Table of content

List of tables

List of figures

List of annexures

List of abbreviations

ACLS	Advanced Cardiac Life Support
A&E	Accident and emergency
AR	Action research
ATLS	Advanced Trauma Life Support
BLS	Basic Life Support
CPR	Cardiopulmonary resuscitation
EAR	Emancipatory action research
EPD	Emancipatory practice development
ICU	Intensive care unit
NGM	Nominal group meeting
NGT	Nominal group technique
PALS	Paediatric Advanced Life Support
PDG	Practice development group
PDF	Practice development facilitator
P1	Priority one
P2	Priority two
P3	Priority three
P4	Priority four
UNISA	University of South Africa

*For the purpose of **anonymity**, the hospital in which the study was conducted will be referred to as **the hospital**, in both text and referencing.*

1 Orientation to the study

I think one's feelings waste themselves in words;
they ought to be distilled into actions which bring results

Florence Nightingale

1.1 INTRODUCTION

Rapid changes in the healthcare environment increase the need for nurse practitioners to be motivated, knowledgeable and skilled in order to ensure quality patient care. Accident and emergency (A&E) units are challenging environments and by ensuring that they work in an enabling environment, nurse practitioners can be motivated, and their skills, knowledge and critical thinking improved with the intention of enhancing innovative and creative ideas to develop their own professional growth and emancipated practice. This in turn may increase the nurse practitioners' job satisfaction, which in turn encourage job retention and may influence patient outcomes positively.

The A&E unit in which this research was conducted, found itself in an emergency situation when 16 (55,2%) of the professional nurse practitioners resigned within a period of 18 months without being replaced (The Hospital 2003; The Hospital 2005), leaving the A&E unit short staffed (see Table 1.2). The consistently heavy workload experienced by the nurse practitioners increased their job tension and decreased their job satisfaction, which in turn increased the percentage of nurse practitioners who resigned (Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, Laschinger, North & Stone 2006:240). Dissatisfied nurse practitioners indicated that they worked in a toxic environment and in their own words this was '*driving and forcing us out of the A&E unit*'. This attitude displayed by the nurse practitioners not only negatively affected their morale, but also negatively influenced the functioning of the hospital and care to the community they serve.

A reflection

The nurse practitioners working in an A&E unit the researcher used to know, welcomed a challenge, thrived on crises and chaos, had an appetite for the unexpected and an aversion to routine. When the researcher no longer experienced these actions, the question arose: What happened? Often when the researcher entered the A&E unit to do the clinical accompaniment of A&E learners, regular complaints were expressed such as -

- *"…salaries are inadequate…"*
- *"'… have applied for a new job… I can't work here anymore…"*
- *"…there is no support from the managers…"*
- *"…nobody understands what we (nurse practitioners) do, we are only three nurses (nurse practitioners) who can take charge and we have to work night and day shifts…"*
- *"…it was so busy in the unit… did not have time to call the patient's family into the unit to see him before he went to ICU (intensive care unit)…he passed away in the lift and I feel so guilty…''*

The researcher is of the opinion that one cannot turn this emergency situation around by only 'dreaming' about a future for nurse practitioners or a shared vision of 'emancipatory practice development'. Action must be taken to address and to rectify this undesirable situation. The action research (AR) for practitioners project was initiated after the researcher was enlightened about the true nature of the emergency situation in the A&E unit. A practice development group (PDG) was established to investigate the situation. This was followed by collaboration with the nurse practitioners in exploring the challenges that prevented them from having a future in the A&E unit. While addressing these challenges, the PDG and nurse practitioners participated in a spiral of interrelated AR cycles involving planning, acting, observing and reflecting on the journey undertaken in the A&E unit to reach the shared vision. AR was used to change the nursing practice in the A&E unit and generate new knowledge as is described by various authors such as Hope and Waterman (2003:120), Morton-Cooper (2000:9) and Williamson and Prosser (2002:587).

The journey towards emancipatory practice development took place over a period of two years. By means of action (vehicle), reflection (learning mode) was used by the researcher (external enabler) to facilitate the learning of the practice leaders (internal enablers), thus enabling them to promote nurse practitioners (travellers) to enhance their own and collective practice. During this journey, the driving force was

change (Kemmis & McTaggart 2003:346; Somekh & Lewin 2005:91). This study was thus concerned with the development of an approach that not only addressed the barriers and challenges identified in the A&E unit, but also changed the toxic environment to an enabling environment, and enlightened, empowered and emancipated the practice leaders and nurse practitioners.

This research is presented as an honest account of the learning experiences of the practice leaders, nurse practitioners and researcher obtained on the journey towards emancipatory practice development. The intention is to share the highs and lows of the journey that led to the realisation of the nurse practitioners' shared vision of 'emancipatory practice development'.

Chapter 1 offers an overview of the setting and background to the research as well as a brief overview of the research design and method.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

Excellence, as perceived by the patients, families and the community starts at the front door of a hospital and, in many cases, it is the A&E unit that fulfils this role. It is the nurse practitioners working in the A&E unit who initially admit, triage, initiate the management of and often stabilise the patients entering the hospital (except direct admissions and booked cases) before these patients are admitted to an ICU or ward within the hospital, transferred to another hospital or discharged to recuperate at home. Excellence should be something the nurse practitioners working in the A&E unit strive for.

Excellence, however, was not being realised in the A&E unit due to nurse practitioner shortages that were the result of the toxic environment in which they worked daily and which was driving them out of the A&E unit. The nurse practitioners who remained were left dissatisfied, distraught, discontent and disempowered. These shortages and negative views of the nurse practitioners concerning the environment could negatively impact on patient outcomes.

1.2.1 The emergency meeting

The nurse practitioners organised an emergency meeting on 16 May 2005 to verbalise their concerns and raise the awareness of management, the head of department and the lecturer of the A&E programme of the true nature and extent of the emergency situation in the A&E unit. Eleven permanent nurse practitioners (one A&E nurse practitioner, six professional nurse practitioners and four enrolled nurse practitioners), the practice leaders (unit manager and clinical facilitator), middle manager, the head of the department (doctor) and the researcher (as lecturer of the A&E programme) attended the meeting.

Field notes were taken by a professional nurse practitioner during the meeting. The findings, based on the concerns expressed by the nurse practitioners, were analysed. The findings were verified with the practice leaders to increase their validity and then summarised (see Table 1.1). Based on the findings, it was evident that action was urgently required in order to ensure a future for the nurse practitioners in the A&E unit.

Table 1.1: Summary of data gathered during the emergency meeting (16 May 2005)

Theme	Category	Subcategory	Enlightenment / discussion
Negative aspects	1. Professional nurse practitioners resigning from the A&E unit	- ***Burnt out*** - ***Stressed*** - ***Unmotivated*** - Not receiving scarce skills remuneration - ***Unsupported*** by management	- ***Shortage*** of nurse practitioners - ***Lack of experienced*** nurse practitioners and ***A&E nurse practitioners*** - Making use of agency nurse practitioners (uncommitted and inexperienced) - Increased patient numbers - Overall bed shortage in hospital - No ***appreciation*** for hard work and sacrifices made - No ***professional development*** - Exposed to situations they are not equipped or staffed to manage (long-term ICU patients)

Theme	Category	Subcategory	Enlightenment / discussion
Negative aspects	2. Top management unsupportive	- Nurse practitioner crisis	- ***Failure to replace*** the nurse practitioners that resigned
		- Do not understand the challenges experienced in the A&E unit	- Refuse to close A&E unit when no hospital beds were available - Nursing of ICU patients in A&E unit if there are no beds available
	3. Ineffective team-work by multidisciplinary team members	- Radiography	- Critically ill and severely injured patients are not regarded as a priority for CT scans - Patients from other hospitals using CT scan facilities are nursed in A&E unit while waiting for scans and results. These patients are high-risk patients due to inadequate history and doctors in A&E unit do not want to take responsibility for these patients - Nurse practitioners working in A&E unit are asked to take these patients to CT scan. This should be done by private ambulance personnel and not by nurse practitioners as it increases their workload
		- Specialists	- Patients waiting a long time in A&E unit to be seen by specialists - Patients with multiple injuries: specialists do not want to take responsibility for them due to bed shortages and there is continuous fighting about who should take the responsibility
		- Transfers	- Patients admitted from other hospitals go via A&E unit and are nursed in A&E unit while waiting for a bed in ICU to become available - Long waiting times in A&E unit
		- Porters and transport of patients to wards	- Porters are not available from 17:00 to 18:00 - This leads to increased frustration of the nurse practitioners

Theme	Category	Subcategory	Enlightenment / discussion
Negative aspects		- ICU nurse practitioners	- Delay admission to ICU - Do not understand the emergency situation - Do not support the A&E nurse practitioners - ICU nurse practitioners seem to be spiteful
	4. Learners	- A&E learners - ICU learners - Pre-graduate learners	- ***Learning opportunities utilised ineffectively*** - Misused as work force instead of acknowledged as learners - ***Unsupported*** by permanent nurse practitioners working in A&E unit
Positive aspects	1. Nurse practitioners	- Trying their best to cope	- Fewer complaints received from patients and their families - Trying their best to attain high standards of patient care under difficult circumstances
Other aspects	1. Recommendations	- Nurse practitioners	- Ask agency nurse practitioners whether they were willing to reconsider permanent positions in unit - Motivate final-year B Cur learners, who are interested, to start their community service in the A&E unit

During the emergency meeting, the nurse practitioners expressed concerns regarding the situation in the A&E unit and stated that they felt unsupported, unmotivated, experienced stress and symptoms of burnout. They perceived the situation as "*unbearable*" and indicated that a number of nurse practitioners had resigned and that, if actions were not taken immediately, the future of the nurse practitioners within the A&E unit seemed desperate. This was specifically true of the professional nurse practitioners.

1.2.2 Shortage of nurse practitioners

Using the off-duty roster books of the A&E unit (The Hospital 2003; The Hospital 2005), the total number of nurse practitioners working in the A&E unit in November

2003 and those working there in May 2005 were compared. Based on these statistics, it was evident that mainly the professional nurse practitioners and trained A&E nurse practitioners were leaving the A&E unit (see Table 1.2). While the number of enrolled and auxiliary nurse practitioners remained relatively constant, the number of professional nurse practitioners dramatically decreased from a total of 29 to only 13 within this period. The A&E nurse practitioners too were leaving, decreasing the number of these specialised nurse practitioners to a total of two.

Table 1.2: Comparing the total number of nurse practitioners working in the A&E unit during November 2003 and May 2005

Nurse practitioners	November 2003		May 2005	
Practice leader				
Unit manager	1		1	
Clinical facilitator	0		1	
Subtotal		***1***		***2***
Professional nurse practitioners				
Professional nurse practitioners (no additional clinical qualification)	*19*		*8*	
A&E nurse practitioners	*6*		*2*	
A&E learners	*2*		*2*	
ICU nurse practitioners	*0*		*1*	
A&E and ICU nurse practitioners	*2*		*0*	
Subtotal		***29***		***13***
Enrolled and auxiliary nurse practitioner	15		16	
Subtotal		***15***		***16***
Total	**44**		**31**	

***Source**: The Hospital (2003); The Hospital (2005)*

1.2.3 Morale of A&E unit personnel

The professional nurse practitioners working in the A&E unit were requesting transfers to other wards in the hospital, inquiring about and leaving for job opportunities in A&E units in the private sector and even leaving the profession. These losses added to the burden on the remaining nurse practitioners, as they lost an immense number of highly skilled and knowledgeable professional nurse practitioners involved in daily patient management. This too verifies the issues

raised by the nurse practitioners during the emergency meeting and the intensity of strain they were working under.

1.2.4 Change in patient population

In addition to the low morale and personnel shortages, the patient population admitted to the A&E unit changed (see Annexure C: Table C1). According to the statistics, the admission of priority 1 (P1) patients remained more or less constant if compared to patients admitted between January and June 2003 and between January and June 2005 (see Annexure C: Table C1; see Section 1.6.3.25 for a description of this concept). However, during the same timeframe, there was an increase of more than seven times the total number of priority 2 (P2) patients admitted to the A&E unit (see Section 1.6.3.25 for a description of this concept). This indicates that the admission of P2 patients has increased since 2003. These statistics confirm the views expressed by the nurse practitioners during the emergency meeting that their workload had increased due to the increased number of patients and the complexity of their conditions.

1.2.5 The A&E unit and learners

The A&E unit was utilised by the researcher as one of the most significant clinical learning facilities for a post-basic A&E programme due to the number of learning opportunities and experiences available. The credibility and sustainability of this clinical environment played an important role in ensuring theory-practice correlation as well as in assisting with the preparation of these learners for the various clinical settings in which they would possibly work following completion of the programme. An average of four A&E learners rotated through the A&E unit on a monthly basis. These learners mainly included professional nurse practitioners from different public and private hospitals in rural, remote and urban areas who were enrolled for the A&E programme. To ensure effective learning and the development of skilled and knowledgeable A&E nurse practitioners, it was important to ensure a safe, friendly and enabling environment in which these learners could work during the programme (Naudé, Meyer & Van Niekerk 2000:84).

However, the A&E learners criticised the A&E unit as a learning environment. The A&E learners reflected that it was "*unacceptable*", that they were "*regarded as the workers and not as learners"*, that they were expected to perform mainly routine tasks and thus that their status as learners was ignored. The A&E learners complained about a lack of support from the A&E nurse practitioners and professional nurse practitioners working in the A&E unit. This influenced the number of learning opportunities these learners were able to utilise effectively. The A&E learners were stressed as they realised that they were missing good learning opportunities. The A&E learners reflected that they experienced the time allocated to them in the A&E unit as very negative and did not learn anything.

1.2.6 Observations by paramedics

The A&E learners also informed the researcher about the negative comments of the paramedics they were working with as part of the clinical component of the A&E programme. These paramedics constantly discussed the situation with the A&E learners and indicated that they did not know most of the professional nurse practitioners working in the A&E unit anymore and that some nights, there was not one nurse practitioner they recognised working in the unit. This frustrated them when bringing patients to the A&E unit as the excellent relationship they used to have with the nurse practitioners was fading. The paramedics also indicated that these 'unknown' professional nurse practitioners were not qualified to work in the A&E environment, as it seemed that they did not have the advanced knowledge and skills to manage the patients. Despite the explanations provided by the A&E learners regarding the 'emergency situation', the increase in patient admittance, lack of personnel and the abundant use of agency nurse practitioners, this did not decrease the criticism they received from the paramedics, and their attitudes towards the A&E unit and its nurse practitioners remained negative.

1.2.7 The learning environment

The learning environment for the A&E learners, including the clinical setting, is crucial in ensuring optimal learning for these clinical specialists. This is where the action is, where the learners will work at the end of the programme – this is the real

world for the A&E learner. Stuart (2003:185) indicates that the learning environment is where learning takes place, and thus becomes an educational environment. It should be conducive to learning as well as professional development. Atherton (2003) describes learning as "*a relatively permanent change in behaviour that results from practice*".

Both these statements are important to consider when planning the clinical environment for the A&E learners, because the environment will not only have an impact on the skills of the A&E learners, but also influence the learners' cognitive processes, values and attitudes. The clinical setting provides unique learning experiences and opportunities for these learners, but should be planned, structured, managed and coordinated. The clinical placement of these adult learners should contribute to their education so that they can become self-directed learners who will also engage in lifelong learning (Stuart 2003:210). It was therefore important to ensure that meaningful learning from experience was achieved. The clinical setting for these learners was therefore vital in their learning curve towards becoming competent A&E nurse practitioners.

1.2.8 Accreditation of the A&E unit

On 1 June 2005, one of the professional nurse practitioners who had worked in the A&E unit for 10 years was formally appointed as the new unit manager of the A&E unit. The Accreditation Committee of the Gauteng Department of Health visited the A&E unit on 7 June 2005 for the purpose of accreditation. The rationale for this accreditation is to provide an external, independent audit of the standards of care set by the Gauteng Provincial Health Department in its healthcare facilities, and then to report the findings to the hospitals (Goba & Masondo 2007; Department of Health 2007:1). The newly appointed unit manager experienced the feedback obtained during this accreditation visit as extremely negative. Realising that something urgently needed to be done to resolve the emergency situation and realising that she could not undertake the matter on her own, she asked the researcher for assistance.

1.2.9 Recognising the emergency situation

The researcher too had reason to believe that an emergency situation existed in the A&E unit. Practice development in the A&E unit could not be initiated in this emergency situation where there were staff shortages, dependence on agency staff, inexperienced staff, high staff turnover rates and a lack of structure, management and support. All these factors contributed to a decrease in the nurse practitioners' morale and led to the development of an emergency situation in the A&E unit.

The researcher, as an A&E nurse practitioner and A&E lecturer, had a moral, ethical, and professional responsibility towards the provision of excellent health care to the community (Searle 2000:392), but it was impossible to do so as an outsider. It was important to consider strategies to obtain a point of entry and become involved in the issue at stake. Being consulted to assist the unit manager and clinical facilitator was thus the ideal opportunity to get involved in the situation.

These factors then formed the starting point for initiating the research can be summarised as:

- the increased rate of professional nurse practitioners leaving the A&E unit, indicating job dissatisfaction as well as dissatisfaction with the work environment,
- the increase in workload of the nurse practitioners due to the change in patient admittance,
- unmotivated, unenthusiastic and apathetic nurse practitioners,
- the concern of nurse practitioners and A&E learners about the realisation and utilisation of learning opportunities in the A&E unit,
- concerns about the quality of patient care provided by nurse practitioners in the A&E unit expressed by other members of the multidisciplinary team, including the paramedics and doctors, and
- the potential negative effect of the above-mentioned factors on patient outcomes.

It became evident that there was an emergency situation in the A&E unit, which was impacting negatively on the nurse practitioners, their job satisfaction and forcing them to leave. This situation, attributed to nurse practitioner shortages and a toxic environment, needed to be addressed urgently. The impact of such a toxic

environment, according to Hayes *et al.* (2006:237) could lead to potential detrimental outcomes for the patients admitted to the A&E unit. Thus, urgent action had to be taken to address the deteriorating situation. One approach that could be used to turn such situations around is practice development.

1.2.10 Taking action through practice development

Practice development is often conceptualised as a continuous journey that is complex and multifaceted (McCormack *et al.* 2004:8). Phase 2 of the study focused on the journey undertaken by the PDG and nurse practitioners towards their shared vision of 'emancipatory practice development' (see Figure 3.1). The term practice development is widely used within the nursing profession in the United Kingdom and Australia. However, it is still not well defined and the world of practice development is complex, evolving and dynamic. In the literature, a multiple set of journeys was explored, including the many facets and dimensions that are embedded in the seemingly simple term practice development (Caldwell, Lynch & Komaromy 2000:37; Down 2004:272; McCormack *et al.* 2004:315; Stokes 2004:246).

According to Mallett, Cathmoir, Hughes and Whitby (1997:38),

> *Professional and practice development is a continuous process and, despite being inextricably linked, the two areas are distinct: the former is concerned with knowledge, skills and values and the latter with how these are used to provide good quality patient-focused care.*

Within this definition, both the terms professional and practice development are used. Practice development as a term has frequently been linked to professional development and at times the terms are used interchangeably. Practice development and professional development are both continuous processes, but the starting point for practice development is the service user, whereas the starting point for professional development is the service provider, which in this research is the nurse practitioner. Both are also associated with questioning the way in which practice takes place in order to attempt some change or improvement (McCormack *et al.* 2004:6).

Based on their findings, Garbett and McCormack (2002:88) define practice development as:

> *… a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflected the perspectives of service users.*

Manley and McCormack (2004:35-36) state that, based on these definitions, the purpose and means of practice development can be understood. Firstly, it is based on quality patient-focused care through personal development. This includes developing knowledge, skills and values. Secondly, it focuses on increased effectiveness of patient-centred care through:

- developing knowledge and skills,
- enabling practitioners or healthcare teams to transform the culture and context of care,
- skilled facilitation, and
- a systematic, rigorous and continuous emancipatory change process.

Practice development is therefore not only concerned with increased effectiveness in patient-centred care, but also with the acquisition of knowledge and skills as a means of moving practice on and securing support from those who are being expected to change. Although the notion of practice development is often associated with innovation, it is also concerned with ensuring that everyday practice is effective and addresses shortfalls where they occur (McCormack *et al.* 2004:8). It therefore includes working with the nurse practitioners to develop their ideas, creating a culture of change, and enabling and empowering them to develop their own practice.

Differences in the purpose of practice development relate to whether there is deliberate attention to staff development and cultural change. Technical practice development is regarded as a consequence of practice development rather than a deliberate and intentional purpose. This is because practice development is considered a technical instrument for achieving the development of services to

patients and changing practice is seen as a technical process. It is regarded as a top-down approach that is based on the assumption that once practitioners have evidence, their practice will change (Manley & McCormack 2004:38; Sanders 2004:303). Therefore, the "*development of staff, if it occurs, is a consequence of practice development rather than a deliberate and intentional purpose*" (Manley & McCormack 2003:24). These authors explain that emancipatory practice development, on the other hand, focuses on the development and empowerment of the practitioners, is deliberate and is closely related to the creation of a specific culture, termed transformational culture. Based on these differences, they added two additional purposes of emancipatory practice development, namely to:

- empower practitioners to develop their individual and collective service, and
- foster the development of an integrative and transformational culture.

Both these purposes are consistent with and reflect the influences of critical social science, with the use of words such as 'transform' and 'emancipatory'. However, there are still multiple facets and dimensions in the seemingly simple term, as well as a lack of clarity and uniformity in the way in which practice development is employed in the clinical setting. However, there are key issues that are adhered to, including an unambiguous concern with improvement of patient care and services. In this study, the practice development group (PDG) was concerned with the progression towards emancipatory practice development only once the professional *development* of the practitioners (technical practice development) had been addressed (McCormack *et al.* 2004:315-319), which then not only influenced the nurse practitioners, but also impacted on the patients.

For practice developers, the professional development accompanying practice development is important. Professional development demonstrates an investment in the nurse practitioners as individuals and is aimed at developing skilled and competent nurse practitioners. It assists the nurse practitioners to learn about their abilities and to acquire new knowledge and skills. This will allow them to progress and challenge issues arising from their working environment (McCormack *et al.* 2004:317). Emancipatory practice development was thus regarded as an outcome.

The challenge in the A&E unit was to create a practice development approach that achieved the shared vision of the PDG: emancipatory practice development. Based

on the needs of the nurse practitioners, an approach was planned focusing on technical practice development, which would ultimately lead to emancipatory practice development. An innovative process was created that not only aimed at identifying the different roles that the PDG members and nurse practitioners would play, but also aimed at providing a framework that proposed an explicit relationship between the conscious awareness, enablement, empowerment and emancipation of the practice leaders and nurse practitioners in an enabling environment by means of a reflective learning process.

The journey towards emancipatory practice development was initiated when the practice leaders took action and started planning a desired future for the A&E unit in which the nurse practitioners could thrive (Capuano, Durishin, Millard & Hitchings 2007:61). This is explained in detail in Chapter 3 to 6. See Figure 2.2 for a schematic presentation of the action research (AR) for practitioners' project.

The practice leaders consulted the researcher following a visit from the Accreditation Committee of the Gauteng Department of Health (see Section 3.2.1). The practice leaders reflected that they wanted to go beyond recruiting nurse practitioners and addressing the challenges. They aimed to create a work environment where nurse practitioners are challenged to reflect on their clinical practice, enlightened on the shortcomings thereof, and then empowered and emancipated to act accordingly. This is indicative and parallel to practice development. The researcher agreed to assist the practice leaders and on 8 June 2005.

The researcher and practice leaders agreed to use AR as research methodology. Action research as an approach involves a process integrates action as an essential element and involves a cyclic process in which research, action and evaluation are interlinked, thus not only including research, but also intervention (actions) and change in the situation under investigation (Herr & Anderson 2005:5; Holloway & Wheeler 2002:189). Action research therefore involves doing research *"with and for people (users and providers of service), rather than undertaking research on them"* (Meyer 2006:274).

The PDG was established (Cycle 1), consisting of the unit manager, clinical facilitator and researcher (see Figure 2.2). These transformational leaders were regarded as

the key drivers of the journey and played the role of the internal enablers of the nurse practitioners in order to reach their shared vision.

Quality patient-centred care is the fundamental core business and hence a key responsibility of nurse practitioners working in A&E units. The PDG reflected that this could only be realised if there were adequate numbers of nurse practitioners working in the A&E unit. The nurse practitioner shortage was regarded as a barrier (Cycle 2) to planning any future actions involving the already stressed and distraught nurse practitioners and was thus addressed immediately (see Section 3.4.1). The journey therefore initially focused on recruiting professional nurse practitioners, as these actions not only would support the nurse practitioners working under difficult conditions, but could also improve patient outcomes.

Although collaboration and participation were valued from the start of the journey, the collaborative approach was emphasised and the nurse practitioners were assured that they had a tangible and important role in the development of clinical practice (Pullen 2000:127). Engaging the nurse practitioners in practice development as opposed to setting specific outcomes is possibly more sustainable as the team can "*pace change according to its capacity and to plan change that is particularly meaningful to its members"* (Fitzgerald & Solman 2003:9). Therefore the PGD was in agreement that the focus should first be on the nurse practitioner shortages and addressing the challenges of the A&E unit. This would indicate that the PDG was serious about planning and acting in an effort to resolve the emergency situation.

Cycle 3 followed, during which the challenges were further explored (see Figure 2.2). Specific challenges facing the nurse practitioners (regarded as the most important travellers of the journey), which needed to be resolved in order to create a future for them, were prioritised during a nominal group meeting (NGM). Five priorities were identified, which, in order of priority, are professional development, patient care, structure, equipment, and research (see Section 3.5.2).

Based on the findings obtained during the NGM, the practice leaders initiated their own action cycles during which the challenges, toxic environment, and opportunities to enhance emancipatory practice development were addressed (see Chapters 4 and 5).

1.3 PROBLEM STATEMENT

An A&E unit requires adequate numbers of nurse practitioners and low turnover to ensure that patients' needs are met and quality care is provided on a day-to-day basis (Shields & Ward 2001:677), as well as to provide time and opportunities for nurse practitioners to develop their own and collective emancipated practice. If this is not realised, it may have a detrimental effect on not only patient outcomes, but also on the job satisfaction of the nurse practitioners (Hayes *et al.* 2006:237). Thus, inadequate numbers of nurse practitioners can be regarded as a barrier to the planning or implementation of any further actions that aim to enable the nurse practitioners to reach a shared vision of 'emancipatory practice development'.

It was found that 55,2 per cent of the professional nurse practitioners had resigned from the A&E unit between November 2003 and May 2005 (see Table 1.2) and that a toxic environment existed in the unit in which they were working. The toxic environment was characterised by bureaucratic and hierarchical management styles, unsupportive managers, and a negative work and learning environment (see Section 1.2; Table 1.2 and Section 3.5), providing no future for the nurse practitioners in the A&E unit. This left nurse practitioners unmotivated, unenthusiastic and apathetic, with increased work stress, burnout, a sense of powerlessness and a lack of a future for them in the A&E unit. As the nurse practitioners experienced decreased job satisfaction, they started leaving the A&E unit, which potentially impacted negatively on patient outcomes. It can be inferred that the toxic environment in the A&E unit contributed to the development of the shortage of nurse practitioners and therefore needed to be addressed decisively and in collaboration with the practice leaders and nurse practitioners in order to ensure a future for these practitioners.

Although the shortage of nurse practitioners was the immediate concern in the A&E unit, an additional concern was that if the PDG was able to recruit more nurse practitioners, they too would leave if the toxic environment in which they worked was not addressed. An approach focussed on resolving the immediate emergency situation, based on quick-fix or short-term solutions, had to be planned and implemented immediately. However, it was even more important that the PDG and nurse practitioners searched for and considered strategies to ensure long-term solutions.

Therefore, the problem statement can be formulated as follows:
An emergency situation in the A&E unit was evident, potentially leading to detrimental outcomes for the patients admitted. The immediate emergency situation had to be resolved, and possible long-term solutions explored and addressed in order to ensure a future for the nurse practitioners and the A&E unit.

1.4 RESEARCH QUESTIONS

In view of the background and problem statement, the following research question was formulated:

How can a journey towards emancipatory practice development, which could create a future for the nurse practitioners, be planned collaboratively in the A&E unit?

Based on the research question, the following sub-questions were formulated as the AR for practitioners project evolved:

- **Question 1:** What is the situation in the A&E unit as experienced by the nurse practitioners?
- **Question 2:** What would a thesis that addresses the situation experienced in the A&E unit entail?
- **Question 3:** How would one initiate the journey in the A&E unit?
  - How is a PDG established?
  - Which barrier prohibits future action in the A&E unit?
  - How can this barrier be addressed?
  - What are the challenges that need to be overcome in order to create a future for the nurse practitioners in the A&E unit?
- **Question 4:** How can these challenges be addressed?
- **Question 5:** What are the possible long-term actions that can be implemented to reach a shared vision of 'emancipatory practice development'?
- **Question 6:** What was the worth of the journey undertaken in the A&E unit?

1.5 AIM AND OBJECTIVES OF THE STUDY

The overall aim of this research was to, by means of AR, collaboratively plan a journey towards emancipatory practice development that would include both short-term and long-term solutions to address the emergency situation and enhance the possibility of creating a future for the nurse practitioners in the A&E unit.

In order to achieve this aim, the objectives and specific objectives of the research, which evolved as the AR for practitioners project continued, were, collaboratively, to:

- **Objective 1:** Enlighten the practice leaders, middle and top management, and the A&E lecturer about the situation in the A&E unit.
- **Objective 2:** Plan the proposal and obtain ethical consent.
- **Objective 3:** Initiate the journey towards emancipatory practice development in the A&E unit (key drivers: PDG, see Chapter 3):
  - Establish a PDG
  - Reach consensus regarding the barrier that exists that prohibits future action
  - Address the barrier
  - In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit
  - Plan the roadmap for a journey towards emanicpatory practice development
- **Objective 4:** Address the challenges (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):
  - Plan actions that could resolve the challenges
  - Address the challenges, following the AR cyclic approach
- **Objective 5:** Explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):
  - Plan long-term solutions
  - Address the long-term solutions, following the AR cyclic approach
- **Objective 6:** Evaluate the worth of the journey towards emancipatory practice development undertaken in the A&E unit (Key driver: researcher/Chapter 6).

1.6 FRAME OF REFERENCE

The frame of reference of the study can be described in terms of the relevant paradigm, assumptions and conceptual definitions.

1.6.1 Paradigm

Appleton and King (2002:642) state that deciding on the appropriateness of a chosen methodology and its philosophical underpinnings is essential. Specifically in relation to the social sciences, Trigg (2001:255) suggests that "*the philosophy of the social sciences cannot be an optional activity, indulged in by those reluctant to get on with real empirical work. It is the indispensable starting point for all the social sciences*". Trigg is thus advocating that the philosophical groundwork must be undertaken before the researcher approaches the 'doing' phase of the research. This is consistent with the views of Wilson and McCormack (2006:46).

With this challenge in mind, the purpose of this section is to outline the paradigmatic perspective of this study, which was used as the basis for the framework that guided the journey taken towards emancipatory practice development.

Parahoo (1997:46-47) states that a paradigm creates its own cultural environment that regulates the behaviour of its followers and flavours research conforming to its own rules. McNiff and Whitehead (2002:30) define a paradigm as:

> *… a set of ideas and approaches, mental models which influence the development of a set of particular intellectual and social frameworks.*

As AR is firmly rooted in the third paradigm of the critical social theory (Morton-Cooper 2000:76, Kemmis & McTaggart 2003:355; Manley & McCormack 2004:37), the researcher's meta-theoretical, theoretical and methodological assumptions were influenced by this specific paradigm. The critical social theory began in Germany during the 1920s as the Frankfurt theory and built on the philosophies of Marx and Hegel, from liberation movements such as feminism (Fulton 1997:530; Wittmann-Price 2004:440). In addition Wittmann-Price (2004:440) states that, according to

Paley (1998), the critical social theory denounced oppression to promote positive change. Oppression is maintained by social institutions in order to control people, their resources and finances (Kuokkanen & Leino-Kilpi 2000:236-237). According to Burns and Bulman (2000:7) Jurgen Habermans was the best-known critical theory philosopher. Habermans, of the Frankfurt School, funded the fundamental conviction, underpinning this philosophy, that no aspect of social phenomena can be understood unless it is related to the history and structure within which it was founded (Fulton 1997:530). Habermans promotes the critical social theory as an imperative branch of scientific inquiry that describes "*distortions and constraints that impede free, equal and uncoerced participation in society*" (Stevens 1989:58).

Research based on critical social theory requires researchers to take an inherently critical stance. Critical theory asks, "*How can this situation be understood in order to change it*?" (McNiff & Whitehead 2006:41). Therefore the researcher brings not only theory to the research setting, but also a desire to change it. Thus, the purpose of the critical social theory is to expose oppressions that may place constraints on individuals or social freedom. Furthermore, emancipation must free not only the individuals but also oppressive social structures and replace them with a humanistic philosophy based on the fundamental value of freedom (Holmes 2002:76). The fundamental value of freedom begins with the right to choose.

Action research focuses on learning (McNiff, Lomax & Whitehead 2003:12). Relating to the emancipatory interest of this study, AR was used as methodology and reflection as a learning tool. Reflection was used to develop the nurse practitioners as they critically reflected on their experiences in the clinical practice and this in turn informed action or praxis. Burns and Bulman (2000:7) state that praxis is an important concept to critical theorists and is developed through the reciprocal relationship between action and critical reflection. In addition, Johns (2000:34) states that, according to Fay (1987), reflection is a critical social process of overcoming the forces that prevent nurse practitioners from fulfilling their therapeutic potential and destiny, moving through the typology of enlightenment, empowerment and emancipation.

Duchscher (2000:454-455) states that Habermans applied the critical social theory to a dialogue and defined it as a reflective practice of communication which

stimulates the cognitive awareness of oppressive practices (Fulton 1997:530). Praxis can be promoted by using and teaching critical social theory. Praxis through reflection was considered a main component of emancipation (Kuokkanen & Leino-Kilpi 2000:237). The critical social theory further recognised human behaviour to be inseparable from environmental influences (Wittmann-Price 2004:440).

Although critical social theory rejects the positivist view, it recognises and acknowledges the interpretivist view. Interpretivist research recognises the capacity to construct or build social realities, but it does not in itself enable nurse practitioners to challenge any of the inequities or oppressive influences that they might experience in their social world. Therefore, although it provides an explanation for the challenges experienced by the nurse practitioners in the A&E unit, it does not provide a solution to resolve these challenges (see Table 1.3). The challenges require certain actions to be taken in order to bring about possible improvement. Empowering or emancipatory research seeks to involve people in making their own decisions with a view to creating a fairer and more just situation (Morton-Cooper 2000:77).

Table 1.3: Philosophical approaches in research (adopted from Harper & Hartman 1997:19)

Research paradigm	Research assumption
Positivism	There is an objective reality that exists independently of the observer, where phenomena are driven by natural laws that are accessible to observation and management
Interpretivism	Reality is mentally constructed and is socially and culturally based. Knowledge is viewed as being constructed in a social and historical context.
Critical social theory	Perceptions, social and personal truths are constructed socially, so that an understanding of social and power structures (race, class, gender) can inform theories of social life. All knowledge is seen as subjective and open to manipulation.

1.6.2 Assumptions of the researcher

Burns and Grove (2005:728) state that assumptions are statements taken for granted or considered true, even though they have not been scientifically tested. In

studies, assumptions are embedded in the philosophical base of the framework, study design and interpretation of the findings (Burns & Grove 2005:39). Action research differs from other kinds of research and has unique underpinning assumptions. The paradigm of critical social theory as well as the assumptions described by McNiff and Whitehead (2006:22-35) influenced the researcher's epistemological, ontological and methodological assumptions. The realisation of these assumptions within this research is discussed in Section 1.6.2.1 to 1.6.2.3.

1.6.2.1 Epistemological assumptions

Epistemology has to do with how the researcher understands knowledge and comes to acquire knowledge (McNiff & Whitehead 2002:17). The epistemological assumptions are:

- In AR, the object of inquiry is not other people, but the 'I' in relation to other 'I's' (McNiff *et al.* 2003:19)
- Knowledge is uncertain and answers are created through negotiations (McNiff & Whitehead 2002:18)
- Truth lies in the constructed and agreed reality, and can thus be generated from individuals' experience of living and learning (McNiff & Whitehead 2002:16,18)
- Learning in this view is rooted in experience and involves reflecting on experience of practice (McNiff & Whitehead 2002:18).

a) The object of the enquiry as the "I"

The object of inquiry refers to the focus of this research. In self-study AR, the focus of the research is on the researcher, in this study, trying to indicate what she did and how the emergency situation in the A&E unit was resolved. This refers not only to the researcher, but also to the individual practice leaders and nurse practitioners. The aim was to indicate how the members of the PDG were held accountable for what they decided to do in this specific situation.

The idea of personal accountability has implications. One of these is that the researcher could not accept accountability for what the other members or nurse practitioners thought and did, but had to accept full responsibility for what she thought and did. Another implication is that the researcher had to recognise that

she could be mistaken. One method of testing rigour is to ask approval of critical friends – this however is not a sufficient safeguard. The researcher also considered the opinions of the PDG and nurse practitioners throughout the research.

Reflection is an essential component of AR and the reflective voice of the researcher is thus regarded as important. The researcher therefore writes in the first person when reflecting on issues, indicated in "*arial and italics*".

b) Knowledge creation is a collaborative process

In AR, one does not work in isolation, but in a social situation. Therefore, what the nurse practitioners do in their professional practice potentially influences others. Action research means working with others in all stages of the process, in a specific setting (McNiff & Whitehead 2002:19; Somekh & Lewin 2005:89).

Academic validation was ensured by working with two research supervisors during all three phases of the research (McNiff & Whitehead 2002:106). Two critical friends, with whom the findings were negotiated throughout the research process to ensure that the findings were valid and truthful, were also included in the process (McNiff & Whitehead 2002:105). In the second phase of this research, the researcher included the views of the practice developers as well as the nurse practitioners and they formed part of the validation group (McNiff & Whitehead 2002:105).

The knowledge obtained throughout the research is uncertain and answers to questions are created through negotiation. Often answers cannot be negotiated and the people then have to learn to live with the situation. As knowledge is the property of individuals, it is often subjective and biased. Therefore, the researcher had to negotiate the meanings with other knowing individuals, who, in this case, were the research supervisors, critical friends and nurse practitioners.

Learning is rooted in reflection and involves reflecting on the experience of practice, deciding whether action was in line with an espoused value base and then deciding on future action as a result of the reflection (McNiff & Whitehead 2002:18).

1.6.2.2 Ontological assumptions

Ontology is the study of being and influences how people view themselves in their relationships with others.

The ontological assumptions were:

- AR is value laden, as both the researcher and nurse practitioners bring their own values with them (McNiff *et al.* 2003:16; Morton-Cooper 2000:9; Somekh & Lewin 2005:91)
- AR is morally committed to enhance change through learning, but not to impose the researcher's values on the participants in the process (Hall 2006:197; Waterman 1998:103)
- AR aims to understand what 'I/we' are doing and not on what 'they' are doing (McNiff *et al.* 2003:20; Morton-Cooper 2000:12)
- AR assumes that the researcher is in relation with everything else in the research field, and influences and is influenced by others – it is thus a collaborative effort (Morton-Cooper 2000:12).

a) Action research is value laden

The researcher holds a set of values. These values as well as the values of the nurse practitioners were clarified during the initiation of the project. The researcher sought to create a set of shared values from which the PDG (including the unit manager, clinical facilitator and researcher) could work to reach the aim of the research. The aim of this project was to live in the direction of these values. These values were the fundamental core around which the project was delineated and acted as the guiding principles. This research was therefore not value free.

b) Action research is morally committed

As an action researcher, the researcher chose the values she subscribed to and indicated in the research how she held herself accountable for the choices made in the research, why these choices were made and what was hoped to be achieved.

The researcher was approached by the unit manager to assist in resolving the emergency situation in the A&E unit. This emergency situation and the influence it

had on the A&E learners and colleagues working in the A&E unit had previously been acknowledged by the researcher. As the researcher agreed to assist in rectifying the situation, this commitment could be perceived as a moral commitment. This commitment not only included a commitment to the practice leaders and nurse practitioners working in the A&E unit, but also entailed a commitment to the A&E learners, the patients and their families.

The researcher provided opportunities for the nurse practitioners to decide for themselves during the research, but did not hold herself responsible for the nurse practitioners' decisions. They were invited to present their own views and these views were respected. Although the researcher provided and encouraged other options during the project and guided reflection was used to direct the PDG and nurse practitioners in making choices, the researcher did not force her ideas on them. Choices made by the PDG and nurse practitioners were thus their own choices.

The main ontological assumption was that, as action researcher, the researcher aimed to live in a way that was consistent with her values. These values concerned the need to see herself in relation with others as well as how inclusive and relational practices could strengthen these relationships. The researcher tried not to impose her values onto others. The researcher realised that she also needed to learn from the nurse practitioners and the values they lived in their environment.

The researcher aimed to make her practice a purposeful and committed practice – that is, praxis.

c) Action researchers perceive themselves as in relation with one another in their social contexts

As action researcher, one should see oneself in relation with others, in terms of their practices and also their ideas and the rest of their environment. The researcher therefore did not adopt a spectator approach or conduct experiments on others, but undertook an enquiry with the nurse practitioners, recognising that people are always in company.

The researcher formed part of the PDG, thus forming a partnership. The focus of the enquiry was on the researcher and the practice leaders asking "How do I improve what I am doing?" (Kemmis & McTaggart 2003:365; McNiff & Whitehead 2002:18). The researcher assumed that the PDG's answer would involve the other people's perceptions and thus influence the entire group's learning. People learn not only as individuals, but also within a group of individuals, thus collaboratively (Kemmis & McTaggart 2003:355).

Differences of opinion are recognised, but understood as the basis of creative engagement. In recognising these differences, it is also important to recognise the uniqueness of each individual. If all the nurse practitioners could agree on certain inclusive ethics, the difficulties within the group's decisions could be limited. If not, the task could become extremely demanding.

It is also important to see the nurse practitioners and the researcher as equals. Power sharing happens when each individual perceives the others as powerful and acknowledges their ability to speak for themselves. One should agree to talk with others on those terms. This was agreed upon at the beginning of the research.

d) The ontological "I"

One other assumption of the research is the ontological 'I'. As researcher, it is impossible to stay out of the research and not contaminate it. As one of the foci of AR is self-study (personal/individual learning), the use of 'I' is normal practice in AR reports (Kemmis & McTaggart 2003:366; Somekh 2006:43; Zuber-Skerritt 2005a:34). The researcher therefore opted to write in two voices. The first voice is as academic writer and researcher. The text is written in the third person. The second voice is the reflective voice of the researcher as reflection plays an integral role in AR. *Reflections* will be indicated by changing the font to *'arial and italics'.*

1.6.2.3 Methodological assumptions

Methodology refers to the way in which the research was conducted (Somekh & Lewin 2005:347) and there is a general agreement that AR has an identity of its own (McNiff & Whitehead 2002:1). The methodological assumptions were:

- Action researchers do not do research on others, but on themselves in the company of others (Fraser 2000:217; McNiff & Whitehead 2002:18; Sense 2006:4) and there is thus a shared ownership of the research project (Kemmis & McTaggart 2003:342; McNiff & Whitehead 2002:15).
- AR begins with the experience of a concern (Kemmis & McTaggart 2003:337) and follows through a developmental process, which shows cycles of action and reflection (Hall 2006:196; Kemmis & McTaggart 2003:381; Somekh & Lewin 2005:89).
- Action researchers aim to investigate their practices with a view to improving them (Morton-Cooper 2000:76; O'Brien 1998:2). The idea of closure is transformed into the idea of one state metamorphosing into another, through learning. Change follows (Hall 2006:196) and is understood as people improving learning to improve practices (Kemmis & McTaggart 2003:338; Somekh & Lewin 2005:91; Zuber-Skerritt 2005c:273).
- There is no neat end to an AR project (Meyer 2006:282).

a) Action research is done by participants who regard themselves as agents

An agent is "*someone who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives, whether or not we assess these terms of some external criteria as well"* (McNiff & Whitehead 2006:31). The main responsibility of agents is to ask questions, implying that, as action researcher, the researcher should always ask questions and not accept final answers.

Action research is value-laden. This involves both taking action and considering what influence the researcher might have on the other members of the PDG, as well as on the learning of nurse practitioners and the researcher's own learning. As action researcher, the researcher acknowledged that her involvement in the research process could influence the practices of the nurse practitioners. The researcher therefore did not do research on others, but on herself in the company of others. It was a collaborative approach that took place within a social context.

b) The methodology is open-ended and developmental

According to Kemmis and McTaggart (2003:381), unlike traditional social science, AR does not aim for closure, nor do nurse practitioners expect to find certain answers.

These authors add that the criterion for success is not whether the participants have followed the steps faithfully, but whether they have a strong and authentic sense of development and evolution in their practices, their understanding of their practices and the situation in which they practice. The process itself is the methodology and is frequently untidy, haphazard and experimental, and the researcher has to work in a flexible and responsible way with issues as they occur in a natural way in the practice (Gerrish & Lacey 2006:275). During the research, the researcher continuously looked for ways that might be useful and tried these out. Researchers need to be open to new possibilities and understand that learning is never complete (McNiff & Whitehead 2002:19).

Action research starts with the experience of a concern and follows through a developmental process that shows cycles of action and reflection and is thus regarded as a learning process (Kemmis & McTaggart 2003:383).

c) The aim of the research is to improve learning with social intent

Traditional research tries to show a cause-and-effect relationship and works on the assumption that if people do this, that will happen. The learners are therefore not expected to think for themselves. In AR, the nurse practitioners should learn to think for themselves and make decisions in their practice. In order to develop their practice, the researcher had to enable the nurse practitioners to obtain new knowledge, work with their new knowledge in ways that were right for them (Stokes 2004:246) and facilitate their learning to create their own new future in the A&E unit (Morton-Cooper 2000:1). Reflection was used as the learning tool.

The social purpose of AR refers to why research is done in relation to informing and improving its social context. These purposes are:

- Action research is work based (Morton-Cooper 2000:1; Sense 2006:4; Somekh & Lewin 2005:89; Williamson 2005:490; Zuber-Skerritt 2005c:273)
- Nurse practitioners evaluate their own work in relation to their values (Kemmis & McTaggart 2003:351; McNiff & Whitehead 2002:17; Somekh & Lewin 2005:91). They do not need external evaluation, but understand the need for stringent testing and evaluation of how to develop their practice further (Rasmussen 1997:262; Zuber-Skerritt 2005c:273).

⇒ ***Develop workplace practice through improved learning***

Action research can be workplace based or non-work based. Within this research, it was work based. The overall aim was to create a better future for both the nurse practitioners and the A&E unit, and this was done by setting off on a journey towards emancipatory practice development. To achieve this aim, their practice had to be improved and this was done through learning. Reflection was used as a learning tool (Zuber-Skerritt 2005c:273). Improved practices do not just happen, but can be achieved when the nurse practitioners start thinking carefully about what they need to do differently in relation to others. It is then the responsibility of the nurse practitioners to show how their improved learning has led to improved practices.

⇒ ***Promote the ongoing democratic evaluation of learning and practices***

AR should justify claims of knowledge by the production of authenticated and validated evidence, and then make the claims public in order to subject them to critical evaluation (Morton-Cooper 2000:78). One should, however, take into account that people have different views and therefore the evaluation of one person can differ from the evaluation of another.

Nurse practitioners evaluate their own work in relation to their values. They do not need external evaluation, but understand the need for stringent testing and evaluation at all stages of the research, which involves the critical insights and judgements of others.

1.6.3 Clarification of the key concepts

In the context of this research, and for simplicity and consistency throughout this thesis, the following key concepts were defined as follows.

1.6.3.1 Accident and emergency (A&E) unit

The Collins English Dictionary (2006:9) defines an accident as "*an unforeseen event or one without an apparent cause"* and "*a misfortune or mishap, especially one that causes injury or death"*. The Collins English Dictionary (2006:511) defines an

emergency as "*an unforeseen or sudden occurrence, especially of danger demanding immediate action"*. The Reader's Digest Oxford Dictionary (1994:478) further states that it is "*a medical condition requiring immediate action"*.

The A&E unit involved in this study is in a Level III tertiary hospital in the Gauteng province. Based on the classification of health establishments (South Africa 2003) in the National Health Act, 2003 (Act No 61 of 2003), the National Department of Health (2006:10) derived the following preliminary definition of a Level III (tertiary) hospital: it includes a facility that provides in-patient services as well as specialist and sub-specialist care in the public sector.

For the purpose of this study, the A&E unit refers to a unit, situated in a Level III tertiary public hospital in Gauteng, which admits, manages, stabilises and refers critically ill or injured patients of all ages to appropriate specialists and then transfers these patients to the appropriate ICU or general wards in the hospital.

1.6.3.2 Action learning

"*Action learning means learning from action and concrete experience, through group discussion, trial and error, discovery and learning from one another. It is a process by which groups of people (in this case nurse practitioners) work on real issues and challenges, carrying real responsibility in real conditions*" (Zuber-Skerritt 2005a:34).

Zuber-Skerritt (2001:10) defines praxis as "*the interdependence and integration – not separation – of theory and practice, research and development, thought and action".* This definition has been adopted for the purposes of this research.

1.6.3.3 Benchmarking

The Collins English Dictionary (2006:143) defines a benchmark as "*a criterion by which to measure something*" or "*a reference point*". Benchmarking is defined as the process by which a company compares its performance with that of other, high-performing organisations (Kreitner & Kinicki 2007:G1).

For the purpose of this study, benchmarking refers to the process of consulting high-performance practice leaders working in A&E units in the private sector and then reflecting on their performances in order to provide additional insight for the practice leaders in the A&E unit as to how the nurse practitioners can improve their practice.

1.6.3.4 Coaching

The Merriam-Webster Online Dictionary (2007) defines a coach as "*a private tutor"* and "*one who instructs or trains"*. A coach typically assists others to meet a particular goal (Parsloe & Wray 2000, as cited in Murphy, Mahoney, Chen, Mendoza-Diaz & Yang 2005:344). Coaching may be solicited by the learner seeking help and unsolicited when the coach "*observes performance and provides encouragement, diagnosis, directions, and feedback"* (Jonassen 1999:233).

For the purpose of this study, coaching is defined as observing learner performance and providing encouragement, motivational prompts and feedback in the A&E unit of a Level III public hospital in Gauteng.

1.6.3.5 Creativity

To be creative is defined as "*having or showing imagination"* (Collins English Dictionary 2006:317) and creativity is regarded as a process of developing something new or unique (Kreitner & Kinicki 2007:G1).

For the purpose of this study, creativity is defined as a process of developing something new or unique and that is implemented in the A&E unit of a Level III public hospital in Gauteng.

1.6.3.6 Culture

Culture is defined as "*the total of the inherited ideas, beliefs, values, and knowledge, which constitute the shared bases of social action"* (Collins English Dictionary 2006:384). Culture is defined by Kreitner and Kinicki (2007:G2) as the beliefs and

values about how a community of people should, and do, act. Manley (2000:35) adopts Drennan's (1992) definition of culture as "*the way things are done around here*" and argues that it is the culture at individual, team and organisational level that creates the context for practice. Drennan's definition of culture was used and applied in this study.

1.6.3.7 Emancipatory process

Caldwell (2004:203), Down (2004:272) and Johns (2000:25) state that, according to Fay (1987), critical social science is concerned with enabling a process of enlightenment, empowerment and emancipation, rather than 'command of' or 'power over' (Merriam-Webster Online Dictionary 2007).

The journey in this study had an emancipatory intent. For the purpose of this study, the emancipatory process is defined as a cyclic process, which is positive and collaborative, and has an outcome. It consists of three interrelated concepts enlightenment, empowerment and emancipation, and it realises an enabling environment as applied to the A&E unit of a public Level III hospital in Gauteng.

a) Enlightenment

Enlighten is defined as "*to give information or understanding to*" (Collins English Dictionary 2006:520). In addition, Manley (2004:71) states that according to Mezirow (1981) and Fay (1987), enlightenment, an antecedent to empowerment, involves identifying taken for granted aspects in everyday life and working through consciousness-raising and awareness to make them obvious. The definition of Manley was applied in this study.

b) Empowerment

Empowerment is defined by Kreitner and Kinicki (2007:G2) as "*sharing a varying degree of power with lower-level employees to tap their full potential"*. Thompson and Martin (2005:857) define empowerment as "*freeing people from a rigid regime of rules, controls and directives and allowing them to take responsibility for their own decisions*". Empowerment is described by Johns (2000:35) as "*a sense of freedom*

to do something significant in changing one's life and involves the energy and will to move from passivity, the perception of self as powerless, and take confident action considering self's and others' needs".

In the critical social theory, the underprivileged groups are often described as oppressed groups, where social institutions and other administrative units maintain oppression. Empowerment, or rather the lack thereof, is associated with the negative, patriarchal and authoritarian concept of power (Kuokkanen & Leino-Kilpi 2000:237). In the context of this study, power refers to the professional status of nurse leaders and to their possible control over the nurse practitioners working in the A&E unit, who thus is regarded as the oppressed group.

Manley (2004:71) states that Giroux (1988) argues for the need to generate knowledge that enables a person to become empowered by seeing the possibilities, a vision of what is possible or how things can be. Empowerment fosters critical thinking through reflection in the clinical practice and involves communicating to nurse practitioners that they have the authority, ability and responsibility to think critically about their practice (Birx 2006:283). Work empowerment is defined as a process whereby the individual feels confident that he/she can act and successfully execute a certain kind of action (Suominen, Savikko, Puukka, Doran & Leino-Kilpi 2005:148).

For the purpose of this study, empowerment is regarded as fundamentally positive, referring to solutions rather than to problems. It is a dynamic concept where power is taken over and given away, or, in other words, power is shared. Empowerment is associated with the development and growth of nurse practitioners by means of reflection in an enabling environment, where the nurse practitioners can unite to achieve their shared vision as applied to the A&E unit in a public Level III hospital in Gauteng.

c) Emancipation

Emancipation follows empowerment. Emancipation as a nursing concept is derived from a long-standing history of social oppression and can be addressed by the critical social theory (Wittmann-Price 2004:437).

Emancipate is defined by the Merriam-Webster Online Dictionary (2007) as (1) "*to free from restraint, control or power over another*", (2) "*to release from paternal care and responsibility"*, and (3) "*to free from any controlling influence"*. The Collins English Dictionary (2006:510) defines emancipate as "*to free from restriction or restrain", "to liberate from bondage*" and "*to give independence"*.

Emancipation is the final concept on the continuum of the emancipatory process. Emancipation is about helping nurse practitioners to free themselves from the things they take for granted in their everyday practice as well as the context in which they work and take action. Integrated in this process is the development of the nurse practitioners' own theories, which describe and explain what they do, why they do it, how they do it and the consequences of these actions. These personal theories are constantly refined and revised through the use of reflection and critique, and refer to the distribution of power, where power is delegated by one person to enhance the enablement of another, thus providing them with an opportunity to make their own decisions (McCormack & Manley 2004:88-89). The definition of McCormack and Manley was applied in this study, with the acknowledgment that praxis through reflection is considered a main component of emancipation (Duchscher 2000:459; Kuokkanen & Leino-Kilpi 2000:239).

1.6.3.8 Emergency meeting

The Collins English Dictionary (2006:511) defines an emergency as "*an unforeseen or sudden occurrence, especially of danger demanding immediate action".* A meeting is defined by the Merriam-Webster Online Dictionary (2007) as (1) "*an act or process of coming together"* and as (2) *"an assembly for a common purpose"*.

Oppression is recognised as the direct antonym and a necessary antecedent of emancipation. Oppression can be overt or insidious, and serves the purpose of dehumanisation by producing a culture of silence and fear of freedom that is exploited for labour in exchange for perceived security (Freire 1970:36). In addition, Freire (1970:44) viewed oppression as "*dehumanisation*" and explained "*it is a concrete historical fact not only given destiny but the result of unjust order*".

Oppression or unequal power decreases a person's self-esteem and autonomy, and thereby restricts choices (Wittmann-Price 2004:441). Oppression is a type of awareness that actions are not harmonious with the individual or group's needs, and an affective experience, which produces the feeling that "*something is not right*", or "*this choice is not right for me*" (Wittmann-Price 2004:441). Therefore, logically, an oppressive force must precede (is an antecedent to) emancipation, because if no oppression existed, there would be no need for emancipation (Wittmann-Price 2004:440).

For the purpose of this study, an emergency meeting is regarded as the antecedent to the process of emancipation. The emergency meeting was organised by the nurse practitioners working in an A&E unit of a Level III public hospital in Gauteng as they became aware that "*something was not right"* in the A&E unit and aimed to take action and make top and middle management as well as the practice leaders aware of the situation.

1.6.3.9 Emergency situation

Crisis is defined as "*a crucial stage or turning point"* (Collins English Dictionary 2006:375). A crisis is defined as "*an unstable or crucial time or state of affairs in which decisive change is impending",* "*one with the distinct possibility of a highly undesirable outcome*" and "*a situation that has reached a critical phase*" (Merriam-Webster Online Dictionary 2007).

In this study, the term emergency situation is used as an analogy for the crisis that was experienced by the nurse practitioners in the A&E unit of a Level III public hospital in Gauteng. In addition, the emergency situation includes the barriers that prevented the implementation of long-term solutions to enable the nurse practitioners to develop their own and emancipated practices.

1.6.3.10 Enablement

The word empowerment stems from the Latin word 'potere', meaning able. The Reader's Digest Oxford Dictionary (1994:482) defines enable as "*to give a person*

the means or authority to do something". The Collins English Dictionary (2006:515) defines enable as "*to provide (someone) with adequate power, means, opportunity, or authority (to do something)*" or "*to make possible"*. Enablement is often used with empowerment in the literature and is defined as to "*provide with the means or opportunity*" (Merriam-Webster Online Dictionary 2007).

For the purposes of this study, enablement refers to the opportunities provided to the nurse practitioners by means of continuous professional development (CPD) as well as reflection (learning tool) to develop both their technical and emancipatory practice as applied to an A&E unit in a Level III public hospital in Gauteng.

1.6.3.11 Environment

The Collins English Dictionary (2006:523) defines an environment as "*external conditions or surroundings" and "external surroundings in which a plant or animal lives, which influence its development and behaviour"*. Environment is defined by the Merriam-Webster Online Dictionary (2007) as "*the circumstances, objects, or conditions by which one is surrounded*".

For the purpose of this study, the A&E environment consists of nurse practitioners who are influenced by their environment. As this study had an emancipatory intent and the importance of adult, experiential and action learning was acknowledged, the environment also refers to the learning environment surrounding the nurse practitioners. When this environment does not influence and support enablement, which in turn may enhance emancipation, it is regarded as a toxic environment.

a) Enabling environment

An enabling environment is defined, in this study, as an environment in which the nurse practitioners working in the A&E unit in a Level III public hospital in Gauteng are provided with opportunities to develop on a continuous basis. Collaboration and participation are emphasised in the decision-making processes as well as in acting, observing and reflecting on the outcomes thereof. Throughout the emancipatory process, the nurse practitioners are supported (professionally and personally), valued and appreciated for their efforts, and successes celebrated.

b) Toxic environment

Toxic is defined as "*containing or being poisonous material especially when capable of causing death or serious debilitation"*, "*exhibiting symptoms of infection or toxicosis" and "extremely harsh, malicious, or harmful'* (Merriam-Webster Online Dictionary 2007).

The term toxic environment is an analogy used to define the environment in which the nurse practitioners worked and were driven out of due to their dissatisfaction. A toxic environment is defined as an environment that is not conducive to learning, unsupportive and hierarchical, with a bureaucratic management style, where nurse practitioners are left disempowered and practice development is prohibited as applied to the A&E unit of a Level III public hospital in Gauteng.

1.6.3.12 Facilitation

The Collins English Dictionary (2006:556) defines facilitate as "*to assist the progress of"*. Reason (1988:342) defines facilitation as the process during which the researcher creates a climate or set of opportunities for the person to reach his/her full potential. Burrows (1997:401) defines facilitation as "*a goal-orientated dynamic process, in which participants work together in an atmosphere of genuine mutual respect, in order to learn through critical reflection"*.

For the purpose of this study, facilitation is defined as a goal-orientated process, in which the facilitator, practice leaders and nurse practitioners form partnerships, in an atmosphere of genuine mutual respect, to learn through action, experience and reflection, thus enhancing both personal and professional development.

a) Clinical facilitator

Microsoft Encarta World English Dictionary (1999) defines facilitator as "s*omebody enabling something to happen: somebody who aids or assists in a process, especially by encouraging people to find their own solution to problems or tasks".* Jarvis (2004:212) states that, according to Freire (1998), the role of a teacher as a facilitator is to be able to stimulate the learning process rather than teach the correct knowledge and values that have to be acquired.

In the context of this study, a clinical facilitator is an A&E nurse practitioner involved in both teaching knowledge and stimulating the learning process, by making use of reflection, both of the nurse practitioners as well as of the A&E learners working in the A&E unit.

1.6.3.13 Job enlargement

The description of Kreitner and Kinicki (2007:G3) of job enlargement, namely that it "*involves putting more variety into a job",* was adopted for this study.

1.6.3.14 Job enrichment

The description of Kreitner and Kinicki (2007:G3) of job enrichment, namely that it involves *"building achievement, recognition, stimulating work, responsibility and advancement into a job*", was adopted for this study.

1.6.3.15 Job satisfaction

Job satisfaction is an affective or emotional response to one's job (Kreitner & Kinicki 2007:G3). For the purpose of this study, this definition was applied.

1.6.3.16 Journey

The Collins English Dictionary (2006:855) defines a journey as "*a travelling from one place to another"*. The Reader's Digest Oxford Dictionary (1994:823) defines a journey is "*an act of going from one place to another*", "*the distance travelled in a specific time*" and "*the travelling of a vehicle along a route at a stated time"*.

For the purpose of this study, a journey refers to the travelling of the PDG (drivers) and nurse practitioners (change agents) in an A&E unit (using action as the vehicle) along the route of 'practice development', starting at the moment when an

emergency situation was diagnosed to reaching a shared vision of 'emancipatory practice development'.

1.6.3.17 Leadership

Kreitner and Kinicki (2007:G3) define leadership as a process whereby an individual influences others to achieve a common goal.

a) Transformational leadership

Transformational leaders transform employees to pursue the organisation's goals over self-interest (Kreitner & Kinicki 2007:G6).

1.6.3.18 Management

Kreitner and Kinicki (2007:G4) define management as a process of working with and through others to achieve organisational objectives efficiently and ethically.

1.6.3.19 Nurse practitioner

Nurse practitioners refer to all the nurses, of all categories, working in the A&E unit. These categories include the professional nurse practitioners, A&E professional nurse practitioners, enrolled nurse practitioners as well as auxiliary nurse practitioners.

a) A&E nurse practitioner and A&E learner

In the context of this study, the A&E nurse practitioner is a professional nurse practitioner registered as a nurse with the South African Nursing Council (SANC) and caring for patients involved in accidents and emergencies in the A&E unit under investigation. An A&E nurse practitioner should also have completed one or more of the following additional qualifications registered at the SANC:

- Medical and surgical nursing science: Trauma and emergency nursing
- Medical and surgical nursing science: Trauma nursing.

The A&E learner is a professional nurse practitioner registered as a nurse with the SANC and caring for patients involved in accidents and emergencies in the A&E unit under investigation. The A&E learner is enrolled for the programme medical and surgical nursing science: trauma and emergency nursing, for an additional qualification at the South African Nursing Council (SANC).

b) Enrolled and auxiliary nurse practitioner

In the context of this study, these two categories are defined as sub-professional nursing personnel (Searle 2000:57) registered with the SANC. These two categories are utilised in the A&E unit to perform basic nursing duties.

c) Professional nurse practitioner

Professional nurse practitioners are nurses registered with the SANC, specifically caring for patients involved in accidents and emergencies in the A&E unit.

1.6.3.20 Performance management

Kreitner and Kinicki (2007:G5) define performance management as a continuous cycle of improving job performance with goal setting, feedback and coaching, rewards and positive reinforcement.

1.6.3.21 Practice development

Manley and McCormack (2004:34) state that the most comprehensive definition of practice development is one provided by McCormack, Manley, Kitson, Titchen and Harvey (1999:256), who stated that

> *Practice development is a continuous process of improvement towards increased effectiveness in person centred care, through the enabling of nurses and healthcare teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous continuous process of emancipatory change.*

This definition should also reflect the importance of professional development for individuals involved in practice development. This is important, because every nurse practitioner working in the A&E unit needs certain knowledge and skills to ensure adequate patient care.

The researcher therefore also made use of the following definition of Garbett and McCormack (2002:88):

> *Practice development is a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflect the perspectives of services users.*

Manley and McCormack (2004:36) identify two related but different worldviews of practice development: technical and emancipatory. A differentiation is made between technical practice development and emancipatory practice development below.

a) Technical practice development

In technical practice development, the practice developer is perceived as the expert authority figure. That is, the practice developers (clinical facilitator and researcher) know what needs to be done and what standards to set, and the criteria for success pre-exist in their minds (Manley & McCormack 2004:40). It is the clinical facilitator's ideas that direct the process, with the end-point already in his/her mind – which, in this research, focused on the improvement of the knowledge and skills of the nurse practitioners in order to render safe and effective patient care. The knowledge and skills attained during the professional development programme were used to generate practical understanding and guide practical judgments during patient care.

In this research, technical practice development refers to professional development offered by the clinical facilitator, aimed at improving the knowledge and skills of the nurse practitioners on a continuous basis in the A&E unit by using various teaching

strategies. The development of the nurse practitioners is therefore a consequence of practice development rather than a deliberate and intentional purpose (Garbett & McCormack 2004:24).

b) Emancipatory practice development

Manley and McCormack (2004:37) state that emancipatory practice development involves the development and empowerment of the nurse practitioners. The process is deliberate and dependent on the creation of a specific type of culture, termed transformational culture. This is a culture where quality becomes everybody's business, positive change becomes a way of life, everyone's leadership potential is developed and there is a shared vision of investment in and valuing of staff.

For the purpose of this study, emancipatory practice development is regarded as an outcome of the emancipation process.

1.6.3.22 Praxis

Praxis is "*thoughtful reflection and action which occur in synchrony",* where *"action is informed by reflection and reflection is informed by action. Praxis involves a shift away from critical thinking as problem solving, to critical thinking as a process in which knowledge and action are dialectically related through the process of critical reflection*" (Van Aswegen, Brink & Steyn 2000b:132).

Praxis is defined by Somekh and Lewin (2005:347) as a process of "*embedding the development of theory in practical action*". This definition was used in this study, with the addition of the fact that praxis through reflection is considered a main component of emancipation (Duchscher 2000:459; Kuokkanen & Leino-Kilpi 2000:239).

1.6.3.23 Professional development

Mallett *et al.* (1997:38) suggest that the terms professional development and practice development are distinct but can easily be taken as synonymous. They

argue that professional development refers to the skills of the individual nurse practitioner while practice development is about creating conditions in which such skills and knowledge can be applied.

In this research, professional development refers to the specific knowledge and skills taught to the nurse practitioners by the clinical facilitator to ensure that the nurse practitioners render adequate patient care and enhance their technical practice development.

1.6.3.24 Reflection

Burns and Bulman (2000:4), and Williams (2001:28) state that the concept of reflection can be traced to Dewey (1933), who described reflection as "*active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends*".

Johns (2000:34) states that reflection is "*a window through which the practitioner can view and focus self within the context of her own lived experience in ways that enable her to confront, understand and work towards resolving the contradictions within her practice between what is desirable and actual practice".*

Reflection is therefore concerned with the growth of the powerful self through which the nurse practitioner can understand and take action to reconstitute patterns relating to more powerful others in ways that enable them to realise a desirable and effective practice. In this research, reflection was used as a learning tool to improve practice in the A&E unit and develop the nurse practitioners in such a way that the shared vision of 'emancipatory practice development' can be reached.

Therefore, for the purpose of this study, reflection is defined as a process used to facilitate learning where the researcher, practice leaders and nurse practitioners work together to analyse and learn from experience in order to develop their own and emancipated practice.

a) Reflection-on- and –in-action

Reflection-in-action refers to the process whereby the nurse practitioner recognises a new situation or problem and then thinks about it while still acting (Burns & Bulman 2000:5). Reflection-on-action refers to the process whereby retrospective contemplation of practice takes place in order to uncover the knowledge used in a particular situation, by analysing and interpreting the information recalled (Burns & Bulman 2000:5-6). These two definitions were adopted in this research.

b) Guided reflection

"*Guided reflection is a combination of techniques intended to enable practitioners to reflect on their professional and personal conduct (experiences) in order to become increasingly effective (critical, creative and reflective)*" (Van Aswegen *et al.* 2000b:131).

For the purpose of this research, guided reflection is used by a supportive facilitator as a learning tool (strategy) to guide learning by providing a structure to explore everyday challenges encountered in practice, and to identify strategies and actions required to improve on certain aspects. This view is shared by Brown, Esdaile and Ryan (2003:142).

c) Critical reflection

Rolfe, Freshwater and Jasper (2001:xi) define critical reflection as *"… using the reflective process to look systematically and rigorously at our own practice …" and ask the question "We all reflect on our practice to some extent, but how often do we employ those reflections to learn from our actions, to challenge established theory and, most importantly, to make a real difference to our practice?"*

In this research, critical reflection is the reflection-on-action process and was used to systematically and rigorously look at practice in order to enhance action learning as well as enable the practice leaders and nurse practitioners to develop their own and collective emancipated practice in the A&E unit.

d) Reflexivity

Gerrish and Lacey (2006:539) define reflexivity as *"the process, used in qualitative research, whereby the researcher reflects continuously on how their own actions, values and perceptions impact upon the research setting and affect the data collection and analysis*". This definition was used during this study.

1.6.3.25 Triage

The Merriam-Webster Online Dictionary (2007) defines triage as the "*the sorting of patients according to the urgency of their need for care*". In the A&E unit, all patients entering the unit were triaged and sorted according to priorities, where a priority 1 (P1) patient requires immediate management, followed by priority 2 (P2) and 3 (P3). Priority 4 (P4) patients are regarded as unsalvageable or dead on arrival. The definitions, as applied to the A&E unit, are:

- **Priority 1 (P1)**: Patients admitted with life-threatening injuries or medical emergencies, such as airway, breathing and/or circulation problems. These patients are so severely injured or critically ill that they will die should they not receive immediate medical interventions.
- **Priority 2 (P2)**: Patients admitted with potential life-threatening injuries or medical emergencies that are not as serious as a P1. Although their condition is stable for the moment, they require watching by trained personnel and frequent re-triaging as the possibility of rapid deteriorations exists.
- **Priority 3 (P3)**: Patients referred to as the 'walking wounded' and who do not require immediate management. These patients have minor injuries or medical conditions and, following management, will usually be discharged from the hospital.
- **Priority 4 (P4)**: These patients are either dead on arrival or unsalvageable when they arrive at the A&E unit.

1.7 THE RESEARCH MODEL

This research was based on AR, as conceptualised by Perry and Zuber-Skerritt (1992:204), and Zuber-Skerritt and Knight (1992:89-103). Morton-Cooper

(2000:12) defines AR, applied in the healthcare setting, as a "*collaborative approach in a real-world health care situation to define a problem and explore possible a solution*".

The reasons for basing this study on the AR model are:

- The researcher was a colleague and collaborator of equal status in the A&E unit. The researcher was also a knowledgeable academic who worked at an academic institution and was the lecturer of the A&E programme. She was personally and professionally flexible, resilient and persuasive, and was open to critique from others. In the A&E unit, where a high premium is placed on trust as well as willingness to collaborate in a team in order to create change the researcher was trusted and respected. This is consistent with the view expressed by Zuber-Skerritt (2005a:66).
- The research problem was perceived as relevant by both the researcher and the nurse practitioners involved in the research. The researcher therefore was consulted and became involved in joint collaboration and facilitating learning through reflective discussions. This is consistent with the views of Morton-Cooper (2000:1-2), Streubert-Speziale and Carpenter (1999:251), and Zuber-Skerritt (2005b:49).
- Action research is a tool to develop the nursing practice, and thus generates practical knowledge intended to assist in raising standards of patient management and service delivery in general. The researcher therefore does not do the research *on* participants, but rather in collaboration *with* the participants. The researcher is a resource person, facilitator or consultant who helps participants to define problems clearly and who then supports them as they attempt to implement effective solutions. This approach is consistent with the approaches suggested by Galvin, Andrewes, Jackson, Cheeseman, Fudge, Ferris and Graham (1999:244), Holloway and Wheeler (2002:189), Kemmis and McTaggart (1988:5), and McNiff, Lomax and Whitehead (2002:1).
- Action research has a 'bottom-up' or grassroots orientation in which stakeholder groups are the primary focus of attention and source of decision-making. This is an approach that requires research facilitators to work in close collaboration with the stakeholders and to formulate 'flat' organisational structures that put decision-making power in the hands of the stakeholders. This approach is

consistent with Hattingh (2001:16), McNiff *et al.*(2003:12), and Morton-Cooper (2000:2).

- This research bridged the theory-practice gap (Holloway & Wheeler 2002:189), as it was carried out in the clinical setting and the nurse practitioners engaged in the research in their own practice area (Koshy 2005:29) in order to overcome this gap through the generation of the direct development of practice as well as nursing knowledge.
- Action research methods were used to assist nurse practitioners, by means of a cyclic process, to sustain efforts to develop and change their practice for the better, while at the same time acknowledging and respecting the contribution of individuals in the change process. This approach is consistent with Morton-Cooper (2000:1).

1.7.1 Introduction to action research

This study made use of AR as a research method (see Figure 2.2). This section provides an overview of AR for clarity and introduces the reader to the thought patterns of the researcher. This is further discussed and elaborated on in Chapter 2.

Although Kurt Lewin, an American social psychologist, was not the first to use or advocate AR, he was the first to develop the theory of AR into a respectable form of research in the social sciences (Herr & Anderson 2005:11). He described the process as "*a spiral of steps*", each revolution being composed of a series of stages: planning, action and fact finding about the results (Kemmis & McTaggart 1988:8). These ideas continued to influence many researchers in the organisation of their work and were reported as a cycle of steps: observe-reflect-act-evaluate-modify. It is therefore generally acknowledged that Lewin developed AR in 1946 (Holloway & Wheeler 2002:189; Koshy 2005:2; McNiff & Whitehead 2002:36; Morton-Cooper 2000:10; Polit & Beck 2004:265).

AR had a parallel but independent development in England by a group of researchers involved in the development of the Tavistock Institute of Human Relations in London, although it was not referred to as AR. These researchers, mainly psychologists, became involved in AR from the late 1940s onwards and developed a problem-solving approach used to help deprived communities to solve both social and

educational problems, and ameliorate the "*cycle of deprivation*" (Holloway & Wheeler 2002:189-190; Morton-Cooper 2000:10). Like Lewin, London's Tavistock Institute of Human Relations was interested in working collaboratively with employees and their managers to study the problems affecting them (Holter & Schwartz-Barcott 1993:299; Morton-Cooper 2000:10). Lewin and the Tavistock Institute were the two major forces behind the development of AR in the world.

Since the original conceptualisation of the process of AR by Lewin and London's Travistock Institute, AR has been developed by various researchers including Kemmis and McTaggart (1988), Elliot (1991) and Zuber-Skerritt (1992). AR has also been carried out under diverse intellectual traditions, including organisational research, community development, education and nursing (Hart & Bond 1995:23; Holloway & Wheeler 2002:191).

In nursing, AR has converged in the past decade, focusing on personal and professional development as well as the improvement of professional practice (Hart & Bond 1995:32; Holloway & Wheeler 2002:191; Morton-Cooper 2000:12). AR and its realignment with creativity, investigation and problem-solving are features that are valued in the nursing profession (Stringer 1996:5) and by the researcher, as opposed to the more mechanistic and technical solutions that could not be applied to the emergency situation in which the A&E unit found itself.

The main attraction for using the AR model in this study was that it offered the possibility of working with the nurse practitioners in a non-hierarchial and non-exploitative way, and could be used to make changes and close the theory-practice gap (Hart & Bond 1995:33; McNiff & Whitehead 2002:16). Engaging in this AR for practitioners project provided the opportunity to develop both the technical and emancipatory aspects of the nursing practice (McCormack & Manley 2004:87), changing nursing practice and generating new knowledge (McNiff & Whitehead 2002:15).

1.7.2 Comparison and integration of the action research model with Lewin's Change Model and the Task Alignment Model

The AR model described by Perry and Zuber-Skerritt (1992:204) follows an eclectic approach. These authors base their AR model on Lewin's Change Model (Lewin 1926, 1948, 1952), the Task Alignment Model and the Action Research Model. The main concepts of these models are described below.

Action research integrates evaluation through a spiral of interrelated cycles involving planning, acting, observing and reflecting (see Figure 1.1). As the name implies, AR is concerned with 'action' and 'research', but also with a process of collaboration. AR manifests in the classical spiral of AR cycles, where each cycle consists of a plan (including problem identification, situational analysis, team vision and strategic plan), action (the implementation of the strategic plan), observation (including monitoring and evaluation) and reflection on the results of the evaluation. These reflections lead to a revised or totally new plan and the continuation of the AR process in a second cycle, which then follows in a third cycle and so forth (Kemmis & McTaggart 2003:381; Zuber-Skerritt 1996:96). In this study, as AR can be used to assist the nurse practitioners to critically reflect on and examine their clinical practice in the A&E unit and reach some consensus of what type of services should be provided and why, it can be described as a critically reflective model, that is both practice-based and patient-centred in its philosophical approach (Morton-Cooper 2000:14).

The components of the AR cycle, namely plan, act, observe and reflect, were used to guide the research (see Chapter 3 to 5). The AR cycles were regarded as flowing into each other and moving in an upward direction, indicating continued enhancement of practice.

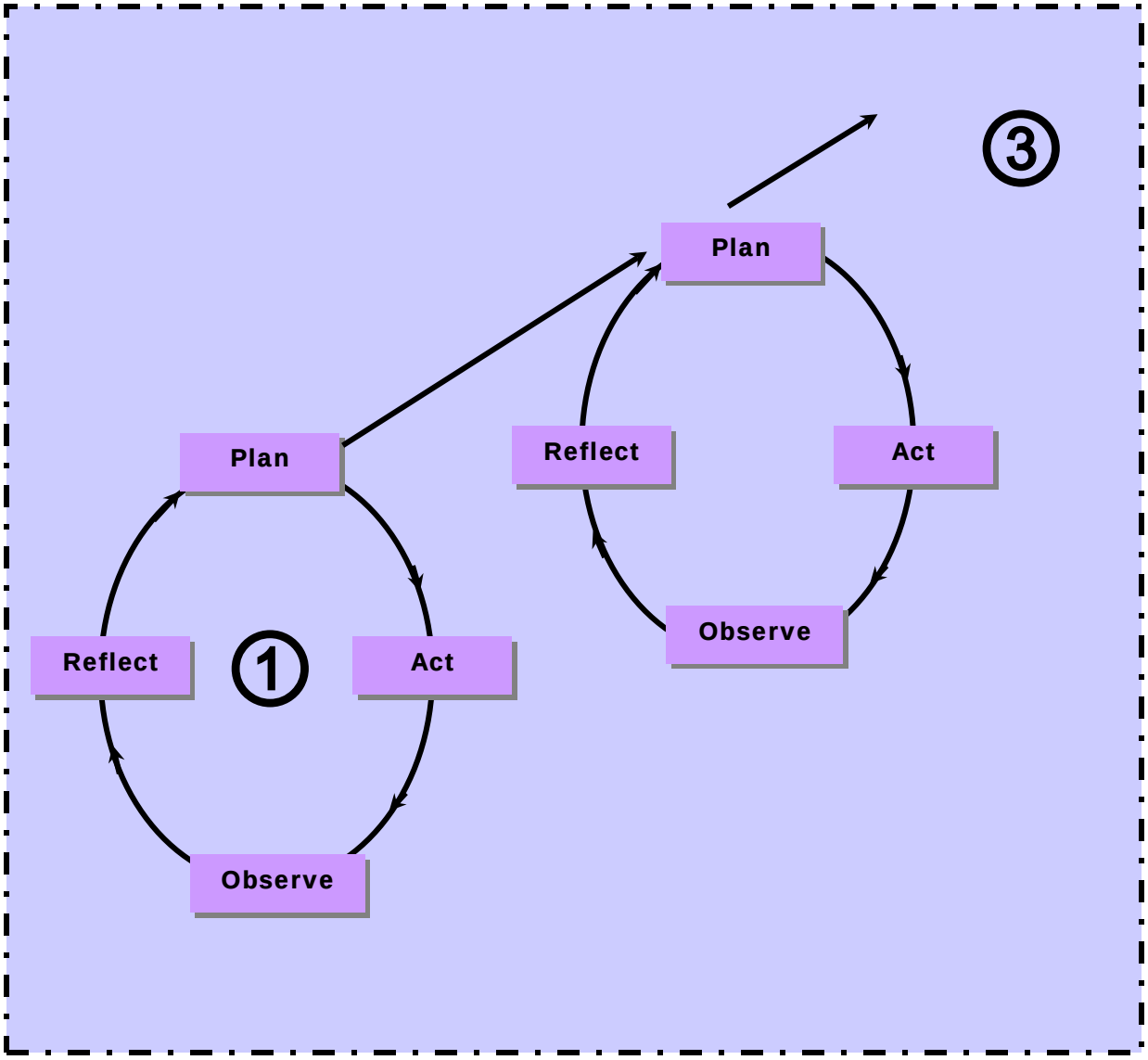


Figure 1.1: The succession of cycles in action research (adapted from Zuber-Skerritt 1992:17)

Concurrent with the views of Kemmis and McTaggart (1988:10) and Zuber-Skeritt (1992:16), the PDG and nurse practitioners engaged in the AR spiral components, as applied to this research, and then collaboratively -

- developed a flexible **plan** of critically informed action to improve their current situation and enhance both technical and emancipatory practice development,
- **acted** to implement the plan which was deliberate and controlled,
- **observed** this action to collect evidence, which allowed thorough evaluation. The observation was planned and a reflective journal was used for recording

purposes. The action process and its effects in the context of the situation were observed individually by the researcher as well as collectively by the PDG and nurse practitioners, and

- **reflected** on the action recorded during observation, which was aided by discussions among the researcher, PDG and nurse practitioners. As group reflection may lead to a reconstruction of the meaning of the social situation and provides a basis for the further planning of critically informed action, it was used extensively to plan the continued action.

