this caring space. Within this caring space, a therapeutic relationship entailing individualized nursing care was offered to each patient. All participants mentioned that the exemplary nurse is non-judgemental when providing nursing care.

The exemplary nurse cares with all her being. Caring is embedded in everything that she does. The exemplary nurse is an advocate for patients.

> I think an exemplary nurse is one who cares from the deepest, darkest, part of her soul, she cares. From the lightest part of her brain, she cares. From the widest part of her ability, she cares. Whoever that person is, they care and that is the big thing, they care enough to learn, they care enough to there, and they care enough to do their very best. I think that is what an exemplary nurse is. (Nominee 3, line 589-596)

> An exemplary nurse would put her patients first; above her own needs is probably one of the big things. She would advocate for her patient with the

> doctors and the other staff. The main focus of her entire day is what that person needs to get better or to get through whatever situation has happened to then in the hospital. Patient focused. (Nominator 8, line 30-36)

Patient care is the focus of all that she does. Such care is patient-focused and individualized. Exemplary nursing care entails seeing the patient as a person, and not simply focusing on physical assessments.

> An exemplary nurse would be a good nurse who has good skills, but that also has the ability to really match what the patient needs at that time. (Nominator 1, line 279-281)

> Knowledge, skill, they have the ability to see, they have a good heart. They are kind and they look beyond what is in front of their face. They look at the whole person. (Nominator 7, line 94-96)

Exemplary nursing is not one act, rather exemplary nursing is revealed in all interactions with patients. Exemplary nursing is a matter of the heart, the spirit, and the mind (intelligence and knowledge). Each of these dimensions of being are necessary in order for exemplary nursing to take place.

> Every nurse does something that is good, they pick things up, and you will say good catch or whatever. I do not think exemplary is one act. I think it is the way a person relates to all their patients. It is knowledge based and it is skill, but it is heart too. You have to have all three. For example when XX looks after a baby, she does not look after a condition she looks after a whole family. (Nominator 7, line 8-15)

> A good nurse provides care that a patient needs. An exemplary nurse provides care that the patient has to have and that goes to mean. I do your blood pressure, I do your vital signs, I do your assessments, I check on you, I do my charting. An exemplary nurse takes time to actually look at the patient, hear the patient. Think in her mind, or his mind, is what they are telling me in line with their diagnosis, with their meds, with what I am doing with them and what my expectations are. If not then you go to the next step, you go maybe to further assessment. A good nurse will do patient teaching, provide them with all the things that they need. An exemplary nurse will make sure that they understand that teaching… they just don't stop when they are done the basic stuff, they keep going. (Nominee 3, line 366-393)

The exemplary nurse is confident in herself. There is also a comfort level in all that she does. The exemplary nurse is professional, but remains emotionally accessible.

> When someone is truly an exemplary nurse I don't think in the big picture [consequences] it matters. Because they are confident in whom they are, or they would not be an exemplary nurse. They are comfortable in what they are doing. I think it probably has its moments that you may feel like you are out of your element, like you don't feel part of the group. You are more isolated. I think if you are an exemplary nurse, you are not going to lower your standard because Joe Blow that you work with doesn't pull her weight and doesn't do her job. (Nominator 8, line 139-149)

> Part of being an exemplary nurse is personality, which is why we have chosen to be nurses, most of us. Because that is part of our personality, that caring, being sensitive, a little warm and fuzzy, not totally, but underneath. I think there is always that. Just that caring about other human beings and what happens to them. (Nominator 8, line 461-466)

> I try to be just like her. I guess just her professionalism and she is very quietly confident and very efficient with what she does. She is very smart, she is patient, and she is a pretty good listener. She listens to her patients and looks after them, anticipates their needs. (Nominee 1, 113-118)

> I have tried to think of my patients as a family member. I mean it is hard sometimes, but to keep emotional distance enough so you can still do your job in a very caring and efficient manner but keeping your emotions a little distant so you don't lose sight of what is best for them and that you don't get all emotionally tied up. (Nominee 1, line 133-140)

Patients quickly come to know that the exemplary nurse is 'there' for them.

> [EN] It is someone who can walk into a room and immediately tune into that individual and make that person feel special. I am here for you. I think that is what each patient deserves because they are in a stressful situation. If they are just a number: We don't like to feel like just a number and I am sure the patients don't. (Nominator 7, 52-58)

Relationships are made; such connections are established by looking the patient 'in the eye' and engaging in touch. Exemplary nursing is about full and authentic relationships with patients. Exemplary nurses connect with patients in the moment.

> They always look the patient in the eye. They often put a hand on them. They carry a demeanour of professionalism and caring and sometimes, even crying with the family. (Nominator 4, line 18-21)

> Just taking the time to sit with parents when their son or daughter has gone off to the operating room, they are scared and crying. You can offer them a drink, a hug, whatever is needed, listen to them, explain that the patient is in good hands and everything is being done…Just letting them know you that we are there for them at any time to help them in any way we can. (Nominator 4, line 283-296)

Sometimes this connection defies words; the nurse and the patient just 'are' together.

> That is usually the time when there is a loss or someone dying. That is more often when we have the real connection in that way that we don't use words. (Nominator 8, line 167-170)

The exemplary nurse recognizes moments of significance within the lives of her patients. She assists patients to understand such moments to become aware of what is happening. These are powerful moments, and the exemplary nurse understands what is at stake for this patient, this family.

> I was in the room with the family, we were just talking a little bit, I was doing my assessment out of the corner of my eye, just checking on how he was doing and I could see his respiratory status changed. I had been in the room for quite a while already and you know, I kind of changed my focus and looked more directly at the patient. The wife was sitting in the chair and so I just said his respiratory status, his breathing is changing. He was very close to death and I said 'I think he is going'. He did pass away within a few minutes. I just quietly told them what was happening so they knew step by step. That his breathing was going to slow down and then there was going to be some gaps in breathing and that is what happened. I think the family really appreciated knowing that and we just talked…well they didn't really talk, I just kept talking. Telling them his breathing was going to gradually slow down and he just slipped away. It made it less stressful for them I guess. (Nominee 1, line 173-193)

> A good nurse is one that actually thinks she is a good nurse when they run out there and get all their assignments done, and all their vital signs are charted, and they are at the desk and all their work is done. Yah, you are a good nurse. You actually did what you are supposed to do. An exemplary nurse understands that is just the bicycle you are riding it's time to sing…to do the little extra things. (line 1241-1248) It's about the cup of tea, it's about bringing them a glass of water, it's about fluffing their pillows, it's not about the IV meds, it's not about getting my jobs done, that is part of my job I have to do. You have to ride the bike first, then you can sing by doing the little things for patients. (Nominee 7, line 1047-1052)

> So the little things that I do, making sure I invite the dad over right away and not being too busy to invite that camera taking moment. "Come over and touch your baby". Tons and tons of moments are available to us, if we pick them up. Sitting with someone as they digest the cancer diagnosis. Bringing that cup of coffee to that 60 year old man who has just found out that his wife has ovarian cancer are huge powerful moments that I witness, nurses sitting in the room, standing in the room, bringing a warm blanket, sitting down, just being in the room as a resource person. (Nominee 7, line 662-677)

Communication

Key to exemplary nursing was good communication along with being a good listener. The need to truly listen to patients and not impose one's views upon a situation was important to participants. Seeking and accepting of others' perspectives was instrumental to continued learning. Communicating well with patients, especially in urgent situations was an important characteristic of exemplary nursing practice. In addition, communicating clearly with physicians and colleagues was noted as important. Complete and concise reporting was critical when sharing information between colleagues and disciplines. Such communication served as the basis for exemplary nursing care.

Exemplary nurses are engaged in honest and transparent communication with patients, especially during urgent or difficult care situations. The exemplary nurse factors in or considers all channels of communication when interacting with patients; verbal and non-verbal.

> I like being with people, communicating with people and the old thing about caring for people. I truly believe that is the best. I like to be there if they need something, whether it is the nurse I am working with, or the student I am working with, the client I am working with. That is the best part of what I see as having value. It is: how do I make them feel comfortable, what can I say to them, how can I touch them, what can I do to make this whole scenario work? It is that equalness. (Nominee 3, line 55-63)

> [She would] tell the patient what was going on even though things were going bad. I have seen her say, 'You know we are worried about the baby's heart beat, this is what we are doing. (Nominator 1, line 62-64)

> Communication would be high up there. A good nurse would probably give point blank information and an exemplary nurse would be able to interlink those communication skills and look at facial expressions, look at body language, see all the other communication factors. (Nominator 2, line 343-349)

> It is communication, but it is listening to people, hearing how they say things. Exemplary nurses go beyond communication; they use therapeutic communication to really understand where the patient is. (Nominee 3, line 397-399; 403-406)

Importantly, the exemplary nurse has learned to really listen to her patient. Sometimes being silent and listening to the patient can open up an intimate dialogue. Sometimes, in the silence, patients confide and share what is most at stake for them.

> Sometimes the thing to learn is not to talk. Learn to listen to what is being said and not always try to resolve the problem, because we can't resolve all problems. Being open for the patient to confide anything they need to in you. Being non-judgemental about what is being said or what has happened. (Nominator 4, line 73-79)

> Certainly, along with time and touch you need to learn to listen. I think you have to learn to observe, that is one of the things that I try to teach my students when I have preceptors. That I want you to be able to just look and listen, without even speaking a word. Then you should be able to tell what is going on in those people's heads and bodies and minds. I think that is part of it too, just the whole environment. (Nominee 6, line 161-168)

With respect to communication with nurse colleagues and physicians, exemplary nurses are solidly positioned in their communication stance. They are level headed and are effective in making their points. Physicians appreciate and rely on such nurses.

> [Exemplary nurses] The way that they were able to present information and the way they were able to stand up for themselves when there was a conflict between the them and doctors about a situation or a patient. Just watching how they dealt with it and being able to keep a level head and still make their points known are some of the things that I strive to achieve. (Nominator 3, line 272-279)

> It was that combination of working together. I think that is really the time we get good successes is when physicians and nurses are listening to each other and the

> patient is included in that too. I really believe physicians really count on and rely on senior nurses who have had lots of experience. (Nominator 3, line 471-477)

Touch

Touch was also an important factor mentioned by participants. Age or years of experience was noted as a barrier to using touch therapeutically. For example, older nurses were identified as being more comfortable in touching patients. These nurses recognized the need for touch and were not afraid to touch their patients when giving comfort or using touch in a diagnostic manner. Touch was also used to create a caring space. Hugging, holding hands, or palpating (clinical assessment) were all mentioned as examples of touch.

Touch was powerful way to connect with patients. Furthermore, touching patients was identified as a 'need' for the nurse; a human connection. Touch was also important in terms of assessment.

> I have to say mainly the older nurses seem not to be afraid to touch the patient, to hold the patient's hand, to give the patient a hug. (Nominator 1, line 71-74)

> I think as a nurse I need to touch my patients. I just can't rely on machines. (Nominator 1, line 98-100)

Touch also provided comfort to patients, as a demonstrative form of caring. Touch helped patients feel better. Nominees also recognized the importance of touch in nurses they observed as well.

> Just being able to help her with a backrub because she can't get up, and knowing in that little bit of comfort that somebody cares about how they are feeling. (Nominator 3, line 593-596)

> Most people, especially in critical situations just a gentle touch often makes them feel better, and I know that is how I feel if I have stresses going on as well. (Nominator 4, line 161-164)

> I didn't think I had really done anything for her but to her it was a big deal and that was just sitting in her room and hugging her, she was crying so I was hugging her. (Nominator 5, line 193-199)

> Even if there was no resolution to the problem – in the terminal phase of life it would be a nurse that had kindness and compassion and one that took the time to maybe hold a hand through the rough pain. (Nominee 5, line 127-131)

> She is just very kind and people love her. They will go looking for her, just because she is kind. It is not so much doing, accessing the port or whatever they have come in for that day, it is the touch, the talking and the connecting that goes with it. (Nominee 2, line 267-272)

> I see touch and time as being crucial to being an exemplary nurse. Maybe others don't see touch as being important but if that nurse took the time to pull up a chair beside the bed and looked me in the eyes and was willing put a cool cloth on my forehead or just talk with me for two minutes while I was crying, that is what an exemplary nurse would do. (Nominee 5, line 138-144)

The exemplary nurse engages in whole patient care. Touch fostered this holistic caring approach. Along with listening, touch was part of offering total nursing care.

> When you have somebody in a hospital setting, they are totally, basically, at your mercy. You are the one who is supposed to be following doctors' orders. You are the one who is providing them with care, but if you are not looking at the whole person, no matter how much care you give them, if you are not hearing them, helping them, touching them, listening to them, giving them what they need to know and do, as well as assessments, that is not total care. (Nominee 3, line 409-417)

One participant (Nominator) described touch as a gift. Not all nurses know how to make use of this gift. In contrast, exemplary nurses are clear about the use of touch with their patients.

> [Touch is important] very much so. I think again it is knowing when to use it. It is almost like a gift I think. Not that there are not a lot of good nurses, I am not saying that. It is just that, there are some that just know when to give that. They know when to put a hand on; they know when a person needs a shoulder to cry on. They know when someone needs a laugh. I think it is a gift. (Nominator 7, 145-152)

Leadership, Mentoring, and Respect

The willingness of exemplary nurses to share their knowledge about teaching, and mentoring was evident among the participants. Providing such information to fellow nurses and patients was recognized as important to exemplary nursing practice as well as nurturing colleagues to engage in exemplary practice.

Nurses sought out exemplary nurses as mentors. The exemplary nurses were not only knowledgeable, but they were friendly and perceived as open to the possibility of mentoring. Their personalities were such (for example, nice, humorous, not easily stressed, and easy to talk with) that other nurses felt comfortable approaching them for guidance or mentoring. Being a role model of professional nursing was noted by a nominee as important within the clinical setting.

> …She taught me a lot of skills that I know today, because I sought her out as a mentor. She was an excellent teacher and she also had a nice personality she was always humorous, she wasn't a stressed out kind of person that she could do the work no matter how heavy it was or how slack it was, a good role model. She was easy to talk to; to ask about deliveries, you know, taking care of patients. (Nominator 3, line 230-238)
>
> I think she was very well rounded and it wasn't difficult for her to make friends with people in different places. I think that part of her personality made it easy for me to seek her out as a mentor. (Nominator 3, line 252-253)
>
> One of the things that came up was to have patience to teach, either young students or new grads, because they don't know, they just have to be taught some of it. I think I am pretty empathetic. I have tried very hard to listen to patients and the family's needs, and then work together as a group for the greater needs of the patient and to find a workable solution whatever the situation might be. I work together with people. I try to have a quiet confident manner. I do use humour, I joke around with my patients quite a bit. I try and keep the patient as the main focus when I am at work. (Nominee 1, line 596-609)
>
> I think that if we want to have great nurses around us we have to become great nurses ourselves and role model that sort of behaviour while we are interacting with students. …In some ways I think that is where we need to role model behaviour, in the clinical area. There is in my mind, a big gap between what is in

> the textbooks about professional behaviour, communication and what actually goes on in the world. Nominee 7, line 1581-1598)

The majority of participants mentioned role modeling, leadership style, not being critical of colleagues, and mentoring. A calm and confident leadership role was important in role modeling for nurses. Colleagues reported observing the exemplary nurse. This observational mentoring was evident in how they modelled their own practice, applying things learned from observing the exemplary nurse.

> We still talk, on our down time we have discussions about how we did this or things that happened. Certainly when you do that, you pick up on who you think is an exemplary nurse. Maybe then you watch them a little closer and pay more attention to what they are doing, but we are not fostering that in our particular unit at all. (Nominator 8, line 593-599)

Nominees also reflected on what they had observed in other nurses who were exemplary in their practice.

> An exemplary nurse passes on his or her skills by setting an example for others. (Nominee 1, line 464-466)

> She was a great nurse! I was always drawn to people who were hard working, skilled at what they did, where it was almost effortless like they knew what they were doing like putting in an IV or quickly assessing a patient and getting it right. I would look forward to working shifts with her. (Nominee 2, 239-244)

Exemplary nurses treat people well. Their leadership style is described as ‘not bossy’. Exemplary nurses put themselves in the position of others and consider what is at stake for patients, co-workers, or physicians.

> Implementing her way of leadership…not being bossy or make people feel belittled in front of her. She always tried to put herself in the other person’s position, in their role as either the patient or her co-workers or the physician she worked with. (Nominator 2, line 22-27)

> An exemplary nurse would be able to critically think through a situation that needed attention in an expedient manner and be able to lead in that situation not become flustered or upset, be able to calm others down. To lead with confidence and assurance, lead by example. Do the best possible job you can within the circumstances, look outside the box for solutions. (Nominee 5, line 104-111)

They were also respectful of patients, nursing colleagues, and physicians.

> Exemplary [nurse] … in their manner and in their knowledge especially, also in the fact that they are respectful. Not only to patients, but to the doctors, and their colleagues. They don't criticize, or gossip. Their nursing skills are very acute and they are able to sense what any individual person needs at any time. (Nominator 4, line 43-49)

> I think a good leader would be exemplary in any situation. An exemplary nurse would have to be able to keep confidences, and maintain privacy. (Nominee 5, line 118-119)

Genuine l*ove of nursing*

A genuine love of nursing was a factor that was evident in the transcripts from both nominators and nominees. They spoke about the love of fellow humans and a genuine love of the art and science of nursing. There was a real sense of joy in the work of nursing. Because they loved their work, exemplary nurses were helpful to patients, peers, and students. They gave freely of their expertise. It was evident that among the exemplary nurses, nursing was much more than a job; it was part of one's being, one's life.

> [Two exemplary nurses] They loved what they did. They actually enjoyed being there. They took part. They helped the patients. They helped their peers. They helped their students. [This was said with such awe and passion] I couldn't ask for more, it was like watching…watching basically a gift come because you got to see them interact, they told you when you did things well and they showed you how to do it if you didn't. It was wonderful, wonderful play and you got to be in the front row seat. That was with both of them, they were just beyond words because they cared and they did so much. I get goose bumps still. (Nominee 3, line 81-92)

> I like making people feel warm and welcome. A lot of those people are in dire situations as cancer patients, and they know their therapy can control their disease but a lot of it isn't curable. So it is just taking a scared individual and welcoming them, making them feel warm and fuzzy. Letting them know this is a safe place. We will help you. (Nominee 2, line 191-197)

> I love what I do. I have always loved what I do or I wouldn't be doing it any more. I enjoy watching a new mom interact. I enjoy visitors. I really enjoy watching new staff see how exciting our job is. I think though, probably patients have to be number one, that is what I enjoy the most or I would not be here. (Nominee 6, line 93-99)

> I am really one of those nurses who really love nursing. Do I like getting up at 5 o'clock in the morning all the time? No, I am not a fool, I actually like to sleep in like everybody else, but I like my job, and I really get a lot of feel good and a lot of satisfaction from both jobs that I do. (Nominee 7, line 20-25)

> I take pride, every year I do my nursing registration; I do it early because I feel those are important things in my life. Without my nursing, I would probably lose part of my identity because it is very important to me. (Nominator 3, line 979-983)

> That exemplary practice to me means showing that love of fellow human beings on your face and not chastising or bring about hurtful comments either to the patient or fellow staff members. (Nominator 2, line 53-57)

> I think it is the hands on, because that is what nurses do, you get so intimate with people they trust you. To be able to just give that kindness and that caring is kind of important to me. That is when I get satisfaction from my job because that is what I want to do. I guess it is the healing part, the caregiver part of my personality. I don't know, but it is really important to me. (Nominator 3, line 596-603)

Summary of Being: Relational approach to patients

Being was 'thickly present' in developing and maintaining therapeutic relationships with patients, colleagues and physicians. Clear, concise, and timely communication was critical in all aspects and levels of patient care. Touch played an integral role in creating a caring, comforting, safe space for the patient in all stages of care. Mentoring, leadership and respect were critical to enhancing and encouraging exemplary nursing practice. A deep and genuine love of nursing underpinned all factors key to exemplary nursing practice as voiced by both nominators and nominees.

Knowing

Deep knowing or intuition: Wisdom

Deep knowing is the ability to take singular datum and interpret the whole patient care situation accurately. Exemplary nurses have the ability to assess a patient situation, attend to discrete pieces of information and, 'all at once' understand the whole. Exemplary nurses can discern and understand what is unique to the patient and then compare, contrast and integrate this unique understanding to their full corpus of experiential understanding. Critical thinking is important in anticipating the patient care situation. Exemplary nurses read the patient on multiple channels, using all of the senses and being ever aware of the patient's status. The exemplary nurse is holistic in her approach in caring for the patient and the patient's family.

> The more we know the more powerful we are for our patients. (Nominee 7, line 761-762)
>
> I think we always talk about senses; we have five senses. I don't believe that, I think we have more. It is called intuition, and I think it is also not only just intuition it is about being involved with provision of care over a period of time. You can see when someone is comfortable or not. Whether they tell you, they are or they aren't. Intuition I think is really pulled into what nursing is, because although we have all of our educational skills, and all of our practice skills, we also learn how to do intuitive things for our client. Because we can see what they are doing, and how they are reacting, and if it is not what we would consider normal for that particular point in time that they are we might know that something else is bothering them. So you might ask another question, or give them some different type of comfort measure, or offer it to them and see if they would try it, and see if that would help. That would be the intuition component. (Nominee 3, line 154-171)
>
> I see all kinds of nurses with intuitions on the maternal floor where those babies are not really presenting affected yet, but they have very subtle signs. They pick those up and there is where you have some conflict. Because heavens are you saying that this baby is sick with these subtle signs, and then are you crying wolf too early? There are the exemplary nurses; they don't have a problem crying wolf even if they are wrong. We get to be wrong, that's ok, I get to go home and sleep with that when I'm wrong, but if I don't raise the alarm and I am wrong, then someone else suffers. (Nominee 7, 866-878)

You start assessing them from the moment they walk on the unit and as you are walking them to the bed or bathroom… by the time you get them to the bed you already have a lot of their history without ever having met them before. You use all your senses when you are assessing, from vision, to touch, to even smell – if you have a diabetic patient that is ketotic, you can smell that right away. (Nominator 4, line 179-191)

[Exemplary Nurse] you can piece all the bits together. That comes again under experience, meaning, that it does not happen overnight. Exemplary nursing does not happen overnight. In a big way because you have to learn – it is predictive and you learn that this is what probably will happen, but you watching for the signs. Nominator 8, line 361-371)

I think a lot of nursing is done on feeling and often getting the doctor there in a timely fashion and having them 'hear' what you are saying. Sometimes when you are in crisis you don't get the message across as efficiently as you normally would. So I always like to take a deep breath and start giving the history first and let the physician know there is a crisis going on that we need his assistance for. (Nominator 4, line 94-102)

Knowing from the patient perspective

The patient recognizes the nurse's experience by her knowledge, understanding, and practice. The patient is attuned to the nurse, the mood of the unit, and is observant of the interaction among nurses and other health care providers. For the exemplary nurse, this knowing is attained by integrating Theory > Practice >Research as well as in the reverse Research>Practice and Theory. Patients and their family members are reassured by the exemplary nurse's knowledge and her application of it to the patient care situation. The exemplary nurse has the ability to integrate theory and research into practice. This knowledge base combines education, a sound substantial knowledge base, and learning from colleagues. A desire for lifelong learning was recognized as a vital characteristic of the exemplary nurse.

I remember when my Mom was dying there was only one nurse on medicine that and it wasn't that the others weren't good. You could just really pick it out, not even really knowing her personally. When she walked into the room, she gave an air of comfort and you could even see it in my mother's face. She just kind of 'Oh she is here', you could tell the tone of voice that nurse used, her gentleness, her way with the family when they came in, she was always there, explaining what had gone on during the day, reassuring. She just showed she had a heart and really cared. It was not that the other nurses were not good, I am not saying that, but there are specific ones that show, when they walk into a room you can see it. When the patients are really sick you can see them give a sigh of relief. Where it is like, I know she is knowledgeable, I know she is here for me, and I know if I need a hug I am going to get it. (Nominator 7, line 115-133)

I think it is so important from the beginning of your career to the end of your career you have got to keep up on your learning, you don't know everything, you can learn from the new grad, to the doctors. It is continuous, learning and teaching that we all go through. (Nominator 4, line 394-399)

I think the more knowledge a nurse has and the more depth of that knowledge...and the more application of that knowledge benefits the client, I think it benefits the nursing profession too. Every time a nurse interacts with a client, that has an effect on how the nursing profession, and nursing in general is viewed by the public. (Nominee 7, line 769-779)

What I think it is, is a need to keep learning that's what makes people become exemplary nurses, on units, in educational institutions. Those who keep learning from example, they are learning from other people who continue to learn. They continue to be open and I think that has a major affect. (Nominee 3, line 554-560)

I can still say that nursing is a real caring profession. I do believe you have to be educated because the public demands it of you and you should demand it of yourself, to be knowledgeable and always learning. There still has to be that huge part of you that cares, that you are giving top notch care because patients are already dealing with enough. (Nominee 2, line 942-948)

Well I think it is always important to stay on top of your skills, and new and better ways of doing things that you can tie in with the old stuff you have learned and make a judgement for yourself on what is going to work. (Nominee 1, 497-502)

That is another thing, continual learning, that is a quality that is good, because I always feel that your experience at work is not your only teacher. Like that is a great thing, but you have to learn and update continuously and I am dead in the water without learning. (Nominee 2, line 388-392)

> Education gives the ability to see that patient, that client in a whole new way, because you are not just looking for a set of symptoms, you are looking to see what caused them, do they psychologically show you anything? Do they physically show you anything? Do they have other components? Education has the ability to look at people differently. To look at opening doors, to look at opening everything else up, and helping. (Nominee 3, line 520-532)

Exemplary nurses have the ability to discern a patient care situation through the use of deep knowing. Of interest, this was sometimes problematic, as other care providers did not see a patient in immediate distress. That is, the patient appeared stable in the moment.

> Sometimes you are reacting to a situation before you know it is as bad as it is, because you have a gut instinct that things are not going to go good. (Nominator 4, line 83-86)

> There is something that is twigging me here, something just isn't right. Those are the hard ones. Because all of their vital signs and all their stuff comes in and it all looks Ok, all within normal parameters, and you just know it is not Ok. I see some really great nursing from intuition. I guess it is their gut feelings of experienced nurses, they just know. (Nominee 7, line 852-858)

> I was just in the room doing some vitals and just watching her. I could see the change, even before the B/P started dropping I could see the change in her, that she was actually going to start to bleed, and I called for help and stuff, and she literally started to bleed – I have never seen blood like that…
> We got her ready and got her over to the OR, anaesthesia met us in recovery, there was no sterility at that point, she went right into the OR, our only thought was get her in and save her life. It was one I will never forget, never, never. I am not sure what it was, it was just a gut feeling that something serious was going to happen with her. I am glad I was there because the younger staff that was on, they would not have had a clue…it would have been too late. (Nominee 6, line 218-223; 230-239)

Life Experience

Life experience of the nurse enhanced her own abilities to take in and interpret a situation. Life experiences potentially produced a well-rounded individual with experiences to draw from, to build on, and which ultimately enhanced patient care. A

strong work ethic was recognized as part of the exemplary nurse; this was felt to have developed from past life experience and family upbringing.

> I think they [nurses] have to have a few years of experience under their belt to develop those exemplary characteristics, but I don't think it takes ten years but I do think it takes 5 years. (Nominator 2, line 372-375)
>
> It is like any other thing in life, it takes experience to make your knowledge base grow broader and your abilities to face certain situations and in the life of a young nurse the more experience she has broadens her horizons in her reaction to things. (Nominator 2. Line 378-382)
>
> I think some of it is innate, probably the basics of it. Part of it is upbringing, you are taught to be respectful. Respectful is a big thing, it comes across. Respectful of them as patients, or other people, respectful of feelings, and others situations. It is a thing that is missing these days; it is not all about me! (Nominator 8, line 469-474)
>
> The more experience you have, and the older you get, the easier it becomes to interact, to touch gentler, to explain what you are going to do before you touch, to use, if you want examples from life before so that they understand what you are going to do and why you are doing it. (Nominee 3, line 433-438)
>
> I think it comes down to your upbringing. It comes down to your values and beliefs. It comes down to how you have been taught to interact with people, it comes down to whether you have been taught to respect people of different belief systems or not. So, I think it is a lot of basics in some ways. I don't think you can teach people to care. (Nominee 7, 1382-1389)
>
> I see it [Exemplary Nursing] as a process. Some young nurses just have it though, you can see it right from the beginning. They connect with the patients; they can see what needs to be done to make the patient comfortable. They have good critical thinking skills. (Nominee 5, line 233-236)

Summary of Knowing: Deep knowing or intuition

Knowing or the deep wisdom of the exemplary nurse is identified as a blend of education, professional and personal life experience. This deep knowing is fundamental in anticipating the needs of the patient, and is also recognized by the patient and his/her

family putting them at ease and instilling confidence in the care provided by the exemplary nurse.

Doing

Nursing practice

Humor and attitude were central in maintaining exemplary nursing practice. Being able to focus on the lighter side of situations was potentially beneficial for both nurse and patient. For the exemplary nurse facing undermining factors of nursing on a daily basis, attitude played an important role in countering these factors. The positive attitude of the exemplary nurse and a central focus on the patient helped overcome some of these undermining factors.

> I think probably one of the greatest things is I have a bit of a sense of humour about myself and people around me. I think humans are funny and I don't think that was are all that much different from each other. (Nominee 7, line 1688-1692)

Going 'above and beyond' in nursing practice was identified by all participants. The exemplary nurse portrays strength and confidence and is an 'in charge' person, but professional in manner. She is calm in all situations such as emergencies. She has the ability to calm the patient, and calm other nurses in critical situations. Open-minded, she thinks outside the box to get the job done. The exemplary nurse has patience, perseverance, is generous with time for the patient and often devotes that time in developing rapport to obtain a solid patient history. The exemplary nurse uses evidence based practice, is prepared, plans care thoroughly and is organized. She respects confidentiality, demonstrates integrity, honesty, self-control, and respect for colleagues. Reflective practice was mentioned by all nurses. This entailed spending time reflecting

on the shift or a patient care situation and how it could have been changed or improved upon. Exemplary nurses reflect on their own practice.

> I guess the quiet confidence that I portrayed helped. I mean that is one of things that I learned at school, and some of our instructors were really big on it: even if you are shaking in your boots inside, you portray a quiet, calm, confident manner to your patients, so they are reassured that you know what you are doing. (Nominee 1, line 415-421)

> That is why we are there as professionals, to be hard working, caring, going the extra mile. I guess that is what I am trying to say: Doing the extra things , if people have financial issues or things they won't tell you unless you are sitting down with them. (Nominee 2, line 356-360)

> Not only the knowledge background but the caring [shown by the exemplary nurse]. The fact that the exemplary nurse takes time to listen, to do the little things that make the patient more comfortable getting the extra blanket for the support person who is tired. Listening, hearing, using all of the senses. (Nominator 4, line 369-375)

> She is very skilled, but she is loving to her patients. She always gives them the extra 10 minutes they need. She will always stick around to talk to them or give them a hug or do something extra for them to make their life easier. (Nominee 2, line 259-264)

> She was very professional and very caring, and she did her job well. She always stood up for her patient, she was always respectful of the doctors, but she didn't let that compromise the respect for the patient. She wasn't afraid to speak up and we all learn that as we get older. I must say I am less afraid as I get older. (Nominator 8, line 112-120)

> At the end of a shift, I value the most that I have done a good job and that I have completed everything that I needed to do to the best of my ability. When I walk off that unit, I know my patients are content, they are happy and everything is done for them that I could possible do. (Nominator 7, 541-545)

> If I have a day where I don't think I went the extra mile, it will bother me a lot. Even though you can't fix it up cause you can't do a redo of the day. (Nominee 2, line 913-915)

Nursing Skills

Nursing skills were described as efficient and thorough. There were no short cuts associated with care, and it was delivered with confidence. Exemplary nurses had high

standards of practice and were demanding of themselves with respect to the provision of patient care. Their nursing care was applied with skill when needed. Exemplary nurses could act with great speed and skill. Nominators saw the 'art' of nursing displayed by exemplary nurses.

> [Exemplary Nurse] was compassionate, she had her personality traits or whatever but she had a very soft heart and always gave her best for the patient, and she was not lazy and she worked and demanded the best from herself and everyone else she worked with. (Nominator 8, line 101-106)
>
> I think an exemplary nurse has to have a lot of patience to be able to repeat a procedure or a task over, and over again… In wanting to make sure it is done properly and there are no short cuts. (Nominator 3, line 43–49)
>
> …is very knowledgeable picking up DIC's (*disseminated intravascular coagulation*) and stuff like that. With her speed and skill, she has saved numerous lives. She is very knowledgeable. Again a prime example she goes in and palpates an abdomen, feels rice crispies – she has a case of flesh eating disease! It is being there and possessing the skills. Being there, checking and following through. (Nominator 7, line 163-169)
>
> …She was great nurse! I was always drawn to people who were hard working, skilled at what they did, where it was almost effortless, like putting in an IV or quickly assessing a patient and getting it right. I would look forward to working shifts with her. When we worked only two at a time I'd go to work and think 'We are going to have a smooth night', because she was so hard working and so skilled and she wasn't going to miss something. (Nominee 2, line 238-248)

Team work

Working together, making herself available as a resource for others, and skill sharing contributed to team work. This included the mentoring of new staff. Exemplary nurses readily shared theoretical knowledge and experiential knowledge. Teamwork was identified in creating a positive environment for both staff and patients. Exemplary nurses do more than their share of the workload; they fostered teamwork to enhance the patient experiences and outcomes. Without teamwork, the effect was detrimental to all involved.