Lewin's Change Model shows a three-stage model of planned change which explains how to initiate, manage and stabilise the change process (Kreitner & Kinicki 2007:584). The three stages of the model are unfreezing, changing and refreezing. The focus of change is to create the motivation for change. In doing so, individuals are encouraged to replace old behaviours and attitudes with those desired by management. In this stage, because change involves learning and doing things differently, the nurse practitioners must be provided with new information, new behavioural models, or new processes or procedures. Refreezing means stabilising the change and reaching a new equilibrium until there is a need for a new cycle of unfreezing, moving and refreezing (Kreitner & Kinicki 2007:585).

The **Task Alignment Model** (Beer, Eisenstat & Spector 1990:158-166) is a linear process. It is however comparable with the cyclic AR model used in this research because it can be argued that organisational management problems (in this research, the challenges which caused the emergency situation) cannot be clearly defined at the onset of the research. These are often vague and have to be reformulated several times as a result of trial and error. It can also be argued that change is not necessarily linear, with a beginning, process and end, but that it is evolving and ongoing. Figure 1.2 illustrates the similarities and differences between the three models and shows that this model lacks an important aspect of the AR process, namely reflection (Hattingh 2001:19).

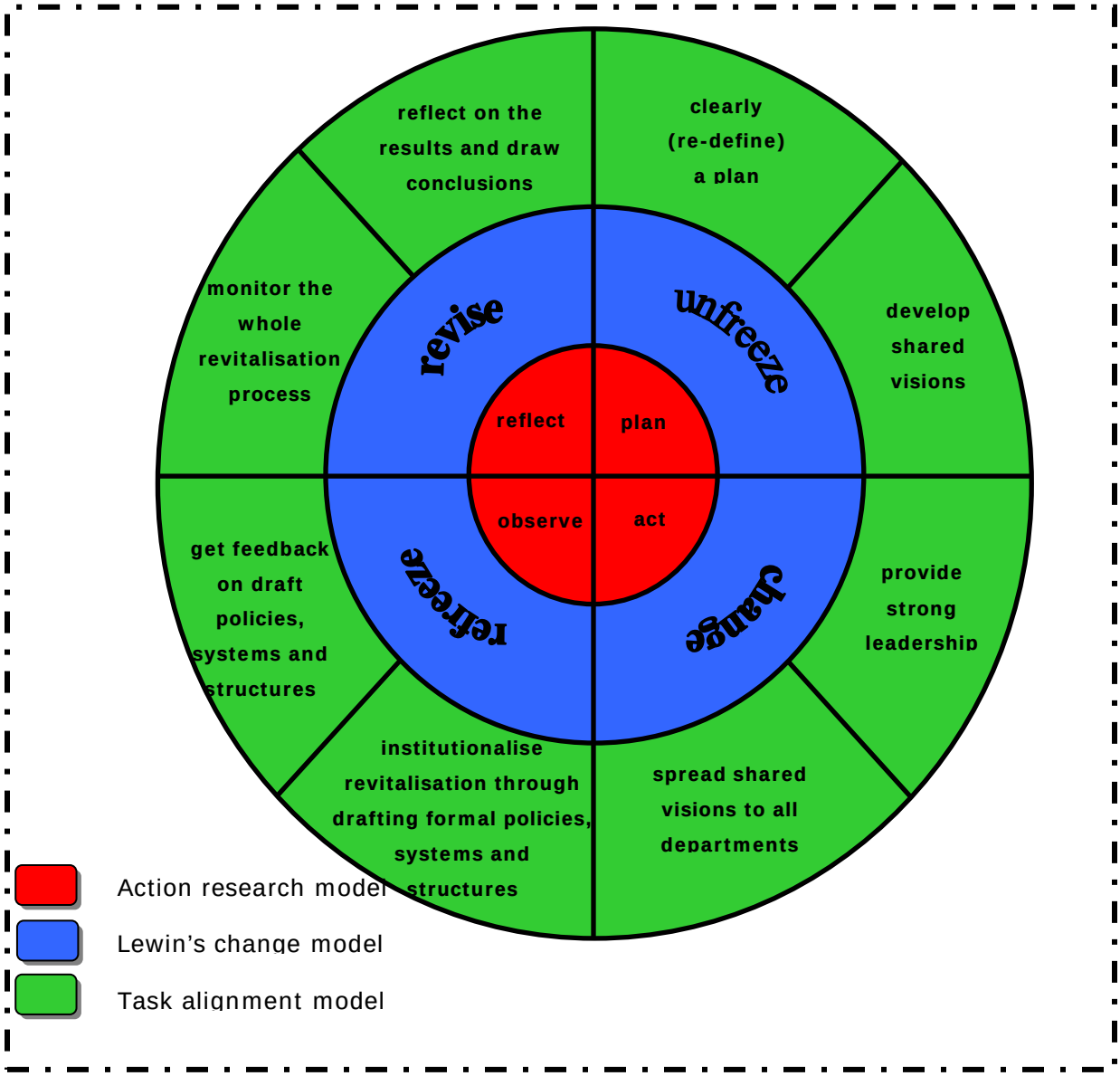


Figure 1.2: An eclectic approach to action research (adopted from Zuber-Skerritt 2005a:66)

1.7.3 The Action Research Model and action learning application

One of the pioneers of action learning, Reg Revans, maintains that "*there can be no learning without action and no action without learning*" (Revans 1998:83). The term 'action learning' is often used as a synonym for experiential learning, since the

implications of these terms are similar and the two terms share philosophical assumptions.

According to Brookfield (2002), the emphasis on experience as the defining feature of adult learning was expressed in Lindeman's (1926) frequently quoted aphorism that "*experience is the adult learner's living textbook"* and that adult education is, therefore, a *"continuing process of evaluating experiences"*. Stuart (2003:241) and Jarvis (2004:90) state that, according to Dewey (1938), all genuine learning comes from experience. This has become central in recent years to a great deal of thinking about adult learning. Learning through reflection, which was used as a learning mode in this research, results in the questioning of one's own insights and actions, and assumes that nurse practitioners can gain and create knowledge, as well as their own personal theory for a learning or problem-solving task in the clinical setting, on the basis of their own concrete experience (Jarvis 2004:101; Zuber-Skerritt 2002:118).

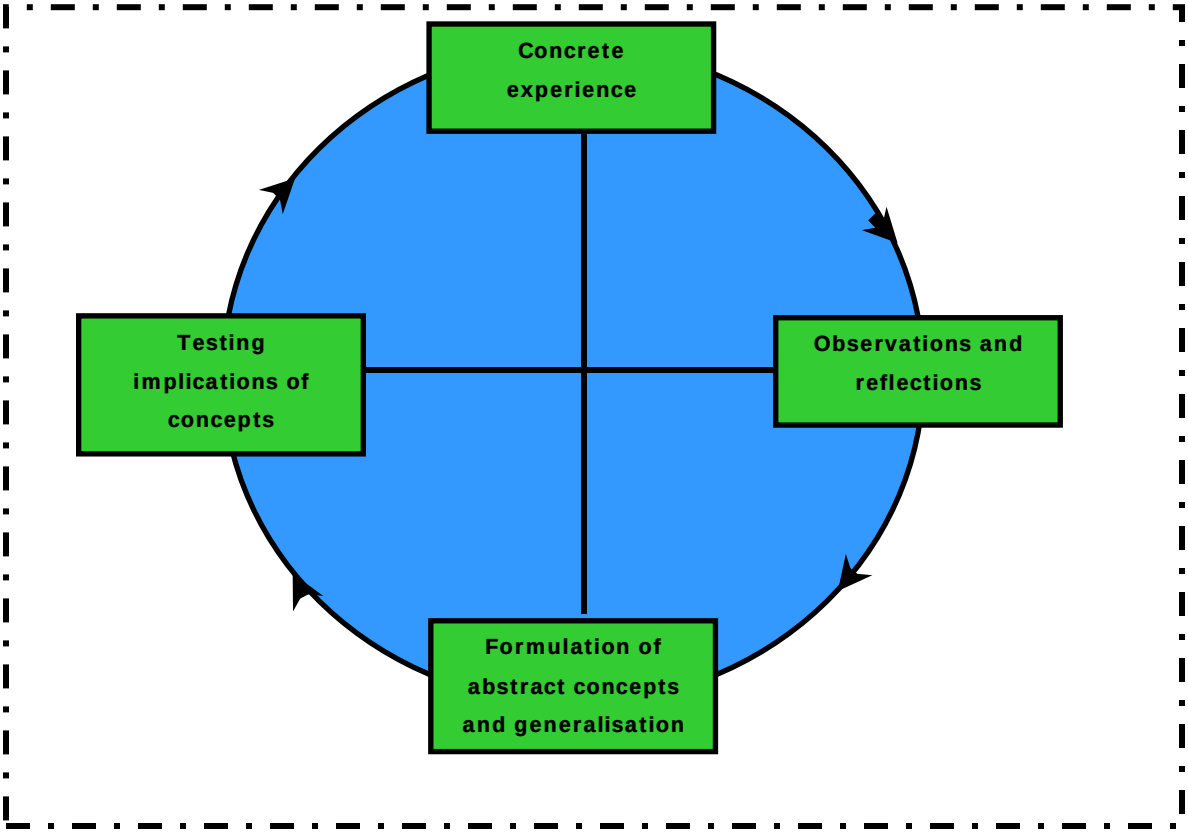


Figure 1.3: Kolb's experiential learning model (adopted from Kolb 1984:21)

Learning is done through observing and reflecting on the experience, forming abstract conceptualisations and generalisations, and testing the implications of these concepts in new situations. The last stage will produce new concrete experience for the nurse practitioner and hence begin a new cycle of observation, reflection, conceptualisation, testing and new action and experience (Jarvis 2004:102; Zuber-Skerritt 2002:118). Figure 1.3 illustrates this cycle (Kolb 1984:21).

There is considerable evidence to indicate that action learning and AR are effective methods for achieving propitious performance, transformational change and success for individuals and organisations as well as personal fulfilment (Zuber-Skerritt 2005b:49-50). Action learning is a suitable method for dealing with adult nurse practitioners who work in an A&E unit, have positive, cooperative and optimistic attitudes, and are not resistant to the notion of AR, change and the empowerment of people. Emancipatory action research (EAR) is seen as the most effective way to achieve organisational change and facilitate organisational learning.

According to Perry and Zuber-Skerritt (1992:195), AR includes three components:

- a group of people working together,
- the involvement of those people in a cycle of planning, acting, observing and reflecting on their work more deliberately and systematically than usual, and
- a public report of the experience (such as a thesis).

1.8 THE RESEARCH DESIGN AND METHOD

The research design and method is the overall plan for collecting and analysing data. It maximises the control over factors that could influence the trustworthiness or validity of the findings and guides the planning and implementation of the study (Burns & Grove 2007:553). A more detailed description of the research design, method and process is given in Chapter 2.

This study was contextual, descriptive and exploratory in nature. Action research was used as the method, utilising both qualitative and quantitative approaches (see Figure 2.1).

As the pursuit of this research is based on AR, Zuber-Skerritt's (1992:197) conceptual model of an AR thesis was used as point of departure (see Figure 1.4). Supported by this conceptual model, the research was conducted in three phases.

- **Phase 1: Independent phase**

This phase involved the planning of the thesis, which included the research problem, design and rationale, literature study and the justification for choosing AR as methodology. This phase is seen as independent research.

- **Phase 2: Collaborative phase**

During Phase 2, action was taken. The action constituted a collaborative effort by the PDG and nurse practitioners to plan a journey towards emancipatory practice development. First the barrier of professional nurse practitioner shortages was addressed. After this action was taken, the challenges, as viewed by the nurse practitioners, which needed to be addressed in order to ensure a future for them in the A&E unit, were explored and addressed. Long-term solutions were planned and implemented to enhance the possibility of reaching a shared vision of 'emancipatory practice development'. Throughout this phase, the cyclic approach of AR – plan, act, observe and reflect – was used. After a period of two years, the worth of the project was evaluated (see Figure 2.2).

- **Phase 3: Independent phase**

During this phase, the researcher was independently responsible for reporting on the material, and writing and presenting the thesis in a scientific manner. The researcher therefore planned the final draft, wrote it, evaluated it and sought comments from the participants, critical friends, external coders and promoters, and then revised, proofread and, finally, formed a conclusion on which recommendations future research could be based.

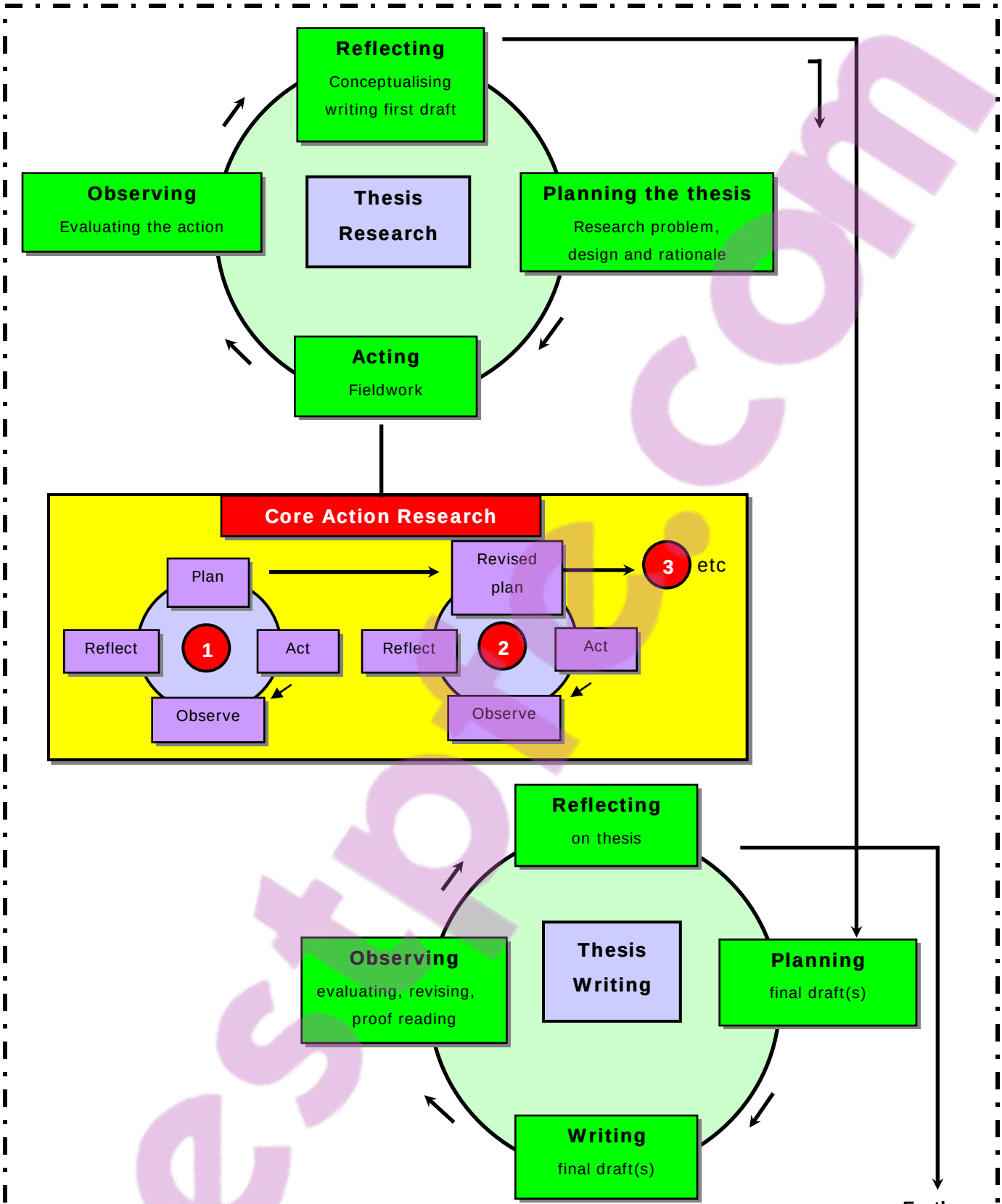


Figure 1.4: Zuber-Skerritt's model of action research (adopted from Zuber-Skerritt, 1992:197)

1.9 VALIDITY AND TRUSTWORTHINESS OF THE RESEARCH

The term 'trustworthiness' was used to indicate how the researcher enhanced the validity of the findings, using the criteria described by Herr and Anderson (2005:55) as guidelines. The mixed-method approach used during data collection included both qualitative and quantitative data collection techniques. This allowed the researcher to capture different kinds of data and indicated discrepancies between how things are and how the nurse practitioners wanted or expected them to be. It not only increased the understanding of the issues under investigation, but also increased the validity and decreased the level of known bias of the research (Somekh & Lewin 2005:275).

The possible subjectivity of the researcher when using a qualitative approach in a situation in which she is closely involved and even, as in this study, formed part of the PDG had its challenges. It was therefore important to enhance the trustworthiness of the findings during the qualitative data collection and analysis. The principles followed, specifically pertaining to the qualitative approach used, are discussed in Section 1.9.2.

During Cycle 3, the nominal group technique (NGT), which is a partial quantitative approach, was used and, during Step 3 of the research process (see Figure 2.1), questionnaires were used to evaluate the worth of the journey. The questionnaires collected quantitative data. The strategies utilised to enhance the validity and reliability of these instruments are discussed in Section 2.8.2.11 and 2.9.2.

The strategies utilised to enhance the validity and reliability of the quantitative data and trustworthiness of the qualitative data is discussed in detail in Chapter 2.

1.10 ETHICAL CONSIDERATIONS

In order to ensure high standards of research, ethical standards and measures are set to direct research. The research proposal was reviewed by the Research Ethics Committee of the Department of Health Studies of the University of South Africa (UNISA) as well as the hospital at which the research was conducted (see Annexure

A.1 and A.2). This was done to ensure that the rights and welfare of the nurse practitioners involved were protected, that appropriate methods were used to secure informed consent and that the potential benefits of the investigation were greater than the risks (Burns & Grove 2005:199).

The conducting of research requires not only expertise and diligence, but also a high degree of honesty and integrity (Burns & Grove 2005:176). The researcher was responsible for conducting the research in an ethical manner. In the light of the confidential nature of information obtained during this research, and the possible legal consequences of any breach of confidentiality, the researcher was bound to maintain a high professional standard regarding the issues and to direct the research. In this section, a brief overview of the ethical issues regarding the study is provided. Ethical principles, as specifically relevant to AR, are elaborated on in Chapter 2.

Significant thought was given to the ethical considerations described by Bandman and Bandman (1988:67), Brink, van der Walt & van Rensburg (2006:31-35), Burns and Grove (2005:176-210), Holloway and Wheeler (2002:47-66), Johnson and Long (2006:31-42), and Piper and Simons (2005:56-63) throughout the research.

1.10.1 Informed consent and autonomy

Burns and Grove (2005:193) state that obtaining informed consent is regarded as essential for the conduct of ethical research. Informed voluntary written consent was obtained from all participants. A participation leaflet accompanied the informed consent letter. This leaflet contained information regarding the research and enhanced the protection of the participants' human rights. The three fundamental principles that guide researchers, namely respect for persons, beneficence and justice (Brink *et al.* 2006:31), were adhered to. This leaflet included an informative letter for each participant that consisted of six important elements as indicated by Burns and Grove (2005:193-194). The elements included were:

- the title, purpose and objectives of the research,
- explanation of the procedures to be followed,
- risk and discomfort involved,
- benefits of the study,

- voluntarily participation and withdrawing from the study, and
- ethical approval.

The participants were ensured of their anonymity by a prominent statement in the letter that the data obtained from them might be reported in scientific journals, but that no information that could identify them as participants or their specific unit would be disclosed. Their rights of privacy and confidentiality would be strictly respected in any research reports.

1.10.2 Principle of beneficence

One of the most fundamental ethical principles of research is that of beneficence, which is encompassed in the maximum 'above all, do no harm'. It is the researcher's responsibility to secure the well-being of the participants (Brink *et al.* 2006:32). This principle has many dimensions.

1.10.2.1 Freedom from harm

Since discomfort and harm may be physical, emotional, spiritual, economic, social or legal (Brink *et al.* 2006:32) and qualitative approaches are regarded as invasive (Brink *et al.* 2006:33), the researcher regarded this principle as important as she entered the nurse practitioners' workplace as well as their lives in the workplace. The researcher recognised that qualitative enquiry risks exploring unresolved issues (Brink *et al.* 2006:33) and therefore remained vigilant throughout the process. The risks to the participants were minimised as far as possible by conducting the data gathering techniques in a safe environment and with sensitivity. Careful consideration was given to the framing of questions so that no harm would be caused to the participants.

1.10.2.2 Freedom from exploitation

Participants were assured that their participation and/or the information that they provided would not be used against them in any manner whatsoever. The

risk/benefit ratio was considered in terms of whether the risks for the participants would be equal to the benefits for society and the nurse practitioners. This research could benefit South African society as well as the nursing profession, although the immediate benefits would be limited to the nurse practitioners working in the A&E unit where the research was conducted.

1.10.3 Principle of respect for human dignity

This principle involved diminished autonomy, the right to self-determination, the right to full disclosure and the right to fair and equitable treatment.

1.10.3.1 Diminished autonomy

Those individuals with diminished autonomy (in this research, each person who participated in the research) were protected by not having their identity disclosed in any way whatsoever.

1.10.3.2 The right to self-determination

The right to self-determination was guaranteed by ensuring the right of the participants to voluntarily participate in the research or to refuse to disclose information of any kind at any stage of the research. Participants could at any stage ask for clarifications about the purpose of the research or any matter concerning the research. Had any person refused to participate, no means of coercion would be applied.

An 'anonymous box' was set up in the A&E unit into which all participants could submit opinions (positive or negative) about the research at any time.

1.10.3.3 The right to full disclosure

The right to full disclosure was never withheld at any time during or after the research. The full nature of the research, the participants' responsibilities, and the likely risks and benefits that could be incurred were fully disclosed in writing.

1.10.4 The right to fair and equitable treatment

Each participant's right to fair and equitable treatment before, during and after his/her participation in this research, was ensured by adhering to the following measures:

- all nurse practitioners working permanently in the A&E unit were invited to take part in the research,
- participants who declined to participate or who withdrew from the research would not suffer any ill effects whatsoever,
- all agreements between the researcher and the participants were honoured, and
- participants were treated with respect and courtesy at all times.

1.10.5 Actions and competence of the researcher

The researcher was ethically obliged to ensure that she was competent and adequately skilled to undertake the research. For this reason, she had completed a postgraduate programme in research methodology and was registered for the action research and evaluation online (AREOL) course. AREOL is a 14-week public course offered each semester as a public service by Southern Cross University and the Institute of Workplace Research Learning and Development in Australia (AREOL 2005). Two experienced supervisors served as promoters for the research. Should a difficult situation or crisis have arisen during the research process, expert advice and/or help would have been acquired.

Other ethical considerations included managing the resources honestly and fairly, and acknowledging those who contributed guidance and assistance to this research project.

1.10.6 Publication of research results

The final report of the research findings should be clear, accurate, objective – giving recognition to sources and people consulted, and admitting shortcomings. The respondents should be informed about the findings, without impairing the principle of confidentiality, in order to express gratitude to and recognition of their participation and collaboration in the research process.

1.11 THE SCOPE AND LIMITATIONS OF THE RESEARCH

Practice development is frequently addressed in the literature in the United Kingdom and Australia with positive results. However, practice development is a new concept in South Africa. Through this study, its importance and potential positive influence on the clinical practice may be realised.

The journey towards emancipatory practice development addressed in this research was context-bound as it was conducted in a Level III A&E unit of a public hospital in Gauteng and included a small population of nurse practitioners. Primarily the PDG designed the strategy utilised in the A&E unit, although the nurse practitioners were consulted throughout the process and consensus was reached before implementing planned actions. Therefore the transferability of the research findings might be challenging due to the uniqueness of the setting, the specific views and needs of the nurse practitioners, and the challenges they faced throughout the process.

Although this research is primarily aimed at initiating and implementing short- and long-term actions, which aimed to resolve the barriers and challenges in the A&E unit and create a better future for the A&E unit and nurse practitioners, there are many possible additional advantages. Nurse practitioners, patients and the community at large gained, as the process led to the recruitment of nurse practitioners and then focused on retaining them within an enabling environment. The journey continued in the enabling environment and focused on collaboration and participation as well as the continuous development of the nurse practitioners with an emphasis on both technical and emancipatory practice development.

Based on the findings regarding the barriers and challenges depicted and the effect of these on the nurse practitioners and A&E unit, this study may assist practice leaders to recognise these factors in their own setting and act on them before an emergency situation develops. This study re-emphasises the importance of focusing on the management style and needs of service providers, which are often neglected as well as the positive outcomes thereof: 'emancipatory practice development' and possible staff retention.

Practice leaders and nurse practitioners may also realise the importance of continuous professional development, the use of AR and practice development strategies in an enabling environment and the potential effect thereof on the clinical practice.

1.12 SIGNIFICANCE AND CONTRIBUTION OF THE RESEARCH

Undoubtedly, recruitment and, more significantly, retention of practice leaders and nurse practitioners in the nursing profession are two high-priority issues (Walker 2005:185). The nurse practitioners in the A&E unit were leaving at a rapid rate, causing severe distress for those staying behind. Staff shortages and high nurse turnover and the effect thereof on the clinical practice and an organisation's capacity to meet patients' needs and provide quality patient care have been researched extensively (Aiken, Clarke & Sloane 2002a; Aiken, Clarke, Sloane, Sochalski & Silber 2002b:1987; Freed 2005:97; Hayes *et al.* 2006:248; Shields & Ward 2001:677). It is time that practice leaders focus on actions that could be taken to retain nurse practitioners and decrease their turnover.

Numerous studies have linked empowerment to job satisfaction and other positive work attitudes (Harwood, Ridley, Lawrence-Murphy, Laschinger, White, Bevan & O'Brien 2007:28; Laschinger & Havens 1997; Laschinger, Finegan, Shamian & Casier 2000; Upenicks 2003). Empowerment has also been found to be associated with nurses' perceptions of autonomy and control over their practice environments (Armstrong & Laschinger 2006:125). Empowered workers feel committed, satisfied, in control and rarely experience burnout (Hayes *et al.* 2006:240; Laschinger 1996:25; Strachota, Normandin, O'Brien, Clary & Krukow 2003:111).

This research focused on recruiting nurse practitioners, then addressing barriers and challenges (short-term solutions) and changing the toxic environment into an enabling environment (long-term solution), in which nurse practitioners were enabled, empowered and emancipated to develop their practice (both technical and emancipatory). This practice development strategy was used in an effort to retain the nurse practitioners and decrease the turnover of nurse practitioners in an A&E unit.

The findings of the research may emphasise the importance of a collaborative and 'bottom-up' approach to reaching a shared vision of emancipatory practice development. Facilitating the learning of the practice leaders, and developing them to enable the nurse practitioners in an enabling environment is an important strategy to enhance the practice of as well as retain nurse practitioners.

Based on practice development and AR principles, the contribution of this research is that it adds to the existing base of knowledge both nationally and internationally. It contributes to raising an awareness of the perceived toxic environment in which nurse practitioners work, the potential difference it can make when the environment is changed to an enabling environment and the effect on the nurse practitioners, nursing profession and clinical practice.

To apply the value and significance of this research to clinical practice, guidelines to emancipate the practice leaders and nurse practitioners to change their environment within which they work from a toxic environment to an enabling environment have been compiled. These guidelines are provided in Annexure I and could be applied in different clinical settings where a toxic environment exists.

1.13 LAYOUT OF THE REPORT

This thesis comprises of the following chapters –

- **Chapter 1** - Orientation to the study
- **Chapter 2** – Research methodology and process
- **Chapter 3** – Initiating and planning the journey
- **Chapter 4** – Journey of the clinical facilitator

- **Chapter 5** – Journey of the unit manager
- **Chapter 6** – Evaluating the worth of the journey
- **Chapter 7** – Conclusions, lessons learnt and recommendations

1.14 SUMMARY

This chapter provides a background to the study. The background information is supported by a summary of the data obtained during an emergency meeting initiated by the nurse practitioners, hospital records (statistics and off-duty record books), feedback obtained from the A&E learners rotating though the A&E unit as part of the clinical component of the A&E programme, feedback obtained from the Accreditation Committee of the Gauteng Department of Health, and supported literature.

Based on the evidence, it was clear that the nurse practitioners working in the A&E unit found themselves in an emergency situation due to the number (16 or 55,2%) of professional nurse practitioners who had resigned due to the perceived toxic environment in which they worked on a daily basis. The remaining nurse practitioners were distressed, distraught and negative about their future in the A&E unit. The effect on the quality of patient-centred care, an outcome of emancipatory practice development, and the future of the nurse practitioners may have had detrimental effects on the A&E unit in the long run. The practice leaders realised the importance of acting and requested the researcher to assist them.

Chapter 2 provides an overview of the research methodology and process adopted for the journey towards emancipatory practice development in the A&E unit.

2 The research methodology and process

Action research has an identity of its own and
should not be spoken about in terms of traditional research

McNiff and Whitehead (2002:1)

2.1 INTRODUCTION

In Chapter 1, an orientation to the study is provided. Chapter 2 is dedicated to the research methodology and the research process. The research design, method, approaches used and research process followed in this study are discussed in-depth.

2.2 THE SETTING

The setting in which the AR for practitioners project took place was an A&E unit of a tertiary public hospital (teaching hospital), which found itself in an emergency situation due to a perceived toxic environment. Two practice leaders worked in the A&E unit. The unit manager, a first-line manager, had been appointed on 1 June 2005 and was mainly responsible for organising the daily activities in the A&E unit as well as short-term planning, and implementing the plans of middle management (Smit & Cronjé 2002:14). The clinical facilitator had been in the post for a period of three years, but was only formally appointed in April 2005. The clinical facilitator was mainly responsible for the professional development of the nurse practitioners and clinical accompaniment of the A&E learners. The unit manager worked office hours (08:00-16:00, weekdays only), whilst the clinical facilitator worked 12-hour shifts (weekdays and day duty only).

At the start of the project, there were 29 permanent nurse practitioners working in the A&E unit. Their expertise could be divided into the following categories:

- Professional nurse practitioners (13)

- Professional nurse practitioners with no additional qualifications (8)
- A&E nurse practitioners (2)
- A&E learners (2)
- Critical care nurse practitioners (1)
- A&E and critical care nurse practitioners (0)

o Enrolled and auxiliary nurse practitioners (16)

These nurse practitioners worked 12-hour shifts, which included both day and night shifts. During weekdays, the A&E unit functioned with seven professional practitioners and six enrolled/auxiliary practitioners per shift and during the weekends, the peak time in the A&E unit, they made use of an additional professional nurse practitioner. At this stage, there was a shortage of 23 professional nurse practitioners and 13 enrolled/auxiliary nurse practitioners (Van Niekerk 2005). In order to address this shortage and ensure that each shift was adequately covered, permanent nurse practitioners (working overtime) and agency nurse practitioners were utilised on a regular basis, especially on night duty and during weekends.

Support staff utilised in the A&E unit included clerks, who assisted with the admission of patients, cleaners, and porters, who aided in the transfer of patients to X-rays, wards, scanners and other facilities.

In January 2006, the hospital was split into two independent hospitals, each with its own name and function. The one hospital (referred to as the old hospital) remained in the old building and focused on primary health care, while the second hospital (referred to as the new hospital) moved to a new building. The new hospital was categorised as a Level III tertiary hospital and focused on tertiary health care. The same applied to the A&E unit.

The A&E unit was also split into two separate functioning A&E units. One unit remained in the old hospital and was responsible for the management of P3 patients (see description under Section 1.6.3.25). A newly appointed unit manager and nurse practitioners were recruited to work in this A&E unit. The newly built and equipped A&E unit in the new hospital was mainly responsible for the management of P1 and P2 patients as well as orthopaedic emergencies (see description under

Section 1.6.3.25). The unit manager, clinical facilitator and nurse practitioners all moved to the new A&E unit. This study therefore continued in the new hospital after the move.

The new hospital, a Level III tertiary hospital, had 832 beds, including 92 critical care and high care beds. The critical care and high care beds included 44 adult critical care beds and 12 high care beds, 29 neonatal critical care beds and seven paediatric critical care beds (Van Niekerk 2007b).

***Note**: The AR for practitioners project was not linear in nature. It was an evolving, intertwined, complex and dynamic project and at times cluttered and fast moving. The entire project took place over a period of two years. To simplify the process, it was broken down into smaller pieces (individual steps, cycles and sections) and discussed in such a way as to provide the reader with insight into the journey towards emancipatory practice development undertaken in the A&E unit. This is consistent with the views of Herr and Anderson (2005:5).*

2.3 AIM AND OBJECTIVES OF THE RESEARCH

The overall aim of this research was to:
By means of AR, collaboratively plan a journey towards emancipatory practice development that would include both short-term and long-term solutions to address the emergency situation and enhance the possibility of creating a future for the nurse practitioners in the A&E unit.

In order to achieve this aim, the objectives and specific objectives of the research, which evolved as the AR for practitioners project continued, were, collaboratively, to:

- **Objective 1:** Enlighten the practice leaders, middle and top management, and the A&E lecturer about the situation in the A&E unit.
- **Objective 2:** Plan the proposal and obtain ethical consent.
- **Objective 3:** Initiate the journey towards emancipatory practice development in the A&E unit (key drivers: PDG, see Chapter 3):

- Establish a PDG
- Reach consensus regarding the barrier that exists that prohibits future action
- Address the barrier
- In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit
- Plan the roadmap for a journey towards emanicpatory practice development

o **Objective 4:** Address the challenges (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):

- Plan actions that could resolve the challenges
- Address the challenges, following the AR cyclic approach

o **Objective 5:** Explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):

- Plan long-term solutions
- Address the long-term solutions, following the AR cyclic approach

o **Objective 6:** Evaluate the worth of the journey towards emancipatory practice development undertaken in the A&E unit (Key driver: researcher/Chapter 6).

2.4 THE RESEARCH DESIGN

This study described and explored the journey towards emancipatory practice development undertaken by nurse practitioners in an A&E unit and was thus context-bound. The research design refers to the overall plan for collecting and analysing the data or, as defined by Burns and Grove (2007:537), it is the 'blueprint' of the research project. The design of this research was contextual, descriptive and explorative in nature.

2.4.1 Contextual nature of the research

A contextual design was used throughout the three phases of the research. According to Babbie and Mouton (2001:272), the researcher should aim to describe and understand the events in the concrete, natural context in which they occur.

The context in which healthcare practice takes place can be seen on one level as infinite as it takes place in a variety of settings, communities and cultures that are influenced by, for example, economic, social, political and historical factors (McCormack, Kitson, Rycroft-Malone, Titchen & Seers 2002:94).

In this research, the term context is used to refer to the cultural environment in which practice takes place. The actions were planned based on the specific needs of the nurse practitioners working in the A&E unit – a specific context. Enablement of the practice leaders and nurse practitioners was emphasised, followed by the continuation of the process of empowerment and emancipation. This was done by following a collaborative approach and valuing their innovations during the action process of the study as well as through professional development and leadership development in a learning environment. The practice leaders and nurse practitioners were given opportunities to participate in this action process and their inputs were valued. They were also included in the planning of the actions, monitoring of the actions, reflecting on the actions and re-planning of the actions when applicable. Their innovations and hard work were acknowledged and celebrated throughout. This research was thus conducted with the objective of changing the 'context' and creating a better future for the nurse practitioners in an attempt to retain them. It was a deliberate action process planned for a specific context.

This research took place in the South African context and was restricted to the A&E unit of a Level III tertiary public hospital. It was therefore not representative of other public or private A&E units in South Africa. In addition, the views and experiences described in this study were based on those of the nurse practitioners working in this context. These nurse practitioners attached specific meanings to their own experiences in the context (Morse 1994:106) and were therefore context-specific and context-bound.

2.4.2 Descriptive nature of the research

A descriptive design was used during all three phases of the research. Babbie and Mouton (2001:80), and Burns and Grove (2007:240) state that the major purpose of many social scientific studies is to accurately portray the characteristics of persons,

groups, situations, events and/or the occurrence frequency of certain phenomena as they naturally happen.

During Phase 2, the collaborative phase, Cycle 3 (see Figure 2.2; Section 3.5), the views of the nurse practitioners regarding the challenges that needed to be overcome in order to create a better future for those working in the A&E unit were described. Phase 2 included a collaborative effort to plan and implement a practice development approach that would not only resolve the barriers and challenges, but also enable the practice leaders and nurse practitioners to develop their own and collective emancipated practice. During this phase, the research was also descriptive, as it aimed to describe the action plan, and the implementation and evaluation of the plan during the eight AR cycles (namely establish a PDG, address the barrier, explore the challenges, define a role, professional development, amended professional development, address the challenges, leadership development and amended leadership development) (see Figure 2.2). The development and empowerment of the unit manager, clinical facilitator, nurse practitioners and researcher are also described. In Phase 3, during the compilation of the final draft of the thesis, the phenomena were again described accurately, based on the data analysis, in the context of the research.

The descriptive nature of this research also refers to the systematic selection of literature relevant to the research methodology and research topic throughout all three the phases of the research. This was also applied by providing conceptual definitions (see Section 1.6.3), indicating the sample selection and size, and describing the data collection and data analysis procedures in detail (Burns & Grove 2007:240-241).

2.4.3 Exploratory nature of the research

The nature of the research was explorative during all three phases of the research. Exploration was done in order to:

- satisfy the researcher's curiosity,
- make the practice leaders and nurse practitioners 'aware' of their current situation and practice,
- have a better understanding of the phenomena,

- plan and implement actions,
- monitor and reflect on the implemented actions, and
- re-plan further actions to take place within a consecutive cycle, if appropriate.

The research had to be explorative in nature, as the researcher wished to explore a phenomenon about which little was known. It also assisted the practice leaders and nurse practitioners in exploring their practice and practice environment, as they were involved in the action process. This design also ensured that the practice leaders (unit manager and clinical facilitator) were able to acquire new insights into the full nature of the barriers and challenges as well as the action plans utilised in order to resolve these challenges (De Vos, Strydom, Fouché & Delport 2002:139).

This explorative design was also used throughout the research process by exploring the literature on relevant issues regarding the research topic in order to verify or contradict the research findings. This implied that the researcher was willing to study new ideas and possibilities, and would not allow predetermined ideas to direct the research. The researcher used bracketing, a "*qualitative research technique of suspending or laying aside what is known about an experience being studied*" (Burns & Grove 2007:532), in an attempt to suspend her own preconceptions and ensure that the phenomenon was studied with "*fresh eyes"* (Todres & Holloway 2006:229).

Polit and Beck (2004:233) describe methodology as the "*investigation of ways to obtain, organise and analyse data*". This study was contextual, exploratory and descriptive in nature. AR was used, as the project was centrally concerned with working with and for the nurse practitioners to create a future for them in the A&E unit as well as learn lessons from the journey towards practice development (Meyer 2006:274). Although the AR for practitioners project mainly drew on qualitative approaches to data collection (Meyer 2006:281), quantitative approaches were used to evaluate the worth of the journey (see Figure 2.1).

2.5 THE RESEARCH METHOD

Action research was used as the method in this study (see Figure 2.1). In view of the background, problem and research questions of the study as well as the specific

context in which it took place, the researcher, agreeing with Meyer (2006:275), was attracted to the underlying principles of AR, namely its participatory character, its democratic impulse, and its simultaneous contribution to social science (knowledge) and social change (practice).

Since the original conceptualisation of the process of AR by Lewin and London's Travistock Institute, it has been developed by various researchers including Kemmis and McTaggart (1988), Elliot (1991) and Zuber-Skerritt (1992). AR has also been carried out under diverse intellectual traditions, including organisational research, community development, education and nursing (Hart & Bond 1995:23; Holloway & Wheeler 2002:190).

Action research has converged on the nursing profession in the past decade, focusing on personal and professional development and the improvement of professional practice (Hart & Bond 1995:32; Holloway & Wheeler 2002:191; Morton-Cooper 2000:12). In 1984, AR played only a small part in nursing, apart from that affecting the organisation of nursing services in hospitals. In 1985, Wright, influenced by Lewin's classic change theory, implemented change strategies in a district general hospital in the United Kingdom (Hart & Bond 1995:32). Lewin's classic change theory was adapted in this study (see Section 1.8.2).

Meyer (1993:1066) argues that "*the development of action research in education is of particular interest to nurses owing to the parallels that can be drawn with nursing research*." Greenwood (1994:13) too welcomes the growing interest in AR in nursing and nurse-education as it "*reflects a recognition…that nursing is a social practice the central purpose of which is to bring about positive change in the health status of individuals and communities*". Stringer (1996:5) suggests that AR has gained ground in the nursing profession as a result of its realignment with creativity, investigation and problem solving. These are features valued by nurse practitioners, who are generally opposed to mechanistic and technical solutions that cannot be applied in all situations. Hart and Anthrop (1996:455) have traced its development in nursing from a focus on the organisation of services to the recognition of its affinity with nursing, defined as *"a social process essentially concerned with people, their actions and interactions"*.

The main attraction of AR in this study was that the researcher had an opportunity to work with the nurse practitioners in a non-hierarchical and non-exploitative way, to attempt to resolve the barriers and challenges they experienced in their practice as well as continue on a journey towards emancipatory practice development. According to McCormack and Manley (2004:88), this could provide an opportunity to enhance their ownership of the project as well as possibly achieve sustainable change.

Nurse practitioners are increasingly engaging in AR projects in order to improve aspects of nursing practice, change nursing practice and generate new knowledge (Greenwood 1994; Hart & Bond 1995; Holter & Schwartz-Barcott 1993; Hope & Waterman 2003; Meyer 1993; Morton-Cooper 2000; Williamson & Prosser 2002). According to Hart and Bond (1995:34), there is also a growing interest among nurse researchers in collaborative or 'new paradigm' research. The term 'new paradigm' research refers to a form of cooperative enquiry which

> … *is a way of doing research in which all those involved contribute both to the creative thinking that goes into the enterprise – deciding on what is to be looked at, the methods of the inquiry, and making sense of what is found out – and also contribute to the action which is the subject of the research. Thus in it's fullest form the distinction between researcher and subject disappears, and all who participate are both co-researchers and co-subjects. Co-operative enquiry is therefore also a form of education, personal development, and social action* (Reason 1988:1).

The literature review revealed various views on what AR is, what its purpose is, who can do it and how. As there exists disagreement on the meaning of the term action research, no single definition was found. McCormack *et al.* (2004:88) confirm that AR can be classified in as many different ways as research itself and is underpinned by the same philosophically different worldviews about reality and truth as other approaches to research. Not all authors recognise the same approaches, but, according to Badger (2000:202), some of these differences might be merely semantic and could be based on similar philosophies.

All the definitions, however, do involve the concepts of change, participation and action (Carson & Sumara 1997:xii; Dick 1993; Morton-Cooper 2000:12; Stringer 1996:9; Waterman, Tillen, Dickson & De Koning 2001:11; Zuber-Skerritt 1992:15).

Stringer (1996:9) states that AR is a non-traditional form of research, which is often community-based and carried out by a nurse practitioner in the field. Carson and Sumara (1997:Xii) define AR as a "*lived practice that requires that the researcher not only investigates the subject at hand but provides some account of the way in which the investigation both shapes and is shaped by the investigator*".

The definition provided by Zuber-Skerritt (1992:15) describes AR by using the acronym CRASP, in which AR is:

Critical	(and self-critical) collaborative enquiry by
Reflective	nurse practitioners being
Accountable	and making the results of their enquiry public,
Self-evaluating	their practice and engagement in
Participative	problem-solving and continuing professional development

Morton-Cooper (2000:12) defines AR by its key features and applies it to the healthcare setting as a "*collaborative approach in a real-world health care situation to define a problem and explore a possible solution*". Others, such as Greenwood (1994:15), identify the purpose of AR as implementing change and generating theory. Dick (1993) states that "*action research is a natural process*" and then continues that it "*is a more formal and critical version of what good nurse practitioners do to learn from experience*".

Waterman *et al.* (2001:11) provide a useful definition for the approach: "*Action research is a period of inquiry that describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future orientated*".

The following definition, provided by Somekh (2006:6), relates to how the researcher envisions AR:

> *Action research integrates research and action in a series of flexible cycles involving, holistically rather than as separate steps: the collection of data about*

the topic of investigation; analysis and interpretation of those data; the planning and introduction of action strategies to bring about positive changes; and evaluation of those changes through further data collection, analysis and interpretation…and so forth to other flexible cycles until a decision is taken to intervene in this process in order to publish its outcomes to date.

Kemmis and McTaggart (1988:5) define AR as "*… a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out"*. Although Kemmis and McTaggart's definition relates to professionals working in the educational context, it equally applies to nurses if the word '*educational'* is replaced with '*nursing'*.

Following extensive investigation and reflection on the literature, the researcher regarded AR as a method that could be used effectively in the A&E unit to develop the practice leaders and nurse practitioners to enhance their practice, as it is an approach that is associated with sustainable change and aims to develop their ownership by making them aware of the way in which they practice (McCormack & Manley 2004:88). For the purpose of the AR for practitioners project, AR is defined as follows:

AR is dynamic, systematic and cyclic approach, which challenges the boundaries between education, practice and research (Meyer 2006:274). As the name implies, AR is concerned with 'action' and 'research' but also with a process of collaboration. It involves doing research *with* the nurse practitioners in a non-hierarchical and non-exploitative way and *for* them rather than *on* them. Furthermore, AR explores, interprets and explains the situation in which the nurse practitioners find themselves, while at the same time collaboratively planning and executing change interventions (with an emancipatory intent) aimed at the continuous enablement of the nurse practitioners, developing them to enhance their own and collective practice, which in turn can be associated with sustainable change. By using this type of research, the theory-practice gap can be decreased, and theory generated and refined.

In this study, the collaboration was mainly confined to Phase 2 of the AR for practitioners project (see Figure 2.2), where the nurse practitioners were involved in diagnosing the emergency situation as well as the challenges in the A&E unit and then continued through a spiral of interrelated cycles to plan, act, observe and reflect in order to develop their own and collective emancipatory practice. Through ongoing consultation and negotiations, a democratic voice was provided to all the nurse practitioners concerning the best way forward. Throughout the two-year journey towards emancipatory practice development, action was regarded as the vehicle and used to reach the shared vision of 'emancipatory practice development'. Reflection (learning mode) was used by the researcher (external enabler) to facilitate the learning of the practice leaders (internal enablers), thus enabling them to develop the nurse practitioners (travellers) to enhance their own and collective practice. During this journey, the driving force was change. The researcher and practice leaders were regarded as facilitators of change.

The researcher was, however, independently responsible for planning the thesis (Phase 1) and writing the thesis, while systematically monitoring the process and outcomes of change. During Phase 3, the researcher continued independently to present the conclusions and recommendations.

2.5.1 Action research purposes

The purposes of using AR in this study were congruent with the views on the purposes described in literature by researchers such as Holter and Schwartz-Barcott (1993:298-300), Hart and Anthrop (1996:455), Streubert-Speziale and Carpenter (1999:251), Holloway and Wheeler (2002:188), Koshy (2005:29), Zuber-Skerritt (2005b:49), and McNiff and Whitehead (2006:27). These purposes of AR include:

- narrowing the gap between theory, research and practice,
- defining individuals as active participants in the change process and not as passive subjects,
- being non-exploitative and collaborative,
- generating practical knowledge intended to assist in raising standards of care and service in general,
- directing towards change and improvement,

- practising a useful way of attempting and evaluating change in order to improve settings and care in the clinical field,
- assisting nurse practitioners to make decisions in the interest of their clients – rather than accepting unsatisfactory decisions imposed on them, they observe and diagnose problems as well as plan and implement changes that are based on knowledge gained through the research,
- providing nurse practitioners as professionals with an opportunity to adopt a thinking and self-critical stance towards their practice, which enables them to justify what they do,
- improving the situation for the clients and patients, and also enlightening the nurse practitioners themselves and enhancing their lives through reflection and engagement in the situation,
- providing opportunities for nurse practitioners to achieve their full potential as well as reach personal fulfilment,
- offering the possibility, through the medium of reflective practice, to emancipate the nurse as an autonomous nurse practitioner, and
- promoting a clinical setting for nurse practitioners with opportunities for active involvement and personal satisfaction, and hence for personal growth through the cyclic processes of AR, mirroring the stages of the nursing process and of the quality cycle.

The problem-solving cycle of AR mirrors the stages of both the nursing process (Hope & Waterman 2003:120) and the quality cycle. The nursing process is a way of thinking and acting in relation to the clinical phenomena of concern to nurse practitioners (Urden, Stacy & Lough 2006:8). In A&E nursing, the nursing process is used as a systematic and collaborative approach followed during the initial assessment of a patient when admitted to the A&E unit (focusing first on life-threatening conditions) and is regarded as essential to the patient's outcome (O'Shea 2005:39).

Table 2.1 provides an overview of the similarities between AR, the nursing process and quality cycles.

Table 2.1: A comparison of action research, the nursing process and the quality cycle

Action research	Nursing process	Quality cycle
Cyclic process *(Koshy 2005:5)*	Cyclic process *(Urden et al. 2006:9)*	Cyclic process *(Cebeci & Beskese 2002:94)*
Systematic problem-solving approach (Koshy 2005:8)	Systematic problem-solving approach *(Urden et al. 2006:8)*	Systematic problem-solving approach *(Cebeci & Beskese 2002:93)*
Continuous improvement *(McNiff & Whitehead 2002:52)*	Continuous improvement *(Young, Van Niekerk & Mogotlane 2003:182)*	Continuous improvement *(Cebeci & Beskese 2002:93)*
Quality control *(McNiff & Whitehead 2002:60)*	Quality control in patient care *(Young et al. 2003:183)*	Quality control to improve service quality *(Millson & Kirk-Smith 1996:75)*
Practical context *(Koshy 2005:3)*	Practical context *(Young et al. 2003:182)*	Practical context *(Cebeci & Beskese 2002:92)*
Process		
Reflect - On current situation - Identify initial idea *(Amsden & VanWynsberghe 2005:359; Zuber-Skerritt 1992:11)*	**Assess** - Data collection - Making a nursing diagnosis *(Urden et al. 2006:8)*	**Plan** - Diagnosing problems - Exploring causes *(Cebeci & Beskese 2002:93)*
Plan - Problem analysis - Strategic plan *(Schoessler, Akin, Boyd, Falconer, Kaiel, Moore-Stout, Payne, Sajko & Sawyer 2005:196)*	**Plan** - Setting goals to improve the outcome of the patient - Planning actions to achieve the goals *(Urden et al. 2006:8)*	**Plan** - Recommending solutions - Planning actions *(Cebeci & Beskese 2002:93)*
Act - Take action - Implement the strategic plan *(Fraser 2000:214)*	**Implement / Act** - Act, set plans in motion *(Urden et al. 2006:8)*	**Implement / Act** - Take corrective actions *(Cebeci & Beskese 2002:93)*
Observe - Gather data - Evaluate the effectiveness of the actions *(Fraser 2000:214)*	**Evaluate / Observe** - Evaluate the success of the actions - Examine need for adjustments and changes - Determine whether goals have been met *(Urden et al. 2006:9)*	**Evaluate / Observe** - Evaluate the success of actions taken *(Cebeci & Beskese 2002:93)*

2.5.2 Action research modes

Action research is an umbrella term covering various modes and types of research that have emerged from different traditions or distinct scientific communities that are in constant evolution (Herr & Anderson 2005:10). Three modes of AR, namely technical, practical and critical or emancipatory action research (EAR), were described by Kemmis and McTaggart (1988:12). Later, three modes were described by Holter and Schwartz-Barcott (1993:301), which included the technical collaborative approach, a mutual collaborative approach and an enhancement approach.

More recently, Hart and Bond (1995:40) have developed an AR typology to illustrate that AR is able to offer a distinct identity whilst spanning the continuum of research approaches from experimental to social constructivist (Hart & Bond 1995:38). These authors describe four types of AR, namely experimental, organisational, professionalising and empowering, and then indicate the relationship between the AR typology (technical, practical and emancipatory) and these four types. The majority of AR types could be placed on a continuum with the three different modes of AR. These do not differ in methodology, but in the underlying assumptions and views of the researcher.

On the journey towards emancipatory practice development, the AR for practitioners project predominantly focused on the EAR approach as well as on the empowering of the practice leaders, who in turn empowered the nurse practitioners. The positioning of this research study on the AR continuum is illustrated in Table 2.2. The researcher thus opted to use the term 'AR for practitioners' (adopted from Stringer 1996:9 and McNiff *et al.* 2003:16) to refer to the AR method used in this study. This term is also applicable to the aim of the study and values of the practice leaders (see Section 3.3.2.1d).

Table 2.2: Action research typology (adapted from Hart & Bond 1995:40)

	Continuum			
AR identity	**Consensus model of society Rational social management**		**Conflict model of society Structural change**	
AR focus	**Research based**		**Action focused**	
AR approach	**Technical**	**Practical**		**Emancipatory**
AR type	**Experimental**	**Organisational**	**Profession-alising**	**Empowering**
Distinguishing criteria: *Educative base*	Re-education	Re-education/ training	Reflective practice	Consciousness-raising
Distinguishing criteria: *Individuals in groups*	- Closed group - Controlled - Fixed membership	Work group	- Professional group - Negotiated team boundaries	- Self-selecting - Open to negotiation
Distinguishing criteria: *Problem focus*	Problems emerge from the interaction of social science theory and social problems	Problem relevant for management	- Problem def. by prof. group - Problem emerges from professional practice/ experience	- Problem emerges from professional practice/experience - Emerging and negotiation of problem by less powerful group
Distinguishing criteria: *Change intervention*	- Social science - Experimental	- Top-down - Directed change towards predetermined aims	- Professionally led - Pre-defined - Process led	- Bottom-up - Undetermined
Distinguishing criteria: *Cyclic process*	Research component dominant	- Action and research components in tension; action dominated	- Research and action components in tension; research dominated	Action components dominant
Distinguishing criteria: *Research relationship (Degree of collaboration)*	- Experimenter - Respondents - Differentiated roles	- Consultant/ researcher - Respondent/ participants - Differentiated roles	- Collaborators - Merged roles	- Co-change agents - Shared roles

The emancipatory focus of the AR for practitioners project was evident as it originated following the enlightenment (consciousness raising) that occurred during the emergency meeting and visit by the Accreditation Committee. The distinguishing criteria set by Hart and Bond (1995:40) (see Table 2.2) that were met included:

- the PDG was self-selecting and open to negotiation,
- the problem emerged from the professional practice of the nurse practitioners working in an A&E unit,
- the problem that emerged was addressed by using a bottom-up approach, ensuring that the nurse practitioners were not undermined in the process,
- the action component was dominant throughout the research,
- the PDG was regarded as co-change agent, and
- each member of the PDG had her own role, as the clinical facilitator focused on professional development, the unit manager on addressing the challenges and leadership development, and the researcher on facilitating, coaching and supporting the practice leaders in reaching their objectives.

This study involved a research partnership between an 'academic' researcher (university-based lecturer) and nurse practitioners (in the A&E unit). All the participants had a commitment to collaborative inquiry to explore the journey undertaken towards emancipatory practice development.

Titchen and Binnie (1993:858) propose two models of AR. These are the 'insider' and 'outsider' approaches. In both models, the researcher role is not founded on the traditional paradigm of the impartial observer. The insider model acknowledges the role of the researcher as a clinical leader with authority for initiating and managing change. Conversely, the outsider model identifies the researcher as someone from an outside setting with no authority in the situation.

This study utilises the *'outsider'* model of collaborative researcher. Titchen and Binnie (1993:862) argue that this model is less successful and identify disadvantages that collaborators need to be cognisant of. Firstly, if the researcher implements change, there is a danger that the participants may not own the innovation and there may be a resultant reversion to the *'old ways'* once the researcher discontinues active involvement. Secondly, there may be conceptual differences between the researcher and the participants. The researcher may be taking the study in a

particular direction, whilst the participants have other priorities for the study. Thirdly, as the researcher is an outsider, with no acknowledged authority in the clinical practice situation, there may be difficulties if the nurse practitioners do not implement agreed upon changes and the researcher has limited power to influence the situation.

However, the researcher in this project had over 15 years A&E nursing experience as clinician, manager and educator. Although the 'outsider' model of AR was adopted, the researcher was known in the A&E unit through her academic role as lecturer of the A&E programme. The nature of the researcher's academic role resulted in the development of a professional collaborative partnership with the practice leaders, thus overcoming some of the difficulties proposed by Titchen and Binnie (1993:862).

The researcher's function in this study as an 'outside' academic researcher was subordinate to the group. The researcher's role focused on that of facilitation, coaching and support, as opposed to imposing ideas for the direction of research on the nurse practitioners.

2.5.3 Validity of action research

The scientific method incorporates all procedures that researchers use to pursue knowledge (Burns & Grove 2005:23). In this study, AR, a sustainable method for nursing (Hope & Waterman 2003:120), was used as the scientific method to conduct the research, using both qualitative and quantitative approaches to gathering data.

Validity with regard to the research findings is of great importance in all research studies (Brink *et al.* 2006:118) and, according to Hope and Waterman (2003:120), is a key test for the researcher. Titchen (1995:47-48) states that valid AR is an ethical enterprise which rests on the researchers' honesty, trustworthiness and integrity.

The quality criteria for AR, qualitative studies and quantitative studies differ (Herr & Anderson 2005:50). Quality, goodness, validity, trustworthiness, credibility and workability have all been suggested terms to describe the criteria for good AR (Herr & Anderson 2005:49). Various researchers have different opinions pertaining to set criteria for quality AR. Hope and Waterman (2003:124) state that there is a view

that the concept of validity has no place in AR. An example provided by these authors (2003:124) is Rolfe (1996) who views "*reflexive AR as subjective"* and states that, consequently, the "*researcher/practitioner is the only important judge of the quality of an intervention"*. According to Holloway and Wheeler (2002:197), Titchen's (1995:48) discussions overlap with other arguments about trustworthiness in qualitative research. Herr and Anderson (2005:49) refer to the "*validity"* of AR but continue that the term is "*ultimately a political decision*".

In this study, AR was regarded as a multifaceted method and therefore components of the validity of AR, the trustworthiness of qualitative approaches, and the validity and reliability of quantitative approaches were used to enhance the validity of the research.

The criteria for validity as related to the goals of AR are described by Herr and Anderson (2005:55). These criteria include outcome, process, democratic, catalytic and dialogic validity (see Table 2.3) and were used to direct the researcher in enhancing the trustworthiness of the study.

Table 2.3: Herr and Anderson's goals of AR and validity (adopted from Herr and Anderson 2005:55)

Goals of action research	Quality / validity criteria
The generation of new knowledge	Dialogic and process validity
The achievement of action-orientated outcomes	Outcome validity
The education of both researcher and participants	Catalytic validity
Results that are relevant to the local setting	Democratic validity
A sound and appropriate research methodology	Process validity

2.5.3.1 Outcome validity

Herr and Anderson (2005:55) state that outcome validity refers to the extent to which actions occur, which then leads to the resolution of the problem that led to the study. Herr and Anderson (2005:55) cite Greenwood and Lewin (1998) as referring to outcome validity as 'workability' and being synonymous with the 'successful' outcome of the research project.

Outcome validity acknowledges the fact that rigorous AR, rather than simply solving a problem, forces the researcher to reframe the problem in a more complex way, often leading to a new set of questions or problems (Herr & Anderson 2005:55). This ongoing reframing of problems leads to the spiralling dynamic that characterises the process of most AR over a sustained period of inquiry, which, in this study, was a total of two years.

In this study the outcome validity was monitored throughout the project by providing evidence of the emergency situation and challenges experienced, actions taken to enhance short-term and long-term solutions, and the observations of and reflections on the outcomes. The worth of the journey was evaluated (see Chapter 6) and the initial challenges expressed by the participants during the NGM were addressed. However, new challenges emerged whilst actions were planned to address the priorities. These challenges for example included defining a role for the clinical facilitator, leadership development of the practice leaders as key drivers of the AR for practitioners' project as well as leadership development of the nurse practitioners.

2.5.3.2 Process validity

Process validity refers to the extent of the problems and whether these were solved in a manner that permitted the ongoing learning of the participants (Herr & Anderson 2005:55). Through collaboration with the practice leaders and nurse practitioners, process validity was enhanced. The AR cycles were used to describe, explore and reflect on each challenge faced.

The process used both qualitative and quantitative approaches. Using mixed approaches allowed the data collection methods to be triangulated and contributed to the credibility of the research findings by mutual confirmation or crosschecking of data. The specific data collection techniques used in this study included a literature review, observation, the use of field notes and a reflective diary, interviews with practice leaders and nurse practitioners, informal group discussions, member checking and consensus meetings, the use of critical friends and an external independent coder used throughout the research process to enhance the

trustworthiness of the data, and expert researchers to review the research as supervisors.

2.5.3.3 Democratic validity

Democratic validity refers to the extent to which the research is done in collaboration with all the parties who have a stake in the problem under investigation (Herr & Anderson 2005:56). The AR for practitioners project was initiated when an emergency situation was diagnosed in the A&E unit based on professional nurse practitioner shortages as well as a perceived toxic working environment. The rationale for addressing the emergency situation and its challenges, and planning and implementing possible long-term solutions was to start a journey that would create a better future for the nurse practitioners.

The involvement of the nurse practitioners was negotiated before the start of the project and consensus was reached that the researcher (outsider) and nurse practitioners (insiders) would share their knowledge to create a new understanding and work together to form action plans, with outsider facilitation. This relation is referred to by Herr and Anderson (2005:40) as "*with/by*", where the mode of participation is referred to as "*colearning*". The entire Phase 2 of the AR for practitioners project was collaborative.

2.5.3.4 Catalytic validity

Catalytic validity is "*the degree to which the research process reorients, focuses and energises the participants toward knowing reality in order to transform it*" (Herr & Anderson 2005:56). In AR, it is important that not only the participants but also the researcher must be open to reorienting their views of reality as well as their views of their roles. All involved in the research should deepen their understanding of the social reality under study and should be moved to some action to change to reaffirm their support. The nurse practitioners initiated the emergency meeting and were therefore aware of the reality of the emergency situation within which they found themselves at the beginning of the project. This was further explored and elaborated on by making use of the NGT in Cycle 3 (see Section 3.5).

2.5.3.5 Dialogic validity

Dialogic validity requires that a form of peer review should monitor the research and that the research should pass through the process of peer review in order to be disseminated through academic journals (Herr & Anderson 2005:57). In this research, the researcher was supervised by two research experts assisting her throughout the research as well as two critical friends, who were familiar with the setting and who could serve as devil's advocates in exploring alternative explanations for the research data.

2.6 RESEARCH APPROACHES

Various methods of enquiry were used in this research. These included the collection of qualitative and quantitative data. This allowed the researcher to capture different kinds of data and indicated any discrepancies between how things are and how the nurse practitioners wanted or expected them to be. It not only increased the understanding of the issues under investigation, but also increased the validity and decreased the level of known bias (Somekh & Lewin 2005:275). The mixed-method approach of using both qualitative and quantitative data collection techniques during data collection assisted with methodological triangulation (Burns & Grove 2005:225; Topping 2006:168), which in turn added value to the study. Although the qualitative approach was used predominantly throughout the study (Meyer 2006:281), quantitative data were gathered during Step 5 to evaluate the worth of the journey (see Figure 2.1). According to Lacey (2006:21), both approaches are valid ways of advancing nursing knowledge.

Throughout Phase 2, the collaborative phase of the study, data were collected in three stages of the inquiry, through exploration, intervention and evaluation (Meyer 2006:281) and involved the practice leaders and all the permanent nurse practitioners as participants. Each cycle's data collection techniques were planned during the course of the cycle. During each cycle, the data collection techniques varied and some of these techniques were used more than once during the research process. For ease of explanation, the data collection techniques as they were used

during the research process are described in detail. If a technique was used in more than one cycle, it is discussed once and thereafter referred to in the text.

The qualitative approach was chosen during the explorative and intervention phase of data collection. This approach was used because the aim of the study was to document a journey undertaken towards emancipatory practice development. Action, committed to the researcher and practice leaders' personal and professional values and informed by careful consideration of its appropriateness, was intentionally undertaken to reach the set objectives (McNiff *et al.* 2003:99). The monitoring process was regarded as the centre of the research and the focus was on discovering and understanding the whole, which is consistent with the qualitative approach (Burns & Grove 2005:23). The qualitative approach was used to describe and explore experiences as well as give meaning to them throughout the action process (Burns & Grove 2007:61), and entailed social processes and human interactions (Streubert-Speziale & Carpenter 2003:107), such as reflective learning, facilitation and coaching.

The quantitative approach was used during the evaluating phase (see Figure 2.1 and Figure 2.2). Questionnaires, distributed to the nurse practitioners (insiders) and A&E learners (outsiders) were used to evaluate the worth of the journey (see Annexure H.1 and H.2). This data collection technique was used to ensure the anonymity of the respondents as, by making use of self-completion questionnaires, the respondents could not be connected to their responses, resulting in a more honest response (McKenna, Hasson & Keeney 2006:267). An additional strength of the self-completion questionnaire is that the respondents had more time to weigh the issues carefully before responding and therefore were less prone to acquiescence. This is consistent with the views of McKenna *et al.* (2006:267).

2.7 POPULATION/RESEARCH PARTICIPANTS

The population refers to the total set from which the individuals of the study are chosen (Burns & Grove 2007:40; Somekh & Lewin 2005:347). However, AR is regarded as a learning process where all concerned in the research study (Koshy 2005:23) learn more about the nature of the problems in which they are involved

(Streubert-Speziale & Carpenter 1999:253) and learn from experiences (Koshy 2005:23).

In this research, the entire population was regarded as research participants in the research process, stakeholders who own the research problem, and learn and create knowledge (Hattingh 2001:80).

*The **population** remained the same throughout the research process as it included all the nurse practitioners working on a permanent basis in the A&E unit. However, it was also **dynamic** and **ever changing** as nurse practitioners were recruited throughout the project.*

The research was based on the researcher's collaboration with the nurse practitioners working in the A&E unit. The researcher considered the nurse practitioners as equal participants in the research process (Phase 2) and not as '*objects'* of the research. Therefore, the researcher sought a form of research that would accommodate this stance. Kemmis and McTaggart (1988:22) describe the features of an AR approach, which appear to fit the researcher's requirements:

> *It is not research done on other people. Action research is research by particular people on their own work, to help them improve what they do, including how they work with and for others. It does not treat people as objects for research but encourages people to work together as knowing subjects and agents of change and improvement.*

This quotation aptly describes the type of equitable and respectful ethos that the researcher hoped would form the framework of the AR for practitioners project. Thus, in order to avoid the negative effects of a power-based relationship, which could result from doing research 'on' the nurse practitioners, the researcher chose instead to undertake the research 'with' the nurse practitioners, an approach that would regard them as co-researchers.

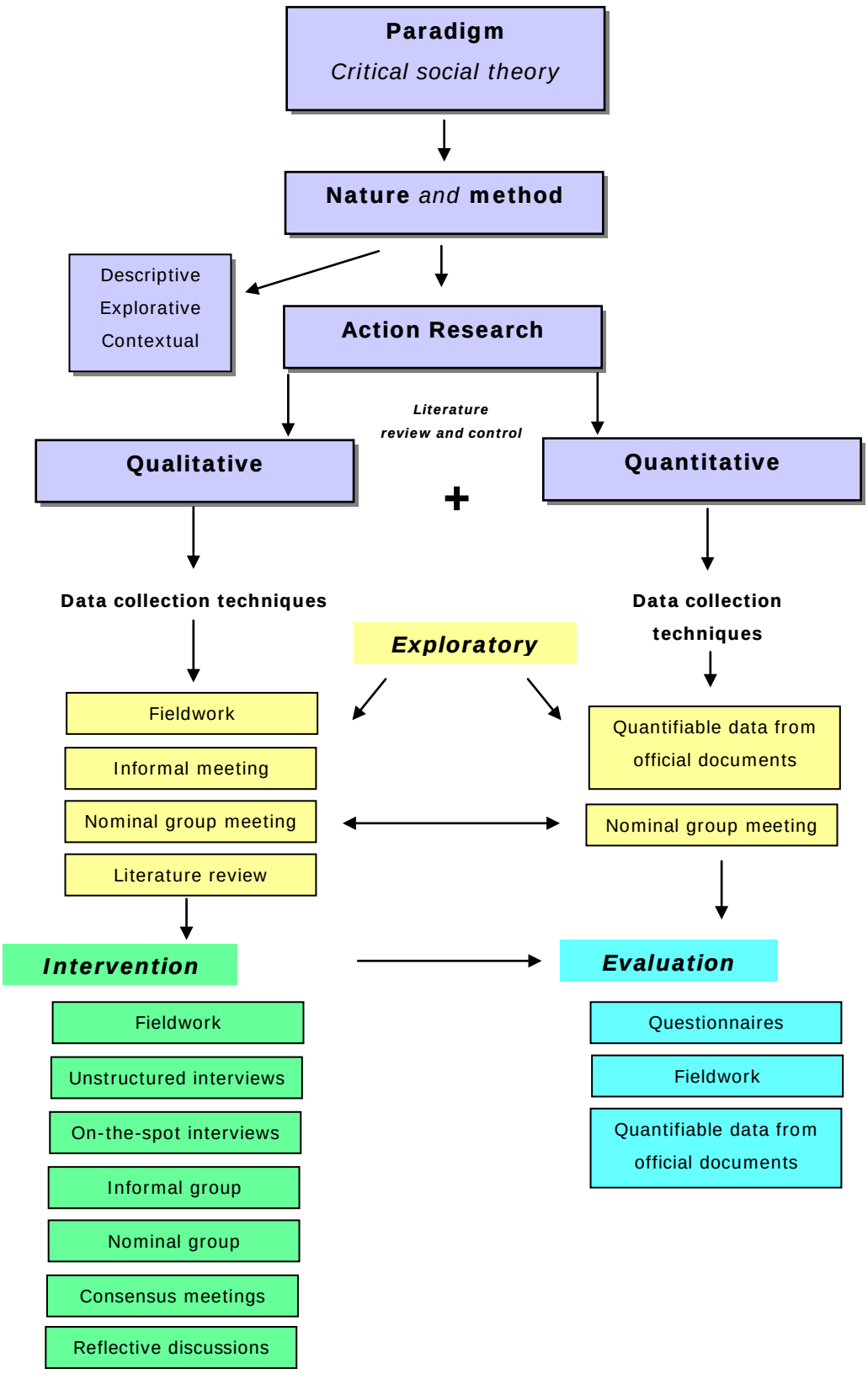


Figure 2.1: An overview of the research process

The research participants of the study included the practice leaders (unit manager and clinical facilitator) and nurse practitioners working on a permanent basis in the A&E unit.

2.8 THE RESEARCH PROCESS

Note*:* The series of ***steps*** and ***cycles*** used in the AR for practitioner's project are ***involving***, ***holistic*** and ***flexible*** rather than separate entities.

Action research by definition includes both action and research. Recognising that with '*action research, process, outcome and application are inextricably linked'* O'Leary (2004:139), an action process (see Figure 3.1) and a research process (see Figure 2.1) were developed during the AR for practitioners project in order to guide the AR process. These processes dictated the entire course of events (action and research) that took place throughout the entire study and were regarded as parallel running processes.

The research process in this study provided a series of phases, steps and cycles to developing knowledge (Gerrish & McMahon 2006:6). Phase 1 and Phase 3 were independent phases (see Section 1.8.3 and Figure 2.1), while Phase 2 was a collaborative phase. Phase 1 included two steps. During Step 1, the extent of the emergency situation was diagnosed, which was based on the findings obtained from the emergency meeting as well as the Accreditation Committee. Step 2 entailed compiling a research proposal and obtaining ethical consent to continue with the study.

Phase 2, the collaborative phase, consisted of three steps. Step 1 included initiating the journey. Step 2 included addressing the challenges and possible long-term solutions to reaching a shared vision of 'emancipatory practice development'. Step 3 involved evaluating the worth of the journey based on criteria set by the practice leaders and nurse practitioners.

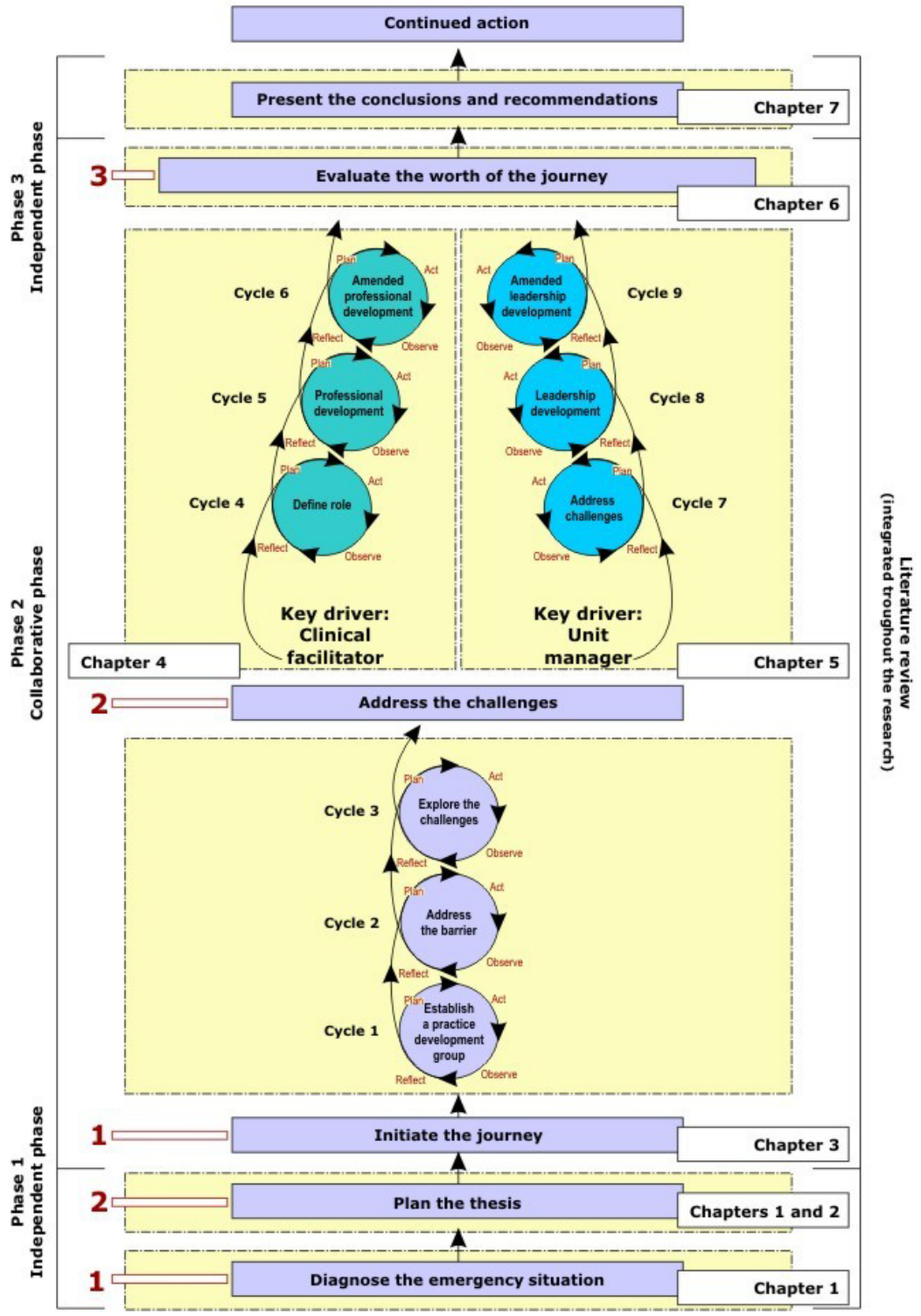


Figure 2.2 Schematic presentation of the AR for practitioners' project

A summary of Phase 2, the collaborative phase, includes:

- Step 1: Initiate the journey (key drivers: PDG).
  - Cycle 1: Establish a PDG
  - Cycle 2: Address the barriers
  - Cycle 3: Explore the challenges
- Step 2: Address the challenges and possible long-term solutions to reaching a shared vision (key drivers: clinical facilitator and unit manager).
  - Cycle 4: Define a role
  - Cycle 5: Professional development
  - Cycle 6: Amended professional development
  - Cycle 7: Address the challenges
  - Cycle 8: Leadership development
  - Cycle 9: Amended leadership development
- Step 3: Evaluate the worth of the journey.

Phase 3 included reporting on the material and writing the final thesis.

Phase 1: Independent phase

Phase 1, an independent phase of the AR for practitioners project, included two steps (see Figure 2.2), namely diagnose the emergency situation and plan the thesis. During this phase, the researcher gathered data to explore the true nature of the problem and focus the study (Meyer 2006:282).

2.8.1 Step 1: Diagnose the emergency situation

On 16 May 2005, the nurse practitioners initiated an emergency meeting during which they intended to make the top, middle and first-line management as well as the lecturer of the A&E programme aware of the extent of the emergency situation in the A&E unit. This step as well as the negative feedback from the Accreditation Committee of the Gauteng Department of Health, after a visit to the unit on 7 June 2005, was regarded as the initiating idea for the AR for practitioners project (see Section 1.2.8).

Although the emergency meeting formed part of the background of the research project, the researcher regarded it important to add this aspect to the research process. This step is thus described in detail as part of the research process, as it was the first step taken on the journey towards emancipatory practice development.

The objective of the diagnosis of the emergency situation which existed in the A&E unit, was to enlighten the practice leaders, middle and top management and the A&E lecturer about the situation in the A&E unit

2.8.1.1 Sampling

The sample for the diagnosis of the emergency situation fits the guidelines provided by Burns and Grove (2005:750), who state that a sample refers to "*a subset of the population that is selected for a study"*. In this study, the population, referred to as the research participants included:

- the practice leaders, forming part of first-line management, and
- the nurse practitioners working on a permanent basis in the A&E unit.

All research participants (practice leaders and nurse practitioners) were invited to the informal discussion group. Four members, who were regarded as stakeholders, were also invited. These stakeholders included one member from top management, one member from middle management (both involved directly with the A&E unit), the head of department (doctor) and the lecturer of the A&E programme.

A total of 14 participants attended the informal group discussions. The participants included 11 research participants and three stakeholders:

- two practice leaders
- nine permanent nurse practitioners
  - one A&E nurse practitioner
  - six professional nurse practitioners
  - two practice leaders
- middle manager
- head of department
- lecturer of the A&E programme

2.8.1.2 Data collection

The data collection techniques used in Step 1 included fieldwork, an informal group discussion (emergency meeting), official documents and a literature review.

a) Fieldwork

Fieldwork was done by the researcher, and included keeping a reflective diary and making field notes. The field notes included observational notes, theoretical notes, methodological notes as well as personal notes.

b) Reflective diary

The reflective diary was used to keep record of what was happening, why and where the researcher's ideas evolved from as well as of the research process itself (Koshy 2005:97). The reflective diary was used to keep a record of significant events observed in the A&E unit, and the feelings and experiences of the researcher during particular situations in the research process. The data obtained were written in reflective journals, and included notes and mind maps.

Guidelines provided by De Vos *et al.* (2002:285-286), Hart and Bond (1995:201-202), Koshy (2005:97), and Lodico, Spaulding and Voegtle (2006:119) were taken into account to guide the researcher in keeping the reflective diary. These included:

- generate data,
- concentrate on specifics,
- provide a chronological description of what happened in the A&E unit, the participants' experiences as well as the progress of the research process,
- make use of a free writing style and keep it short,
- report on what is heard and seen,
- be alert to the behaviour, conversations and activities of the practitioners,
- make use of a flexible structure in order to be able to make notes regarding aspects which do not fit into the predetermined structure,
- reflective writing supports professional development,
- can be used to support data analysis and discussion,
- can be used to assess the researcher's performance, and
- is a means of evaluating the process.

According to Koshy, the advantages (2005:97-98) and disadvantages (2005:98) of keeping a reflective diary include:

- Advantages -
  - keeping a diary personalises the project
  - a diary can assist in keeping track of the progress of the project
  - the process of reflective writing is an integral part of professional development
- Disadvantages -
  - the researcher may be tempted to write too much which may lead to difficulties at the time of analysis
  - it is sometimes difficult to keep up the writing regularly as maintaining proper field notes take time
  - when the research is not going according to plan, there may be a tendency to stop writing
  - personalising the incidents may lead to subjectivity

The data recorded in the reflective diary include the time and date of observation, and details of the informal group discussions held during the emergency meeting and consensus meeting. Remarks made by members of the multidisciplinary team and ambulance staff concerning the situation in the A&E unit as well as remarks made by the A&E learners concerning the A&E unit as learning environment were also recorded in the reflective diary.

c) Field notes

Field notes are written descriptions of what the researcher observed in the A&E unit and included both descriptive and reflective field notes (Lodico *et al.* 2006:119). Participant observation has a long history and has been described as being fundamental to all research (Denzin & Lincoln 2000:673), and is typical of the qualitative paradigm (De Vos *et al.* 2002:278-279). Observational, theoretical, methodological and personal notes were taken.

- Observational notes are described as events experienced through watching and listening. It entails being present in the environment and making notes of one's impressions of what takes place in the environment (Jones & Somekh 2005:138). Notes were made over a period of two years of both the practitioners' activities and the physical A&E unit (Denzin & Lincoln 2000:673). Babbie and Mouton

(2001:294) describe the researcher's presence as the greatest advantage of participant observation, as thinking about or interpretation of an observed action occurs on site and analysis begins during data collection. The observational notes incorporated the monitoring of actions. These actions included the researcher's actions, as facilitator of the unit manager and clinical facilitator, the practitioners' actions and critical conversations about the research (McNiff *et al.* 2003:99-102).

- Theoretical notes were purposeful attempts to derive meaning from observational notes. In this research, the researcher used theoretical notes to generate mind maps of theory-practice correlation.
- Methodological notes included ideas and instructions to the researcher, as well as critiques of the tactics used and reminders of the methodological approaches that might be useful. The researcher continuously evaluated the approaches used against the proposed research design and method. The researcher also evaluated the data collection techniques used and ensured that she was informed regarding the practical application thereof as well as of relevant advantages and disadvantages of these techniques.
- Personal notes included notes on the researcher's own reactions, reflections and experiences. In this research, the researcher's personal notes contained reflections on her own practice as lecturer of the A&E programme as well as her role as consultant, facilitator and researcher.

d) Informal discussion group

The nurse practitioners initiated an emergency meeting (referred to as an informal group discussion) on 16 May 2005 to verbalise their concerns and raise the awareness of management, the head of department and the lecturer of the A&E programme of the true nature and extent of the emergency situation in the A&E unit.

The emergency meeting was regarded as a source of valuable data as it captured the responses of the nurse practitioners to the situation (McNiff & Whitehead 2002:96). It was an open-ended discussion, led by the nurse practitioners. During the meeting, middle management, first-line management and the head of the department were enlightened concerning the true nature of the situation.

The data collection technique during the emergency meeting was an informal group discussion. The emergency meeting was not tape recorded as the AR for practitioners project had not formally started at this point. The researcher and one of the professional nurse practitioners took extensive notes during the discussion. The notes were taken mainly for two purposes. Firstly, the nurse practitioners specifically asked the professional nurse practitioner for extensive notes to provide them with evidence of the details that were discussed. The second reason was that discussions had been held between the unit manager (at this stage not appointed in the post, but working as a professional nurse practitioner in the A&E unit) and the researcher pertaining to the challenges experienced in the A&E unit. The unit manager and researcher discussed various possibilities of addressing the concerns once she was formally appointed and had considered a possible research project. The researcher therefore regarded it as an opportunity to gather data for a potential research project.

Whilst the researcher took notes, other thoughts and insights into the emerging situation were recorded as reflective remarks (Burns & Grove 2007:82) in a reflective diary. Additional information recorded in the reflective diary included the date on which the meeting took place, what was happening, why and where the researcher's ideas evolved as well as of the research process itself (Koshy 2005:97).

e) Official documents

A report compiled by the Accreditation Committee from the Gauteng Department of Health (see Annexure E) was included, as it provided evidence of the findings and supported the claim made in the clinical practice situation (Koshy 2005:96).

f) Literature review and control

The literature review and control formed an integral part of the entire process. An in-depth literature review followed once the practice leaders and researcher realised the extent of the emergency situation that existed in the A&E unit. Although the initial reason for conducting a literature review was to compile an ethically approved proposal that would then initiate the project formally, it also served three additional purposes.

Firstly, it was used to underpin the paradigm of the study (De Vos *et al.* 2002:265) and acquaint the researcher with the research methodology to be used in the study. Secondly, it was used to acquaint the researcher with existing knowledge by providing a background to the problem studied. This ensured that the researcher discovered the most recent and authoritative theory available on the subject and enabled the researcher to state why the research project was important (Babbie & Mouton 2001:87; Burns & Grove 2007:135; Koshy 2005:43). It was therefore necessary that the researcher was thoroughly knowledgeable regarding the topic, that she understood the nature and meaning of the problem under study, and was able to refine and redefine the aim and objectives of the research study (De Vos *et al.* 2002:127, 128 & 267; Parahoo 1997:82). Thirdly, literature was reviewed in order to indicate why the current study was important and where it would fit into the overall body of knowledge on the topic being researched (Parahoo 1997:98).

The literature review therefore aimed to place the research in the context of what is already known about the topic (Parahoo 1997:91). The aim of the literature review was the same as the overall aim and objectives set out for this research and provided the researcher with an overview of the literature in context of the study.

The literature control involved the examination and verification of trends and similarities in the data that were obtained during the research process. It is used to confirm the findings obtained during the study, and to indicate deficiencies and gaps (Burns & Grove 2007:138; De Vos *et al.* 2002:267). Although evidence is sought, a literature control can uncover presuppositions (Morse 1994:120). An ongoing literature search was done throughout the study and linked to the findings of the study (Holloway & Wheeler 2002:35). Thus, the literature control was used to confirm or contradict the findings of the study.

2.8.1.3 Data analysis

During Phase 1, Step 1 both qualitative and quantitative data were collected (see Figure 2.1).

a) Qualitative data

The qualitative data collection techniques used (fieldwork, reflective diary, field notes and informal group discussions) dictated an inseparable relationship between the data collection and data analysis. Therefore, as qualitative data were collected, qualitative data analysis principles were followed.

The data analysis was regarded as a process of bringing order, structure and meaning to the mass of collected data obtained during the informal group discussion (De Vos *et al*. 2002:339). Although software programmes are available for data analysis, their acquisition was regarded as unnecessary as handwritten notes or the MS Excel software programme could also be used. It was decided to do the coding by hand, written in the margin of the transcribed pages. The data were analysed by the researcher as well as a skilled qualitative researcher.

Notes that were made during the emergency meeting were used as units of analysis (Graneheim & Lundman 2004:105). The field notes were read and a coding system for the major topics and ideas was developed (Holloway & Wheeler 2002:116). This coding system was used to transform the raw data into a standardised form (Polit & Beck 2004:573).

A large margin was left on the notes for coding and categorising (Holloway & Wheeler 2002:116). First, the notes were read to obtain a sense of the comprehensiveness of the concerns expressed by the participants. The notes were read a second time. Then they were read for a third time, and the most important concepts written in the left-hand margins, while the concerns were noted in the right-hand margins. The notes regarding the concepts and concerns were read again. The analysers (researcher and external coder) then read through the concepts noted in the left-hand margins, and selected the themes. Throughout the analysis, reflective remarks were made. These were written on separate pieces of paper, or in the right-hand margins of the transcriptions, but in different colours. Making these notes and remarks assisted in interpreting and connecting parts of the transcripts, and in retaining a thoughtful stance (Burns & Grove 1997:55).

According to Polit and Hungler (1997:329) coding was used to transform the raw data into a standardised form. Graneheim and Lundman (2004:106) discuss the

confusion surrounding terms used in qualitative research and explain the concept '*meaning unit'* as follows: *"A meaning unit … has been referred to as a content unit or coding unit (Baxter, 1991), an idea unit (Kovach, 1991), a textual unit (Krippendorff, 1980), a keyword and phrase (Lichstein and Young, 1996), a unit of analysis (Downe-Wamboldt, 1992), and a theme (Polit and Hungler, 1991)."*

In this study, the term '*theme'* was used to refer to the first level of coding. At this level, an attempt is made to shed light on the specific '*areas of content'* but with little interpretation. Graneheim and Lundman (2004:106) define *'areas of content'* as follows*:* "*For level one coding, words, sentences or paragraphs that related to each other through their contents and context were considered"*.

In this study, the concept '*cluster'* was used to refer to the second level of coding. Level three coding or axial coding was done to link the themes to the clusters and explain the meanings inherent to the situation (Burns & Grove 1997:534; Graneheim & Lundman 2004:106; Holloway & Wheeler 2002:159). Concerning this study, the third level of coding is referred to as '*categories'*. A category answers the question: 'What?' Clusters and themes within a category share a commonality, and therefore a category can be identified as a thread that runs throughout the codes (Graneheim & Lundman 2004:107).

The process of coding was followed step by step (see Figure 2.3.). By applying this process to raw data, the data were systemised (Henning, Van Rensburg & Smit 2004:107). Coding entailed the recognition of repetitive words, phrases, themes, and concepts or the recognition of words, phrases, themes, and concepts with similar meanings. This was done by paraphrasing the participants' words in order to identify themes (first level coding). By incorporating the themes into clusters (second level coding) and categories (third level coding), they were refined (Holloway & Wheeler 2002:239,240). By comparing the themes to the whole, surplus themes were eliminated. The themes could then be represented visually. Figure 2.3 illustrates the process of coding.

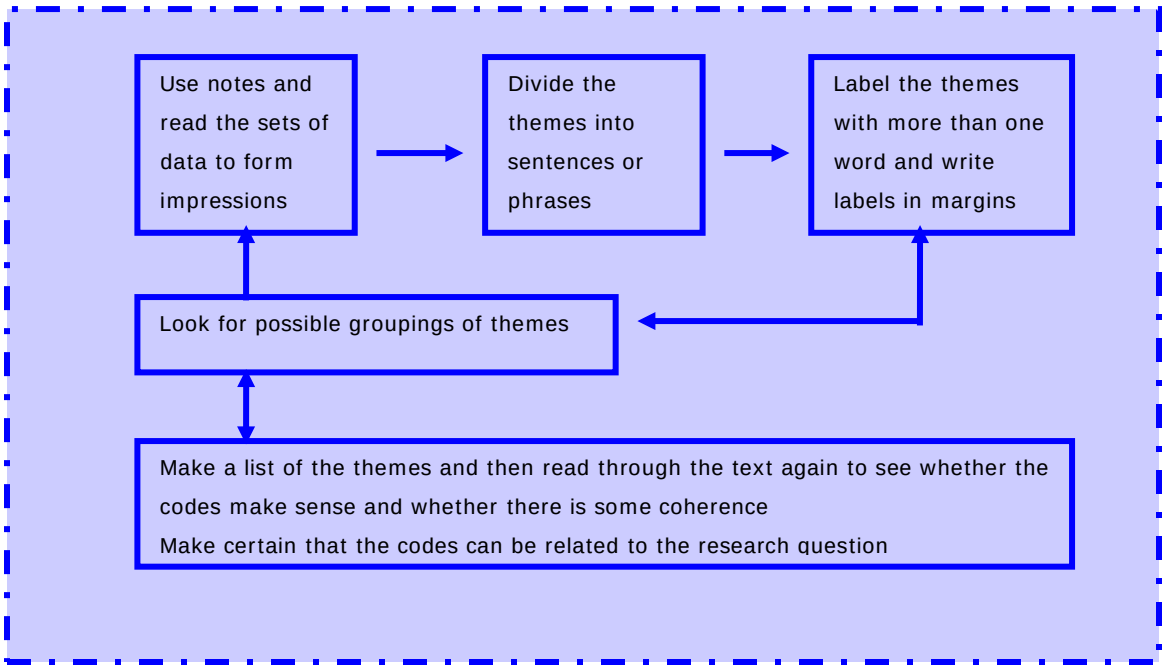


Figure 2.3: Process of coding (adopted from Henning *et al.* 2004:104)

b) Quantitative data

The quantitative data included official reports obtained from the hospital, including the off-duty record books, statistics available regarding the number and priority of the patients managed in the A&E unit and summary of the accreditation findings.

The quantitative data were analysed and interpreted, using descriptive statistics. The descriptive statistics allowed the researcher to organise the data in such a way that it gives meaning and creates objective scientific knowledge which can enhance understanding and insight (Burns & Grove 2005:499; De Vos *et al*. 2002:166).

2.8.1.4 Trustworthiness, validity and reliability

The measure of truth and accuracy of qualitative approaches is judged by trustworthiness and the measure of truth and accuracy (Burns & Grove 2005:21). The trustworthiness of Phase 1, Step 1 was enhanced by adhering to the principles as described in Section 2.9.1.

Furthermore, trustworthiness was enhanced by having a consensus meeting with the unit manager, clinical facilitator and a professional nurse practitioner following the data analysis to ensure that the findings were accurate.

Consensus is defined by the American Heritage Dictionary of the English language (2000:391) as "*an opinion or position reached by a group as a whole; general agreement or accord'*. Consensus means that all the group members can live with and support a decision regardless of whether they totally agree. In the consensus meeting, the group members worked to support a final decision, and individual ideas and opinions were valued. The consensus meeting was used to increase the trustworthiness of the findings of the analysis of the data obtained during the emergency meeting.

2.8.2 Step 2: Plan the thesis

The researcher continued to plan the thesis by compiling a proposal and obtaining ethical consent from UNISA's Department of Health Sciences and the hospital (see Annexure A). Once ethical consent was obtained, Phase 2, the collaborative phase, followed.

Phase 2: Collaborative phase

Phase 2 included three steps, namely initiate the journey, address the challenges and evaluate the worth of the journey (see Figure 2.2).

2.8.3 Step 1: Action: Initiating the journey

The journey towards emancipatory practice development was initiated by means of three AR cycles, which included establishing a PDG, addressing the barrier and exploring the challenges.

2.8.3.1 Step 1: Cycle 1: Establish the practice development group

Cycle 1 was constructed over a period of six months (22 June 2005 to 22 November 2005).

The objective during Cycle 1 was to establish a PDG. This included reaching consensus amongst the members concerning the following issues:

- possible activities of the PDG,
- shared vision and purpose of the AR for practitioners project,
- roles of the PDG members,
- ethical responsibilities of the PDG, and
- values of the PDG.

a) Sampling

The practice leaders and researcher agreed to form part of the PDG. These three members of the PDG were the only research participants included in the decision-making processes throughout Cycle 1 and were thus part of the sample. The sample was therefore chosen by means of purposive sampling. Purposive sampling, a non-probability sampling method used in qualitative research, refers to the conscious selection of participants by the researcher (Burns & Grove 2005:352). The researcher purposively included the practice leaders, as they were the central focus of Cycle 1 and its set objective.

b) Data collection

Data were collected by means of informal group discussions, consensus meetings and a literature review. Fieldwork, including the keeping of a reflective diary and making field notes, was also used. In addition to this, observational notes, theoretical notes, methodological notes and personal notes were made throughout the cycle.

⇒ ***Informal group discussions and consensus***

The PDG decided to work as group, as group performance is generally superior to the performance of individuals. The fact that the group members knew one another

further enhanced the success of the outcomes of the group work (Kreitner & Kinicki 2007:389).

Group discussions between the practice leaders and researcher were regarded as important throughout the study, as more ideas can be generated in groups, thus allowing for more choices. This increases the likelihood of higher-quality outcomes (Little-Stoetzel 2003:436). The generation of new and creative ideas was regarded as vital to the AR for practitioners project. The group, consisting of the practice leaders and researcher, used group discussions for creative problem solving to find solutions for the barriers and challenges experienced in the A&E unit. Creative as well as critical thinking requires tools such as brainstorming and critical reflection.

Brainstorming was created by AF Osborne (Kreitner & Kinicki 2007:390), who started with groundbreaking work in the field of brainstorming with group discussions. Osborne (1957:229) stated that the results produced by a group would be superior to the results produced by an individual. These group discussions were mainly held to reflect on the barriers and challenges, 'brainstorm' on actions that could be implemented to resolve the barriers and challenges, and reflect on the observations made during the implementation of actions. Valuable data were captured during these group discussions (McNiff & Whitehead 2002:98; Morton-Cooper 2000:70).

Learning formed an integral part of the study, and reflection, as learning tool, was used throughout these discussions and the research process, permitting a journey of guided discovery (Blackburn & Twaddle 1996, Borcherdt 1996 & Lam 1997, as cited by Calvert & Palmer 2003:33). Discussion in itself has long been used as a reflection strategy and was used to engage the practice leaders, include and examine their individual perspectives on the issues and provide a vehicle of sustained reflection (Daroszewski, Kinser & Lloyd 2004:189).

In the process of the group discussion, the researcher undertook reflection-in-action and reflection-on-action, for the purpose of developing practice. These reflections were documented in the researcher's reflective diary. Habermans (1978:102) outlines some of the benefits of the reflective process: "*Self-reflection is at once intuition and emancipation, comprehension and liberation from dogmatic*

dependence. Only the ego apprehends itself in intellectual intuition as the self-positioning subject obtains autonomy."

Critical reflection on one's actions enables the assessment of those actions, in terms of their effectiveness in achieving the aim and objectives of the research. It can also prove to be a useful medium for determining the learning and outcomes resulting from the research. The researcher agrees with Elliot's (1991:50) statement that *"… improving practice, when viewed as the realisation of the values which define its ends into concrete forms of action, necessarily involves a continuing process of reflection on the part of the practitioners."*

Socratic questioning was used during the discussion group and was regarded as an effective communication skill that avoids interpretation and raises questions about thoughts, feelings and behaviour, and, in this study, facilitated the practice leaders' awareness of issues and extended their horizons (Calvert & Palmer 2003:33). It was also used to encourage the practice leaders to reflect and think independently, mimicking critical thinking performed at individual level (Daroszewski *et al.* 2004:189).

The Socratic Method is about moving people along in a direction that they want to go. The 'moving' was done by guiding the practice leaders (and nurse practitioners) in examining assumptions, beliefs and experiences (Norman & Patnode 2002:48). The Socratic Method uses a critical questioning technique, which is linked to critical thinking that challenges these assumptions, beliefs and experiences, and checks their accuracy and completeness. It is thus a questioning technique used to guide people on a journey of discovery and move them towards a greater understanding and increased performance (Norman & Patnode 2002:48). It is more than eliciting a one-word response or an agreement/disagreement from the learner (Thoms 2007). Socratic questioning requires the learner to make assumptions, distinguish between relevant and irrelevant points, and explain points.

The features stated by Calvert and Palmer (2003:33) pertaining to Socratic questioning were regarded as important as they involved asking questions that

- the practice leaders had the knowledge to answer,

- drew the practice leaders' attention to information that was relevant to the issue being discussed but which might have been outside their current focus,
- generally moved from the concrete to the more abstract, and
- gave information that the practice leaders could, in the end, apply in order to either re-evaluate a previous conclusion or construct a new idea.

The researcher facilitated the discussion groups. Each objective was addressed individually and the Socratic questions 'how, what, where, when and why' played a vital role throughout the discussion. Questions were asked to probe for additional meanings, peruse problematic areas of thought and assist the practice leaders to structure their own thought as well as enable them to judge their own reasoning (Thoms 2007).

Examples of the questions asked when using the Socratic Method for questioning as adapted from Paul (1993:267-277) included:

- questions of clarification
  - Why do you say that?
  - How does this relate to our discussion?
- questions that probe assumptions
  - What are you assuming?
  - What could we assume instead?
  - You seem to be assuming_____. How would you justify taking this for granted?
- questions that probe reasons and evidence
  - What would be an example?
  - What is another way to look at it?
  - How do you know?
  - Why do you think that is true?
  - What difference does it make?
  - What other information do we need?
  - Could you explain your reasons to us?
- questions about viewpoints or perspectives
  - Can/did anyone see this another way?
  - What is an alternative?
  - What would someone who disagrees say?

- questions that probe implication and consequences
  - What are you implying by that?
  - What effect would that have?
  - If this and this is the case, then what else must also be true?
  - If we say that this is unethical, how about that?
- questions about the question
  - How can we find out?
  - Would you put the question differently?
  - Is this question clear? Do we all understand it?

An outcome of these group discussions was often group decision-making. An advantage of the group decision-making process is that when followers participate in the decision-making process, the acceptance of the decision is more likely to occur (Little-Stoetzel 2003:436). Other advantages and disadvantages of group-aided decision-making as explained by Kreitner (2001:243) were considered in the use of group discussions in this study (see Table 2.3).

The possible disadvantages were addressed by an agreement during a meeting of the PDG that all the members were regarded as equals in the group. It was agreed that each member would be provided an equal opportunity to give input in a round-robin fashion and that the remaining members would actively listen first without providing feedback. Once the members had given their input, reasons were sought for their arguments by means of Socratic questioning. The researcher assured the participants that all comments made would be acknowledged and valued throughout the discussion and no comments would be regarded as unimportant or ridiculed.

Throughout the informal group discussions, the researcher took extensive notes. It was agreed that the data would not be audiotaped. The rationale provided by the practice leaders was that the tape recorder increased their stress during the discussions, made them feel uncomfortable and that they were not able to say what they wanted to.

Table 2.4: Advantages and disadvantages of group-aided decision-making (adopted from Kreitner 2001:243)

Advantages	Disadvantages
Greater pool of knowledge - A group can bring much more information and experience to bear on a decision or problem than an individual acting alone	**Social pressure -** Unwillingness to 'rock the boat' and pressure to conform may combine to stifle the creativity of individual contributors
Different perspectives - Individuals with varied experiences and interests can help the group see decision, situations and problems from different angles	**Domination by a vocal few -** Sometimes the quality of group action is reduced when the group gives in to those who talk the loudest and longest
Greater comprehension - Those who personally experience the give-and-take of group discussions about alternative courses of action tend to understand the rationale behind the final decision	**Logrolling -** Political wheeling and dealing can displace sound thinking when an individual's pet project or vested interest is at stake
Increased acceptance - Those who play an active role in group decision-making and problem solving tend to view the outcome as 'ours' rather than 'theirs'	**Goal displacement -** Sometimes secondary considerations such as winning an argument, making a point, or getting back at a rival displace the primary task of making sound decisions or solving problems
Training ground - Less experienced participants in group action learn how to cope with group dynamics by actually being involved	**Groupthink -** Sometimes cohesive in-groups let the desire for unanimity override sound judgement when generating and evaluating alternative courses of action

The data obtained by means of fieldwork were summarised by the researcher and then given to each of the practice leaders at least three days before the next group discussion. This was done to allow the practice leaders to read through the summary and make notes before continuing with the next discussion. As it was a group effort, it was required that decisions were made by consensus (Kreitner & Kinicki 2007:390) before commencing with the next session.

In this study, consensus was reached when all three members, namely the unit manager, clinical facilitator and researcher agreed with the content of the summary. At the start of each informal group discussion, the summary was read and only once consensus was reached concerning the content, the discussions continued. This increased the trustworthiness of the research findings.

⇒ ***Literature review***

The rationale for including the literature review was discussed in Section 2.8.1.2f and the same principles applied to this section.

⇒ ***Fieldwork***

Fieldwork was done in the same manner as explained in 2.8.1.2a.

c) Data analysis

Qualitative data analysis was gathered and analysed as discussed in 2.8.1.1b.

d) Trustworthiness

Trustworthiness was enhanced through reaching consensus with the practice leaders following each group discussion.

2.8.3.2 Step 1: Cycle 2: Address the barrier

Cycle 2, which dealt with the barrier of shortages of specifically professional nurse practitioners, started on 13 June 2005. Although it was a major focus during the first six months of the project, this cycle continued throughout the project.

In collaboration with the practice leaders and nurse practitioners, the objectives for Cycle 2 included:

- reaching consensus on the barrier that exists that prohibits future action, and then
- addressing the barrier.

a) Sampling

All the participants were formally invited to take part in the consensus meeting. The sample included seven nurse practitioners, the practice leaders and researcher. Consensus was reached by collaboratively planning action, which aimed at resolving the barrier.

At this stage of the project, the members of the PDG took the responsibility for the implementation of planned actions. This was done to prevent placing a further burden on the already short-staffed nurse practitioners. The PDG involved stakeholders when they planned to address the barrier. The stakeholders included the head of department, a middle manager and a top manager.

b) Data collection

The data collection techniques used during Cycle 2 included group discussion, fieldwork, on-the spot interviews and official documents.

⇒ ***Informal group discussion***

The unit manager led the discussion group. First the group was asked whether they agreed that the most important barrier that needed to be overcome in order to continue with the journey towards 'emancipatory practice development' was nurse practitioner shortages. The group agreed unanimously with this statement. The participants were then asked to provide suggestions regarding possible actions that could be implemented to address the barrier. Once consensus was reached on the planned actions, the PDG implemented the actions.

The same principles discussed in Section 2.8.1.2d applied to this group discussion. Socratic questioning was used during probing.

⇒ ***Fieldwork***

Regular (at least once a week) fieldtrips were taken to the A&E unit. Fieldwork was conducted by means of observing the actions of the practice leaders in terms of the implementation of the planned actions (also see Section 2.8.1.2c).

⇒ ***On-the-spot interviews***

A total of three on-the-spot interviews were held with the practice leaders to inquire about the actions implemented and the success thereof.

On-the-spot interviews as described by McCormack and Slater (2006:137) were used. These interviews were kept short (a maximum of 15 minutes) in order to reduce the burden on the practice leaders. The interviews were not recorded out of respect for the practice leaders' request. Extensive field notes were taken during the discussions. The timing of the actual interviews during the field trips was important, as the practice leaders could not be interviewed when they were too busy or their attention was divided. Patient care, family care and attention to the multidisciplinary team members were at all times given a higher priority than being interviewed.

All interviews took place in the office of the clinical facilitator. The door was closed and a sign was placed on the door that indicated that an interview was taking place.

Reflection-on-action was used to guide the on-the-spot interviews. The two main questions that were asked were:

- Tell me about the actions you have implemented so far to resolve the barrier of nurse practitioner shortages.
- What have you learnt during this cycle?

Socratic questions were used to obtain more in-depth data when required as discussed in Section 2.8.2.2a.

⇒ ***Official documents***

Official documents were used to gather documentary evidence (Koshy 2005:96). The off-duty record book was used to compare the number of nurse practitioners working at different time intervals in the A&E unit. This provided quantifiable data (Koshy 2005:110) and was thus regarded as useful evidence, and served as triangulation of data collection techniques. Section 2.8.1.1a contains further details of this data collection technique.

c) Data analysis

The qualitative data were analysed as described in Section 2.8.1.1b. The data obtained from the off-duty record books were tabulated and thus utilised as quantifiable data.

d) Trustworthiness

Using group discussion to reach consensus and collaborate when planning actions enhanced trustworthiness. Various data collection techniques were used during the implementation of the planned actions, including on-the-spot interviews, fieldwork and obtaining evidence from off-duty record books. Using these different data collection techniques enhanced the trustworthiness of the findings. The researcher also confirmed the findings with the practice leaders once the data were analysed.

2.8.3.3 Step 1: Cycle 3: Explore the challenges

Following the establishment of a PDG (Cycle 1) and the initiation of actions to address the emergency situation (Cycle 2), it was important to further explore the perceptions of the nurse practitioners concerning the challenges that existed in the A&E unit, which they perceived needed to be addressed in order to create a better future for them in the A&E unit. This led to Cycle 3, exploring the challenges. Cycle 3 formed part of the exploratory phase due to its explorative nature and objective, and is therefore discussed in this section.

The objective for Cycle 3 was to explore the challenges, in collaboration with the nurse practitioners, which had to be overcome in order to create a future for them in the A&E unit.

a) Sampling

The sample included a total of 14 nurse practitioners. All the research participants were formally invited by the PDG to attend the NGM. A participant leaflet (see Annexure B.3) was handed out to each individual practice leader as well as the nurse practitioners. A reminder was also placed on the notice board the week before the NGM, encouraging participation as well as providing the relevant information about the date, time and venue.

b) Data collection

The data collection technique used during Cycle 2 was a *nominal group technique* or NGT, which took place on 17 August 2005. A number of practical concerns were

taken into consideration before deciding on the most appropriate technique to use during this stage of the study. Firstly, planning the actions needed to involve the nurse practitioners, not only to increase their ownership of the project but also to reach the aim and objectives of the study. Secondly, although the technique could not be time-consuming due to the emergency situation diagnosed in the A&E unit, it also needed to be comprehensive and provide immediate results. Thirdly, there was no financial support for the study and it therefore needed to be inexpensive.

One option for data collection was the collection of self-report data by means of questionnaires or interviews as described by Polit and Beck (2004:240). However, preparing a well-developed questionnaire or interview is very time-consuming (Polit & Beck 2004:361; Holloway & Wheeler 2002:93). The data analysis would also take a lot of time and be labour intensive (Holloway & Wheeler 2002:94).

Zuber-Skerritt (2005a:38) describes a variety of useful data collection techniques that can be used in AR. These techniques include the focus group interview, AR journals, concept mapping and model building, the NGT and the repertory grid technique. An additional technique that the researcher considered was the Delphi technique. Once the researcher studied the purpose of each of these methods, three options remained, namely the focus group interview, Delphi technique and NGT.

The focus group interview's main strength is that there is a production of data through social interaction based on dynamic interaction that stimulates the thoughts of the participants. The focus group also provides both new and spontaneous ideas and all the participants have the opportunity to ask questions. The disadvantage, however, is the fact that one or two individuals might dominate the discussion and influence the outcome of the research findings (Holloway & Wheeler 2002:117-118). The researcher intended to obtain data from all the participants and provide each participant with an equal opportunity to give his/her view.

The Delphi technique is a technique whereby one obtains written judgements from a panel of experts about an issue of concern. The experts are questioned individually in several rounds, with a summary of the panel's views circulated between rounds in order to obtain consensus (Polit & Beck 2004:716). This method is also time-consuming. The purpose of the repertory grid technique was to elicit personal

constructs of AR attributes and effectiveness, to aid people in constructing their own theories-in-action, to negotiate their personal meanings or to evaluate the effectiveness of the AR (Zuber-Skerritt 2005a:51).

Taking the emergency situation experienced in the A&E unit into consideration, the practice leaders and researcher discussed the options and agreed on the NGT. This choice was based on the fact that, although the nurse practitioners had initiated the emergency meeting and provided important information regarding the emergency situation, further exploration was needed. The definition of the NGT, as described by Scott and Deadrick (1982) cited by Jamieson, Griffiths and Jayasuriya (1998:16), that it is *"…a special purpose group process appropriate for identifying elements of a problem situation and establishing priorities"*, further increased the rationale for using the technique. Another consideration was the need to involve the nurse practitioners beyond merely reaching consensus about the challenges (Allen, Dyas & Jones 2004:110), but also to increase their sense of ownership (Jamieson *et al.* 1998:16). The PDG was trying to achieve consensus, which when working with a group where there is a potential for hierarchical relationships, may have led to misinterpretation of views and the potential of bias. The NGT had the potential to provide the best overall nurse practitioner input in addressing the question and is specifically used for developing consensus (Allen *et al.* 2004:110), thus enhancing its appropriateness.

Zuber-Skerritt (2005a:45) described the NGT as a proven, effective qualitative method for collecting feedback/data from a group of people, eliciting their views of some issues in response to a vocal question. Zuber-Skerritt (2005a:45) also states that it is a valuable tool for needs analysis and problem definition. It is a time-effective way to obtain data within one or two hours (Potter, Gordon & Hamer 2004:126), as well as conduct data analysis (half an hour) and report (one hour). It was also regarded as a time and resource effective way of capturing essential features, identifying problem areas and indicating a group's priority ranking of those problem areas (Jamieson *et al.* 1998:16).

Besides considering the different designs described in the literature, advice was also sought from colleagues in research and education. Based on these factors, the researcher, in collaboration with the practice leaders, decided to conduct the NGT.

An overview is provided on the NGT, including the definition, background history, purpose, rationale for using this design, advantages and disadvantages, and procedure.

⇒ *Background, definition and purpose of the NGT*

Gibson and Soanes (2000:461) as well as Potter *et al.* (2004:126) state that the NGT was originally developed in the 1960s from an analysis of group decision-making in aerospace, environmental and industrial fields, and was initially described by Delbecq, Van de Ven and Gustafson (1975) and detailed by Moore (1987).

The NGT is designed to receive inputs from all the group members (Asmus & James 2005:350) and, in doing so, avoid the potential dominance of the interview by the more vocal members of the group (MacPhail 2001:164; Perry & Linsley 2006:348). It is described by Van De Ven and Delbecq (1972:338) as a "*structured meeting which seeks to provide an orderly procedure for obtaining qualitative information from target groups who are most closely associated with a problem area*".

The NGT is also defined as a group in which individuals work in the presence of others but do not verbally interact (Jamieson *et al.* 1998:16; Zastrow & Navarre 1977:113). It is a proven, effective and structured qualitative method for collecting data from a target group, eliciting their views of some issues in response to a focal question. The target group comprises the practitioners most closely associated with the problem, who have the required expertise in the subject under study to identify the issues of importance and to attain consensus (Aspinal, Hughes, Dunckley & Addington-Hall 2005:395; Zuber-Skerritt 2005a:46).

Van De Ven and Delbecq (1972:337) developed the NGT for "*qualitative judgemental problem exploration which is particularly applicable to the subjective and judgemental character of many health planning efforts*".

In this study, the purpose of the NGT was to use a highly structured group format (Allen *et al.* 2004:112), which deliberately aimed to limit the interplay of the researcher in the generation of ideas, clarification of issues and setting of priorities in the A&E unit (Aspinal *et al.* 2005:395; Jamieson *et al.* 1998:16). These ideas then

formed the initial challenges that guided the negotiating and planning of actions in an attempt to resolve the emergency situation in the A&E unit.

⇒ ***Advantages and disadvantages***

The advantages and disadvantages had to be considered before making use of the NGT. These are described by Andrews (2005), Bamford and Warder (2001:316-317), Gibson and Soanes (2000:461-462), MacPhail (2001:163), and Zuber-Skerritt (2005a:46-47).

The advantages include the fact that the NGT promotes more and better quality ideas than brainstorming. The initial independent generation of ideas is the deciding factor. Although brainstorming is easy to conceptualise, it can prove difficult to undertake, as once the process starts some of the participants may become intimidated by other group members for fear of criticism, ridicule or failure. This is avoided by making use of the NGT, as the views of each group member are presented through the advancement of their own statements and each has a choice to allocate votes to his/her own statements or to others that have come forward (Zuber-Skerritt 2005a:46). The process is therefore a balanced participation from all the participants (Perry & Linsley 2006:348) and inhibits one participant from dominating the discussion (Jamieson *et al.* 1998:16; Zuber-Skerritt 2005a:46).

The process can be conducted in one session. This was exceptionally appealing when inviting the practitioners to contribute and participate. It also meant that sufficient information was obtained to start the journey almost immediately, before the practitioners became despondent about the situation.

The highly structured format (Potter *et al.* 2004:126) was useful, as neither the facilitator nor the practitioners and only one of the two assistant researchers had used this technique before. As the two assistant researchers and the facilitator had experience in undertaking group work, they felt that these skills were sufficient based on the fact that the sequential steps were known and could be studied beforehand. The researcher's confidence in undertaking the process was also increased by avoiding distractions such as note-taking and tape-recording typical of other group interview formats. The assistant researchers were responsible for taking notes.

The initial silence allowed the participants to put their ideas on paper, thus giving each participant an equal opportunity to contribute through the initial independent generation of ideas (Zuber-Skerritt 2005a:47). This also assisted in avoiding potential problems typically associated with group discussions, such as the domination of the discussion by the more expressive and articulate participants. Each participant was given the same amount of time to think, generate new ideas and to rank the ideas, and then had equal opportunities to contribute and vote regardless of their status. This was also seen as one of the first steps in giving the practitioners ownership of the whole project. The process was task orientated, and therefore made effective use of resources and avoided personality clashes. It was depersonalised and all the contributions became group property. Group cohesion and purpose were quickly achieved, and the group members were stimulated to enhance innovative thinking (Zuber-Skerritt 2005a:47).

Research on group dynamics indicates that more ideas are expressed by individuals working alone but in a group environment than by individuals engaged in a formal group discussion – group consensus can therefore be reached faster (Kreitner & Kinicki 2007:389). This was evident during the implementation of this group technique. The influence of the facilitator was restricted and therefore she was unable to influence the discussion line. The structure provided a format of closure and the making of final decisions. It was also noted that the group motivation and sense of purpose were high. Participation satisfaction in this technique is also higher than in unstructured, open discussions. Voting is anonymous and therefore a true valuation of reality. There is therefore no need for respondent validation of the data, as the members of the group themselves weighted the importance of their statements in the process of engagement in the NGT.

The disadvantages are that the success of the session depends largely on the discussion leader's facilitation and process management skills (Zuber-Skerritt 2005a:47). An untrained facilitator might get into discipline and time problems. If the group is too small (fever than five to six), the process does not work well, because there is insufficient variety and richness of ideas and data. On the other hand, if the group is too large (more than 15), the process can be slow and boring, especially in the phase of collecting individual statements, one by one, to produce collective lists (step 4), and the participants may be frustrated by the rule that

forbids any discussion or criticism (Zuber-Skerritt 2005a:47). The facilitator often needs to interrupt the discussion for time reasons, when participants are still keen to continue the discussion.

These disadvantages were taken into consideration before starting the session. The researcher deliberately chose two expert researchers to accompany her during the NGT, as she had not previously been involved as a facilitator of a NGT. However, the researcher and one of the expert consultants had been participants in a NGT done by Zuber-Skerritt at a workshop in May 2005 and therefore had some experience as to the procedure that was to be followed.

⇒ ***Procedure***

The NGT was a group process that allowed for the generation of ideas by the expert participants, who were the nurse practitioners working in the A&E unit during this study. The process was guided by the researcher who acted as facilitator and controlled the group process through the management of information flow, acting as a collector of ideas as opposed to leading the discussion (Bamford & Warder 2001:317). The work of the facilitator was complemented by two independent research experts who acted as note-takers throughout the process, ensuring that the process was followed as planned and assisting with the data analysis throughout the process.

The equipment needed for the activity was minimal and included a black board and pens for generating ideas and small cards for choosing the 'best ideas' from the final list. The room used was quiet, with appropriate furnishings and freedom from interruptions. The researcher as facilitator led the group and two independent researchers assisted with taking notes and with the data interpretation. Once the data were organised and ordered by merging the items that had the same meaning and grouping these into themes, categories and subcategories, both the nurse practitioners and independent researchers were asked to confirm the findings.

The NGT process consisted of eight steps. The steps (described by Bamford and Warder 2001:317-318, Gallagher, Hares, Spencer, Bradshaw and Webb 1993:78-79, and Steward 2001:299-300) were used to compile the specific steps utilised during

the NGM as well as to delineate the specific actions that took place during each step. These steps, as applied to this research, are summarised in Table 2.5.

Step 1: Welcoming and explanation

The facilitator introduced herself as well as the two assisting research experts and welcomed the nurse practitioners (Potter *et al.* 2004:128). The participants were given a clear message that their contribution was valuable and would support the journey towards emancipatory practice development. An explanation of the purpose of the meeting, the individual roles of the facilitator, researcher and participants, and what the practitioners were likely to contribute during the meeting was given to the participants. It was emphasised that participation was voluntary. The participants were informed that the issues raised could have one of two elements, either subjective or objective, and that it was the intention to explore both elements regarding the challenges faced in the A&E unit and the feelings and emotions of the individuals in the room.

The nominal group question and task were then displayed and read aloud. Each participant received a copy of the question and tasks to refer to throughout the proceedings. The two assistant researchers took notes throughout the discussions to support subsequent data analysis.

Step 2: Asking the focal question

Before initiating the process, a focal question was asked to direct the study in order to explore the views of the participants. The wording of the focal question was crucial to the success of this inquiry (Potter *et al.* 2004:127; Zuber-Skerritt 2005a:45). The two assistant researchers and the researcher designed the focal question before the initiation of the NGT. The question was open-ended, one dimensional, short and clear, and in a language that could be easily comprehended by all the participants (Allen *et al.* 2004:111; Zuber-Skerritt 2005a:46). The question aimed to stimulate ideas and were thoroughly planned as being the most important ingredient for the success of the NGT and the study.

The focal question asked during the NGT was:

In your view, what are the challenges in the A&E unit that need to be overcome in order to create a better future for the nurse practitioner working in the unit?

Step 3: Silent generation of ideas

Each participant was provided adequate time to 'brainstorm' individually and write down responses to the focal question asked (Asmus & James 2005:350; Potter *et al.* 2004:128).

Step 4: Round-robin collection of ideas

Each participant's list was then compiled into a public list by the *round-robin collection of ideas*, which were then documented as items (Allen *et al.* 2004:111; Zuber-Skerritt 2005a:45). This took place without any discussion (Potter *et al.* 2004:128). The ideas generated by each participant were written on the black board (Potter *et al.* 2004:128).

Step 5: Serial discussion for clarification and categorising data (items)

The facilitator then led the discussion and clarification of the public items, correlating any overlapping statements. Each item was discussed and the participants were encouraged to share their thoughts, both pros and cons, about each item (Asmus & James 2005:350; Potter *et al.* 2004:128). All the participants in the group understood the meaning of each item (Andrews 2005).

The rule during this step was that criticism or judgement of any item could be expressed (Potter *et al.* 2004:128). This allowed for every individual's item to be given an equal standing whether it was unique or not. It also provided encouragement and the opportunity for all participants to contribute equally. The facilitator's task was to ensure that each participant was allowed to contribute and that the discussion of all ideas was thorough, without spending too much time on a single idea (Potter *et al.* 2004:128).

First, the data were reduced by merging the items that had the same meaning and therefore thematically grouping the items to aid analysis (Perry & Linsley 2006:348). The themes were generated through an interactive process of grouping and regrouping the items until five main themes emerged that could not be improved on (Perry & Linsley 2006:348). The two independent researchers carried out the same process. Once consensus was reached (facilitator, participants and the two independent researchers), the five major themes identified were professional development, structure, patient care, equipment and research. The entire process was done interactively with the participants and the findings confirmed thereafter with the assistant researchers.

Step 6: Anonymous voting

Ranking followed the discussion and anonymous voting (Potter *et al.* 2004:128). Each participant (independently and silently) was asked to list five items that he/she considered to be the most important. These items were then written on five separate paper slips. The participants were then asked to rank (prioritise) each of the items. This was done by assigning a weight to each theme. The following criteria were used: A=5 points, B=4 points, C=3 points, D=2 points and E=1 point. The facilitator then collected these paper slips. The total number of points was calculated for each theme and the themes with the highest number of points indicated the group's collective priority list.

Step 7: Calculate ranked scores

A refreshment break was then held, while the facilitator and two independent researchers calculated the ranked scores given to each item and produced the final ranked list of priorities (see Annexure D). Each participant therefore had contributed equally to the outcome, but was not identifiable in the result.

Step 8: Results

Finally, the group results emerged and were shared with the participants. The results showed all the items and indicated each item's ranking order. The facilitator then asked the participants to confirm the findings, thus enhancing their trustworthiness. The results obtained from the NGT are presented in Section 3.5.

Table 2.5: Summary of the steps as applied during nominal group meeting

Step 1 Welcoming and explanation 5 - 10 minutes
Step 2 Asking the focal question 1 – 2 minutes
Step 3 Silent generation of ideas in response to the focal question 5 – 10 minutes
Step 4 Round-robin collection of ideas 5 – 10 minutes
Step 5 Serial discussion for clarification and categorising data (items) 20 – 30 minutes
Step 6 Anonymous voting 10 minutes
Step 7 Calculating ranked scores 15 – 20 minutes
Step 8 Results 10 – 20 minutes

c) Data analysis

The data collection and analysis were conducted during the NGM. The analysis of the data obtained from the NGT was exploratory in nature and the reporting of the results was carried out by using both qualitative and quantitative approaches (Perry

& Linsley 2006:346), hence the reference to the NGT as a mixed method technique (Potter *et al.* 2004:128).

In the qualitative approach, inductive content analysis was used, as the process included drawing conclusions and building theory from data that had been collected and analysed (Gerrish & Lacey 2006:537). Each participant's comments were checked against his/her written comments (Step 3), the information on the blackboard, and notes made by the two assisting researchers. Themes, categories, clusters and subclusters were generated during the NGM as discussed under the explanation of Step 5 of the process.

The quantitative analysis of data resulted from the scoring and ranking methods used during Step 6 to conclude the meeting process and identify the priorities. Thus, throughout the process, the participants acted as both catalysts for the generation of ideas and analysts in that they provided means of identifying the priority challenges (Aspinal *et al*. 2005:397).

d) Trustworthiness

The trustworthiness of the data was enhanced as two expert consultants attended the NGM and agreed on the findings. Extensive field notes were taken throughout the process. The participants who attended the NGM agreed on the findings which further enhanced their trustworthiness.

2.8.4 Step 2: Address the challenges

Step 2 was driven primarily by the practice leaders and included six AR cycles. During this phase, the research cycles emerged as spirals of activity (Meyer 2006:282) by the practice leaders, as action was taken to reach a shared vision of 'emancipatory practice development'. Each AR cycle comprised of a period of planning, acting, observing and re-planning.

The researcher facilitated the process and assisted the practice leaders in setting and reaching their objectives for each cycle as the process developed. Step 2 took place over a period of almost 23 months (August 2005 to 30 June 2007).

Before commencing the cycles, the PDG planned the journey forward. The practice leaders were made aware of the toxic environment and the challenges experienced by the nurse practitioners in the A&E unit, as delineated in the emergency meeting and the NGM. These problems had to be re-assessed, possible actions that could be taken to resolve the barriers and challenges discussed, and then consensus reached on who would take responsibility for which challenge.

The objectives that were collaboratively delineated by the PDG included:

- planning actions to resolve the challenges,
- reaching consensus on who would be responsible for resolving each of the challenges,
- defining the toxic environment,
- planning actions to address the toxic environment, and
- reaching consensus (practice leaders and nurse practitioners) regarding the planned actions.

2.8.4.1 Sampling

The sample for the first and second group discussion included only the three members of the PDG, who were chosen by means of purposive sampling (see Section 2.8.2.4b). The third group discussion was held with the nurse practitioners to discuss the planned actions and get more input from their side on possible additional actions that could be taken. The entire set of research participants was invited to take part at this stage. The practice leaders were involved throughout this cycle, and 14 nurse practitioners responded and took part in the consensus meeting.

2.8.4.2 Data collection

The data collection techniques included three group discussions, field notes and consensus meetings regarding the planned actions and the person responsible for each action.

The first group discussion was held with only the practice leaders and researcher present. The challenges delineated during the NGM were discussed, possible actions

planned to address the challenges and consensus was reached regarding who would take the responsibility for which challenge. Once consensus was reached, a second group discussion was organised.

During the second group discussion, the PDG discussed the toxic environment diagnosed in the A&E unit and planned actions to change it to an enabling environment. During the second discussion group, the PDG also discussed the broad components of the roadmap that would be used during the journey towards a shared vision of 'emancipatory practice development' (see Figure 3.1). The researcher took extensive field notes throughout the two group discussions.

Fourteen nurse practitioners attended the third group discussion. The unit manager led the discussion group, whilst the researcher took extensive field notes. Each nurse practitioner was given a copy of the tabulated challenges and suggested planned actions. The group discussed each challenge and planned the actions in detail. The nurse practitioners were asked to give their input and feel free to add suggestions. Each input was valued and added to the actions planned. Once consensus was reached, the action plan was accepted and the unit manager started addressing the challenges (Cycle 7). The unit manager thanked the nurse practitioners for their valuable input. The unit manager then discussed the components of the toxic environment with the nurse practitioners and provided the relevant information on how the specific components would be addressed in future.

The tabulated challenges and planned actions were also made available to the nurse practitioners who opted not to attend the meeting or who worked night duty and were not able to attend. These nurse practitioners were encouraged to give their input to the unit manager if they wished to do so.

2.8.4.3 Data analysis

The data were analysed by making use of the extensive field notes the researcher took during both the discussion groups. The challenges and planned actions were tabulated and discussed by making use of a black board, thus making the documentation and record keeping thereof much easier and simpler. The data obtained remained in table format (see Table 3.5).

The components of the toxic environment were also tabulated and the preliminary actions planned were listed. All the data were recorded in a reflective diary.
The principles described in Section 2.8.1.3a were used to analyse the qualitative data.

The objectives of Step 2 were set in collaboration with the practice leaders. These collective objectives were to:

- address the challenges
  - Plan actions that could resolve the challenges
  - Address the challenges, following the AR cyclic approach
- explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development
  - Plan long-term solutions that could enhance the realisation of a shared vision
  - Address the long-term solutions, following the AR cyclic approach

In order to reach these objectives, six AR cycles followed. Although the researcher facilitated the process, the practice leaders remained the key drivers of the action process that took place in the A&E unit. The clinical facilitator was the key driver for Cycles 4 to 6 (see Chapter 4), while the unit manager was the key driver responsible for Cycles 7 to 9 (see Chapter 5).

2.8.4.4 Trustworthiness

Trustworthiness was enhanced by asking the practice leaders to agree/disagree with the findings once the final data were tabulated, and a list compiled of the components of the toxic environment and possible actions planned to change the toxic environment to an enabling environment. The third group discussion enhanced the trustworthiness as the elements of consensus.

a) Step 2: Cycle 4: Define a role

Cycle 4 took place between 22 August 2005 and 15 December 2005.

In collaboration with the clinical facilitator, the following objectives were set for Cycle 4:

- initiate an in-service training programme,
- delineate a role pertaining to the clinical facilitation of the first and second-year learners
- delineate a role for the clinical facilitator pertaining to the A&E unit, and
- determine ways of providing structure in the daily activities of the clinical facilitator.

⇒ ***Sampling***

Purposive and convenient sampling was used during Cycle 4. Purposive sampling was used for collecting the data, as the clinical facilitator, as key driver of the cycle, was purposively selected for the unstructured interview. Convenient sampling was used during the on-the-spot interviews, as the researcher interviewed the nurse practitioners on duty during her weekly visits to the A&E unit. The researcher visited the A&E unit once a week for observation purposes and, if appropriate, assist the practice leaders in implementing their planned actions in order to reach the set outcomes for the journey.

⇒ ***Data collection***

Data were collected during the reflective discussions held with the clinical facilitator, fieldwork was conducted in the A&E unit during the weekly visits and on-the-spot interviews held with the nurse practitioners. Once the cycle was completed, an unstructured interview was held with the clinical facilitator to reflect on the cycle and re-plan objectives for Cycle 5. This was followed by a consensus meeting with the clinical facilitator during which the findings were discussed and either confirmed or contested (see Section 2.8.1.4). Documentary evidence was gathered throughout the cycle.

A total of 23 reflective discussions were held with the clinical facilitator throughout Cycle 4. During these discussions, the researcher facilitated the learning process by using guided reflection as well as Socratic questioning (see Section 2.8.3.1b). The researcher also visited the A&E unit at least twice a week specifically to assist the clinical facilitator in reaching the set objectives. During these visits, observations were made and extensive field notes kept on:

- realisation of the in-service training programme,

- use of a diary to provide structure in the daily activities, and
- clinical facilitation of the A&E learners.

The researcher formed part of the PDG and therefore became part of the group in the A&E unit. In order to observe the research participants as an insider, she had to use participant observations (Babbie & Mouton 2001:293). Any observation that could possibly influence the study was documented in a research diary as soon as possible after the discussions. Observational notes as well as theoretical notes, including the researcher's interpretation of the observations, were documented (De Vos 1998:285-286). Babbie and Mouton (2001:294) describe the researcher's presence as the greatest advantage of participant observation, as 'thinking about' or interpretation of an observed action occurs on-site and analysis begins during data collection.

Throughout this timeframe, 15 on-the-spot interviews were held with nurse practitioners. The same principles were followed as explained in Section 2.8.3.2b. The rationale for using on-the-spot interviews was to maximise opportunities for participation as well as lessen the burden of participation on the nurse practitioners (McCormack & Slater 2006:137). Nurse practitioners working night shifts were also interviewed to allow their opinions to be heard. During the on-the-spot interviews, one standardised question was asked to elicit information regarding the specific cycle and Socratic questioning (see Section 2.8.2.1a) was used to obtain elaboration if needed. The central question was:

- Tell me about the in-service training programme that has been implemented in the A&E unit.

One informal unstructured interview was held with the clinical facilitator, at the end of the cycle, which also made use of the Socratic Method of questioning. The central questions asked were:

- Tell me about the actions you have implemented so far during this cycle.
- What worked and what did not?
- What have you learnt during this cycle?
- What actions should be planned for the next cycle?

Documentary evidence was gathered to confirm the data obtained. This included the:

- o job description that was compiled,
- o action plan pertaining to the clinical facilitation of the A&E learners, and
- o planned and executed in-service training programme.

⇒ ***Data analysis***

The qualitative data were analysed as explained in Section 2.8.1.3a. The documentary evidence was quantifiable data and utilised as such.

⇒ ***Trustworthiness***

Trustworthiness was enhanced by holding a consensus meeting with the clinical facilitator to ensure that the analysed data reflected the truth. The trustworthiness of the data was also enhanced through the use of more than one data collection technique.

b) Step 2: Cycle 5: Professional development

Cycle 5 took place during the timeframe: 1 March 2006 to 31 January 2007.

In collaboration with the clinical facilitator, the following objectives were set for Cycle 5:

- o Plan a continuous professional development programme (CPDP),
- o Implement the CPDP,
- o Plan a cardiopulmonary resuscitation (CPR) champions programme,
- o Implement the CPR champions programme, and
- o Keep record of the clinical facilitator's activities.

⇒ ***Sampling***

Non-probability, purposive and convenient sampling was used. The same principles applied as in Section 2.8.1.1.

⇒ ***Data collection***

Data were collected by means of reflective discussions that were recorded in a reflective journal. Throughout the cycle, the clinical facilitator and researcher met once a month to hold reflective discussions concerning the set objectives, the actions planned, the implementation of these actions and the challenges experienced.

The researcher did extensive fieldwork following each discussion. The researcher also visited the A&E unit at least once a week for a minimum period of two hours. Specific observations that were focused on during this cycle included the:

- implementation of the CPDP, and
- realisation of the CPR champions' programme.

On-the-spot interviews were held with 16 nurse practitioners. The same principles as discussed in Section 2.8.2.2a were followed.

An unstructured interview was held with the clinical facilitator at the end of Cycle 5. The following questions (in addition to the use of Socratic questioning) were asked:

- Tell me about the actions you have implemented so far during this cycle.
- What worked and what did not? If it did not work, why not?
- What have you learnt during this cycle?
- What actions should be planned for the next cycle?

The documentary evidence gathered during this cycle included:

- evidence of the implementation of the CPDP,
- evidence of the implementation of the CPR champions' programme, and
- evidence of the activities of the clinical facilitator.

⇒ ***Data analysis***

Qualitative data analysis was conducted as described in Section 2.8.1.1b. The documentary evidence was used to quantify the findings.

⇒ ***Trustworthiness***

Using various data collection techniques during Cycle 5 enhanced trustworthiness. The clinical facilitator was asked by the researcher to verify the analysed data in order to enhance the trustworthiness of the data.

c) Step 2: Cycle 6: Amended professional development

Cycle 6 followed during the period of 1 February 2007 to 30 June 2007. The clinical facilitator remained the key driver of the cycle.

In collaboration with the clinical facilitator, the following objectives were set for Cycle 6:

- Involve experts in the CPDP,
- Include topics that do not focus on professional development,
- Start a CPDP on night duty, and
- Motivate the CPR champions to act.

⇒ *Sampling*

Purposive and convenient sampling was used and applied as discussed in Section 2.8.2.3a.

⇒ *Data collection*

Data were collected during the reflective discussion held by the researcher and clinical facilitator once every two months. Topics selected by the clinical facilitator as well as the challenges experienced during the implementation of the actions planned were discussed. Fieldwork was done. The researcher visited the A&E unit weekly for a minimum of two hours. She observed whether the planned actions were implemented. Seventeen on-the-spot interviews were held with the nurse practitioners. The same principles as explained in Section 2.8.2.2a were followed.
An unstructured interview was held with the clinical facilitator at the end of Cycle 6. The following questions (in addition to the use of Socratic questioning) were asked:

- Tell me about the actions you have implemented so far during this cycle.
- What worked and what did not? If it did not work, why not?
- What have you learnt during this cycle?
- What actions should be planned for the next cycle?

The documentary evidence gathered during this cycle included:

- evidence of the implementation of the CPDP
- evidence of the implementation of the CPR champions' programme
- evidence of documented activities of the clinical facilitator

⇒ ***Data analysis***

The qualitative data were analysed as explained in Section 2.8.1.1b. The documentary evidence was used to quantify the findings.

⇒ ***Trustworthiness***

Throughout the cycle, various data collection techniques were used in order to enhance the trustworthiness of the research data. The clinical facilitator was asked to give feedback on the data collected and analysed, and verify the findings, thus enhancing the trustworthiness of the study.

d) Step 2: Cycle 7: Address the challenges

The unit manager agreed to take the responsibility for Cycles 7 to 9. Cycle 7 was initiated on 29 August 2005 and completed on 31 May 2006.

In collaboration with the unit manager the following objective was set for Cycle 7:

- Implement the planned actions set for each of the challenges during Step 4.

⇒ ***Sampling***

Sampling included purposive and convenient sampling. The unit manager was included in the unstructured interview as she was the key driver of the cycle. Convenient sampling was done in terms of the on-the-spot interviews. A total of 17 on-the-spot interviews were conducted with the nurse practitioners.

⇒ ***Data collection***

Data collection techniques involved reflective discussions, fieldwork, on-the-spot interviews, an unstructured interview and a consensus meeting with the unit manager to discuss and reach consensus on the findings.

Twelve reflective discussions were held with the unit manager during Cycle 7. Discussions concerned the challenges experienced. During these discussions, the researcher facilitated the learning process by using guided reflection as well as Socratic questioning (see Section 2.8.3.1b).

The researcher visited the A&E unit at least once a week for a minimum of two hours. During this time, the researcher conducted fieldwork (see Section 2.8.1.2a). Observations were made specifically regarding the implementation of the set objective for the cycle. Observation findings were recorded in a reflective diary.

A total of 17 on-the-spot interviews were held with the nurse practitioners. Nurse practitioners were asked whether they were willing to participate in the interview. The same principles applied as discussed in Section 2.8.3.2b.

Once the cycle was completed, an unstructured interview was held with the unit manager. The following questions (in addition to the use of Socratic questioning) were asked:

- Tell me about the actions you have implemented so far during this cycle.
- What worked and what did not? If it did not work, why not?
- What have you learnt during this cycle?
- What actions should be planned for the next cycle?

⇒ ***Data analysis***

The qualitative data were analysed as explained in Section 2.8.1.1b.

⇒ ***Trustworthiness***

A consensus meeting was held with the unit manager and the findings were discussed and confirmed. This process enhanced the trustworthiness of the data.

e) Step 2: Cycle 8: Leadership development

Cycle 8 was started on 1 June 2006 and ended on 31 January 2007. The unit manager was the key driver of the cycle.

In collaboration with the unit manager, the following objectives were set for Cycle 8:

- Rotate the professional nurse practitioners through the unit manager's office, make them aware of the responsibilities and challenges of the unit manager, and provide them with the opportunities to develop leadership,
- Initiate teamwork, and

o Celebrate successes in the A&E unit.

⇒ ***Sampling***

Sampling included purposive and convenient sampling. The same principles applied as discussed in Section 2.8.1.3. The professional nurse practitioners who were rotated through the unit manager's office were also purposively selected to partake in on-the-spot interviews.

⇒ ***Data collection***

Data were collected by the researcher by means of a total of eight reflective discussions with the unit manager throughout the cycle. These discussions revolved around the set objectives and challenges experienced during the implementation thereof.

The researcher was involved in doing fieldwork throughout the project. The researcher visited the A&E unit weekly for a minimum of two hours, during which she observed the extent to which the planned actions were implemented. The principles discussed in Section 2.8.1.1a applied to the data collected during fieldwork.

A total of six on-the-spot interviews were held with the professional nurse practitioners who were involved in the rotation. The following questions (in addition to the use of Socratic questioning) were asked:

o Tell me about your experience while rotating through the unit manager's office.
o What did you learn from this experience?

Eleven on-the-spot interviews were held with the nurse practitioners regarding teamwork. The questions that were asked were:

o Tell me about your experience of the teamwork you are involved in.
o What did you learn from this experience?

Once the cycle was completed, an unstructured interview was held with the unit manager. The following questions (in addition to the use of Socratic questioning) were asked:

o Tell me about the actions you have implemented so far during this cycle.

- What worked and what did not? If it did not work, why not?
- What have you learnt during this cycle?
- What actions should be planned for the next cycle?

⇒ ***Data analysis***

The qualitative data were analysed as explained in Section 2.8.1.3a.

⇒ ***Trustworthiness***

A consensus meeting was held with the practice leaders to discuss the findings of the analysed data. This meeting increased the trustworthiness of the data.

f) Step 2: Cycle 9: Amended leadership development

Cycle 9 started on 1 February 2007 and ended on 30 June 2007. The unit manager was the key driver of the cycle.

In collaboration with the unit manager, the following objectives were set for Cycle 9:

- Enhance teamwork, and
- Continue celebrating successes.

⇒ ***Sampling***

Sampling included purposive and convenient sampling. The same principles applied as discussed in Section 2.8.1.1.

⇒ ***Data collection***

Data were collected by means of reflective discussions, on-the-spot interviews and an unstructured interview. One reflective discussion was held with the unit manager every two months to discuss the challenges experienced during the cycle. The researcher continued to gather data by means of fieldwork (see Section 2.8.1.2a). The implementation of the set objectives was observed on a continuous basis, as the researcher visited the A&E unit once a week for a minimum of two hours.

On-the-spot interviews were held with 19 nurse practitioners concerning teamwork. The following questions were asked:

- Tell me about your experience of the teamwork you are involved in.
- What did you learn from this experience?

Once the cycle was completed, an unstructured interview was held with the unit manager. The following questions (in addition to the use of Socratic questioning) were asked:

- Tell me about the actions you have implemented so far during this cycle.
- What worked and what did not? If it did not work, why not?
- What have you learnt during this cycle?

⇒ ***Data collection***

The qualitative data were analysed as explained in Section 2.8.1.3a.

⇒ ***Trustworthiness***

A consensus meeting was held with the practice leaders to discuss the findings of the analysed data. This meeting increased the trustworthiness of the data.

2.8.5 Step 3: Evaluating the worth of the journey

The worth of the journey was evaluated during Step 3. Insider and outsider evaluations were performed.

In order to complete the evaluation of the worth of the journey towards emancipatory practice development undertaken in the A&E unit, the following objectives were set in collaboration with the PDG:

- Insider evaluation -
  - Determine to what extent the challenges have been resolved in the A&E unit as viewed by the nurse practitioners.
- Outsider evaluation -
  - Determine the views of the A&E learners concerning the support they received in the A&E unit.

- Determine the views of the A&E learners concerning the A&E unit as learning environment for the A&E programme.
- Compare the data obtained from the Accreditation Committee during two consecutive visits to the A&E unit (June 2005 and August 2006).

In terms of insider evaluation, qualitative data had been collected throughout the journey which verified the worth of the journey as well as its outcomes. The PDG set the outcomes for the journey and these outcomes were discussed with the nurse practitioners. Consensus was reached and the outcomes were accepted. These outcomes included the following:

o Resolve the barrier,
o Change the toxic environment to an enabling environment,
o Address the challenges experienced in the A&E unit to such an extent that the majority of the nurse practitioners regard these challenges as resolved, and
o Create an emancipatory practice development culture.

Consensus was reached that both qualitative data and quantifiable data had been collected throughout the project in order to evaluate the above outcomes. However, no data were available to determine the views of the nurse practitioners regarding the degree to which the challenges expressed in August 2005 were resolved or not. This objective therefore needed to be evaluated and was done by means of a questionnaire.

The A&E learners and the Accreditation Committee of the Gauteng Department of Health were involved in the outsider evaluation.

2.8.5.1 Sampling

Purposive sampling was used during Step 3. The entire set of research participants (excluding the practice leaders) was included in the insider evaluation pertaining to the extent to which the challenges had been resolved. Forty-six copies of the questionnaire were distributed to the permanent nurse practitioners working in the A&E unit. The sample was made up of thirty-four respondents who completed the questionnaire, representing a response rate of 73,9 per cent. All the respondents completed all the questions.

Six A&E learners were working in the A&E unit during the time that the outsider evaluation phase was conducted. Questionnaires were given to each of the six A&E learners. Six completed questionnaires were received.

The two members involved in the accreditation of the A&E unit (June 2005 and August 2006) were involved as outsiders in the evaluation phase as well as the official report compiled by the Gauteng Department of Health.

2.8.5.2 Data collection

The data collection techniques used included questionnaires, during which quantitative data were obtained, an official report obtained from the Accreditation Committee and one on-the-spot interview.

a) Questionnaires

A questionnaire is a self-report form designed to elicit information through written or verbal responses from a participant (Burns & Grove 2007:382). Although the data obtained are similar to data obtained during an interview, the data collector cannot use probing strategies and the participants are not permitted to elaborate on their responses or ask questions (Burns & Grove 2007:382). These disadvantages were overcome in the questionnaire by inserting an open-ended question (Burns & Grove 2005:399) after each section, thus allowing the participants to add remarks to their responses if appropriate (see Annexure H.1). There was, however, less opportunity for bias and this was the main reason for using this technique to reach the set objectives.

Two questionnaires were used to evaluate the project (see Annexure H.1 and H.2). The questionnaires were presented in a consistent manner to each participant and consisted of both open- and closed-ended questions. By making use of a questionnaire, facts could be obtained from participants regarding their perceptions of the success of the action plans implemented in the A&E unit to resolve the emergency situation and challenges experienced by the nurse practitioners.

The following advantages, as proposed by Polit and Hungler (1997:259), were taken into consideration when deciding on this method of data collection:

- questionnaires provide anonymity, which is important to ensure that the respondents are as honest as possible, and
- the absence of an interviewer helps to eliminate bias in the responses.

Burns and Grove (2005:427) confirm the above advantages, but note that questions should be presented in a consistent manner to all the participants. The researcher also took note of the disadvantages, as proposed by Koshy (2005:89):

- the researcher may be subjective and introduce bias in the type of questions asked, and
- the responses may be influenced by what the respondents believe the researcher wants to hear.

In order to overcome these disadvantages, the researcher asked a statistician and critical friend to evaluate the questionnaire before using it. In addition to this, by ensuring the participants' anonymity, not being present when the questionnaires were completed and being involved in the setting for a prolonged period, these disadvantages were minimised.

Two questionnaires were compiled during Step 3. Questionnaire 1 (insider evaluation) explored the views of the nurse practitioners as to the degree to which the challenges in the A&E unit had been resolved (see Annexure H.1). The items used in this questionnaire were based on the data obtained during the NGM (Cycle 3).

The layout of the sections included in the questionnaire was as follows:

- Participant leaflet and informed consent
- Instructions for completing the questionnaire
- **Section A** – Priority 1: Professional development
- **Section B** – Priority 2: Patient care
- **Section C** – Priority 3: Structure
- **Section D** – Priority 4: Equipment
- **Section E** – Priority 5: Research

To obtain evaluation responses, the questionnaire made use of a Likert scale (Burns & Grove 2007:388) which consisted of the following five categories: strongly disagree, disagree, unsure, agree and strongly agree. One open-ended question was added to provide the participants the opportunity to elaborate on issues if they wanted to do so.

Questionnaire 2 (outsider evaluation) was developed as an evaluation instrument for the A&E learners (see Annexure H.2). As the A&E learners complained about the A&E unit as learning environment for the A&E programme, a questionnaire was compiled to determine whether their views of the environment had changed. The items were therefore based on the concerns of the A&E learners expressed to the researcher as lecturer of the A&E programme before the initiation of the study.

The layout of the sections included in the questionnaire was as follows:

- Participant leaflet and informed consent
- Instructions for completing the questionnaire
- **Section A** – A&E unit as learning environment
- **Section B** – Support in the A&E unit
- **Section C** - Overview

As described by Burns and Grove (2007:388), to obtain evaluation responses, the questionnaire made use of a Likert scale which consisted of the following five categories: always, most of the time, often, seldom, and never. One open-ended question was added to provide the participants with the opportunity to elaborate on the issues if they wanted to do so.

The newly constructed questionnaires were pilot-tested before being used in the main investigation. This ensured that errors could be rectified at limited expenditure as described by De Vos *et al*. (2002:177). Questionnaire 1 (see Annexure H.1) was first given to three participants, including the practice leaders and one of the ICU clinical facilitators, to complete. Following their feedback, the questionnaires were distributed by hand to the entire set of research participants, excluding those who participated in the pilot testing.

Questionnaire 2 (see Annexure H.2) was tested by three participants who were A&E learners working in private hospitals and who did not form part of the research. Thereafter the questionnaires were distributed to the six A&E learners working as students in the A&E unit where the research was conducted.

Space was left on the questionnaire for comments and evaluation. In this manner, the researcher obtained a general impression of the feasibility of the questionnaire and the data that could be obtained. The data obtained by the questionnaires used during the pilot study did not form part of the sample and were discarded once feedback was obtained from the voluntary participants.

The questionnaires were delivered to the participants by hand. First, a list of all the permanent nurse practitioners and A&E learners working in the A&E unit was obtained and then questionnaires delivered to all of them. They were asked to complete the questionnaires in their own time and then place the completed questionnaire in a marked container in the unit manager's office.

b) Official report

A report compiled by the Accreditation Committee of the Gauteng Department of Health formed part of the external evaluation of the project. The data collected on its first visit to the unit on 8 June 2005, just after initiating the project, were compared to the data collected during a second visit on 6 August 2006. The Accreditation Committee worked totally independently from the study.

c) On-the-spot interview

One on-the-spot interview was held with the two members of the Accreditation Committee who were involved in the accreditation (June 2005 and August 2006) of the A&E unit. The same principles were followed as explained in Section 2.8.3.2b.

2.8.5.3 Data analysis

Quantitative data were collected during Step 3 and included questionnaires and a report obtained from the Accreditation Committee of the Gauteng Department of

Health. The quantitative data were analysed and interpreted with the assistance of a professional statistician. The quantitative variables took on numerical values (De Vos *et al*. 2002:225), the data were measured at ordinal level and descriptive statistics were used during the interpretative phase (Brink *et al*. 2006:171).

According to Burns and Grove (2005:499), descriptive statistics allow the researcher to organise the data in such a way that it gives meaning and facilitates insight. Numerical descriptive measures provide precise, objectively determined values that can easily be interpreted and compared (Keller & Warrick 2000:90).

The data were described by determining its representative characteristics, such as frequencies, percentages and numbers (N). The data were organised and presented by means of frequency distribution graphs and pie charts.

Each of the above-mentioned terms and phrases is briefly described below:

- Frequency and frequency distribution: The term frequency refers to the occurrence of the event, that is the number of times that a result or value occurs. Frequency distribution refers to the spread of a series of measurement or values grouped into classes, and their corresponding frequencies (Brink *et al.* 2006:172).
- Percentage: Percentage indicates a fraction with 100 as its dominator (Brink *et al.* 2006:176). All the percentages used in this study were rounded off to the first decimal place.
- Number (N): "N" denotes the total number of observations (Keller & Warrick 2000:90).

The qualitative data obtained during the on-the-spot interview were analysed as discussed in Section 2.8.1.1a.

2.8.5.4 Reliability, validity and trustworthiness of the data

Questionnaires were used as the method of data collection during the process of evaluation. According to De Vos *et al*. (2002:166), a measuring instrument should measure what it is actually supposed to measure. Reliability refers to the accuracy and consistency of the measuring instrument (Burns & Grove 2005:395). Validity of

the content, face validity and other methods were used to ensure the validity of the questionnaires. Each of these strategies will be discussed individually.

Content validity refers to the representativeness of the content of the instrument (Brink *et al.* 2006:160; De Vos *et al*. 2002:167). To enhance content validity, the researcher constructed the questionnaire by making use of the data obtained during the emergency meeting and the NGM. The questionnaire was then given to three of the participants involved in the emergency meeting and NGM, as well as the researcher's supervisor, critical friend and the statistician to review. The necessary amendments were made accordingly, preceding the actual data collection. Although this method is judgemental, it is relied on to ensure content validity (De Vos *et al*. 2002:167).

De Vos *et al*. (2002:167) state that it is important to structure an instrument in such a manner that it measures the attributes of the research project and appears to be a relevant measure of these attributes. Although face validity is regarded as the weakest (Brink *et al.* 2006:160), it was enhanced by making use of a critical friend and statistician to evaluate the questionnaire items for consistency with the data obtained during the NGM.

Other methods used to enhanced the reliability of the questionnaires included a covering letter (see Annexure H.1 and H.2), which was attached to the questionnaire, explaining its purpose, indicating the target population and clarifying the implication of obtaining informed consent from a specific participant. The instructions for completing the questionnaires were clear and the contact details of the researcher were included to allow participants to contact her in case of misinterpretation and/or misunderstanding. Open spaces were allocated for elaborating on responses, allowing each respondent to give his/her opinion on specific items (Burns & Grove 2005:430).

An official document compiled by the Accreditation Committee was used to obtain quantifiable data to determine the worth of the project.

The measure of the truth and accuracy of qualitative approaches is judged by trustworthiness and the measure of truth and accuracy of quantitative approaches is

referred to as validity (Burns & Grove 2005:214). One on-the-spot interview was conducted with two of the members of the Accreditation Committee when the researcher collected the official document. Confirming the data with both members following the data analysis to ensure that the findings were accurate enhanced the trustworthiness thereof.

Phase 3: Independent phase

During Phase 3, the researcher reported in the findings and presented the thesis in a scientific manner.

2.9 Validity and trustworthiness of the research

The researcher employed a number of different strategies to assure that the study was valid and trustworthy. The validity of AR, used as method in this study, was is discussed in Section 2.5.3. The methods used to ensure the validity of the questionnaires (quantitative data) is discussed in Section 2.8.2.11 and elaborated on in Section 2.9.2.

Additional measures taken into account to enhance the trustworthiness of the qualitative data are discussed in Section 2.9.1.

2.9.1 Trustworthiness of the qualitative data

Streubert-Speziale and Carpenter (1999:333) define ***trustworthiness*** as establishing the validity and reliability of qualitative research. Qualitative research is trustworthy when it accurately represents the experiences of the study participants. Rather than focussing on reliability, this study focussed on trustworthiness (Creswell 1998:197) and rather than seeking internal and external validity, the focus was on the ***authenticity*** of data.

The authenticity and trustworthiness of the research were enhanced by meeting evaluation criteria, such as confirmability, meaning in context, recurring patterning, saturation, credibility and transferability (Morse 1994:105-7). Janesick (2000:379) is of the opinion that crystallisation offers a better lens through which to view qualitative research designs. The process of crystallisation entails viewing the data from different perspectives. According to Denzin and Lincoln (2000:5), the central image of qualitative inquiry is crystallisation and not the concept of triangulation.

Guba's model of trustworthiness (Krefting 1991:215-217) was combined with the principle of crystallisation, as it applies to qualitative research, in order to ensure the trustworthiness of the qualitative approach used in Phase 2 of the study. The concepts of credibility, dependability, transferability and confirmability were used to describe the various aspects of trustworthiness.

2.9.1.1 Credibility

Credibility addresses the question of whether the research has established confidence in the truth of the results, and deals with the question of how the results of the research match the reality of the context of the study (De Vos *et al.* 2002:351).

Credibility was addressed by doing an extensive literature review through all three phases of the research (O'Leary 2004:66). Prolonged engagement was ensured as the researcher was actively involved at the research site for a period of two years. Persistent observation was enhanced throughout the study. Data were consistently collected by means of observation and interpreted in different ways by following a process of constant and tentative analysis.

During the data analysis stages of the research, a second analyst was employed to co-code the data and a third independent data analyst authenticated the coded data (Holloway & Wheeler 2002:173; Morse 1994:119). Member checking was enhanced through the involvement of critical friends in the data analysis stage of the research, in which they read through the field notes and transcribed notes, and then discussed the data analysis through critical reflection (Graneheim & Lundman 2004:109; Morse 1994:105), which in turn enhanced credibility.

2.9.1.2 Dependability

The researcher ensured that a dense description of the research design and methodology was provided. Field notes, reflective diary, personal logs and audiotapes were kept throughout the research. Triangulation was enhanced by comparing the independent coder's data analysis with the researcher's own version as well as using more than one source of data. The code-recode procedure was followed by means of a consensus discussion between the coder and researcher.

2.9.1.3 Transferability

Transferability refers to the degree to which the findings can be applied to other contexts or with other respondents (Babbie & Mouton 2001:277; De Vos *et al.* 2002:352). AR differs from other types of research in that it takes account of its unique social context. However, this does not necessarily mean that the findings of one specific context cannot be applied in other contexts. The researcher should be able to apply the knowledge and skill learnt in one situation to another setting (Holloway & Wheeler 2002:199). This AR project was appropriate for the context in which it was used, as actions were specifically planned according to the needs of the nurse practitioners. The aim of the research was not to generalise the findings, but to address specific challenges in a specific context. The transferability of the findings of this study will depend on the individual who wants to use it for future research (Graneheim & Lundman 2004:109).

2.9.1.4 Confirmability

Confirmability is the degree to which the results of the study are the product of the enquiry (Babbie & Mouton 2001:278). Confirmability was evaluated by seeking repeated evidence in the setting as well as by making use of an extensive literature review, expert supervisors, critical friends and two independent coders.

The application of each of these strategies as realised in this study is summarised in Table 2.6.

Table 2.6: Summary of the strategies used to enhance trustworthiness

Strategy	*Actions*	Application criteria
Credibility	Prolonged engagement	*Researcher profile:* - Actively involved in A&E unit during clinical accompaniment of A&E learners (average of four per year) - Various positions as A&E nurse practitioner in the emergency care environment over a period of ten years (pre-hospital, A&E unit, management and lecturer) *Practice leaders' profile:* - Both practice leaders had been actively involved as professional nurse practitioners in the A&E unit for more than ten years
	Persistent observation	- Consistently pursued interpretations in different ways - Followed a process of constant and tentative analysis
	Triangulation/ Crystallisation	- Used mixed method approach - Held consensus meetings - Used an independent coder - Used critical friends
	Referential adequacy	- Made extensive field notes - Transcribed verbatim - Made debriefing summaries
	Peer debriefing	- Analysed data confirmed by respondents - Discussed data analysis with critical friends
	Member checks	- Used independent coder - Used expert supervisors
Transferability	Thick transcription	- Provided rich, comprehensive description of data obtained - Provided in-depth description of research methodology and data collection technique
	Purposive sampling	- Purposively selected participants

Strategy	*Actions*	Application criteria
Dependability	Dependability audit	- Kept personal logs and field notes - Used an independent coder
	Dense description	- Described research methodology in-depth as well as the research process
	Triangulation / Crystallisation	- Compared independent coder's data analysis with researcher's version to enhance correctness - Used more than one source of data (qualitative data, quantitative data, reports, statistical data obtained from the A&E unit regarding patients and off-duty records, personal communication with top and middle management)
	Peer examination	- Data given to nurse practitioners involved to review - Used independent coder - Used two critical friends - Used supervisors with experience in health and AR
	Code-recode procedure	- Held a consensus discussion between independent coder and researcher
Confirmability	Confirmability audit	- Provided a dense description of the methodology and results - Included a literature control, more that one participant, co-controller and consensus meeting - Used independent coder - Used experienced supervisors
	Triangulation and reflexivity	- The researcher prevented over-involvement of own perceptions, background, views and interest by applying strict ethical guidelines and bracketing

2.9.2 Validity of the quantitative data

In this research, the term 'validity' is used to refer to the judgements made of the integrity, truth and trustworthiness of the AR (see Section 2.5.3) and quantitative approach utilised. During Step 5, questionnaires were developed and used to evaluate the worth of the journey. Instrument validity refers to whether the data collection instrument measures what it is supposed to measure (Burns & Grove 2005:401) given the context in which it is applied (Brink *et al.* 2006:159). The validity of the questionnaires utilised for the purposes of evaluation is discussed in Section 2.8.2.11.