They are always available as a resource; new staff are able to go to the senior staff for support, for information, to learn how to do something new, or just to review a skill that they need to learn. So I think there is always education going on from the most experienced to the least experienced staff. (Nominator 3, line 19-25)

She [Exemplary Nurse] would sit there some days after work and go through sometimes 20 charts, phoning these girls trying to get all these messages out that they need to come for a repeat visit with us. What nurse does that anywhere else? Exemplary nurses do more than their share of the workload for the day. (Nominee 2, line 688-693)

I was just at a retirement party, and each one of those nurses, as we were celebrating their nursing careers, said that they never stopped learning from their nursing practice, never stopped taking into their daily lives and learning from their fellow colleagues. Whether that is a nurse just fresh out of nursing school or her fellow colleagues that she was retiring with, and all the years in between. (Nominator 2, line 504-512)

I think it was all our expertise; it wasn't just one person certainly. We were a family, we worked together, we listened to each other, we tried new things, we used certainly, what worked best for us, but we certainly weren't afraid to use something that someone else suggested. It was just fun to share with everybody and work together. (Nominee 6, line 24, 28-33)

It was with a cancer patient, the whole unit came together, we got her all dressed for the wedding. We made up a bed for him so he could spend the night. It ended up getting busy and we had to put a patient in there, and we couldn't do it. The girls all worked together and that was a good feeling. We worked with the doctors to get her a pass for this and that. It was nice, it made you feel like you were helping and making a change for her. She really showed appreciation for it. It was so sad when she did die. (Nominator 7, line 236-245)

So everybody played a critical part. It was that combination of working together. I think that is really the time we get good successes is when the physicians and nurses are listening to each other and patient is included in that too. (Nominator 3, line 471-475)

It was an environment where the staff worked like a team, they supported each other, and helped each other. The patients were lovely to us and I thought, 'That is why I went into nursing', it all came back again. (Nominee 2, line 116-120)

Good nurses get their work done, and then close their books and go home….An exemplary nurse will get her workload done that is assigned to her and she will go looking for what will help her colleagues. Exemplary nurses do more than their share of the workload for the day. "(Nominee 2, line 652-653; 658-660; 692)

Advocate

The exemplary nurse focuses on her patients and demonstrates bravery as she advocates for both patients and colleagues. This entails an assertive approach to practice when the situation dictates. The exemplary nurse presents all care options to patients. The exemplary nurse is not afraid to push the boundaries to provide safe patient care, even moving against the system when required. This necessarily entails risk taking and the possibility of "push back" or even confrontation from others in the health care system.

> Not being afraid to stand up for the patient or colleague, be able to employ what is ultimately best route for both patient and the family members being brought into that patient's care. (Nominator 2, line 71-75)
>
> Well, sometimes you just take the side road instead of going down the whole path, you just skip. No, not skip. You decide that step is more important to get to than going through and trying to find somebody else that way. (Nominee 3, line 360-363)
>
> …She actually thinks about her patients and is a very strong patient advocate and really doesn't mind shaking the waters for her patient and whether she is right or wrong in some ways in the general scheme of things she stands by what she believes about her patient and she actually doesn't care about what happens about that. There she shows some bravery, in some interactions with other nurses and doctors. I think we need that in nursing; we need those kinds of role models who are actually willing to stand up when she is definitely going against the stream. (Nominee 7, 390-402)
>
> A specific time was with a lady who was in pain, and we called the GP and he wouldn't give her anymore pain meds. Just my intuition told me we had a sick woman, and I kind of went over and above and asked one of the OB's to look at her. Within an hour she was in ICU and in another hour she was on her way to Calgary…we would have lost her! (Nominator 7, line 176-182)
>
> About a week later the physician phoned me and said we are going to treat her from now on. So I knew I was right. But I had to go way out of line and do things I probably shouldn't have done for the patient's sake. But the Medical Unit had a good day, we had a good day. Can you imagine with platelets of 2 she was a very difficult IV start. We got it right away and she got her drug. So really, it is all about the patient… Sometimes you just have to do what you got to do. (Nominee 2. Line 557-563; 575-576)

Summary of Doing: Nursing practice

Doing was reflected in the skill of the exemplary nurse. They were described as being efficient and thorough. The exemplary nurse holds high standards of practice and is demanding of herself in the provision of patient care. This is reflected when advocating for patients or other staff members. The exemplary nurse fosters teamwork in the mentoring of new staff and sharing of theoretical knowledge and experiential knowledge thus creating a positive and skilled work environment for both colleagues and patients. The exemplary nurse engages in an advocacy role for patients and for colleagues.

Giving and Receiving

The act of giving and receiving was recognized by the participants as they provided nursing care. The giving of comfort and caring to their patients and the receiving of tangible gifts were mentioned. Participants seemed to remember the spiritual and emotional gifts with greater clarity than the material ones.

> Every patient; you learn something from them and about yourself. Things that maybe you could handle differently. What works for one patient doesn't necessarily work for another patient. (Nominee 1, line 310-314)

> She came into emergency, and I was pretty sure she had appendicitis. We just started talking about her family and it kind of helped her focus on something else and helped relieve some of the stress she was feeling. That is one of the ladies I got roses from. One of the other nurses said "I don't know what you did for Jane but it must have been pretty special". I don't know what I did, but really I didn't think it was anything unusual, but to her it must have been meaningful. (Nominee 1, line 392)

The ability of an exemplary nurse to share of herself, to ease the pain of a family and offer spiritual comfort was evident in the next excerpt. Following the death of a baby the mother wished to have her baby baptised. By giving of herself this nurse was

received into the family circle and made a difference in their lives as well as receiving an emotional gift herself.

> I am a Eucharist minister would you like me to baptize your baby with you? And they thought that would be really good. So what we did was, we went into the room and I got a lovely little plastic med cup of water and blessed it as you are allowed to do when you are Catholic and there were six of us and we all …actually seven counting me, and we all joined hands and the baby was in the middle and we said some prayers and then I took the cup and I blessed it and I poured it over the baby's head and I made the sign of the cross and I picked up the baby and I presented it to each of the people who were there, and they did too. Afterwards we held the baby and said another prayer. Then I put the baby down and I thanked them and left the room and I went downstairs and got a card and I gave them the card that said that the blessing they gave everyone by sharing their baby was more than anyone could ask for. So that was my way of giving and receiving all in one. And that is one of the things that I will never forget. (Nominee 3, line 206-225)

For the exemplary nurse being welcomed into the family following hospitalization carries with it a sense of awe that they are even remember by patients and their families during a time of critical illness.

> I have been welcomed into a family many times, even to things as huge as weddings. Like say the patient marries or someone in their family marries and they say, "We want all of you nurses to come because you have been such a big part of my life and because of you I am alive to go to my daughter's wedding and I want you to be there too". Oh my goodness! It was like WOW! (Nominee 2, line 635-640)

Factors Undermining Exemplary Nursing Practice

Factors undermining exemplary nursing were evident in the nurse's reflections. The nurses could not control many of these undermining factors, and they lamented the inability to overcome them. These factors fell into three thematic areas of concern; Unit Level / Practice Context; Management and Administration (at the level of AHS [Alberta Health Services] and at the Unit level); and Intra and Inter Professional Relationships. [See Table 4]

Table 4: Thematic Analysis: Factors Undermining Exemplary Nursing Practice

Unit Level/Practice Context	Management and Administration	Intra and Inter Professional Relationships
1. Lack of Time: with patients; to give care; to learn from colleagues 2. Medicalization and Technology: Lack of connection with patients; losing hands on skills; decreased comfort care 3. Fragmented Care: less teamwork singular unit report; Pulled from patient to patient; unable to build a rapport with patient	Employer: Lack of respect Lack of recognition Unit Manager: Lack of recognition Lack of recognition from patients Isolation	Intra Relationships Inter-generational issues among nurse Nurse to Nurse consequences In nursing for the wrong reason Inter Relationships Physicians and Colleagues lack of respect Consequences of being an exemplary nurse

Unit Level/Practice Context

At the unit level within the practice context, nominators and nominees identified three main undermining factors: Lack of time; medicalization and technology; and fragmented patient care. Each of these took the nurse from the bedside, shifting the central focus away from the patient.

Lack of Time

Lack of time affected all areas of the nursing unit. This lack of time had an impact on patients, that is, decreased time that the nurses could spend with the patient. Opportunities to really listen to the patients were compromised. Time constraints limited mentoring and/or learning from the experienced colleagues. The lack of time also negatively impacted teamwork and generally affected staff morale. These were not isolated experiences but were reflected in some way by all participants.

Lack of time for patients

Lack of nursing time can affect the provision of safe patient care and makes exemplary nursing care difficult. Nurses were placed under pressure to "rush around" to complete their care. One nominee referred to "assembly line nursing" as the nature of care offered in a time-compressed setting.

> Time is a big factor in exemplary nursing, I would say. When that is cut short you are rushing around trying to get too much done, then you can't spend the time being an exemplary nurse as you may want to. (Nominator 6, line 42-46)

> …in the early years we used to have a lot of hands on, back rubs that sort of thing. That kind of went as it became more assembly line nursing, just with the busyness. (Nominee 2, line 281-284).

Limited time can affect safe nursing care as well as patient confidence in the care received. Patients can leave the unit dissatisfied; nurses can become frustrated with the kind of care they care offer to patients in a shortened time frame. Limited time can serve as a threat to the nurse-patient relationship. Contact between the nurse and the patient becomes minimal, and the ability of the nurse to monitor and reassess the patient can be compromised. Of interest, the exemplary nurse was identified as making time to listen and not make her colleagues feel "rushed". These situations are potential patient safety concerns.

> The big problem we have is we just don't take the time now. Time is a big thing it is 'hurry up, hurry up. You gotta do this, you gotta do that. You gotta get them out. You gotta be here, you gotta be there. Time, you have to give your patient time. The time of being there and really 'being there', that is where we are at. (Nominee 3, line 277-282)

> It is not just appropriate to just give someone morphine and send them home. It may be more appropriate to keep a patient for an hour or two even, and reassess. At least they will think they are being heard; that they are being assessed and people care about them. Often you hear patients saying, 'I was in for 10 minutes and sent home', well that is not nursing. (Nominator 4, line 265-273)

Patients are also aware of the time factor; they see the nurses are busy and are acutely aware of the time a nurse spends with them. It takes time to connect with a patient. Connection between the nurse and the patient was identified as critical to effective treatment and positive outcomes.

> It is the time factor. I try hard not to reveal my stress to my patients. If your patients see that you are stressed they are more stressed and are sicker, more anxious. (Nominee 1, line 59-62)

> I have actually had patient apologize for using their bloody call bell. I mean as nurses aren't we horrified at that? We are giving them the message that we are too busy to take care of them. What is more important than that interaction with them at the bedside, of what they need at that moment or discussing what they need; Do I need to be charting at the desk? I think there is a priority about that. I think it is about not hiding from our patients and being genuine. (Nominee 7, line 622-633)

> …Yes, I was way more open. She [nurse] probably gathered all the information she needed, way more than the others did because I was willing to talk to her, and she was willing to listen and not make me feel rushed. She was willing to talk to me without making me feel judged. (Nominator 6, line 19-23)

Nurses lamented the lack of available time. Unable to provide the kind of care they wanted to, or to meet their own standard of care, had a direct impact on their personal feelings and well-being. In the following textual excerpt, the nurse speaks to resistance and the need to exercise her autonomy regarding patient care.

> I remember one time that I wasn't spending time with a patient and I felt bad about it later." (line 180) "I remember thinking, "From now on I am going to go with my gut feeling and not think I need to do what other people are telling me. (Nominator 5, line 161-162)

> I don't think you ever have time to do all that you want to do any more but I think that you still, even though you are short staffed and working to the ends of our rope, we need to make that time for patients. They don't need a lot of time, they just need to know that you are there when they need you, and that that they are still important and I guess that is how I work the best. I try never to let them know how busy I am, I try to let them know that they are number one and that is what it is all about. It is about them and yah, you just do what you have to do, you work a little harder. (Nominee 6, line 41-51)

Time also plays a factor in the ability to offer comfort to the patient and his/her family. The opportunity to be with patients and offer comfort was undermined. Sitting with patients (being with them) became "questionable" in a time-limited context. Exemplary nurses are aware of not only delivery of direct patient care, but the impact of the limited time on the hospital system. The increased number of patients and the decreased number of beds by necessity rushes the patient through the system.

> Sitting with a patient offering comfort….. "So that sort of thing as nurses we need to have time to do that without someone coming by and saying, 'Did you get that done?' Or 'time for coffee' or whatever. (Nominator 5, line 196-202).

> …you start worrying about all the extra things attached to patient care, not the direct care of the patient. Things like when we get deliveries you have to worry is there going to be a bed for this patient, now that I have started this induction does she have to stay on the unit with us all night if she delivers. The stress just changed it all. You just couldn't be as engaged with the patient, I don't think. (Nominee 2, line 40-47)

Limited time meant spending less time with colleagues to learn from their experiences. Time constraints were implicated in the general undoing of staff morale. Teamwork was negatively impacted, that is, undermined.

> I would say that is pretty rare that we have that [time]. And I have to say that is how I learned a lot about nursing is that when I was younger we used to be able to sit and… I had a friend that was really interested in it and we would discuss it [nursing] That really, really helped me to learn, to give you different ideas. (Nominator 1, line 368-378)

The busier we are getting the less teamwork we have. (Nominator 3, line 530)

Medicalization and Technology

Participants expressed concerns about technology and how it seemed to distance the nurse from the patient. They perceived that the increased focus on technology caused changes to nursing practice. That is, a move away from a "hands on" approach to patient care.

> I see a move away from that comfort stuff; we don't have that 'hands on' approach we used to have" (line 304-306). It is a move toward the "more technical, there is more intervention, although we don't admit to it and the patients don't see it that way, or the physician because for the physician it is convenience, the focus is on the machinery. (Nominator 3, line 316-322)

Nurses recognize the increased use of technology shifts the focus of nursing from the patient to the machinery. Comfort care and a hands on approach were reported as diminished and seemed to negatively impact the nurse-patient relationship. Being unable to answer a patient's phone call immediately and provide advice or answers until the end of shift caused frustration among the participants. They recognized the gap in care but were unable to provide the care they wanted to. Requiring patients to leave a voice message when calling the unit caused feelings of guilt for exemplary nurses, guilt that they could not respond to a patients need immediately or even answer the phone in a timely manner.

> Now a good example is we now have voice mail, so when you can't get to the phone, you can get your ten messages later, when you are suppose to be off. You are supposed to answer the phone and help these people. How does voice mail help them? (Nominee 2, line 302-306)

> Now it seems that it is more mechanical and everything is about the monitor, about the pain pump. It is not about how the patient is feeling. I really think we have gone a long way away from doing proper care" (Nominator 4, line 230-234).

Nominators were clear about the impact of technology on nursing care. Of interest, no participants spoke to any positive consequences of technology; participants were concerned that nurses provided less "hands-on" care and were at risk for not developing solid assessment skills.

Deep knowing (intuition) could be potentially undermined by technology. For some of the participants, technology eclipsed basic nursing skills, for example blood pressure

machine. Being attentive to the patient provides critical information needed for care; the detection of subtle signs and symptoms that can be missed when relying on technology.

> I think it is more medicalized, where before it was more hands on. We rubbed backs, we encouraged them [patients] more. (Nominator 1, line 157)

> I think because they have had machines to rely on they aren't as likely to develop the intuition, that sense that things are changing [for the patient] (Nominator 1, line 241-244).

> …young nurses are not as willing to sit in with patients and learn the skills that we developed because we had to be in with our patients. We didn't have the machines to do the work. (Nominator 1, line 230-233)

> I feel bedside nursing is lacking in the [nursing] programs. I feel basic skills are lacking. I make everyone [students] use the manual blood pressure anyone can push a stupid button to take a blood pressure that takes absolutely no skill. The machine is not always accurate. Do the doctors use the machine? No. If you have an internist come, he takes a manual blood pressure himself. (Nominator 8, line 510-516)

> I think intuition plays a part, I think it does. I think you can get a sense of what is going on in situations a lot of times, some things machines can't pick up. I guess another time comes to mind where a patient was drug seeking and I just had a sense that was happening. (Nominee 1, line 277-281)

Fragmented Care – no continuity of care

Nurses recognize the fragmentation of care and the lack of continuity between the nurse and the patient. The rapid change in patient flow and frequent reassignments within a shift to accommodate the more critically ill patient makes it difficult to connect with a patient for any length of time.

> We do much more fragmented care in nursing now that you don't have patients for as long now. (Nominator 1, line 202-204)

> [Care] …is definitely fragmented and maybe that is just the way health care is today, and that is just a symptom of the whole system. (Nominator 3, line 547-549).

> I think too that we have such a turnaround in nursing, like, you know, the shift work and everything, that you are not always that patients nurse anymore. Where before you would have a little more continuity. (Nominator 1, line 209-214)
>
> I think people are just rushed in and rushed out. They are just seen as another patient…we have to get them home in 24 hours and patients leave unsatisfied. (Nominator 3, line 571-575)
>
> Fragmented care leaves me as a nurse with a sense of incompletion in my client care. Whether this is an issue of mistrust on my part – is it that I am unwilling to let other people carry on with the care? I think it is that I can see some things can easily get missed, meds not given on time, variation in nursing skill sets as one nurse gets pulled to care for a more critically ill patient. (Nominee 5, 59-68)
>
> You know, I do go home frustrated at the end of the day, certainly. Feeling that I would have liked to give more, but I certainly feel like I have given everything I have got to give. I know I get a lot of patient comments coming back saying that they appreciate the time I spent with them, even if I sometimes feel I don't spend enough time with them, obviously just the time I do…I guess it is more quality that quantity at this point. We just do not have the time, so you make the best of what you have. (Nominee 6, line 54-63)

Pressures of the system, reality of shift work, and management decisions contributed to the fragmentation of care. Participants were concerned regarding the movement to nurse-to-nurse reporting instead of a group or unit report. Although the nurse may be pulled from one patient to another, she has only received report on one patient. Team building and teamwork became less as no one but the charge nurse knew the full patient load and who may need help during the shift. Participants voiced that nurses felt isolated from the unit as a whole and were concerned with the loss of conferencing about a patient as a source of learning that was the norm in a communal report. The loss of a unit-based reporting model (change of shift report) was viewed as contributing to the fragmentation of nursing care and the undermining of exemplary nursing practice.