2.10 ETHICAL ISSUES IN ACTION RESEARCH

Ethics is one of the two key issues likely to confront the researcher at the beginning of the study (Morton-Cooper 2000:54-56). Although the general ethical considerations are discussed in Chapter 1, there were a few issues specifically regarding AR that required further consideration and attention (Streubert-Speziale & Carpenter 2003:266).

2.10.1 Specific ethical considerations

According to Koshy (2005:84) and Morton-Cooper (2000:41-42), the following ethical considerations require attention in AR and therefore apply to this research:

- participation was voluntary throughout the research
- participants gave informed consent
- participants retained the right to withdraw from the study and/or to retract consent
- the names and identities of the participants were kept confidential and unrecognisable (confidentiality and anonymity)
- the data produced by the study were accurately recorded and safely managed
- the information was shared with participants, critical friends and supervisors in order to verify the relevancy and accuracy of findings
- the researcher was sensitive to the feelings of the participants
- the researcher was as non-intrusive as possible during the data collection
- when researching socially sensitive issues, the researcher took extra care in sharing the purpose and objectives of the study

Although the researcher aimed to adhere to all the above-mentioned ethical considerations, they posed some potential difficulties in the scope of this study, specifically the issues of informed consent and confidentiality, and problems with exploitation.

2.10.1.1 Informed consent

Informed consent and the right to withdraw from the study at any time are central to research ethics and were regarded as central to the research. Burns and Grove (2005:206) state that informed consent consists of four elements, namely disclosure of information, comprehension, competency and voluntarism. All four elements were included in this research prior to data collection, except during observation (see Annexure B).

A participation leaflet was added to the informed consent form and given to each participant who took part in the data collection. Each of these forms was based on the specific role the participant played in the study. It always included the title, purpose and/or objectives of the research and/or data collection techniques used. Essential information was disclosed. Voluntary consent was obtained by assuring each participant that participation was voluntary and that they had the right to refuse to participate or stop at any time without stating a reason.

Comprehension was assured by providing all the participants with knowledge regarding the rationale and purpose of the study and/or the data collection techniques, and briefing the participants on the issue of informed consent. Consistent terminology was used and the participants were directly addressed as 'you'.

Although consent was obtained at the beginning of the project from the practice leaders and nurse practitioners, the right to withdraw from the project in practice may have been impossible once the project started (Badger 2000:205). This was specifically relevant to the practice leaders who committed themselves to the project beforehand. Participation was negotiated before the project commenced and the practice leaders realised that it was not a short-term, but a long-term involvement they had committed to. The practice leaders acknowledged their responsibility to the nurse practitioners once they had committed to addressing the emergency situation and challenges in the A&E unit. The practice leaders also realised that they were accountable for their actions and omissions once the project had been initiated. Great care was taken to prevent a "*smash-and-grab approach"* and leave the practitioners "*to clear up the mess"* as described by Lathean (1996:36).

2.10.1.2 Confidentiality

Confidentiality also posed a potential problem, specifically when reporting on the AR for practitioners project. There were potentially two problems, as noted by Lathean (1996:38), that could impact confidentiality issues in this study. The first problem was that only one person fulfils the role of the unit manager and one person the role of the clinical facilitator. These participants were therefore readily identifiable. Secondly, research ethics requires the raising of issues without naming individuals, whereas managerial pressure from within the organisation may be to name "who said that" in order to validate findings. Encouraging individuals to scrutinise the report and maintaining continuous feedback to both the practice leaders and the nurse practitioners may have partly resolved these concerns. The researcher indicated from the start that no names would be mentioned when reporting findings to the practice leaders. Throughout the project, the researcher referred to the 'group as a whole,' rather than to individuals.

2.10.1.3 Problems with exploitation

Hart and Bond (1995:94) identify some problems with exploitation, where researchers view the practitioners as objects of change, rather than starting with the needs and concerns of the practitioners. This was overcome by basing the project on the findings of the emergency meeting and NGM.

The researcher was concerned with not only her own development and empowerment, but mainly the enablement of the practice leaders and nurse practitioners in order to create a better future for them in the A&E unit. This too prevented exploitation, as the researcher did not only focus on her own agenda.

2.10.2 Caring and action research

'Caring' is one of the central features of nursing and should be central to nursing research (Pera 1996:3; Williamson & Prosser 2002:591). In this research, caring (which advocates professional morality) was not limited to, although it focused on, the practice leaders and nurse practitioners. It also included the nursing profession

and the patients. Through consultation and coaching, the practice leaders were enabled to resolve the emergency situation and challenges experienced in the A&E unit. The practice leaders then facilitated the enablement of the nurse practitioners in developing their own and collective emancipated practices. This led to emancipated practice development, which focussed on patient-centred care. The project's success therefore could benefit not only the practice leaders and nurse practitioners, but also the nursing profession and patients.

2.10.3 Ethical questions in action research

Williamson and Prosser (2002:589-591) state that there are three important ethical questions in AR that need to be cleared up and discussed between the researcher and the participants before the project begins. This was done and the agreed upon answers stated.

One question that should be asked is, if the researcher and participants collaborate closely, how can confidentiality and anonymity be guaranteed? According to Lathean (1996:38-39), others within the organisation will know who participated in the AR project, and although data collection and analysis can be made confidential and anonymous, completely disguising the data in reports and theses may be problematic. Lathean (1996:38) further argues that complete confidentiality and anonymity are sometimes inappropriate. For example, if the '*trainee ward sisters'* were not suitable for the posts for which they were being prepared, this could not go unreported.

In this project, it was difficult to ensure the anonymity of the practice leaders, as there were only two people in the specific posts and it was therefore easy to recognise them, even if the researcher never stated their names. The researcher and practice leaders agreed that their names would never be used in research reports or presentations. They were otherwise not concerned and indicated that they regarded it as a group rather than individual effort.

The second question that should be asked is, if an AR study is a 'journey' and 'evolves', how can informed consent be meaningful? AR evolves through participation, reflection and purposeful action. This implies that neither the

researcher nor the participants know where the journey will take them in advance and therefore cannot know what they are consenting to. In Lathean's (1996:38) AR work, participants refused to complete the questionnaire, but could not refuse to be observed at work; they had implicitly consented to on-going involvement by taking up their 'trainee' posts and withdrawal or sabotage might have had severe consequences for their careers. Meyer (1993:1069) argues that the traditional concepts of informed consent are inadequate in AR, as consent involves participants' willingness to take part in the project and support the initial ideas for change. For Meyer, cooperation in AR is always to some degree forced, contradicting the ethos of willing collaboration.

In this project, the unit manager asked the researcher for assistance in dealing with the emergency situation in the A&E unit. The unit manager was concerned about the morale amongst the nurse practitioners in the A&E unit and the fact that the nurse practitioners were resigning. The unit manager and researcher agreed that 'change' was vital to creating a better future for them in the A&E unit. It was also agreed that it needed to be a collaborative effort and that actions needed to be implemented to realise this goal. This led to the AR for practitioners project conducted in the A&E unit.

The practice leaders recognised the concerns regarding informed consent and realised that the journey ahead could not be planned in advance, but needed to be planned as the journey evolved. The nurse practitioners were also informed about this concern.

The third question that should be asked is, if AR can have political consequences, how can the researcher avoid doing harm to the participants? According to Williamson and Prosser (2002:591), there are two potential responses to this question: the establishment of ethical codes for action researchers, and the realisation that the extent to which collaboration and negotiation take place in AR means that participants own the findings as much as the researcher.

Regarding the establishment of ethical codes, the PDG and researcher agreed on specific ethical responsibilities (see Section 3.3.2.1c). These ethical guidelines were discussed and agreed on to ensure that the PDG members realised the extent of

their commitment, not only towards each other, but also towards the nurse practitioners who had found themselves in an emergency situation and trusted the group to attempt to resolve the situation.

The extent to which collaboration and negotiation took place in the AR for practitioners project was negotiated before the project was initiated. It was agreed that the researcher would take the full responsibility for Phase 1 and 3 of the project. The PDG and nurse practitioners collaborated during Phase 2. The members of the PDG agreed that the final decision would always be with the practice leaders and nurse practitioners, but that they would be given the opportunity to make an informed decision.

The researcher stated clearly that the data collected in the course of the AR for practitioners project would be used as part of a doctoral thesis. This was agreed to by the PDG as well as the nurse practitioners. The researcher agreed that the practice leaders and nurse practitioners could use the actions implemented for their individual performance appraisal.

2.11 SUMMARY

Chapter 2 outlines the research methodology and process implemented in this research project. In includes an in-depth discussion of the objectives, techniques used during data collection and analysis as well as actions implemented to enhance the trustworthiness and validity of the data collected throughout Phases 1 to 3 of the AR for practitioners project. This is followed by a discussion on the specific ethical issues taken into consideration in the project. In the next chapter, the planning and implementation of the actions pertaining to initiating the journey, and monitoring and reflection on these actions, are presented.

3 Initiating and planning the journey

Go to people, live among them,
Learn from them, love them,
Serve them, plan with them,
Start with what they have,
Build on what they have.

Author unknown

3.1 INTRODUCTION

Chapter 2 provides an overview of the research methodology and process of the AR for practitioners project. In Chapter 3, Step 1 and Step 2 of Phase 2 of the research process are discussed and an overview of the initiation and planning of the collaborative journey in the A&E unit (see Figure 2.2 and Table 3.1), which formally started on 8 June 2005 following the visit by the Accreditation Committee on 7 June 2005, is provided.

Chapter 3 thus discusses Step 1, the initiation of the AR for practitioners project, which includes three AR cycles, namely establishing a PDG, addressing the barrier of the shortage of nurse practitioners and exploring the challenges perceived by the nurse practitioners as necessary to overcome in order to ensure a future for them in the A&E unit. Cycle 1 included the establishment of a PDG, which consisted of two practice leaders (the unit manager and clinical facilitator) and the researcher. These members were the key drivers of the AR for practitioners project. During Cycle 1, various discussions were held among the PDG members concerning the role and ethical responsibilities of each member of the PDG. Once all three members reached consensus, the purpose of the project and vision for the future were negotiated. Action then continued and Cycle 2 followed. In this cycle, the barrier of nurse practitioner shortages was addressed. Then, during Cycle 3, a NGT was used to explore and prioritise the challenges viewed by the nurse practitioners as necessary to overcome in order to ensure a future for them in the A&E unit.

Each cycle is discussed according to the timeframe in which it took place, the actions planned and implemented, the observations and reflections made regarding the cycle that formed part of the journey in the A&E unit, and the outcomes of the journey.

During Step 2, the journey forward was planned.

Table 3.1: Phase 2: Step 1 and Step 2: summary of the timeframe

Step	**Step 1: Initiating the journey**			**Step 2: Address the challenges**
Cycle	**Cycle 1**	**Cycle 2**	**Cycle 3**	
Timeframe	8 June 2005 to 22 November 2005	13 June 2005 *(continued throughout the project)*	17 August 2005	18 August 2005 to 22 August 2005
Objective	Establish a PDG	Address the barrier	Explore the challenges	Plan the journey forward

Table 3.1 reflects the timeframe in which Step 1 and Step 2 of the AR for practitioners project took place as well as the objectives for each of the steps.

Note: The researcher made use of **two voices** in reporting on the AR for practitioners project: an academic voice and a reflective voice. The **academic voice**, written in the third person, was used to write the report, with the font "Verdana" used to represent this voice throughout the thesis. Quotations from the literature as well as from the participants were written in "*Verdana and Italics*".

The **reflective voice** was used to present reflections on the findings. It was written in the first person and in *"Arial and Italics"* in the thesis.

3.2 INITIATING THE JOURNEY (STEP 1)

The AR for practitioners project was initiated during Phase 2 of the study, following the diagnosis of an emergency situation (see Section 1.2). The visit by the Accreditation Committee on 7 June 2005 can be regarded as the turning point of the emergency situation in the A&E unit as well as the official start of the AR for

practitioners project. The unit manager reflected that both the insiders (nurse practitioners) and outsiders (Accreditation Committee) confirmed the effects of the emergency situation in terms of the resignation of specifically professional nurse practitioners in the A&E unit and that actions needed to be implemented immediately to address the situation.

The idea to initiate the AR for practitioners project was elaborated on in Section 1.2. In essence, it was based on the following:

- the emergency situation diagnosed by the increased rate of specifically professional nurse practitioners leaving the A&E unit, confirming their dissatisfaction with the toxic environment in which they worked on a daily basis
- the findings obtained during the emergency meeting initiated by the nurse practitioners on 16 May 2005 (see Section 1.2 and Table 1.1)
- the fact that the remaining nurse practitioners working in the A&E unit were unmotivated, unenthusiastic, apathetic and complained of burnout
- the negative experience of the unit manager during an accreditation visit by the Gauteng Department of Health on 7 June 2005
- complaints received from the A&E learners regarding the A&E unit as learning environment for the clinical component of the A&E programme
- remarks made by members of the multidisciplinary team and ambulance staff regarding the deterioration of nursing care provided in the A&E unit as reported by the A&E learners

These concerns were confirmed by the fact that the numbers of A&E nurse practitioners, A&E learners and professional nurse practitioners working in the A&E unit were declining at a rapid rate (see Table 3.6). The allocated number of nurse practitioners for the A&E unit was a total of 65 nurse practitioners (Van Niekerk 2007a). Only 29 nurse practitioners (excluding the practice leaders) were working fulltime in the A&E unit, which substantiated the practitioners' concerns, frustration and low morale. This is consistent with similar findings in a study conducted by Aiken and Patrician (2000:146). Researchers such as Abualrub (2006:117), and Shields and Ward (2001:701) state that optimal patient care can only be provided if an adequate number of permanent nurse practitioners are present to deliver such care. In addition to this, the maintenance of professional nurse practitioners is

imperative, highlighting the importance of ensuring a future for the nurse practitioners working in the A&E unit.

The idea to act was initiated by the unit manager and clinical facilitator, with the practice leaders distinguished as the initiators of change. The practice leaders became aware of the challenges facing the A&E unit and realised the extent of the emergency situation in the A&E unit. The unit manager then asked the researcher to assist the practice leaders to resolve the situation in order to ensure a future for the A&E unit.

3.2.1 Reflection

The events leading to the diagnosis of an emergency situation in the A&E unit and the initiation of the AR for practitioners project are summarised.

16 May 2005

The A&E unit found itself in an emergency situation as a total of 13 professional nurse practitioners, of which four were A&E nurse practitioners, resigned (see Table 3.6). The effect thereof on the remaining nurse practitioners was evident based on the data gathered during the emergency meeting initiated by the nurse practitioners (see Table 1.1).

The clinical facilitator and I had discussed the issues pertaining to the A&E learners months before the emergency meeting and I (as lecturer of the A&E programme) informed the unit manager that I was concerned about using the A&E unit as learning environment for the A&E programme. I had even considered using another clinical facility for the clinical component of the A&E unit, realising the importance of providing not only appropriate theoretical knowledge in the A&E programme, but also appropriate clinical experience (Altmann 2006:1).

Based on the data gathered during the emergency meeting, two barriers were diagnosed that would prohibit the PDG from reaching its shared vision of emancipatory practice development. These barriers were the shortage of professional nurse practitioners, which was regarded as the cause of the emergency situation, and the toxic environment in which the nurse practitioners worked on a daily basis in the A&E unit. The toxic environment was regarded as non-conducive to job satisfaction. The PDG was of the opinion that by changing the toxic environment to an

enabling environment, the nurse practitioners could be empowered and emancipatory practice development would follow.

1 June 2005

One of the professional nurse practitioners, who had been working in the A&E unit for 10 years, was appointed as the unit manager in the A&E unit.

7 June 2005

The Gauteng Department of Health visited the A&E unit for accreditation purposes. These visits formed part of a quality assurance system and dealt specifically with the accreditation of healthcare institutions of the Gauteng Department of Health. Accreditation means recognition that an institution meets the official standards set by the Gauteng Department of Health. It is a process whereby an institution periodically evaluates its own activities as a whole and seeks independent judgment that it substantially achieves the predetermined and published standards, and is generally equal to comparable institutions (Goba & Masondo 2007).

This was a scheduled visit and the hospital and A&E unit were aware of the date and time of the visit. The purposes of the accreditation visit (Department of Health 2007:1) were:

- *to monitor the achievement and/or improvement of the standards of care in healthcare institutions,*
- *to identify institutions and areas within the institutions that need special intervention in order to comply with the standards, and*
- *to recommend strategies for improvement of care.*

8 June 2005

Whilst I was busy with the clinical accompaniment of the A&E learners in the A&E unit, the unit manager and clinical facilitator asked to speak to me. The unit manager was clearly upset about the Accreditation Committee's visit. She stated that the nurse practitioners had known about the accreditation visit, but did not even make an effort to tidy the A&E unit before the visit. During the ward round with the members of the accreditation team, the nurse practitioners could not answer a single question, the A&E unit was untidy and patients were left unattended. Patients complained to the accreditation team members about the service. The newly appointed unit manager and clinical facilitator stated that they had never felt so ashamed.

Some direct quotes provide evidence of their distress and concerns:

- *"… they (the nurse practitioners) could not answer simple questions asked by the accreditation team … they could not even give the CPR sequences … and they (nurse practitioners) are working in a trauma unit (A&E unit) where it (CPR) is done every day…"*
- *" … the unit (A&E unit) was in a mess … it was so untidy and in a mess … they (nurse practitioners) did not even make an effort to clean the place (A&E unit) … I (unit manager) asked them so nicely … they have no respect for their work … they have no pride …"*

The unit manager consulted me and asked whether I would be willing to assist the practice leaders in addressing the emergency situation that existed in the A&E unit. This was the first step taken in the initiation of the AR for practitioners project.

The visit by the Accreditation Committee can be regarded as the turning point in the emergency situation in the A&E unit as well as the official start of the AR for practitioners project. The unit manager reflected that both the insiders (nurse practitioners) and the outsiders (Accreditation Committee) confirmed the existence of an emergency situation in the A&E unit and that actions needed to be implemented immediately to address the situation).

13 June 2005

On 13 June 2005, the first meeting was held between the practice leaders and the researcher. The PDG was formally formed and the data gathered during the emergency meeting reflected on in order to plan actions that could begin to address the emergency situation.

Recognising that various challenges had been explored and described during the emergency meeting, it was decided that Cycle 1 would focus on only the most important barriers. Two barriers were diagnosed and considered obstructions to reaching the PDG's shared vision of emancipatory practice development (see Figure 3.1). These two barriers were professional nurse practitioner shortages and the toxic environment in which the nurse practitioners perceived they were working.

A total of 16 professional nurse practitioners resigned during the period from November 2003 until May 2005 (see Table 3.6). Not one had been replaced during this period. Resolving the professional nurse practitioner shortages was considered a short-term solution and the PDG was aware that long-term solutions needed to be implemented to retain these nurse practitioners.

The second barrier was the toxic environment in which the nurse practitioners found themselves working on a daily basis. The toxic environment was the leading cause of the emergency situation in which the A&E unit was.

This toxic environment became evident based on remarks made by the nurse practitioners during the emergency meeting –

- *"… there are no development opportunities for us … there are no professional development opportunities … we learn nothing new … we come to work and sometimes do not even drink tea … it is impossible to stay here …"*
- *"… the students (A&E learners, critical care learners and pre-graduate learners) just work here … they do not get the opportunity to learn … they work in this stressful circumstances … they are here to learn, but we do not teach them anything … it is unfair …"*
- *"… no appreciation for our hard work …"*
- *"… they (top management) do not appreciate the sacrifices we make … working overtime … sorting out problems … taking the responsibility for everything…"*
- *"… top management do not understand the problems we have … they (top management) do not care about us …"*
- *"… everybody (nurse practitioners) are [sic] leaving … they do not want to work in this place (A&E unit) anymore … we cannot do this anymore … we get sick … I shout at my children … it is affecting me negatively…"*
- *"… it is impossible to stay here (A&E unit) … the work is interesting … I really like to work with the patients … we cannot give the patients the care we need to … we are not enough … but we do not get support … we are the dumping site …"*
- *"… nobody wants to work here anymore … they (nurse practitioners) are looking for other jobs … they (nurse practitioners) do not want to work like this for the rest of their lives …"*
- *"… we (nurse practitioners) are in a crisis now … we have to take responsibility … if we want to work here we must do something … it cannot go on like this … it is unfair to expect the nurses (nurse practitioners) to work like this … we do not get any support and everybody (nurse practitioners) is leaving, but nobody cares …"*
- *"… top management must stop making nursing decisions … they do not understand the crisis we are in …"*

Based on these remarks, the characteristics of the toxic environment were summarised. The A&E unit lacked:

- *a participative management style as it was managed in a predominantly hierarchical and bureaucratic style,*
- *an adequate number of professional nurse practitioners,*

- *support,*
- *appreciation, and*
- *a learning environment.*

Both short-term and long-term solutions needed to be planned to augment emancipatory practice development. Both the barriers identified were regarded as immediate threats to the daily functioning of the nurse practitioners and of the A&E unit, and needed to be addressed without delay.

Furthermore working with only 45 per cent (29) of the total number of allocated nurse practitioners was at this stage considered as unfair practice as the remaining nurse practitioners would be expected to take on more responsibility in a collaborative approach to planning and implementing actions that lead to emancipatory practice development. Thus, before initiating any strategic action plan to reach our collective vision and focus on long-term solutions to the toxic environment (Cycle 2 – 7), it was agreed that the barrier pertaining to the shortage of professional nurse practitioners (Cycle 1) had to be addressed.

The practice leaders also conveyed the fact that they regarded the recruitment of professional nurse practitioners as a personal challenge and that, if this challenge could be addressed effectively, they would win the trust of the nurse practitioners', which in turn would make future collaboration easier.

Reminder*:* The series of ***steps*** and ***cycles*** used in the AR for practitioners project are ***involving***, ***holistic*** and ***flexible*** rather than separate entities.

3.3 ESTABLISH THE PRACTICE DEVELOPMENT GROUP (STEP 1: CYCLE 1)

The first cycle during Step 1 included the establishment of a PDG (see Table 3.2).

Table 3.2: Step 1: Cycle 1: Establish a practice development group

Step	Step 1: Initiating the journey			Step 2: Address the challenges
Cycle	**Cycle 1**	**Cycle 2**	**Cycle 3**	
Timeframe	8 June 2005 to 22 November 2005	13 June 2005 *(continued throughout the project)*	17 August 2005	18 August 2005 to 22 August 2005
Objective	Establish a PDG	Address the barrier	Explore the challenges	Plan the journey forward

Prior to the study, the clinical facilitator and researcher (as lecturer of the A&E programme) had become increasingly concerned about the anxieties voiced by the A&E learners concerning the lack of support in the A&E unit, which had lead to the lack of optimal use of learning opportunities. The middle manager and top management shared these concerns and expressed further concerns regarding the negative attitudes of the nurse practitioners, the number of nurse practitioners leaving the A&E unit and the number of complaints received from the patients in the A&E unit.

The unit manager (then working as a professional nurse practitioner in the A&E unit) and researcher discussed the situation in the A&E unit for several months before the initiation of the study. The turning point, however, was brought about by the nurse practitioners themselves when they organised the emergency meeting. This was followed by the unit manager's negative experience during the Accreditation Committee evaluation on 7 June 2005. The practice leaders asked the researcher on 8 June 2005 to assist. Therefore, the project group was almost self-selecting as those who contributed to these discussions were asked to participate in the initial meetings.

The researcher requested that she use the project as part of a doctoral thesis. This was agreed upon. Both the practice leaders volunteered to be involved and verbally confirmed their full support. A research partnership was negotiated with the practice leaders, namely the unit manger and clinical facilitator. This partnership included both insiders (unit manager and clinical facilitator) as well as an outsider (researcher). Although they agreed to the researcher as outsider, they did not want

to include "*people from the outside*" (middle management and top management) in the project, but insisted that the "*people working inside*" (the practice leaders and nurse practitioners) resolve the emergency situation themselves. This was agreed upon and the members of the group opted to refer to the group as the PDG (see Figure 3.2).

This form of researcher/collaborator relationship is described by Titchen and Binnie (1993:859) as one in which the researcher possesses no authority in the research area and has only a "*diagnostic function"*, supporting and promoting the feedback of information to the participants and change agents, but has no responsibility for carrying out the change. Although it involved collaboration, it was important to ensure that the practice leaders took ownership of the project. This statement is consistent with the view of Manley and McCormack (2003:26). Thus actions were planned and implemented collaboratively regarding the establishment of a PDG in the A&E unit.

3.3.1 Actions planned and implemented

The PDG held weekly discussions to collaboratively plan actions and their implementation until consensus was reached amongst the PDG members regarding the following issues:

- possible activities of the PDG,
- shared vision and purpose of the AR for practitioners project,
- roles of the PDG members,
- ethical responsibilities and
- values of the PDG.

3.3.2 Observations

Eleven informal group discussions were held by the PDG members between 8 June 2005 and 15 December 2005 to discuss the topics listed above. The originally planned weekly discussions could not always be realised due to unforeseen

circumstances, but these sessions were rescheduled immediately. All three members of the PDG attended all the informal discussion groups.

The PDG's activities, which were collaboratively agreed upon and congruent with the key characteristics of practice development provided by Garbett and McCormack (2002:87-89) and Page (2002:34), aimed to:

- ensure that the project took place in a real setting (A&E unit),
- incorporate a range of approaches, such as recruiting professional nurse practitioners, planning and implementing a CPDP, making use of professional portfolios during performance management, working in groups and increasing informal socialisation,
- develop and actively engage the nurse practitioners throughout the project,
- collaborate and use multidisciplinary involvement,
- include evolutionary processes,
- focus on transferability rather than generalisability, and
- improve patient care.

3.3.2.1 Consensus reached among the practice development group

After critically reflecting on the role that the practice leaders and researcher would play during the project, the group agreed to be referred to as the PDG, and that each member would be regarded as practice development facilitator. The practice development facilitators were regarded as a potential key resource for improving a patient's experience in the A&E unit. Down (2004:269) regards the practice development facilitator as a key role player in important strategic and operational action, leading and facilitating patient focused changes in clinical practice (Down 2004:269). Essentially the PDG continually sought to underpin practice with appropriate evidence, develop skilled and competent nurse practitioners and teams, and transform the context of care to one that is conducive to putting patients' needs first and where the culture is one of effectiveness (McCormack *et al.* 1999:257).

Following the founding of the PDG, it was important to reach consensus regarding a shared vision and the purpose of the project. The PDG acknowledged and agreed that there was a need for change in the A&E unit, based on the data gathered during

the emergency meeting in May 2005. Reflecting on both the external and internal forces that indicated a need for change, as outlined by Kreitner and Kinicki (2007:579-581), the PDG members were of the opinion that two external forces, namely the educational and skill levels of the nurse practitioners and the appointment of a new unit manager, were indicative of the need for change in the A&E unit.

According to Searle (2000:300), in order to enhance the effective practice of the nurse practitioner's profession and ensure that the health needs of the community are met, nurse practitioners require continuous professional development (CPD). During the NGM, the nurse practitioners confirmed that they too viewed professional development as the most important challenge in the A&E unit that needed to be overcome (see Figure 3.3). The nurse practitioners were also concerned that there were an inadequate number of A&E nurse practitioners caring for critically ill or injured patients in the A&E unit and that the professional nurse practitioners were not interested in enrolling in the A&E programme. These specialist professional nurse practitioners play an important role in rendering high-quality patient care as confirmed in research conducted by Strachota *et al.* (2003:116). The significant loss of A&E nurse practitioners and professional nurse practitioners placed a huge burden on the remaining nurse practitioners and further increased the frustration they experienced in the A&E unit.

The second external force was the appointment of a new unit manager, who brought with her new ideas and leadership styles, which then too created a need for change. The unit manager had worked in the A&E unit for 10 years and therefore knew the two previous unit managers' management and leadership styles, which were predominantly hierarchical and bureaucratic in nature.

The internal forces became evident during the emergency meeting, when the nurse practitioners' complaints made the practice leaders and middle and top management aware that their needs were not being met in the A&E unit, their job satisfaction had declined and a feeling of hopelessness had emerged among them. This was confirmed by the increased turnover of specifically A&E and professional nurse practitioners (see Table 3.6), low morale, negative attitudes, and frustration expressed by the nurse practitioners (see Table 1.1). The actions planned therefore

needed to incorporate innovative change, which was recognised as the strategic challenge confronting the PDG.

Innovative change, according to Kreitner and Kinicki (2007:582), involves introducing a practice new to the A&E unit, focusing first on resolving the barriers (professional nurse practitioner shortages and the toxic environment) and then resolving the challenges. Thus, creating change focused on:

- Resolving the barriers through
  - recruiting professional nurse practitioners
  - changing the toxic environment to an enabling environment (emancipatory practice development)
- CPD (technical practice development), by
  - enabling the practice leaders and nurse practitioners to develop their own and collective practice.

The PDG therefore did not perceive itself as merely a solution to the barriers and challenges experienced in the A&E unit. The group also aimed to drive the change process in the A&E unit by focusing on both a technical approach and emancipatory processes that would enhance the nurse practitioners' ownership and create sustained change. This is consistent with the findings of Manley and McCormack (2003:26). As patient care remained the core business of the nurse practitioners, it was regarded as an important aspect throughout the project. However, the focus of this study was on enabling the practice leaders and nurse practitioners. The group envisioned that by addressing the barriers and challenges, and changing the toxic environment to an emancipatory environment, in which the enablement of the nurse practitioners is possible, job enrichment, nurse practitioner retention and emancipatory practice development (the shared vision of the PDG) would follow.

Both practice leaders supported the idea of not only addressing the immediate emergency situation and challenges, but also focusing on long-term solutions and working towards emancipatory practice development . Realising that this would be a long-term commitment and that the nurse practitioners would rely on them once they committed to initiating an action plan, the two practice leaders stated that they were prepared to participate fully in the project. This indicated not only that they were committed to the A&E unit and nurse practitioners, but also that they took ownership of the project.

Once the practice leaders agreed to facilitate the project, four main issues were reflected upon, discussed and agreed to before the start of the project. First, the PDG had to *"begin with the end in mind"* as stated by Jooste (2004:218). Agreement regarding a shared vision that would serve the interests of the nurse practitioners and the patients was regarded as crucial (Freed 2005:118). The PDG therefore spent time reflecting on the aims, goals and core values of the group. Secondly, once consensus on these matters was reached, the PDG discussed and agreed on the different roles of the practice leaders and the researcher. Thirdly, it was important to make the practice leaders as well as the researcher aware of their ethical responsibilities once the project was initiated. Lastly, as change would follow, strategies were planned to overcome resistance to change.

a) Vision for the future

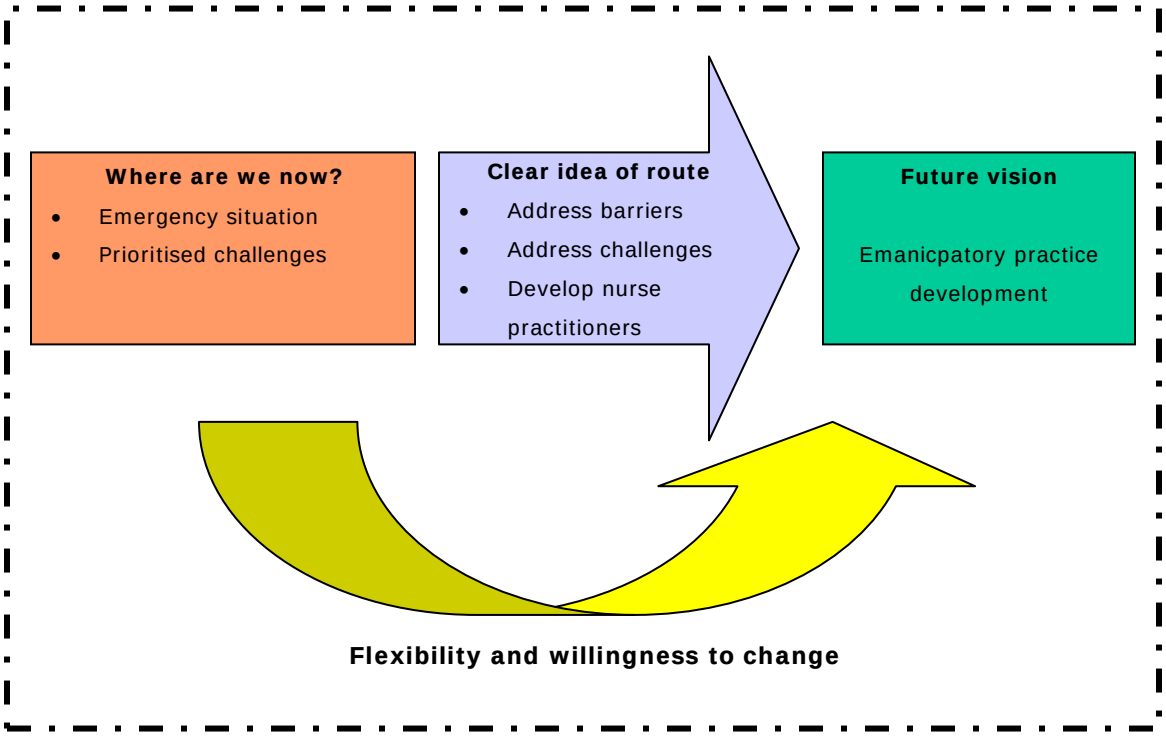


Figure 3.1: Strategic journey planned in A&E unit (adopted from Thompson & Martin 2005:27)

The shared vision for the future was recognised as a statement of the future standing of the A&E unit (Thompson & Martin 2005:863), and could bridge the gap between the A&E unit's present barriers and challenges and its future goals and aspirations (Kreitner & Kinicki 2007:526). It was also referred to as an inspirational motivation and assisted the practice leaders in leading the A&E unit into the future (Kreitner & Kinicki 2007:526). The shared vision of 'emancipatory practice development' promoted change and formed the basis of the action plans (Smit & Cronjé 2002:144). The journey is schematically visualised in Figure 3.1.

Each member of the PDG was asked to envisage the project in five years' time and to write this down. Each member then had the opportunity to explain her own vision to the other two members. From this, a shared vision was compiled based on the ideas of each member and the vision agreed upon – emancipatory practice development. The group agreed that the nurse practitioners were the most important resources in striving to reach the PDG's future vision (Smit & Cronjé 2002:277), and that working with frustrated and negative nurse practitioners and high turnover rates would mean that the vision of emancipatory practice development would not be realised.

b) Roles of the practice development group members

The PDG consisted of the practice leaders (the unit manager and clinical facilitator) and the researcher. Consensus was reached regarding referring to the group as the PDG, as emancipatory practice development was the group's shared vision.

Although the group members had shared roles, each group member played a predominantly different role in the project. The shared and specific roles of each member were discussed and agreed upon by all the group members. To a certain extent, this process continued to develop as the project evolved. The agreed upon roles are tabulated in Table 3.3.

Table 3.3: Key roles of the practice development group

Shared roles	
Role	**Description**
Practice developer	Forms part of the PDG, which aims to enable the nurse practitioners by planning actions that would be the origin of a systematic, rigorous and continuous process of change to improve the future of the nurse practitioners
Collaborator	Creates an environment of trust, respect and cooperation with the nurse practitioners to ensure that the nurse practitioners buy into the action plans as this could enhance the success of the project
Visionary	Is able to see into the future, understands what can be and realises the potential worth of the practice leaders and nurse practitioners involved
Planner	Plans actions that aim to solve the emergency situation and challenges experienced by the nurse practitioners
Problem solver	Is able to see what everyone else sees and come up with possible solutions
Observer	Observes the outcomes of the planned actions implemented
Specific roles	
Unit manager	
Negotiator	Negotiates the planned actions to be implemented by the nurse practitioners with the nurse practitioners
Leadership developer	o Enables nurse practitioners to develop their leadership by means of shared leadership activities, teamwork and facilitation o Assists the nurse practitioners to examine and question their practice by means of reflection o Supports the nurse practitioners in articulating, developing, implementing and evaluating their ideas o Supports and encourages reflection on practice o Provides performance management and feedback based on a professional portfolio o Facilitates change
Clinical facilitator	
Role	**Description**
Facilitator	o Plans, develops, implements and continuously evaluates a professional development programme o Focuses on individualised and group training o Uses evidence-based research to support professional development o Assists the nurse practitioners to examine and question their clinical practice by using structured reflection o Is involved in activities supporting and raising an awareness and helping to create a culture of change in the clinical setting o Supports and encourages reflection on practice o Enables the A&E nurse practitioners to become involved in the professional development of their peers

Researcher	
Facilitator	*Within the PDG –* Supports and encourages reflection on current practice Facilitates the learning and enablement of both the unit manager and clinical facilitator on individual level to be able to resolve the emergency situation and challenges experienced in the A&E unit *Unit manager–* Facilitates learning by assisting the unit manager during the planning of actions, implementation of the actions and continuous observation and reflection on the outcomes of actions in order to resolve the challenges and realise leadership development *Clinical facilitator –* Facilitates learning by assisting the clinical facilitator during the planning of actions, implementation of the actions and continuous observation and reflection on the outcomes of the professional development programme
Researcher	o Writes a proposal and obtains ethical consent to do the project o Keeps notes of all the activities, findings and outcomes o Writes the thesis

c) Ethical responsibilities of the practice development group

In contrast with other types of research, the researcher could not predetermine the nature of the study, as it was dependent on the views and wishes of the PDG and nurse practitioners. Gaining formal ethical approval for the study was not adequate and it was important that the ethical practice was discussed and agreed upon at the start of the study (Gerrish & Lacey 2006:275). The ethical responsibilities of each of the group members were discussed. Consensus was reached that the principles outlined by Wilson (2005:27-30) would be used to guide the group members in reflecting on the ethical considerations that needed to be adhered to during the project.

The ethical responsibilities of the PDG members included having to give up their individual sovereignty to ensure that the group could work. The members within the group were seen as equal and worked both dependently and independently of each other. The important standards that were agreed upon were that the members would:

- **Do their best within the group:** Each member was regarded as knowledgeable, with ideas and opinions of his/her own. The other group members had to value these ideas and opinions.

- **Determine to behave with the group's good in mind:** The members had to put their personal goals in second place so that group consensus could be achieved. Each member therefore had to be committed to completing tasks on the basis of the evidence and the group's best understanding of that evidence, even though doing so may have left personal and private agendas unfulfilled.
- **Make a commitment to fair play:** Group problem solving was understood as a cooperative event and not a competition. Standard behaviour during discussions was important and each member had to be given the opportunity for free and full participation within the group.
- **Listen carefully and participate fully:** Each member had the opportunity to say something and had the right to expect other members to carefully provide feedback, understand what had been said and consider these ideas seriously.
- **Take on a participant-analyst role:** This required the members to engage in the group process as well as direct attention not only to what was happening in the group, but also to what was happening in the A&E unit.
- **Has a responsibility towards the nurse practitioners:** As the vision of the group was to improve the future of the practitioners, there were certain expectancies of the group and group members. The group therefore needed to respect the views of the nurse practitioners and take these into consideration during group discussions and decision-making.

d) Strategies utilised to overcome resistance to change

Some difficulties were expected in the implementation of the action plans, but the PDG and nurse practitioners were committed to change and were prepared to do whatever it took to effectively implement this. Five strategies, adapted from Kotter and Schlesinger (1979) as cited in Kreitner and Kinicki (2001:676), were utilised by the PDG to overcome resistance to change:

- enablement and communication,
- participation and involvement,
- facilitation and support,
- negotiation and agreement, and
- manipulation and co-optation.

These strategies to overcome resistance to change in the A&E unit were discussed amongst the PDG members on various occasions throughout the project and adapted

to the specific situation. The final approaches agreed to and implemented during the AR for practitioners project are represented in Table 3.4.

Table 3.4: Strategies planned to overcome resistance to change

Approach	Application
Enablement and communication	*Unit manager* o Created awareness by involving the nurse practitioners in exploring the challenges experienced in the A&E unit o Communicated by means of a communication book and monthly meetings o Developed the leadership of the nurse practitioners by means of shared leadership, teamwork and portfolio development o Provided continuous feedback with regard to the AR for practitioners project *Clinical facilitator* o Instituted a professional development programme (formal and informal) o Provided individualised teaching with regard to non-nursing tasks as requested by nurse practitioners o Encouraged reflection on action
Participation and involvement	*All the nurse practitioners were involved in-* o Determining the challenges, finding possible solutions, and implementing and evaluating actions to resolve the challenges o Teamwork o Evaluating the AR for practitioners project *Professional nurse practitioners* o Shared leadership *A&E nurse practitioners* o Professional development programme
Facilitation and support	o Practice leaders facilitated the project o Practice leaders supported the nurse practitioners o Support and encourage the service provided by the hospital and situated in the A&E unit, consisting of a group of pastoral psychologists and psychologists, were available to support patients, their families as well as the staff and their families o Innovation was encouraged and acknowledged o Successes were celebrated

Approach	Application
Negotiation and agreement	*Leadership development* o Professional nurse practitioners who were interested in learning more about the management of the A&E unit were provided the opportunity to rotate through the unit manager's office and given specific management tasks to perform o Although being a team member was compulsory, the nurse practitioners were allowed to determine the challenges they perceived as important and wanted to address o Challenges addressed in the different teams were negotiated and agreed upon before starting the process *Professional development* o Topics for the in-service training programme were discussed and agreed upon before implementation (see Annexure F.5)
Manipulation and co-optation	o Teamwork o Portfolio development

e) Values pertaining to the project

Following the agreement regarding the shared vision "emancipatory practice development", the PDG reflected on the values that would form the basis of implementing the AR for practitioners project. Based on the shared vision, the values delineated and agreed upon by the PDG included:

- commitment
- mutual trust, respect and honesty
- openness
- collaboration
- nurse practitioner enablement
- practice development (technical and emancipatory)
- celebrate success
- patient-centred care

3.3.3 Reflection

A graphic presentation was designed in an attempt to explain the enabling roles of the practice leaders and researcher. Reflection was used to facilitate the development of the practice leaders, which in turn facilitated the development of the nurse practitioners in the AR for practitioners project.

In Figure 3.2, the nurse practitioners and practice leaders were the primary focal group in the enabling environment, which is indicated by a rounded rectangle. The nurse practitioners are indicated by a rectangle containing a drawing of stick figures. Each of the three PDG members is represented by a circle. These three circles are interlinked and overlap, which indicates the interaction between the members of the PDG, as they reflected, gave support, encouraged each other and participated in peer group checking. These members were regarded as equal partners in the group.

The circle representing the researcher only overlaps with the circles representing the unit manager and clinical facilitator. This is because the researcher's role was to facilitate the learning and development of the unit manager and clinical facilitator in order to enable them to resolve the emergency situation and challenges experienced in the A&E unit. The circles representing the practice leaders overlap with each other as well as with the nurse practitioners, which indicates the role these leaders played as key drivers of the project, in collaboration with the nurse practitioners, as well as in providing the nurse practitioners with CPD and leadership development opportunities in order to enable them. The researcher therefore can be described as an external enabler, whereas the practice leaders were the internal enablers. All three PDG members guided development through reflection.

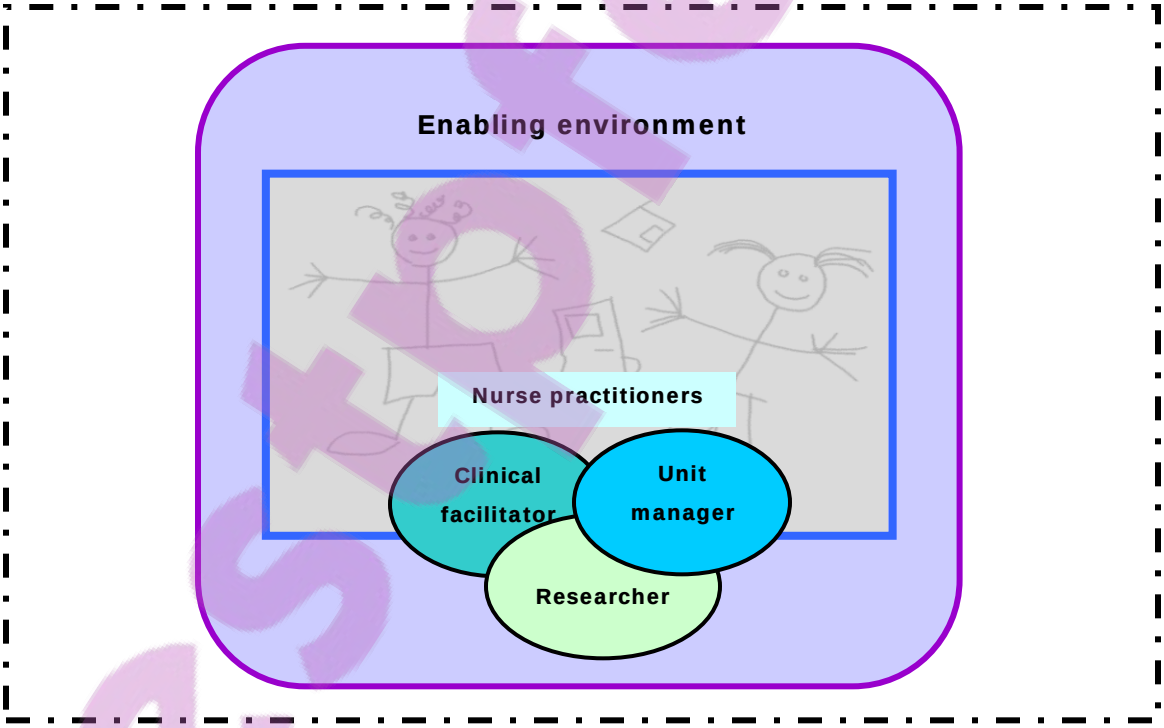


Figure 3.2: Graphic presentation explaining the enabling roles of the practice development group

3.4 ADDRESS THE BARRIER (STEP 1: CYCLE 2)

The emergency situation that was the result of the professional nurse practitioner shortages needed to be resolved urgently and this led to Cycle 2 of the AR for practitioners project (see Table 3.5). Actions were planned and implemented, and the actions and outcomes then observed and reflected upon.

Table 3.5: Step 1: Cycle 2: Address the barrier

Step	**Step 1: Initiating the journey**			**Step 2: Address the challenges**
Cycle	**Cycle 1**	**Cycle 2**	**Cycle 3**	
Timeframe	8 June 2005 to 22 November 2005	13 June 2005 *(continued throughout the project)*	17 August 2005	18 August 2005 to 22 August 2005
Objective	Establish a PDG	Address the barrier	Explore the challenges	Plan the journey forward

3.4.1 Actions planned and implemented

The shortage of nurse practitioners is a global concern, as practice leaders all over the world are faced with the same situation, with predictions that it will worsen in the future (Buchan 2002:751; Larkin 2007:162). The A&E unit has not escaped this global trend. The PDG realised that it was crucial to act immediately as the nurse practitioners' morale was low and they were leaving the A&E unit at a rapid rate, leading to increased frustration and decreased job satisfaction, which in turn compromised patient care (Strachota *et al*. 2003:111).

In designing an action plan, the PDG incorporated the actions suggested by the nurse practitioners (see Table 1.1) to indicate that their input was valued and to enhance their ownership of the AR for practitioners project. The actions planned included the recruitment of mainly professional nurse practitioners. It also involved the head of the department putting increased pressure on top management to listen to the complaints of the nurse practitioners expressed during the emergency meeting. The actions planned were to:

- Involve the practice leaders in:
  - suggesting potential agency professional nurse practitioners with whom they would want to work permanently in the A&E unit,
  - asking these agency professional nurse practitioners, who practically worked fulltime in the A&E unit as agency staff, whether they would consider accepting permanent positions, and
  - giving feedback to the nurse practitioners on a regular basis to keep them up to date on what actions had been taken and the outcomes thereof.
- Involve the researcher in:
  - asking the final year B Cur learners (who would be starting their two-year community service following the completion of their programme in November 2005) whether any of them were interested in working as professional practitioners in the A&E unit once they had completed their programme successfully – this process would be repeated annually to ensure that the A&E unit recruited young, enthusiastic practitioners, who have a passion for A&E nursing and are willing to enrol as A&E learners within two years of starting to work in the A&E unit.
- Involve the PDG and head of department in collaboratively writing letters to top management, indicating the concerns regarding the professional nurse practitioner shortages experienced in the A&E unit and the effect they have on the morale of the nurse practitioners and patient care. The names and contact details of professional nurse practitioners willing to work fulltime in the A&E unit would be provided with motivations for the appointment of the available candidates in fulltime posts.

The practice leaders and researcher recognised that resolving this barrier would be an opportunity to gain the trust of the nurse practitioners. If this barrier was addressed successfully, it would be an indication that the practice leaders' intent to create a future for the A&E unit was sincere. Once the nurse practitioners saw that the practice leaders were not only talking about possible actions, but had actually acted on their appeals and were serious about resolving the emergency situation, it might be easier to obtain their cooperation at a later stage when planning a collaborative effort to create a better future for the A&E unit. A great effort was therefore made to succeed with this initial stage of the action plan.

3.4.2 Observations

The practice leaders and researcher carried out the actions as planned. Three agency nurse practitioners and five BCur learners were given permanent posts as professional nurse practitioners in the A&E unit. By the end of November 2005, there were a total of 21 professional nurse practitioners working in the A&E unit, compared to 13 professional nurse practitioners in May 2005 (see Table 3.6).

The unit manager was informed by top management that once the A&E unit moved to the new hospital in February 2006, the orthopaedic A&E unit, which had functioned independently, would be merged with the A&E unit in the new hospital. This would lead to a further increase of nine permanent nurse practitioners of whom eight were professional nurse practitioners.

The immediate barrier of the professional nurse practitioner shortage in the A&E unit was resolved. By November 2005, the number of professional nurse practitioners had increased to a total of 21 and, by June 2007, a total of 29 permanent professional nurse practitioners were working in the A&E unit. However, the total number of nurse practitioners (48) in the A&E unit was only 74 per cent of the 65 nurse practitioners required (Van Niekerk 2007a). This shortage should, however, be viewed in context of the shortage of nurse practitioners experienced in all the units of the hospital (Van Niekerk 2007b).

The total number of practitioners working in the A&E unit remained 48 from February 2006 to July 2007. During this time, one professional nurse practitioner asked to be transferred to the critical care units, while another working in the critical care unit asked for a transfer to the A&E unit. Permission was obtained from middle management to exchange these two professional practitioners.

Table 3.6: Summary of total number permanent nurse practitioners working in the A&E unit (November 2003 – July 2007)

Nurse practitioners		November 2003	May 2005	November 2005	February 2006	July 2007
Practice leaders		1	2	2	2	2
Professional nurse practitioners		29	13	21	29	29
	Professional nurse practitioners	*18*	*8*	*16*	*20*	*17*
	A&E nurse practitioners	*6*	*2*	*2*	*4*	*6*
	A&E learners	*2*	*2*	*2*	*3*	*4*
	Critical care nurse practitioners	*0*	*1*	*1*	*1*	*1*
	A&E and critical care nurse practitioners	*2*	*0*	*0*	*1*	*1*
Enrolled and auxiliary nurse practitioners		15	16	16	17	17
Totals	**Practice leaders**	**1**	**2**	**2**	**2**	**2**
	Nurse practitioners	**44**	**29**	**37**	**46**	**46**
	Total	**45**	**31**	**39**	**48**	**48**
			←			→
			Project timeframe			

Two professional nurse practitioners (final year BCur learners) and one auxiliary nurse practitioner were appointed in January 2007. Two professional nurse practitioners then asked to be transferred to the critical care units and one auxiliary nurse was transferred to the wards as she wanted to continue her studies in order to become an enrolled nurse practitioner. The total number of nurse practitioners therefore remained unchanged. In Table 3.6, a summary of the total number of nurse practitioners from November 2003 until July 2007 is presented. As indicated in the table, there was, in most cases, a decline in permanent nurse practitioners in May 2005. However, since November 2005, a gradual gain in nurse practitioners was observed.

3.4.3 Reflection

The recruitment strategies specifically regarding the BCur learners were very successful and would be repeated annually. However, the recruitment of professional nurse practitioners was a short-term solution and, although it resolved the immediate emergency situation, it did not address the reasons these professional nurse practitioners had left. To find a long-term solution would be more difficult and was regarded as a challenge for the practice leaders and researcher.

Although the PGD was convinced that a collaborative effort by all the nurse practitioners working in the A&E unit, rather than individual efforts by the practice leaders, would result in the shared vision of emancipatory practice development, the exact action plan was still unclear. The emergency situation in which the A&E unit had found itself as a result of the nurse practitioner shortage was not a unique situation, but is also a global challenge (Buchan 2002:751). Practice leaders all over the world are faced with a shortage of nurse practitioners, with predictions that it will worsen in the future (Larkin 2007:162). Factors influencing these shortages include the migration of nurse practitioners from the public sector to private hospitals, and from developing countries to the more sophisticated first world countries – attracted by substantially higher wages (Buchan 2002:751).

The PDG was aware of these factors, but had little or no control over them. The only thing the PDG could control was what took place in the A&E unit. They were of the opinion that changing the environment from a toxic to an enabling environment could be a possible solution. In an enabling environment, the nurse practitioners would be valued for their knowledge, experience and input, and continuous learning would take place, which should result in increased levels of job satisfaction. This could contribute to nurse practitioner retention.

It was decided to use the NGT, as a proven and effective qualitative method for group inquiry, to obtain data to test these views (Zuber-Skerritt 2005a:45). This technique would be used, not only to enhance a sense of ownership amongst the nurse practitioners, but also to ensure that the nurse practitioners realised that their knowledge and experience in the environment were acknowledged and their input was valued. The outcomes of the NGM were used as the starting point for delineating an action plan that would focus on long-term rather than short-term solutions.

3.5 EXPLORE THE CHALLENGES (STEP 1: CYCLE 3)

Following the planning and implementation of short-term actions to resolve the immediate emergency situation and thus remove the barrier of the professional nurse practitioner shortage (Cycle 2), the PDG started focusing on possible long-term actions that could create an enabling environment. The practice developers realised the importance of including the nurse practitioners in the decision-making process and thus enhancing ownership of the project. Cycle 3 followed (see Table 3.7).

Table 3.7: Step 1: Cycle 3: Explore the challenges

Step	Step 1: Initiating the journey			Step 2: Address the challenges
Cycle	**Cycle 1**	**Cycle 2**	**Cycle 3**	
Timeframe	8 June 2005 to 22 November 2005	13 June 2005 *(continued throughout the project)*	17 August 2005	18 August 2005 to 22 August 2005
Objective	Establish a PDG	Address the barrier	Explore the challenges	Plan the journey forward

The PDG agreed that it was important to involve the nurse practitioners in diagnosing the contextually-related challenges with which they were faced in the A&E unit. This would enhance the nurse practitioners' ownership of the project and also contribute to a collective awareness, leading to the engagement in reflective discussion by the nurse practitioners and practice leaders in order to arrive at a means of addressing these challenges (Sturt 1999:1059). Awareness of the challenges could be regarded as the precursor to enablement (Wittmann-Price 2004:440). The NGT was used to enhance the awareness of the nurse practitioners.

The aim of the AR for practitioners project was not to purely follow the technical collaborative approach (involving intervention or theory testing) or the mutual collaborative approach (which involves researcher and participants identifying problems together, followed by mutually agreed upon action cycles). Its aim was to follow the enhancement typology described by Holter and Schwartz-Barcott (1993:298).

3.5.1 Actions planned and implemented

The practice leaders personally invited all the nurse practitioners working in the A&E unit on a permanent basis to the NGM and gave each participant a leaflet and informed consent form (see Annexure B.3). On 17 August 2005 at 08:00, the NGM was held in a lecture room in the A&E unit. It was regarded as the first step taken in the collaborative effort to finding a long-term solution to creating a better future for the A&E nurse practitioners.

The steps as summarised in Table 2.5 were used to guide the NGM. The findings are explained in detail in Section 3.5.2.

3.5.2 Observations

Fourteen practitioners (45% of the total population) volunteered to participate (see Table 3.8) in the NGM. All the categories of nurse practitioners, with varying qualifications and levels of expertise, were represented as indicated in Table 3.8. This was indicative of the willingness of the nurse practitioners to give their views on the challenges experienced in the A&E unit and share their knowledge and expertise with the practice leaders and researcher.

Table 3.8: Profile of participants in the nominal group meeting

Qualification	Population	Sample
Practice leaders (unit managers)	1	0
Professional nurse practitioners	15	11
Professional nurse practitioners with no additional qualification	*8*	*4*
A&E nurse practitioners	*2*	*2*
A&E learners	*2*	*2*
Critical care nurse practitioners	*1*	*1*
A&E and critical care nurse practitioners	*1*	*1*
Clinical facilitators (practice leaders)	*1*	*1*
Enrolled and auxiliary nurse practitioners	16	3
Total	**31**	**14**

Fourteen participants, a facilitator (researcher) and the two independent expert research consultants were involved in the data collection during the NGM. Two independent expert research consultants conducted the fieldwork. They took field notes and ensured that the technique was followed step by step, as this was the researcher's first attempt at facilitating the NGT. During Step 7 (see Table 2.5), the two independent researchers assisted the facilitator in calculating the ranked scores given to each item and produced the final ranked list of priorities.

The NGM was held in a quiet room with a black board. The chairs were organised in such a way that all the participants faced the black board and were able to see one another. The facilitator set the mood for the group by creating a non-threatening, warm, accepting, enthusiastic and objective environment, which encouraged all the participants to share their views.

In her opening remarks, the facilitator extended a hearty welcome to all the participants, thanking each one for his/her willingness to participate. The fieldworkers were introduced and an overview of the topic and outline of the purpose of the research and NGM provided. The eight steps of the NGT were provided to each participant and discussed briefly. The participants were allowed to ask questions regarding the study and/or NGM.

The focal question was written on the black board:

In your view, what are the challenges in the A&E unit that need to be overcome in order to create a future for you as nurse practitioner working within the unit?

Five themes, with subsequent categories, clusters and sub-clusters were identified during the NGM. The five themes, in order of priority, were:

- Priority 1: Professional development
- Priority 2: Patient care
- Priority 3: Structure
- Priority 4: Equipment

o Priority 5: Research

A schematic overview of each priority is presented in the following sections of this chapter, indicating the main themes, categories, clusters and sub-clusters obtained during the NGM. It is then discussed in detail as was expressed by the participants.

3.5.2.1 Priority 1: Professional development

Overall, professional development was viewed as the most important challenge that had to be addressed to create a future for the nurse practitioners in the A&E unit. All the participants, except the clinical facilitator (who voted for structure as Priority 1), voted that professional development was the first priority that needed to be addressed (see Annexure D). Each category, cluster and sub-cluster is discussed based on the views of the nurse practitioners who attended the NGM.

In Figure 3.3, the overview of Priority 1 (professional development) is given. From the figure, it is evident that three categories were identified, namely knowledge and skills, attitudes and values, and socialisation. These categories and subsequent clusters and sub-clusters are discussed in Section a to c.

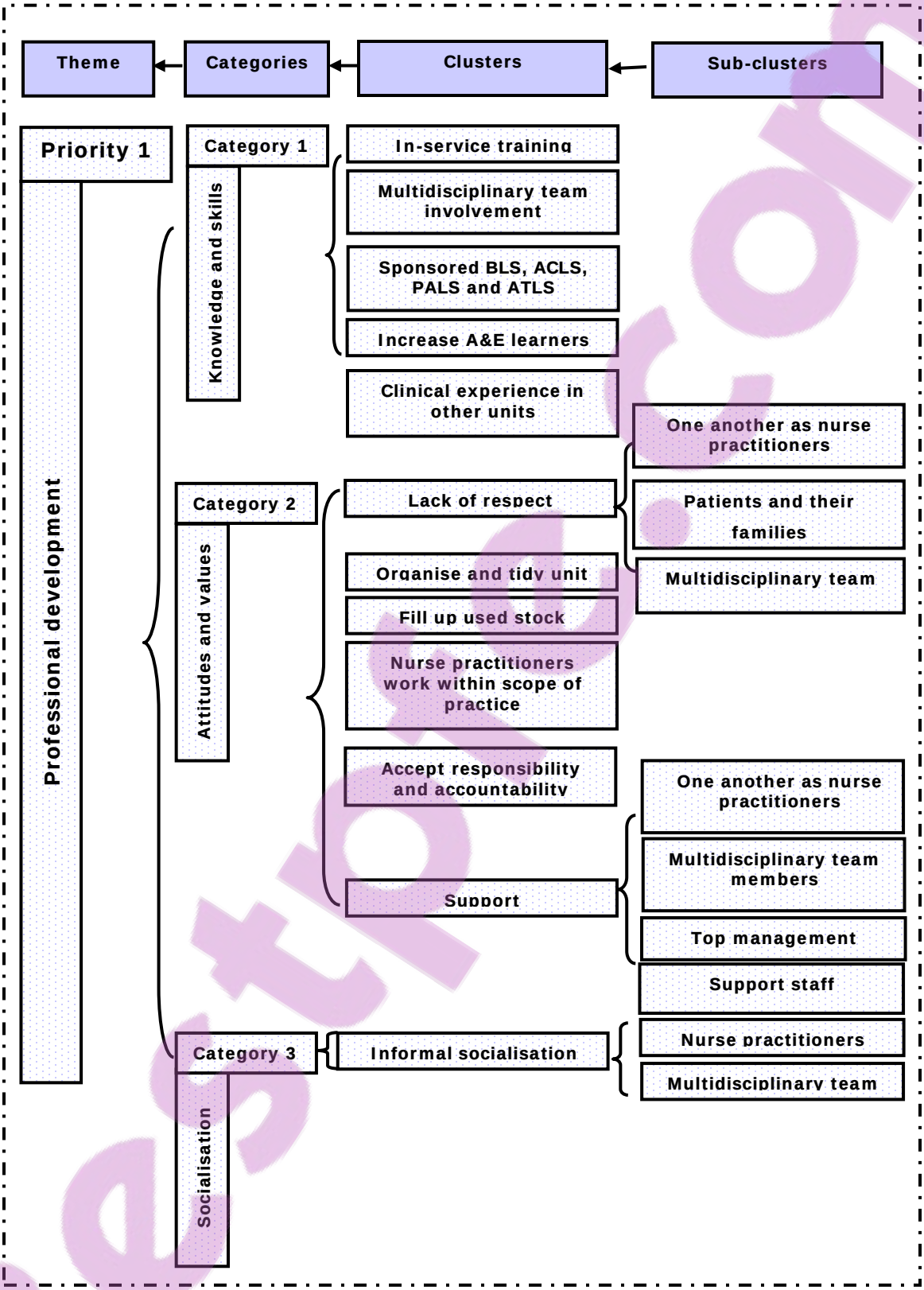


Figure 3.3: Overview of Priority 1 (Professional development)

a) Knowledge and skills

The participants expressed an urgent need for professional development. They stated that, in order to create a future for the nurse practitioners, it was important that their current basis of knowledge and skills be improved upon by means of an in-service training programme.

The participants stated that their knowledge and skills were neither up to date nor up to standard. The participants stated that it was of the utmost importance that they should be "*kept up to date*" and "*empowered*" on a continuous basis as this would lead to improved patient care. They suggested that there should be an in-service training programme to keep their knowledge and skills up to date. They also indicated that they would prefer the in-service training not only to be done by the nurse practitioners, but also by other members of the multidisciplinary team and specifically the doctors working permanently in the A&E unit.

The participants requested that the hospital provide sponsorship to attend the Basic Life Support (BLS), Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS) and Paediatric Advanced Life Support (PALS) courses. These courses are recognised international courses and are provided by various companies and individuals. The doctors working in the A&E unit were sponsored and, in many cases, nurse practitioners working in the private hospitals are sponsored by their hospitals. They stated that both the nurse practitioners and patients would benefit from these actions.

One of the major concerns was that only one or two of the professional nurse practitioners working in the A&E unit enrolled annually for the A&E programme. It was regarded as an important speciality and the participants indicated that the A&E nurse practitioners played an important role in patient management in the A&E unit. The participants asked that more professional nurse practitioners should be encouraged to enrol for the A&E programme. The reason provided for the low enrolment rate for the A&E programme in the A&E unit was that, once qualified, the A&E nurse practitioners were not valued and did not have additional status in the A&E unit.

The general perception of the participants was that the A&E nurse practitioners were not acknowledged as clinical specialists because nobody working in the A&E unit knew what additional knowledge and skills they had. Another reason was that there was no financial gain for the nurses once qualified as A&E nurse practitioners. They felt that it was not worth their while to enrol for the A&E programme, as it was costly and they received no recognition for it in the A&E unit.

Professional nurse practitioners that specialise in either theatre nursing or critical care nursing receive scarce skills remuneration once qualified. This was not the case for the A&E practitioners, although negotiations were ongoing within the hospital. The group agreed that the issues pertaining to scarce skills payment were being investigated and negotiations were going on within the hospital. It was therefore not an item that should be included in this study, as it was beyond the control of the individuals in the A&E unit. One of the professional nurse practitioners working in the A&E unit was involved in the negotiations and stated that he would provide feedback to the nurse practitioners on a regular basis.

The participants requested that they be given opportunities to work in other units, such as an ICU or ward, in the hospital. The participants indicated that ICU patients were nursed in the A&E unit due to shortages of ICU beds in the hospital. Their stay in the A&E unit varied from 4 hours to 14 days (The Hospital 2007b). It would therefore be worthwhile for the nurse practitioners to work in the ICU for additional experience and to promote patient care once they returned to the A&E unit.

b) Attitudes and values

One of the main issues of concern was respect. This included a lack of respect for one another and a lack of respect for nurse practitioners by the multidisciplinary team members working in the A&E unit. The participants indicated that the nurse practitioners did not always show respect to patients and their families visiting the A&E unit. Patients were often treated with disrespect, for example when nurse practitioners shouted at them for going to the A&E unit for treatment rather than the outpatients department. The participants also regarded the fact that the nurse practitioners' knowledge and skills were not up to date as a lack of respect for the patients' right to optimal care.

Families were often rudely prohibited from quickly seeing a patient in the A&E unit. Although this was done because the A&E unit was busy, the participants still felt that this was unacceptable, as the families had a right to visit their loved ones. Patients' families were also not involved in discussions regarding their management in the A&E unit or kept up to date with their health status. The participants stated that nurse practitioners should pay more attention to the families and treat them with respect. The patients and their families were clients of the A&E unit and deserved the respect of the nurse practitioners.

One of the concerns that was mentioned was the fact that the nurse practitioners did not ensure that used stock was adequately replaced. This made it very difficult to manage the patients adequately and effectively, as the nurse practitioners had to look for equipment or stock in the midst of managing the patients. This was time-consuming and led to frustration – not only for the nurse practitioners, but also for other members of the multidisciplinary team. In order to be able to work effectively, it was important that the A&E unit be kept neat and tidy and that the used stock was replaced at regular intervals. This should be the responsibility of all the nurse practitioners working in the A&E unit.

Because there were different categories of nurse practitioners working in the A&E unit, the participants regarded it as important that not only the nurse practitioners, but also the doctors know the scope of practice of each category of nurse practitioner. This would ensure that the doctors did not expect nurse practitioners of the lower categories to perform tasks beyond their scope of practice. On the other hand, it is also important that the nurse practitioners are able to indicate that a task is beyond his/her scope of practice if asked to perform a specific task. This signifies the importance of accepting responsibility and accountability for the work one does.

Participants regarded support in the A&E unit as being of the utmost importance. For example, nurse practitioners should show support for one another by ensuring that the A&E unit is tidy and the stock filled up before going off duty. This shows not only respect, but also support for fellow workers by enabling them to perform their tasks when they come on duty.

Support was also referred to when problem-solving issues were discussed. The nurse participants expressed the importance of top management acknowledging the problems that are experienced in the A&E unit and then attending to these problems instead of ignoring them. They indicated that it was unjust for the other members of the multidisciplinary team and top management to ignore the situation in the A&E unit and blame the remaining nurse practitioners for the problems. Without the support of the multidisciplinary team members, top management and support staff, working in the A&E unit becomes very difficult. Everybody should have one goal in mind: to ensure high-quality patient care. High-quality patient care can only be achieved if everybody works as a team and supports one another.

c) Socialisation

The participants indicated that there was inadequate informal socialisation amongst the nurse practitioners as well as amongst the multidisciplinary team members.

3.5.2.2 Priority 2: Patient care

Patient care was voted as the overall number two priority. The auxiliary nurse practitioners, however, regarded equipment as the second priority. This could be because they use the equipment, specifically equipment pertaining to monitoring vital signs, on a regular basis.

In Figure 3.4, the overview of Priority 2 (patient care) is given. From the figure, it is evident that six categories were identified, namely nurse practitioners, improved basic patient care, patient education, decreased patient waiting times, psychiatric patients and pharmacy. These categories and subsequent clusters and subclusters are discussed in Sections a to f.

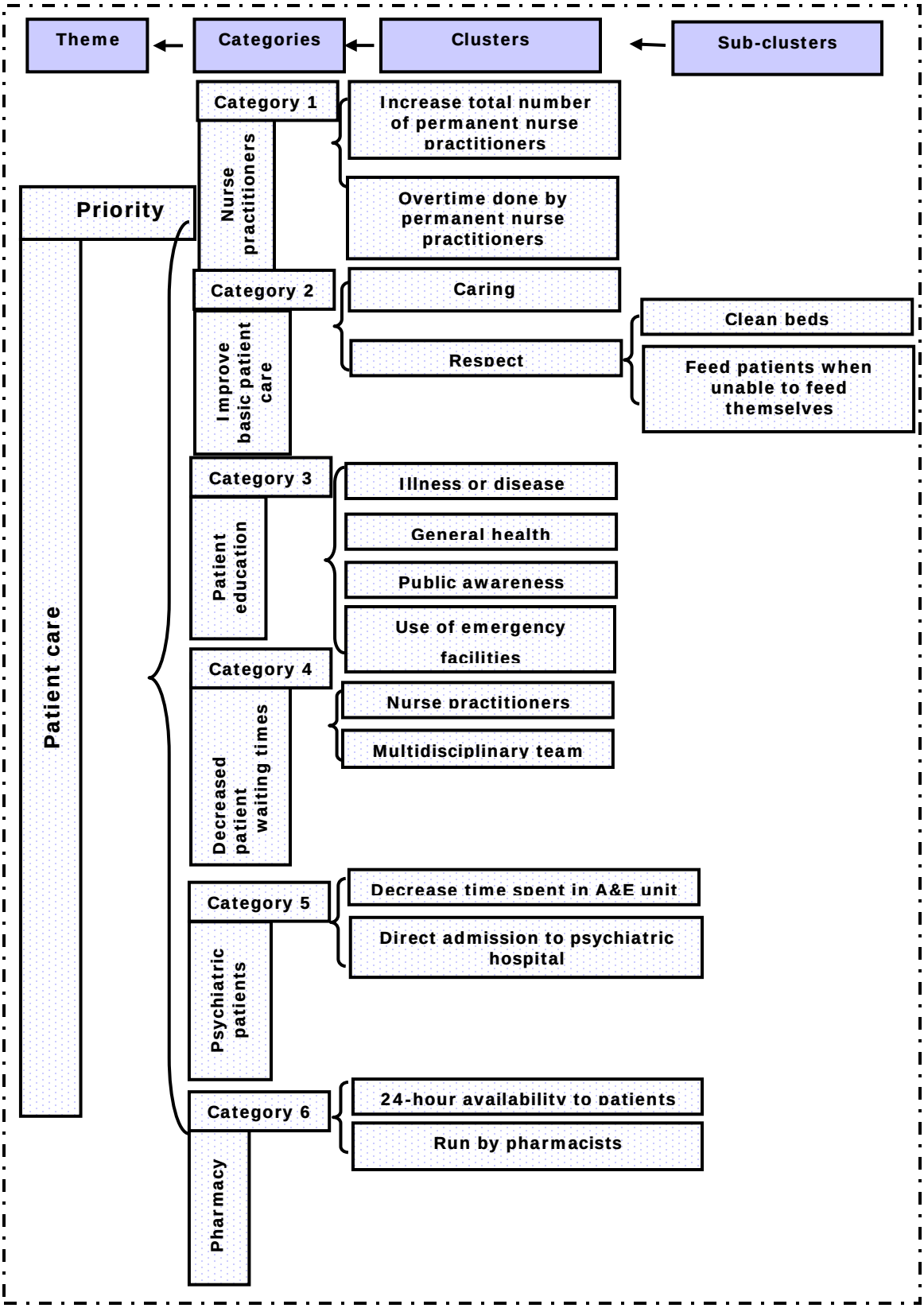


Figure 3.4: Overview of Priority 2 (Patient care)

a) Nurse practitioners

Optimal patient care cannot be delivered in the A&E unit if there is a shortage of nurse practitioners. The shortages experienced in the A&E unit increased the stress and workload of the permanent nurse practitioners. Although agency nurse practitioners were used, these nurse practitioners did not accept responsibilities such as keeping the A&E unit neat and tidy, and filling up the used stock. The participants indicated that they felt frustrated and realised that these agency nurse practitioners were just there for the day to earn additional income.

Participants suggested that the permanent nurse practitioners should be given preference to work overtime if additional staff is needed. One of their motivations for this was that these permanent nurse practitioners know the A&E unit. This would decrease the responsibilities, stress and frustration of not only the nurse practitioners, but also the multidisciplinary team members and support staff in the A&E unit. There would then be fewer complaints in general, and patient care and the general functioning of the A&E unit would improve.

b) Improve basic patient care

The issues of concern regarding adequate patient care mentioned by the participants included a lack of caring and individualised patient care. The participants indicated that it was as if the nurse practitioners came to work merely to receive a salary. They neglected one of the main functions of a nurse practitioner - "*caring for patients and their families*".

The nurse practitioners did not take the individual patients' needs into consideration when managing them. Their basic needs, such as a clean and tidy bed, were often neglected. Patients who were unable to feed themselves were often not assisted with eating. The participants regarded a focus on the basic needs of patients, and not only on advanced management knowledge and skills, as important and something that should not be neglected.

c) Patient education

The participants indicated that patients do not know that only emergencies are managed in the A&E unit. Patients therefore come to the A&E unit for minor problems, which should actually be managed at the outpatients department. The

participants were of the opinion that the community should be educated in this regard. This would decrease the number of triages as well as the referrals to clinics and the outpatient department. The patients would then understand why they are asked to seek alternative options and cannot be managed in the A&E unit. This will decrease patient dissatisfaction and aggression towards the nurse practitioners.

Patients are often managed in the A&E unit and then discharged with a prescription for medication. If a patient is asked what his/her diagnosis is, the patient often does not know. This implies that neither the nurse practitioners nor the doctors inform patients about their illnesses.

The nurse practitioners should also increase the public's awareness concerning certain issues, such as the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), diabetes, asthma, hypertension and tuberculosis. The participants suggested that the nurse practitioners provide the patients and their families with this information while they are waiting for a doctor in the A&E unit. Different approaches could be used, including pamphlets, videos and posters. The information should be available in different languages to ensure that the patients and their families understand and can benefit from it.

d) Decrease patient waiting times

Patient waiting times were a big concern for the participants. The time patients spend waiting for doctors or specialists should be limited.

e) Psychiatric patients

Psychiatric patients who are admitted to the A&E unit pose challenges to the nurse practitioners. These patients are admitted and spend two days in the A&E unit for observation before being transferred to a relevant facility. While being observed in the A&E unit, they often escape and the nurse practitioners are blamed. The participants indicated that they felt that this was unfair, as they could not be expected to look after these patients in such a busy A&E unit. The participants suggested that these patients be admitted to wards where they could be observed under more stable conditions.

f) Pharmacy

The hospital pharmacy closes at 16:00. If patients require prescribed medication after 16:00, the nurse practitioners are expected to dispense this from a medicine store located in the A&E unit. The participants were concerned that the nurse practitioners did not have adequate knowledge and skills to do this and that it further increased their workload. The participants felt that the hospital's pharmacy should be open for patients from 0:00 to 24:00.

3.5.2.3 Priority 3: Structure

Structure was voted as the third priority that needed to be addressed. In Figure 3.5, the overview of Priority 3 (structure) is given.

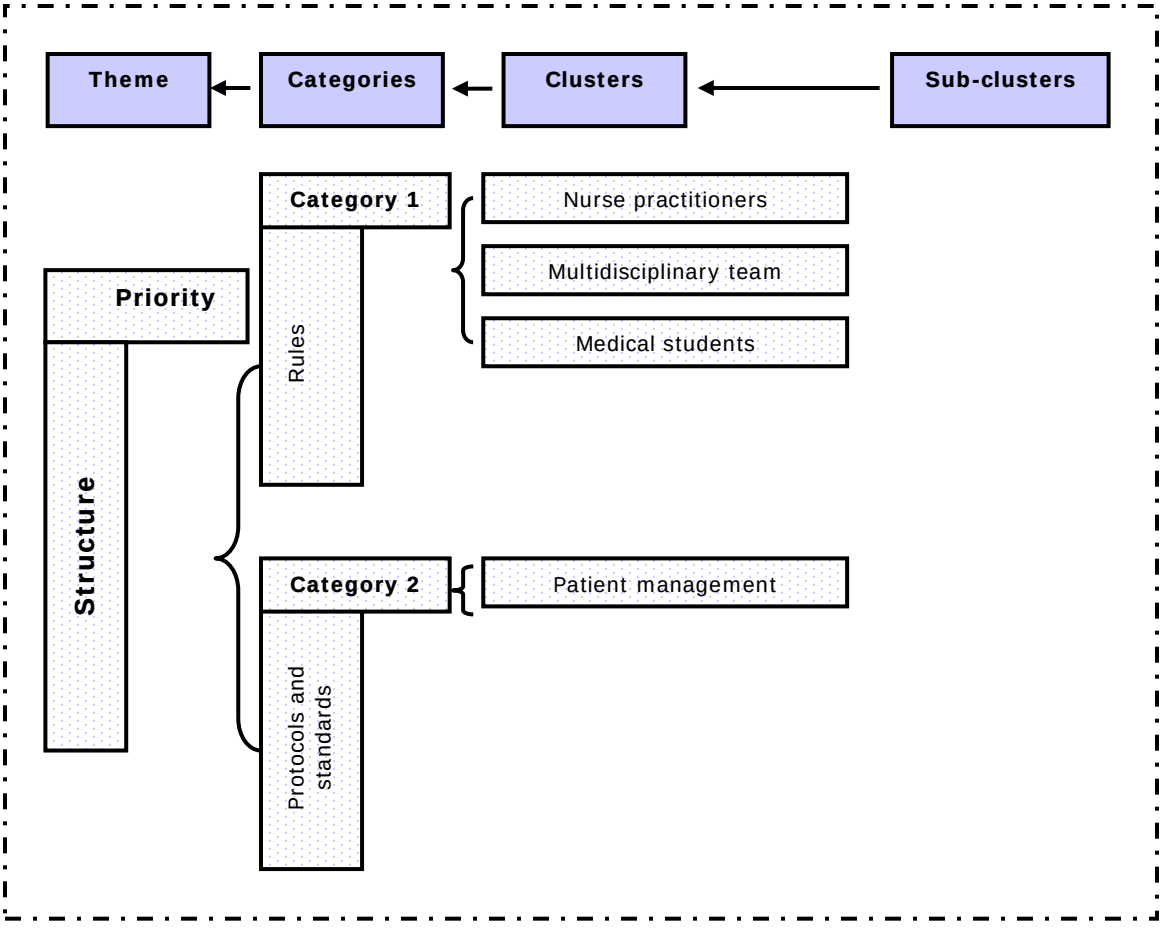


Figure 3.5: Overview of Priority 3 (Structure)

From the figure, it is evident that two categories were identified, namely rules, and protocols and standards. These categories and the subsequent clusters and sub-clusters are discussed in Sections a and b.

a) Rules

The participants explained that there were no fixed rules in the A&E unit. This meant that the nurse practitioners could do what they wanted to do. The specific examples given were of lunch and tea breaks. Each nurse practitioner could decide when he/she wanted to take a break for lunch or tea, without asking anybody's permission. Some of the nurse practitioners would disappear for long periods of time and, when confronted about this, say that they were on lunch or tea. On busy days, this would mean that some of the nurse practitioners took long breaks while others did not have an opportunity to take a break at all. This frustrated some of the nurse practitioners who felt it was unfair and that it had a negative impact on patient care.

The participants indicated that there were also no fixed rules pertaining to the multi-disciplinary team members and the medical students.

b) Protocols and standards

According to the participants, there were no protocols and/or standards visible in the A&E unit. The participants felt that guidelines that are in-line with evidence based practices should be available to guide the nurse practitioners in their daily actions and patient management. These protocols and standards would assist not only the nurse practitioners, but also the doctors, by ensuring that everybody in the A&E unit knows what the guidelines are and patients receive the best possible management.

The participants stated that without these basic protocols and standards, optimal patient care could not be provided as each nurse practitioner and doctor did what they thought was right, resulting in the inappropriate management of some patients.

3.5.2.4 Priority 4: Equipment

Equipment was voted as the fourth priority. In Figure 3.6, the overview of Priority 4 (equipment) is given. From the figure, it is evident that two categories were

identified, namely available equipment and lack of equipment. These categories and subsequent clusters and sub-clusters are discussed in Sections a and b.

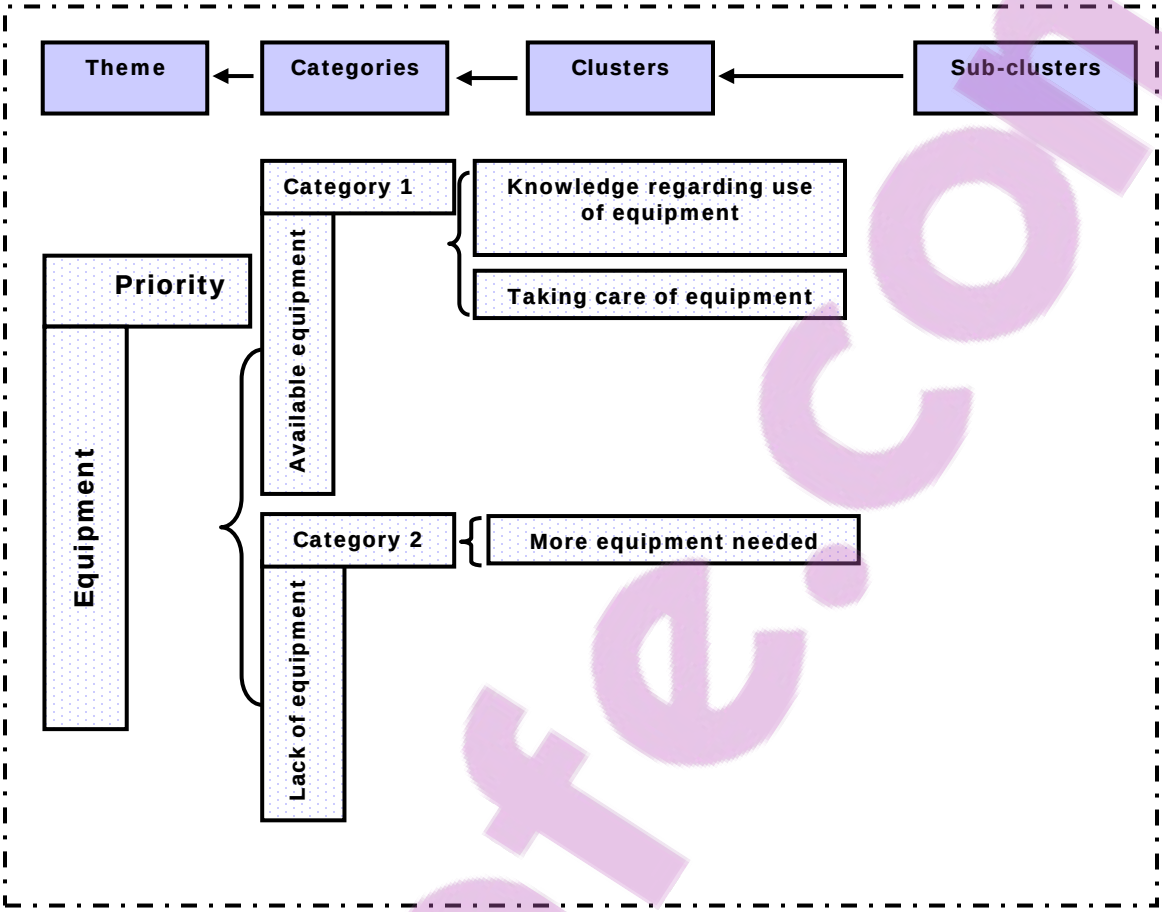


Figure 3.6: Overview of Priority 4 (Equipment)

a) Available equipment

The participants were concerned that there was not enough equipment available to manage the number of patients admitted to the A&E unit. They also expressed their concern about the lack of knowledge the nurse practitioners had regarding the effective use of the equipment and the lack of care the nurse practitioners took of the available equipment. This resulted in broken equipment which was unavailable for use in patient management. Although on paper it seemed that the A&E unit was well equipped, some pieces of equipment were either not working or sent in for repair.

b) Lack of equipment

The participants stated that the A&E unit needed more equipment. The participants felt frustrated at not having enough mechanical ventilators and monitors to monitor the vital signs of the number of seriously ill patients admitted to the A&E unit. This meant that patients sometimes had to share monitors and the continuous monitoring of the seriously ill patients could not always be realised.

3.5.2.5 Priority 5: Research

The fifth priority identified during the NGT was research. In Figure 3.7, the overview of Priority 5 (research) is given. From the figure, it is evident that one category was identified, namely practice. The participants argued that although patient statistics were calculated in the A&E unit, the nurse practitioners were not aware of their significance. The participants stated that the statistics should be available to all the nurse practitioners as it would be interesting to have an idea of how many patients were managed in the A&E unit every month as well as the different types of accidents and emergencies that were managed.

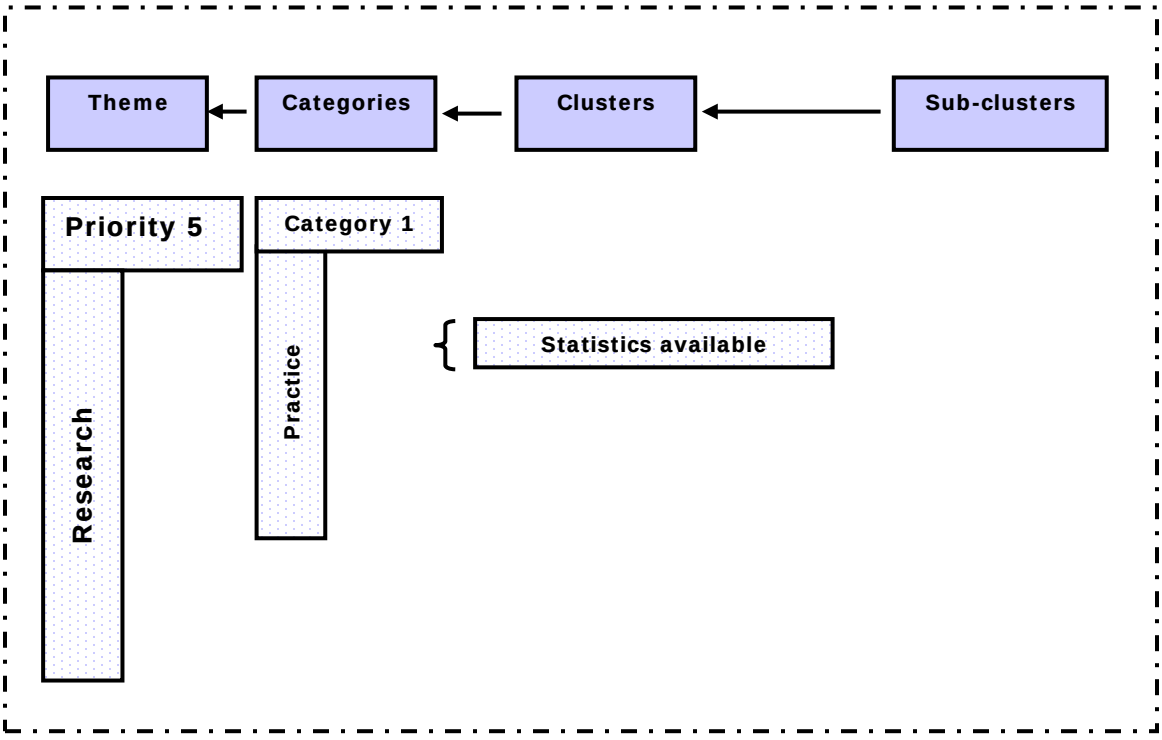


Figure 3.7: Overview of Priority 5 (Research)

3.5.3 Reflection

The NGM was a positive and great experience. I did not expect the nurse practitioners attending the meeting to be so positive and excited about the efforts made by the PDG to initiate the project. I came to realise that they too not only wanted to resolve the challenges for their own gain and advantage but also regarded the patients and their families' care as one of the most important challenges and concerns. Patient care was the central theme addressed throughout all five of the priorities, as professional development, patient care, structure, equipment and research could all be related to patient care and the optimal management of the patients in the A&E unit.

The NGM was a data collection technique formally planned by the PDG. It was not only used to explore and describe the challenges perceived by the nurse practitioners, but also regarded as a precursor to change. Through the process of critical reflection between the practice leaders and the researcher, the researcher raised awareness of the cultural norms and conflicts that contributed to the identified challenges. Through this consciousness raising experience, "praxis" emerged and the practical situation could be addressed in a more meaningful and emancipated manner (Sturt 1999:1059).

By establishing what the nurse practitioners regarded as priorities, the PGD could make it possible to draw up an action plan that would not only resolve the prioritised challenges, but also create a better future for the A&E unit and form part of a long-term solution.

Actions to ensure long-term solutions needed to be planned and implemented. At this stage, it was evident that changes regarding the second barrier that was diagnosed, the toxic environment, were essential. The actions, which focused on environmental changes, could be regarded as long-term solutions as they entailed creating an enabling environment that would increase job satisfaction and enhance the retention of the nurse practitioners. Step 3 included the planning of actions to change the toxic environment to an enabling environment as well as overcoming additional challenges, highlighted by the nurse practitioners, in order to create a future for the nurse practitioners working in the A&E unit (see Figure 2.2).

The actions planned in the A&E unit came from visionary input from the PDG, who recognised the emergency situation in the A&E unit as an opportunity and took on the responsibility to act (Thompson & Martin 2005:16). Action plans were regarded as strategies that could be seen as "means to ends". As there was no right answer or single doctrine which satisfied everyone's views (Thompson & Martin 2005:8), the actions planned by the PDG were based on the input of

the nurse practitioners obtained during the emergency meeting and NGM, a literature review, knowledge obtained by the unit manager when enrolled in a management programme and on the best intentions of the PDG. The actions planned were related to the pursuit of the collective aim of the PDG – to create a better future for the nurse practitioners working in the A&E unit – and were discussed and negotiated with the nurse practitioners before being implemented.

The PDG reflected on the data gathered from both the emergency meeting and NGM. Actions were planned to resolve the immediate barrier of professional nurse practitioner shortages. By doing this, immediate support was given to the nurse practitioners to accomplish their daily tasks in the A&E unit. Another reason why it was important to address the shortage was that the main function of the A&E unit remained patient care. Working with a group of nurse practitioners who are negative as well as a shortage of professional nurse practitioners, made rendering optimal patient care impossible. The nurse practitioners needed immediate support and this could only be provided if additional professional nurse practitioners were appointed.

As discussed, the A&E unit was regarded as a toxic environment where no learning took place. The nurse practitioners worked without being acknowledged for their experience, knowledge and input, and were not appreciated, supported or involved in decisions made in the A&E unit (see Section 1.2). Thus, the diagnosis of a toxic environment was made and it was decided that this environment needed to be changed.

3.6 ADDRESS THE CHALLENGES (STEP 2)

During Step 2, the PDG planned the journey forward by using reflection and mind mapping in their group discussions (see Table 3.9).

Table 3.9: Step 2: Address the challenges

Step	**Step 1: Initiating the journey**			**Step 2: Address the challenges**
Cycle	**Cycle 1**	**Cycle 2**	**Cycle 3**	
Timeframe	8 June 2005 to 22 November 2005	13 June 2005 *(continued throughout the project)*	17 August 2005	18 August 2005 to 22 August 2005
Objective	Establish a PDG	Address the barrier	Explore the challenges	Plan the journey forward

The journey was designed by planning actions that would guide the changes in the A&E unit. Change was reflected by the selection of the different components of the journey, their implementation and observing the progress (Thompson & Martin 2005:22-24).

Mind mapping is an adjunct to learning (McAleese 1999:351) and draws on the same processes as reflection (McAleese 1998:251). It was used to provide a general overview of the actions planned for a way forward as negotiated and agreed upon by the PDG (see Figure 3.1). The PDG agreed upon the outcomes that would indicate that the journey had been successful. Then, actions were planned for each of the challenges expressed during the NGM. The outcomes and the actions pertaining to the overall journey as well as those aimed at addressing the challenges were discussed and negotiated with the nurse practitioners. Once consensus was reached, the journey continued.

The nurse practitioners agreed to these actions, but raised concern about acknowledgement of their individual inputs and efforts during the project. The nurse practitioners suggested that each nurse practitioner should "*have a portfolio in which they could indicate their inputs in the A&E unit"*. Consensus was reached that the portfolio could then be used during professional performance management to determine annual bonuses. This would not only motivate the nurse practitioners to increase their productivity, but also increase the fairness of performance management. This suggestion was agreed upon and included in the action plans (see Table 3.10 and Chapter 5 and 6).

3.6.1 Overview of the change planned

The PDG reflected on and reached consensus regarding the outcomes that would indicate the success of the journey. The outcomes agreed upon were:

o Insider evaluation:

- resolve the barrier of professional nurse practitioner shortages (short-term),
- change the toxic environment to an enabling environment (long-term),

- address the challenges experienced in the A&E unit to such an extent that the majority of the nurse practitioners regarded these challenges as resolved (short-term),
- create an emancipatory practice development culture (long-term), and
- retain the nurse practitioners.

o Outsider evaluation:

- obtain positive feedback from the A&E learners regarding the A&E unit as a learning and supportive environment, and
- obtain an average of 75 per cent or more by the Accreditation Committee of the Gauteng Department of Health on their next visit to ensure the accreditation status of the A&E unit.

The PDG reflected on and drew a mind map of the overall framework for the actions planned based on the set criteria (see Figure 3.8). The initial actions focused on professional development that would enhance the enablement of the practice leaders as well as the nurse practitioners. The opinion of the PDG was that, through enablement, change in the practice would follow. In order to support the nurse practitioners, emphasis was also placed on changing the environment from a toxic environment to an enabling environment.

The components of the mind map (see Figure 3.8) were:

o **Environment:** The toxic environment diagnosed during the emergency meeting and NGM needed to be changed to an enabling environment in order to reach the shared vision of 'emancipatory practice development'. The practice leaders envisioned creating an enabling environment through CPD and leadership development. The PDG also aimed to create an appreciative and supportive work environment, where every nurse practitioner was valued for his/her experience, knowledge, skills, suggestions and input. Support would be made available to the nurse practitioners in both their professional and personal capacity. Such an environment would be more likely to foster the nurse practitioners' commitment as well as the increased performance needed for the successful resolution of the emergency situation and the creation of a better future for the A&E unit. This included creating a -

o **Learning environment:** Knowledge is regarded as a vital asset and therefore the advancement and improvement of learning and knowledge in the A&E unit

were primary objectives of the project to guide change. Learning is a basic human need and therefore formed the main pillar on which the action plans were built. Principles of adult learning, including facilitative teaching, experiential learning and reflection, are used in a learning environment.

- **Enabling environment:** Learning can only take place in an enabling environment. Enabling is a process initiated by awareness. This process is followed by empowerment and emancipation.
- **Appreciative work environment:** The PDG felt it was important to create a positive work environment, in which every nurse practitioner could feel valued and appreciated. In this environment, the nurse practitioners are acknowledged for their inputs and successes celebrated. Such an environment would be more likely to foster the commitment and performance needed for the success of the project.
- **Supportive environment:** Professional and personal support would be provided in the A&E unit. Professional support would be provided by making the practice leaders available to enable the nurse practitioners and to assist them with specific tasks when required. Pastoral services, including both psychologists and pastoral psychologists, were appointed to further support the nurse practitioners both professionally and personally, if required.
- **PDG:** The PDG consisted of the practice leaders and researcher. The researcher facilitated the action process as well as the enablement of the unit manager and clinical facilitator, who in turn facilitated the enablement of the nurse practitioners.
- **Nurse practitioners:** The practice leaders facilitated the enablement of the nurse practitioners. As the nurse practitioners were regarded as adult learners, strategies focusing on adult learning principles were used to facilitate enablement. These strategies include experiential learning and reflection.
- **Challenges:** The challenges were addressed by means of collaboration between the practice leaders and nurse practitioners. The predicted outcomes were resolving the emergency situation and challenges.
- **Enablement**: The PDG envisioned a change in the responsibilities of the practitioners. This included enablement and empowerment not only with regard to patient care (professional development), but also with regard to shared leadership and teamwork (leadership development).

- **Job enrichment**: By involving the nurse practitioners in the action process, there was a move away from the purely task-based nature of the nurse practitioners' practice to the development of an adult learning culture, in which the nurse practitioners were included in the decision-making processes, the planning of actions to enhance their practice and the evaluation of these actions. This would lead to their enablement and empowerment, and enhanced job satisfaction. Also, by improving the corporate image of the A&E unit through practice development, nurse practitioners would be retained and attracted to work in the unit, thus improving the future of the practitioners in the A&E unit. Practice development in a learning environment was therefore used as the theoretical framework for creating the action plan.
- **Nurse practitioner retention**: Changing the toxic environment to an emancipatory environment, resolving the emergency situation and challenges experienced by the nurse practitioners and focusing on enablement, was aimed at job enrichment, which in turn would enhance the retention of professional nurse practitioners.
- **Practice development:** Practice development in health care comprises various strategic initiatives to continuously develop the quality of the patients' healthcare experiences as well as the professional development of the practitioners who provide the service (McCormack *et al.* 1999:255). Although the primary purpose of practice development is to increase the effectiveness of patient-centred care (Garbett & McCormack 2004:25), this was not the main aim of this research. It was considered a result of the project and remained a central value throughout the study.

The mind map was used as a tool to direct the action plans of the practice leaders. The realisation and outcomes of the actions planned by the unit manager and clinical facilitator are discussed in Chapter 4 and 5 respectively.

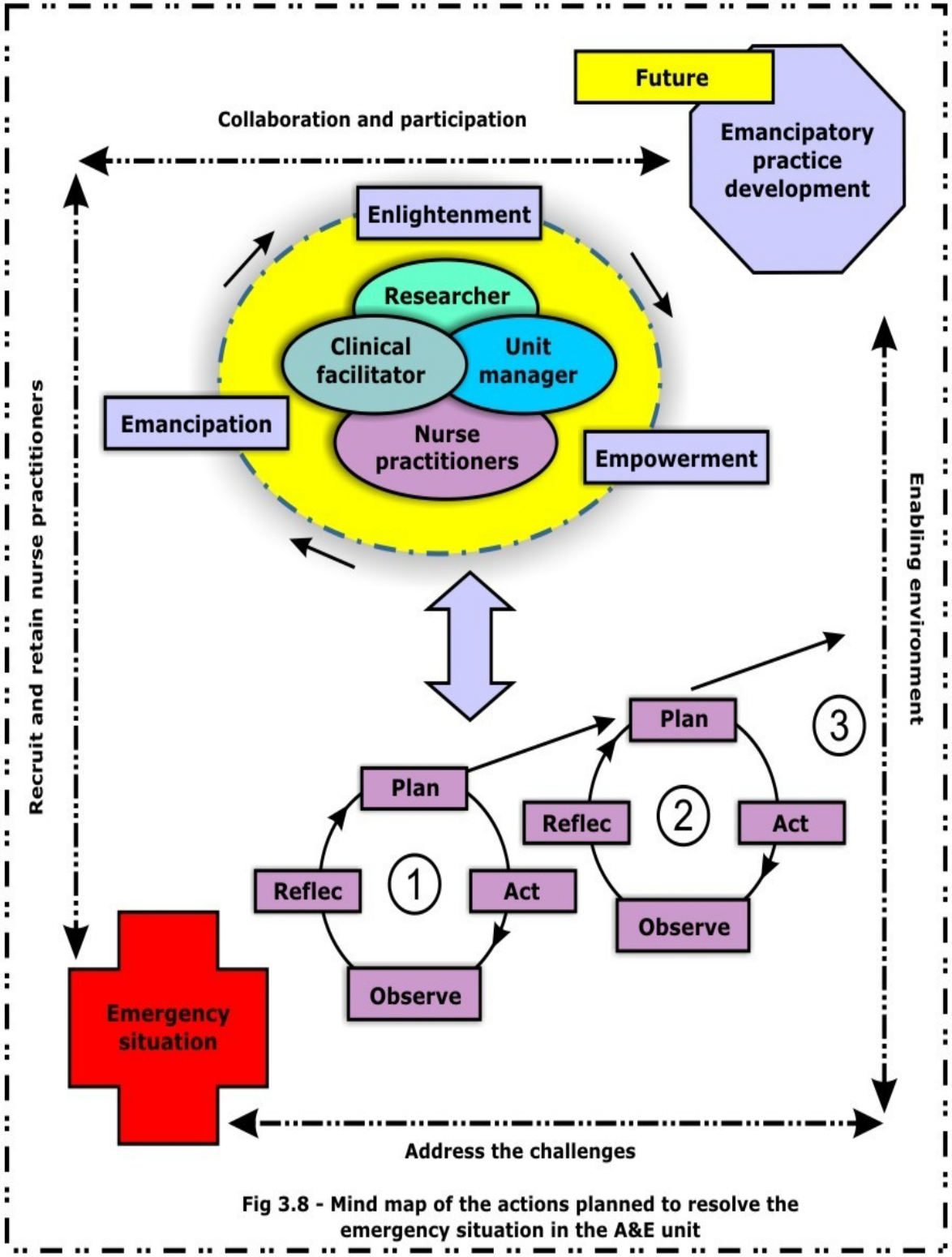


Fig 3.8 - Mind map of the actions planned to resolve the emergency situation in the A&E unit

3.6.2 Overview of the actions planned

On 18 August 2005, the PDG reflected on the findings obtained during the NGM. These findings as well as the additional suggestion by the nurse practitioners of making use of a portfolio were used by the PDG to plan actions that could potentially resolve the challenges and change the toxic environment to an enabling environment. The PDG planned specific actions and the practice leaders negotiated who would take the responsibility for implementing the planned actions. A summary of these actions and the outcome of the negotiations are tabulated in Table 3.9.

Table 3.10: The journey forward: challenges and specific actions planned

Priority 1: Professional development		**Responsibility**	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
Knowledge and skills - Professional development programme	- Initiate a CPDP	√	
- Multidisciplinary team involvement	- Involve the multidisciplinary team members in the CPDP	√	
- Sponsored BLS, ACLS, PALS and ATLS attendance	- Collaborate with head of department, and then discuss and negotiate sponsors with top management for these courses		√
- Increase number of A&E learners	- Promote the programme by informing the professional nurse practitioners about the content and outcomes of the programme - Involve the A&E nurse practitioners in the CPDP	√ √	
- Clinical experience in other units	- If requested by nurse practitioners, discuss and negotiate with middle management		√

Challenges	Actions planned	Clinical facilitator	Unit manager
Attitudes and values - Lack of respect For one another as nurse practitioners From the multi-disciplinary team members For patients and their families	- Re-enforce attitudes and values during monthly meetings - CPD to enhance enablement - Role modelling	 √ √	 √ √
- Organised and tidy A&E unit	- Implement daily ward rounds and monitor		√
- Fill up the used stock	- Implement daily ward rounds and monitor		√
- Nurse practitioners work within scope of practice	- Implement daily ward rounds and monitor - Focus on scope of practice during the in-service training programme	 √	√
- Accept responsibility and accountability	- Portfolio development and performance management - Participative management principles Shared leadership Teamwork (*These actions were only to be implemented following the move of the A&E unit to the new hospital*)		√ √

Priority 1: Professional development (*continued*)		**Responsibility**	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
- Support Each other as nurse practitioners Multi-disciplinary team members, support staff Top management	 - Re-enforce this value during monthly meetings - Role modelling - Monthly meeting with multidisciplinary team members and support staff - Request support from top management when need arises, instead of waiting for support	 √ 	 √ √ √ √

Challenges	Actions planned	Clinical facilitator	Unit manager
Socialisation - Informal socialisation Nurse practitioners Multidisciplinary team members	- Nurse practitioners: Organise informal functions to celebrate successes - Multidisciplinary team members: Organise year end function		√ √
Priority 2: Patient care		**Responsibility**	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
Nurse practitioners - Increase total permanent nurse practitioners	- Recruit and appoint professional nurse practitioners (Cycle 2) - Monitor retention of the professional nurse practitioners	√	√ √
- Overtime by permanent nurse practitioners	-Give permanent nurse practitioners the first option to work available overtime shifts in the A&E unit		√
Improve basic patient care - Caring	- Increase support for the nurse practitioners - Recruit and appoint professional nurse practitioners (Cycle 2) - Monitor retention of the professional nurse practitioners and explore reasons for leaving if appropriate - Focus on improving basic patient care during ward rounds and CPDP	√	√ √ √ √
- Respect Clean beds Feed patients when unable to feed themselves	-Daily ward rounds -Focus on improving during professional development programme	√ √	√ √

Priority 2: Patient care *(continued)*		Responsibility	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
Patient education - Illness or disease	- Focus on patient education as outcome for performance management and CPDP	√	√
- General health education	- Obtain pamphlets available from the Department of Health and make available in A&E unit	√	√
- Public awareness - Use of emergency facilities	- Make public aware of the Level III status of the A&E unit as well as alternative options to obtaining medical support by means of posters		√
Decrease patient waiting times - Nurse practitioners	- Nurse practitioners should admit patients as soon as they arrive in A&E unit - Assign tasks to the shift leader - Monitor during regular ward rounds		√ √ √
- Multidisciplinary team	- Monitor time spent in A&E unit and inform doctors or specialists if patients wait more than 4 hours		√
Psychiatric patients - Decrease time spent in A&E unit - Direct admission to psychiatric hospital	- Should be resolved by move to new hospital as psychiatric patients would not be admitted to A&E unit - Monitor once A&E unit is moved to new hospital		√
Pharmacy - Available 24-hours to patients - Run by pharmacist	- Discuss and negotiate with top management		√

Priority 3: Structure		Responsibility	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
Rules - Nurse practitioners	- Allocate a shift leader to take charge of each shift - Determine tea and lunch breaks daily and indicate in the delegation book		√ √
- Multidisciplinary team - Medical students	- Involve the head of department		√
Standards and protocols Patient management	- Involve the head of department		√

Priority 4: Equipment		Responsibility	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
Available equipment Taking care of equipment	- Focus on improving during daily ward rounds - Teamwork: Allocate a specific team to be responsible for taking care of equipment		√ √
Lack of equipment More equipment needed	- Use opportunity when A&E unit moves to new hospital to order adequate amount of equipment		√
Priority 5: Research		**Responsibility**	
Challenges	**Actions planned**	**Clinical facilitator**	**Unit manager**
Patient management Statistics available regarding patient management	- Allocate a team to be responsible for statistics in A&E unit - Make statistics available during monthly meeting		√ √

3.7 SUMMARY

In this chapter, the initiation of the AR for practitioners project in the A&E unit is discussed. First, the PDG was established and consensus amongst the group members reached regarding the roles that each member would play in the project as well as a shared vision and the purpose of the project. As the intention was change in the A&E unit, strategies that could be used to overcome resistance to change were discussed and consensus reached regarding the inclusion of these strategies in the project.

The shortage of professional nurse practitioners was collaboratively addressed and challenges that needed to be overcome in order to create a future for the nurse practitioners explored. Professional development, patient care, structure, equipment and research were the five priorities identified during the NGM. Based on these findings, actions were planned by the PDG that not only aimed to turn the toxic

environment into an enabling environment and resolve the challenges, but also aimed to realise the group's future vision of emancipatory practice development.

Chapter 4 includes a discussion of the journey undertaken by the clinical facilitator in order to resolve the challenge of professional development in the A&E unit.

4 Journey of the clinical facilitator

There is nothing more difficult to take in hand,
more perilous to conduct, or more uncertain in the success,
than to take the lead in the introduction of a new order of things

Machiavelli

4.1 INTRODUCTION

Chapter 3 provides a detailed analysis of Phase 2, Step 1 (initiating the journey) and Step 2 (planning the journey forward). In this chapter, the journey of the clinical facilitator, as key driver of the professional development programme initiated in the A&E unit, is addressed. This chapter provides a detailed description and analysis of initiating the clinical facilitator's journey as well as Cycles 4, 5 and 6 that followed.

Chapter 4 thus explores and describes the journey undertaken by the clinical facilitator as practice leader and key driver of the process of enabling the nurse practitioners by means of a CPDP, and thereby enhancing their technical practice development (see Table 4.1). Throughout this journey, the researcher facilitated, supported and coached the clinical facilitator, using guided reflection as an emancipatory process.

Strategies for enabling professional development are well established in healthcare organisations as one of the key components of approaches to lifelong learning. Continuous practice development includes professional development as a strategy to enhance clinical practice (enhancing technical practice development). Practice development in nursing should be rigorous as the benefits thereof include the maintenance of high standards of patient care, the improvement of the development of services, ensuring the competency of all nurse practitioners and guaranteeing the accountability of nurses for their actions (Hughes 2005:45; McCormack & Slater 2006:135; Nolan, Owen, Curran & Venables 2000:461).

4.2 OVERVIEW OF THE CLINICAL FACILITATOR'S JOURNEY

During the NGM, the practice leaders became enlightened when they became aware of the importance of professional development. The nurse practitioners too acknowledged the importance thereof and prioritised it as the most important aspect that needed to be addressed to ensure a future for them in the A&E unit (see Figure 3.3). The clinical facilitator took responsibility for addressing this challenge. Patient care (priority 2) and equipment (priority 4) were also emphasised and addressed during the CPDP initiated by the clinical facilitator (see Figure 3.4 and Figure 3.6).

4.2.1 Timeframe

Between 22 August 2005 and 30 June 2007, three action cycles (Cycles 4, 5 and 6) of the journey undertaken by the clinical facilitator in the AR for practitioners project took place (see Table 4.1).

Table 4.1: Clinical facilitator's journey: summary of the timeframe

Phase 2			
22 August 2005 to 15 December 2005	**January 2006 – February 2006**	**1 March 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 4	**Move to new hospital**	**Cycle 5**	**Cycle 6**
Define a role		**Professional development**	**Amended professional development**

Cycle 4, as indicated in Table 4.1, involved defining the role of the clinical facilitator in the A&E unit and included the development and implementation of an in-service training programme. Cycle 5 was initiated after moving to the new hospital in March 2006 and ended in January 2007. This cycle involved the initiation of professional development. From February 2007 to June 2007, Cycle 6, in which amendments were made to the professional development programme, took place.

4.2.2 Coded data

In Figure 4.1, the clinical facilitator's journey is visually depicted by means of a summary of the coded data that were obtained during the journey. The data were analysed as discussed in Section 2.8.1.3a. Two themes were identified during the clinical facilitator's journey, namely working in an enabling environment and developing partnerships.

In the enabling environment, the clinical facilitator was motivated and reflective learning was utilised to enhance emancipation. The clinical facilitator reflected that she was motivated to act in her new role because she was supported by the researcher, unit manager and supervisor throughout her journey in the A&E unit. The positive feedback obtained from the supervisor and nurse practitioners regarding the CPDP and the trust in her abilities to fulfil the new role motivated the clinical facilitator to take further action. The clinical facilitator also obtained positive feedback from doctors working in the A&E unit concerning the effect of the CPDP on the knowledge and skills of the nurse practitioners. The support, positive feedback and trust in her abilities as well as being valued for her efforts enhanced the clinical facilitator's job satisfaction.

Reflective learning strategies were used by the researcher throughout the facilitation process. During this process, the clinical facilitator became aware that the nurse practitioners regarded professional development as the most important challenge that needed to be addressed if they were to have a future in the A&E unit. This finding, obtained during the NGM, made the clinical facilitator conscious of the importance of delineating a role for herself in the A&E unit and initiating a CPDP as soon as possible in order to enhance technical practice development in the A&E unit.

The clinical facilitator made the researcher as A&E lecturer aware of the fact that she did not know what clinical outcomes were expected of the A&E learners while they were in the A&E unit as part of the clinical component of the A&E programme. The researcher enabled the clinical facilitator by involving her in the planning of both the theoretical and clinical component of the A&E programme. The clinical facilitator was thus able to plan and implement the theory-practice correlation of the A&E learners

while they were in the A&E unit. Throughout the journey and facilitation process, the clinical facilitator spoke openly and freely about her concerns regarding her new role.

The clinical facilitator was empowered and enabled to plan and implement actions, observe their outcomes and then amend the planned actions if appropriate. Evidence of empowerment was based on the clinical facilitator's increased autonomy, self-efficacy and self-esteem. The clinical facilitator took ownership of her new role and responsibility for implementing the planned actions.

Emancipation followed based on the fact that the clinical facilitator enabled the A&E nurse practitioners by acknowledging their knowledge and skills, and involving them in the CPDP. The clinical facilitator enabled the nurse practitioners through the CPDP by initiating an in-service training programme and on-the-spot teaching. The CPR champions programme was a spin-off of the project, and allowed these nurse practitioners to enable their peers to perform effective CPR in a clinical setting.

During the clinical facilitator's journey, three partnerships were formed, namely with the A&E lecturer working at a tertiary institution, the ICU clinical facilitators working in the hospital, and the PDG and A&E nurse practitioners in the A&E unit. The clinical facilitator reflected that the development of these partnerships decreased her professional isolation as clinical facilitator.

4.3 INITIATING THE CLINICAL FACILITATOR'S JOURNEY

Prior to planning actions to address the first priority challenge (professional development) identified by the nurse practitioners during the NGM, the clinical facilitator and researcher had two reflective discussions. These discussions were not only regarded as the first steps taken on the clinical facilitator's journey, but also provided an opportunity for both participants to reach consensus as to where this journey should lead. A reflective overview of the first discussions held and the agreement of what the term "professional development" means is provided next. An overview of the second discussion, which was concerned with the specific actions the clinical facilitator believed were needed in order to support and enable her to continue planning and implementing a CPDP, follows.

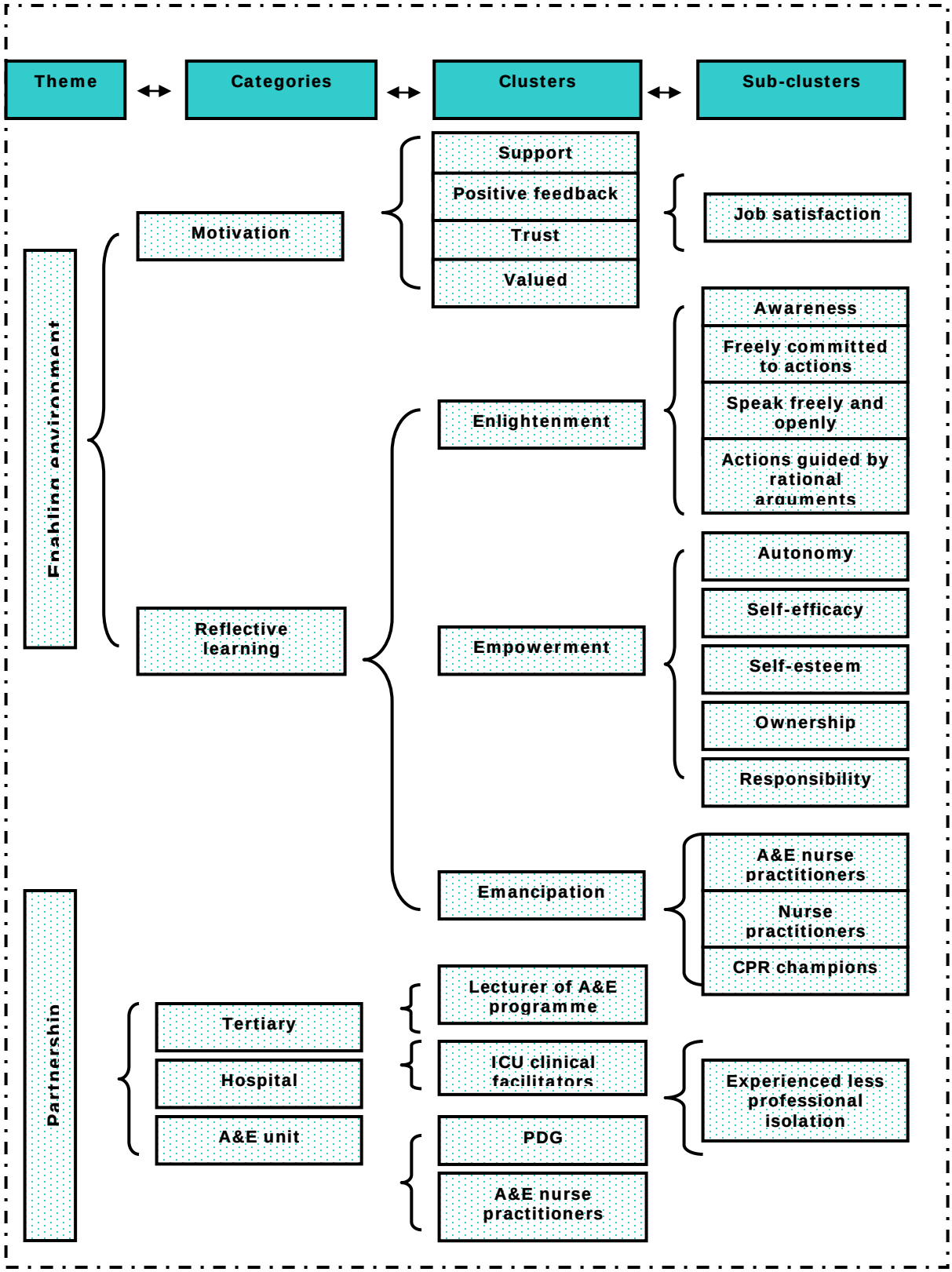


Figure 4.1: Clinical facilitator's journey: summary of coded data

4.3.1 Reflection

Following reflective discussions between the PDG members on 18 August 2005 regarding the findings obtained during the NGM and possible actions that could be implemented to resolve the toxic environment as well as the identified challenges (see Section 3.6.2 and Table 3.10), the first meeting between me and the clinical facilitator was scheduled. This meeting was held on 22 August 2005. It was regarded as the start of the clinical facilitator's journey towards enabling the nurse practitioners and enhancing emancipatory practice development during the AR for practitioners project.

Professional development was the first priority that had to be addressed in order to ensure a future for the nurse practitioners. This was the view of the nurse practitioners and had to be respected by the PDG and addressed immediately. In addressing this challenge, the first meeting focused on the following question:

What is the meaning of the term professional development and how could it play a role in achieving the shared vision of the PDG?

Throughout the reflective discussion, the importance of acknowledging the views of the nurse practitioners concerning the role of professional development in ensuring a future for them in the A&E unit was highlighted. Through the immediate planning and implementing of an in-service training programme, the nurse practitioners would become aware that their views were regarded as significant and that action had been taken by the PDG to address the challenge.

The clinical facilitator reflected that an in-service training programme, as suggested by the nurse practitioners, was only one strategy that could be utilised to promote CPD. The clinical facilitator was of the opinion that various additional strategies, such as "on-the-spot" teaching, hands-on practising of clinical skills on manikins and "problem-based learning", could be used to continuously develop and enable nurse practitioners to learn new knowledge and skills or maintain these.

The clinical facilitator viewed professional development as necessary to maintain and continue to refine knowledge and skills as well as to assure the quality of healthcare service provision. This view is shared by Nolan et al. (2000:457), as well as Schober and Affara (2006:132). The clinical

facilitator also regarded herself as a 'facilitator' of the CPDP in the A&E unit. According to the clinical facilitator:

> *Professional development is a continuous process during which various teaching strategies are utilised that aim to enable the nurse practitioners to deliver effective and quality patient-centred care.*

The term practice development is widely used in the nursing profession in the United Kingdom. However, it is still not well defined and the world of practice development is complex, evolving and dynamic. In the literature, a multiple set of journeys, which explored the many facets and dimensions that are embedded in the seemingly simple term practice development, were explained (Caldwell et al. 2000:37-41; Down 2004:267-287; Golden & Tee 2004:225-241; McCormack et al. 2004:315; Stokes 2004:246-263).

The term practice development has frequently been linked to professional development and at times the terms are used interchangeably. Both these terms are regarded as continuous processes, but the starting point for practice development is the service user, while the starting point for professional development is the service provider. Both are also associated with questioning the way in which practice takes place in order to attempt some change or improvement (McCormack et al. 2004:6).

On the other hand, Garbett and McCormack (2002:88) state that practice development focuses on the improvement of nurse practitioners' knowledge and skills as well as on service users in their definition of practice development as:

> *… a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflected the perspectives of service users.*

During the reflective discussion, it became evident that the clinical facilitator's focus was on developing knowledgeable and skilled nurse practitioners by means of an in-service training programme, thereby placing emphasis on technical practice development. While this would be valuable and beneficial to the A&E unit, in this "technical approach" to practice development, the focus remains on the service provider as well as on the delivery of specific initiatives rather than

on the processes that enable the nurse practitioners' sense of ownership as well as sustained change (Manley & McCormack 2003:23).

The clinical facilitator and I agreed that, although this approach was 'technical' in nature, the first step would be to initiate an in-service training programme, as it was one of the suggestions expressed by the nurse practitioners during the NGM. Once the in-service training programme was in place, additional actions to enhance emancipatory practice development would be considered, during which the focus would shift to the service user, thus linking the actions of the clinical facilitator to the PDG's vision of 'emancipatory practice development' (see Figure 3.8).

A second meeting was scheduled for the following week. During this meeting, reflective discussions were facilitated in order to explore the clinical facilitator's views on what she expected to achieve during Cycle 4 of this research. The second reflective discussion focused on the following question:

In your view, what are the challenges in order of priority that you as clinical facilitator need to overcome in order to implement actions with regard to the CPDP?

The following three challenges, in order of priority, were identified by the clinical facilitator:

- *Know what my role is as clinical facilitator*
- *Have the right knowledge and skills to perform my new role*
- *Have structure to enable me to perform my new role*
  - *Regarding the A&E learners*
  - *Regarding the nurse practitioners*

These priorities were used to formulate the planned actions during Cycle 4. The clinical facilitator and I also agreed that the in-service training programme should be implemented and could not be postponed until these challenges were resolved. It was then agreed that the researcher would start an in-service training programme, while the clinical facilitator focused on the challenges needed to be overcome according to her perception. This was done in an effort to support the clinical facilitator, as the researcher realised that the clinical facilitator was under tremendous strain and the nurse practitioners were eager that a CPDP be implemented.

4.4 DEFINE A ROLE (STEP 2: CYCLE 4)

Cycle 4 was facilitated over a period of four months, and focused on defining the role of the clinical facilitator (see Table 4.2) and planning and implementing an in-service training programme. The clinical facilitator's journey was linked to Cycle 1, 2 and 3, as discussed in Chapter 3. From Table 4.2, it can be seen that Cycle 4 started on 22 August 2005 and ended on 15 December 2005. Two important issues were addressed during Cycle 4, namely initiating an in-service training programme and delineating the role of the clinical facilitator.

Table 4.2: Step 2: Cycle 4: Define a role

Phase 2			
22 August 2005 to 15 December 2005	**January 2006 – February 2006**	**1 March 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 4	**Move to new hospital**	**Cycle 5**	**Cycle 6**
Define a role		**Professional development**	**Amended professional development**

4.4.1 Actions planned

Actions that were to be implemented by the clinical facilitator during Cycle 4 were planned collaboratively during the reflective discussions between the clinical facilitator and researcher. These actions were planned according to priorities as jointly decided by the clinical facilitator and researcher, and included the following:

- **Action 1**: Plan and implement an in-service training programme for the timeframe August 2005 to December 2005
- **Action 2**: Delineate a role regarding the clinical facilitation of the first and second-year A&E learners
- **Action 3**: Delineate the role of the clinical facilitator regarding the A&E unit
- **Action 4**: Determine ways of providing structure in the daily activities of the clinical facilitator

To further enable the clinical facilitator, in terms of the clinical accompaniment of the A&E learners, the researcher planned the following actions, which were included in order to enhance the outcomes of Action 2:

- **Action 5**: Increase the involvement of the clinical facilitator in the A&E programme
  - involve the clinical facilitator in the revision of the A&E learners' study guides and clinical workbooks
  - involve the clinical facilitator in both the formative and summative assessment of the A&E learners
  - implement monthly meetings with the clinical facilitator during which issues regarding the A&E learners rotating through the A&E unit could be discussed
  - involve the clinical facilitator in the A&E programme during the researcher's study leave in 2007

The researcher agreed that the in-service training programme should be implemented immediately, as this had been a request from the nurse practitioners during the NGM. The researcher volunteered to support and assist the clinical facilitator with the implementation of a weekly in-service training programme during Cycle 4. This was agreed upon and the actions implemented.

4.4.2 Act and observe

The actions planned and implemented were intentionally researched and modified throughout the entire set of cycles, as AR is not merely research, but research that is hoped will be followed by action (Wadsworth 1997:78). The clinical facilitator was observed during regular (once or twice weekly) visits paid to the A&E unit by the researcher. The researcher observed whether the action plans were implemented and had unstructured reflective discussions with the clinical facilitator (12), unit manager (1) and nurse practitioners (8) to confirm the findings observed. The observations were briefly and concisely noted in the reflective diary kept by the researcher. Descriptions are supported with *verbatim* quotes from the unstructured reflective discussions.

4.4.2.1 Action 1: Plan and implement an in-service training programme

The first action that was planned in Cycle 4 was the implementation of an in-service training programme. The in-service training programme was held every Friday morning. A schedule was placed on the information board in the A&E unit informing the nurse practitioners of the topics, the time of the sessions and the venues where each session took place (see Table 4.3). The first session was held on 26 August 2005 and these continued until 9 December 2005 (16 sessions in total). The clinical facilitator and researcher agreed upon the first topic and asked an expert in nursing record keeping to present three sessions on the topic.

The nurse practitioners were then asked to reach consensus amongst themselves regarding topics for the remaining sessions. As they all worked shifts, it was decided that each topic would be repeated for three consecutive weeks to ensure that all the nurse practitioners had an equal opportunity to attend the sessions. It was agreed that the in-service training programme would be discontinued on 9 December 2005, as most of the permanent nurse practitioners would be going on leave and the remaining nurse practitioners would be taking turns to organise the new unit in order to facilitate the move in January 2006.

An education specialist with an interest in portfolio development was asked to present a session on this topic. All the nurse practitioners that attended the session received portfolio files, which were obtained through a sponsorship (see Section 5.2.2.1). The topics *'components of history taking and the importance thereof in an A&E unit'* and '*pathophysiology of diabetes mellitus and relevant patient education*' were presented by the researcher. The clinical facilitator then volunteered to present the topic '*pathophysiology of asthma, drugs used in the management thereof and relevant patient education*'. The clinical facilitator stated that she "*felt ready and confident"* to now take over the in-service training programme from the researcher after the initial examples had been set. The nurse practitioners were positive about the in-service training programme and indicated that it enabled them to manage the patients more effectively as well as give appropriate patient education. They reflected that:

- *"… I (nurse practitioner) have attended all the lectures and it was very interesting … I was even able to diagnose asthma and call [the clinical facilitator] to come*

and help us … the patient was in a serious condition and I think if I did not attend the lecture I would not have realised how sick he was …"

- *"… sometimes the unit (A&E unit) was too busy and we (nurse practitioners) could not all attend the programme (in-service training programme) … we (nurse practitioners) had to take turns, so it was good that the lectures were repeated …"*
- *"… it helps us (nurse practitioners) … we learn from it and use the knowledge to manage the patients …"*
- *"… I (nurse practitioner) did not know exactly what diabetes was … we see many patients every day with diabetes and I (nurse practitioner) have it too … I can now give the patients education and tell them why they must use their insulin and check their glucose … the patients listen to me because I feel confident when I tell them about their diabetes and how they can monitor for complications … it helped me too to understand my disease …"*

It was evident from remarks that the nurse practitioners enjoyed and learnt from the specialists in the various fields. The nurse practitioners reflected that:

- *"… the programme (in-service training programme) was excellent … I (nurse practitioner) really enjoyed the discussions on nursing records and it was good that it was presented by an expert … it makes it more interesting and it shows us that the expert is interested in us and willing to share her knowledge with us …"*
- *"… we (nurse practitioners) are often told about the importance of nursing records and to me it was a boring topic … one of the nurses (nurse practitioners) told me that she has attended the first lecture and that I should go … I was sceptical but it was so interesting … she is really an expert and she gave us examples from court cases and cases at SANC … I now realise it is important and I (nurse practitioner) do pay much more attention to it in the unit (A&E unit)"*
- *"… the lecture on nursing records was excellent … everybody (nurse practitioners) spoke about it and everybody (nurse practitioners) is giving more attention to record keeping in the unit (A&E unit) …"*
- *"… the presenter told us how to develop our own portfolio … sometimes the lectures are just on patient management, but it is also good to attend something that is to develop yourself …"*
- *"… I (nurse practitioner) learnt how to compile my portfolio and why it is important … I think it will help me with my performance evaluation … it is nice to*

attend something that is for yourself … everybody always focuses on patients … I know that is important, but we are also important …"

Table 4.3: A&E unit: In-service training programme (2005)

Date	Time	Venue	Topic
26 August	08:00 – 09:00	Lecture room A&E unit	The importance of **nursing records** and the legal implications of the neglect thereof
2 September	08:00 – 09:00	Lecture room A&E unit	The importance of **nursing records** and the legal implications of the neglect thereof
9 September	08:00 – 09:00	Lecture room A&E unit	The importance of **nursing records** and the legal implications of the neglect thereof
16 September	08:00 – 09:00	Lecture room A&E unit	Components of **history taking** and the importance thereof in an A&E unit
23 September	08:00 – 09:00	Lecture room A&E unit	Components of **history taking** and the importance thereof in an A&E unit
30 September	08:00 – 09:00	Lecture room A&E unit	Components of **history taking** and the importance thereof in an A&E unit
7 October	08:00 – 09:00	Lecture room A&E unit	**Portfolio development** for the purpose of performance management
14 October	08:00 – 09:00	Lecture room A&E unit	**Portfolio development** for the purpose of performance management
21 October	08:00 – 09:00	Lecture room A&E unit	**Portfolio development** for the purpose of performance management
28 October	08:00 – 09:00	Lecture room A&E unit	Pathophysiology of **diabetes mellitus** and relevant **patient education**
4 November	08:00 – 09:00	Lecture room A&E unit	Pathophysiology of **diabetes mellitus** and relevant **patient education**
11 November	08:00 – 09:00	Lecture room A&E unit	Pathophysiology of **diabetes mellitus** and relevant **patient education**
18 November	08:00 – 09:00	Lecture room A&E unit	**Portfolio development** for the purpose of performance management
25 November	08:00 – 09:00	Lecture room A&E unit	**Portfolio development** for the purpose of performance management
2 December	08:00 – 09:00	Lecture room A&E unit	Pathophysiology of **asthma**, **drugs** used in the management thereof and **patient education**
9 December	08:00 – 09:00	Lecture room A&E unit	Pathophysiology of **asthma**, **drugs** used in the management thereof and **patient education**

In November 2005, the nurse practitioners requested that the in-service training sessions on portfolio development be repeated for two more sessions, as there were some that had been unable to attend the sessions and others who wanted to attend

the session again. The education specialist was contacted and agreed to repeat the sessions. The in-service training programme was re-organised to accommodate these requests. Two additional sessions on portfolio development were given (see Table 4.3). From Table 4.3 it is also evident that a wide variety of topics were presented to the nurse practitioners and that, from August 2005 to December 2005, specialists in the field presented a total of 16 hours of relevant in-service training. This provided a clear example of how the role of the clinical facilitator could be structured in terms of an in-service training programme.

4.4.2.2 Action 2: Delineate a role regarding the clinical facilitation of the first and second-year A&E learners

The second action that was planned and implemented in Cycle 4 included delineating the role of the clinical facilitator specifically regarding the first and second-year A&E learners. The clinical facilitator reflected that one of her main responsibilities was the facilitation of the learning of the A&E learners while they rotated through the A&E unit as part of the clinical component of the A&E programme presented by a residential university in Gauteng. The clinical facilitator reflected that her role in the facilitation of the learning of the A&E learners was "*unclear"* as there was not enough "*guidance from the lecturer's side"*, thus *"making the job very difficult to be the clinical facilitator".*

The researcher (as lecturer of the A&E programme) gave the clinical facilitator a copy of the curriculum of the A&E programme and then explained the layout of the programme as well as the micro and macro curricula of both the first and second-year A&E learners. As it was September and time to revise the A&E learners' study guides and clinical workbooks, the researcher asked the clinical facilitator to assist her with the revision process to ensure, firstly, that the theoretical component was in-line with clinical practice and, secondly, that the clinical workbook's outcomes were realistic in terms of clinical practice. The researcher's aim was to acknowledge the clinical facilitator's knowledge and skills as A&E nurse practitioner by consulting her in the revision process. The clinical facilitator's ideas were included and her input valued and appreciated throughout the process. She was thanked for her contribution and her name included on the documents.

Following the revision process, the clinical facilitator and researcher collaboratively planned the clinical accompaniment of the A&E learners during their rotation through the A&E unit and the action plan was then summarised by the clinical facilitator (see Annexure F.1 and F.2).

The researcher involved the clinical facilitator in the assessment of the A&E learners during the clinical component of the A&E programme. This was aimed, firstly, at facilitating the emancipatory process by making the clinical facilitator consciously aware of the outcomes of the A&E programme. Secondly, it aimed to increase the clinical facilitator's understanding of the lecturer's expectations of the A&E learners during the assessment. Finally, it aimed to enable the clinical facilitator to plan and implement learning opportunities in the clinical setting that facilitate the learning of the A&E learners based on the outcomes of the A&E programme. As lecturer, the researcher also reflected that the value of establishing such a partnership was that it could be regarded as continuous development for both parties, with the researcher's strength being the theoretical component and the clinical facilitator's strength the clinical component. The clinical facilitator supported this view.

In February 2007, the researcher was granted study leave to complete the study and the clinical facilitator took over the responsibility of the lecturer to present the theoretical component of the A&E programme. This decision was made in order to acknowledge the clinical facilitator for her knowledge and skills in the area of A&E nursing and continue the process of enabling her by providing opportunities to increase her understanding of the A&E programme, which would further enable her to facilitate the learning of the A&E learners in the A&E unit. The clinical facilitator accepted this role.

The clinical facilitator stated that the structure provided by the delineation of a schedule for the clinical accompaniment of the A&E learners assisted her to facilitate effective "*development by the bedside*" on the part of the A&E learners, which she believed would "*enhance theory-practice correlation*". The clinical facilitator used these guidelines to plan specific topics, which were addressed during on-the-spot teaching. The clinical facilitator also reflected that *"planning the clinical accompaniment of the students (A&E learners) helped me to realise when and what they (A&E learners) did in theory and this helped me to know what to focus on in the*

clinical setting … the students (A&E learners) used to say that they have not addressed certain topics in class yet … now that I know what they have done and they (A&E learners) cannot just say they don't know or have not done the theory part yet … I also know what to expect from them (A&E learners) … I think the clinical facilitation is much better organised now …".

4.4.2.3 Action 3: Delineate a role pertaining to the A&E unit

The third action planned and implemented during Cycle 4 was the delineation of the role of the clinical facilitator regarding the A&E unit. The role of the clinical facilitator was developed over a period of four months (August 2005 to December 2005). Mind mapping, a learning strategy of reflection described by Cimolino, Kay and Miller (2003) as well as McAleese (1999:351), was primarily used to outline and reach consensus on the different roles of the clinical facilitator (see Annexure F.3). Benchmarking was incorporated in the facilitating process, as described by Kreitner and Kinicki (2007:G1), who state that the term refers to the *"process by which a company compares its performance with that of high-performing organisations"*. In this research, benchmarking was used to unfreeze the clinical facilitator by comparing her performance to that of another high-performing clinical facilitator at a private hospital. 'Unfreeze' refers to the creation of the need to change resulting from the benchmarking as well as the feedback the clinical facilitator received regarding the importance of professional development during the NGM (Kreitner & Kinicki 2007:584).

Benchmarking was conducted by consulting with a clinical facilitator at a private hospital. A meeting was organised during which the clinical facilitators reflected on the roles of clinical facilitators in private hospitals and in general. The clinical facilitator and researcher also performed Internet searches to obtain literature investigating the role and expectations of clinical facilitators internationally.

An educational specialist was also consulted and three reflective discussions held concerning the following topics:

- the role of a clinical facilitator in general,
- the role of a clinical facilitator regarding learners visiting the A&E unit,
- the value of learning contracts,

- structuring one's role as a clinical facilitator, and
- possible solutions to the challenges posed by the CPRP.

These benchmarking strategies were used to provide the clinical facilitator with the opportunity to reflect, ask questions concerning her job description and acquire suggestions and information regarding what was expected of a clinical facilitator in the private sector as well as from an educational specialist viewpoint.

The clinical facilitator conducted literature searches through Medline, EbscoHost and Google using key words such as adult learning, reflective teaching and learning, in-service training programme, CPD, life-long learning and clinical facilitation. These topics were reflected on throughout the study to enhance the knowledge of the clinical facilitator regarding her new role.

Following the first session with the educational specialist, the clinical facilitator reflected that *"… I did not understand one word of the discussions … the terminology used was unclear and I realised that you understood it … I will have to read more about education …".* The researcher realised that the clinical facilitator did not have the equivalent educational background of either the educational specialist or the researcher. The researcher then explained the terminology that was unclear to the clinical facilitator. Two additional sessions were held with the educational specialist and, before each meeting, it was agreed that if a term was used that the clinical facilitator did not understand, she would ask and time would be taken to define the term.

Following the third session with the educational specialist, the clinical facilitator reflected *"… I am beginning to understand what it is about and I can actually follow what [the educational specialist] is saying … it was so interesting to talk to somebody that supports me and actually listens to the problems I experience in the clinical practice … somebody with an open mind … all the suggestions made are not appropriate because I do not think she actually understands the clinical practice … she (education expert) make it sound so simple … it is not and I think it is important that the nurses (nurse practitioners) are not enrolled for a programme … so to motivate them is not so easy … they (nurse practitioners) do not have to do it … the*

idea of the CPR champions was excellent and I will definitely use it … I also think a learner contract could be of use …"

A role, as perceived by the clinical facilitator, was delineated using mind mapping (see Annexure F.3). The role was then formatted into a job description, which was compiled by the clinical facilitator and used to negotiate her role with her supervisor (see Annexure F.3).

4.4.2.4 Action 4: Determine ways of providing structure in daily activities

The fourth action planned and implemented in Cycle 4 was determining ways to provide structure for the clinical facilitator in her daily activities in the A&E unit. Structure was an important concern and voted as the first priority to be addressed by the clinical facilitator in order to ensure a future for the A&E unit (see Annexure D). The exact meaning of structure was unclear during the facilitating process, but, through reflection, the clinical facilitator stated that "… *it guides me what to do and when I must do it … it gives me structure every day and assists me to plan my day … I need this structure to function … I must do my work according to a plan …*". Reflecting further on the concept, the clinical facilitator and researcher agreed that structure, as perceived by the clinical facilitator, included two separate issues. Firstly, it related to defining a role and, secondly, to the planning of daily activities.

Actions had been implemented to delineate the role of the clinical facilitator. It was therefore necessary to plan and implement actions that would assist the clinical facilitator to plan her daily activities. Jonassen (1999:233) cites that, according to Perkins (1992), coaching should be used to guide learners in developing task management skills. In this study, coaching was used to assist the clinical facilitator to manage daily, weekly and monthly tasks, and then observe performances and provide encouragement, diagnosis, direction and feedback.

The clinical facilitator suggested that she *"… use a diary and write in all my appointments … plan every day so that I know what I have to do every day …*". The researcher coached the clinical facilitator to use her diary effectively, but withdrew after two weeks, as the clinical facilitator could then use the diary effectively without assistance.

4.4.2.5 Action 5: Increase the involvement of the clinical facilitator in the A&E programme

The fifth and final action planned, was implemented during Cycle 4, was increasing the involvement of the clinical facilitator in the A&E programme. The clinical facilitator had been involved in the A&E programme before the AR for practitioners project was initiated. This involvement included mainly formative and summative clinical assessment. Following reflective discussions, it became evident that the clinical facilitator did not know exactly how the programme was structured, when specific theory was addressed and what was expected of her during the clinical practice. During Cycle 4, Action 2 the researcher involved the clinical facilitator in revising the study guides and clinical workbooks of the A&E programme. The clinical facilitator was also involved in revising the assessment tools used for the clinical assessment of the A&E learners.

The clinical facilitator and researcher agreed to revise the study guide and divide it into study units. Each unit would indicate what the A&E learners would be addressing in the theoretical component of the A&E programme (see Annexure F.4). Through her involvement in the actions of Cycle 4, the clinical facilitator reflected that *"… I would be able to help the students (A&E learners) in the clinical practice to actually see and apply what they learn in class … to also know what they are supposed to know so that they cannot tell me in the unit (A&E unit) that they don't know because they have not done it … I will also give more attention to the drugs we use … I now realise that it is emphasised in the theoretical component …".*

As the clinical facilitator was now consciously aware of the theoretical and clinical outcomes expected of the A&E learners, she was able to plan and implement the A&E learners' theory-practice correlation by developing them at the bedside. This is evident from the following statement: *"the fact that I know what is expected of the students (A&E learners) in the trauma course (A&E programme) helped me to plan their clinical accompaniment in the unit (A&E unit) … I know what to focus on when I work with them and I also know what they are supposed to know and what not … this makes it much easier … like this week I focused on chest X-rays because I knew they did it in class … I also focused on asthma because it is winter and we (nurse practitioners working in A&E unit) see these patients every day now … so although*

they did not do it in class I first gave them an overview and we have discussed the drugs used to manage the patients … now I can help them in the practice … it is much more structured and I know what I must do …".

4.4.2.6 Action 6: Continuous development of the clinical facilitator

Cycle 4 of the clinical facilitator's journey started on 22 August 2005. Through facilitation in an enabling environment and the employment of an in-service training programme, both the clinical facilitator and nurse practitioners were provided with continuous developing opportunities.

The clinical facilitator reflected that the environment was supportive, trusting and provided opportunities for learning to take place. The clinical facilitator reflected that she felt supported for the first time in her new post.

- *"… you (researcher) helped me … you (researcher) understood what I (clinical facilitator) needed to do in the unit (A&E unit) and you (researcher) were able to help me … could always ask you and you would help me …"*
- *"… I would not have been able to do this on my own … you have helped me to get on my feet and to realise that I have to do this job in totally a different way than what I thought …"*
- *"…I have also asked [the clinical facilitator of the critical care units] for help and she helped me a lot … with things like sorting out the study leave and leave of the students (A&E learners) and doing the paperwork … the administrative things …"*

The clinical facilitator was positive that she would be able to fulfil her new role. She reflected that *"… you and [supervisor] believe in me … otherwise I would not have had this job … if [supervisor] thought I cannot do it … I am a good sister (A&E nurse practitioner) … but not yet a good clinical facilitator … with your help I know I can get there … I know I can do it … I must just know how …".* This confirmed that the clinical facilitator was confident because of the trust her supervisor and the researcher had in her abilities as well as the support she was given in her working environment.

Kreitner and Kinicki (2007:144) describe self-efficacy as a belief in one's ability to do a task. They describe the relationship between self-efficacy and performance as a cyclic one that can either spiral upwards to success or downwards to failure and state that researchers have documented strong links between high-efficacy expectations and success. Thus by making a positive statement such as "*… I know I can do it …"* the clinical facilitator indicated that she believed in her ability to do the task, which was a possible sign of her future success as clinical facilitator.

At times, it was evident that the clinical facilitator had a low self-esteem. Self-esteem is one's overall self-evaluation (Kreitner & Kinicki 2007:142). This was evident from negative statements such as *"… they (nurse practitioners) do not think I am doing my job … they do not realise what I am worth … maybe somebody else must do this job … I cannot do it …"* and *"… I worked very hard, but that was not enough for them (nurse practitioners) … they did not see that, they only saw that I did not teach them anything … maybe I am not good enough …"*.

Although supported mainly by the researcher during this cycle, as is evident from statements such as *"… you are the only one who understands what I should do in the unit [A&E unit] … the others [clinical facilitators of the critical care units] cannot help me … they do not understand that it is different here …"*, the clinical facilitator had started to reach out to the clinical facilitator working in the critical care units by asking for support in the administrative issues concerning the A&E learners. This step was later reflected on as the starting point for a partnership that developed between these clinical facilitators. This step can also be regarded as the first step in the clinical facilitator's taking ownership of and responsibility for her new post, providing evidence that she had become empowered.

When the clinical facilitator was enlightened during the NGM about the views of the nurse practitioners regarding the importance of professional development and the lack thereof in the A&E unit, it became evident that an environment to enhance learning was being created and that the enabling process was being initiated through facilitation. The clinical facilitator also became aware of the need to be assisted in her new role in order to ensure that she met the needs of the nurse practitioners.

Evidence that the first step of the emancipatory process was taking place was based on the following quotations:

- *"… I (clinical facilitator) was hurt when the nurses (nurse practitioners) said in that group (NGM) that there was no in-service training programme … I know there was nothing in place … but I did not know what to do … I wanted to leave … I did not have a clue where to start …"*
- *"… I (clinical facilitator) did not realise that I had a problem … I thought I was pouring myself into my work … working hard every day and giving my best … only when you (researcher) started asking me questions and asking me what my plans were for my new role did I realise that working myself to death and taking all the responsibility of things … things that had nothing to do with me in my new role … I really think I need that experience … experience as a facilitator (clinical facilitator) to come out on top again …"*
- *"… I (clinical facilitator) realised during that group (NGM) that I needed help … I did not do what they (nurse practitioners) expected of me … I did what I thought was right … and I think I don't know how to do it … I did go and do education (postgraduate programme in nursing education) … but it seems that I have learnt nothing there … it is what you (researcher) always call the practice-theory gap …"*

Enablement followed, with the enhancement of the clinical facilitator's theoretical knowledge. She noted that *"… I only realised what my job was once I wrote the job description …".* The clinical facilitator remained concerned that the way she perceived her role differed from her supervisor. The researcher suggested that she discuss the mind map with her supervisor before implementing it in the A&E unit. The clinical facilitator did this and reported that they agreed that she could use the mind map to guide her role as clinical facilitator. According to her, the supervisor was *"impressed"* and "*even complimented me"*, indicating that positive feedback had been received. Role conflict and role ambiguity do affect employees negatively and have been associated with job dissatisfaction, tension, anxiety, lack of organisational commitment, intentions to quit and, to a lesser extent, poor job performance (Kreitner & Kinicki 2007:318). This was confirmed by a remark made by the clinical facilitator that *"… I am not going to work like this anymore … I must look for something else … this place frustrates me and nobody can help me to do my job properly … now they (nurse practitioners) are telling me that I do not do my job …".*

Benchmarking with the clinical facilitator of a private hospital, holding discussions with an educational specialist and conducting literature reviews also promoted enablement.

Reflective discussions indicated that these were valuable strategies. The clinical facilitator remarked that even though she understood the theory, she needed "*practical experience",* as "*everybody can give you information and help you, but you still need to apply and implement what you have learnt in your own clinical setting … it is different than private (private practice) and yes, [the educational specialist] gave me a lot of tips … but she too does not understand the problems I have in practice … it is easy if you read the book, but to actually do it … that is my challenge".* As self-awareness is about being able to identify and understand one's emotions, values and goals (Manley 2004:73), this statement indicates that the clinical facilitator had a goal in mind regarding her new role. She elaborated on this by stating that "*… now they have realised that I want to help them (nurse practitioners) to become better nurses (nurse practitioners), nurses (nurse practitioners) who have knowledge and do not just do things but know why they are doing it … this can help to improve the patient care in this unit (A&E unit) …".* This statement indicates that the clinical facilitator had taken ownership of her new role.

Regarding the literature reviews, the clinical facilitator stated that *"… we (clinical facilitator and researcher) discussed so many articles … on clinical facilitation, job descriptions and different teaching strategies … that helped me … to see how others do it … it also gave me ideas on what I (clinical facilitator) should do …".* This was therefore also a relevant strategy as it enabled the clinical facilitator to carry out her new role.

It was observed that the clinical facilitator focused on the A&E learners and spent hours facilitating their learning in the clinical setting. When reflecting on this observation, the clinical facilitator maintained that this was her "*primary function"* in the A&E unit. Thus, only the in-service training sessions, which had been implemented by the researcher, had been put in place, which was a concern.

However, the clinical facilitator initiated an orientation programme for the new appointees in the A&E unit. She independently developed the orientation

programme and implemented it in the A&E unit in order to support and enable the newly appointed nurse practitioners when starting to work in the A&E unit. This provided evidence that the clinical facilitator had started taking responsibility for and ownership of her new role in the A&E unit.

A partnership was established between the clinical facilitator and the researcher, first in her capacity as lecturer of the A&E programme and, secondly, as member of the PDG. As lecturer of the A&E programme, the researcher involved the clinical facilitator in the A&E programme, resulting in the facilitation of the learning of the A&E learners becoming "*easier"* as she *"understood what it is about"* and started to realise *"… what is expected from them (A&E learners) in the programme (A&E programme) …".*

4.4.3 Reflection

Throughout Cycle 4, I used guided reflection and support to facilitate the enablement of the clinical facilitator in her new role. Brown et al. (2003:119), and Williams (2001:28) state that the concept of reflection can be traced to Dewey (1910), who described reflection as "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends". Reflection is an activity which can be undertaken by oneself; however, engaging in critical reflection with another (in this case myself as the facilitator of learning) can have its advantages in extending personal interpretations to include other perspectives and viewpoints (Burns & Bulman 2000:106).

Johns (2000:51,54) refers to this type of reflection as guided reflection and states that when reflection on experience, guided by another, is used to provide a challenging and supportive milieu for nurse practitioners to learn through, desirable work can be achieved. Williams (2001:28) citing Mezirow (1990) argued that professional practice comprises largely routine and habitual action that is non-reflective, and that routine practice is guided by impulse, tradition or authority. Guided reflection is regarded as necessary to overcome these routine and habitual actions and make sense of professional experience. In this study, it enabled the clinical facilitator to access the vast array of knowledge that she possessed.

Although the clinical facilitator was employed in a new position, guided reflection on previous experiences could be used effectively, as the clinical facilitator had been involved in the clinical accompaniment of the A&E learners for four years before being officially appointed as clinical

facilitator in the A&E unit. Burns and Bulman (2000:11) agree that learning through reflection is the learning technique most suited to adults who have a wealth of past experience and the intellectual maturity to cope with autonomy, differing perspectives and shifting ideas. Socratic questioning and discussions, brainstorming and literature reviews were used as reflective techniques, and reflective learning occurred as a result (Van Aswegen et al. 2000b:131).

During the guided reflection, it was important not to tell the clinical facilitator what I as facilitator thought would be the right action, but allow the clinical facilitator to decide for herself and learn through personal experience whether or not this action was effective. However, viewpoints were shared. This was the most difficult skill that I had to learn as facilitator of the guided reflective process. At times, I was tempted to give the answer or complete a task quickly on behalf of the clinical facilitator, because I believed that I knew the answer and that the process could continue if I completed one of the planned actions. This would have been against the nature of guided reflection, experiential learning and adult learning principles, and was therefore intentionally not put into practice.

The in-service training programme was initiated and organised by myself. Although the main objective was to support the clinical facilitator during this period, it was also regarded as an opportunity to act as a role model for the clinical facilitator, who attended all the sessions. The researcher asked the nurse practitioners what they believed were important topics that needed to be addressed during the programme. The topics of the in-service training programme were based on their requests, and were chosen using a collaborative approach. The researcher also asked two experts to talk on two of the requested topics (record keeping and portfolio development).

The actions planned for Cycle 4 were implemented effectively. The delineation of the clinical facilitator's role and the minimisation of role ambiguity were regarded by the clinical facilitator as the most important outcomes of Cycle 4. She reflected that "… everybody expects you to just do the work, but nobody can help you … they too did not know what I was supposed to do … it is stressful and it is easier to just do what you always do and that is nurse the patients … I know I can do that well, so it was easy for me to do it … this was new … it is such a relief that I now know what is expected of me and I can now work on it …" and that "… because I did not have a proper job, I was given odd jobs, things that had to be done, but nobody wanted to do it or had the time to do it … that is not nice … you can not plan your day...".

In January 2006, the A&E unit moved to the new hospital. The PDG agreed that the project would only continue in March 2006 to give the practice leaders and nurse practitioners a chance to reorganise the new A&E unit, and get settled.

4.5 PROFESSIONAL DEVELOPMENT (STEP 2: CYCLE 5)

Cycle 5 as realised during Step 3 of this study was initiated in the first week of March 2006 and facilitated over a period of 11 months. This cycle was driven by the clinical facilitator, and focused on planning and implementing a CPDP in the A&E unit (see Table 4.4).

Table 4.4: Step 2: Cycle 5: Professional development

Phase 2			
22 August 2005 to 15 December 2005	**January 2006 – February 2006**	**1 March 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 4	**Move to new hospital**	**Cycle 5**	**Cycle 6**
Define a role		**Professional development**	**Amended professional development**

4.5.1 Actions planned

In March 2006, the project continued in the new A&E unit. While reflecting on Cycle 4, the clinical facilitator stated that actions concerning the A&E learners had been planned and implemented during this cycle. The clinical facilitator reflected that *"… I feel confident that I will be able to do the clinical accompaniment of the students (A&E learners) … it is going much better and I am using the study guide, clinical workbook and the guidelines we (clinical facilitator and researcher) compiled to guide me on what to do in the unit (A&E unit) …".* Consensus was reached that the clinical facilitator did not need any more assistance with the clinical accompaniment of the

A&E learners and reflected *"… I think we should focus on the professional development programme because that is a priority … I am OK with the students now … I have even changed the way I do their clinical accompaniment … we use to get together in the lecture room, but now I actually make more use of on-the-spot teaching … they (A&E learners) also said they like it more … they do not want lectures they want me to show them on the patients … they want to learn at the bedside…"*.

These reflections show that the clinical facilitator had consulted the A&E learners about their needs and was accommodating them instead of independently deciding what to address and how during clinical accompaniment. The clinical facilitator planned to continue with the A&E learners as she had been doing during Cycle 4. The clinical facilitator and researcher agreed to continue with the monthly meetings regarding the A&E learners and that, if there was any additional support or coaching needed, it could be planned during these meetings. The clinical facilitator agreed that actions could be planned to continue with Cycle 5 of her journey.

The findings obtained during the NGM were re-looked and discussed (Chapter 3, Section 3.5). Consensus was reached that, based on these findings, the clinical facilitator should start a CPDP in the A&E unit. This programme should include in-service training as requested by the nurse practitioners (see Figure 3.3). The clinical facilitator agreed to address the basic nursing care of patients and patient education during on-the-spot teaching (see Figure 3.4) as well as give attention to the use and care of equipment (see Figure 3.6).

Following the reflective discussions, the clinical facilitator planned the following actions:

- **Action 1:** Plan and implement a CPDP based on the needs of the nurse practitioners, including:
  - An in-service training programme
  - On-the-spot teaching
- **Action 2:** Plan and implement the CPR champions programme
- **Action 3:** Keep record of the clinical facilitator's activities

The researcher suggested that the clinical facilitator ask the nurse practitioners to evaluate the CPDP on a regular basis in order to ensure that their needs were being met and then, if appropriate, implement their suggestions. An instrument was given to the clinical facilitator to be able to evaluate the programme.

4.5.2 Act and observe

The three actions planned by the clinical facilitator for Cycle 5 were implemented. These are discussed below.

4.5.2.1 Action 1: Plan and implement a continuous professional development programme

The first action planned and implemented during Cycle 5 was the creation a CPDP. The clinical facilitator reflected that she planned to use an in-service training programme and on-the-spot teaching to enhance the professional development of the nurse practitioners.

a) In-service training programme

The clinical facilitator asked the nurse practitioners for suggestions regarding topics that should be addressed during the in-service training programme. The nurse practitioners and clinical facilitator collaboratively decided to include topics related to the knowledge and skills required by nurse practitioners working in an A&E unit to assess and manage the airway, breathing and circulation of patients admitted (see Annexure F.5). The researcher assisted the clinical facilitator in compiling a preliminary in-service training programme of a year's duration. This programme was then presented to the nurse practitioners for further input. The nurse practitioners' suggestions were considered and the programme adapted accordingly.

On 7 April 2007, the clinical facilitator presented the first in-service training session. The clinical facilitator ensured that the programme took place every Friday. When on leave, she asked one of the A&E nurse practitioners to present the session on her behalf.

The clinical facilitator and unit manager agreed that attendance of the in-service training programme should be compulsory for on-duty nurse practitioners. As the in-service training programme was regarded as an outcome for their performance management, an attendance list was kept as proof of their attendance. The practice leaders agreed that each nurse practitioner should be given a certificate of attendance if they attended the in-service training programme (see Annexure F.6). The certificate could be included in the nurse practitioners' portfolio files and serve as evidence that they had attended these sessions. This in turn would be used during their performance management evaluation, thus increasing their motivation to attend the programme.

Positive feedback was obtained from the nurse practitioners regarding the in-service training programme and their reflection provided evidence that enablement took place:

- *"… I (nurse practitioner) go to every lecture … it is good as we get to practise our skills … [the clinical facilitator] makes use of real-life scenarios … this helps us to use it again when we work in the unit (A&E unit) …"*
- *"… sometimes I (professional nurse practitioner) feel that I already know what [the clinical facilitator] is going to teach us … then I do not feel like going … now that [the clinical facilitator] is including additional lectures for us (professional nurse practitioners) I do find that it means more … I am learning new things and that excites me … I am actually improving my own knowledge and I can apply it when I manage the patients …"*
- *"… the in-service training programme is fun … we sometimes play games … so it does not get so boring … I really like going …"*
- *"… the knowledge and skills we learn there (in-service training programme) helps us (nurse practitioners) … we use it everyday in the ward (A&E unit) … I (nurse practitioner) for example did not realise how important the percentage of oxygen was and how important it was to give the exact oxygen flow to ensure the patient receive the correct percentage of oxygen …"*

b) On-the-spot teaching

The clinical facilitator made use of a teaching strategy she labelled "on-the-spot teaching" on a daily basis. In this strategy, she assumed the role of the clinical teacher for the nurse practitioners and provided opportunities for development

consistent with one-to-one relationships and the bridging of the gap between theory and practice (Altmann 2006:1). This learning strategy was based on the principles of adult, experiential and reflective learning, and aimed to develop the nurse practitioners at the bedside. The clinical facilitator made use of patients the nurse practitioners were managing at that time in the A&E unit. She optimised learning opportunities to teach the nurse practitioners at the bedside of these patients.

The researcher observed that, while the clinical facilitator was conducting on-the-spot teaching, specifically involving the professional nurse practitioners and A&E nurse practitioners, these practitioners would leave to do something else instead of taking part in the development opportunity. The clinical facilitator would then continue to manage the patient, involving the remaining nurse practitioners. She remarked that "*… they (professional nurse practitioners) always leave when I come to do on-the-spot teaching … it does not help at all … they are not interested …".*

Reflective discussions held with the professional nurse practitioners and A&E nurse practitioners indicated that the manner in which the clinical facilitator approached the learning opportunity frustrated them, as the clinical facilitator would *"… come and take the patient over …".* The professional and A&E nurse practitioners reflected that:

- *"… [the clinical facilitator] takes over and does not give me a chance to do it … I (A&E nurse practitioner) then feel incompetent and it seems as if she (clinical facilitator) does not trust me …"*
- *"… it frustrates me when she (clinical facilitator) takes over … I (professional nurse practitioner) want to do it … she (clinical facilitator) should show me how when I struggle … she should not do it for me …"*
- *"… it irritates me (professional nurse practitioner) when she takes my patient over … I have worked with the patient the whole morning and then she (clinical facilitator) just comes and takes over … I then leave her to do it herself …"*
- *"… does not trust us … she (clinical facilitator) rather does things herself … she takes it from my hands and then do it for me … then I learn nothing …"*

Based on these reflections, it was evident that the clinical facilitator had not approached on-the-spot teaching effectively, as she was not enabling the nurse practitioners but rather taking over and performing the tasks herself. The researcher enlightened the clinical facilitator that her actions frustrated the nurse practitioners.

The clinical facilitator replied *"… I do not do it intentionally … I was not aware of this … it comes naturally … when I see something is wrong I want to fix it … I will have to change that …".* The clinical facilitator also stated that *"… it seems as if I do not understand the term on-the-spot teaching …"* and asked the researcher to demonstrate on-the-spot teaching. The researcher involved the clinical facilitator in three sessions where on-the-spot teaching strategies were used in the training of A&E learners. The techniques were role modelled with the A&E learners used as the learners.