> Even the way we are reporting to other nurses now we are not getting teamwork, it is very fragmented care, and it is getting worse. It is encouraged by management because the manager is behind it. So if you get a patient it is the

> only one you hear about, you don’t know what is happening on the unit. (Nominator 3, line 531).
>
> Since we changed to only getting report on your patient and only knowing what your patient is doing” (line 556). “I heard a direct quote from the unit manager that I just needed to get over that, I didn’t need to know what the whole unit was doing. (Line 561) So when I am asked what the other patients are doing…I don’t know I didn’t get report on them. (Nominator 8, line 552,556,561)

Participants recognized the reality of shift work, part-time status, or being reassigned to other patients or units made it difficult to build trust with patients.

> I found that working part-time that you couldn’t really establish a rapport, especially in Psych, somebody would just start to trust you and then you would be off for a couple of days. You would come back and you would have to rebuild that trust. (Nominator 6, line 310-315).

Management and Administration

Lack of respect from administration

A general feeling pervaded the interviews that the health system as a whole did not respect nurses or view them as central in the provision of health care. They were simply seen as an expense to the system and as years of experience increased so did the wages of experienced nurses making then a liability in the business world.

Nurses wished for greater support and encouragement by way of professional development and learning opportunities.

> I don’t know if it is just the atmosphere of Alberta Health Services but it seems that they don’t appreciate the experienced nurses, and that is a feeling that many have. (Nominator 1, line 340-344)
>
> I think the whole Alberta Health Services needs to implement and encourage young nurses and those of us that have been there 33 years. [on professional development] (Nominator 2, line 447-450)
>
> I think that a hospital or an institution run by the government can afford to provide something that would support their nurses. (Nominator 3, line 813-815).

I think nurses from where I work now - well that is changing too with Alberta Health Services, we get less too. But I think that nurses who work in the hospital are not supported in the same way we are to attend in-services, conferences, teleconferences, learning opportunities as we are, it is just too busy on the ward and you can't get away" (612). It should be that hospital nurses get the same opportunities to further their education" (Nominator 5, line 605-610)

Lack of Recognition from the system

Overall participants felt they were not recognized for their skill, education or commitment to healthcare. Participants suggested that the restructured health care system and those in senior positions had little understanding of those in its employ.

I don't think nurses are appreciated in Lethbridge. I think you get much more recognition in Calgary where they appreciate knowledge and skill more than they do here. (Nominator 7, Line 570-574)

I don't know that I have ever gotten huge encouragement from management, somewhat I guess. But it was more of a unit thing, we all sort of come together as a group, that camaraderie. It was relationship building within the unit and we don't have that anymore. I think that is part of the way the Health Region is going." (Nominator 8, line 630-635).

Well I see my employer now being Alberta Health Services and I don't see our CEO being the one that is going to give me my sense of worth, or my unit manager." "…cause it doesn't come from my employer. (Nominator 2, line 488-491)

They want you to always do more with less! That is just the prevailing theme…to run the unit really "lean". You only have so much staff and you are not getting any more help so just be more efficient, figure it out and be more creative. I hate when people say that to us. Creative with what? You have given us no resources, no help, nothing. (Nominee 2, line 296-302)

I don't think I work for the "company" in my mind. Like I think I am a good employee, but that is not why I work hard. I am not even trying to impress my boss. I don't really care about that. I know they watch you and might even do your evaluation or whatever but when I go to work, I go to work for the patient. So I have to meet their needs. (Nominee 2, line 311-317)

Unit Manager

Concerns regarding lack of recognition and its effect of undermining exemplary nursing, individual self worth, and quality of patient care became evident in the transcripts. Participants reported feelings of isolation and lamented the loss of cohesive nursing practice. Implicated in these losses were unit managers.

Lack of Recognition from Unit Manager

The influence and impact of a good manager were evident and important to the emotional and physical well being of the nurses, which ultimately reflected on the quality of care given to the patient. Positive feedback, recognition and professional respect were key factors in building a solid, positive work climate. Exemplary nurses found it difficult to continue nursing without positive feedback from the Unit manager. Nominators suggested that positive and genuine feedback from the Unit manager fostered exemplary nursing practice.

> I mean it is always nice to get a compliment right? It does make you want to try your best, and do your best rather than being criticized all the time. So yes, positive recognition is always kind of nice. (Nominee 1, line 629-633)
>
> Well I think it is really difficult to do well if you don't get some positive feedback. (Nominator 1, Line 394-400)
>
> I know that I have done the best I could, and have been attentive to that persons need for support plus the coaching and the only way you can really tell, because you don't get the perks or the slaps on the back saying, 'Hey you did a great job!' you don't get that on our unit. (Nominator 3, line 366-371)
>
> I guess it is nice when your manager notices that you are doing a good job but I don't think they ever really see anyway. (Nominator 7, line 552-554).
>
> If you have an employer who thinks you can never do anything right, that is very discouraging. You just feel like; 'Okay, then I will just do my job but I am not doing any extra'. (Nominator 5, line 654-657)

Respect for one another was seen as requiring a top – down approach. A leader who puts the patient and her staff before her own personal goals was recognized as deserving of respect in return. A strong leader is seen to be one who can 'push the boundaries' and address the problems of the unit, promoting exemplary nursing. However, retribution for speaking up was noted by the participants. Participants also recognized their own responsibility to foster respect.

> If management were to set the example; respect the staff, the staff will start respecting each other. I think it has to start from the top down, and I think that when people don't respect each other, we should be comfortable saying, 'I don't like the way you are treating me.' 'I don't like the way you are talking to me', and be able to do it without causing hard feelings or retribution, because I think there is a lot of that. (Nominator 3, line 820-828)

> I want to follow a leader who isn't about her personal growth, isn't about personally moving up the ladder, being the big shot. I don't want to follow a leader who thinks that all they have to do is show up wearing high heels clicking through the unit…So I think it is the leader promoting exemplary nursing, which means probably not doing what everybody else is doing around you. I think difference does matter. I think that is what really can make some changes. I'm not talking about the loose cannon that's out there hurting people, but I want to see leaders who can push out the boundaries a little bit, who promote difference in their nursing, who actually addresses the crap that is going on. (Nominee 7, line 1869-1887)

Praise, sincere praise, was important to nurses in general and to the exemplary nurse in particular. The mention of insincere or false praise came up in several instances; it amplified a feeling of disrespect to the nurse and her colleagues.

> Sincere praise; there is a lot of insincere praise out there. Yes, there is! For sure [recognition matters] it does, we all want to be validated for what we are doing. If we are doing a good job for sure. If we are doing a bad job, in some ways it is good to hear about it too, that is how you can grow. Insincere praise you sometimes have to muddle through it to realize it is insincere, depending on who is giving it, or how it comes across sometimes. If the praise is given and then the actions following do not match, then you go Oh! they didn't really mean that. Then you lose some trust, or the interest they show you isn't genuine. We do see some of that. (Nominee 8, line 650-661).

> Praise needs to be sincere, yes. I have received some insincere recognition too and yah, it is a bit of a slap in the face actually! (Nominee 1, 639-642).

> Certainly, people like to hear when they have done something right. They like to be recognized, they like to have someone say that. To the other extent we have a manager that will pick certain people out that she will give praise to, that is the worst thing that you could do. I think everyone deserves praise and yes somebody on a Friday shift has done something immensely well probably the Thursday night shift and Thursday day shift did it three times as well to make it so the Friday person could get where they were. So personally, I would rather see praise to the unit rather than individuals in most cases. (Nominee 6, line 691-701)

> You can be praised to the hilt and not be an exemplary nurse. (Nominator 2, line 474-475)

> To feel appreciated and cared for regarding your fellow colleagues goes a long way to making you want to come back to work the next day. (Nominator 2, line 482-485)

Lack of recognition from patients

Recognition of the work done by nurses, especially exemplary care is appreciated by nurses; however, recognition is not necessary to providing exemplary care. Among the participants, an underlying sense of perhaps they failed in providing exemplary care to the patient was pervasive. That observation made, a card or gift was not seen as ultimate recognition of exemplary care. It is acknowledged that patients often do not see all that a nurse does on their behalf; the phone calls, the searching for physicians, coordinating of services, and getting the required medication from pharmacy. The use of technology as in e-mails and texting was recognized as a possible reason for the lack of written recognition from patients. The immediacy of texting as opposed to the time taken to select and send a hand written card was suggested as a possible reason for the lack of patient appreciation.

> We don't get as many cards as we used to, but that is fine. I would rather have someone personally thank me than get a card. I am not sure why we don't get the thank you cards. People are too busy I suppose. I think a lot of them [cards] are monitored now. They don't come to the floor anymore, they go to the managers, and I am not sure why, but we will have a meeting and they will say 'Oh yah, we have received two thank you cards during this time period'. (Nominee 6, line 384-391)

> I think especially now a days you have to feel that [sense of a job well done] within yourself because people aren't as gracious as they used to be. I have many, many presents and cards from people that I've helped, but it seems like I get less of that now. (Nominator 1, line 151-155).

> Though your skills are needed, I do not think people recognize that. (Nominator 1, line 162).

> I used to receive thank you cards and I find now that I don't. I don't know why; if it is that people just don't do that anymore. (Nominator 3, line 560-562).

> I don't really think the patients really see [what nurses do]".(line 587) I don't believe people really see, especially in our area, they don't really see what we do. (Nominator 7, line 579 & 587).

> Somewhat, it could be that we are the e-mail generation. It could be generational as well, people just move on. Lots of patients will say thank you, as a matter of fact, every patient will say thank you when you leave them in their room. Some say more, some say less. (Nominator 8, line 429-434).

> No they don't, they just see if you are standing doing nothing. Particularly if they are waiting for the Dr for an hour and you have paged him four times or he has called you and said he is in the OR and you don't always go and tell them, sometimes you do. You become their scapegoat. (Nominator 8, line 449-454).

A devaluation of nursing skills, lack of support and professional development by management has a negative impact on nurses. Nurses strive to be at the top of their field in skills and knowledge in order to provide exemplary care. When not supported in the pursuit of furthering knowledge and skills, and the opportunity to apply new knowledge in practice, nurses felt they had been let down by management. In turn, they felt they were letting their patients down with lesser quality care.

> Well I think availability to go to good conferences because I think that widens your base. … They don't make it easy for you to go. You have to pay your own way and many people can't afford it, you have to beg for time off (Nominator 1, line 348-353).

> If your employer isn't supporting you in what you do, like saying, 'What good do those classes do anyway?' That is discouraging. I think recognition is important. (Nominator 5, line 661-664).

> Opportunities to further education with time given by the employer would be beneficial, and help with the financial end of it. There are lots of nurses who are working that just can't take days off to go. (Nominator 5, line 624-628).

> Yes going to classes and courses, yes for sure and that has not been encouraged at all. We used to go to conferences as a group, like those monitoring things taught us a lot, now it is not encouraged and it is just whatever the other person told you. (Nominator 8, line 622-626)

Isolation

Isolation from peers in a nursing facility, hospital, or unit makes it difficult to provide exemplary nursing care. It is working as a team for the health of the patient that realizes the strength of exemplary nurses. Nurses are continually bombarded by stressors; those from administration and individual people. Withdrawing is seen as a means of professional and personal protection. In reality, withdrawal negatively affects exemplary nursing practice.

> I think the stressors today cause nurses to become more insular or isolated. They are dealing with the stress of the unit, and the stress of individual people as well as the unit manager and the people above them. When they do that, they are protecting themselves so they kind of withdraw, or have very small little cliques. When they do that, what they do is provide themselves a sort of protection, but they don't necessarily see all the needs of the client, the patient, whomever you want to call it, as well as they use to because of that insular component that we have. It is a workplace stress that doesn't change and hinders your ability to provide really, really, good nursing care. (Nominee 3, line 24-36)

> I think [EN] probably has its moments you may feel like you are out of your element, like you don't feel like you are part of the group. You are more isolated." (Nominator 8, 143-146).

> Everyone knew each other, they praised each other, the Administrator even knew who we were. We had a sense of belonging and I know that can happen in a big unit, I know it can, because I see it happening in big companies, but I see that lacking in management where I work. (Nominator 1, line 394-400)

> I have seen instances and been the brunt of it myself where there has been no cohesiveness in the staff where it has been said, 'Don't help her she isn't busy enough, she just sits around'. Well you know, I don't buy that. That made me ill. Who do you turn to when that came from management? (Nominator 3, line 876-881).

The need for peer support following a critical incident was recognized. This lack of support and the need to attach blame underscored feelings of isolation and limited personal self worth.

> Debriefing, I think that would help after a critical incident. I find that there is a lack of support after you have gone through a difficult case; I think it would help to break it down and talk it over with other people who have experienced something similar. It is overwhelming sometimes the things that happen, and you are just left to deal. There is a certain amount of fear as well, because they are always trying to attach blame. You would have to debrief in a truly non-judgemental way. I think it would be extremely helpful. (Nominator 6, line 225-235)

Intra Relationships

Inter-generational Issues Among Nurses

Working relationships between and among nurses is essential to exemplary nursing practice. It is recognized that generational issues, differences in education and perspectives between the generations, play a role in workplace cohesiveness. From the perspective of the participants, respect is an important factor in fostering exemplary nursing practice.

As new nurses start their nursing career they are often seen as being dismissive of the knowledge possessed by seasoned nurses. It is that lack of respect and over confidence that colors this perception. Senior nurses feel they are not respected, their knowledge dismissed. There is a pervasive feeling that their experience and education is belittled.

In the past, it was the experienced nurse that was consulted for advice. The participants observed that now it seems there is uncertainty as to who to approach for help and advice.

> Again, we have a state in our unit where it is the junior nurses that are mentoring the new people, even though it is the senior nurses that have the experience. As you know, we are not encouraged to help each other these days. I hope it is only temporary. (Nominator 4, line 339-344)

> I think many times I get the feeling that sometimes they think they know it all, and that is youth, I understand. How can they know everything that I have experienced after 35-36 years of nursing when they have only been working a year? (Nominator 1, 355-360).

> The general feeling is that they don't respect what we know and what we have been through. (Nominator 1, line 363-364).

> These kids work but, do they really care about their work? I guess that is it, you have to care about your work, care about your patients, not scowl every time the bell rings and you have to go back in there. Even though sometimes that is hard. Experience is also important, as people gain experience they grow. (Nominee 6, line 460-466)

> [Number of years needed to become exemplary]…Nope, some of them come right out of the chute that way [exemplary]. Some of the nurses we get now days, and they don't even have to be young, most of them are young though. Some of them are just cocky. 'Yup, I'm a nurse too and I can do whatever you can'. They don't even know what they don't know and they don't know what to be afraid of…So many things can go wrong. They don't even know. Even the patients can sense it that they are too cocky. (Nominee 2, line 740-747)

New nurse's over-confidence in their skills and lack of acknowledgement of the years needed to acquire these skills is of concern to experienced nurses. They viewed the lack of hands on nursing and an unwillingness to accept advice as detriments to exemplary nursing care. This disregard of knowledge and experience was seen as a potential danger to patients, as well as undermining teamwork within the unit.

> If I am not sure of something, I do ask. That is probably a huge skill set that is missing, I can honestly say, is missing from the new people in the next generation of nurses and in the next generation age wise. Not to ask, they like to be more autonomous, *I don't need to know it or I just make it up, it doesn't*

> *matter.* But it does! If a more experienced nurse had told me to do something, I would have jumped and said Ok. Because she would have had more experience, I would never have argued with her. That situation was dangerous and could have turned out ugly, because what is most important isn't whether I am right but what is best for the patient. That nurse was rewarded for dangerous situation and next time she will do the same thing. That is the counterpoint of exemplary nursing, that sort of going off on your own little tangent and not learning, not being mentored, not learning from your mentor. (Nominator 8, line 305-330)

> It angers a lot of nurses, one scenario when I told a patient to ask for a shot before bed and a young nurse comes on and says, ' You are over 24 hours and don't need one.' The patient cried all night! Why would someone do that? According to the book, you don't need it. Well that patient is not a book! It is a person!' (Nominator 7, line 85-90).

> I think there is a move from there [hands on nursing], and I also think it is a generational thing because the nurses coming out now have never experienced that hands-on nursing. (329) I think that nurses graduating now have never been taught that and they don't want to learn it. (Nominator 3, line 322-325).

> I find that the grads now don't seem to have as much clinical experience when they graduate from school, so a lot of the stuff they have in their heads on a certain procedure but really they have only done it once or twice. (Nominee 1, line 27-31)

> I would love to be able to teach every single nurse that ever comes through that the patient is number one; that is just not the way it seems to go now. Charting is number one. Nobody makes beds anymore. Nobody cleans up their rooms anymore, because that is not part of their job. Nobody unloads linen carts so that you can help the next staff. I guess they do not see the big picture; they are focused on what they have to do, and what time they get to go home. (Nominee 6, line 470-478)

Generational differences were recognized as potential areas of discord between experienced nurses and newer nurses. Intolerance for differing approaches needs to be examined and a kinder approach taken when teaching new nurses. In order to build a cohesive team understanding from both sides is required. A willingness to learn from each other is in order, each bringing valuable skills to the unit.