Following these role-modelling sessions, the clinical facilitator and researcher collaboratively redefined on-the-spot teaching as "*development at the bedside*". The clinical facilitator and researcher agreed that the clinical facilitator should not manage the patient at all during on-the-spot teaching, but rather focus on guided reflection and problem-solving skills to enhance the learning and development of the nurse practitioners. The clinical facilitator implemented these strategies.

Observations made by the researcher during clinical practice confirmed that the clinical facilitator used the strategies, which included guided reflection and problem-solving skills, as planned. Positive feedback was obtained from the nurse practitioners:

- *"… she (clinical facilitator) guides me and teaches me to assess the patient … I never used those skills and now I am using it every day … I think it improved my patient care …"*
- *"… I no longer feel so incompetent when she (clinical facilitator) helps me … she guides me and teaches me how to think about what I am doing and not just doing things without knowing why …"*
- *"… the teaching [the clinical facilitator] gives when I (nurse practitioner) am busy with a patient helps me a lot … I learn how to think about what I am doing instead of just doing it like I have done it every day in the past … in the end I think this will help the patients, because I am starting to think for myself now … I will become a good nurse (nurse practitioner) and I will be able to help the patients better …"*

The researcher discussed the positive feedback obtained from the nurse practitioners with the clinical facilitator. These reflections provided evidence that the clinical

facilitator had not only been enabled to use this teaching method, but had also been empowered and emancipated.

4.5.2.2 Action 2: Plan and implement the cardiopulmonary resuscitation champions programme

The second action planned and implemented during Cycle 5 was the CPR champions programme. The clinical facilitator was asked to do the CPR training for all the nurse practitioners in the hospital. This appeared to be an overwhelming task. The clinical facilitator was of the opinion that *"… it is a fulltime post for one person … I cannot be expected to do it …".* After having reflective discussions with the education specialist and researcher, the clinical facilitator decided to make use of a programme she referred to as "*CPR champions*" (see Section 4.5.2.2). The clinical facilitator stated that *"… it may be possible, but I will have to get assistance … I cannot do this alone … it is just too much asked from one person …".*

The clinical facilitator started the CPR champions programme by personally visiting each ward in the hospital. During these visits, the clinical facilitator explained the programme as well as the responsibilities of a CPR champion to the nurse practitioners and asked whether there were volunteers interested in the project. Once the volunteers had been decided upon, dates for the training were negotiated. The training officially started in April 2006 and was initially facilitated by the clinical facilitator.

The clinical facilitator gave each CPR champion a certificate for attending the CPR champions programme. A file which included the international CPR protocols, tips for teaching CPR, the clinical facilitator's contact details and a form that they needed to complete for every nurse practitioner they had trained in their respective wards was given to each CPR champion.

The clinical facilitator consulted the two ICU clinical facilitators and asked whether they would be willing to support and assist her with the training of the CPR champions. Both agreed and a partnership was formed.

The clinical facilitators of the A&E unit and ICU trained 86 nurse practitioners over a period of four months. In turn, the CPR champions were asked to train at least two nurse practitioners a month in their respective wards. However, this did not materialise. During reflective discussions, the clinical facilitator was enlightened that the CPR champions had expressed uncertainty and did not feel competent to train their peers.

The clinical facilitator asked the CPR champions how they suggested this challenge could be overcome. The clinical facilitator and CPR champions collaboratively agreed that the clinical facilitator would present the first session, while the CPR champions watched (role-modelling). The CPR champions would then present the second session, with the clinical facilitator attending the session and supporting them if the need arose. These actions indicate that the clinical facilitator took ownership of the project as well as the responsibility of making it a success, thus supporting emancipation. These actions also provide evidence that the clinical facilitator enabled and supported the CPR champions, thus creating an enabling environment that enhances development.

4.5.2.3 Action 3: Keep record of the clinical facilitator's activities

The third and final action planned and implemented during Cycle 5 was keeping record of the clinical facilitator's activities in her new role. The clinical facilitator kept record of the in-service training programme implemented in the A&E unit as well as of the CPR champions project. The time spent in the A&E unit doing on-the-spot teaching was recorded; however, the topics discussed with individual nurse practitioners were not recorded.

Reflecting on these actions, the clinical facilitator indicated that *"… it is easy to provide evidence of the in-service training programme and CPR champions programme … I only ask them (nurse practitioners) to sign the attendance list …"*. Regarding neglecting to keep records of the content discussed during on-the-spot teaching, the clinical facilitator reflected *"… it takes up so much time to record these actions … I do not like to do it … I know I have to as it would provide evidence of my actions … [the supervisor] also expects me to do it … I always find an excuse not to do it … it also does not mean much if I do it … I cannot use it …"*.

The clinical facilitator and researcher reflected on the rationale for keeping records of the time spent with each nurse practitioner as well as the topics reflected on during these on-the-spot teaching sessions. The researcher reflected that it would not only show what the clinical facilitator had done, but also indicate the specific needs and professional development progress of each nurse practitioner. The clinical facilitator would then be able to plan the on-the-spot teaching ahead of time to ensure that the needs of the nurse practitioners were being met. Consensus was reached that a file would be created for each nurse practitioner and the specific actions taken to enhance their professional development recorded in these files. The files were made, but never used. The clinical facilitator reflected "… *I did not use those files … it takes too much time … the unit (A&E unit) is too busy when I want to document their professional development …".*

The clinical facilitator and researcher reflected that a less complex method should be used. The clinical facilitator compiled a record tool and suggested that this tool be completed on a daily basis (see Annexure F.7). The researcher emphasised the importance of providing evidence of these sessions for the purposes of performance management in order to motivate the clinical facilitator to take the appropriate action.

4.5.2.4 Continuous development of the clinical facilitator

Observations made during Cycle 5 provided evidence that the clinical facilitator perceived the work environment as supportive and motivating, and that she was valued for her efforts by the doctors, her supervisor and the nurse practitioners. This was evident during reflective discussions in which the clinical facilitator stated that:

- *"… you (researcher) have helped me … the job description give me guidance … [the nurse educator] helped me to cope with the CPR … the job description is something I use a lot … it helped to clear my mind and it helped me to realise what I must do every day and without this I do not think I would have made it …".*
- *"… I think keeping record of everything I do … they (unit manager and supervisor) know what I do and they realise the effort I put into my work … they tell me that I am doing a great job."*

- *"… [the unit manager] also supports the professional development programme … it is compulsory and it forms part of the nurses' (nurse practitioners) performance management … that helps me to get the programme off the ground …".*

The clinical facilitator was motivated and perceived that her efforts were valued following positive feedback from her supervisor and the improvement of her performance management final mark. The clinical facilitator reflected that her supervisor *"… has acknowledged my professional growth during my performance management sessions …"* and *"… my performance management is getting better and better … I am always improving … this keeps me going …".* The clinical facilitator pointed out that her overall performance management mark had improved from an average of 3,9 to 4,7 (5 being the maximum).

The doctors involved the clinical facilitator in their in-service training programme on a regular basis and, in the A&E unit, often asked her to assist them with patient management. This provided evidence that the clinical facilitator was valued for her knowledge and skills in the work environment, which in turn increased her intrinsic motivation.

The fact that the clinical facilitator had become empowered was evident from the way she took ownership of her new role. The clinical facilitator's supervisor suggested that since the CPR champions programme was running successfully, it might be the right time to hand it over to another clinical facilitator. The clinical facilitator refused and stated *"… I cannot give it up now … I am not going to let someone else go on with my project … I started it and it is mine … I made a success of it and I would like to continue … it is the only thing that is working well now and I am proud of it …"*.

The clinical facilitator's ownership of her new role increased her sense of responsibility as *''… by teaching the nurses (nurse practitioners), the patient care in the unit (A&E unit) improved and the doctors are respecting us (nurse practitioners) more …"; "… the nurses' (nurse practitioners) knowledge and skills have improved and the patient care improved … that is the goal I (clinical facilitator) strive for … better patient care … I must make sure that I reach this goal …".*

Another reflection made by the clinical facilitator confirmed that she felt ownership of her new role and was becoming more autonomous: *"… the job description also helped me when [the supervisor] wanted to give me more work … I told her that we have agreed on the job description and that I do not have time to do that as well … I want to do my work well and be proud of what I do … I cannot do everything and I am not prepared to do the work of others which has nothing to do with my work … they should do their own work …".* The following additional quotes also support the clinical facilitator's ownership and autonomy:

- *"… [the supervisor] used me (clinical facilitator) for doing everything … I (clinical facilitator) had to do odd jobs in ICU (critical care unit) … I could not say no … but after we (clinical facilitator and supervisor) agreed about my job description I (clinical facilitator) can say no … I (clinical facilitator) can focus on my real job …"*
- *"… I (clinical facilitator) can say no to things that is not my responsibility … this makes my job easier …"*
- *"… in the beginning I was fighting for survival … trying to teach them (professional nurse practitioners) something … I could not get through to them … trying to get them to work with me and not against me … we are working together now … they can see I want to help them and that I am not against them … all that work to sort out my role and to teach me how to perform in my role was all worth it … I can see I am coming somewhere and reaching something and I have realised the importance of my job …".*

The A&E unit had changed from a toxic environment to an enabling environment for the clinical facilitator as well as for the nurse practitioners and A&E learners. The clinical facilitator was consciously aware that *"… it is difficult to find my feet in my new role … I have to give attention to it … it is easier to fall back to my old role (A&E nurse practitioner) because I know it well and I know I am good at it, but I am really concentrating to not do that … my role as clinical facilitator is actually more important than that, although I did not think so before … I have realised by teaching other nurses (nurse practitioners) to be as competent as me I am making a difference to patient care … alone I cannot do it, but in a team of good nurses (nurse practitioners) we will be able to do it …*". In the clinical setting, it became evident that the clinical facilitator had started to focus on her new role as clinical facilitator and did not get involved in the daily activities of the A&E unit in terms of patient management.

Not only was the clinical facilitator enabled by means of facilitation, but she was also emancipated as she took up the responsibility to enable the nurse practitioners, A&E learners and the CPR champions. The clinical facilitator was using her diary on a daily basis to plan and record her daily, weekly and monthly activities. Keeping a diary enabled the clinical facilitator to structure her daily activities. She realised the value of the diary and reflected *"… I keep record of everything I do … the results are visible … it gives me an idea of what I have accomplished every month …".* Having structure and planning ahead not only motivated the clinical facilitator but enabled her to achieve her goals: *"… with more structure, my productivity improved … it guides me and therefore I do more every day and I achieve more …".* This too led to improved job satisfaction, as she reflected "*… I am actually starting to enjoy my job again … I can see that I am now getting somewhere".*

The clinical facilitator knew what was expected of her in her new role, which enabled her to succeed in this role. She stated that *"… I (clinical facilitator) know what to do … I know what is expected of me in the unit (A&E unit) and now I am doing it …*" and *"… the job description is something I use a lot … it helped to clear my mind and it helped me to realise what I must do every day …".*

In the clinical setting, it was observed that the clinical facilitator was spending more and more time facilitating learning in the A&E unit. This was evident from the unit manager's statement that "*I see [the clinical facilitator] teaching them (nurse practitioners) in the unit (A&E unit) … she is showing them how to work with the ventilator and she discusses with them the patients … it is the first time that I am seeing this … she used to do it herself and not show the nurses (nurse practitioners) how to do it …"*. The researcher also observed that the in-service training programme had been implemented and that the clinical facilitator was becoming much more involved in facilitating the learning of the nurse practitioners. Positive remarks from the nurse practitioners also confirmed that the clinical facilitator was enabling them by means of the in-service training programme and on-the-spot teaching sessions:

- *"… I (nurse practitioner) now know what the normal heart rate and blood pressure is … I also know the difference between a young person and a old person … I can now call the doctor or [clinical facilitator] if I see a problem …"*

- *"… I have learnt so much since I have worked here … I can go to the in-service training programme of [the clinical facilitator] every week …"*
- *"… I can now nurse a patient on a ventilator and I know how to monitor for problems …"*
- *"… if we have a problem we can call [the clinical facilitator] and she helps us to solve the problem … I learned so much and sometimes I can now solve the problem on my own without her help …"*

The facilitation of the learning of the A&E learners continued. During Cycle 4, it was observed that the clinical facilitator made appointments with the A&E learners, during which she presented the skills or topics she felt should be addressed in these sessions. This changed in Cycle 5, with the clinical facilitator involving the A&E learners in their own development by asking them what their learning needs were and focusing on these issues during clinical accompaniment. The clinical facilitator thus collaborated with the A&E learners in order to determine their needs and thereby enhanced learning by focusing on their needs rather than independently deciding what their needs were. The clinical facilitator reflected *"… it does not help that I decide what we must do … they (A&E learners) then just sit there and they do nothing … I must do the talking and they just listen … when they tell me what I should focus on, I give them a chance to think about their learning needs … they are more interested in the topic then … I do not give them lectures, but give them problems to solve and I let them work together to solve the problems … they can then learn from each other …".* These findings provide evidence that the clinical facilitator had changed her approach to planning and implementing learning and development opportunities for the A&E learners from domination (independent decision-making by clinical facilitator) to participation (collaborative decision-making).

Positive feedback was obtained from the A&E learners, and other A&E learners working in private hospitals started to request working sessions in the A&E unit in order to *"… work with [the clinical facilitator], because she helps us and teaches us … we learn when we work there … it is not like in our hospitals where we must just work … we can ask her (clinical facilitator) anything and she help us to get our clinical skills in … she looks for us for opportunities where we can practise our skills …"*. The A&E learners acknowledged the clinical facilitator's knowledge and skills.

This positive feedback increased her self-esteem as reflected by her statement *"… I am recognised for what I know now … the students (A&E learners) come and work here so that I can teach them … they have clinical facilitators, but they prefer to work here … I actually think I am becoming a good clinical facilitator …".*

The clinical facilitator continued developing the CPR champions programme. She reflected that the CPR champions were not training nurse practitioners in their wards on a monthly basis and asked the researcher "*what should I do? How can I get them to actually do what they are supposed to do?"* The researcher suggested that she go back to the group and ask them to plan actions that could be implemented to resolve the challenges they faced. The clinical facilitator followed this advice and, together, the clinical facilitator and CPR champions decided that the clinical facilitator would assist them with their first training sessions, as they were still unsure about their ability to train their peers.

In addition to this, two monthly meetings in which the CPR champions could give feedback on the training they had done in their wards as well as the challenges they experienced with the CPR training, were organised. The clinical facilitator became consciously aware of not only the CPR champions' concerns and uncertainties regarding the training of their peers, but also the importance of collaboration. Acknowledging the CPR champions as adult learners and working collaboratively with them to ensure the success of the programme enhanced their ownership of the CPR champions programme, gave them a feeling of responsibility for their role and motivated them to start the training in their wards. The clinical facilitator reflected *"… it worked and the programme is now running … not everybody is doing what they are supposed to do, but with the pressure of seeing others perform they are realising that they will have to do something …".*

The clinical facilitator facilitated the development and enablement of the nurse practitioners, A&E learners and CPR champions, who in turn confirmed that emancipation had taken place. Another incident that confirmed this occurred after a new ICU clinical facilitator was appointed in April 2006 for the critical care units. The ICU clinical facilitator asked the clinical facilitator in the A&E unit to assist her with defining her role, as she had to present a job description to her supervisor during her next performance management appointment. Over a period of two weeks, the

clinical facilitator used guided reflection and mind mapping to assist the ICU clinical facilitator to develop a job description. The researcher observed that the ICU clinical facilitator regularly consulted the clinical facilitator for advice and/or to reflect on the challenges and possible actions that could be implemented in the ICU.

In July 2006, the clinical facilitator started to involve the A&E nurse practitioners in the CPDP, which reflected her emancipation. The A&E nurse practitioners were given opportunities to present the in-service training programme in both the hospital and A&E unit on behalf of the clinical facilitator. The clinical facilitator reflected that *"… I am using the trauma nurses (A&E nurse practitioners) to help me with the professional development programme … they enjoy it very much and I am now giving them a chance to develop …".* The A&E nurse practitioners were positive about this initiative and reflected that:

- *"… I am enjoying it so much to teach the nurses (nurse practitioners) … it keeps me up to date …"*
- *"… I think the nurses (nurse practitioners) never realised that I know so much … they now see me as a specialist (A&E nurse practitioner) … they can see I am not just a normal sister (professional nurse practitioner) …"*
- *"… even in the unit (A&E unit), they are asking me more questions … they never asked me before because I don't think they realised what I know …"*
- *"… I am forced to go back to my books when I prepare for the lectures … it is good for me and I am keeping up to date …"*
- *"… when I walk in the hospital the nurses recognise me and they greet me … they have realised what I know … when I do CPR in the wards they respect me for what I know because they have attended my lectures in the hospital's in-service training programme …"*
- *"… it makes me proud to see that other sisters (professional nurse practitioners) are realising that we (A&E nurse practitioners) are good at what we do … it is the first time I think that they realise what we learn in the trauma course (A&E programme) …"*

The clinical facilitator and A&E nurse practitioners reflected on these remarks and concluded that the involvement of the A&E nurse practitioners in the CPDP enlightened the nurse practitioners regarding their specific knowledge and skills, which, in turn, led to an increased interest in enrolling in the A&E programme. These

reflections were supported by the increase in the number of professional nurse practitioners that had enrolled for the A&E programme from two in 2005 to six in 2007 (see Table 3.6).

The A&E nurse practitioners showed that they took ownership of their role as educators in the A&E unit and it was observed that they too facilitated the learning of the A&E learners and nurse practitioners in the A&E unit, mainly through the use of on-the-spot teaching. Thus, by providing the A&E nurse practitioners with this opportunity to enable, they were acknowledged for their knowledge and skills which led not only to the enhancement of the learning environment, but also to their emancipation. Facilitating learning was not regarded as the clinical facilitator's responsibility alone, but as a collective responsibility.

For the first time, the nurse practitioners were attending workshops and lectures outside the hospital. They paid for themselves and even drove to Johannesburg to attend these. This indicated their eagerness to learn and also confirmed that they were motivated to take responsibility for their own CPD as well as make use of opportunities to enhance their development. This is indicative of the emancipation of the nurse practitioners.

4.5.3 Reflection

The clinical facilitator implemented the actions planned for Cycle 5. The in-service training programme took place on a weekly basis, the CPR champions programme was implemented, a partnership with the ICU clinical facilitators was formed and the clinical facilitator recorded the activities (in-service training programme and CPR champions programme) in which she was involved. The actions planned by the clinical facilitator were therefore not merely plans but were actually translated into action, indicating that she took ownership and responsibility for her new role and was motivated to implement plans and take action. These findings provide evidence that the clinical facilitator was enlightened, empowered and emancipated in an enabling work environment during Cycle 5.

In the enabling environment, the clinical facilitator was motivated and enabled through guided reflection to take action. Motivating factors included:

- *support obtained from myself, the unit manager and her supervisor,*

- *the fact that she was valued for her efforts by the unit manager, supervisor and nurse practitioners, and*
- *positive feedback given by myself, the unit manager, supervisor and nurse practitioners.*

The facilitative processes used were predominantly reflective strategies and included guided reflection, mind mapping and Socratic questioning. Guided reflection was regarded as the core element of the emancipatory intent of the project, which is in line with the critical social theory paradigm (Sanders 2004:308). This type of reflection was used as it provided a non-threatening and enabling environment in which the clinical facilitator could evaluate her own practice and recognise the challenges and value thereof (Maggs & Biley 2000:192).

Central to the critical social science are the challenges that arise in everyday life and the acknowledgement that barriers need to be removed if these challenges are to be solved. Manley (2004:70) states that, according to Fay (1987), this requires action that arises from enlightenment. Enlightenment was evident as the clinical facilitator became aware of what the nurse practitioners expected regarding professional development during the NGM as well as the everyday challenges of her new role. Down (2004:272), Kuokkanen and Leino-Kilpi (2000:235) and Wittmann-Price (2004:440) state that enlightenment is the precursor of empowerment.

Awareness is an affective experience that certain actions are not harmonious with the individual or group's needs and produces the feeling that 'something is not right', or 'this choice is not right for me' (Manley & McCormack 2004:37; Wittmann-Price 2004: 441). The clinical facilitator did not ignore the challenges experienced during her journey as practice developer. Challenges were acknowledged and actions planned and implemented in order to remove these challenges. Two examples highlight and confirm this statement:

- *amending the A&E learners' clinical facilitation strategies to ensure participation, and*
- *amending the CPRP to suit the needs of the nurse practitioners.*

These two examples indicate that the clinical facilitator was able to determine the causes of the challenges and attempt to solve them in collaboration with the nurse practitioners. Changes were made to the way in which actions were implemented, with a view to increase the effectiveness of the clinical facilitation strategies utilised as well as the CPR champions programme, by accommodating the needs of the nurse practitioners involved.

Enlightenment was also evident from the clinical facilitator's commitment to the actions initiated, her ability to speak freely and openly with me and the unit manager about her concerns and the fact that her decision-making regarding actions planned and implemented was guided by rational

arguments and not by considerations of power. These indicators of enlightenment are confirmed by Manley (2004:70).

The empowerment of the clinical facilitator was evident from her active involvement and participation in the reflective discussions, and her sense of responsibility for and ownership of her new role. Characteristics of high self-efficacy and self-esteem as well as increased autonomy were observed. The clinical facilitator became less dependent on me and continued her daily activities without consulting me. During Cycle 4, I was involved in the facilitation of the clinical facilitator every week for at least four to six hours. During Cycle 5, this time spent with the clinical facilitator decreased. Initially, two-hour reflective meetings were held once a week. These meetings gradually decreased and, in June 2006, two-hour reflective meetings were held once every fortnight. By August 2006, these meeting were held monthly.

It became evident that the clinical facilitator had gained confidence in her new role. This was also confirmed by her colleagues and the head of department, who provided the following positive feedback:

- *"… the students (pregraduate students) are saying that [the clinical facilitator] is helping them to prepare for their final clinical assessment …"*
- *"… dit gaan baie beter in noodgevalle, met al die opleiding wat [die kliniese fasiliteerder] gegee is, is die standaard van die verpleging baie beter …" [Translation: … the situation in the A&E unit has improved substantially, all the training the clinical facilitator has received has greatly improved the standard of nursing].*

4.6 AMENDED PROFESSIONAL DEVELOPMENT (STEP 2: CYCLE 6)

Cycle 6 was facilitated over a period of five months (February 2007 to June 2007), during which the clinical facilitator focused on planning and implementing an amended CPDP (see Table 4.5).

Table 4.5: Step 2: Cycle 6: Amended professional development

Phase 2			
22 August 2005 to 15 December 2005	January 2006 – February 2006	1 March 2006 to 31 January 2007	1 February 2007 to 30 June 2007
Cycle 4	Move to new hospital	Cycle 5	Cycle 6
Define a role		Professional development	Amended professional development

4.6.1 Actions planned

During Cycle 6, the clinical facilitator planned actions and then discussed these actions with the researcher. This indicates that the clinical facilitator not only had become able to work independently, but also now showed an increased responsibility for and ownership of her new role. Empowerment as well as emancipation had thus been realised.

The clinical facilitator reflected that the CPDP had been implemented and that she felt comfortable and confident in her new role as clinical facilitator. Consensus was reached between the clinical facilitator, unit manager and nurse practitioners that the planned in-service training programme on Friday mornings as well as the on-the-spot teaching should continue (see Annexure F.5). New topics for the in-service training programme were discussed with the nurse practitioners and implemented in April 2007. Based on suggestions by the nurse practitioners, the following actions were planned:

- **Action 1:** Involve experts in the CPDP
- **Action 2:** Include topics that do not focus on professional development
- **Action 3:** Start a CPDP on the night shift

The clinical facilitator reflected that the CPR champions programme needed to be amended as the CPR champions still neglected to train their peers in the wards. Thus, the following additional action was included in Cycle 6:

- **Action 4:** Motivate the CPR champions to act

4.6.2 Act and observe

The actions planned by the clinical facilitator during Cycle 6 were implemented and are discussed below.

4.6.2.1 Action 1: Involve experts in the programme

The first action planned and implemented during Cycle 6 was the involvement of experts in the CPDP. The in-service training programme continued as planned during Cycle 5 and was completed by the end of March 2007 (see Annexure F.5). In February 2007, the clinical facilitator started planning a new programme in collaboration with the nurse practitioners. The nurse practitioners suggested that the topics addressed should enable them to nurse the critically ill and injured patients that remained in the A&E unit for more than eight hours.

Patients that remain in the A&E unit for more than eight hours are classified as ICU patients. The nurse practitioners in the A&E unit nurse between two and eight ICU patients per day due to shortages of ICU beds in the hospital. Critically ill and injured patients remain in the A&E unit between 24 hours and 14 days, on average for seven days (The Hospital 2007b). The nurse practitioners were aware that they lacked the appropriate knowledge and skills that were required to nurse these patients.

The clinical facilitator compiled a preliminary in-service training programme, which was presented to the nurse practitioners and unit manager. All three parties involved reached consensus regarding the content as well as the order of priority in which these topics should be addressed during the programme. The in-service training programme was implemented in April 2007 (see Table 4.6). From Table 4.6, it is evident that the in-service training programme addressed not only issues of professional development presented by the clinical facilitator, but also other topics of interest presented by experts.

Table 4.6: A&E unit: In-service training programme (April 2007 to July 2007)

Month / Year	Topics
April 2007	**Clinical facilitator** Principles of basic nursing care of the ICU patient **Expert** *(last Friday of the month)* Wear the colour and type of clothes that suit you
May 2007	**Clinical facilitator** Sterile endotracheal and tracheal suctioning (open and closed suctioning techniques) **Expert** *(last Friday of the month)* Snake bites
June 2007	**Clinical facilitator** Basic principles of mechanical ventilation and specific monitoring of the mechanically ventilated patient **Expert** *(last Friday of the month)* Basic principles of skin care and applying make-up for work

Experts were asked to talk about various topics (both work and non-work related) every last Friday of the month as requested by the nurse practitioners (see Table 4.6).

Reflecting on the use of experts in the in-service training programme, the clinical facilitator stated that for the session on "*… snakebites … the lecture room was full for the first time and even the doctors and paramedics attended … so it really works …".* The clinical facilitator reflected that she had received positive feedback both from the nurse practitioners and doctors. They requested her to repeat the lecture on snakebites and inform them when these types of lecture were presented in the future.

4.6.2.2 Action 2: Include topics that do not focus on professional development

The second action planned and implemented during Cycle 6 was the inclusion of topics in the in-service training programme, which do not deal with professional development. Experts were asked to talk about topics that were not work related.

On the last Friday of every month, the clinical facilitator organised an expert to present a talk on an interesting topic. Topics such as 'wear the colour and type of clothes that suit you' and 'basic principles of skin care and applying make-up for work' were presented (see Table 4.6). The nurse practitioners working in ICU were invited to attend these lectures, which some of them did.

The clinical facilitator reflected that *"… I have started with something new … I have realised that the nurses (nurse practitioners) were bored with my in-service training programme and have started inviting speakers on different topics … it is not necessarily about work issues … topics that can mean something else to the nurses (nurse practitioners) … develop them personally … topics such as using make-up … the ladies really liked that …".*

4.6.2.3 Action 3: Start a professional development programme on the night shift

The third action planned and implemented during Cycle 6 was the initiation of a CPDP on night shift. The nurse practitioners working predominantly night shift requested that the in-service training programme be repeated on night shift. The clinical facilitator agreed. She consulted the A&E nurse practitioners and asked whether they would be willing to repeat the in-service training programme every fortnight when they worked night shifts. The A&E nurse practitioners agreed.

The in-service training programme was repeated at least once a month on night shift. The A&E nurse practitioners reflected that it was difficult as the best time to repeat the programme was 04:00. The nurse practitioners were often not interested and the session cancelled.

The lectures presented by experts on topics not related to the nursing profession were presented at 07:30. This allowed the nurse practitioners that worked night shift to attend the lectures as their shift ended at 07:00. Not one nurse practitioner attended these lectures after night shift. The nurse practitioners reflected that:

- *"… I have to make sure that my children go to school … I have to pick them up after work and then drop them off …"*

- *"… I cannot keep my eyes open after night duty … it is just not worth waiting for the lecture …"*
- *"… I will not benefit at all … I am tired and all I can think of is my bed …"*
- *"… I have to get up by 13:00 because my children return from school … I cannot stay at work because I must get enough sleep to make sure I can work again the next night …"*

Based on these reflections, it is evident that the challenges of involving all the nurse practitioners would have to be addressed.

4.6.2.4 Action 4: Motivate the cardiopulmonary resuscitation champions to act

The fourth action planned and implemented during Cycle 6 was the motivation of the CPR champions to act. Only ten of the 86 CPR champions were training other nurse practitioners (The Hospital 2006; The Hospital 2007c).

The clinical facilitator organised a meeting with the CPR champions and reflective discussions were conducted in order to plan actions to resolve the challenge. The CPR champions were asked to suggest possible actions that could be implemented in order to increase their training of the other nurse practitioners in their respective wards. The CPR champions suggested that meetings should be held during which the following actions would be implemented:

- **Action 1:** Give feedback on CPR training that took place in the clinical setting
- **Action 2:** Reflect on challenges experienced in the clinical setting during CPR training sessions
- **Action 3:** Plan actions that could be implemented to address the challenges experienced during CPR training sessions
- **Action 4:** Discuss one of the drugs used during CPR to ensure that the CPR champions keep their knowledge up to date
- **Action 5:** Using a manikin, give a scenario and practise the CPR skills to ensure that the CPR champions keep up to date

In April 2007, the first meeting was held to implement the above actions. In addition to this, other actions, including peer assessment and giving recognition to the CPR champion that had trained the most nurse practitioners each month, were

implemented by the clinical facilitator to motivate the CPR champions. Peer assessment was used during the practising of CPR on the manikin. The CPR champions received an assessment tool and were asked to give feedback to their colleagues regarding their performance. The clinical facilitator presented the CPR champions that trained the most nurse practitioners each month with a certificate and the results were forwarded to their supervisors. The clinical facilitator reflected that this was done to "*acknowledge*" and *"motivate"* the CPR champions to train more nurse practitioners.

The second meeting was held in June 2007. The exact same actions were implemented. Following this meeting, the CPR champions reflected that they regarded the meeting as *"… a huge success"*:

- *"… the meeting is compulsory and that is good … we are able to practise CPR and that gives me confidence …"*
- *"… we (nurse practitioners working in general ward) do not do CPR often … we forget how to do it … now that I have a chance to practise it I will be able to teach the others (nurse practitioners) with more confidence …"*
- *"… everybody (CPR champions) has the same problems … all of us do not have enough confidence to give the training … practising it regularly will keep me up to date …"*

The clinical facilitator confirmed that due to peer pressure the CPR champions were training more nurse practitioners. The majority trained "*between two and four nurse practitioners per month*".

4.6.2.5 Continuous development of the clinical facilitator

During Cycle 6, the empowerment, emancipation, increased job satisfaction and forming of additional partnerships of the clinical facilitator were observed.

Empowerment was evident based on findings, which included autonomy, an increase in self-esteem and self-efficacy, and an increased motivation due to positive feedback (see Section 4.5.2.2). The clinical facilitator's self-esteem as well as self-efficacy was high as is shown by the following reflective quotations:

- *"… I now think I can make a difference in this new job … that I will be able to do it without your (researcher) help … I now realise what I am supposed to do … I*

can make a difference in this unit (A&E unit) by teaching others … I can make a difference to the patient care delivered …"

- *"… I do make a difference in the unit (A&E unit) … I can see that every day … it is great … I really like that … I know I am in the right job now …"*

The clinical facilitator's positive self-efficacy and confidence gained during her journey was verified by her perception of herself as a leader in the A&E unit:

- *"… I am a leader now …"*
- *"… I can now lead … I am not a follower anymore, but a leader … I make a difference in the unit …"*

Additional evidence confirming the creation of an enabling environment was based on the clinical facilitator's experience of being valued and appreciated for her efforts. These findings can be seen in the following quote: *"… I get very good feedback from the doctors … they (doctors) say they can see the difference in the nurses (nurse practitioners) now … I am making a difference … others can see it now … the hard work is really paying off …".*

Based on the evidence, it was clear that the clinical facilitator experienced job satisfaction. This finding was based on the fact that she was no longer looking for another job, which had been the case just before the project commenced. This finding was further confirmed by the clinical facilitator's reflection that *"… by teaching the nurses (nurse practitioners), the patient care improved and the nurses (nurse practitioners) started seeing abnormalities and recognising them … the doctors have more respect for us as nurses (nurse practitioners) … this gives me a lot of satisfaction … it makes my job worthwhile … I am actually enjoying it (job) now …".*

The clinical facilitator's empowerment and emancipation by means of facilitation, guided reflection, Socratic questioning and coaching continued, although the input from the researcher had decreased substantially to one two-hour meeting monthly. The clinical facilitator worked independently and reflective discussions were now regarded as peer discussions rather than the facilitation of the development of the nurse practitioners working in the A&E unit. Evidence of emancipation was based on the following quotations:

- *"… I realise that I cannot do the job (patient care) on my own … I need to train others (A&E nurse practitioners) … to teach them how to teach the others (nurse practitioners) do it (patient care) … to teach them to be just as good as what I am … if I leave one day they can just take over (laugh) … not that I plan to … I am just starting to enjoy my job …"*
- *"… in the beginning I was working with the students (A&E learners) and teaching them everything I knew … you know like giving them one lecture after the other … becoming stressed if they are not doing it as I do it … now I give them a chance to do it the way they want to … they choose what they want to know … it is as you say, they are adult learners and they have a responsibility … I was like their friend … it was difficult to draw the line between being a friend and doing their (A&E learners) assessment … now I have a professional relationship with them (A&E learners) … it makes it a lot easier …"*
- *"… I used to spoon-feed them … now that I know my role and feel confident … I treat them as adult learners and expect of them to take the responsibility for their own learning …"*
- *"… [an A&E nurse practitioner] has told me (clinical facilitator) that she (A&E nurse practitioner) is now recognised by other nurses (nurse practitioners) in the unit (A&E unit) … they (nurse practitioners) have started to realise that she (A&E nurse practitioner) knows a lot about trauma nursing and that was because I (clinical facilitator) involved her in the professional development programme … that makes me feel proud of her …"*
- *"… I (clinical facilitator) can determine every nurse's (nurse practitioner) weaknesses and strengths in the unit (A&E unit) and then I use this information to determine the next topics for the in-service training programme if I see the problem is a general problem … otherwise I just spend extra time with the specific nurse (nurse practitioner) to ensure that she understands it …"*

Partnerships were formed with the following people in the course of the clinical facilitator's journey:

- The lecturer of the A&E programme,
- ICU clinical facilitators,
- Members of the PDG, and
- A&E nurse practitioners.

Rivalry between the clinical facilitator and one of the ICU clinical facilitators was observed during Cycle 4. The clinical facilitator reflected that it might be due to *"a lack of communication"* or the fact that "*they were working independently not telling one another what the other was doing"*. When a second ICU facilitator was appointed, she consulted the clinical facilitator to assist her to develop a job description and had regular reflective discussions with her (see Section 4.4.2.4). This could be regarded as the initial step taken towards the development of a partnership between the three clinical facilitators. In April 2006, the second step was taken when the clinical facilitator asked the ICU facilitators if they would assist her with the CPR champions programme and they agreed. The partnership continued to develop throughout Cycle 5 and 6 as is evident from the quotations below:

- *"… [the ICU clinical facilitator] and me (clinical facilitator) are having monthly meetings now … we discuss problems experienced with students (A&E learners and ICU learners) …"*
- *"… we (clinical facilitators) have started sharing our work … we only have one orientation week for all the newly appointed nurses (nurse practitioners working in the A&E unit and critical care units) … we are taking turns to do the lectures and orientation sessions … it helps us all …"*
- *"… we (ICU clinical facilitator and clinical facilitator) did not get on at all … I think she thought I knew nothing … she did not understand what I do in the unit (A&E unit) … now we get on very well … we help each other and support each other … if I cannot manage to give an in-service training lecture for the hospital [the ICU clinical facilitator] will help me out …"*
- *"… she (ICU clinical facilitator) does not hide things like the students' (A&E learners and ICU learners) honorary appointments or annual leave … she shares it with me and reminds me if I forget … we are at long last working together as a team and not as individuals …"*
- *"… we work like a team now …"*

Another partnership that developed was between the two practice leaders. This was evident from reflective discussions held with the unit manager (see Section 5.4) as well as the reflections of the clinical facilitator:

- *"… [the unit manager] supports me (clinical facilitator) and I support her … we are becoming colleagues as well as friends now …"*

- *"… myself and [the unit manager] are closer now than ever before … we support each other … she talks to me about personal stuff and we can even now discuss the problems we experience in the unit (A&E unit) and then decide together what the best plans are to solve the problems …"*

A partnership also developed between the clinical facilitator and A&E nurse practitioners. During Cycle 5 and 6, the clinical facilitator started to involve the A&E nurse practitioners in the CPDP. They were asked to give input when the clinical facilitator planned the in-service training programme and they were asked to present the in-service training programme when the clinical facilitator was on leave. The A&E nurse practitioners were also asked whether they would present the in-service training on night shift. These actions indicated that the clinical facilitator acknowledged their clinical competence.

The clinical facilitator involved one of the A&E nurse practitioners in assisting her with the development of a CPR checklist that could be used during CPR to make the recording of actions and drugs administered easy (see Annexure F.8). The clinical facilitator included the name of the A&E nurse practitioner on the document, thus acknowledging her for her input.

The clinical facilitator was asked whether she would be willing to present the theoretical component of the A&E programme during the researcher's sabbatical leave in 2007. The clinical facilitator agreed to do this and regarded it as an opportunity and a challenge.

The clinical facilitator and A&E nurse practitioners gave input into the creation of the assessment tools used for the A&E learners. They were acknowledged for this by the inclusion of their names on the assessment tools and were thanked formally for their valuable contribution. One of the A&E nurse practitioners volunteered to organise a three-day getaway in September 2007 for the A&E learners. The A&E nurse practitioner organised the entire weekend, which included activities such as abseiling and water rescue. The A&E nurse practitioners volunteered to get involved in the clinical facilitation and assessment of the A&E learners. This was agreed upon.

Based on these observations and actions, it was evident that a partnership had developed between the researcher (as lecturer of the A&E programme), clinical facilitator and A&E nurse practitioners, and the A&E learners. Involving the clinical facilitator in the revision of the study guides and clinical workbooks, and collaboratively planning the clinical facilitation of the A&E learners might have encouraged this partnership (see Section 4.4.2.2 and Section 4.2.2.5). The professional nurse practitioners had taken ownership of and responsibility for the A&E programme. The following remarks made by A&E learners validated this statement:

- *"… we (A&E learners) are going to see [an A&E nurse practitioner] after class … she is helping us with the interpretation of chest X-rays today …"*
- *"… I (A&E learner) am working overtime in [the hospital] now … I work when [an A&E nurse practitioner] is working … she helps me with my procedures and the mechanical ventilator … I learn so much when working with her …"*
- *"… I meet [an A&E nurse practitioner] before I come to class … she helps me with problems I have … we do not see so many critically ill patients in my hospital …"*

4.6.3 Reflection

The facilitation process used by myself to continuously develop the clinical facilitator during the AR for practitioners project included primarily guided reflection, Socratic questioning and coaching. Recognising that learning is crucial to achieving sustainability (Sumner 2003:43), I used these strategies rather than directive teaching, as they supported the clinical facilitator and enhanced the possibility of lasting change (Brown et al. 2003:220). A summary of the coded data obtained during the clinical facilitator's journey is given in Figure 4.1.

After initiating the facilitation process in August 2005, I became frustrated at times because I thought the enabling process would be simpler and quicker. I have now realised that change takes time and that every person should be valued and provided with the opportunity to develop at his/her own pace. As the clinical facilitator was an adult learner, it was also important to take the six characteristics of adult learning identified by Malcolm Knowles (1970) into consideration. The process of adult learning as self-directed inquiry is described by Jarvis (2004:126) and Russell (2006:350) in terms of these six characteristics as:

- *autonomous and self-directed,*
- *accumulating a foundation of experiences and knowledge,*

- *goal orientated,*
- *relevancy orientated,*
- *practical as well as experiential and applied knowledge, and*
- *linked to the need to be shown respect.*

These characteristics were used to direct the facilitative and learning processes throughout this journey, providing the clinical facilitator with opportunities to make mistakes and learn from those mistakes (Brown et al. 2003:113; Jarvis 2004:90; Russell 2006:349). These characteristics also explain why the clinical facilitator did not always implement my suggested actions, but rather implemented those actions she planned. An example that provides evidence of the autonomous and self-directed characteristics of the clinical facilitator's journey is that she did not implement my suggestion that she evaluate the CPDP on a regular basis. The clinical facilitator stated that she did not "… feel ready to be evaluated by the nurse practitioners …" as "… I am just finding my feet first … as soon as I feel more confident I will ask them (nurse practitioners) to evaluate the programme …".

Change had taken place specifically regarding the priority one challenge identified by the nurse practitioners as needing to be addressed in order to ensure a future for them in the A&E unit. The changes that occurred during the clinical facilitator's journey included both personal changes and changes in the A&E unit. These changed occurred in terms of:

- *the clinical facilitator's professional development as a result of the enabling environment and an awareness of the expectations of her new role as perceived by the nurse practitioners as well as herself:*
  - *enablement*
  - *empowerment*
  - *emancipation*
  - *forming new partnerships (tertiary institution, ICU clinical facilitators, A&E nurse practitioners and unit manager)*
- *the A&E unit:*
  - *implementation of a CPDP*
  - *implementation of the CPR champions programme*
  - *enablement of the nurse practitioners*
  - *enablement, empowerment and emancipation of the A&E nurse practitioners*
- *the organisation:*
  - *the enablement, empowerment and emancipation of the ICU clinical facilitator*

As there is currently a significant emphasis on CPD in nursing and it is no longer viewed as optional but as an integral part of career progression (McCormack & Slater 2006:136), this was regarded as a crucial and important outcome of the clinical facilitator's journey.

The emancipation of the clinical facilitator was demonstrated by her enrolling for a master's programme. The topic she chose to address was "The development of a nursing record tool for critically ill or injured patients nursed in an A&E unit". Reflecting on her choice of topic, she stated that "... record keeping is neglected in the unit (A&E unit) ... it is an important function of nurses (nurse practitioners) ... the current tool that we are using has big gaps ... we (nurse practitioners) need a tool that is developed for our needs ... it must be straightforward and easy to use ...".

4.7 SUMMARY

In this chapter, the journey of the clinical facilitator is described and the results that show that the toxic environment was changed to an enabling environment discussed. In this enabling environment, the clinical facilitator was enlightened, continuously developed and empowered to delineate a role and continue to implement a CPDP for the nurse practitioners in the A&E unit. This in turn enhanced technical practice development in the A&E unit. The enablement of the nurse practitioners by the clinical facilitator is evidence that she was emancipated in the process.

As partnerships developed with the A&E lecturer, the ICU clinical facilitators, the PDG and the A&E nurse practitioners, the clinical facilitator experienced a decrease in professional isolation. Throughout the journey, the clinical facilitator took ownership of her new role and the responsibility to implement the actions planned.

Chapter 5 focuses on the journey of the unit manager during the three AR cycles (Cycle 7, 8 and 9) of Step 3 of the research process.

5 Journey of the unit manager

Philosophers have always interpreted the world,
the point is to change it

Karl Marx (1975)

5.1 INTRODUCTION

Chapter 4 focuses on the journey undertaken by the clinical facilitator in developing a role, and planning and implementing a CPDP to address the most important challenge identified during the NGM that needed to be addressed in order to create a future for the nurse practitioners in the A&E unit. The clinical facilitator addressed the priority one challenge (professional development) and changed the toxic environment to an enabling environment, thus contributing to technical practice development.

Chapter 5 focuses on the journey undertaken by the unit manager in addressing the remaining challenges, further promoting an enabling environment and establishing strategies to develop the leadership of the nurse practitioners. The latter two actions were planned with an emancipatory intent, aiming to achieve the shared vision of 'emancipatory practice development'.

5.2 OVERVIEW OF THE UNIT MANAGER'S JOURNEY

During the NGM, the nurse practitioners were enlightened by becoming aware of the challenges that needed to be addressed in order to ensure a future for them in the A&E unit. Five priorities were identified, namely professional development, patient care, structure, equipment, and research. The clinical facilitator took the responsibility of addressing the priority 'professional development' as well as giving attention to basic patient care, respect for patients, including ensuring that patients

have clean beds and are fed if unable to do so themselves, and patient education (see Figure 3.3).

The unit manager volunteered to address the remaining challenges (see Table 5.2) and thus continued to plan and implement actions, and observe and reflect on the outcomes. On request of the nurse practitioners, participative management was implemented.

5.2.1 Timeframe

From 29 August 2005 to 30 June 2007, three action cycles (Cycle 7, 8 and 9) took place as part of the journey undertaken by the unit manager in the AR for practitioners project (see Table 5.1).

Table 5.1: Unit manager's journey: summary of the timeframe

Phase 2			
29 August 2005 to 31 May 2006	**January 2006 – February 2006**	**1 June 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 7	**Move to new hospital**	**Cycle 8**	**Cycle 9**
Address the challenges		**Leadership development**	**Amended leadership development**

The journey of the unit manager is presented in Table 5.1. It is evident that the journey started on 29 August 2005, when Cycle 7 was put into action and the challenges in the A&E unit addressed. During January and February 2006, the A&E unit was moved to the new hospital and, from 1 June 2006 to 31 January 2007, Cycle 8 was put into action with the initiation of participative management. Cycle 9, in which the participative management was amended, took place from 1 February 2007 to 30 June 2007.

5.2.2 Coded data

In Figure 5.1, the unit manager's journey is visually depicted by means of a summary of the coded data obtained during the journey. The data were analysed as discussed in Section 2.8.1.3a. Two themes were identified during the unit manager's journey, namely working in an enabling environment and developing partnerships.

In an enabling environment, the unit manager motivated the nurse practitioners and utilised reflective learning to enhance their enablement in order to reach the shared vision of 'emancipatory practice development'. Throughout the unit manager's journey, the researcher used the facilitative process, and supported, coached and enabled the unit manager to address the challenges she took responsibility for and ownership of.

The unit manager, in turn, motivated the nurse practitioners by enhancing trust between herself and the nurse practitioners, using participation when making decisions regarding management issues in the A&E unit, supporting the nurse practitioners, being fair, valuing their input, knowledge and experience, and celebrating their successes. This provided opportunities for job enrichment and increased the nurse practitioners' job satisfaction.

Trust was enhanced between the unit manager and nurse practitioners during the voluntary rotation of professional nurse practitioners through the unit manager's office in order to provide them with learning opportunities regarding the day-to-day management of the A&E unit. The nurse practitioners were involved in the majority of the decisions made in the A&E unit as a participatory approach was utilised throughout the unit manager's journey. Examples of this include the involvement of the nurse practitioners in teamwork, asking their opinion regarding who should be sponsored to attend BLS, ACLS, PALS and ATLS courses and following their suggestion regarding the portfolios which could be used for performance management. It was observed that the nurse practitioners perceived the implementation of the portfolio system as suggested by them as enhancing the fairness of performance management. The nurse practitioners felt that, by providing a portfolio with evidence of their worth, the unit manager's value for their input would be enhanced. Participation enhanced the ownership and responsibility of the

nurse practitioners while simultaneously acknowledging and valuing their knowledge and experience.

Enlightenment was evident during the unit manager's journey. The nurse practitioners were provided opportunities to develop enhanced autonomy, self-efficacy, self-esteem, ownership and responsibility. Examples of enlightenment during the unit manager's journey include the nurse practitioners who became aware of the gaps in their own professional knowledge and skills, and the consequences of this on patient care, as well as the professional nurse practitioner who saw that the nurse practitioners showed a lack of respect towards patients and their families. These nurse practitioners took up the responsibility to act, showing that they were empowered. Evidence of autonomy was observed when three nurse practitioners requested to rotate through the ICU and medical wards in order to bridge the gap in their professional knowledge and skills, and enhance their clinical experience. The other professional nurse practitioner took ownership of and responsibility for the challenge of the disrespect shown to patients and their families, and addressed it in the A&E unit. This indicates that the unit manager provided the nurse practitioners with the opportunities to develop plans and participate in addressing the challenges.

Emancipation of the unit manager and nurse practitioners could be observed. The unit manager provided the nurse practitioners with the opportunities to develop by involving them in participative management initiatives. The nurse practitioners were emancipated, as they too enabled other nurse practitioners. An example of this is when the nurse practitioners who had rotated through the ICU showed the nurse practitioners how to apply suction when they returned to the A&E unit.

During the journey of the unit manager, three partnerships were formed, namely with the researcher working at a tertiary institution, the PDG and nurse practitioners in the A&E unit.

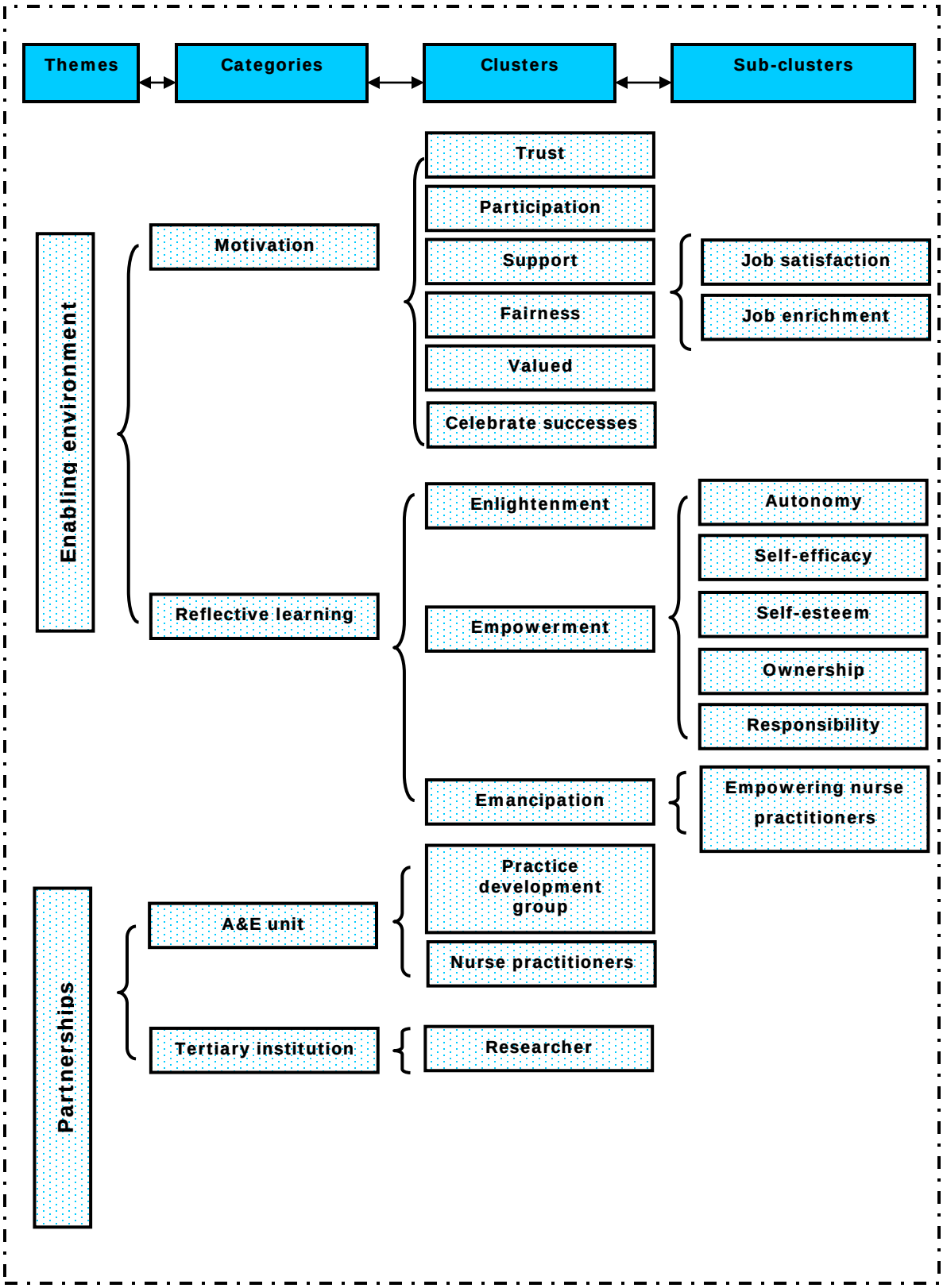


Figure 5.1: Unit manager's journey: summary of coded data

5.3 ADDRESS THE CHALLENGES (STEP 2: CYCLE 7)

Cycle 7 was facilitated over a period of six and a half months, which started on 29 August 2005 and ended on 31 May 2005, excluding January and February 2006 during which time the A&E unit moved to the new hospital (see Figure 5.2). Cycle 7 focused on addressing the challenges that were not addressed by the clinical facilitator (see Table 5.2).

Table 5.2: Step 2: Cycle 7: Address the challenges

Phase 2			
29 August 2005 to 31 May 2006	**January 2006 – February 2006**	**1 June 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 7	**Move to new hospital**	**Cycle 8**	**Cycle 9**
Address the challenges		**Leadership development**	**Amended leadership development**

5.3.1 Actions planned

The unit manager accepted the responsibility of addressing during Cycle 7 the remaining challenges identified at the NGM (excluding the actions planned and implemented by the clinical facilitator discussed in Chapter 4). A list of the challenges was compiled based on the findings of the NGM and actions planned for each challenge (see Table 5.3).

Reflecting on the challenges explored, the unit manager concluded that some of the challenges would not be relevant once the A&E unit moved to the new hospital. Although the new A&E unit would remain a Level III tertiary facility, only P1, P2 and orthopaedic emergencies would be admitted and managed. These challenges would be placed on the sideline and then re-evaluated for their relevance once the A&E unit had moved to the new hospital (see Table 5.3).

Table 5.3: Unit manager: challenges and specific actions planned

Priority 1: Professional development	
Challenges	**Actions planned**
Knowledge and skills - Sponsored BLS, ACLS, PALS and ATLS	Collaborate with head of department, and then discuss and negotiate sponsors with top management
- Clinical experience in other units	If requested by nurse practitioners, discuss and negotiate with middle management
Attitudes and values - Lack of respect For one another as nurse practitioners For patients and their families	- Re-enforce attitudes and values during monthly meetings - Role modelling
- Organised and tidy A&E unit	Implement daily ward rounds and monitor
- Fill up the used stock	Implement daily ward rounds and monitor
- Nurse practitioners work within scope of practice	Implement daily ward rounds and monitor *and* Focus on this challenge during the CPDP
- Accept responsibility and accountability	- Portfolio development and performance management - Participative management principles Shared leadership & Teamwork (*Only to be implemented in Cycle 8 following the move of A&E unit to new hospital*)
- Support Each other as nurse practitioners Multidisciplinary team members Top management Support staff	- Re-enforce attitudes and values during monthly meetings - Role modelling - Monthly meetings with multidisciplinary team members and support staff - Ask top management for support when need arises, instead of waiting for support
Socialisation Informal socialisation Nurse practitioners Multidisciplinary team members	- Nurse practitioners: Organise informal functions to celebrate successes - Multidisciplinary team members: Organise year-end function
Priority 2: Patient care	
Challenges	**Actions planned**
Nurse practitioners - Increase total number of permanent nurse practitioners	- Recruit and appoint professional nurse practitioners *and* - Monitor the total number of permanent nurse practitioners as this was regarded as a barrier (addressed in Cycle 2)
- Overtime by permanent nurse practitioners	Give permanent nurse practitioners the first option to work available overtime shifts

Priority 2: Patient care *(cont.)*	
Challenges	**Actions planned**
Improve basic patient care - Caring	- Increase support for the nurse practitioners *and* - Focus on improving basic patient care during the CPDP - Increase total number of nurse practitioners - Monitor total number of permanent nurse practitioners as this was regarded as a barrier (addressed in Cycle 2)
- Respect Clean beds Feed patients when unable to feed themselves	Monitor during daily ward rounds
Patient education - Illness or disease - General health education - Public awareness	- Portfolio development for use during performance management - Obtain pamphlets available from the Department of Health
Decrease patient waiting times Nurse practitioners	- Nurse practitioners should admit patients as soon as they arrive in A&E unit - Assign tasks to the shift leader - Monitor during regular ward rounds
Multidisciplinary team	Monitor time spent in A&E unit and inform doctors or specialists if patients wait more than four hours
Psychiatric patients - Decrease time spent in A&E unit - Direct admission to psychiatric hospital	- Challenge should be resolved by move to new hospital as psychiatric patients would not be admitted to A&E unit *thus* Monitor once A&E unit moves to new hospital
Pharmacy - Available 24 hours per day to patients - Run by pharmacist	- Discuss and negotiate with top management
Priority 3: Structure	
Challenges	**Actions planned**
Rules - Nurse practitioners	- Allocate a shift leader to take charge of each shift - Determine tea and lunch breaks daily and indicate these in the delegation book
- Multidisciplinary team - Medical students	Involve the head of department
Standards and protocols Patient management	Involve the head of department

Priority 4: Equipment	
Challenges	**Actions planned**
Available equipment Taking care of equipment	- Focus: Daily ward rounds - Teamwork: Allocate a specific team to be responsible for taking care of equipment
Lack of equipment More equipment needed	- Use opportunity when A&E unit moves to new hospital to order adequate amount of equipment
Priority 5: Research	
Challenges	**Actions planned**
Patient management Statistics available regarding patient management	- Allocate a team to be responsible for statistics in A&E unit - Make statistics available during monthly meetings

In Table 5.3, the actions planned based on the five priorities identified during the NGM are summarised. The priorities are reflected in the first column of the table and are, in sequence: professional development, patient care, structure, equipment and research. In the second column, the actions which were planned to address these priorities are provided.

5.3.2 Act and observe

The implementation of the actions planned (see Table 5.1) and the outcomes as perceived by the unit manager and nurse practitioners were observed and reflected upon. The implemented actions are briefly discussed, followed by a summary of the outcomes.

5.3.2.1 Priority 1: Professional development

The unit manager addressed challenges regarding knowledge and skills, attitudes and values, and socialisation under priority one.

a) Knowledge and skills

The actions planned to address priority one were getting sponsorships for BLS, ACLS, PALS and ATLS courses and providing the nurse practitioners with the opportunity to obtain clinical experience in the ICU or wards if requested.

⇒ ***Sponsored BLS, ACLS, PALS and ATLS courses***

The unit manager discussed the request of the nurse practitioners for sponsored BLS, ACLS, ATLS and PALS courses with the middle manager. Discussions with the head of department and top management followed, during which they consented to the annual sponsorship of two professional nurse practitioners for the BLS course as well as one of the advanced courses (ACLS, ATLS and PALS).

The rationale for sponsoring only professional nurse practitioners was that, firstly, training sessions regarding the principles of basic CPR, which all the nurse practitioners were attending, were being provided on a weekly basis in the A&E unit by one of the consultants. Although these sessions were not internationally recognised (as is the case with BLS, ACLS, PALS and ATLS), the skills and knowledge obtained during these sessions were in line with international standards and protocols. Secondly, although all nurse practitioners qualify for the BLS course, only professional nurse practitioners qualify for the advanced courses (ACLS, PALS and ATLS). However, BLS is also a prerequisite for the advanced courses. Therefore, the professional nurses first had to successfully complete the BLS course before they could continue with the advanced courses. As these courses are expensive, consensus was reached that only professional nurse practitioners would be sponsored to attend these courses, but basic CPR sessions would continue to be provided in the A&E unit to ensure that all the nurse practitioners would have an opportunity to obtain the necessary knowledge and skills.

The professional nurse practitioners were involved in deciding the criteria for the professional nurse practitioners who would attend these courses each year. The professional nurse practitioners reflected on the different possibilities and consensus was reached that two professional nurse practitioners, who were not A&E nurse practitioners and who had not enrolled for the A&E programme or any other post-basic programme, would be given the opportunity to attend these courses. This gave the professional nurse practitioners the chance to acquire new knowledge and

skills that could be applied in the A&E unit, thus enhancing technical practice development.

The professional nurse practitioners' responded to the realisation of the action plans as follows:

- *"… two registered nurses (professional nurse practitioners) were given an opportunity to attend the courses this year …"*
- *"… two registered nurses (professional nurse practitioners) attended the BLS and ACLS course … at least that is a start … I (professional nurse practitioner) think we should all be given the opportunity to go every two years …"*
- *"… I (professional nurse practitioner) still think we (professional nurse practitioners) all should have been given the chance to go this year … but at least it is something …"*
- *"… I do think it is unfair that they do not give the sisters who have done trauma (A&E nurse practitioners) the opportunity to go … they only send the sisters who have not done trauma (professional nurse practitioners) to go … they say we (A&E nurse practitioners) know it …"*

Two professional nurse practitioners were selected to attend the BLS and ACLS courses in 2006. Both passed the BLS (a basic course), but did not pass the ACLS course. The unit manager discussed this with the professional nurse practitioners who had failed. They stated that they were unable to interpret the electrocardiographs (ECGs) and that the contents of the advanced course were too difficult. The unit manager gave feedback to the professional nurse practitioners concerning these issues.

The professional nurse practitioners were given the opportunity to develop and, after using this opportunity, were enlightened about their own knowledge and skill gaps. One of the professional nurse practitioners stated:

> *… I have learnt something, but the ACLS course was difficult and we (professional nurse practitioners) need to have more knowledge about ECGs and the drugs before we go … maybe we must only send the trauma nurses (A&E nurse practitioners) to the ACLS course … they already have more knowledge and skills and they can then come and teach us …*

The suggestion that the professional nurses be given the opportunity to attend the BLS course, but that only the A&E nurse practitioners should attend the ACLS, ATLS and PALS courses (all advanced courses) in the future was accepted by all the professional nurse practitioners. The rationale was that the A&E nurse practitioners had a better chance of succeeding in the advanced courses, as they had obtained the necessary knowledge and advanced skills during the A&E programme.

It was also decided to include all the professional nurse practitioners in the code red team. The code red team was an initiative started by one of the doctors. The team included a doctor and A&E nurse practitioner, and was responsible for assisting the personnel in the wards with patients who went into cardiac arrest by responding to the alert, going to the ward with the necessary equipment and starting advanced CPR as soon as possible in order to increase the patients' outcomes. By being part of the team, the professional nurse practitioners would be given the opportunity to go with the team and develop in the process. This action was implemented during clinical practice. The professional nurse practitioners were motivated and empowered to act and change things, which is indicative of emancipation. Participation was also evident.

In 2007, two A&E nurse practitioners were given the opportunity to attend the BLS and ACLS courses. Both passed and these courses are now regarded as an additional incentive to the professional nurse practitioners for completing the A&E programme. Throughout this process, the autonomy of the professional nurse practitioners was respected.

⇒ ***Clinical experience in other units***

During the two-year timeframe of the project, two professional nurse practitioners requested to be rotated through the ICUs and one auxiliary nurse practitioner requested to be rotated through a medical ward in order to obtain additional clinical experience. This is indicative of their autonomy and the exercising of their right to be self-governing. It was evident, when reflecting on the reasons the nurse practitioners wanted to rotate through other units, that they had become aware of their clinical shortcomings and had taken up the responsibility of addressing these shortcomings by using the opportunity to develop themselves and return in order to improve the patient care in the A&E unit.

The request by these nurse practitioners provides evidence that they had become enlightened, through their awareness of the gaps in their required knowledge and skills, and the consequences of this (Down 2004:272). Motivated to act, the nurse practitioners requested to work in wards in order to enhance their knowledge and skills, indicating that they were empowered and emancipated during the process of improving patient care in the A&E unit. The following reflective quotations made by the nurse practitioners confirmed this:

- *"… we (professional nurse practitioners) are looking after ICU patients every day … we do not know how and it is not fair towards the patients … we are neglecting them (patients) …"*
- *"… I (professional nurse practitioner) want to learn how to look after an ICU patient … I am stressed when I have to nurse them in trauma … we do not know how to do it …"*
- *"… most of the patients in trauma are medical patients … they are diabetics or they have hypertension … I want to learn more about that … I want to learn how to nurse the patients in [the medical ward] …"*
- *"… I want to go and work in ICU … I want to be able to look after the ICU patients in the trauma unit (A&E unit) … I am so stressed when I have to look after the ICU patients … I want to know how to do it …"*

The unit manager acted immediately on these requests by negotiating the possibility with middle management. All three the nurse practitioners were granted permission to rotate through one of the ICUs and a medical ward in order to gain experience in the management of critically ill and injured patients in the A&E unit. The nurse practitioners returned to the A&E unit after a period of six months and were asked to reflect on their experiences, as well as what effect these experiences had on their clinical practice in the A&E unit. Based on these reflections, it became evident that, during the process, they had not only become enabled, but also emancipated.

Enablement was evident from the following reflective quotations:

- *"… I have learnt such a lot of new skills … suctioning a patient … looking after the ventilator (mechanical ventilator) and then nursing the patient on the ventilator (mechanical ventilator) …"*
- *"… I can now understand how the ventilator (mechanical ventilator) works … I know what to look for and how to interpret the blood gas (arterial blood gas) … it*

helps me so much when I look after the patients who stay in our unit (A&E unit) for such a long time …"

- *"… [the ICU clinical facilitator] helped me such a lot … she told me how to interpret the vital signs and how to mix the adrenaline infusions … we use it so much in our unit (A&E unit) but now I know how to mix it and how to use it …"*

Emancipation was evident as it became clear that the nurse practitioners used the knowledge and skills they had learned in ICU to enable nurse practitioners working in the A&E unit:

- *"… we (nurse practitioners) do not focus on basic patient care in this unit (A&E unit) and we are really looking after ICU patients more and more in this unit (A&E unit) … because the patients stay so long … because there are no beds … we do not give attention to pressure care and mouth care … I teach the other sisters (professional nurse practitioners) to do this now in our unit (A&E unit) …"*
- *"… I was able to mix the Dobutrex (Dobutamine) when the doctor asked us (nurse practitioners) … the others (nurse practitioners) did not know how … I showed them how to do it …"*
- *"… they (nurse practitioners) cannot do closed suctioning … I have given each sister that I work with in-service training … so that they can do it properly …"*

b) Attitudes and values

The nurse practitioners regarded the lack of respect they had for one another, the disorganised and untidy state of the A&E unit, nurse practitioners working outside their scope of practice and nurse practitioners not accepting responsibility and accountability, as challenges in the A&E unit.

⇒ ***Lack of respect***

Although it was planned that monthly staff meetings be held, these meetings did not realise on a regular basis. Addressing this specific challenge did not realise as planned, but the unit manager reflected that:

- *"… if I show them respect and be a role model then they will start showing me and their colleagues some respect …"*
- *"… it is not something I can teach them in a meeting … they must see how others do it … it remains a huge challenge …"*

The nurse practitioners reflected that teamwork (see Cycle 8, Section 5.4) improved their respect for one another:

- *"… we (nurse practitioners) are working much better as a team (A&E unit) … I (professional nurse practitioner) think it is because we are working in teams … we (nurse practitioners) are starting to know one another better … we know what the other person is good with and what not …"*
- *"… the teamwork helped us (nurse practitioners) a lot … we know one another now and we respect each other more …"*

One of the professional nurse practitioners not only became enlightened that some of the nurse practitioners showed a lack of respect toward the patients and their families, but also took ownership of the challenge and the responsibility to resolve it, confirming that empowerment as well as emancipation had realised. The professional nurse practitioner reflected that *"… some nurses (nurse practitioners) are rude to the patients and their families …"* and continued *"… it is not right … .we are responsible for providing a service to the community … it is our job … it is not their fault that they are sick or that their families are sick … I feel ashamed of my colleagues … what must the community think of us (nurse practitioners) if we treat them like this … as nurses (nurse practitioners) they should not speak to the patients like that …".* By giving the professional nurse practitioner the opportunity to address the concern he had voiced, the unit manager showed that she allowed the nurse practitioners to act on challenges experienced, respected their autonomy and thus provided them with opportunities to become emancipated and develop their clinical practice. In this enabling environment, these actions may lead to emancipatory practice development.

The professional nurse practitioner consulted the researcher and asked for information relating to this challenge, thus taking responsibility for and ownership of addressing the challenge. The researcher assisted him in performing an Internet search, and he found various articles on the subject, thus enabling him to succeed in his task. Based on the literature, the professional nurse practitioner decided that he would address this important challenge by role-modelling and directly confronting nurse practitioners in the A&E unit when he noticed this type of behaviour.

Thus, it was evident that the professional nurse practitioner was not only enlightened regarding the negative impact of this kind of behaviour on the status of nurse practitioners and on patients, their families and the community, but also took ownership of the challenge, enabling himself by reading about the topic, and becoming emancipated as he reinforced the awareness of the nurse practitioners regarding this issue in the A&E unit and reminding them of its importance.

Reflective discussions with the nurse practitioners confirmed that the professional nurse practitioner took actions to enlighten them of the value of respect in the clinical setting by speaking to them if he noticed that it was not being practiced. The nurse practitioners reflected:

- *"… [the professional nurse practitioner] will confront you if he sees you are not speaking nice to a patient or their families … he also tells you that it is not right … I see the sisters (professional nurse practitioners) feel very bad and sorry if he speaks to them … I don't think we (nurse practitioners) always realise how we speak to patients … he makes you feel very sorry for speaking to the patients like that … it is not right, we have to respect them (patients) and show them that we respect them …"*
- *"… nurses (nurse practitioners) do not speak like that to patients in the private hospitals because they pay for the service … here (A&E unit) we think we can talk to patients how we want to because they are not paying … it is not fair … we must respect the patients if they have money to pay or not …"*

⇒ ***Organised and tidy A&E unit / Fill up the used stock***

Although the unit manager conducted ad hoc rounds in the A&E unit, this was not done on a daily basis. However, the A&E unit was kept tidy most of the time and the nurse practitioners confirmed that the stock was filled up *"every morning and every evening".*

⇒ ***Nurse practitioners work within their scope of practice***

The unit manager did not do daily ward rounds and therefore the actions she had planned to implement to address this challenge were not realised. However, the clinical facilitator implemented other actions to address this challenge. The clinical facilitator collaborated with the different categories of nurses by means of group

discussions during which each group discussed their roles in the A&E unit and what they perceived their scope of practice should include. The clinical facilitator discussed the findings with the unit manager and consensus was reached between the practice leaders and nurse practitioners that these roles would be accepted. The clinical facilitator continued to address the issue during on-the-spot teaching and emphasised the nurse practitioners' (specifically the auxiliary nurse practitioners') responsibility to inform the doctors when they were not able to perform specific tasks that were regarded as beyond their scope of practice. The clinical facilitator also spoke to the doctors, enlightening them of the different categories of nurses and these categories' different scopes of practice. The clinical facilitator thus took responsibility for addressing this challenge.

⇒ ***Accept responsibility and accountability***

The unit manager consulted the nurse practitioners and asked their input regarding possible actions to resolve this challenge, suggesting that she valued their input, experience and knowledge, and that the nurse practitioners were provided with opportunities to participate in the decision-making processes. The nurse practitioners suggested that they each have a portfolio in which they provide the evidence of their contribution in the A&E unit as well as in the project. The nurse practitioners indicated that these portfolios would not only motivate them to accept responsibility for specific actions, but also increase the fairness of the allocation of bonuses based on the outcomes of the performance management evaluations.

The researcher consulted an expert on portfolio development and asked whether she would be willing to give three lectures on the topic. The expert agreed. After the lectures, each nurse practitioner received a portfolio file with the performance dimensions for their specific category as determined by the hospital. Annexure G.1 provides an example of the performance dimensions of Level 6 to 10 Nurse Practitioners, which include team leaders and A&E nurse practitioners. The portfolio was implemented with the performance management and, after discussions with the various categories, it was evident that the use of the portfolios during performance management as well as the setting of goals and objectives for each individual nurse practitioner was perceived as changing the toxic environment specifically in terms of developing the nurse practitioners' ownership, responsibility, accountability and trust, thus enhancing an enabling environment.

Through the implementation of the portfolios, the nurse practitioners were motivated because they were provided with direction as to what was expected of them in the A&E unit and their contribution was valued, not only verbally but also financially. Nurse practitioners who obtained an average of 80 per cent receive an annual financial incentive determined by the hospital (Van Niekerk 2007b).

The following reflective quotes confirm that the nurse practitioners felt that they had direction for the first time:

- *"… it gives me the information on what is expected of me … what I (professional nurse practitioner) need to do extra to get a bonus …"*
- *"… ek was soos iemand wat in 'n bos loop en nie weet hoe om uit te kom nie … nou weet ek wat van my verwag word … dit is baie duideliker …" [Translation: I was like someone who was lost in a jungle … now I know what is expected of me … it is much clearer …]*
- *"… I now know what my duties in the unit (A&E unit) are and now that I (enrolled nurse practitioner) know, now I can do it … as best as I can …"*
- *"… I did not know what I was supposed to do to get good marks for my performance management … now it is clear … [the unit manager] explained it to me … I know what is expected of me …"*
- *"… my (enrolled nurse practitioner) portfolio gives me direction and tells me what to focus on … it is like my study guide …"*
- *"… it guides you and helps to structure you in your work in the unit (A&E unit) …"*
- *"… ek het gedink my pos gaan oor basiese verpleging … nou na vier jaar besef ek eers waaroor dit gaan … waaroor die performance management gaan … dit gaan oor baie meer …" [Translation: I thought my post was about basic nursing … only now after four years do I realise what it is about … what performance management is about … it is so much more …]*
- *"… I (professional nurse practitioner) have realised what is expected from me … I never knew and I have been working here for seven years …"*

The fact that the nurse practitioners felt that, for the first time, they were valued by the unit manager was based on the following quotes:

- *"… [the unit manager] now realises that I (nurse practitioner) am a good nurse and that I work hard …"*

- *"… [the unit manager] can now see what I (auxiliary nurse practitioner) do and I also realised that I play an important role … they need me in the unit (A&E unit) because I can now see that I am a good nurse …"*
- *"… it makes me (professional nurse practitioner) feel important and valued …"*
- *"… makes you feel confident about yourself and your abilities …"*
- *"… because of acknowledgement you feel important …"*
- *"… ek kry die erkenning vir wat ek regtig werd is…" [Translation: I get the recognition I really deserve …]*

The nurse practitioners indicated that the use of the portfolios increased their trust in the unit manager as well as the fairness of the performance management:

- *"… die gebruik van die 'portfolios' (Afrikaans: portefeuljes) is baie meer regverdig … ek weet wat van my verwag word en as ek my uitkomste bereik, dan kan ek 'n bonus kry …" [Translation: … the use of portfolios is much more fair … I know what is expected of me and if I achieve my outcomes I can get a bonus …]*
- *"… nobody knew why some people got a bonus and others not … now at least it is fair … if you do what is expected of you and you reach your aims then you can get a bonus …"*
- *"… everybody is treated equally and the bonuses are not just given to you … you have to earn it and it is fair now …"*
- *"… we (nurse practitioners) always went for performance management and then we did not know what we were going to be assessed on … now at least we know … we know what we need to work on in the next three months … it is fair now …"*
- *"… it makes the performance management fairer … everybody has the same opportunity to do well … because we all know what is expected of us …"*
- *"… one thing has improved, everybody is responsible for something and we are actually doing something as we are working in teams … everybody is involved … the work is shared and everything is not done by one person …"*

The following reflective quotes provide evidence that the nurse practitioners accepted ownership, and that responsibility and accountability were enhanced by the implementation of portfolios, which were used to provide evidence for performance management:

- *"… it gives me (enrolled nurse practitioner) a sense of responsibility … I know I must do what is expected of me … what I have aimed to do …"*

- *"… ek weet nou wat van my verwag word en nou kan ek daarvoor verantwoording neem …" [Translation: … I now know what is expected of me and I can now be accountable for it …]*
- *"… it made me more responsible … I (professional nurse practitioner) have to prove that I do what I say I do …"*
- *"… I (professional nurse practitioner) have also learnt to take responsibility for my own actions … the in-service training is compulsory … I did not want to go, but [the unit manager] looks in my portfolio if I went … I got bad marks the first time and then I started to attend … now I enjoy it (in-service training programme) and I even get better marks (performance management) …"*
- *"… most of the nurses (nurse practitioners) are now getting involved in the unit (A&E unit) … this was not always so … they (nurse practitioners) were always just involved in the admission of patients and doing their observations … but they now start to get involved in other things … taking the responsibility of additional tasks … one of the nurses (nurse practitioners) made us a birthday calendar …"*
- *"… yes, I (nurse practitioner) do think they (nurse practitioners) take on more responsibilities than just doing the admissions of patients … they (nurse practitioners) follow up on patients lying in the unit (A&E unit) for more than four hours by phoning the specialists and asking them to come and see the patients … this reduces the waiting times of patients …"*

The use of the portfolios empowered the nurse practitioners by increasing their self-esteem and self-efficacy, as well as their ownership as is evident by the increase in their responsibility and accountability.

The use of the portfolios increased the nurse practitioners' self-esteem and confidence. This was evident based on the following quotations:

- *"… it makes me feel confident about myself and my abilities …"*
- *"… I am even more confident outside my work … because I get good marks at work, it is as if I have more confidence at home … even my husband says so … without the portfolio this was not possible … now I have evidence of what I do in the unit (A&E unit) …"*

The following quotations provide evidence that the nurse practitioners' self-efficacy was positive:

- *"… it motivated me (professional nurse practitioner) … [the unit manager] now sees what I do and how good I am in what I do …"*
- *"… I (professional nurse practitioner) have realised the importance of a nurse … we are not just here to nurse patients, but we have other functions as well … I did not know it was important to give patient education … [the unit manager] is very strict on that …"*

Although the professional nurse practitioners kept their portfolios up to date, recorded their actions and ensured that their aims and objectives were met, the enrolled and auxiliary nurse practitioners did not. They reflected that:

- *"… would like somebody to help me … one of the sisters (professional nurse practitioners) maybe … then my portfolio will be even better …"*
- *"… I (auxiliary nurse) leave it too long and then I do not remember what I have done … I am not sure how to do it …"*
- *"… I do not know how to do it … I wish somebody will help me … then I will get better marks (performance management) …"*
- *"… I (enrolled nurse) only do it the week before my performance management … the week before I go … I am not sure how to do it and now I leave it too late …"*

The findings were discussed with the practice leaders and professional nurse practitioners, who then took responsibility for assisting the lower category nurse practitioners with their portfolio files. The professional nurse practitioners and specifically the clinical facilitator enabled these nurse practitioners by ensuring that they understood their key performance areas, set goals and provided evidence that they had reached these gaols. Taking action is evidence of emancipation according to Down (2004:272).

⇒ ***Support***

The unit manager supported the nurse practitioners by being available. The unit manager's office door was kept open and the nurse practitioners felt free to ask the unit manager for support, whether personal or professional. This was evident in a remark made by a nurse practitioner, who stated that *"… [the unit manager] is assisting us … when we have a problem we can go to her at any time … her door is*

always open and we can go and ask her for anything … she will help if she can …". Another said *"… [the unit manager] does not ignore us, her door is open and we can go to her any time … she will get up and come and help us sort out our problems … even if she goes to [the head of department] …"*

Reflective discussions were held with 14 nurse practitioners and they were all of the opinion that the NGM enlightened them regarding the lack of support they had for each other in the A&E unit. They reflected that their support for each other increased after the NGM as they realised:

- *"… (nurse practitioners) did not support each other … everybody was doing their own thing and did not care about their colleagues …"*
- *"… we (nurse practitioners) are working much better together … that meeting (NGM) made us aware that we were only working for ourselves … we were working to survive and not because we enjoyed it … we were not always helping our colleagues when there are a lot of patients or when the unit (A&E unit) was busy … it is better now … we are standing together and working together as a team …"*

Their support for each other also increased because:

- *"… there were more nurses appointed in the unit (A&E unit) …"*
- *"… we (nurse practitioners) have more time for one another … we do not just bite each other's heads off … everybody is more relaxed …"*
- *"… we were not so overworked and tired … there was time again to laugh and talk to each other … we knew each other and there were not new agency staff (nurse practitioners) everyday that we had to orientate … we work as a team now …"*

Two additional medical doctors were appointed as consultants and it was evident that they were willing to support the nurse practitioners. Monthly meetings were held between the unit manager, clinical facilitator, head of department and the two consultants. During these meetings, the unit manager discussed issues regarding the day-to-day work and collaboration between the nurse practitioners and doctors. Examples of topics that were addressed were *"… [the doctor] not seeing patients, but waiting for his colleague to see the patients …"* and *"… [the doctor] coming late on duty and he is in charge of shift …".* Actions were planned to resolve these

issues. The head of department then discussed the issues and possible solutions with the doctors working in the A&E unit, while the unit manager discussed these with the nurse practitioners. Both practice leaders felt that the head of department and medical consultants listened to their plight and made an effort to support them where possible.

The support required from top management by the nurse practitioners mainly included dealing with the lack of bed space in the hospital and closing the A&E unit when there were no longer beds available in the A&E unit and/or hospital. These concerns were discussed at various meetings, but remained an ethical dilemma. Top management did not want to give the authorisation to close the A&E unit when it was too busy and/or all the beds were occupied, as they felt that the hospital was a Level III tertiary facility and was compelled to admit critically ill or injured patients. The A&E unit could not close its doors to these patients, as there was no other Level III tertiary hospital in the area. They also felt that the A&E unit should not be closed for orthopaedic emergencies, as it was the only hospital in the area that employed orthopaedic specialists. This challenge remained unsolved throughout the project.

Although the practice leaders understood the predicament in which top management found themselves, the fact that the critically ill patients remained in the A&E unit for between eight hours and 14 days, and that orthopaedic patients waited for four days at a time for bed space in the hospital (while admitted in the A&E unit) frustrated the nurse practitioners (The Hospital 2007b). The patients often went to theatre and then returned to the A&E unit to be nursed as ward patients. This is an issue which is discussed on a regular basis with top management, but no solutions have been found for the shortage of beds. In the new hospital, two beds in the A&E unit were declared permanent critical care beds in order to increase the annual budget for the A&E unit. The A&E unit was also given permission to use an additional two critical care nurse practitioners on a daily basis to nurse these patients. The total number of nurse practitioners working per shift increased to a total of 21 in the new hospital.

Top management realised that although fewer patients were being admitted – an average of 64 patients per day – the nurse practitioners' workload had increased due to a change in the patient profile (The Hospital 2007b). Patients managed in the A&E unit were mainly P1 and P2 patients, and orthopaedic emergencies, and the

time spent by patients in the A&E unit had increased as a result of the inadequate number of beds available. In order to counteract this, the number of nurse practitioners per shift was increased from 12 to a total of 21 to ensure that adequate patient management took place. This showed that top management supported the nurse practitioners.

The middle manager phoned the ICUs and specialists in order to arrange the transfer of patients to wards when appropriate or to ensure that the beds that opened up were used for patients that had been in the A&E unit for more than 12 hours. This worked very well. The shift leader made a list of the patients that had remained in the A&E unit for more than 12 hours and gave this list to the middle manager, who took it up with the specialists and top management. This challenge was thus addressed by the middle manager, which indicated that she also supported the unit manager and the nurse practitioners.

The support staff remained a concern, as the practice leaders had no say over them. The porters were often not available to assist with the transport of patients to and from the wards as well as to Radiology for X-rays or scans. These patients then had to be accompanied by two nurse practitioners, leaving the A&E unit short staffed and the nurse practitioners frustrated. In order to rectify this, one porter was dedicated to the A&E unit for each shift. This porter remained in the A&E unit and supported the nurse practitioners by transferring patients to the wards and Radiology. This meant that only one nurse practitioner was needed to accompany the patients, freeing up the other nurse practitioner to attend to other patients in the A&E unit.

Security guards were also placed at the entrance of the A&E unit in order to regulate the flow of patients through the A&E unit and to ensure that patients did not leave the A&E unit without first being discharged (specifically the psychiatric patients). This supported the nurse practitioners, as it reduced their workload; however, *"… the security are not always at their post … they walk around … or they are on tea …".* This concern was discussed at the monthly meeting and it was agreed that the security guard should not leave his/her post until relieved by someone else. These suggestions were implemented, although the security staff still left the entrance unattended at times. The unit manager regularly addressed this concern at the monthly meetings held with the support staff.

c) Socialisation

During reflective discussions, the nurse practitioners noted that no socialisation had taken place amongst the nurse practitioners in the first six months of the project. When reflecting on this, the practice leaders commented that they had *"forgot"* about it. They reflected that they were "*both in new positions*" and *"needed to adjust to their new roles"*. It was agreed that action to rectify this should take place as soon as the A&E unit had moved to the new hospital.

Socialisation took place amongst the different members of the multidisciplinary team members. The annual year-end function was held for all the staff working in the A&E unit. However, this had taken place for the past ten years, with the staff sponsored every year.

5.3.2.2 Priority 2: Patient care

The barrier of the shortage of nurse practitioners had to be addressed in order to improve the basic patient care in the A&E unit (see Chapter 3, Section 3.4). After this barrier had been addressed, with the number of practitioners increased significantly to 37 by November 2005 (see Table 3.6), the unit manager used mainly permanent nurse practitioners to work overtime in the A&E unit when necessary. If no nurse practitioners were available, only committed and reliable agency nurse practitioners, indicated by the nurse practitioners, were used. This indicates that the unit manager not only had resolved the challenge, but also, through participation in the choice of which agency nurse practitioners were used for overtime, had acknowledged the nurse practitioners' input, knowledge and experience.

a) Nurse practitioners

It was collaboratively decided to use only the nurse practitioners working on a permanent basis in the A&E unit for overtime. This decision was implemented except when no permanent nurse practitioners were available. Only then was an agency nurse practitioner contacted. The nurse practitioners were asked to provide a list of agency nurse practitioners who they considered to be reliable and competent to work in the A&E unit. The names on this list were used when agency nurse practitioners were required to work overtime in the A&E unit.

Evidence that the nurse practitioners' suggestion was followed (to use only the nurse practitioners working in the A&E unit on a permanent basis for overtime), is based on the following quotes:

- *"… preference for overtime is always given to us (permanent nurse practitioners) … if we cannot work, we first contacted the agency staff we work with regularly and we trust … we use the same agency staff over and over … they already know the unit (A&E unit) …"*
- *"… if agency staff (nurse practitioners) are used … use those who are on our list and who work here on a regular basis … they are almost like permanent staff (nurse practitioners) …"*
- *"… we (permanent nurse practitioners) are always asked first to work overtime before phoning the agency staff (nurse practitioners) … then we ask the nurses (nurse practitioners) who work here regularly … they are more committed and their work is better …"*

The nurse practitioners reflected that this increased their trust in the unit manager as "*… [the unit manager] kept her word…*" and *"… we know she (unit manager) will give us the overtime … she will not say it and then not do it … we know her well now and she has never given the agency staff (nurse practitioners) overtime before she asked us (nurse practitioners) if we wanted to work …"*

b) Improve basic patient care

This challenge involved improving the basic care of patients nursed in the A&E unit and showing the patients and their families respect.

⇒ ***Basic nursing care***

The clinical facilitator addressed the improvement of the basic nursing care of patients in the A&E unit during the CPDP and specifically during on-the-spot teaching (see Section 4.4.2.1). The unit manager did not hold regular monthly staff meetings, but when meetings did take place, the importance of basic nursing care was emphasised.

⇒ ***Respect***

The unit manager did not, as agreed during meetings held by the PDG, address the challenge regarding respect by doing daily ward rounds. In following reflective discussions with the practice leaders, the unit manager acknowledged that she did not do daily ward rounds and reflected *"… I (unit manager) do not get the time … there is so much other things … there is a shift leader who can do it …".* It was evident that the unit manager did not take responsibility for doing daily ward rounds and had not taken ownership of this action. The unit manager delegated the task to the shift leader.

c) Patient education

Patient education was regarded as an important challenge and the unit manager insisted that it formed part of the performance management of each nurse practitioner. It was set as an outcome for each nurse practitioner and they had to provide evidence of their efforts by writing the name of the patient, the specific education provided and their own name and signature in an allocated book in the A&E unit. The nurse practitioners also had to provide evidence of providing patient education in their portfolios. The clinical facilitator stated that specifically the auxiliary and enrolled nurse practitioners *"… asked many questions regarding relevant patient education… specifically for diabetes, hypertension and HIV/AIDS…".* This indicates that the nurse practitioners took ownership of this challenge and responsibility for enhancing their knowledge. They had acted to ensure that patients received relevant education, suggesting that they were motivated, empowered and emancipated.

The nurse practitioners, however, gave contradictory feedback when asked whether patient education had taken place in the A&E unit:

- *"… it has dropped to zero and we have to give more attention to it …"*
- *"… [the clinical facilitator] focuses on this issue everyday, but I think it still needs a lot of improvement …"*
- *"… we (nurse practitioners) do not give any patient education, because the patient is admitted to the ward or to the ICU (critical care unit) …"*
- *"… we (nurse practitioners) give patient education to the patients that are discharged … [the professional nurse practitioner] is very strict and he reminds us every day to give patient education … we have to put the patient's name and*

patient information we give in a book … that is evidence we use in our performance management … it is important …"

During observation, it became evident that predominantly patients with orthopaedic emergencies and the families of patients admitted with HIV/AIDS received patient education.

One of the enrolled nurses asked the researcher to assist her with getting hold of the pamphlets and posters made available by the Department of Health. The researcher drove the enrolled nurse practitioner to the Department of Health to collect pamphlets and posters on subjects she thought were relevant to the A&E unit. The posters were put up in the A&E unit and the pamphlets were made available to the patients. The patients showed interest in the pamphlets and read them. However, once the pamphlets were finished, the enrolled nurse practitioner did not collect more.

d) Decreased patient waiting times

Patients had to wait to be assessed by the nurse practitioners and the doctors working in the A&E unit, as well as the specialist if they had been referred.

⇒ ***Nurse practitioners***

The unit manager consulted the nurse practitioners and asked what actions could be implemented to decrease the time spent by patients waiting to be assessed by the nurse practitioners in the A&E unit. The nurse practitioners identified the reason patients had to wait for nurse practitioners to admit them as the fact that patients sometimes entered the A&E unit unnoticed by the nurse practitioners, as they were busy with other patients. They suggested that a shift leader could change this. One of the shift leader's roles could be to ensure that patients were assessed as soon as possible once admitted to the A&E unit. A shift leader was put in place.

These actions provide evidence that the unit manager utilised a participative style of management and valued the suggestions made by the nurse practitioners by implementing them.

However, it was not until the A&E unit had moved to the new hospital, when the number of patients decreased and the nurse practitioners per shift increased, that the nurse practitioners were able to admit and assess patients as they entered the A&E unit:

- *"… it has decreased as we (A&E unit) have more nurses (nurse practitioners) working in the unit (A&E unit) and we have more time … we do not see so many patients every day, so it is easy to admit all the patients immediately …"*
- *"… because we are more nurses (nurse practitioners) working in the unit (A&E unit) so we have more time and more hands to do the job …"*
- *"… we (nurse practitioners) see the patients immediately when they are admitted …"'*
- *"… there are fewer patients entering our unit (A&E unit) every day, so it is easy to attend to every patient as they are admitted …"*

⇒ ***Multidisciplinary team***

Due to the insufficient number of specialists available to cope with the number of patients, these specialists had to see patients in both the outpatient clinics and the A&E unit (Van Niekerk 2007b). Patients often had to wait hours to see the specialists once they had been referred to them by the doctors working in the A&E unit. This was also the main complaint received from the patients, specifically those admitted with orthopaedic emergencies (Van Niekerk 2007a). This challenge is almost impossible to resolve without the involvement of top management.

The unit manager discussed this challenge on various occasions with middle management and the head of department, as well as during the monthly meetings held with the various specialists. Specialists saw critically ill and injured patients as soon as possible if consulted. However, the specialists only assessed patients admitted with non-life threatening orthopaedic emergencies once they had finished the patients on the orthopaedic outpatient clinic and theatre lists for the day. This was at approximately 18:00. Patients thus had to wait for the orthopaedic specialists for hours at a time and often complained to the nurse practitioners.

Although frustrating, the nurse practitioners realised that there was a shortage of orthopaedic specialists in the hospital and explained this to patients and their

families when they complained. The challenge remains on the priority list of both the unit manager and head of department.

This was confirmed by the middle manager: *"… the patients do not complain that they do not see a nurse (nurse practitioner) or casualty (A&E unit) doctor … they are complaining because they have to wait so long before they are seen by the specialists or waiting too long for a bed to be admitted in the ward …".* Discussions concerning this challenge continue.

e) Psychiatric patients

The challenge concerning the prolonged time psychiatric patients spent in the A&E unit and the possibility of admitting these patients directly to a psychiatric hospital was put on hold. It was predicted that the move to the new hospital would resolve this challenge, as only P1, P2 and orthopaedic emergencies would be admitted in the new A&E unit. Psychiatric patients would be admitted to the A&E unit that remained in the old hospital.

Once the A&E unit moved to the new hospital, the challenge was resolved.

f) Pharmacy

The unit manager and the head of department discussed the challenge regarding the availability of a pharmacist to supply patients with their prescribed medication after hours. The unit manager referred to the Pharmacy Amendment Act, 1997 (Act No. 88 of 1997), according to which the current practice of expecting the professional nurse practitioners to dispense patients' prescribed medication was not legal. Although the hospital had a dispensing licence, the professional nurse practitioners did not and were therefore not allowed to dispense the prescribed medication. Top management stated that having a pharmacist available 24 hours a day would be too costly and, after prolonged negotiations, it was agreed that the professional nurse practitioners would give patients their prescribed medications if they were discharged between 16:00 and 07:00.

However, before being allowed to dispense the medication, the professional nurse practitioners had to enrol and pass a dispensing licence course. They would then be granted permission to dispense the prescribed medication, as section 29(3)(e) allows

qualified professional nurse practitioners to supply patients with prescribed medication that is pre-packed and labelled under the direct supervision of a medical practitioner (Pharmacy Amendment Act, 1997). This option was discussed with the professional nurse practitioners. Although the practice leaders and the professional nurse practitioners felt that "*… they (top management) did not listen to us … it increases our workload and should not be our responsibility …"*, they also realised that *"… for the sake of the patients, we have to commit ourselves to give them (patients) their prescribed medication … they cannot wait in the foyer until the next morning to get their medication … we have to do it for the patients … and the patients are too poor to come back the next day for their medication … the transport is too expensive …"*.

Fifteen professional nurse practitioners attended and passed the dispensing course after August 2006. Patients were supplied with their prescribed medication by the professional nurse practitioners in the A&E unit if they were discharged between 16:00 and 07:00. This was not optimal, as the patients only received medication sufficient for 48 hours, which meant that patients had to return to the hospital during office hours to collect the rest of the medication. Returning to the hospital for a second time is often too costly for patients and they therefore take the prescribed medication for only 48 hours. The result was that the patients eventually returned to the A&E unit with severe complications, repeating the entire cycle.

5.3.2.3 Priority 3: Structure

The third priority identified by the nurse practitioners that needed to be addressed was the current structure in the A&E unit. A lack of structure in terms of rules, protocols and standards was viewed as a challenge by the nurse practitioners.

a) Rules

Rules regarding the nurse practitioners as well as the multidisciplinary team members were addressed.

⇒ ***Nurse practitioners***

Making use of a participative management style, the practice leaders consulted the nurse practitioners and, by means of reflective discussions, decided on specific actions that could be implemented to resolve the challenge of the lack of rules in the A&E unit, specifically regarding the nurse practitioners.

The A&E unit is divided into the following different areas:

- triage area
- trauma resuscitation (area I and area II)
- medical resuscitation (area I and area II)
- P2 trauma emergencies
- P2 medical emergencies (area 1: male patients; area II: female patients; area III: female gynaecological emergencies)
- orthopaedic emergencies
- Plaster of Paris (POP) room
- stitching room
- paediatric resuscitation
- P2 paediatric emergencies

The nurse practitioners collaboratively agreed that every shift should have a dedicated team leader for each area as well as a shift leader, who would take charge of the entire shift. Both the team leaders and shift leader should be professional nurse practitioners.

The unit manager organised a workshop for the nurse practitioners who worked in the A&E unit so that they could collaboratively decide on and develop the roles of team leaders and shift leaders. The participation of the professional nurse practitioners in determining the specific tasks of the shift leaders provides evidence of the participative management style utilised by the unit manager. Negotiations with top and middle management were held and, in September 2005, permission was granted to use the suggested structure in the A&E unit.

One of the concerns of the unit manager was that the scheduled medication used in the A&E unit was not always correctly recorded in the drug books. This concern was shared by the middle manager and the Accreditation Committee that had visited the

A&E unit in June 2005. Consensus was reached that this task would be one of the roles of the shift leaders. The shift leader would thus be responsible for ensuring that all the scheduled medication used on his/her shift was recorded in the drug book as well as for keeping the drug cupboard keys with him/her at all times in order to enhance the control of the scheduled medication.

The team leaders and shift leaders were assured that they would be supported by the clinical facilitator or unit manager if they were unable to resolve a challenge in the clinical setting. The unit manager reflected that *"… by using this system, everybody (professional nurse practitioners) had an opportunity to develop as leader … as well as developing their problem-solving skills …*".

The shift leaders were also asked to attend to the challenge of the increased numbers of medical students standing around doing nothing in the resuscitation areas. If there were too many, the shift leaders should address the situation and negotiate the number of medical students that was acceptable for the specific situation. The team leaders were asked during a monthly staff meeting to address the challenge of the doctors leaving suturing materials and sharp needles on the trays after stitching up patients. These doctors expected the nurse practitioners to tidy up. However, this was dangerous because of potential needle prick injuries, and the doctors and medical students had to be reminded that it was their own responsibility to dispose of all sharp objects used during procedures.

Involving the professional nurse practitioners in the management of the A&E unit also enhanced participative management and ownership, which in turn enhanced responsibility.

The nurse practitioners reflected on the efficiency of the strategy of appointing shift leaders and team leaders:

- *"… there are now rules in place and the nurses (nurse practitioners) in each area go to either first tea and lunch or second tea and lunch – this works well and it is organised … everybody gets the same time and now we do not have the problem with some nurses (nurse practitioners) staying an hour on tea and others not having a chance at all …"*

- *"… this is working much better and because the unit (A&E unit) is so big, each area have a sister in charge of the area (team leader) … she organises the area and ensures that the patients are attended to and properly managed … it makes the patient care better and it decreases the patient waiting times …"*

The unit manager also planned the annual leave in such a way that it was not only organised, but fair, as the nurse practitioners were given the opportunity to choose when they wanted to take their annual leave. One nurse practitioner reflected that *"… the holidays were also always a problem … because it was not organised … now we all have an equal opportunity to plan our leave and go when it suits us … we are not told when to go, but we can choose … I know that the leave was always planned ahead, but we were told when to take leave … now we can choose …".*

The above statement is evidence of the emancipation of the unit manager. The unit manager acted on the challenges identified by the nurse practitioners, provided opportunities for the nurse practitioners to participate in the decision-making processes and enabled them by developing their leadership and problem-solving skills.

⇒ ***Multidisciplinary team members***

The team leaders and shift leaders were responsible for ensuring that the multidisciplinary team members adhered to the rules of the A&E unit. If they could not resolve a situation, they were to consult the unit manager, who in turn would consult the head of department.

⇒ ***Medical students***

The team leaders and shift leaders were responsible for ensuring that the medical students adhered to the rules of the A&E unit. If they could not resolve a situation, they were to consult with the unit manager, who in turn would consult the head of department.

b) Standards and protocols

Standards and protocols were used to enhance patient management. Utilising a participative management style, the unit manager asked the nurse practitioners to

suggest specific protocols that needed to be developed and implemented in the A&E unit. Three suggestions were made, namely a protocol for the management of the valuables and clothing of patients admitted to the A&E unit, the management of diabetic ketoacidotic patients and the management of the rape victims admitted to the A&E unit after office hours. These three protocols were regarded as important, as they were used on a daily basis and there was confusion as to what was expected of the nurse practitioners in these situations. The unit manager consulted the head of department and asked that he compile the suggested protocols. This provides evidence that the unit manager valued and acknowledged the contribution of the nurse practitioners. The unit manager was not only enlightened regarding the needs of the nurse practitioners, but also empowered and emancipated by taking action to resolve the challenges.

Concerning standards, the clinical facilitator indicated that the standards compiled by Van Der Merwe, Kuit, Schmollgruber and Delgety (1996) would be used and adapted if appropriate. The use of these standards was observed during the in-service training programme.

5.3.2.4 Priority 4: Equipment

The lack of equipment in good working order, as well as the lack of advanced equipment to manage patients, was identified as a challenge to be resolved by the unit manager.

Although the unit manager did not implement daily rounds as planned, she did appoint a permanent professional nurse practitioner whose primary function was to ensure that the equipment was in working order and, if not, sent in for repair. This nurse practitioner was also responsible for ensuring that the equipment sent in was returned and for placing orders for stock with top and middle management. This task was delegated to a stock keeper appointed in a 40 hours per week post in October 2005. The unit manager informed the nurse practitioners about this positive outcome, which was well received by them as evidence that the unit manager supported them. They stated that *"… the stock was ordered by one person and we (nurse practitioners) do not have to do it as well now … we can focus on our work …*

the stock used to be in a mess and now it is organised … everybody knows who to ask if there is no stock or if the equipment is not working … it helps us so much …".

The stock keeper continued in this post throughout the study. In April 2006, the stock keeper was given an assistant to relieve her during her absences and leave. This was done because the unit manager realised that nobody could take over her job and that the stock would then not be ordered and the equipment not maintained. The unit manager negotiated with middle management and they agreed that an additional assistant could be employed to assist her. The feedback obtained from the multidisciplinary team members and head of department was that this system worked and one of the doctors stated that it was *"… an excellent idea … we (doctors) know who to go to if we need something … she (stock keeper) then gets it for us …"*

The unit manager discussed the shortage of equipment with the middle manager. The unit manager was informed that the head of department and previous unit manager had ordered new equipment and that, once the A&E unit had moved to the new hospital, there would be adequate equipment to work with.

The new equipment that had been ordered, arrived after the A&E unit moved to the new hospital. The nurse practitioners agreed that the challenge was resolved and that there was adequate equipment to ensure the optimal monitoring of critically ill or injured patients.

5.3.2.5 Priority 5: Research

The previous unit manager had recorded all the statistics herself on a monthly basis. The current unit manager decided to continue doing this until after the A&E unit had moved to the new hospital.

Once the A&E unit had moved to the new hospital, teams of nurse practitioners were formed. One of these teams was given the responsibility of keeping the statistics up to date as well as giving feedback to the nurse practitioners. This is evidence of the unit manager's participative management style. By providing opportunities for the nurse practitioners to develop, the emancipation of the unit manager was also demonstrated.

5.3.3 Reflection

The findings obtained during the NGM enlightened the unit manager regarding the challenges and priorities of the A&E unit as viewed by the nurse practitioners. The unit manager immediately took ownership of the project as well as the responsibility of her new position as unit manager, and implemented the planned actions to resolve the identified challenges. The actions implemented provided evidence that she valued the views and concerns of the nurse practitioners and acted on these in order to improve their working conditions. This continued throughout the cycle.

The unit manager started changing the toxic environment into an enabling environment, which was an indication that she was empowered. Motivating the nurse practitioners and ensuring that learning opportunities were available in the environment enhanced the development of the nurse practitioners. The nurse practitioners were motivated by the trust established between them and the unit manager. The fact that she addressed the challenges as she had said she would further increased her reliability. An example of this was that the unit manager assured the nurse practitioners that agency nurse practitioners would only be allowed to work in the A&E unit if there were no permanent nurse practitioners available. This was implemented, increasing the trust the nurse practitioners had in the unit manager.

The nurse practitioners were supported by various actions implemented by the unit manager. A nurse practitioner, working 40 hours per week, was made responsible for the stock and equipment. In addition to this, following the move to the new hospital, the unit manager realised that, although the patient numbers had decreased, the patient disease and injury profile had changed, thus increasing the number of nurse practitioners required to work each shift. Following negotiations, the total number of nurse practitioners per shift was increased to from 12 to 21. The unit manager also negotiated for a porter to be allocated to the A&E unit during each shift to assist the nurse practitioners with the transportation of patients to the wards, ICUs and Radiology. The fairness of performance development was enhanced through portfolio development.

Recognising the importance of professional development in enhancing technical practice development as well as the factor it plays in ensuring job satisfaction and reducing staff turnover (Gould, Kelly, Goldstone & Maidwell 2001:7), the unit manager acted immediately to resolve the challenges she had agreed to address. These actions are evidence that the unit manager was not only empowered, but was providing enabling opportunities and thus empowering the nurse

practitioners themselves. This was accomplished by negotiating sponsored basic and advanced courses for the professional nurse practitioners as well as by providing opportunities for the nurse practitioners to obtain clinical experience in other units if requested.

Zimmerman (1995:597) articulates an important refinement of empowerment theory by stating that this theory differentiates between empowerment and empowering. When a person is empowered, that person shows mastery of skills, control over aspects of his/her environment and the ability to make changes that lead to a higher quality of life for him/herself, as was evident in the situation with the nurse practitioners. Zimmerman (1995:598) carries on to explain that when someone is empowering, this person is able to foster empowerment in others and facilitate changes in other individuals in order to make changes in their circumstances. However, in order to empower the nurse practitioners, the unit manager required power, which refers to her ability to influence the behaviour of the nurse practitioners (Hellriegel, Jackson, Slocum, Staude, Amos, Klopper, Louw & Oosthuizen 2004:287; Smit & Cronjé 2002:247). This does not imply that empowerment is merely an outcome of power and its exercise. According to Kreitner and Kinicki (2007:482), there are two dimensions of power: socialised versus personalised power. Socialised power is directed at helping others, whereas personalised power is directed at helping oneself. As a responsible manager, the unit manager strove for socialised power, while avoiding personalised power. Socialised empowerment was evident in the A&E unit by the change in management style from being predominantly autocratic, as had been utilised by the previous two unit managers, to participative in an enabling environment.

By allowing one of the professional nurse practitioners to take responsibility for addressing the challenge of respect, the unit manager acknowledged his autonomy as well as his knowledge and skills as a professional nurse practitioner. This in itself promoted the self-development of the nurse practitioner and is recognised as a viable strategy for life-long learning (Harris 2005:47). The unit manager was able to support the nurse practitioners and allow them to develop themselves as well as their collective clinical practice. This was one of the first indications of the realisation of emancipatory practice development. The professional nurse practitioners aimed at enhancing their respect not only for each other (as nurse practitioners), but also for patients and their families.

In Cycle 7, it was evident that the toxic environment had been changed to an enabling environment. Technical as well as emancipatory practice development took place, as

empowerment as a developing process played a key role in the professional development of the nurse practitioners (Kuokkanen & Leino-Kilpi 2000:236).

The unit manager was satisfied with her efforts and the actions implemented during Cycle 7. She reflected "… we can now see the difference we make … it is good …" and "… I (unit manager) can use it for my performance management … it is working … it is good to know what challenges we have and then to work on those … it does not help to just go on and on … you get nowhere … we all (practice leaders and nurse practitioners) need to work together, otherwise we will not make it …".

5.4 Leadership development (STEP 2: CYCLE 8)

Cycle 8 stretched over a period of eight months, starting 1 June 2006 and ending 31 January 2007 (see Table 5.4). Cycle 8 focused on involving the nurse practitioners in the day-to-day decision-making processes in the A&E unit, thus enhancing participative management.

Table 5.4: Step 2: Cycle 8: Leadership development

Phase 2			
29 August 2005 to 31 May 2006	**January 2006 – February 2006**	**1 June 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 7	**Move to new hospital**	**Cycle 8**	**Cycle 9**
Address the challenges		**Leadership development**	**Amended leadership development**

5.4.1 Actions planned

According to Ghaye (2005:15), focusing on resolving the challenges could be regarded as merely a 'quick-fix' solution. The PDG reflected that it was therefore important to redirect their focus on possible long-term solutions to achieving the shared vision of 'emancipatory practice development'. Although Cycle 7 focused

mainly on resolving the challenges identified by the nurse practitioners during the NGM, the PDG agreed that during this timeframe (August 2005 to March 2006) both the unit manager and clinical facilitator had contributed to changing the toxic environment to an enabling environment.

Organisations have implemented the concept of empowerment more and more during the past decade and their perspectives suggest that the environment in which the nurse practitioner works solely determines his/her capacity to be empowered (Corbally, Scott, Matthews, Gabhann & Murphy 2007:170). An important advantage of the enabling environment is that it will result in increased job satisfaction and quality of nursing care (Hayes *et al*. 2006:240), thus increasing technical practice development.

Consensus was reached that the actions planned and implemented during Cycle 8 should focus on long-term solutions aimed at enhancing emancipatory practice development. It was therefore important to focus on the professional development of the nurse practitioners and to move away from a hierarchical 'command and control' management style towards a participative management style (Kreitner & Kinicki 2007:19). Increasing involvement would motivate the nurse practitioners by changing the content of their jobs. This could lead to an increase in job satisfaction and job performance (Kreitner & Kinicki 2007:254), which in turn could enhance emancipatory practice development.

The unit manager reflected that she wanted to implement two specific actions to enhance participative management: the rotation of professional nurse practitioners though the office of the unit manager and the initiation of teamwork. Both these actions aimed at increasing staff involvement, which is regarded as the pinnacle of development and empowerment (Ghaye 2005:25). The unit manager agreed to celebrate the successes of the A&E unit and the nurse practitioners during this cycle.

The actions planned for Cycle 8 included:

- Action 1: Implement participative management, by:
  - Rotating the professional nurse practitioners through the unit manager's office in order to make them aware of her responsibilities and challenges, and provide them with opportunities to develop leadership, and

- Initiating teamwork.

o Action 2: Celebrate successes

5.4.2 Act and observe

The actions implemented during Cycle 8 and the observed outcomes of these actions are discussed below.

5.4.2.1 Action 1: Implement a participative management initiative

The first action planned for Cycle 8 was the implementation of a participative management initiative. Participative management is defined by Kreitner and Kinicki (2007:487) as a process whereby employees play a direct role in setting goals, making decisions, solving problems and making changes to the organisation. Advocates of participative management claim that participation increases employee satisfaction, commitment and performance, and decreases employee turnover (Hayes *et al*. 2006:240). Kreitner and Kinicki (2007:488) predict that by increasing the nurse practitioners' motivation, their three basic needs, namely autonomy, meaningfulness of work and interpersonal contact, will be fulfilled.

Two specific actions were implemented to enhance participative management. The first action plan involved the voluntary rotation of professional nurse practitioners through the office of the unit manager. These professional nurse practitioners were provided with the opportunity to work out the monthly duty roster for all the nurse practitioners in the A&E unit and were involved in solving the daily challenges normally experienced only by the unit manager.

The second action plan implemented was teamwork. The nurse practitioners were divided into nine different teams, each with a specific purpose. Each team consisted of a team leader and between four and five team members. The teams were not prescribed what to do, but given the opportunity to choose a challenge that they perceived as important, plan actions to resolve the challenge and evaluate the success of their actions planned. The teams had to give feedback during the monthly staff meeting.

a) Rotating professional nurse practitioners

The professional nurse practitioners were asked who among them was interested in rotating through the office of the unit manager. The volunteers were given the opportunity to work for a period of one month (at two-week intervals) in the office. They were given specific tasks, which included working out the monthly duty roster, organising nurse practitioners to do overtime, ensuring that nurse practitioners were on duty and handling the day-to-day challenges experienced in the A&E unit concerning patient inquiries from families, and top or middle management.

Six professional nurse practitioners volunteered and reflective discussions were held with all six. The volunteers were asked to reflect on two questions:

Tell me about your experience while rotating through the unit manager's office?

and

What did you learn from this experience?

Five of the six professional nurse practitioners experienced the rotation positively, and indicated that the experience had enlightened them regarding their likes and dislikes in the nursing profession in general, and the route they should follow in future studies. These findings were based on the reflective statements:

- *"… I started doing nursing education last year, because I thought I would like to work in that area (nurse educator) and maybe get a job as lecturer one day … I have now realised that is not so and that I prefer being involved in management … I have enrolled for a management course this year and I am really enjoying it … I want to be a manager one day …"*
- *"… it was good that I work in the office … I can see that I can do it too and that I have an ability to work as a manager or as a nurse (professional nurse practitioner) … I will definitely enrol for a management programme in the future …"*
- *"… I never want to be a manager … I enjoy working with patients and I really like teaching much more … I do not like all the paperwork and sorting out of daily*

problems … I want to work with the patients … really become a good nurse (nurse practitioner) …"

The professional nurse practitioners were also made aware of the daily challenges the unit manager was confronted with, and were thus enlightened:

- *"… the people (nurse practitioners) have so many requests (off duty requests) … I think it is really unfair … we sorted it out now, because we did not think we realised how difficult it was to do it … everybody (nurse practitioners) only gets three requests and that is it and only one weekend request …"*
- *"… I did not realise they (nurse practitioners) had so many problems at home and [the unit manager] must solve it … it is difficult because you feel sorry for them (nurse practitioners) … I know what their problems are so I understand them better now …"*

The professional nurse practitioners were also enabled, empowered and emancipated in the process. Enablement was mainly in terms of increased problem solving skills and collaborating with members of the multidisciplinary team, including the doctors, consultants and specialists, to resolve problems:

- *"… the main thing I have learnt is to solve problems … problems in the unit with patients, but also with the staff (nurse practitioners) …"*
- *"… I now know what to focus on if I am the shift leader … we (shift leaders) can prevent a lot of the problems if we do something in the unit (A&E unit) and not waiting for it to become a problem … we can prevent most of the problems …"*

The professional nurse practitioners, who realised the responsibilities that the unit manager carried, often reprimanded the nurse practitioners in the A&E unit who did not perform their duties. In terms of EAR, this is an indication of enlightenment (Caldwell 2004:203). Their awareness of the role of the unit manager and her responsibilities enhanced empowerment as well as emancipation. The professional nurse practitioners indicated that they should participate and take ownership of their assigned responsibilities in order to ensure that the management of the unit was done correctly and actions performed timeously. The following reflections were evidence of the above:

- *"… it helped me with my team … my team does the stats (statistics) every month and now I have realised we must not wait until the end of the month to do it …*

the matron (top management) is phoning to hear about the different patients we see and if you do not have the stats (statistics) ready it puts us (nurse practitioners) in a bad light … we do it on a daily basis now and I have asked the clerk to help us … I have put a form at the front desk which the clerk fills in for the patients we triage and refer to [the old hospital] …"

- *"… the doctors are expected to assess the patients when they are triaged, but they do not do it … we get so many problems because of that, and then the super (superintendent) phones, and it is as if the nurses (nurse practitioners) do not do their job … I have spoken to [the head of department] to sort it out … now the doctors are forced to assess the patients within 20 minutes … if they don't want to do it, I phone [the head of department] … they are scared of him … now we are not so much in trouble anymore …"*

This action enhanced the professional nurse practitioners' confidence and self-esteem, which is evident in the following quotations:

- *"… we are all more confident now, because our colleagues can see we are now able to solve the problems … they even come to us when we are working on the floor (A&E unit) … they do not go to [the unit manager], because they know we can help them too …"*
- *"… I can do [the unit manager's] job if she is away on leave … I have realised that I can do it and that I am a good manager … at first I was scared to decide on my own what to do … I asked [the unit manager] every time before I decided … now I can do it on my own …"*

Emancipation was evident in two of the professional nurse practitioners. They stated that they could enable the nurse practitioners based on their experience of rotating through the office of the unit manager:

- *"… it has helped me with my teamwork … my team is responsible for record keeping and now I have seen how important it is to record everything … because the patients' families come back to say we are doing nothing for the patient, but if the nurse (nurse practitioner) wrote it down we have proof … so my team now gives in-service training to improve the record keeping …"*
- *"… when I work in the office I do regular rounds to make sure the patients do not stay in the A&E unit without being seen by the specialists … if the patients wait*

too long I show the team leader what she must do and who she must contact to make sure the patient is seen by the specialists …"

From the following quotations obtained during reflective on-the-spot interviews, it was evident that job enrichment and job satisfaction were enhanced:

- *"… it was so good to be out of the unit (A&E unit) for a bit … to learn new things about management … we always do the same thing and it was good to do something else … I really liked it …"*
- *"… I did not know what to expect … to work as a (unit) manager was good and I learnt so much … it teaches you things that you do not learn on the floor (A&E unit) … other skills … I really enjoyed it and I think we must do it again … I want to become a good manager … maybe I can be a unit manager one day …"*
- *"… I think it is important in this unit (A&E unit) … we have had (unit) managers, but they did not involve us … we were just the workers … it is good to know how things work and what we can do to make it work better …"*

The unit manager reflected that *"… for the first time I know them (professional nurse practitioners) … I did not know them at all … I know about their children and what their husbands do…"*. The unit manager reflected that the trust between herself and the professional nurse practitioners had increased and that *"… we have time to talk …"*. During these discussions, the unit manager and nurse practitioners were able to talk openly to one another, which enlightened her: *"… they have told me that I am sometimes too harsh on the nurses (nurse practitioners) when they come to the office for a problem … it is as if I am angry at them and then they become scared to tell me about things … now I make a point to put down what I was doing when they (nurse practitioners) enter my office and I ask them to sit down and really listen to what they say … it resolves the problem much quicker and they are also more happy …"*.

b) Initiating teamwork

Delegation is regarded as the highest degree of empowerment and refers to the process of granting decision-making authority to lower-level employees. Delegation is a recommended way to lighten a busy manager's load while at the same time developing employees' abilities (Kreitner & Kinicki 2007:488).

The unit manager identified nine areas in the A&E unit that could be used to develop the nurse practitioners as well as enhance participative management and emancipatory practice development. The nurse practitioners were given the opportunity to decide in which team they wanted to work. Once the team members were finalised, a meeting was held with all the team members regarding what was expected of the teams. Consensus was reached that each team could choose a challenge that they felt was important to address. Once the challenge was identified, actions should be planned and implemented to resolve the challenge and the outcomes of the actions evaluated. Feedback from the different teams would be provided during the monthly staff meetings.

Team members were asked to reflect on their team's efforts. The output of each team is summarised in Table 5.5. From this table, it can be seen that there were nine teams dealing with specific tasks in the period 1 March 2006 to 31 January 2007. It was found that only four of the nine teams were able to plan and implement actions to address the challenge they had decided as being important to their role in the A&E unit.

Table 5.5: Outputs of teamwork

Team	Outputs (1 March 2006 to 31 January 2007)
Clothing and valuables	- Compiled a protocol for the safekeeping of clothes and valuables - Monitored and ensured that the protocol was implemented
Professional development	- Implemented an in-service training programme for the night staff
Patient records	No teamwork initiatives
Scheduled drugs	No teamwork initiatives
Conflict management	No teamwork initiatives
Infection control	No teamwork initiatives
Statistics and research	- Monthly statistics provided (paper based)
Stock and equipment	- Stock was ordered once a week - For stockpiling, worked out the minimum and maximum needs of the A&E unit - Broken equipment was taken in to be repaired - Ensured equipment was returned to the A&E unit as soon as it was repaired - Storerooms were kept neat and tidy
Quality	No teamwork initiatives

After further observation, it became evident that only four of the teams functioned as teams, and had collaboratively planned and implemented actions to address specific challenges. These teams were the:

- clothing and valuables team
- professional development team
- statistics and research team
- stock and equipment team

It was observed that the teams that functioned as teams were empowered in the process as they took ownership and responsibility for their teamwork:

- *"… our team is performing so well … we work together and the one that is on duty makes sure that our statistics are done … we request that one of us work at the end of the month when the stats (statistics) must go in to make sure that it is not late …"*
- *"… we are giving the lectures at night (in-service training) to make sure that everybody (nurse practitioners) that work in the unit (A&E unit) have a chance to attend the in-service training programme … they really enjoy it …"*
- *"… the stock are ordered … we (nurse practitioners) do not have the problems experienced at first … there are stock available in the stockroom … this supports us to do our jobs …"*
- *"… we (nurse practitioners) do not have to run around borrowing stock from other wards … we (nurse practitioners) have enough stock every day to do our work …"*

The fact that the four teams took action is indicative of the emancipation of the members of these teams during the teamwork initiative.

The positive feedback that the teams received from a member of top management as well as positive feedback obtained from the unit manager or nurse practitioners played an important role in increasing their motivation. The following quotations illustrate the results of the teamwork initiative:

- *"… my team is performing well … even the matron (top management) congratulated us on our performance … the stats (statistics) are finished in time and all my people (team members) are working together … the one that is on duty makes sure that our work is done …"*

- *"… [the unit manager] showed our protocol to [middle management] … [the unit manager] told us that the clothing and valuables are sorted out now … there are fewer complaints … we (nurse practitioners) were congratulated in the meeting (monthly staff meeting) … and our names are on the protocol … this gives us recognition for our hard work … we are now going to motivate for cupboards in which the clothes can be locked up … that will make the situation even better …"*

These reflections are congruent with a team-friendly organisation where both team performances and the viability of the teams to continue are possible. On the other hand, some teams did not experience the A&E unit as team-friendly. Five of the teams did not achieve any output and the members were unwilling to continue contributing to the team efforts (Kreitner & Kinicki 2007:344). The team members indicated that there was a lack of support from the unit manager as well as an inability of the members to work as a team. These findings were based on reflective statements made by some team members:

- *"… it is difficult to work in a team because everybody (team members) work different shifts …"*
- *"… we (team members) could not think of anything, so it was difficult … we could not agree on a challenge to address …"*
- *"… it is not fair … because my team never did anything, so I (nurse practitioner) am penalised in my performance evaluation …"*
- *"… we (team members) were not helped and it was the first time we had to do something like this … we could not do it … we did not know how to do it …"*
- *"… my team did not know what to focus on … we (team members) did not see one another every day and the time goes by so quickly … we could not decide what to do … we have not achieved anything …"*

5.4.2.2 Celebrating successes

The unit manager organised a party on 24 August 2006 to celebrate the success of the positive feedback received from the Accreditation Committee on 6 August 2006 (see Annexure E). This too is evidence that the unit manager had accepted ownership of the AR for practitioners project. All the nurse practitioners attended the celebration.

During the celebration, the unit manager gave a brief overview of the feedback that she had received from the members of the Accreditation Committee and the successes of the AR for practitioners project. The unit manager formally thanked the nurse practitioners for their hard work and dedication in making the project and the A&E unit successful. This showed that the unit manager valued the input of the nurse practitioners.

5.4.3 Reflection

Practice leaders have the essentials of authority, power and influence to lead followers to reach their goals (Jooste 2004:217). Effective leadership in the A&E unit was about enabling the nurse practitioners to produce extraordinary things (Charlton 2000:30). The unit manager, as practice leader, aimed to reach the PDG's shared vision of 'emancipatory practice development' by changing the power and control management style used by previous unit managers to a participative management style, and thereby enhancing participation and empowerment.

The unit manager regarded the rotation of the professional nurse practitioners through her office as "…very successful…". These nurse practitioners reflected that the opportunity developed their problem-solving skills as well their ability to collaborate with other members of the multidisciplinary team. They also indicated that they experienced job enrichment and increased job satisfaction.

The unit manager regarded the implementation of teamwork as successful, but reflected that the nurse practitioners needed further motivation to ensure that all the teams succeeded. Four of the teams reached the goals they set for their individual teams. The team responsible for the stock and equipment in the A&E unit did not have any other responsibilities in the A&E unit and functioned independently. The nurse practitioners involved in the other teams were responsible for the management of patients admitted to and nursed in the A&E unit. The team addressing professional development enhanced technical practice development through the in-service training programme, and the team responsible for the statistics addressed priority five (research). The team that compiled a protocol for the safekeeping of patients' clothes and valuables was involved in components of emancipatory practice development, as they questioned the way in which clinical practice took place and then attempted to change or improve it. This team

addressed a specific shortfall and compiled an innovative protocol that was concerned with ensuring that everyday practice was effective (McCormack et al. 2004:8).

The PDG reflected that, although not perfect, the introduction of teamwork as a participative management initiative resulted in positive outcomes in the clinical practice, enhancing both technical and emancipatory practice development.

The unit manager realised the effect and importance of celebrating the successes of the A&E unit. The unit manager reflected "… we have to celebrate more … it was so good for all of us to get together and celebrate our achievements … the nurses (nurse practitioners) were proud of what they have achieved …". The unit manager proposed continuing the focus on celebrating successes during Cycle 9.

5.5 AMENDED LEADERSHIP DEVELOPMENT (STEP 2: CYCLE 9)

Cycle 9 was facilitated over a period of five months (see Figure 5.5). It started on 1 February 2007 and was completed on 30 June 2007, the date on which consensus was reached that the AR for practitioners project for the purposes of this study would be completed. However, as indicated in Figure 2.2, the project continued in the A&E unit, although not for the purposes of this study.

Table 5.6: Step 2: Cycle 9: Amended leadership development

Phase 2			
29 August 2005 to 31 May 2006	**January 2006 – February 2006**	**1 June 2006 to 31 January 2007**	**1 February 2007 to 30 June 2007**
Cycle 7	**Move to new hospital**	**Cycle 8**	**Cycle 9**
Address the challenges		**Leadership development**	**Amended leadership development**

5.5.1 Actions planned

The researcher provided the unit manager with the feedback obtained from the nurse practitioners during Cycle 8. The unit manager reflected that *"… celebrating the successes really motivated my staff (nurse practitioners) … it is important to show them that I appreciate the hard work they do … it is not always easy … they (nurse practitioners) really work hard …*". Based on this statement, the unit manager indicated that she felt that the successes of the nurse practitioners should be celebrated more often, as she noticed the positive effect this had on them. Regarding the teamwork, the unit manager reflected *"… I will have to guide them (team members) more … I will have to show them how to do it …*".

The unit manager decided that the actions planned for Cycle 9 should include:

- **Action 1**: Enhance teamwork
- **Action 2**: Continue celebrating successes

5.5.2 Act and observe

The actions implemented and the observations made are described below.

5.5.2.1 Action 1: Enhance teamwork

The first action planned for Cycle 9 was enhancing the teamwork in the A&E unit. The unit manager formally invited the team leaders to come and see her any time to discuss their teamwork. The team leaders did not do this, but consulted the unit manager during their performance management when they were asked directly what they had planned their team's outputs would be.

Table 5.7: Comparing outputs of the individual teams (Step 2: Cycle 8 and Cycle 9)

Team	Outputs (1 March 2006 to 31 January 2007)	Outputs (1 February 2007 to 30 June 2007)
Clothing and valuables	- Compiled a protocol for the safekeeping of clothes and valuables - Monitored and ensured that the protocol was implemented	- Continued to monitor and ensure that the protocol was implemented - No new initiative was taken
Professional development	- Implemented an in-service training programme for the night staff	- Actions were planned to start an in-service training programme on night duty - Actions were implemented
Patient records	No teamwork initiatives	- No new initiative were taken
Scheduled drugs	No teamwork initiatives	- Actions were planned to check the scheduled drug books at least once a week to ensure that all the scheduled drugs could be accounted for - Actions were implemented
Conflict management	No teamwork initiatives	- Although the team leader was involved in conflict management in the A&E unit, no observable teamwork occurred
Infection control	No teamwork initiatives	- Attended monthly meetings in conjunction with the hospital infection control department - Compiled a record file of all patients admitted to the A&E unit with infectious diseases as well as the nurse practitioners who nursed these patients - Attended workshops on topics concerning infection control
Statistics and research	- Monthly statistics provided (paper based)	- Finished statistics on time - Developed a spreadsheet to do statistics on in the future - Included the waiting times of patients waiting for ICU beds

Team	Outputs (1 March 2006 to 31 January 2007)	Outputs (1 February 2007 to 30 June 2007)
Stock and equipment	- Stock was ordered once a week - For stockpiling, worked out minimum and maximum needs of the A&E unit - Broken equipment was taken in for repairs - Ensured that equipment was returned to A&E unit as soon as it had been repaired - Storerooms were kept neat and tidy	- Equipment in each area was marked to ensure that it remained in the area and was not moved around, as this increased the risk of it being lost or broken - Equipment was listed and a service record of each individual piece compiled in order to keep track thereof
Quality	No teamwork initiatives	- Attended the hospital's quality meetings monthly - Planned actions to improve the layout of the medical resuscitation area and implemented the actions - Collaborated with the ICUs to obtain the protocols used on a regular basis in the management of ICU patients, then made posters of the protocols and put them in the areas where ICU patients were nursed in the A&E unit for the nurse practitioners' use

From Table 5.6, it is evident that seven of the nine teams reached their planned outcomes during Cycle 9. Only one team, namely those who had to manage the nursing records, did not function at all. The team responsible for conflict management did not function as a team, although the team leader was actively involved in conflict management matters in the A&E unit. Examples of this included negotiating with top management for scarce skills payment for A&E nurse practitioners and improved salary scales.

The unit manager reflected that *"… although the teams are working I know they can function much better … the teams are working according to their outcomes they have set for themselves … but they can do much better … I know it is my limitation … I still do not give them enough guidance … but you know, I don't know how to do it … I am unsure of what I want them to achieve and then I cannot help them … I don't know how to motivate them … maybe we (unit manager and researcher) must work on it together …".* These reflections provide evidence that the unit manager became

aware of her own shortcomings. Although the majority of the teams functioned, she reflected *"… they can do better if I support them more …"*.

The unit manager was willing to continue to address this challenge in the future.

5.5.2.2 Action 2: Continue to celebrate successes

The second action implemented during Cycle 9 was celebrating the successes achieved in the A&E unit. These successes included teams that reached their goals and nurse practitioners who completed short courses or formal programmes, such as the A&E programme, and nursing education, nursing management and HIV/AIDS courses.

5.5.3 Reflection

The outcomes of the teams increased in Cycle 9 and only one team did not function at all. Three teams began taking action – the teams responsible for scheduled drugs, infection control and quality. The remaining teams all reached their outcomes. The unit manager realised that in order for the teams to work together, she would have to invest a great deal of effort in them. It was observed that she did support the team members and help them when they requested assistance. The unit manager reflected that she might have expected too much from the nurse practitioners initially and that she needed to focus on enabling them to work together as a team. The unit manager indicated that she felt she did not have adequate knowledge and skills to ensure that the teamwork in the A&E unit was effective. The unit manager and I agreed that once I completed my thesis, we would collaborate and address this challenge.

5.6 SUMMARY

In this chapter, the journey of the unit manager was discussed. This journey included three AR cycles (Cycle 7, 8 and 9). The results indicated that the 'toxic environment' was changed to an 'enabling environment', as the nurse practitioners were motivated through trust, participation and support.

The nurse practitioners reflected that the implementation of the portfolios enhanced the fairness of performance management. The portfolios also provided the unit manager with opportunities to show appreciation for the nurse practitioners' input, and knowledge and skills in the A&E unit. Successes were celebrated and, as a result of the enabling environment, the nurse practitioners experienced job enrichment and job satisfaction.

Reflective learning was used throughout the journey during the participative management initiatives to enlighten the nurse practitioners. The empowerment and emancipation of the unit manager and nurse practitioners followed.

Partnerships were developed with the researcher, the clinical facilitator and the nurse practitioners. Throughout the journey, the unit manager took ownership of the majority of the planned actions and the responsibility for implementing these actions.

Chapter 6 focuses on evaluating the worth of the journey.

6 Evaluating the worth of the journey

Beliefs influence perception.
Perception structures reality.
Reality suggests possibilities.
Possibilities generate choices.
Choices initiate actions.
Actions affect outcomes.
Outcomes impact beliefs…
Awareness facilitates change.
Change anywhere becomes change
Everywhere.

Tobin Quereau, 1994

6.1 INTRODUCTION

In Chapter 3, the initiation of the journey is described. Chapter 4 and 5 discuss the journeys towards emancipatory practice development of the clinical facilitator and unit manager respectively. In this chapter, the worth of the project is addressed, based on the set outcomes of success, decided upon by the practice leaders and nurse practitioners, of the AR for practitioners project (see Section 3.6.1).

6.2 SET OUTCOMES FOR SUCCESS OF THE ACTION RESEARCH FOR PRACTITIONERS' PROJECT

Evaluation refers to the everyday occurrence of making judgements of worth (McCormack & Manley 2004:83; McNiff & Whitehead 2006:69) and is a normal part of life. In general, evaluation focuses on concerns, issues and problems in order to develop solutions and, therefore, search for what is wrong and what is not working

(Preskill & Coghlan 2003:1). Evaluation was used to come to a conclusion regarding the worth of the AR for practitioners project.

Even though evaluation took place throughout the project by means of qualitative data collection strategies, it was regarded by the PDG as essential to evaluate the project after a period of two years. It was important to determine whether the efforts made by the PDG and nurse practitioners to plan and implement both short-term and long-term solutions to resolving the emergency situation in the A&E unit were worthwhile and whether the nurse practitioners' needs had been met (Wadsworth 1997:12). The evaluation process would not only add to the validity of the study, but also provide valuable feedback to the practice leaders and nurse practitioners regarding their efforts, in terms of both their successes and the gaps in the actions taken to create a better future for the nurse practitioners in the A&E unit.

Both insider (internal) and outsider (external) evaluation was used to evaluate the worth of the project. The insider evaluation was done by the PDG and permanent nurse practitioners working in the A&E unit, while the feedback from the A&E learners and reports received from the Accreditation Committee were used as the outsider evaluation.

The outcomes for success of the AR for practitioners project were set by the practice leaders and nurse practitioners during the initiation of the journey. For the insider evaluation, these included:

- resolve the barrier of the shortage of nurse practitioners (short-term)
- change the toxic environment to an enabling environment (long-term)
- address the challenges experienced in the A&E unit to such an extent that the majority of the nurse practitioners regard these challenges as resolved (short-term)
- create an emancipatory practice development culture (long-term)
- retain the nurse practitioners (long-term)

One component of the outsider evaluation process was the feedback obtained from the A&E learners regarding the A&E unit as a learning and supportive environment during the clinical component of the A&E programme. One of the researcher's concerns, as lecturer responsible for the A&E programme, was the continued use of

the A&E unit as a clinical facility for the A&E programme. These concerns were based on the complaints received from the A&E learners before the initiation of the project. At the completion of the project, the A&E learners were given a questionnaire to complete specifically evaluating the A&E unit as learning environment for A&E learners.

Another component of the outsider evaluation was the results of the second visit of the Accreditation Committee of the Gauteng Department of Health to the A&E unit on 6 August 2006. As the project formally started after a visit by the Accreditation Committee, the follow-up visit was used as a means of evaluating the worth of the journey by comparing the second report to the first. The Accreditation Committee was not aware of the project in the A&E unit and the researcher did not determine or influence their criteria for evaluation.

Outsider evaluation was used to increase the validity of the project. The outcomes for success of the AR for practitioners project for the outsider evaluation included:

- obtain positive feedback from the A&E learners regarding the A&E unit as a learning and supportive environment, and
- obtain an average of 75 per cent or more from the Accreditation Committee of the Gauteng Department of Health on their next visit to the A&E unit.

6.3 INSIDER EVALUATION

The insider evaluation is discussed based on the set criteria.

6.3.1 Resolve the barrier of nurse practitioner shortages

The barrier of the shortage of professional nurse practitioners was addressed predominantly by the PDG. The total number of professional nurse practitioners increased from 31 to 48, an increase of approximately 55 per cent (The Hospital 2007a; The Hospital 2006; The Hospital 2005).

6.3.2 Change the environment

The second barrier diagnosed in the A&E unit, which was considered important to overcome in order to enhance the chance of reaching the shared vision of emancipatory practice development, was the toxic environment in which the nurse practitioners were working. The PDG envisioned changing the toxic environment that existed in the A&E unit, which was characterised by a predominantly hierarchical and bureaucratic management style, inadequate numbers of professional nurse practitioners and a lack of support, appreciation and learning opportunities (see Section 3.2.1).

For the sake of clarity, a visual representation is given to indicate the change that took place during the project. From Figure 6.1, it can be seen that all those working in the A&E unit were at the centre of the change from toxic to enabling environment. This includes the PDG, which consisted of the unit manager and clinical facilitator (insiders), and the researcher (outsider). This also included the nurse practitioners, who were adult learners experienced in the field of A&E nursing care, working in the A&E unit. To enable change in the toxic environment, relationships between the PDG and the nurse practitioners had to be of mutual facilitation and learning. This relationship was established during the journeys of the clinical facilitator and unit manager (Chapter 4 and 5).

In order to create an enabling environment, certain aspects indicated in Figure 6.1 had to be established in the environment. These included valuing the knowledge, skills, experience and input of the nurse practitioners, creating mutual trust, showing appreciation, maintaining fairness, creating a learning environment, providing positive feedback, celebrating successes, ensuring the active participation of all in the A&E unit and ensuring that each individual is supported. These aspects were the main themes of the research findings established through the analysis of the qualitative data.

Evidence obtained during the AR for practitioners project confirmed that change had taken place and that the toxic environment had been changed to an enabling environment (see Figure 6.1).

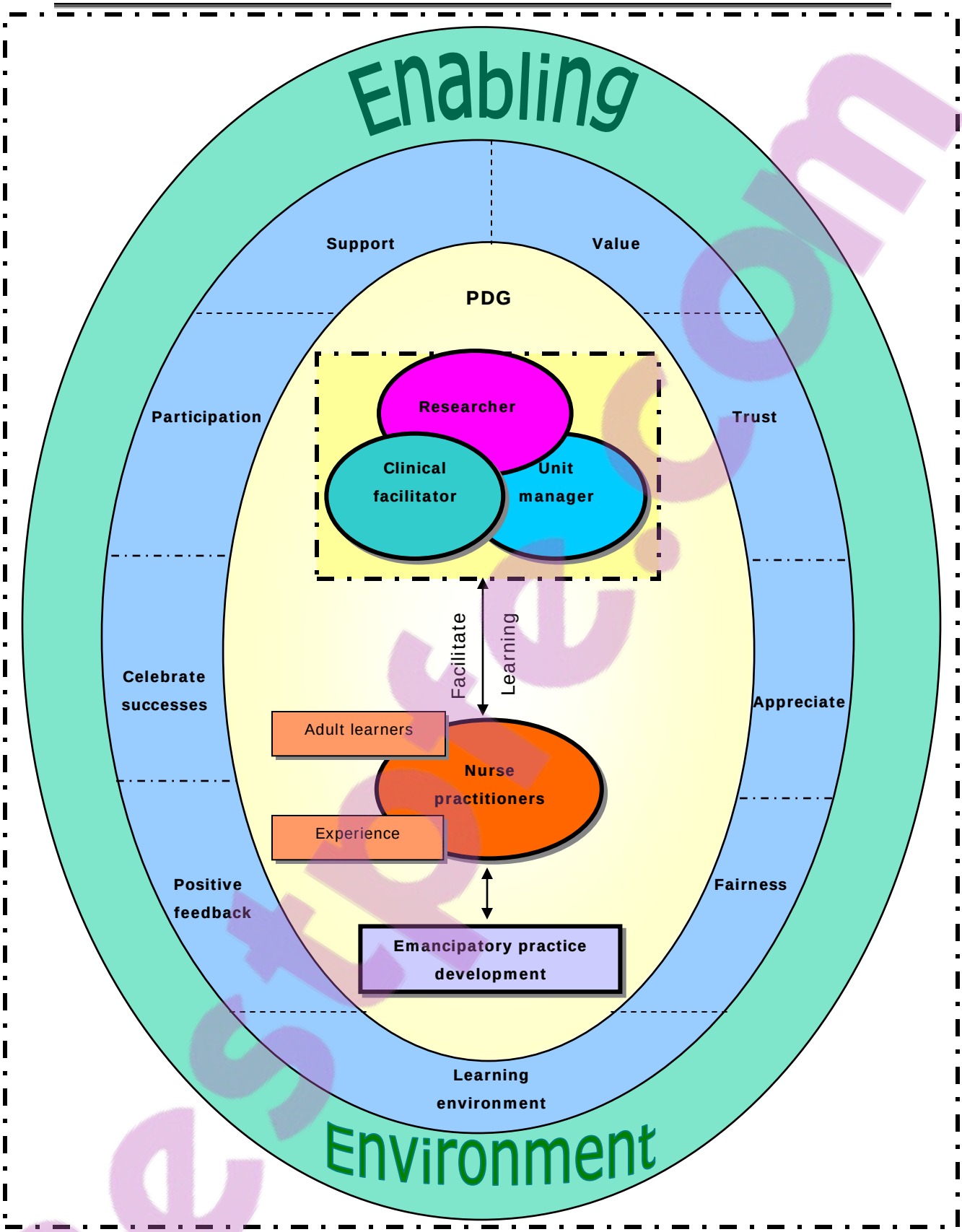


Figure 6.1: Enabling environment

For further clarity and analysis of the enabling environment, see Table 6.1.

Table 6.1: Summary of the evidence concerning an enabling environment

Characteristics of the enabling environment	Evidence of actions taken during research	Chapter / Section
Support	The researcher (as facilitator) supported the clinical facilitator throughout the project and enabled her to resolve the challenge of professional development	Chapter 4 Section 4.4.2.6
	The researcher supported the unit manager throughout the project and enabled her to resolve the challenges delineated during the NGM as well as those pertaining to leadership development	Chapter 5
	The unit manager supported the nurse practitioners by being available	Section 5.3.2.1
	Support for each other in the A&E unit increased	Section 5.3.2.1
	Top management supported the nurse practitioners by agreeing to increase the number of nurse practitioners per shift	Section 5.3.2.1
	A porter remained in the A&E unit to support the nurse practitioners	Section 5.3.2.1
	Security was placed at the entrance of the A&E unit, which supported the nurse practitioners as it reduced their workload	Section 5.2.2.1b
Valued	Nurse practitioners indicated that their input was valued	Section 5.3.2.2
	The clinical facilitator indicated that she was valued by the nurse practitioners, doctors, supervisors and the researcher for her efforts concerning the CPDP implemented in the A&E unit	Section 4.4.2.2
Trust	The clinical facilitator reflected that the environment was a trusting environment and that she was trusted by her supervisor and the researcher in her new role	Section 4.4.2.6
	The use of the portfolios increased the trust of the nurse practitioners	Section 5.3.2.1
	Giving priority to the nurse practitioners for working overtime increased their trust in the unit manager	Section 5.3.2.2
	Rotating the professional nurse practitioners through the office of the unit manager increased the trust between the unit manager and professional nurse practitioners	Section 5.4.2.1

Characteristics of the enabling environment	Evidence of actions taken during research	Chapter / Section
Appreciative	The unit manager appreciated the input of the nurse practitioners	Section 5.4.2.2
Fairness	The use of the portfolios increased the fairness	Section 5.3.2.1
Learning environment	Creating a CPDP	Chapter 4
	Creating an in-service training programme	Table 4.1
	The clinical facilitator expressed that the environment was a learning environment as opportunities during which she was enabled were provided	Section 4.4.2.6
Positive feedback	The clinical facilitator received positive feedback from unit manager and supervisor	Section 4.4.2.3 Section 4.4.2.6
	Teams obtained positive feedback from top management and the unit manager	Section 5.4.2.1
	The clinical facilitator indicated that she received positive feedback regarding the in-service training programme	Section 4.4.2.1
	The researcher gave the clinical facilitator the positive feedback obtained from the nurse practitioners regarding the on-the-spot teaching strategies utilised	Section 4.4.2.1
Celebrate success	The positive feedback obtained from the Accreditation Committee was celebrated	Section 5.4.2.2
Participation	Nurse practitioners participated in decision-making processes concerning BLS, ACLS, PALS and ATLS training	Section 5.3.2.1
	Nurse practitioners participated in deciding on their different scopes of practice	Section 5.3.2.1
	Through participation, nurse practitioners were recruited	Section 5.3.2.2
	A participative management style was followed	Section 5.3.2.2 Section 5.3.2.3 Section 5.3.2.5
	The nurse practitioners participated in planning the in-service training programme	Section 4.4.2.1

From Table 6.1, it is evident that the themes that emerged from this research are based on the qualitative data obtained during the reflective discussions, observations and personal on-the-spot interviews conducted by the researcher.

6.3.3 Address the challenges

From the analysis of the qualitative data obtained from the NGM, the five priorities, identified by the nurse practitioners as the most important challenges that needed to be resolved to ensure a better future for them in the A&E unit, emerged. The data were used to compile the questionnaire (see Annexure H.1), which was distributed to the permanent nurse practitioners in order to evaluate the success of the AR for practitioners project implemented over a period of two years to resolve the identified challenges.

The questionnaire consisted of five sections:

- **Section A** – Priority 1: Professional development
- **Section B** – Priority 2: Patient care
- **Section C** – Priority 3: Structure
- **Section D** – Priority 4: Equipment
- **Section E** – Priority 5: Research

The quantitative data obtained from the questionnaire were analysed according to the principles described in Chapter 2, Section 2.8.2.5. Each of the five sections was discussed individually and the results of each variable reported on.

Forty-six copies of the questionnaire were distributed to the permanent nurse practitioners working in the A&E unit. This, however, excluded the practice leaders. Thirty-four respondents completed and returned the questionnaire, which represents a response rate of 73,9 per cent. All the respondents completed all the questions.

6.3.3.1 Section A: Priority 1: Professional development

Section A focused on the challenges identified regarding professional development.

a) In-service training programme

Question 1 was concerned with the realisation of an in-service training programme. Eighteen respondents (52,9%) indicated that they agreed and 16 respondents (47,1%) indicated that they strongly agreed that an in-service training programme

was in place. None of the respondents indicated that they were unsure, disagreed or strongly disagreed with this question. This is reflected in Figure 6.1.

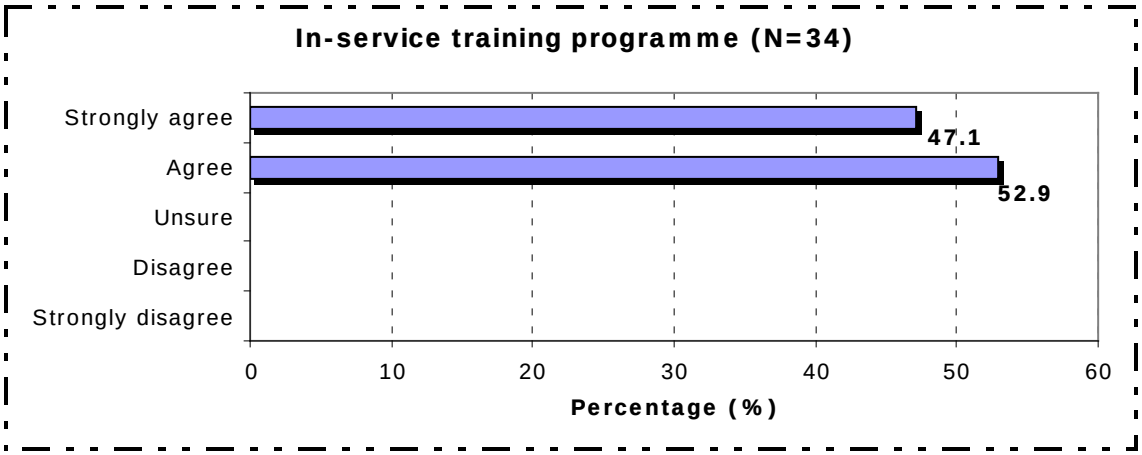


Figure 6.2: In-service training programme

b) Multidisciplinary team involvement

Question 2 was concerned with the involvement of the multidisciplinary team members in the in-service training programme. Eleven respondents (32,4%) indicated that they strongly agreed and 14 respondents (41,7%) indicated that they agreed that the multidisciplinary team was involved in the in-service training programme for nurse practitioners. Five respondents (14,7%) were unsure, while four respondents (11,7%) indicated that they disagreed that there was any multidisciplinary involvement in the in-service training programme. None of the respondents indicated that they strongly disagreed with the statement. These data are reflected in Figure 6.2.

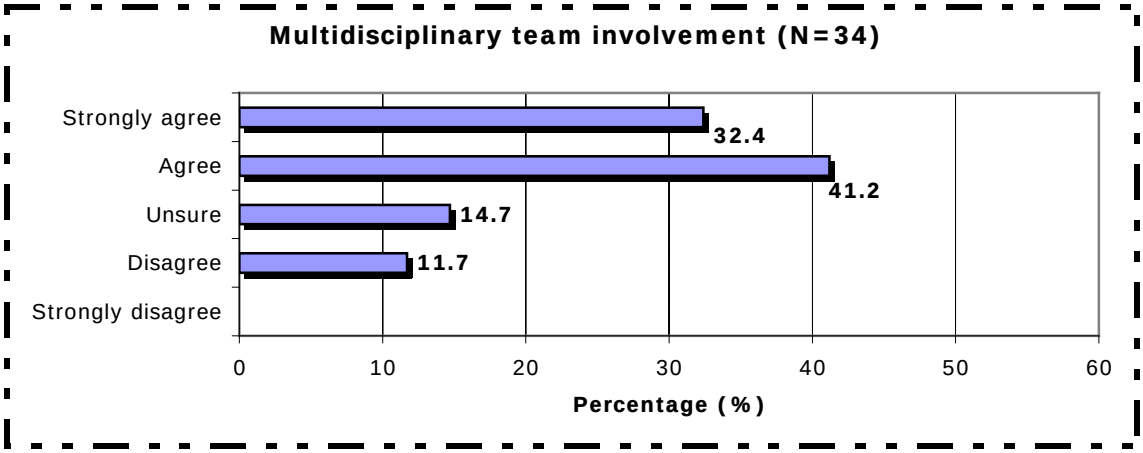


Figure 6.3: Multidisciplinary team involvement

c) Sponsored BLS, ACLS and PALS

Question 3 was concerned with whether the hospital had sponsored the nurse practitioners for the BLS, ACLS and PALS courses. One respondent (2,9%) indicated that he/she was unsure whether the hospital had sponsored the nurse practitioners for the BLS, ACLS and PALS courses, while 20 respondents (58,9%) agreed and 13 respondents (38,2%) strongly agreed that the hospital had sponsored the nurse practitioners. None of the respondents indicated that they disagreed or strongly disagreed with the statement.

These data are reflected in Figure 6.3.

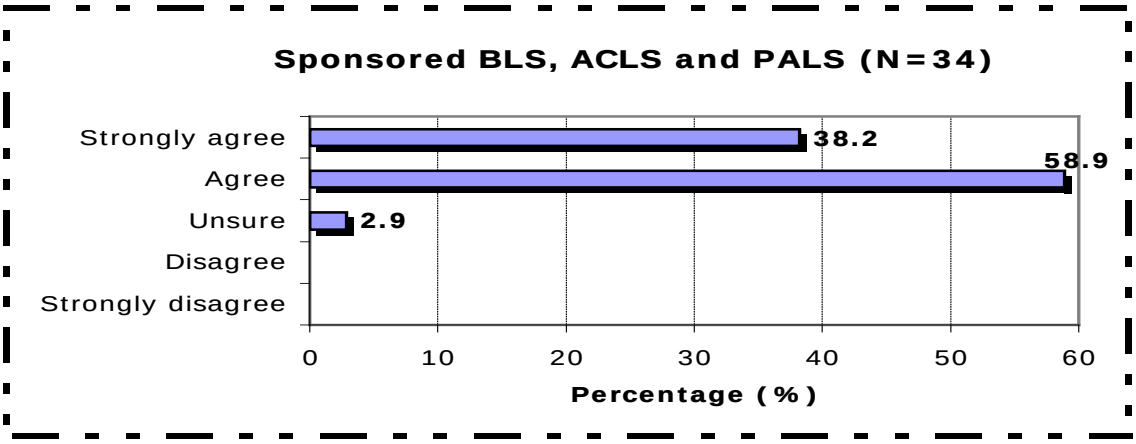


Figure 6.4: Sponsored BLS, ACLS and PALS

d) Increased number of A&E learners

Question 4 was concerned with whether there were an increased number of professional nurse practitioners enrolling as A&E learners in the A&E programme. Twenty-four respondents (70,6%) agreed and ten respondents (29,4%) strongly agreed that more professional nurse practitioners were enrolling for the A&E programme. None of the respondents indicated that they were unsure, disagreed or strongly disagreed with the statement. These data are reflected in Figure 6.4.

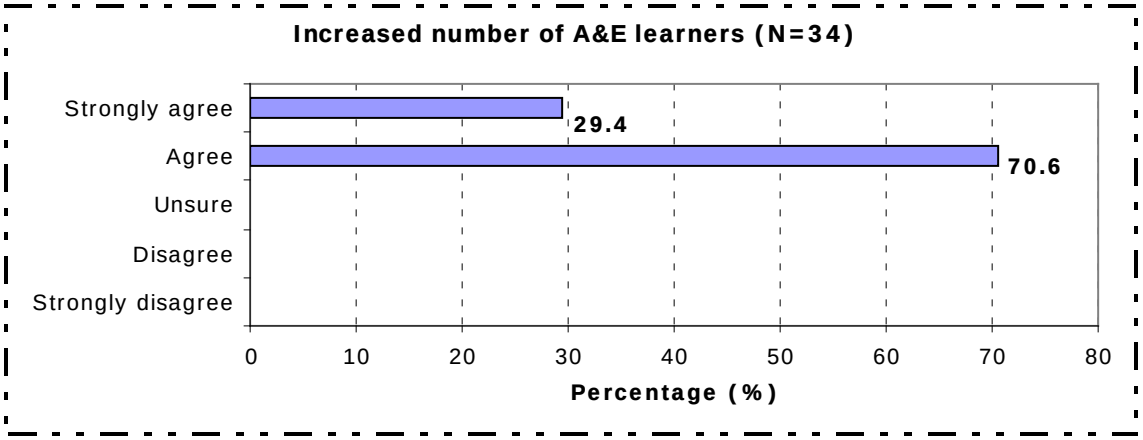


Figure 6.5: Increased number of A&E learners

e) Exposure to other units

Question 5 was concerned with whether the nurse practitioners were provided with the opportunity to be exposed to other units in the hospital if, requested. Sixteen respondents (47,1%) strongly agreed and 17 respondents (50,0%) agreed that the nurse practitioners were provided with the opportunity to be exposed to other units in the hospital if they requested this change. One respondent (2,9%) was unsure. None of the respondents indicated that they disagreed or strongly disagreed that the challenge had been resolved. These data are reflected in Figure 6.5.

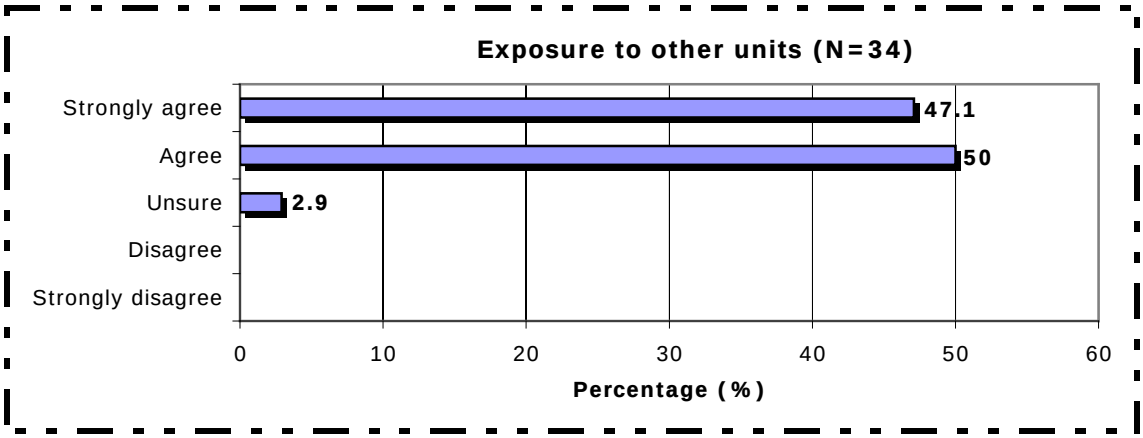


Figure 6.6: Exposure to other units

f) Scarce skills dilemma

Question 6 was concerned with the fact that the A&E nurse practitioners did receive a monthly scarce skills allowance like other clinical specialities, such as critical care

nurse practitioners. Four respondents (11,8%) strongly agreed and 30 respondents (88,2%) agreed that the A&E nurse practitioners did receive scarce skills allowances like other clinical specialists. None of the respondents indicated that they were unsure, disagreed or strongly disagreed with the statement. These data are reflected in Figure 6.6.

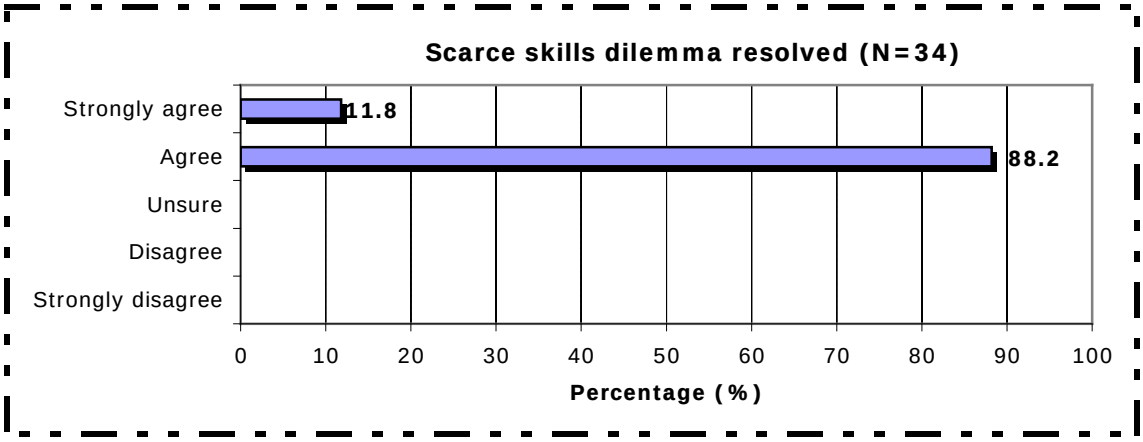


Figure 6.7: Scarce skills dilemma resolved

g) Disrespect among nurse practitioners

Question 7 was concerned with whether the nurse practitioners continued to disrespect one another in the A&E unit. Four respondents (11,8%) strongly agreed and four respondents (11,8%) agreed that the disrespect amongst the nurse practitioners continued. Five respondents (14,7%) were unsure. Eighteen respondents (52,9%) disagreed and three respondents (8,8%) strongly disagreed that this statement was true. These data are reflected in Figure 6.7.

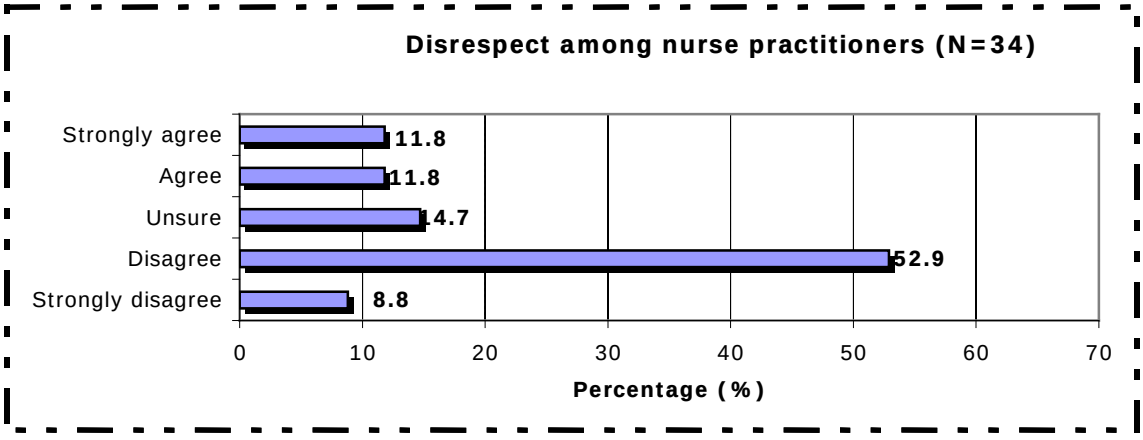


Figure 6.8: Disrespect among nurse practitioners

h) Multidisciplinary team members disrespect nurse practitioners

Question 8 was concerned with whether the multidisciplinary team members showed disrespect to the nurse practitioners. Four respondents (11,8%) strongly agreed and four respondents (11,8%) agreed. Five respondents (14,7%) were unsure. Eighteen respondents (52,9%) disagreed and three respondents (8,8%) strongly disagreed that the multidisciplinary team members showed disrespect to the nurse practitioners working in the A&E unit. These data are reflected in Figure 6.8.

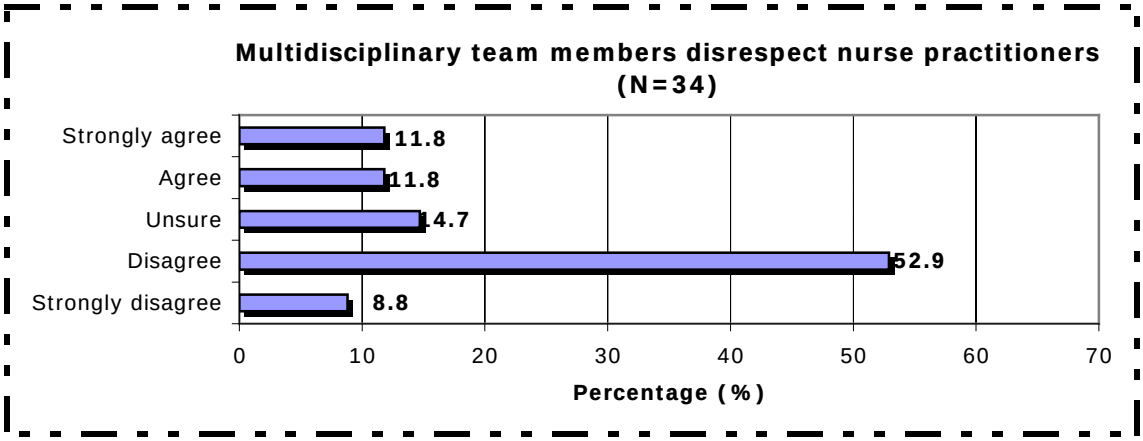


Figure 6.9: Multidisciplinary team members disrespect nurse practitioners

i) Disrespect towards patients and families

Question 9 was concerned with whether the nurse practitioners' disrespect for patients and their families continued. Eleven respondents (32.4%) strongly agreed and 21 respondents (61,8%) agreed that disrespect continued. One respondent (2,9%) was unsure. One respondent (2,9%) disagreed and no respondents strongly disagreed that the nurse practitioners' disrespect towards the patients and their families continued. These data are reflected in Figure 6.9.