> I remember a few other nurses who were also on at that time and they were bossy and would say, 'Well why would you do it that way? This is the right way. or 'This is the way we do it'. They never gave a reason for it. (Nominator 7, line 68-73).

> We are just building walls between us [between seasoned nurses and our new nurses], that is all we are doing. If they take the initiative to learn and seek out the nurses, as with any of us. Where did I learn most of my stuff? It was from watching other people. You can only learn so much in school. (Nominator 8, line 586-590).

Nurse to Nurse Consequences

Nurses voiced concerns about colleagues not supporting or encouraging exemplary nursing practice. Being different, going against the normal way of performing duties was often ridiculed by others. Exemplary care was sometimes viewed as a threat rather than something to achieve. Trust and respect of colleagues was important and when it was lacking, exemplary nursing was threatened and patient care potentially undermined.

Making nursing judgements based on the comments or assessment of others was cause for regret by some exemplary nurses. They recognized the importance of forming their own opinions about patients and their families. The 'squashing' of the exemplary nurse by those in authoritative positions was mentioned. Some participants observed that nurses can be mean spirited toward exemplary nursing practice. Overall, there was an awareness that patients and families were aware of discord within the unit.

> I think that it is easy to be influenced by other people's judgements. Especially, for example, at report when you hear another person's opinion about that patient or their family and it is difficult to disregard that as you go into the room. (Nominator 6, line 35-39).

> Sometimes too, the attitude and moral around the unit, when we are all stressed, it affects the patient care or how the patient reacts to their illness. They can feel the tension, and they can feel the vibes of stress. (Nominee 1, line 65-69)

> I've had lots of times that I have been given information about a family that has a very interesting view point, where a judgement was made. That quick little moment when a judgement was made without substance. I have done that, and then I've thought that is a big hunk of crow I've got to cook up on my stove afterwards 'cause I was a schmuck! I believed what I heard. (Nominee 7, line 1229-1236)

> Now I think a lot of people you really do look at and think ‘How did you make it through nursing training’? I don’t know and they are really challenging to work with, they are rude to co-workers and I don’t know how that makes for good care on the unit, it has got to be a team, you have to be supportive to each other, and the patients witness that. The patients pick up on the mood of the unit. (Nominee 2, line 838-846)

> So people who are closed, who are flat up mean, who are unkind, who think it is ok to be mean to people just because they don’t do it exactly like I do, who make snap judgements about comments that are made. Those kind of people squash things all the time. People in power can be flat up mean. So I think those things squash, I think it squashes being an exemplary nurse. Nominee 7, line 1910-1918)

Trust of co-workers was identified from the transcripts. Being able to depend on co-workers, especially in a critical situation was key to a cohesive working environment.

> I think your co-worker, the nurse working beside you, if you don’t trust her it really affects your ability to practice. (Nominator 3, line 939-941).

> So I think it is a profession as a whole that has trust. I guess, that is why sometimes it is a shock when you find you are working with someone who is not such an exemplary nurse. You think, ‘Boy, people are putting their trust in you, it is a big thing to live up to. (Nominator 5, line 706-711)

Respect is central to exemplary nursing practice; respect of colleagues and respect for patients. Mutual respect and recognition for the work was noted as important.

> There are some people who do not respect anyone whether it be the patients, the physicians, their co-workers, and I really think that diminishes the care that the patients receive. (Nominator 4, line 384-387).

> You know it has been stressful recently, some days I think should I go to another department, but when I come and put the politics and the awful back biting aside what I get out of it is my patients and I know that I have made a difference to them. (Nominator 4, line 448-454).

> I don’t think a lot of those young girls know what we do on the floor and we are minimized a lot. I would gladly switch positions with them and go back and forth and I bet I can keep up with their workload better than they can keep up with mine. What I would like to see is more appreciation among ourselves. (Nominator 7, line 589-594)

In nursing for the wrong reason

The participants [seasoned nurses] viewed nursing as a calling, a life choice, whereas they viewed newer nurses as simply taking on a well paying job. Many nurses referred to their love of nursing. They saw nursing more than just a job but as something alive inside them. Nursing for the exemplary nurse was developing a deep emotional bond with their patients. They were aware of the professional boundaries, but did not let that separate them from the emotions experienced by their patients.

> People ask me if I cry. Yah, I cry, but the thing is, I cry with them, I don't cry so that they have to comfort me, my crying is comforting them. Yah, I have shed tears, I have sat there, we have hugged, all of those things, and that is important, 'cause guess what? We are all people, and that is where it comes from, your heart. If you don't have a heart, don't be a nurse. (Nominee 2, line 235-241)

Participants were concerned that student nurses had unrealistic expectations of all that nursing entails; shift work, stress, hard work, and time away from family. Financial reward was viewed as a driving factor for some entering nursing, but exemplary nurses did not see this as a sufficient motivating factor to choose nursing as a profession.

> I think if you go into nursing thinking you are not going to work shift work and I am not going to do this or that well you won't be able to put up with the stress because there is lots of stress just dealing with management, the doctors, with other nurses, with patients, plus having to work shift work. That is one reason you have to know why you are going into nursing. I think you have to be prepared to work hard. (Nominator 3, 743-750)

> It used to be that people only went into nursing because they cared about people but sometimes I think with the fact that we earn a fairly decent wage that I am not complaining about, but sometimes people go in it more for the money than the caring part of it. (Nominator 4, line 325-330)

> I think some of it is their nature, maybe how they were nurtured. I have met a few nurses, single parents, teenagers, they went and took their two year nursing and they just come across, 'Yup, I am a nurse', I wonder if they went into it for the money? They just come off 'wrong'. They are way too confident. We had one nurse the other day say, 'Well I'm not your slave' when another nurse asked her to help out. It was just that type of attitude. (Nominee 2, line 753-761)

I am not sure if nurses are going into it [nursing] for the same reasons we did. Money is good but I hope that is not the biggest reason to go into nursing, because you work hard for that money, or you should. You should have to work very hard; I think you owe it to your patients. (Nominee 2, line 907-912)

I am not sure how you would teach someone to care, you must be able to but I don't know how you would, it has to come from their heart. It has to.
I am not sure a lot of nurses go into nursing because of the job, I think a lot of them go into it because of the money. (Nominee 6, line 479-484)

How do you teach a caring attitude to someone? It is just part of their personality. So, should they be in nursing? Should they be picking a different career? Should they be picking a different field of nursing, maybe? (Nominee 1, 548-553)

Inter Relationships

Physicians and Colleagues – lack of respect

Participants identified that nursing skills were devalued by physicians. Issues of power and inconsistent responses became a detriment to exemplary nursing. When some nurses advocated for their patients, the physicians felt they were being opposed and respond negatively. Nurses also realized that it was necessary to build trust with physicians to ensure they were 'heard' when speaking on behalf of the patient.

I think nurses are always being challenged especially by physicians, and it gets very frustrating. (Nominator 3, line 158-161).

My solution is just to keep calling them, and advocating for my patient. When they snap at me I don't take it personally. (Nominator 8, line 270).
I think as well there are some newer physicians that don't value the senior nurses. They just see them as 'old nurses' who are grouchy and don't know anything. Maybe I am being a little harsh but they do get a little intimidated. A senior nurse will talk from experience and we need to do this, this, and this, and they get upset thinking we are telling them what to do. It is really not the case at all, it is just experience being shared and it is not being accepted sometimes. (Nominator 3, line 477-485).

Their skills are different and I guess it is the new generation of doctors too. It does affect your practice, the response you get from the doctors. You do have to earn their trust in a way. (Nominator 8, line 296-298).

> I am sad about that, we will have people [nurses] phone the doctor and say this lady is bleeding badly and the doctors will question them and that bothers me more than anything. We shouldn't have to do that, they should know us well enough to come. (Nominee 6, line 246-251)

> The doctor didn't believe me and I think he was a little miffed at me because I voiced my concerns too and he didn't believe me. As it turns out I was right… I phoned the pharmacy and they confirmed my suspicions. (Nominee 1, line 282-284, 297-298)

> I guess fear of others not agreeing with your point of view. Like for me at this point in time when I mentioned that I was suspicious of the drug seeker, and for me to stand up to a doctor and voice my concerns, I would have never done that when I was a new grad or even probably for the first 10 years of my career. I wouldn't have. I may have had those suspicions myself, but I wouldn't have said something to the doctor. Know I am confident enough to say something, but still that fear inhibited me earlier in my career. (Nominee 1, line 428-438)

Frustration was clearly evident within the transcripts by the number of situations identifies therein. Participants felt they were not being heard and were at a loss as to how they could have achieved the desired response in a more timely fashion and prevented a less desirable outcome for the patient.

> I knew she was breech. I phoned the physician and he would not believe me. He would not listen to me. I even to this day don't understand why he would not listen. I told him and told him. (Nominator 3, line 503-507).

> It is frustrating when you know something is not right or you have evidence to say she is breech and they don't listen. It is very frustrating. One time they listen to you and the next time they don't, and you wonder what was different. (Nominator 3, line 515-517).

> It was a PPH. We had a piece of placenta missing, something we don't see very often. Dr Z agreed, big piece missing! Dr XX is on call and he won't come. It is like her eighth baby, and she had a retained placenta and he won't come. She is bleeding, not excessively bleeding but she is bleeding too much. So I have the IV running at a good rate, syntocinon running, and he won't come. G was in charge that night. We move her to the AP room and I kept massaging the uterus for about an hour, and all it is doing is hurting her and it is not getting smaller, because there is placenta in there and she is still bleeding, and I keep her blood pressure up because I have the IV running fast enough. I just keep phoning him, every half hour, and finally at 3 in the morning he comes in and does a D&C! I mean he could have done it at 11 and saved everybody from coming in. Then her hemoglobin is 50! I was really ticked at him because now she has to have

> blood, because he wouldn't come in. I think well, I guess I saved her life! It wasn't just me because G was very supportive. You just think 'Really' I know what is going on here, why don't you believe me? (Nominator 8, line 184-207).

At times it is the patient who provided support for the nurse. This was a touching moment for the nurse as the patient was critically ill and still defended her nurse when being unfairly accused.

> I just knew that she was in trouble. So I kept phoning and phoning the doctor. It was Dr ZZ and he wouldn't come and he wouldn't come. I would come out and phone every couple of minutes, and the patient was starting to drift in and out of consciousness. I am massaging her fundus and doing everything I can think of to do, and finally he shows up, and the patient is really in bad shape, and he says, ' Oh somebody hasn't been rubbing that uterus.' The patient spoke up for me and said, 'Oh yes she has', as she is drifting in and out of consciousness. It was the worst night of my life. (Nominator 6, line 76-88).

Validation for the nurse, personal satisfaction in making the right judgement, and advocating correctly for her patient was evident in the transcripts. This did not negate the level of frustration that was experienced while trying to get the physician to listen and respond to nursing assessments.

> A specific time was with a lady who was in pain, and we called and called the GP and he wouldn't give her anymore meds. Just my intuition told me we had a sick woman, and I kind of went over and above and asked one of the Ob's to look at her and within an hour she was in ICU and in another hour she was on her way to Calgary, we would have lost her! She had Cor Pulmonale and was full of fluid up to her ears, but we couldn't get a doctor to listen! (Nominator 7, line 176-185).

> Can you imagine doing all this and then the doctor comes in and he gets the praise not you. I don't think I have ever gotten praise…Oh I think I did once, years ago from a doctor once. In NICU years ago, one of the pediatricians said 'Oh good catch or good eye or observation' or whatever. (Nominator 5, line 246-251).

> So sometimes, you do feel vindicated because yes she was bleeding too much! Like, Okay are you listening to me, I don't call wolf! It is to the patient's detriment while you get them to trust you. Especially that lady who was bleeding that is so unfair! She had a hemoglobin of 52 and had to go home to 7 children…like why! Because you don't believe me? (Nominator 8, line 246-253).

Consequences of Being an Exemplary Nurse

The consequences of being an exemplary nurse were not always positive. Participants presented a wide range of negative consequences either observed or experienced. Courage and bravery were often required when dealing with situations requiring patient advocacy. Personal safety may also be in jeopardy when the possibility of personal attacks and bullying occur. Despite these consequences, the participants identified that exemplary nurses persevered for their patient's sake. They did what they felt was right without stopping to think about the consequences, personal or professional. This speaks to their level of commitment to the patients and nursing profession as a whole.

> I do have to say when you get really good at what you do and you become efficient they just add more work to your load. The stress just became unbearable. (Nominee 2, line 61-63)
>
> I knew that we were going to lose her if we didn't get her to the operating room. How bad I was going to get yelled at was the last of my worries I just didn't care. (Nominee 6, line 255-258)
>
> She actually thinks about her patients, and is a very strong patient advocate and really doesn't mind shaking the waters for her patient…she stands by what she believes about her patient and she actually doesn't much care about what happens about that. There she shows some bravery in some interactions with other nurses and doctors. I think that is needed in nursing and we need those kinds of role models who are willing to stand up when she is definitely going against the stream. (Nominee 7, line 390-402)
>
> With patient advocacy, you often have to step out on a limb and you could easily take a fall. (Nominator 6, line 186-187).
>
> Sometimes people seem to look down on people that spend time with a patient, which is really sad. (Nominator 4, line 335-337)
>
> So I called him [doctor] back again and thought I will probably get yelled at…and I did. He was mad at me for bothering him. But he begrudgingly came in and later it turned out she had Creutzfeldt-Jakob disease, she was later diagnosed with "Mad Cow disease" and she was seizing. I felt like – it never

> comes back to you like 'good job' you just had to put up with basically getting told 'What is your problem'. (Nominator 5, line 236-244).

> The expectation is always there that you will do it right, and that is kind of a scary thing, but being exemplary you sometimes have to cross the line, such as go against the physicians direction, or working overtime, it can take a lot out of nurse, the dedicated nurse that gives all and does her best. I think sometimes it is those nurses that burn out faster than others. (Nominator 9, line 414-421)

Personal safety and retribution were possible consequences to exemplary nursing practice. However, such threats did not prevent the provision of exemplary care.

> I just know I had been in there the whole morning trying to help her and at noon the Social Workers came and I had to take the baby to the nursery so they could take it. It was horrible, and that mom cried and cried, like she was sobbing and it was such loud cries that I just went home from work that night just sick, thinking how would it be to have that happen to you. I had a lot of trouble even looking after her the rest of the shift. I think by the end of that shift, I had even asked someone else to take over her care, because it was just too hard. Her partner was getting pretty angry as well. I think he eventually had to be removed; like it really got nasty. I saw them a while ago in Safeway, my heart just started pounding I just saw him looking at me and I turned down a different aisle, because I didn't want a confrontation. You sometimes become involved in not a good way, a deeply personal way; you still try and do your best for that patient in a horrible situation, even though you would rather not be involved. You still try and give comfort. (Nominator 5, line 452-472).

> Well some situations you are going in there and you know it is not going to be easy. Sometimes to just face the doctor down takes courage to get your concerns heard. Just to go into a difficult situation with a patient, knowing that maybe they are combative or just that they are really sick and you are going to have to be top notch that day takes courage. (Nominator 6, line 289-295).

> We had done so much and got nothing but yelled at by the GP, basically we got yelled at as well as the patients husband…demeaned. But, Yah I was willing. If I ever do something like that, I am willing to take the rap! I will stand up, because I wouldn't do something if I truly didn't think it was the right thing to do. I really in my heart didn't think I would be punished for something that is in my scope of practice which is patient advocacy. (Nominator 7, line 301).

> I guess worst case scenario they wouldn't have sectioned her and I would have gotten my arse kicked." (Nominator 7, line 320-322).

> Where you just do it because you know it is the right thing to do. You don't stop and think of the consequences at the time. What are they going to do to you? Worst-case scenario you are going to get yelled at by everybody! Well fine if it was the right thing to do it is worth it! (Nominator 7, line 329-334).

> Nursing is personal, it takes something out of you, you are giving; sometimes more than others and different personalities. We are not all GG, I think GG has aged herself a lot by being very caring, by giving a lot of herself. (Nominator 8, 539-543).

Summary of undermining factors

Significant factors were shown to affect exemplary nursing practice. Time was mentioned as a key factor in providing exemplary care. Exemplary nurse nominees were better able to work around these time constraints, or simply take whatever time was needed for patient needs. When this was not possible, participants lamented their inability to practice in the manner they desired.

Administrative, unit management, interpersonal relationships (nurse to nurse, nurse to physician, and patient to nurse) affected the provision of exemplary nursing practice. Recognition played a large role in allowing participants to feel valued, and consequently encouraging exemplary nursing practice. Sadly, this recognition was not always offered by management, peers, or patients. Participants identified the need to look within themselves, to know they had done the best they possibly could and continue in providing exemplary patient care despite the lack of recognition, feedback or praise. Consequences of exemplary nursing practice became apparent in the form of reprimand, criticism, bullying and isolation. Despite the consequences these exemplary nurse continues to advocate for her patients.

Summary

The phenomenon of exemplary nursing practice raised strong feelings within the participants. Deep emotions were revealed as nominators and nominees recounted their observations and personal encounters. All participants expressed a personal desire to provide exemplary nursing care.

Study participants identified the importance of a relational approach to patients, one that is genuine, welcoming and open. A genuine love of nursing was mentioned by both nominees and nominators, a sincere love of fellow human beings, instilling confidence and trust with the patient; the patient as the central focus at all times.

Touch was identified as important in a therapeutic way, in diagnosing as well as a way to offer comfort. Mentoring was a means of fostering exemplary nursing practice in other nurses. Observational mentoring was specifically mentioned as a way nurses learn from their colleagues. Thematic themes of being, knowing and doing revealed such examples as being present for patients: sharing the moment or experience of the patient. Knowing included 'deep knowing', expertise, and continuing education throughout a nursing career. "Going above and beyond" what was expected was a major factor in doing. A positive attitude and a sense of humor were central in maintaining exemplary nursing care, especially when dealing with the undermining factors working in opposition to exemplary nursing practice. The exemplary nurse is an advocate for both patients and her colleagues.

Chapter Five

Discussion

This chapter discusses findings specific to this study and situates them within existing literature. The demographics of the participants are reviewed, as well as the purpose and method used in the study. Limitations of the study are acknowledged and factors undermining exemplary nursing practice revealed in Chapter 4 are discussed. New findings, implications for practice, administration and education are also discussed.

The intent of this research was to have bedside nurses identify and reflect on the positive and exemplary nursing practice that is provided to patients. To help identify and foster common understanding of the words ‘exemplary nursing practice’ a brief explanation was included in the invitation to participate in the study: A nurse who goes above and beyond; a nurse who serves as a role model to other nurses. The following research questions guided the study: 1) How do peer nominators define, observe, and identify, their colleagues as exemplary nurses? and 2) How do peer-nominated nurses describe and reveal their own exemplary practice?

Participants

Of the 17 bedside nurses who participated in this study, Nominators (N=9) and Nominees (N=8), all were experienced registered nurses. The participants were identified by word of mouth and peer nomination. I initially asked several of my colleagues who they thought was an exemplary nurse. From that beginning, others came forward and an invitation was extended to participate in the study. These nominators offered the names of their exemplary colleagues and they extended a written invitation

to each of the nominees. The list of exemplary nurse nominees was in excess of the 10 that was planned; coordinating interview times, or the willingness to participate reduced the number of nominees to eight. Years of nursing experience for the nominators and nominees spanned from 8 to 38 with an average number of 25 - 36 practice years. The mode was 31-35 years of nursing practice. Collectively, this experience factored into the identification of exemplary nursing practice by allowing years of clinical practice and observation to speak to the phenomenon. All nominators were required to have more than five years nursing experience; this requirement was met as all nominators had more than 20 years experience.

Research Design and Method

The research design was exploratory-descriptive, and qualitative methodology was appropriately suited as it allowed the participants to express their perceptions and intimate knowledge of the subject. Person-centered interviewing (Levy & Hollan, 1998 Weiss, 1994) worked well as a method as it permitted the nurses to discuss their experiences, observations, and feelings freely – and thoroughly. Nominators and nominees were interviewed separately; the data revealed that there was little difference in perception between these two types of participants with the exception of fragmented care as an undermining factor identified by the nominators. Nominees did not identify this phenomenon. As well, nominees did not dwell on system problems but tended to focus on the patient aspect of nursing care they provided. In general, data revealed undermining factors of exemplary nursing were identified less so by the nominees than the nominators.

All participants chose to meet outside the hospital environment. Interviews took place at either the participants' homes or my own residence and at the participants' discretion. Interviews were face-to-face with no other individuals present or interruptions. I believe this environment allowed for a greater sense of trust and freedom for the participants to share their personal feelings and observations in a safe context.

The duration of each interview was approximately an hour, with post interview conversations lasting as long as another hour and a half as the participants were given the freedom to voice any other observations after the recorder was turned off. Permission to use an audio recorder, which was in view during the interview process, posed no deterrent to the openness of the responses. From my perspective, the respondents were sincere and frank with their responses. Several of the participants did request a break during the course of the interview in order to 'regroup' because of the emotions or memories that were brought to the surface.

Saturation was met when no new data was revealed and characteristics were being repeated. Thus, the interview process concluded with 9 nominators and 8 nominees being interviewed. Recorded interview transcripts were transcribed verbatim by this researcher. Data analysis was then undertaken by reviewing the transcripts and the engagement of thematic analysis (Burnard, 1994). Mapping of raw data into thematic categories with the use of a white board was then undertaken, during which data fell naturally into the categories of being, knowing and doing, which mirrors the findings of Styles (1990) and those of Kendall, (1999). Although as the interview questions were developed from their framework, the data were not analyzed as such. Data were open coded and the resultant themes arose from the consideration of the entire data set.

Exemplary Nursing Practice

The research questions that guided the study were:

1. How do peer nominators define, observe, and identify, their colleagues as exemplary nurses?
2. How do peer-nominated nurses describe and reveal their own exemplary practice?

While Appreciative Inquiry (Cooperrider & Whitney, 1999) was used as a means to identify positive influences about exemplary nursing practice, findings revealed negative influences were prevalent in the accounts offered by the participants. These negative influences potentially undermined nursing practice, however, it was how exemplary nurses dealt with these influences that was revealing in this study. Nominees identified their focus as being on the patient and his or her needs and not on the undermining factors that were common on nursing units. Nominators identified undermining system and unit factors much more frequently that served to impede exemplary nursing.

Literature has given us a broad spectrum of words and concepts that have been used interchangeably dependent upon the writer's and reader's personal understanding of what it means to be an exemplary nurse. These include novice to expert (Benner, 1984), good nurse (Nightingale 1890; Rush and Cook, 2006), quality nursing care (Burhans and Alligood, 2010), and excellence and exemplary care (Nobel-Adams, 2001; Perry, 2009, 2008, 2005, 1998). The use of exemplary and a singular definition has not appeared with any consistency or understanding; it is variable at best as it applies to nursing practice. Arbon (2004), states, "The concept of the expert nurse has limited, and over simplified, our understanding of exemplary nursing practice". (p.152) Valiga (2010)

acknowledged the difficulty in defining the word excellence and what it meant in terms of nursing educators and recognized the "complexity of the concept of excellence and its myriad of elements" (p.427). Valiga (2010) refers to Grossman and Valiga (2010) who suggest excellence means, "setting high standards for yourself and the groups in which you are involved, holding yourself to those standards despite challenges and pressures to reduce and lower them" (p.183). These challenges are evident in the many negative and undermining factors and consequences of exemplary nursing practice revealed in the findings of this study. Burr, Stitchler, and Poeltler (2011) suggest "exemplary nursing practice describes ways nurses practice, collaborate, communicate and develop professionally to provide the highest quality of care to their patients". (p.222) Noble-Adams (2001) states she "coined" the word exemplary "to describe the profession's finest [nurses] across a range of criteria. In so much as they are the ones who epitomise the positive aspects of nursing, they are those whom others wish to role model, and who are most respected by patients. These nurses are not only clinical experts, but also have other special qualities which make them stand out" (p. 24). What Adams does is offer us conceptual clarity regarding the term "exemplary practice". She conveys the breadth and depth of the concept and does justice to it.

How do peer nominators define, observe, and identify, their colleagues as exemplary nurses? Nominators in this study identified in their colleagues' personalities' descriptors that in many instances were similar when describing an exemplary nurse. Such descriptors included words such as kind, caring, patient, truthful, trustworthy, compassionate, and the love of nursing. Of interest, without knowing of Nobel-Adams work, the nominators conveyed the essence of Nobel-Adams definition of exemplary nursing; their descriptors paralleled Nobel-Adams definition of exemplary nursing.

A focus on 'nursing work' revealed descriptors such as professional, organized, skilled, educated, knowledgeable, experienced, lifelong learner, patient focused, patient advocate, making a difference, team player, thinks outside the box, student and staff mentorship, and effective communication. These qualities and descriptors are in alignment with previous research (Jasovsky et al, 2010). They are qualities that go beyond doing a job in a skilled and knowledgeable way. Findings revealed that expert is not recognized as being interchangeable with exemplary, in relation to day-to-day patient care. Exemplary carries with it more than being an expert in technical knowledge and expertise. Beyond technical knowledge and expertise, exemplary nurses have the ability to intuitively know (deep knowing) what the patient needs or when to listen. Exemplary nursing carries with it a constant "striving to". If this striving stops, nurses may no longer exhibit exemplary nursing practice. It is a constant undertaking to engage in exemplary nursing practice. Not just labor, but a labor of love – a passion. Hardy et al (2002) "propose that practice evidence of clinical nursing expertise develops from a practitioners' ability to 'see beyond' what is evident and capture a 'deeper understanding' of the clinical situations, clinical decision making and clinical outcomes." (p.201)

How do peer-nominated nurses describe and reveal their own exemplary practice?

This study revealed exemplary nursing is not defined by one descriptor but includes the entire complex dimensions of the exemplary nurse. Personality, passion for practice, personal experiences, knowledge, skill, spirituality, and an overall patient-care focus constitute the exemplary nurse. "Nurses bring to practice understandings about people and situations that they utilize in their work and that are grounded in understandings about the lived world that they have developed from experience in all its forms" (Aubon,

2004, p.153). This provides an holistic understanding of the phenomenon of exemplary nursing.

Exemplary nursing is not static; it is changing. It is the constant striving to attain and maintain exemplary nursing practice. The exemplary nurse nominees voiced that they felt honoured to be thought of as an exemplary; however, they also felt they had not achieved exemplary status as an end point but continued to strive for it on a daily basis using all that they had to give toward their nursing practice.

Repeatedly nominees mentioned their nursing practice was “focused on the patient”. This included being an advocate, educator, and providing comfort and knowledgeable care to the best of their ability. They may have been aware of undermining system problems, but they did not refer to them as frequently when discussing exemplary nursing practice compared to nominator participants. Nominators were able to articulate what they felt were identifiable exemplary characteristics in their colleagues, and the importance of patient focused care. They were also aware of the undermining factors present on nursing units and easily identified them in the context of stressed workplaces.

Theoretical Framework

The theoretical framework of being, knowing and doing, giving and receiving assisted to guide the exploration of the phenomenon of exemplary nursing. The data are free standing in that being, knowing and doing, surfaced independently during data analysis. These thematic areas surfaced during data analysis and the data were not analyzed according to these categories a priori. Of course, several of the interview questions were formulated based on this theoretical framework – and thus, shaped the data in some respect.

Arising from the data were the three thematic areas of Being, Knowing and Doing similar to Styles (1990) and Kendall (1999). Taken together, being, knowing, doing, giving and receiving, encompass the scope of the exemplary nurse (Styles, 1990; Kendall, 1999). These are not particularly new ideas; however, of interest, these were the theoretical domains as articulated and which have been identified and studied individually (Godkin, 2001; Zikorus, 2007).

Being

In the literature there were many references to the power of ‘being present for the patient’, a human-to-human connection. (Godkin, 2002; Noble-Adams, 2001; Perry, 2008, 2009) The importance of listening, communication, touch, empathy and respect for the patient and colleagues were mentioned by the participants and were confirmed by existing literature.

Zikorus (2007) observes, “sometimes holistic caring is revealed in the quiet simplicity of the nurse just being present” (p. 208), i.e., just being there, sharing time and maintaining presence. Being with the patient in silence allows patients the time and safe environment to confide and share what is most important to them. Findings also revealed exemplary nursing creates a caring space that instils confidence and trust between nurse and patient. This in turn builds and nurtures a therapeutic relationship matching skill with patient need. Newman (2008) refers to Rogers (1970), who postulates, “relating with another occurs as trust is established and authenticity recognized. The ability of the nurse and the patient to relate and connect with the other in a meaningful way occurs in dialogue” (p. 52), this can only be achieved with time spent “being” with the patient.

The exemplary nurse is able to really *see* the little things that will make the patient most comfortable. Study participants also mentioned being able to “hear” what is ‘not’ being said. To identify what is important to the patient, time must be spent at the patient’s side and beyond therapeutic interventions. For example, does the patient need a blanket, or a glass of water, or just to talk for a minute? Often the little things related to comfort care make a difference for patients. Noble-Adams (2001) agrees, “Being there is important within the nurse-patient relationship”. (p.27) Nobel-Adams (2001), who based her work on that of Benner and Wrubel, (1989) goes on to state, “the presence required is not only mere physical presence but also something that reflects being in tune with another, an awareness of the other’s uniqueness that is perceived as caring”(p. 28). Parse (1999), refers to her human becoming principles as “true presence: a non-routinized way of being with others that honours the others’ views and choices” (p. 1384) This allows the patient to allocate personal meaning to a situation and the nurse acting as a witness, rather than a director of the process. “Nursing presence is a way of being with a patient in an authentic relationship that promotes mutual respect, honesty, and integrity (Zyblock, 2010, p. 122)

Caring, for the exemplary nurse, is something she offers with all her being. Throughout the literature, caring is positioned as fundamental to nursing. (Alliex and Irurita, 2004; Cody & Squire, 1998; Duffield & Lumby, 1994; Kuhse, 1998; Mackintosh, 2000; Watson, 2002) In this study, touch was identified as a powerful way to connect with patients and demonstrate caring. Exemplary nurses were not afraid to touch their patients in diagnostic, consoling and comforting ways; they viewed this as an important gift. Touch connected the nurse with the patient in a therapeutic way. Touch is recognized as “bridging the physical and emotional gap between people, touch is a

medium through which we directly express care, comfort, and compassion" (Leder & Krucoff, 2008, p.323). Touch is a powerful form of communication when the patient is ill and feeling most vulnerable. It was central to the practice of exemplary nursing.

Mentoring and "being there" for colleagues was identified as important when describing exemplary nurses. Hard working, skilled, approachable, and respectful to physicians, nurses, and patients, were used in describing the exemplary nurse. Above all, the joy and genuine love of nursing was evident in both nominators and nominees. Nightingale (1860) referred to this as "enthusiasm for nursing". Because of this love of nursing, nominees gave freely of their time and expertise as mentors, encouraging others to take pride in exemplary nursing. Exemplary nurses showed a unique and deep passion for their nursing practice that is unique to the exemplary nurse. Exemplary nurses can identify such passion in other nurses and are willing to nurture and mentor this love of nursing in others.

Knowing

Knowing encompassed being knowledgeable, continuing education, practice or clinical experience, intuition or deep knowing (knowing what is transpiring with the patient); anticipating, and knowing when to take action. Benner (2001) described the expert nurse as one who uses intuitive practice. The participants in this study often described knowing or intuition within their daily practice that enabled them to anticipate or take action on behalf of the patient. Lyneham et al., (2008) refers to six components of intuitive nursing practice as "knowledge and experience, feeling (a physical response), connection (to the patient), syncretism (undertaking unusual or out of place assessments), and trust (in one's ability)" (Lyneham et al., p. 382). In the Lyneham study, each of 14 emergency room nurses described situations where intuition played a

role in their practice. The participants in this thesis study had been in practice greater than 5 years – the approximate time Benner (2001) stated it takes to become an expert nurse. (p.31) Within the transcripts, participants observed that they 'read' their patients on multiple channels, and gathered vital information on their patients' status. This ability validates Benner (2001) in that it takes time and experience to develop these skills.

As described, exemplary nurse nominees and nominators reacted to situations where patient signs and symptoms were not conclusive or not yet evident during assessment. These nurses were not afraid to trust the 'feeling' that they should assess the patient further or take action by calling in the physician. This is in agreement with Benner (2001) that " expert nurses know that in all cases definitive evaluation of a patient's condition requires a more than vague hunches, but through experience they have learned to allow their perceptions to lead confirming evidence" (p. xxii). Exemplary nurses acknowledged the sense of deep knowing or 'feeling' that something was about to transpire. McCutcheon (2001) recognized "when nurses act on their intuition the result is that the patient either directly or indirectly, benefits in some way. Intuition therefore is a skill that affects the quality of patient care and patient outcomes" (p.343). Lyneham (2008) explains this as "The expert [nurse] uses cognitive intuition so efficiently that the clinical behaviour does not appear to be externally supported or the nurse may not even be aware of its effect" (Lyneham, 2008, p. 383). There is agreement in the literature that intuition does exist (Hams, 2000; Lyneham, 2008; McCutcheon, 2001), and that the number of years in clinical practice and experience does play a factor in enhancing the courage or confidence required to act upon the intuitive feelings however they come about. In this thesis study, exemplary nurses evidenced deep knowing as a kind of intuitive knowing.

The findings in this study also resonates with Carper's (1978) Fundamental ways of knowing: 1) Empirical knowing, 2) Aesthetic knowing 3) Personal knowing 4) Ethical knowing. Empirical knowing was described in the transcripts by both nominees and nominators as the need for ongoing education and a continued evaluation of skills. Personal knowledge and attitudes were mentioned as important to envisioning themselves in the patient situation and imagine how they might feel or respond. This was identified by descriptors such as "if it was me" or "if it was my family member". Ethical knowing or moral choices, was identified by "doing the right thing", often requiring courage and strength to advocate on behalf of the patient, and doing the right thing, even though no one is watching. Aesthetic knowing is described in the data as taking in the whole situation, one indicator of this was providing for the family wishing to have their infant blessed following its demise. This aesthetic knowing required immediate practical action in which the nurse involved provided comfort of the whole family, she was able to take in the whole situation, not only physical but emotional and spiritual as well.

Life experience also played a role in the nominator's view of exemplary nursing. It was recognized that clinical experience was important to exemplary nursing but also the personal experiences of the nurse. Will (2001), agrees and recognizes that "few authors have made explicit reference to nurses' lives outside clinical practice, or have sought to understand how life experiences contribute to the way in which they know nursing" (p.107). Arbon, (2004) after a review of literature, concluded that the "development of exemplary nursing practice leads to the conclusion that the individuality of nurses, that may be related relatively more to their non-nursing experiences, tends to be overlooked within the profession and among authors" (p. 150). How exemplary nurses interact with

their patients and perform within their nursing practice is often directly related to their personal experiences (Arbon, 2004). "Nurses bring to practice understandings about people and situations that they utilize in their work and that are grounded in understandings about the lived world that they have developed from experience in all its forms" (Arbon, 2004, p. 153). Based on the work of Carper (1978), Billay et al (2007) describe aesthetic knowing, as not only performing a nursing skill competently, but, "going that extra mile" for the patient by providing that patient with often unrecognized nursing acts, such as a reassuring squeeze of the hand, a compassionate smile, or a funny joke, each act in its small yet significant way demonstrating artful nursing care" (p. 150). The participants in this study often referred to "going the extra mile" in their descriptors of the exemplary nurse.

Exemplary nurses were seen as well rounded individuals with life experiences to draw upon. Both nominators and nominees indicated that it was rare for a new graduate nurse to reach exemplary status. They agreed it would take some time to develop skills and knowledge to perform exemplary nursing practice. No definitive number of years was offered by the participant's vis-à-vis exemplary practice, realizing many factors come into play such as life experience and type of patient experiences. It was recognized these nurses' qualities stood out from their colleagues even as they continued to grow in their nursing practice.

Lifelong learning was integral to exemplary nursing practice. The ability to discern a knowledge deficit and the willingness to learn from experience, physicians, fellow nurses, and students was apparent among exemplary nurses. Formal learning was valued as well as enhancing practice skills by attending workshops and in-services. This

enthusiasm for learning was identified by the exemplary nurse as being critical to her ability to integrate theory, practice, and research.

All participants mentioned self-reflection as a daily means of assessing the care that they provided to patients and their families. Such reflection made them consciously aware of their practice. "Reminiscence requires reflection on our own meaningful experience and provides the foundation for a developing understanding of self that can be applied to practice" (Aubon, 2004, p.156). Learning from what worked well, or not well, during their shift aided in their professional growth. Exemplary nurses readily shared their theoretical and experiential knowledge with others to enhance patient experiences and outcomes.

Doing

Doing for the exemplary nurse was reported as being skilled and competent, engaging in patient teaching, and remaining calm in all situations.

Patients are clear on the values they recognized as being exemplary. "There are few whom I will remember as outstanding… Her words were few, her voice was calm and present" (Zikorus, 2007, (p. 208-209). Nurse participants recognized similar values and skills and identified them in the exemplary nurse.

The exemplary nurse was described as being skilled, efficient and thorough. This nurse holds high standards of care and is demanding of herself. She is not willing to give a lesser standard of care even if others choose to. This high level of care and compassion is part of who she is and is done unconsciously; it is what others identify when describing exemplary care. Simms, Erbin-Roesmann, Darga and Coeling (1990) defined work excitement as "personal enthusiasm and commitment for work evidenced by creativity, receptivity to learning, and the ability to see opportunity in everyday

situations". (p.178) Exemplary nurses were viewed a team players, creating a positive work environment for colleagues and patients. They went the extra mile, doing more than their share to make the unit function in the best possible way, and they created a positive environment for both staff and patients. These descriptors accurately describe the exemplary nurse as her colleagues see her; committed, enthusiastic, and thinks outside the box to accomplish what needs to be done.

Perry (2009) identified an optimistic attitude as being critical to being an exemplary role model. This was born out within the transcripts of this study with identifiers of exemplary nurses such as "a sense of humor, being positive, making it work, and thinking outside the box to make a quality experience for the patient". Exemplary nurses were not afraid to laugh at themselves and share humor with their patients to help ease some of their anxiety during care (Noble-Adams, 2001). In describing these upbeat people Noble-Adams (2001) used the term "positive energy people" (p. 29) from the work of Mabbett (1987).

Courage also describes the exemplary nurse. As an advocate for both patients and colleagues, she must be assertive as the situation dictates. Voicing concern to physicians and providing all care options to patients regarding their care takes strength, courage and well-developed communication skills. Boundaries may be pushed at times, and strength is required when the need arises to move against the system for the patient's sake. As an advocate, personal consequences are accepted if it decreases suffering for the patient. Lachman (2010) identifies that "moral courage involves the willingness to speak out and do that which is right in the face of forces that would lead a person to act in some other way (p.1). Lachman (2010), maintains the ability to act in a morally courageous way is

the nurses knowledge, emotional control, skills to manage risk and the courage to address the problem (p.4).

Undermining factors to Exemplary Nursing Practice

Undermining factors were brought into focus mainly by the nominators. At the unit/practice level, they identified lack of time, medicalization and technology, and fragmented care as areas of concern. At the management and administration level, a lack of respect and lack of recognition, insincere praise, decreased morale, and isolation undermined nursing practice.

The exemplary nominee recognized the presence of these undermining factors and tried to overcome them in the act of offering exemplary nursing care. Their focus remained at all times on the patient. They worked at providing the best care they could within their abilities. Some of these undermining factors cannot be ignored, and they do have a negative impact on exemplary care. Nominators recognized time constraints, voicing this concern more frequently than the nominees did. Exemplary nurse nominees recognized the need for time spent with the patient and seemed able to work within these constraints focusing on patient need, seemingly one patient at a time without losing sight of the workings of the whole unit. When they were unable to meet the demands as they would have liked, all participants lamented the ability to give the care they wished. This finding resonates with the findings of Enns and Gregory, (2007).

Limited time meant spending less time with colleagues to learn from their experiences and to function as a group. Time constraints were implicated in the general undoing of staff morale. Exemplary nurses did not make excuses for systems issues such as staffing ratios or the impact of change and technology. Isolation from peers was

identified as a form of self protection from the continual bombardment of stressors. Nurse to nurse reporting (a recently established protocol) instead of the traditional group report was seen by these participants a detrimental to overall cohesive team function. Oral group report was identified as an opportunity to brainstorm and use more experienced nurses as a resource, as well as identifying nurses with a heavier patient load who may require help. Skaalvik et. al., (2010), agrees that "oral shift reporting may be a important learning opportunity. This is especially true when nursing students engage in professional discussions with their colleagues and superiors" (p.2300). Study participants felt this type of professional socialization enhanced peer learning and exemplary patient focused care. Further research is needed as to the long-term detriments to the staff nurse in creating an isolating practice of individual nurse to nurse reporting.

The need for peer support and debriefing after a critical incident was also recognized. Attaching blame following an incident underscores isolation and diminishes personal self worth. Exemplary nurses were shown to learn from situations, good or difficult. When blame is attached to incidents, openness and learning is diminished. Ross-Adjie, Leslie, and Gillman (2007) asked nurses to rank workplace stressors. Violence against nurses was ranked number one, and skill mix second. Critical incidents were ranked third. Most (60%) of participants did not receive debriefing following a critical incident. (p. 118). Respondents in that study felt debriefing should be mandatory and conducted by specially trained professionals. (p. 118)

As identified by the nominators, medicalization and technology were ever-present and mostly had a distancing effect for the nurse and from her patient. For the exemplary nurse, it did not seem to be the main focus of her nursing practice; the patient remained

at the center, not marginalized by technology. None of the participants spoke to the benefits of technology but they did mourn the loss of hands-on care and the decrease in developing solid assessment skills as dependence on technology has become more prevalent. Scientific and generalizable knowledge is necessary for nursing practice as nurses often work in ambiguous situations needing practical judgement" (Flaming, 2002, p. 152). Nurses cannot simply rely on technology in such situations.

Nominators, but not the nominees, identified fragmented care as an undermining factor in exemplary care. Again, this seemed to reflect on the exemplary nurse's ability to focus on the patient and his individual needs in the moment. Exemplary nurses were aware of this undermining factor – but consistently "worked around" it. From the participant interviews, nominators seemed to be generally more aware of system flaws in a larger context and saw flaws as they filtered down to the patient level, in a top down fashion. Nominees tended to focus centrally on the patient and their care, attempting to work around the system for the patients benefit or attempt to "fix" the health care system one patient at a time. Reflectively, this does not correct system failures but provides a temporary solution for that particular situation. In reality, this does not provide a long-term solution for a damaged system.

Personal recognition or acknowledgement is important to an overall sense of well-being but not fundamental to what fuels the exemplary nurse or provides her with self worth. It is acknowledged that recognition of the work that is done, and the overall quality of patient care being recognized, boosts morale (Nobel-Adams, 2001). Respect is an important factor in team morale and ultimately exemplary nursing practice. The participants identified the need for respect arising from the health care system, management, physicians, and colleagues. Unit management plays a significant role

influencing the work/unit environment. Wiggins and Hyrkas (2011) comment that the "challenge for leadership and management today is not just to achieve excellence, but also to nurture and sustain it" (p.1) Participants acknowledged the unit environment as an important factor for patient care. Moreover, patients can sense discord on a unit and this can hinder their recovery. Wiggins and Hyrkas (2011) agree that "a healthy work environment is crucial for nursing practice, optimal patient outcomes and ultimately clinical excellence." (p.1) Issues of power and the feeling that nursing skills were being devalued were voiced as personal frustration and an impediment to patient care. The findings from this study suggest that there is a need for critical and healing conversations between nurses and physicians. At times, physicians are perhaps unaware of just how inappropriate their behaviour is which potentially causes a breakdown of relationship and communication critical to patient care. Nurses have a voice and wish to be heard and the value of their assessment skills acknowledged. Wiggins and Hyrkas (2011) reference Heath, Johanson and Blake (2004) that literature supports "a healthy and effective work environment includes at least the following four characteristics: 1) respectful and fair treatment of employees, 2) strong sense of trust between management and employees, 3) organizational culture that supports communication and collaboration and 4) feeling of emotional and physical safety." (p.1) If these four factors were met on nursing units much of the power issues and feelings of being devalued could be solved. Analysis of the transcripts showed leadership and trust in management was important to both nominators and nominees. Nursing as a profession faces challenges, and changes on a daily basis. Participants voiced their desire for improved communication and collaboration among nurses, management and physicians in order to effectively deal with the many challenges they face. These are similar to the findings of McVicar (2003)

who identified the main sources of stress to be workload, leadership/management style, professional conflict and the emotional cost of caring.

Intergenerational issues played a role in exemplary nursing. Respect and recognition of previous experience aided in the willingness of mentoring opportunities. Participants identified a tension between new graduates and registered nurses in the workplace; both nominators and nominees mentioned this phenomenon. Participants voiced concern that the ideation of nursing was not accurate in the minds of newer nurses; it was simply a job for them that they could take or leave. In contrast, the exemplary nurse viewed nursing as a part of her being. This level of commitment is commendable and certainly benefits the patient with dedicated care. In the long-term, this total commitment may in fact foster irreconcilable stress and burnout.

The consequences of being an exemplary nurse were evident within the interview transcripts. Many negative consequences were mentioned. Courage and bravery were required when advocating for patients and colleagues. Moral and ethical values propelled them to persevere for their patient’s sake with minimal regard for personal or professional discomfort. Exemplary nurses showed a high level of commitment to patients and the nursing profession as a whole.

New Findings

False praise was mentioned by several participants and has not been identified in previous literature. False praise was described by participants as being praise given that is not deserved; praise given to others while failing to recognize those who truly deserve recognition for a job well done. Participants identified that false praise mostly came from unit managers. Undeserved praise was regarded as demeaning and worse than no

recognition at all. This engendered a sense of distrust among the participants. The participants in general did not rely on praise to be exemplary nurses, but recognised the insincerity this kind of praise carried and how it was detrimental to unit morale.

A consequence of the undermining factors of exemplary nursing was isolation. The registered nurse interacts less with colleagues and her patients as stress levels rise as a means of self-protection. Teamwork and unit moral suffers as a result, with the potential for burnout to the individual nurse.

Observational mentoring was a new finding, separate from the formal mentoring process in place. Observational mentoring occurred when other nurses visually engaged with exemplary nurses in the performance of their nursing practice, often unnoticed by the exemplary nurse. Both nominees and nominators mentioned that they frequently watched other nurses perform their duties and how they handled difficult situations, ultimately learning from these situations and often incorporating these observed skills into their practice. The exemplary nurses in this study seemed unaware that they had been the focus of observation and an influence to other nurses.

A genuine love of nursing was identified as an important factor in exemplary nursing practice. The individual nurse was seen as practicing far beyond the level of a job, more as a calling or deep love of her fellow human: A committed effort to make the patient as comfortable as possible without regard of self.

Implications for Practice and Administration

Study participants made observations and voiced concerns regarding bedside report. Associated with nurse-to-nurse reporting was incomplete information, lack of privacy, and loss of teamwork and valuable teaching opportunities. Sharing expertise and

knowledge regarding patient care in a group report setting would seem to benefit safe and exemplary patient care.

Trossman (2009) describes a shift-reporting situation where the charge nurse gave report that provided information on all the patients on the unit. The nurses then proceeded to get individual reports from their colleagues from the previous shift. (p.7) This may be a reasonable compromise meeting the staff need for professional socialization and learning during shift report as well as benefitting patient care with a complete change of shift report.

Implications for Education

Education of our future nurses needs to create an awareness including frank discussions with students regarding the realities of nursing and the forces that impinge upon exemplary practice. This would serve to open the door to greater understanding of what they will face as nurses and equipping them with the knowledge of how to address care undermining factors. Nurses at present are continuing in much the same way they have for the past century. Nurses are trying to provide exemplary care with ever decreasing resources; making the best of an unhealthy situation. The current system needs to be challenged, and moved beyond that of one which sees nursing mainly as a commodity and easily replaced. From this perspective, nursing is understood economically, rather than the recognition of the person embodying a wealth of knowledge, skill and compassion.

Nursing economics will become increasingly more important as healthcare across the country struggles financially to provide healthcare in a fiscally responsible way while maintaining patient focus. Our new nurses need to be equipped with the knowledge of

unions and the benefits they bring to the workplace and the health of nurses. Information regarding what students can do as change agents within the healthcare system should be standard knowledge in nursing curricula. Nursing education can create an awareness of the politics involved in healthcare and provide them with the knowledge to challenge a dysfunctional system, including the undermining of nursing practice.

As nurses struggle to provide comfort and compassion to patients, ethics plays an even greater role in providing that care. Today's nurses are accepting of the guilt that arises if they fail to meet business expectations while they strive to provide skilled care, comfort and compassion to their patients. In other words, nurses are compensating for the gaps, limitations and care undermining factors in the practice setting.

Limitations

Within the limitations of this study there is agreement with a comment by Benner (2001)

> "because excellent caring practices as well as diagnostic, monitoring, and therapeutic interventions are relational and contextual, the clinician cannot be sure whether such excellent practice should occur in other settings, relationships, or circumstances. Local specific knowledge, as well as general knowledge, is evident in every nursing story" (p.xiii)

These are the participant's personal reflections and are situationally specific.

In this study, there were no male nurses brought forward as nominees or nominators; there was a reliance on female nurses' perspectives. Including the male nursing perspective may include other qualities that were not identified in these research findings. Age and number of years in practice may play a factor in understanding what newer graduates see as exemplary nursing as they develop their own nursing practice outside of their formal educational experience. As all of the participants had at least five

years of nursing experience it may be that the new graduate would identify exemplary in a different way.

Nursing management, physicians, patients and their families were not included in the interview process; their perspectives are important to understanding exemplary nursing practice.

Recommendations for Future Research

As MacDonald (2008) claimed, there is little research to show whether knowing the patient is important to nursing care (p. 149). However, the participants in this study did voice the importance of getting to know their patients, as well as clinical knowledge, and the use of deep knowing or intuition to provide exemplary nursing care. Nurses acknowledged a need to spend focused time with patients to understand their needs and concerns. Therefore, further research is needed with respect to knowing patients and how this affects exemplary patient care.

Nurses reflected that nursing was "part of them", further research on what kind of nursing practice experiences impacts nurses personal lives. In addition, participants identified that nursing was core to their being. In contrast, new graduates were noted as simply engaging in a job. These differing perspectives will need to be addressed to avoid the impact of discord on the unit, recognizing each can learn from the other's perspective building a stronger foundation to nurture exemplary practice.

In regards to end of shift reporting, further study of the implications of nurse-to-nurse bedside reporting would be beneficial to determine if the detriments outweigh the benefits. There is some research reflective of patient preference and a desire to hear what the nurse has to say about them, thus patients are said to desire this type of shift

reporting (Chapman, 2009, Trossman, 2009). There is a need for further research as to how it affects patient care and overall patient safety, and nurse perceptions regarding the effectiveness of bedside reporting.

Further research into how to empower nurses to take action and address the undermining factors related to exemplary nursing would be beneficial to the profession and to the knowledge base of nursing.

Reflection and Reflexivity

At the onset of this research, I had planned to employ the services of a transcriptionist. The spacing of the interviews and time available allowed me to transcribe the recorded interviews myself. This proved to enhance the experience and helped me to understand the context and emotion of the shared data in greater depth. I was able to repeatedly immerse myself in the experiences of the participants. Providing the research questions ahead of time to the participants was beneficial as it allowed them time to reflect on their practice and their perceptions of exemplary nursing practice. This facilitated the interview process, as participants were more relaxed knowing the questions that would be asked.

As the research questions were explored, the findings revealed the extent to which nursing influenced the personal lives of the participants. The participants entrusted me with their feelings; their stories - good and bad; their personal reflections and introspections; and at times shared their personal pain. They shared memories that they keep safe and close to their hearts. These nurses spoke with awe and admiration when describing a colleague they felt to be exemplary, and offered great insight as to how these nurses had influenced their personal nursing practice. Of interest, all of the

interview conversations continued after the recorder was turned off. This permitted time for the nurse participants to relax from the interview format and voice any other topics or insights as they wished, off the record. These post-conversations, some as long as an hour and a half, made it very clear the intensity of feeling each nurse felt towards her nursing practice and the significance it played in their personal lives. It was apparent nursing was much more than a job limited to hours spent on duty. The dedication of these nurses carried into their personal lives and influenced how they conduct themselves in general. Self-reflection was continuous and governed their personal growth as well as their nursing practice by indicating areas of success, improvement and future educational pursuits.

Both nominators as well as nominees saw themselves at least in some aspects of practice as being exemplary. This was evidenced in the way some of the responses were made. Nominees were often surprised at being nominated as exemplary and that other nurses had been observing their practice. The willingness of these bedside nurses to share their thoughts and feelings spoke to their need and desire to provide exemplary nursing care. Once these participants relaxed post-interview, it was clear that they had suggestions to offer regarding nursing practice and felt that they had not previously in their practice been given the forum to speak out in a retribution free environment.

The freedom these nurse participants felt in sharing their stories with me was in part that I too was a nurse and possessed a certain understanding of the workings of a nursing unit. I could relate to the emotion and involvement of the nurse in each patient situation.

From this research I have gained a greater understanding of nursing practice outside of my own practice and unit. I have gained knowledge that concerns raised are not unique but are evident in other units and hospitals. I had originally thought to reveal

findings that focused only on the best exemplars that all nurses could follow towards being exemplary. This was not solely the case, closely interwoven within the narratives were the negative or undermining factors that could not be ignored.

Summary

To be able to identify and nurture these identified qualities of the exemplary nurse will do much to enhance nursing practice and the care and safety of the patients under our care. Providing sincere recognition of the exemplary nurse, allowing time for the patient, encouraging new nurses to continue and expand their knowledge base are some of the ways to nurture our nurses. Exemplary nursing practice is a cumulative process as well as coming from personal characteristics. While exemplary nursing practice may not be formally taught in an educational setting, it can be learned by example and with the expectation that to be an exemplary nurse, is the minimum standard of care. Mentoring builds the backbone of nursing. Nurses need to take advantage of the passion, knowledge and skills exemplary nurses have to offer in mentorship and collaboration before these exemplary nurses reach retirement.

Nominees and nominators varied very little in their perceptions of exemplary nursing practice. Nominators were able to identify systems failures in a larger scale, while the nominees focused on the individual patient, often working around the system to provide the immediate care required. Nominators also identified fragmented care as an undermining factor while nominees did not, as their focus tended to be centrally on the individual patient and their needs.

The participants of this study are indeed an amazing, resourceful group of nurses who have achieved exemplary nursing practice in the eyes of their colleagues.

“Excellence is never an accident. It requires ongoing attention and an individual investment; as noted by Aristotle, it is not an isolated act, but a habit or way of life”. (Valiga, 2010)

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Appendix A: University Ethics Approval

University of
Lethbridge

Office of
Research Services

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2431
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CERTIFICATE OF HUMAN SUBJECT RESEARCH
University of Lethbridge
Human Subject Research Committee

PRINCIPAL INVESTIGATOR: Sheila McRae (Supervisor: Dr. david Gregory)

ADDRESS: Faculty of Health Sciences
University of Lethbridge
4401 University Drive
Lethbridge, AB
T1K 3M4

PROJECT TITLE: Nurse Perceptions of Exemplary Nursing Practice in the Context of Stressed Workplaces
(Protocol #919)

FUNDING SOURCE: Unfunded

The Human Subject Research Committee, having reviewed the above-named proposal on matters relating to the ethics of human subject research, approves the procedures proposed and certifies that the treatment of human subjects will be in accordance with the Tri-Council Policy Statement, and University policy.

Human Subject Research Committee

Date

Appendix B: Chinook Health Research Approval

RESEARCH AGREEMENT
(Section 54 of *Health Information Act*)

THIS AGREEMENT made effective the 1st day of ~~July~~ Sept, 2010,

BETWEEN:

SHEILA MCRAE
(the "Researcher")

OF THE FIRST PART

- and -

ALBERTA HEALTH SERVICES
("AHS")

OF THE SECOND PART.

WHEREAS:

A. The Researcher intends to conduct research, as defined in the *Health Information Act*, R.S.A. 2000, c. H-5 (the "Act"), and has received from the University of Lethbridge Research Ethics Board (the "Board") approval of the Researcher's research proposal, a copy of which Board approval is attached hereto as Schedule "A" (the "Board Approval");

B. The Board is an ethics committee, as defined in the Act and the regulations under the Act (the "Regulations");

C. Pursuant to the Act, AHS is the custodian of health information (as defined in section 48 of the Act);

D. The Researcher has applied in writing to AHS for disclosure of health information to be used in the Researcher's research (the "Requested Information"); and

E. AHS has considered the Researcher's application and decided to disclose the Requested Information, and it is a requirement under section 54 of the Act that the parties enter into an agreement containing the following covenants on the part of the Researcher.

NOW THEREFORE in consideration of the decision by AHS to disclose the Requested Information and the covenants of the Researcher contained herein, the parties hereby agree as follows:

1. The Researcher shall:

   (a) comply with:

      (i) the Act and the Regulations;

      (ii) the conditions (if any) imposed by AHS, as set out in Schedule "B" attached hereto, relating to the use, protection, disclosure, return and/or disposal of the Requested Information;

(iii) the conditions (if any) suggested or imposed by the Board, as set out in the Board Approval;

(iv) the requirements (if any) imposed by AHS, as set out in Schedule "B" attached hereto, to provide safeguards against the identification, direct or indirect, of an individual who is the subject of the Requested Information (an "Individual"); and

(v) the requirements (if any) imposed by the Board, as set out in the Board Approval, to provide safeguards against the identification, direct or indirect, of an Individual;

(b) use the Requested Information only for the purpose of conducting the Researcher's proposed research, as approved by the Board (as indicated in the Board Approval);

(c) not publish the Requested Information in a form that could reasonably enable the identity of an Individual to be readily ascertained;

(d) not make any attempt to contact an Individual to obtain additional health information, unless and until:

(i) the Researcher has requested in writing that AHS seek from the Individual consent to such contact; and

(ii) the Individual has provided AHS with the said consent; and

(e) allow AHS to access or inspect the Researcher's premises to confirm that the Researcher is complying with the enactments, conditions and requirements referred to in subsection 1(a) hereof.

2. The Researcher shall comply with any additional conditions and requirements as may be imposed in writing by AHS or the Board after the date of this agreement with respect to the matters contemplated in subsections 1(a)(ii) through 1(a)(v) hereof.

3. If the Board has recommended that consents be obtained, the Researcher represents and warrants to AHS that the Researcher has, or will prior to the disclosure have, obtained consents from the Individuals for the disclosure of the Requested Information.

4. Upon the due execution of this agreement by the parties, and provided that (if the Board has recommended that consents should be obtained) AHS has received the consent of the Individuals, AHS shall disclose to the Researcher the Requested Information.

5. AHS may set the costs of:

(a) preparing the Requested Information for disclosure;

(b) making copies of the Requested Information; and

(c) obtaining the consents referred to in subsection 1(d) hereof,

which shall not exceed the actual cost of providing the same, and the Researcher shall pay the said costs within thirty (30) days of receiving an invoice or invoices for the same.

6. The Researcher shall be liable to AHS for, and shall and does hereby indemnify and save AHS harmless from and against, any and all losses, claims, expenses, damages, liabilities and actions whatsoever (including, without limitation, legal costs on a solicitor and own client basis) which may be brought or made against AHS, or which AHS may sustain, pay or incur, in either case as a result of, or in connection with, a breach by the Researcher of its obligations under this agreement or the wilful or negligent acts of the Researcher or those for whom the Researcher is responsible at law. The provisions of this section shall survive the termination of this agreement.

7. If the Researcher contravenes or fails to meet the terms and conditions of this agreement, the agreement shall be terminated.

8. The Researcher understands that if the Researcher knowingly breaches the terms and conditions of this Agreement, the Researcher is guilty of an offence under the *Health Information Act* and liable to a fine.

9. Any notice to be given under this agreement shall be given in writing and effectually given if personally delivered, sent by registered mail or transmitted by fax as follows:

   if to the Researcher, to:
   Sheila McRae

   if to AHS, to:
   Chinook Regional Research Committee
   Chinook Regional Hospital
   960 – 9th Street South
   Lethbridge, AB
   T1J 1W5
   Fax No: 403-388-6708
   Attention: Trudi Jersak

   and shall be deemed to have been received if personally delivered when delivered, if sent by registered mail on the third (3rd) business day following the date of mailing, and if transmitted by fax on the date of transmission if a business day or the first business day following the date of transmission if not a business day.

10. The Researcher shall not assign this agreement without the prior written consent of AHS, which consent may be arbitrarily withheld.

11. This agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns.

12. This agreement shall be governed in accordance with the laws in force in the Province of Alberta.

IN WITNESS WHEREOF the parties hereto have executed this agreement effective as of the day and year first above written.

(Signature of Witness)	(Signature of Researcher)
	Sheila McRae
(Printed Name of Witness)	(Printed Name of Researcher)

ALBERTA HEALTH SERVICES

Per: [signature]
Name: Huey Chong
Title: Office of the Senior Vice President, Research

Per:
Name:
Title:

Consent form for participants

Nurse perceptions of exemplary nursing practice in the context of stressed workplaces.

You are being invited to participate in an exploratory study giving Registered Nurses a voice in identifying what exemplary nursing practice means to them. The purpose of this research is to gain valuable insight, through person-centered interviews, the nature and characteristics of exemplary nursing practice. Information will be gathered on how Registered Nurses observe, identify, and define exemplary nursing practice. Secondly, how do these peer nominated nurses identify and define their own nursing practice. With greater understanding of exemplary nursing practice it is hoped that we can encourage and promote exemplary nursing practice in other nurses.

Participation is voluntary. If you agree to participate, interviews will be conducted in spring and summer 2010. Each interview will take approximately one hour of your time at a location of your choosing. With your permission the interview will be audio recorded for accuracy and transcribed exactly as spoken. Participants have the option to withdraw from the study at anytime without negative consequences and all data collected will be destroyed as confidential waste. As well, the audio recorder can be stopped at any time during the interview. You may also be asked to participate in member checking by reviewing your typed transcript for accuracy of content and meaning. Participants will be contacted by phone or e-mail 1 week following the interview to give them an opportunity to voice any further recollections or comments if they wish.

Following the interview, both nominators and nominees will be asked to fill out a short demographic information sheet addressing: gender, age, education, type of nursing unit, and years of nursing practice. Confidentiality and anonymity will be maintained by assigning a numeric identifier (known only to myself), to each participant. This number will replace the name in order to assure anonymity of the respondent. No names or unit numbers will be used.

Security of raw data in the form of transcripts, and tapes will be kept separately under lock and key in my home office in Lethbridge, Alberta for the duration of the project. Upon completion of the project, transcripts will be kept in a secure, locked environment

in my home office in Lethbridge, Alberta for five years accessible solely by the researcher, and will subsequently be shredded and destroyed as confidential waste.

There is no monetary compensation or direct benefit from participation in this study, although you may benefit in knowing you have recognized or been nominated as being an exemplary nurse. There is no harm or risk associated with participation in this study.

You are under no obligation to participate. You may also refuse to answer any question you are not comfortable with, and reveal as much information as you wish. It is anticipated that through the shared experiences of nurses like you we will gain a comprehensive understanding of exemplary nursing practice.

It is anticipated that the final results of this study will be shared with others by presentation and journal publication.

This research is being conducted by Sheila McRae R.N. as part of the Master's Program, Faculty of Health Sciences, University of Lethbridge.

If you have any further questions she may be reached by Email at sheila.mcrae@uleth.ca or (403) XXX-XXXX.

Your signature below indicates that you understand the nature and purpose of this study. You are agreeing to participate in a one hour interview and be audio recorded for accuracy. You have been given the opportunity to have all questions answered by the researcher.

Please check the applicable box if you wish to receive a copy of your transcript and/or an executive summary of the findings.

I wish a copy of my transcript. ☐ I wish to receive an executive summary of the findings. ☐

e-mail address________________________________ Contact number ___________________________

_________________________________ _____________________________ ______________

Name of Participant *Signature* *Date*

A copy of this consent will be left with you, and copy will be kept by the researcher.

Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge (Phone: 403 329-2747 or Email: research.services@uleth.ca)

Appendix D: Nominator Introduction

Do You Know An Exemplary Nurse?

As part of Master's thesis research:

Nurse Perceptions of Exemplary Nursing Practice in the Context of Stressed Workplaces.

You are invited to nominate a nurse who goes above and beyond:
A nurse who is an example of exemplary nursing practice,
the nurse who serves as a role model to other nurses.

If you know of such an exemplary nurse please nominate your peer by giving them one of the enclosed information letters.
Any actively practicing Registered Nurse is eligible for nomination.

By participating in this Masters Thesis research study you will be providing valuable information on exemplary nursing practice.

Through an approximate 1 hour interview:

You will be asked to describe the nature and characteristics of exemplary nursing practice.

You will also be asked to fill out a short information sheet providing pertinent demographic information.

With the information you provide will come a greater understanding of exemplary nursing practice and how it can be encouraged in today's stressed workplace.

To participate or for more information regarding this research please call

Sheila McRae R.N. BN
at (403) XXX-XXXX
or e-mail: sheila.mcrae@uleth.ca
Masters Candidate at the University of Lethbridge

Appendix E: Nominee Invitation

Congratulations!

You have been nominated by a nursing peer as being an exemplary nurse!

A nurse who goes above and beyond: a nurse who is an example of exemplary nursing practice; one who serves as a role model.

By participating in this Masters Thesis research study you will be providing valuable information on exemplary nursing practice.

Through an approximate 1 hour interview:
You will be asked to describe the nature and characteristics of your nursing practice.

You will also be asked to fill out a short information sheet providing pertinent demographic information.

With the information you provide will come a greater understanding of exemplary nursing practice and how it can be encouraged in today's stressed workplace.

If you wish to participate in this unique opportunity

or for more information please call:

Sheila McRae RN, BN, PNC(C)

Masters Candidate at the University of Lethbridge

(403) XXX-XXXX or e-mail: sheila.mcrae@uleth.ca

Appendix F: Demographic Questionnaire

Participant Demographics

Please circle the applicable answer. This information will be used to situate the respondents within the study, not to individually identify participants.

1. Are you: a) a nominator b) a nominee?

2. Gender: a) male b) female

3. Age:
   a) 20–29 yrs b) 30-35 yrs c) 36-40 yrs d) 41- 45 yrs e) 46-50 yrs

   f) 51- 60 yrs g) > 60 yrs

4. How many years have you been a Registered Nurse? __________

5. Number of years worked___________________

6. Do have additional post basic RN education or certification?

a) yes (If yes please identify) _____________________ b) no

8. Do you work full-time or part-time?

a) full-time b) part-time c) casual

9. Approximately how many shifts a month would you usually work?

____

Appendix G: Nominator Interview Guide

Interview Guide for Nominators

Research question: How do peer nominators define, observe, and identify, their colleagues as exemplary nurses?

- Can you describe a situation when you felt exemplary nursing occurred?
- Is, or has there been, other nurses in your life that you would call exemplary?
- Can describe the influence these nurses have had on your practice?
- Would you describe the qualities you think an exemplary nurse possesses?

  Being:

  Knowing:

  Doing:

  Giving:

  Receiving:

  Welcoming of a stranger:

- How do you think people develop these qualities?
- What do you see as the differences between a good nurse and an exemplary nurse?
- Do you think a given number of years of experience plays a part in being an exemplary nurse? Why?
- Having nominated an exemplary nurse, has this made you identify what is exemplary in your own nursing practice?

- What learning, curriculum, experiences pr professional development do you think would contribute to exemplary nursing?
- When you are feeling the most positive about your work, what do you value most?
- Do you think recognition or praise from peers or your employer has an effect on exemplary nursing practice?

Appendix H: Nominee Interview Guide

Interview Guide for Nominee's

Research question: How do peer-nominated nurses describe and reveal their own exemplary practice?

- What would you describe as being a high point in your nursing career, a time when you were most alive and engaged?
- How do you cope with the stresses of the job?
- What do you like about your job, what do you value most?
- What is difficult or challenging about your job?
- Is, or has there been, a nurse in your life that you would call exemplary, and has that had an influence on your practice?
- How would you describe what qualities you think an exemplary nurse possesses?

Being, Knowing, Doing, Giving and receiving, Welcoming a stranger.

- What do you see as the differences between a good nurse and an exemplary nurse?
- Do you think a given number of years of experience plays a part in being an exemplary nurse? Please explain.
- What importance do you think education plays a part in being an exemplary nurse?
- What learning, curriculum, experience or professional development do you think can contribute to exemplary nursing practice?
- Can you explain what unique qualities you possess that made it possible for you to be recognized as an exemplary nurse?

- Has being nominated as an exemplary nurse had an effect on the way you view your nursing practice? How so?
- Is there anything you would like to add about exemplary nursing practice or something about an exemplary nurse?