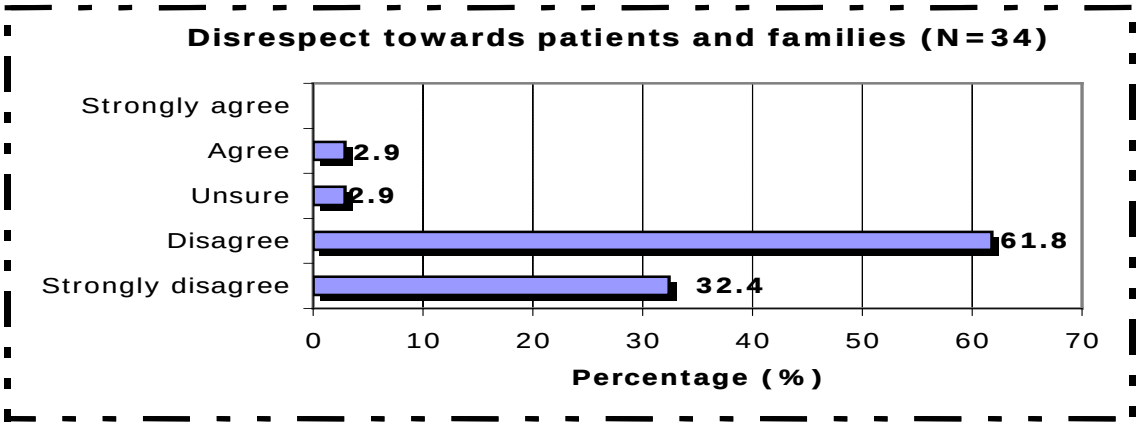


Figure 6.10: Disrespect towards patients and families

j) Filling up used stock

Question 10 was concerned with whether the nurse practitioners filled up the used stock on a regular basis. Six respondents (17,6%) strongly agreed and 24 respondents (70.6%) agreed. No respondents were unsure. Four respondents (11,8%) disagreed and no respondents strongly disagreed that the nurse practitioners filled up the used stock on a regular basis. These data are reflected in Figure 6.10.

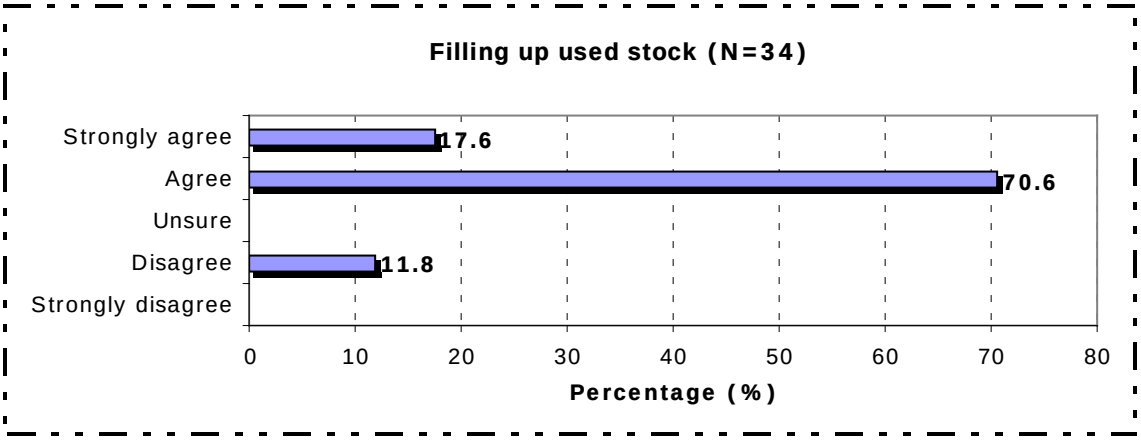


Figure 6.11: Filling up used stock

k) Nurse practitioners work within scope of practice

Question 11 was concerned with whether the different categories of nurse practitioners were working within their scope of practice. Eighteen respondents (52,9%) strongly agreed and 13 respondents (38,2%) agreed. Three respondents (8,8%) were unsure. No respondents disagreed or strongly disagreed that the

different categories of nurse practitioners were working within their scope of practice. These data are reflected in Figure 6.11.

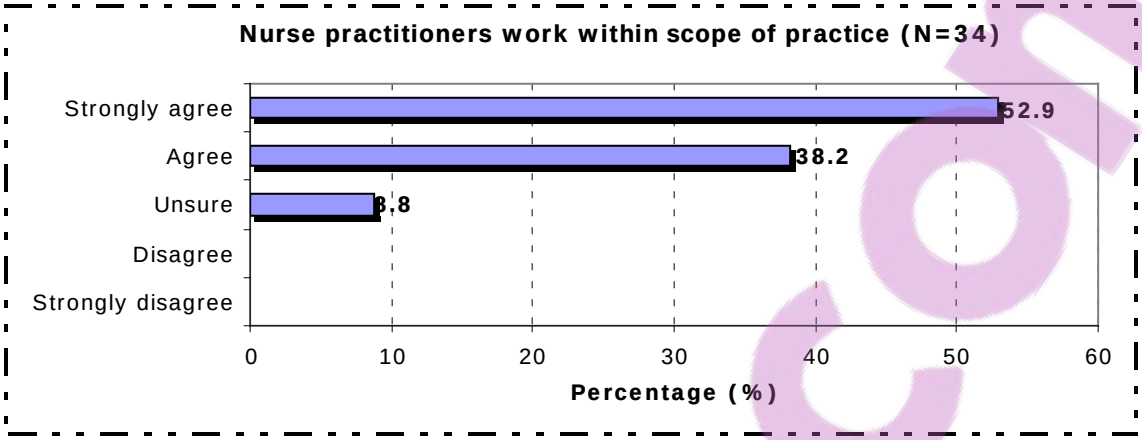


Figure 6.12: Nurse practitioners work within scope of practice

I) Accept responsibility and accountability

Question 12 was concerned with whether the nurse practitioners were accepting responsibility and accountability. One respondent (2,9%) strongly agreed and 27 respondents (79,4%) agreed that the nurse practitioners were accepting responsibility and accountability. Four respondents (11,8%) were unsure. Two respondents (5,9%) disagreed and no respondents strongly disagreed that the nurse practitioners were accepting responsibility and accountability. These data are reflected in Figure 6.12.

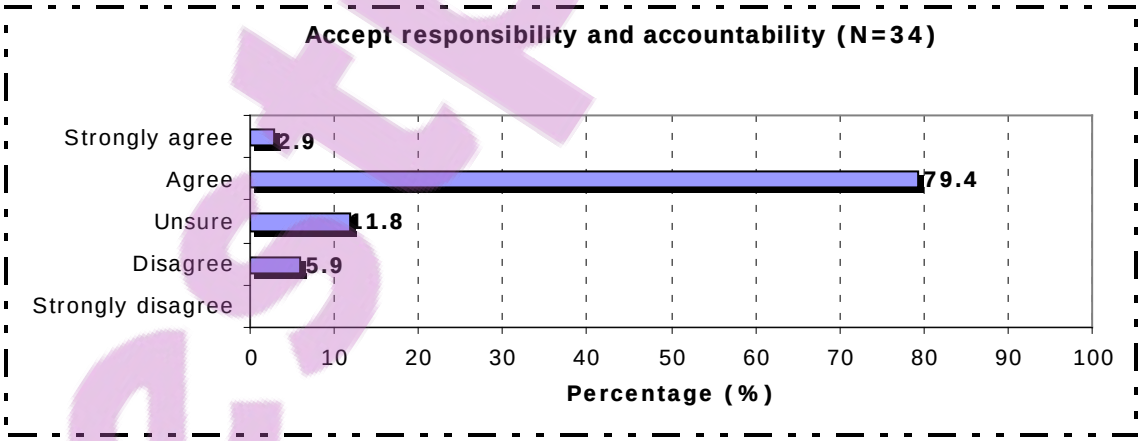


Figure 6.13: Accept responsibility and accountability

m) Nurse practitioners support each other

Question 13 was concerned with whether the nurse practitioners were supporting each other in the A&E unit. Seven respondents (20,6%) strongly agreed and 27 respondents (79,4%) agreed that the nurse practitioners were supporting each other in the A&E unit. No respondents indicated that they were unsure, disagreed or strongly disagreed with the statement. These data are reflected in Figure 6.13.

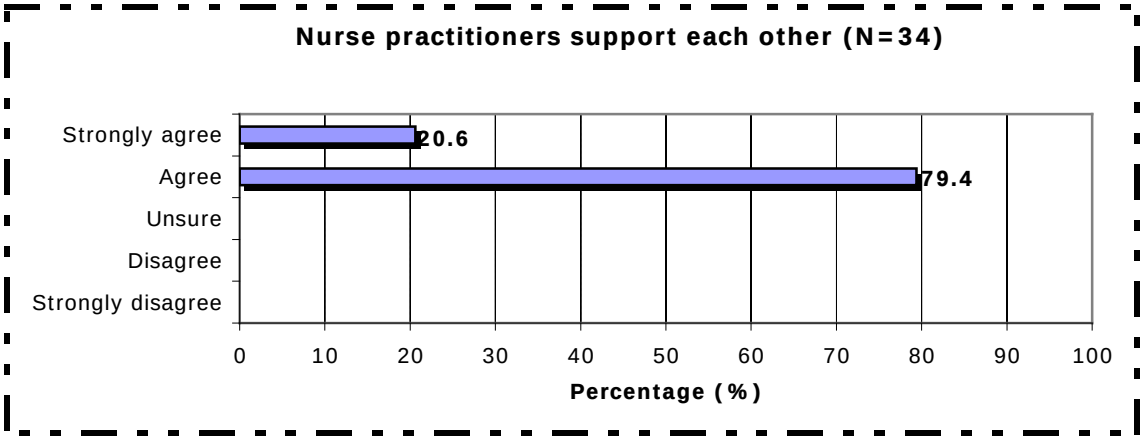


Figure 6.14: Nurse practitioners support each other

n) Supported by the multidisciplinary team

Question 14 was concerned with whether the nurse practitioners perceived that the multidisciplinary team members supported them. No respondent strongly agreed and 14 respondents (41,2%) agreed that the multidisciplinary team members supported the nurse practitioners. No respondents indicated that they were unsure. Twenty respondents (58,8%) indicated that they disagreed with this statement. None indicated that they strongly disagreed with the statement. These data are reflected in Figure 6.14.

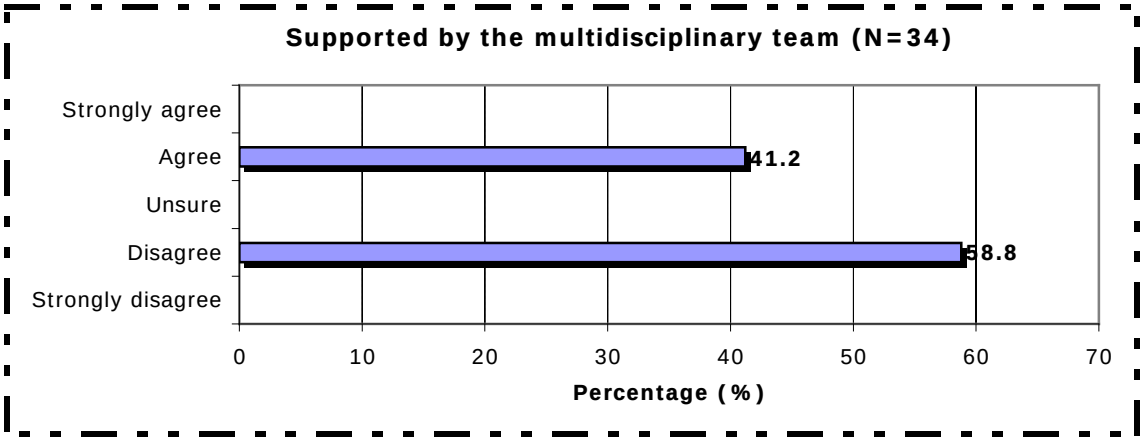


Figure 6.15: Supported by the multidisciplinary team

o) Supported by top management

Question 15 was concerned with whether the nurse practitioners perceived that top management supported them. None of the respondents indicated that they strongly agreed or strongly disagreed with the statement that top management was supportive. Seventeen (17) respondents (50,0%) agreed that top management supported the nurse practitioners. Eight respondents (23,5%) were unsure. Nine respondents (26,5%) disagreed that top management was supportive. These data are reflected in Figure 6.15.

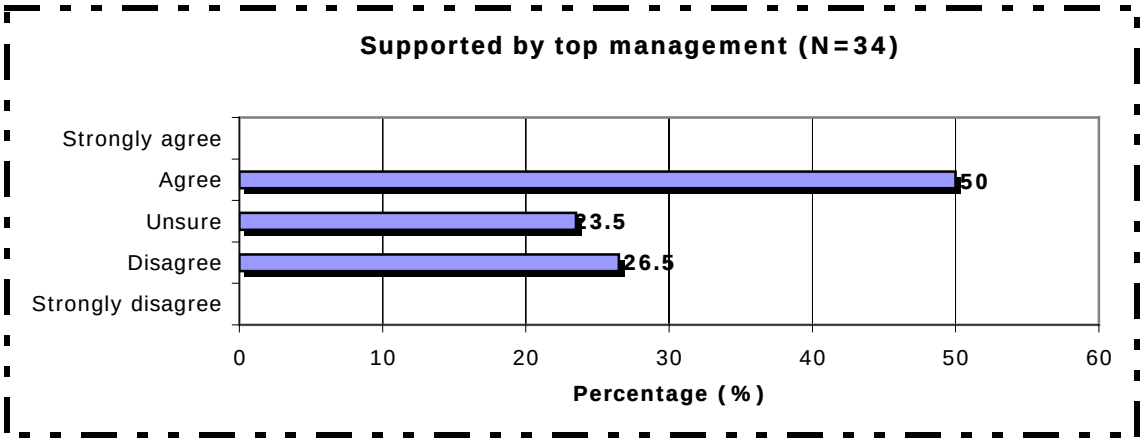


Figure 6.16: Supported by top management

p) Supported by support staff

Question 16 was concerned with whether the nurse practitioners perceived that the support staff supported them in the A&E unit. Three respondents (8,8%) strongly

agreed and 30 respondents (88,2%) agreed that the support staff supported them in the unit. One respondent (2,9%) was unsure. No respondents disagreed or strongly disagreed that the support staff supported them in the A&E unit. These data are reflected in Figure 6.16.

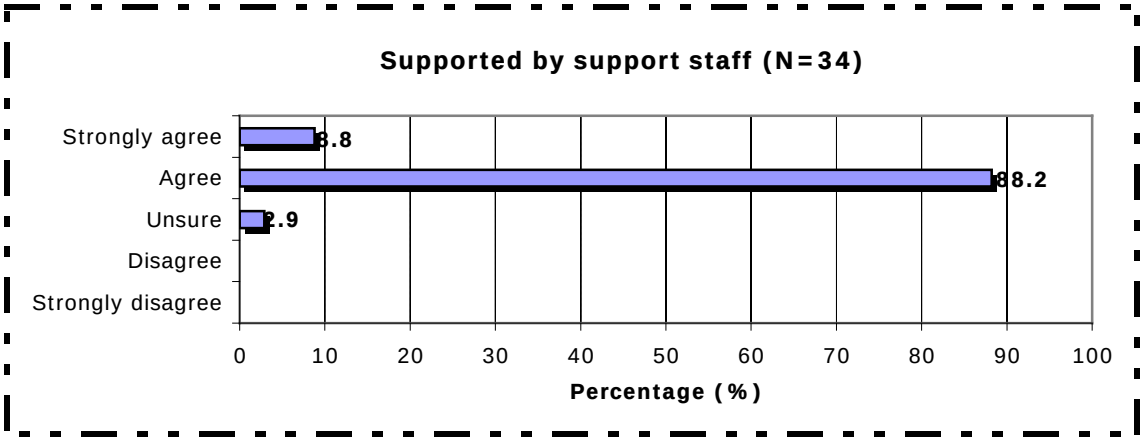


Figure 6.17: Supported by support staff

q) Transporting patients

Question 17 was concerned with whether the nurse practitioners perceived that the challenge regarding the transportation of patients was resolved. Twenty-eight respondents (82,4%) strongly agreed and six respondents (17,6%) agreed that the challenge of transporting patients had been resolved. None of the respondents indicated that they were unsure, disagreed or strongly disagreed. These data are reflected in Figure 6.17.

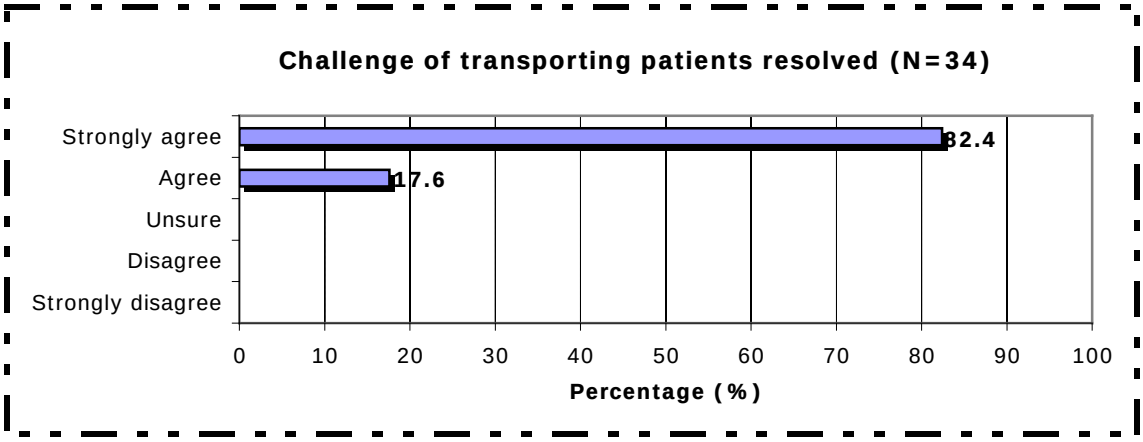


Figure 6.18: Challenge of transporting patients resolved

r) Socialisation among nurse practitioners

Question 18 was concerned with whether the nurse practitioners perceived that there was adequate socialisation amongst the nurse practitioners. Five respondents (14,7%) strongly agreed and 29 respondents (85,3%) agreed that there was adequate socialisation amongst the nurse practitioners. No respondents indicated that they were unsure, disagreed or strongly disagreed. These data are reflected in Figure 6.18.

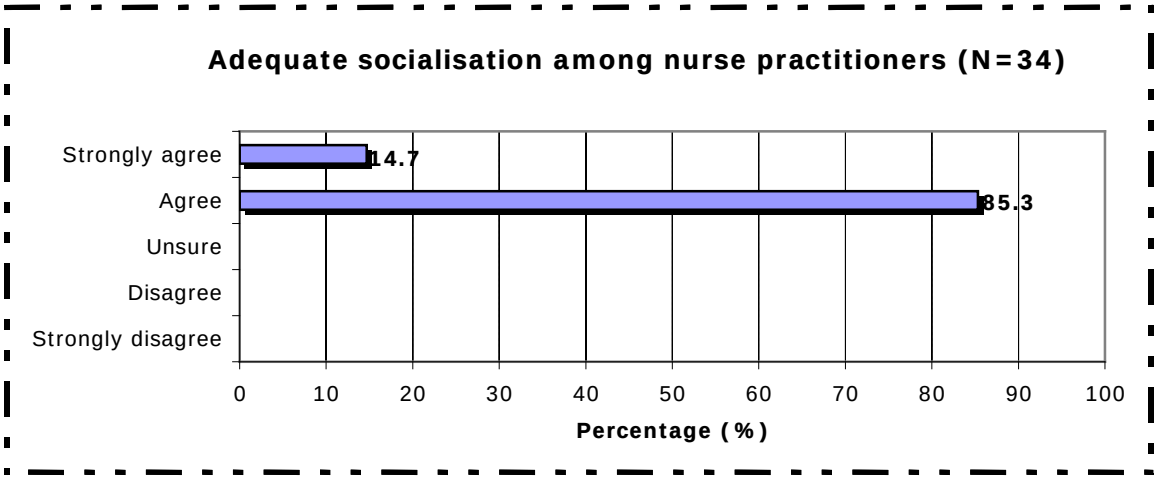


Figure 6.19: Adequate socialisation among nurse practitioners

s) Socialisation among multidisciplinary team members

Question 19 was concerned with whether the nurse practitioners perceived that there was adequate socialisation amongst the multidisciplinary team members. No respondent strongly agreed, agreed or were unsure. Twenty-nine respondents (85,3%) disagreed and five respondents (14,7%) strongly disagreed that there was adequate socialisation amongst the multidisciplinary team members. These data are reflected in Figure 6.19.

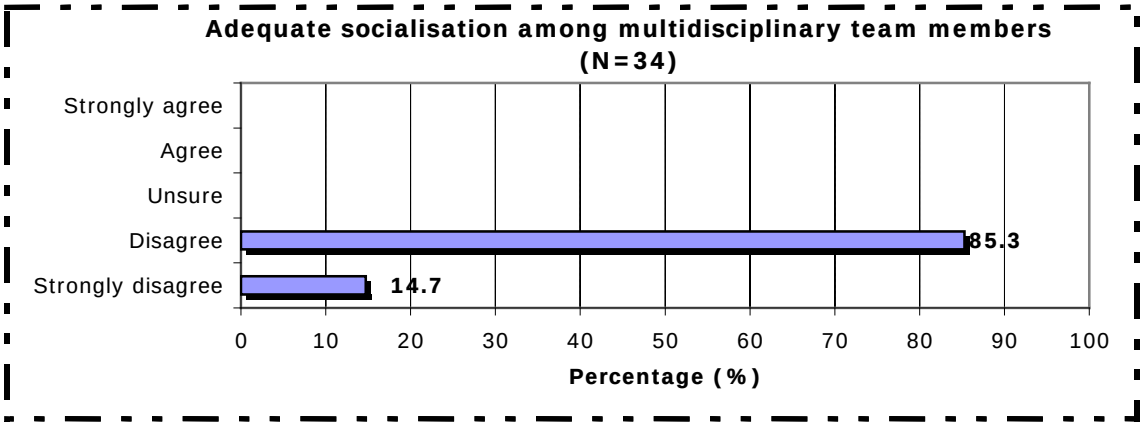


Figure 6.20: Adequate socialisation among multidisciplinary team members

6.3.3.2 Section B: Priority 2: Patient care

Section B focused on the challenges identified regarding patient care.

a) Permanent nurse practitioners

Question 1 was concerned with whether the nurse practitioners perceived that there were an adequate number of nurse practitioners to ensure optimal patient care. No respondents strongly agreed and 25 respondents (73,5%) agreed that there were an adequate number of nurse practitioners working in the A&E unit. No respondents indicated that they were unsure. Nine respondents (26,5%) indicated that they disagreed and no respondents indicated that they strongly disagreed. These data are reflected in Figure 6.20.

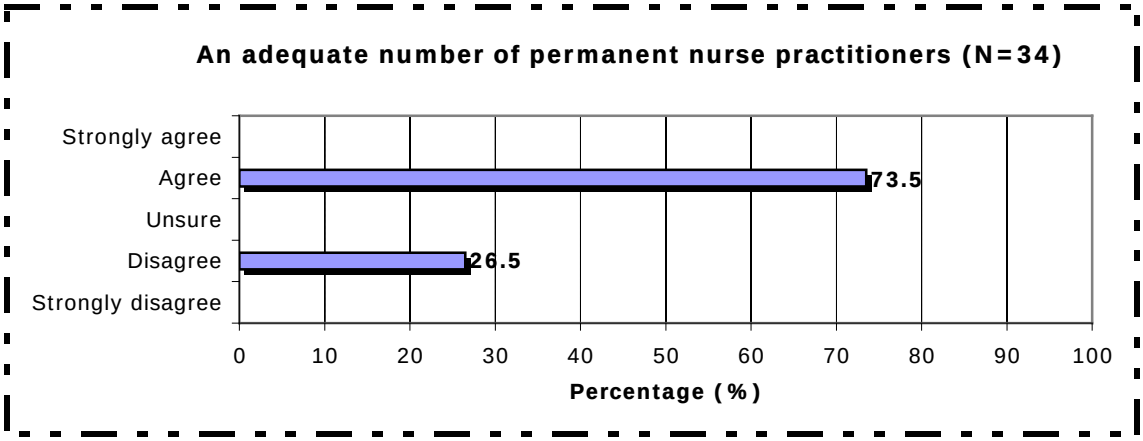


Figure 6.21: An adequate number of permanent nurse practitioners

b) Overtime by permanent nurse practitioners

Question 2 was concerned with whether the nurse practitioners perceived that the majority of overtime available in the A&E unit was given to nursing practitioners who were not permanent nurse practitioners working in the A&E unit. Thirty-four (34) respondents (100%) strongly disagreed that the majority of overtime was given to agency staff or other nurse practitioners who were not permanent nurse practitioners working in the A&E unit. No respondents disagreed, were unsure, agreed or strongly agreed with the statement. These data are reflected in Figure 6.21.

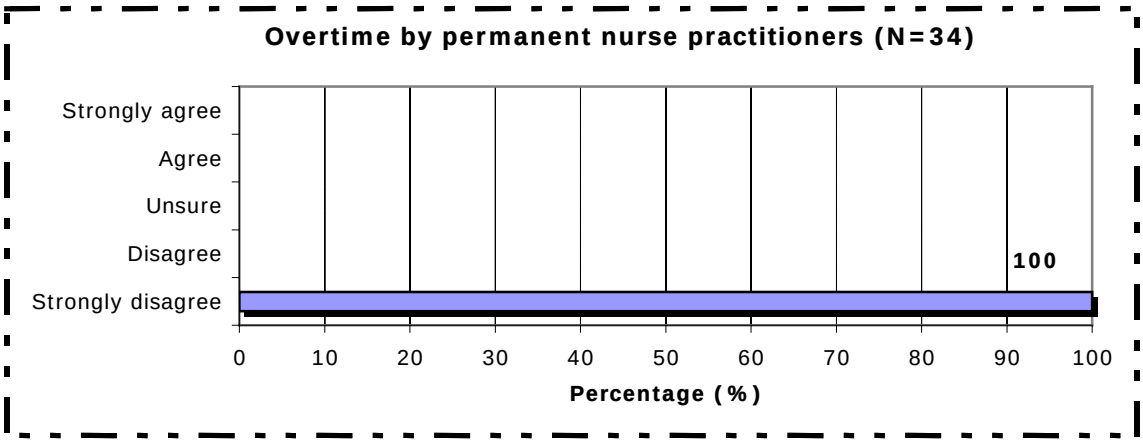


Figure 6.22: Overtime by permanent nurse practitioners

c) Basic nursing care

Question 3 was concerned with whether the nurse practitioners perceived that basic nursing care was not up to standard. Five respondents (14,7%) strongly disagreed and 26 respondents (76,5%) disagreed with the statement. No respondents were unsure. Three respondents (8,8%) agreed and no respondents strongly agreed that basic nursing care was not up to standard. These data are reflected in Figure 6.22.

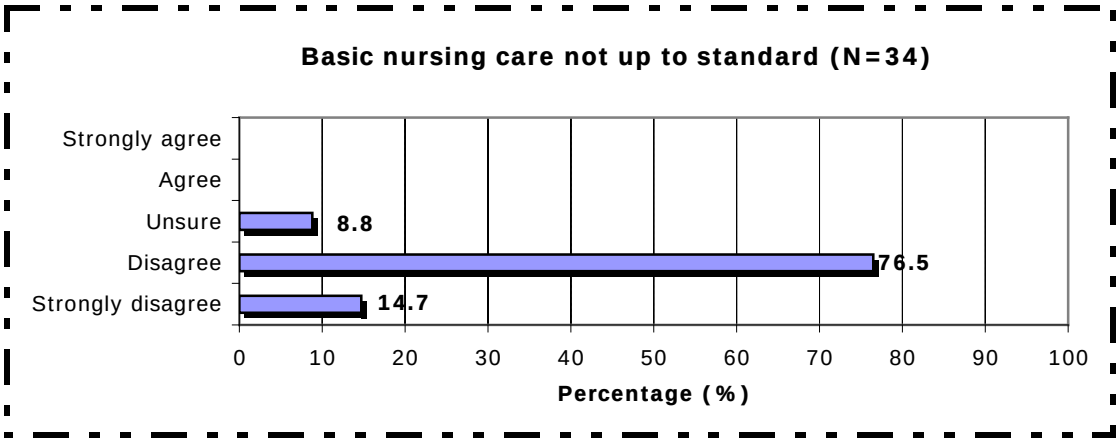


Figure 6.23: Basic nursing care not up to standard

d) Respect for patients

Question 4 was concerned with whether the nurse practitioners perceived that they showed respect to the patients admitted to the A&E unit. No respondents strongly disagreed, disagreed or were unsure. Twenty-one respondents (61,8%) agreed and 13 respondents (38,2%) strongly agreed that the nurse practitioners showed respect to patients admitted to the A&E unit. These data are reflected in Figure 6.23.

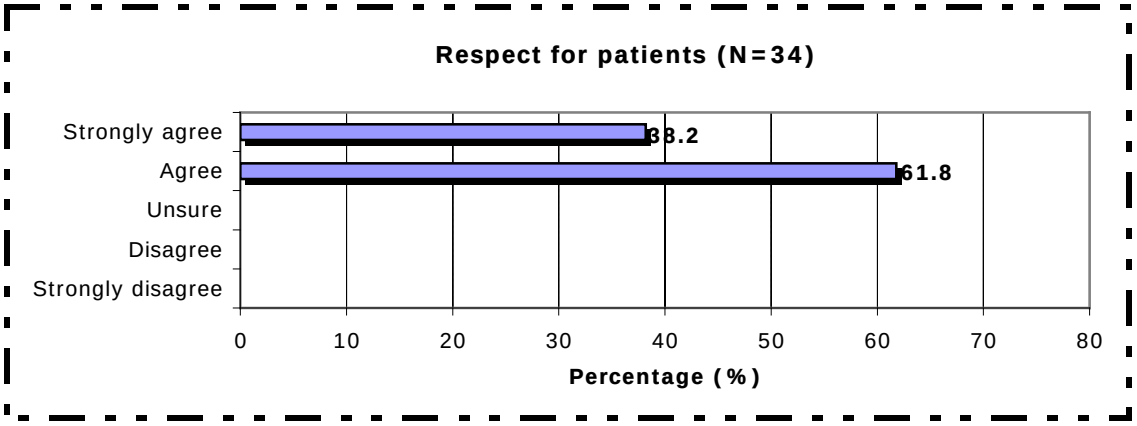


Figure 6.24: Respect for patients

e) Respect for families

Question 5 was concerned with whether the nurse practitioners perceived that they showed respect to the families of patients admitted to the A&E unit. No respondents strongly disagreed, disagreed or were unsure. Five respondents (14,7%) agreed and 29 respondents (85,3%) strongly agreed that the nurse practitioners showed respect

to the families of patients admitted to the A&E unit. These data are reflected in Figure 6.24.

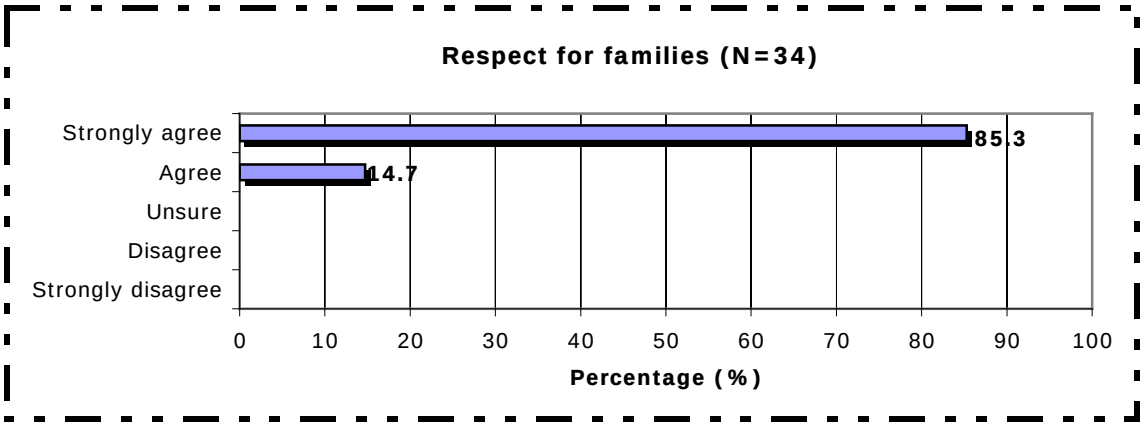


Figure 6.25: Respect for families

f) Patient education

Question 6 was concerned with whether the nurse practitioners perceived that they gave patient education in the A&E unit. Two respondents (5,9%) strongly disagreed and eight respondents (23,5%) disagreed that they gave patient education in the unit. No respondents were unsure. Twenty respondents (58,8%) agreed and four respondents (11,8%) strongly agreed that the nurse practitioners gave patient education in the A&E unit. These data are reflected in Figure 6.25.

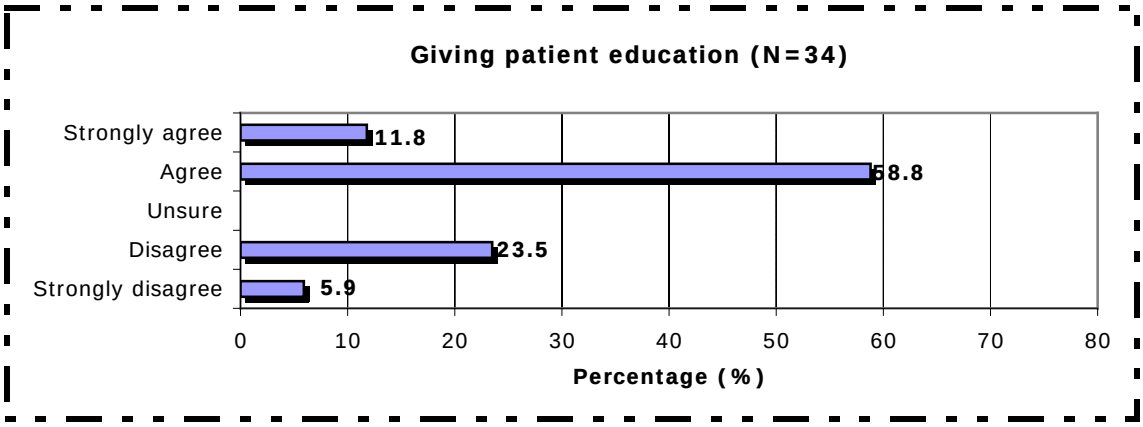


Figure 6.26: Giving patient education

g) Patient waiting times: nurse practitioners

Question 7 was concerned with whether the nurse practitioners perceived that the time patients spent waiting to be managed by the nurse practitioners had decreased. No respondents indicated that they strongly disagreed, disagreed or were unsure. Twenty-one respondents (61,8%) agreed and 13 respondents (38,2%) strongly agreed that the time patients spent waiting to be managed by the nurse practitioners had decreased. These data are reflected in Figure 6.26.

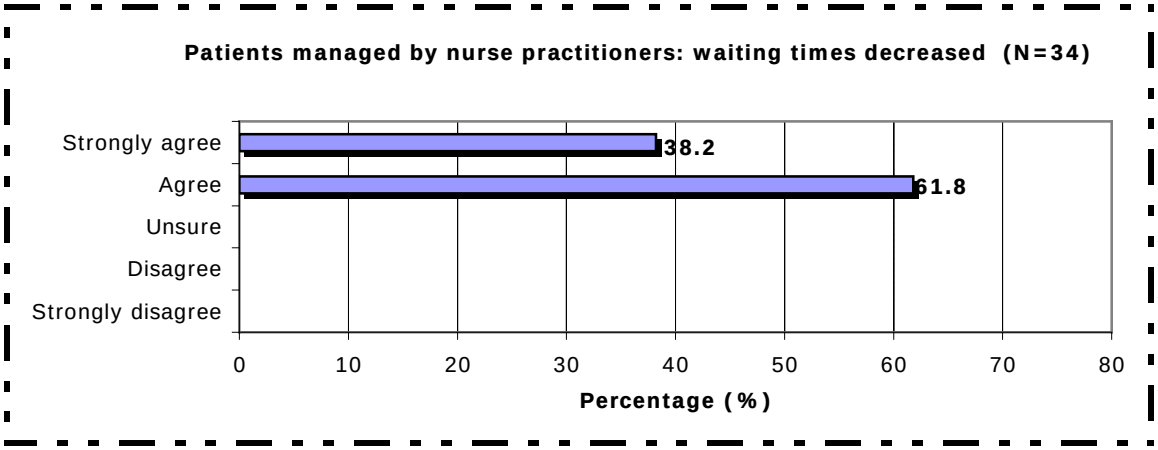


Figure 6.27: Patients managed by nurse practitioners: waiting times decreased

h) Patient waiting times: A&E unit doctors

Question 8 was concerned with whether the nurse practitioners perceived that the time patients spent waiting to be managed by the A&E unit doctors had decreased. No respondents indicated that they strongly disagreed/disagreed. Eight respondents (23,5%) indicated that they were unsure. Nineteen respondents (55,9%) agreed and seven respondents (20,6%) strongly agreed that the time patients spent waiting to be managed by the A&E unit doctors had decreased. These data are reflected in Figure 6.27.

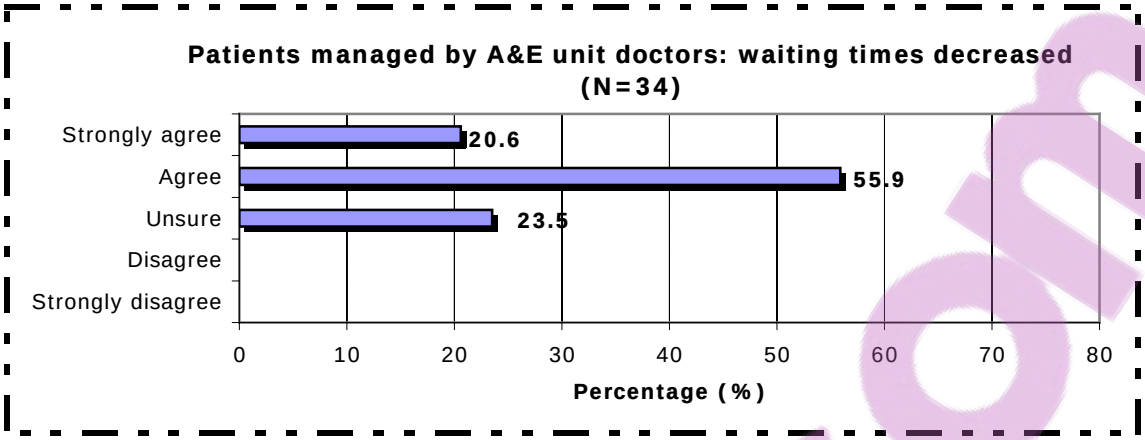


Figure 6.28: Patients managed by A&E unit doctors: waiting times decreased

i) Patient waiting times: specialists

Question 9 was concerned with whether the nurse practitioners perceived that the time patients spent waiting to be managed by the specialists had decreased. No respondents indicated that they strongly disagreed, disagreed or were unsure. Twenty respondents (58,8%) indicated that they agreed and 14 respondents (41,2%) strongly agreed that the time patients spent waiting to be managed by the specialists had decreased. These data are reflected in Figure 6.28.

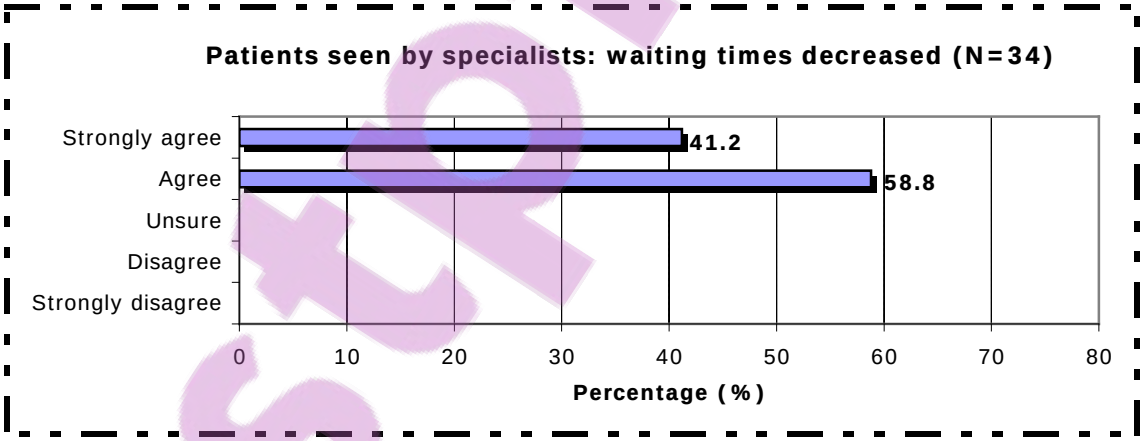


Figure 6.29: Patients seen by specialists: waiting times decreased

j) Psychiatric patients

Question 10 was concerned with whether the nurse practitioners perceived that the challenge regarding the prolonged stay of psychiatric patients in the A&E unit continued. Thirty-four respondents (100%) strongly disagreed that the challenge

regarding the prolonged stay of psychiatric patients in the A&E unit continued, while no respondents disagreed, were unsure, agreed or strongly agreed. These data are reflected in Figure 6.29.

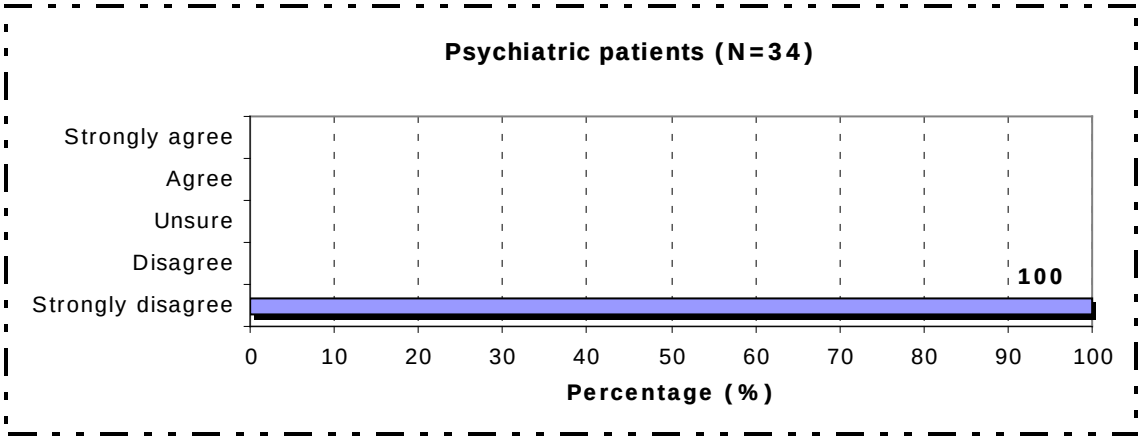


Figure 6.30: Psychiatric patients

k) Pharmacy availability

Question 11 was concerned with whether the nurse practitioners perceived that the pharmacy was open for 24 hours a day for patients. Thirty-four respondents (100%) strongly disagreed that the pharmacy was open for 24 hours a day for patients, while no respondents disagreed, were unsure, agreed or strongly agreed. These data are reflected in Figure 6.30.

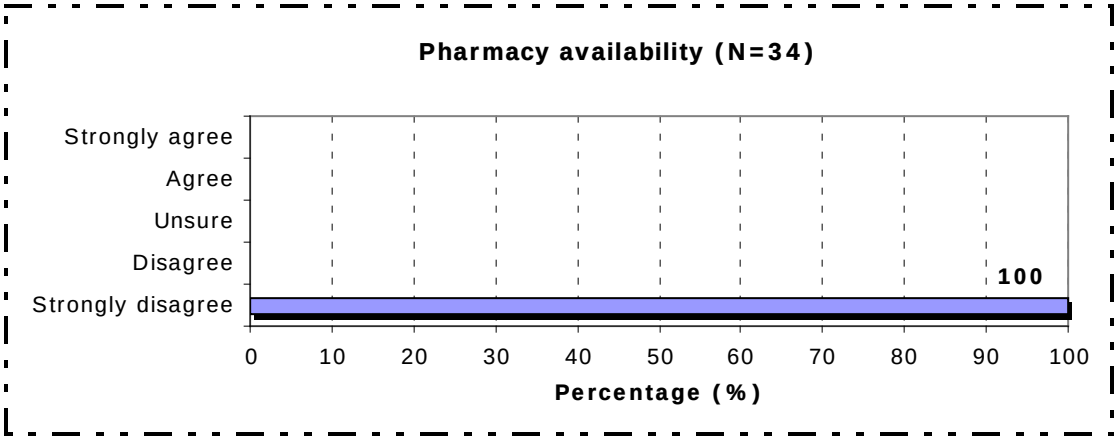


Figure 6.31: Pharmacy availability

l) Patients able to obtain prescribed medication

Question 12 was concerned with whether the nurse practitioners perceived that the patients were able to obtain their prescribed medication at the pharmacy or A&E unit 24 hours a day. No respondents strongly disagreed/disagreed or indicated that they were unsure. Thirty respondents (88,2%) agreed and four respondents (11,8%) strongly agreed that the patients were able to obtain their prescribed medication at the pharmacy or A&E unit 24 hours a day. These data are reflected in Figure 6.31.

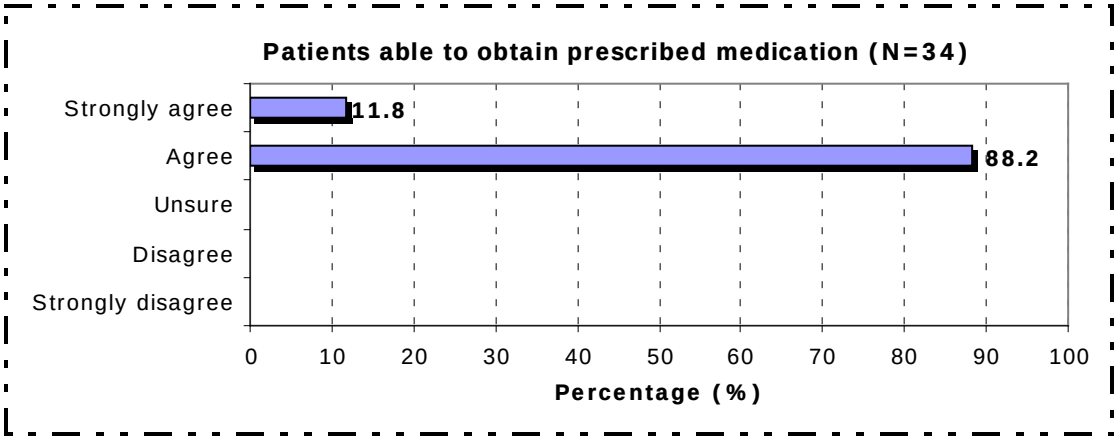


Figure 6.32: Patients able to obtain prescribed medication

6.3.3.3 Section C: Priority 3: Structure

Section C focused on the challenges identified regarding structure.

a) Rules: nurse practitioners

Question 1 was concerned with whether the nurse practitioners perceived that there were adequate rules for the nurse practitioners in the A&E unit. No respondents strongly disagreed and one respondent (2,9%) disagreed with the statement. One respondent (2,9%) was unsure. Twenty-seven respondents (79,4%) agreed and five respondents (14,7%) strongly agreed that there were adequate rules for the nurse practitioners in the A&E unit. These data are reflected in Figure 6.32.

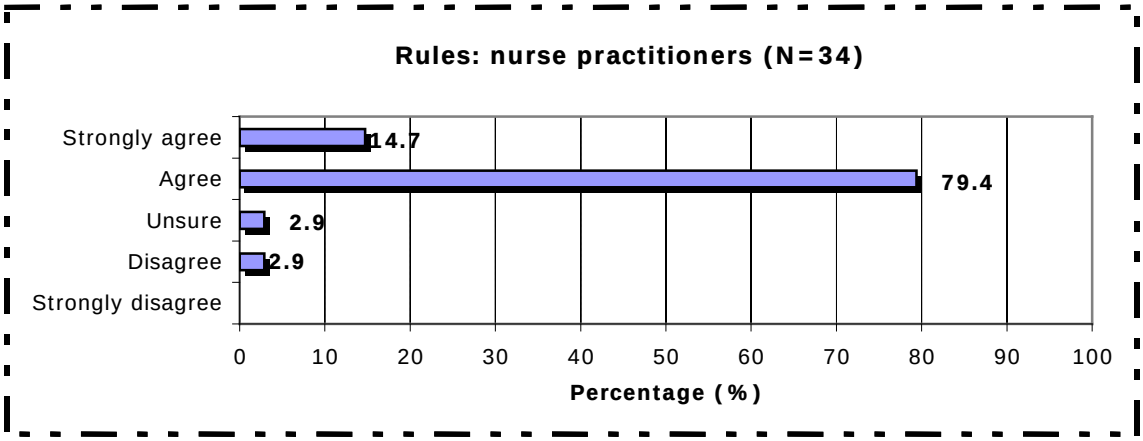


Figure 6.33: Rules: nurse practitioners

b) Rules: medical students

Question 2 was concerned with whether the nurse practitioners perceived that there were adequate rules for the medical students in the A&E unit. No respondents strongly disagreed or disagreed. Eleven respondents (32,4%) were unsure. Eighteen respondents (52,9%) agreed and five respondents (14,7%) strongly agreed that there were adequate rules for the medical students in the A&E unit. These data are reflected in Figure 6.33.

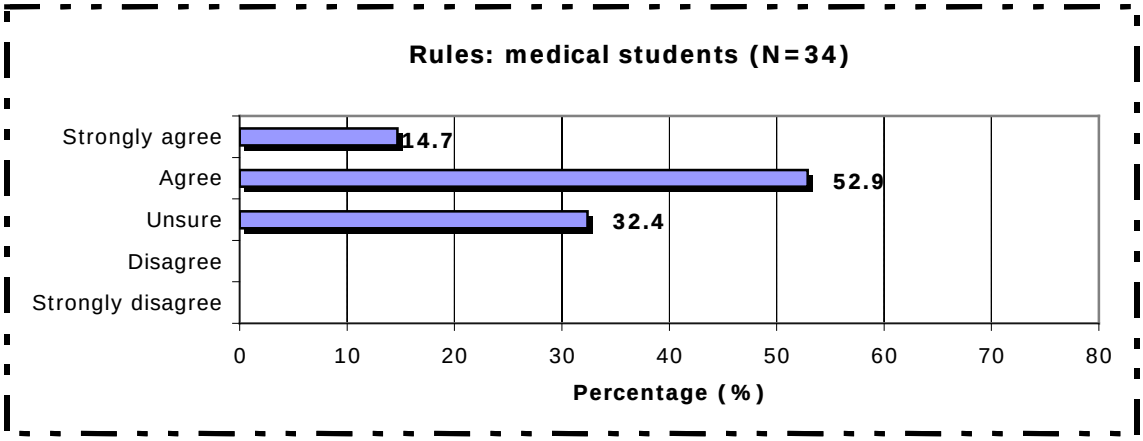


Figure 6.34: Rules: medical students

c) Protocols

Question 3 was concerned with whether the nurse practitioners perceived that there were adequate protocols available to the nurse practitioners to guide patient management. No respondents strongly disagreed and 20 respondents (58,8%)

disagreed with the statement. Two respondents (5,9%) were unsure. Twelve respondents (35,3%) agreed and no respondents strongly agreed that there were adequate protocols available to the nurse practitioners to guide patient management. The data are reflected in Figure 6.34.

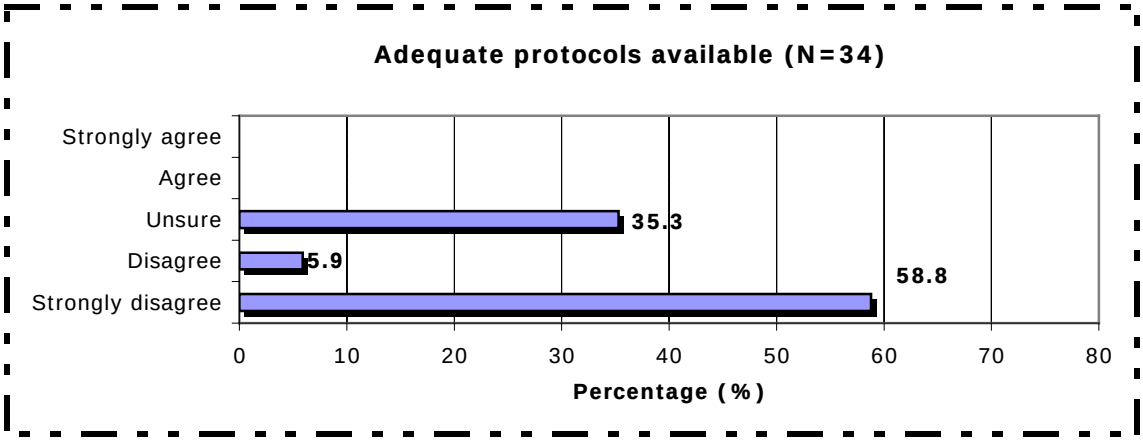


Figure 6.35: Adequate protocols available

d) Standards

Question 4 was concerned with whether the nurse practitioners perceived that there were standards available to guide the nurse practitioners when performing procedures. Twenty-three respondents (67,6%) strongly disagreed and four respondents (11,8%) disagreed that there were standards available to guide the nurse practitioners when performing procedures. Seven respondents (20,6%) were unsure. No respondents agreed or strongly agreed with the statement. The data are reflected in Figure 6.35.

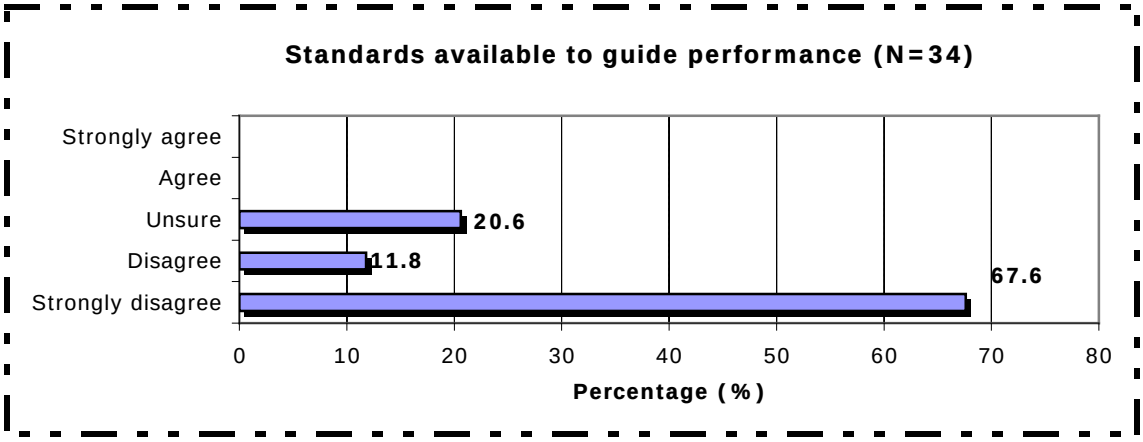


Figure 6.36: Standards available to guide performance

6.3.3.4 Section D: Priority 4: Equipment

Section D focused on the challenges identified regarding equipment.

a) Equipment available

Question 1 was concerned with whether the nurse practitioners perceived that there was an adequate amount of equipment available in the A&E unit to ensure appropriate patient care. No respondents strongly disagreed, disagreed or were unsure. Seventeen respondents (50,0%) agreed and 17 respondents (50,0%) strongly agreed that there was an adequate amount of equipment available in the A&E unit to ensure appropriate patient care. These data are reflected in Figure 6.36.

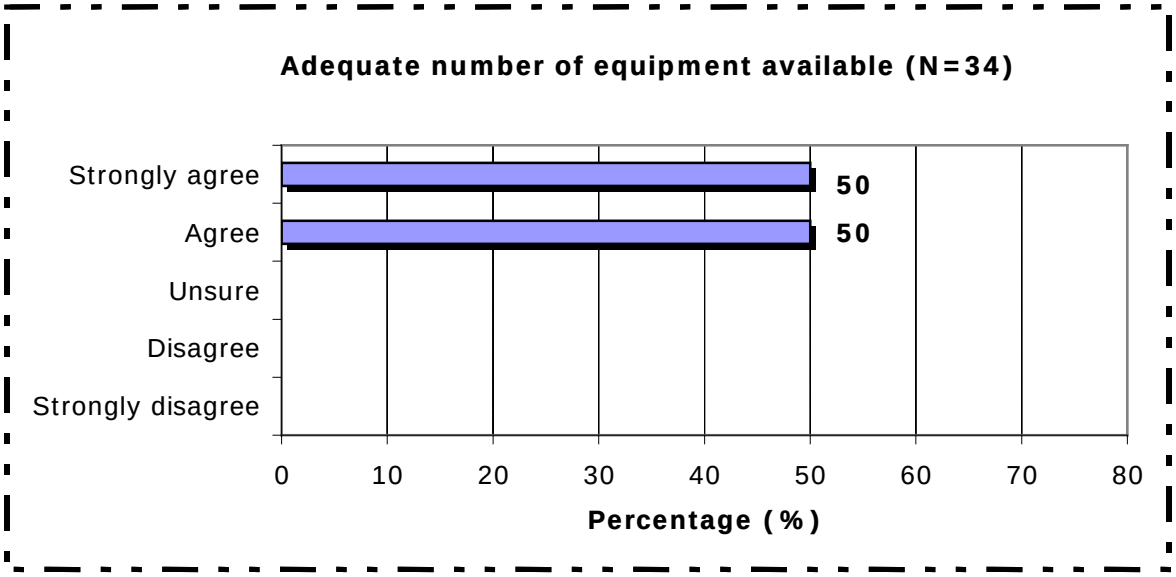


Figure 6.37: Adequate number of equipment available

b) Operate equipment

Question 2 was concerned with whether the nurse practitioners perceived that they knew how to operate the equipment used in the A&E unit. No respondents strongly disagreed and one respondent disagreed with the statement. No respondents were unsure. Twenty-two respondents (64,7%) agreed and 11 respondents (32,4%) strongly agreed that they knew how to operate the equipment used in the A&E unit. These data are reflected in Figure 6.37.

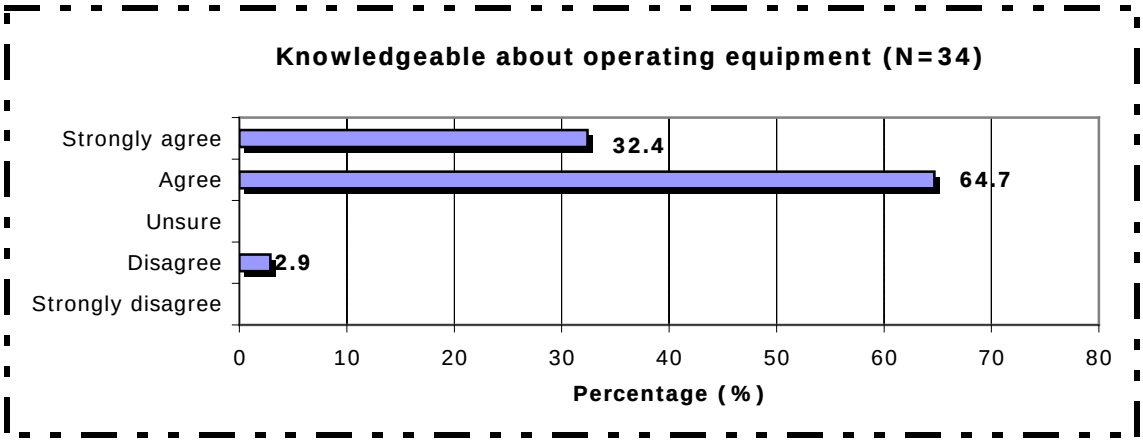


Figure 6.38: Knowledgeable about operating equipment

c) Taking care of equipment

Question 3 was concerned with whether the nurse practitioners perceived that the equipment used in the A&E unit was taken care of. No respondents strongly disagreed or disagreed with the statement. Three respondents (8,8%) were unsure. Twenty-six respondents (76,5%) agreed and five respondents (14,7%) strongly agreed that the equipment used in the A&E unit was taken care of. These data are reflected in Figure 6.38.

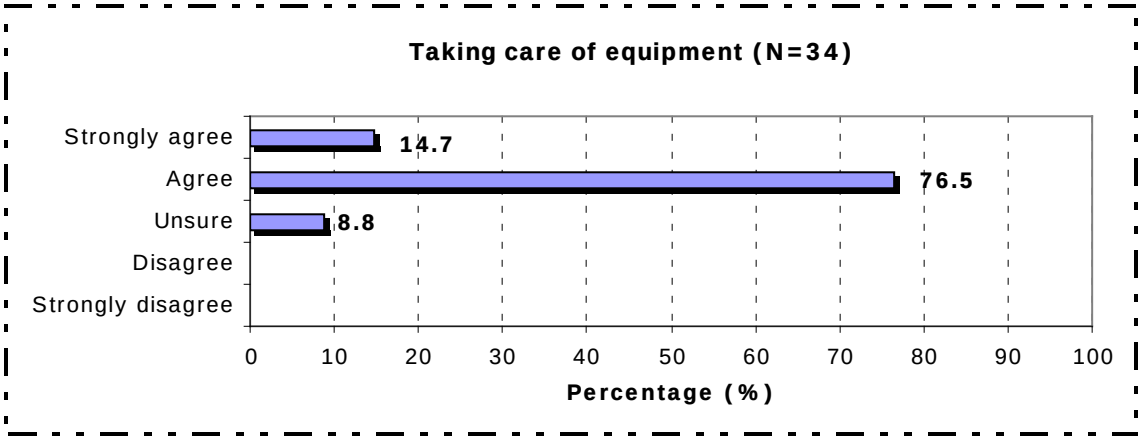


Figure 6.39: Taking care of equipment

6.3.3.5 Section E: Priority 5: Research

Section E focused on the challenges identified regarding research.

a) Patient statistics

Question 1 was concerned with whether the nurse practitioners perceived that they were informed of the patient statistics on a monthly basis. No respondent strongly disagreed and one respondent (2,9%) disagreed with the statement. Two respondents (5,9%) were unsure. Twenty-two respondents (64,7%) agreed and nine respondents (26,5%) strongly agreed that they were informed of the patient statistics on a monthly basis. These data are reflected in Figure 6.39.

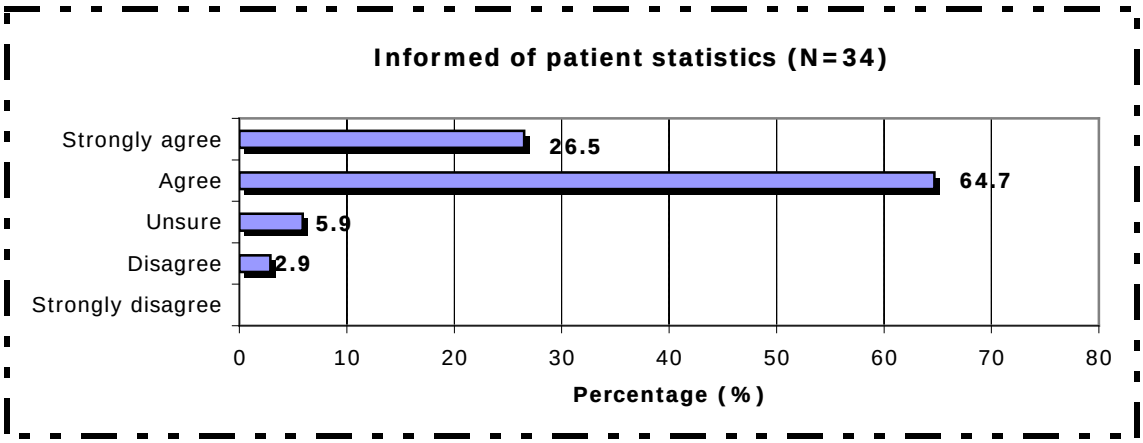


Figure 6.40: Informed of patient statistics

6.3.4 Summary of quantitative data obtained from the questionnaires of the nurse practitioners

For the sake of clarity, a short summary is given of the quantitative data collected through the questionnaires completed by the nurse practitioners. It must be noted that the questionnaire (see Annexure H.1) was compiled based on the findings obtained during the NGM. The insider evaluation thus included a questionnaire completed by the nurse practitioners to determine their views on whether the challenges depicted during the NGM had been resolved.

The most pressing concern identified during the NGM was that there were no professional development programmes in place. Actions were planned and implemented to provide a CPDP in the A&E unit by means of an in-service training programme and on-the-spot teaching. This priority was accepted as having been adequately addressed. Although the majority of the challenges were viewed as

being resolved, there were still concerns about four challenges, which the respondents indicated would need further exploration and action:

- disrespect amongst nurse practitioners for one another
- lack of support from the multidisciplinary team members
- lack of support from top management

The first challenge is disrespect amongst nurse practitioners for one another in the A&E unit. Just below 25 per cent of the nurse practitioners agreed and strongly agreed that the disrespect continued. Although this is the minority, the PDG reflected that this value may influence the shared vision of the PDG for the nurse practitioners, namely emancipatory practice development and therefore require future attention.

As many as 50 per cent of the nurse practitioners disagreed that top management supported them or were unsure about top management support, while the other fifty per cent agreed that top management supported them.

All the respondents agreed that an in-service training programme was in place and the majority agreed that there was multidisciplinary team involvement in the in-service training programme. The challenge regarding the transportation of patients to different hospitals or facilities in the hospital seemed to be resolved as all the nurse practitioners (100%) agreed with this. This could be due to the move to the new hospital. At the old hospital, the nurse practitioners often had to transport the patients with orthopaedic emergencies to the orthopaedic hospital and patients admitted with psychiatric emergencies to the psychiatric hospital. After the move to the new hospital, patients with orthopaedic emergencies were admitted to the new hospital and the psychiatric patients were admitted directly to the old A&E unit, thus resolving the challenge.

All the nurse practitioners agreed that the challenges regarding socialisation amongst the nurse practitioners had been resolved [according to r) of Section 6.3.3.1. The results, however, indicate that socialisation with multi-disciplinary team members had not been resolved (see Section 6.3.3.1r).

Patient care, the second priority identified during the NGM, was also perceived as having been addressed. The challenge regarding staff shortages that had been regarded as a barrier to the success of the project was regarded as resolved by 73,5 per cent of the nurse practitioners. The majority of the challenges were regarded as having been resolved, with only the challenge regarding the time spent by patients waiting for the specialists remaining a concern [in i) of Section 6.3.3.2 to all the nurse practitioners.

The respondents felt that the challenges regarding the prolonged waiting times for patients to see the nurse practitioners (100%) and doctors (76,5%) working in the A&E unit had been resolved. These findings could be based on the fact that the patient turnover had decreased in the new A&E unit and therefore the nurse practitioners and doctors could assess the patients as they were admitted.

All the respondents agreed that preference for overtime was given to the permanent nurse practitioners working in the A&E unit.

All the nurse practitioners indicated that the pharmacy was not available for patients 24 hours a day but agreed that the patients were able to obtain their medication 24 hours a day. Prescribed medication was dispensed by the professional nurse practitioners in the A&E unit after hours and therefore the challenge had been partially resolved.

Structure, the third priority, was viewed as having been addressed by the majority of nurse practitioners with the exception of the challenges regarding the availability of protocols and standards. This challenge needs further exploration and action.

The respondents believed that the challenges regarding rules for nurse practitioners (94,1%) and medical students (67,6%) had been resolved. As many as 65 per cent of the respondents felt that the challenge regarding the availability of protocols was not resolved, [in c) of Section 6.3.3.3. The majority of respondents (79,4%) indicated [in d) of Section 6.3.3.3 that the challenge regarding the availability of standards to guide nurse practitioners when performing procedures on patients remained unresolved.

Equipment, the fourth priority, as well as research, the fifth priority, were viewed as having been resolved by the majority of nurse practitioners.

The challenge regarding research, which was concerned with the dissemination of patient information in the A&E unit, was regarded as having been resolved by the majority of nurse practitioners (91,2%).

6.3.4.1 Create an emancipatory practice development culture

Evidence that an emancipatory practice development culture had been created is based on the spin-offs of the AR for practitioners project. The nurse practitioners developed professionally, and, through their enablement, emancipatory practice development was realised. This is evident from the spin-offs that focus on patient-centred care. The following spin-offs of the AR for practitioners project are the result of the emancipatory process followed in the A&E unit:

- A triage system was implemented by one of the A&E nurse practitioners when she became aware that there were no formal definitions for P1, P2 and P3 patients. This made it possible to refer P3 patients, thus decreasing the nurse practitioners' workload.
- The professional nurse practitioners dispensed the patients' prescribed medication between 16:00 and 07:00. One nurse practitioner felt that, although the patients received their medication, they did not receive adequate patient education about the medication. The A&E nurse practitioner compiled information pamphlets for each medication dispensed and, in collaboration with another professional nurse practitioner, translated the pamphlets in order to make each pamphlet available in both English and Setswana, the two main languages spoken in the area.
- Three professional nurse practitioners enrolled for their masters degrees during the project based on questions raised in practice:
  - The development of a nursing record tool for P1 patients.
  - Best practice guidelines for the resuscitation of patients in phase 2 hypovolaemic shock.

- The specific knowledge and skills required by the professional nurse practitioners nursing critical care patients in the A&E unit in order to develop an in-service training programme to accommodate their needs.

o Two professional nurse practitioners tidied the paediatric resuscitation room, which was disorganised and resulted in chaotic resuscitations, according to PALS standards.

o The unit manager contacted the pastoral services in the old A&E unit and morning prayer sessions were held in the A&E unit twice a week. These became daily sessions after the move to the new hospital and were attended by the nurse practitioners voluntarily. Patients often joined in when the nurse practitioners started singing hymns. The unit manager and pastoral services reflected on the often neglected need for support for patients' families. Pastoral services were made available 24 hours a day to support critically ill or injured patients and their families. The nurse practitioners often referred patients to pastoral services when they were discharged and had no clothes or transport money. This supported the nurse practitioners, patients and their families. The pastoral psychologist was also available to the nurse practitioners for either personal or work related concerns.

o Professional nurse practitioners started attending workshops, congresses and lectures organised outside the hospital at their own cost

o A professional nurse practitioner initiated 'high tea workshops' in the A&E unit. Nurse practitioners were invited to attend a high tea where everybody dressed up, tea was served and issues in the A&E unit discussed. The role of the shift leader was refined and improved, and became known as a floor manager.

An additional, unexpected achievement of the project was the four partnerships that were formed. Firstly, a partnership was formed between the PDG members who initiated the project and facilitated the emancipatory process. During this process, a partnership between the two practice leaders evolved. At the start of the project, the unit manager and clinical facilitator each planned and implemented actions in order to reach the aim of the project, but there was no professional collaboration between them. It was not until the last six months of the project that the two practice leaders started working together and supporting each other both professionally and personally in the practice.

The researcher formed an additional partnership between the clinical facilitator and A&E nurse practitioners, who became more involved in the A&E programme. This resulted in spin-offs such as the refinement of existing assessment tools, valuable input into the theoretical component of the programme and the weekend away organised by the A&E nurse practitioners for the A&E learners.

The clinical facilitator also developed a partnership with two clinical facilitators in the critical care units. The three clinical facilitators collaboratively planned their orientation programmes, decreasing their workload. They held monthly meetings and worked together with the CPR champions training.

6.3.4.2 Retain the nurse practitioners

Although the total number of nurse practitioners increased by approximately 55 per cent during the project, it was important that these nurse practitioners be retained. All the actions planned were implemented with this outcome in mind.

During the timeframe of the project, four professional nurse practitioners asked to be transferred to the ICU. One auxiliary nurse practitioner enrolled for a programme in order to advance to an enrolled nurse practitioner and was thus rotated through the wards for further training purposes. This enrolled nurse was, however, not regarded as one of the nurse practitioners that left the A&E unit, as she indicated that she would return to the A&E unit once she completed the training programme. These findings show a turnover of less than one per cent in the A&E unit during the course of the project (May 2005 to June 2007).

6.4 OUTSIDER EVALUATION

The A&E learners and the Accreditation Committee of the Gauteng Department of Health formed part of the outsider evaluation.

The outsider evaluation took the form of a questionnaire distributed to the A&E learners to evaluate the environment as a learning environment during the clinical component of the A&E programme (see Annexure H.2). The A&E learners were

regarded as outsiders, as they did not have permanent posts in the A&E unit but worked fulltime in other hospitals. These learners held honorary student posts in the A&E unit for a period of one year, as the hospitals in which they were employed were not accredited by the SANC for the A&E programme.

The researcher felt that this component of the evaluation was important, as one of her personal reasons for conducting the research was to change the toxic environment into an emancipatory environment, in order to make it more conducive to learning for the A&E learners. The questionnaire consisted of four questions concerning the A&E unit as a learning and supportive environment for the A&E learners.

The unit manager realised the extent of the emergency situation in the A&E unit following a report of the Accreditation Committee of the Gauteng Department of Health. On 6 August 2006, the Accreditation Committee re-evaluated the A&E unit. The findings of the two reports (June 2005 and August 2006) were compared and also used as external evaluation to determine the success of the project.

6.4.1 Results and analysis of the questionnaires completed by the A&E learners

A questionnaire (see Annexure H.2) was distributed to all the A&E learners working in the A&E unit as part of the clinical component of the A&E programme. The A&E learners made no additional comments.

Each question is discussed separately and the results of each variable reported on.

Six copies of the questionnaire were distributed. Six respondents completed the questionnaire, representing a response rate of 100 per cent. All the respondents completed all the questions.

6.4.1.1 A&E unit as learning environment

The A&E unit as learning environment plays an important role in the training of A&E learners during the A&E programme. The purpose of this questionnaire was to obtain the view of the A&E learners regarding the A&E unit as a learning and supportive environment while they worked in the unit during their training.

Question 1 was concerned with evaluating the extent to which the A&E unit was regarded as conducive to learning by the A&E learners. Whether the environment was conducive to learning was evaluated on a 5-point Likert scale. Five respondents (83,3%) described the environment as always conducive to learning and one (16,7%) as most of the time. No respondents described the environment as often, seldom or never conducive to learning. These data are reflected in Figure 6.40.

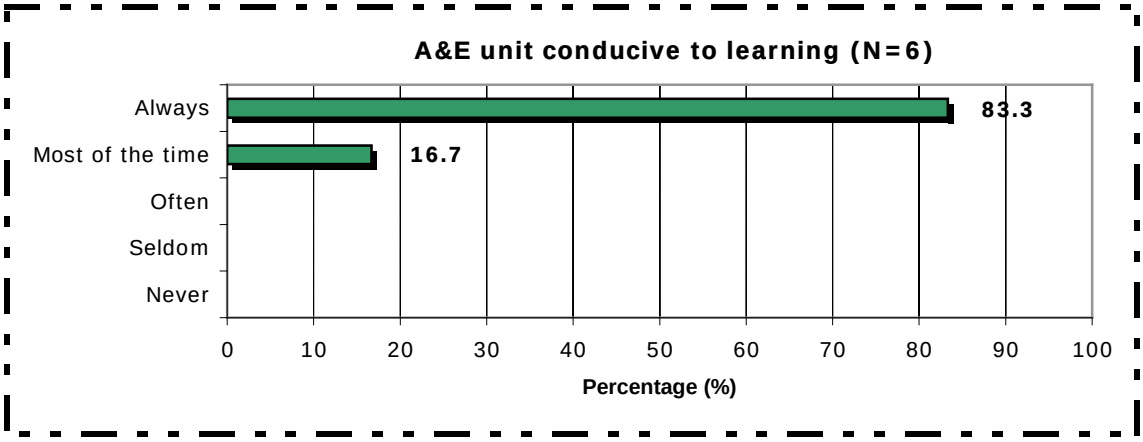


Figure 6.41: A&E unit conducive to learning

Question 2 was concerned with evaluating the support provided by the clinical facilitator. All six respondents (100%) indicated that the clinical facilitator always supported them. No respondents indicated that the clinical facilitator most of the time, often, seldom or never supported them. These data are reflected in Figure 6.41.

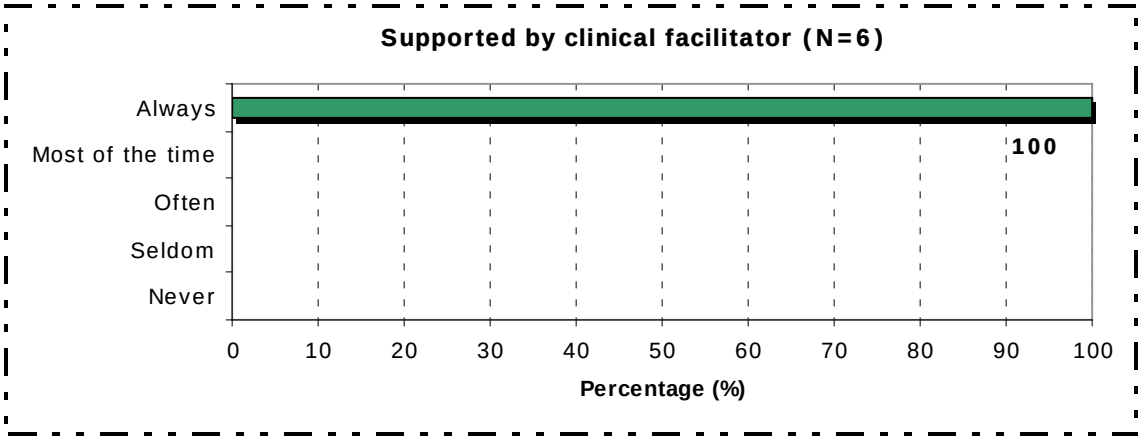


Figure 6.42: Supported by clinical facilitator

Question 3 was concerned with evaluating the support provided by the A&E nurse practitioners. Two respondents (33,3%) indicated that the A&E nurse practitioners always supported them and four (66,7%) indicated that they did most of the time. No respondents indicated that the A&E nurse practitioners often, seldom or never supported them. These data are reflected in Figure 6.42.

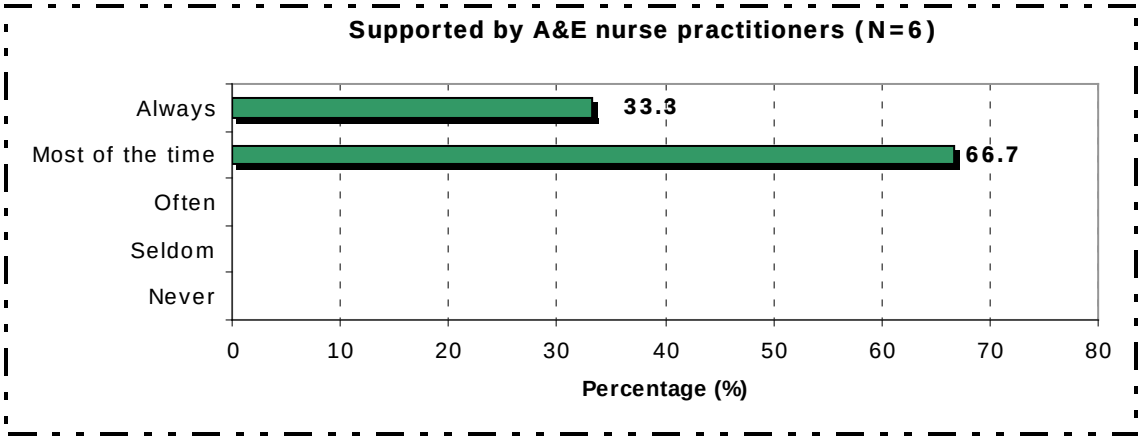


Figure 6.43: Supported by A&E nurse practitioners

Question 4 was concerned with evaluating the support provided by the professional nurse practitioners. Two respondents (33,3%) indicated that the professional nurse practitioners always supported them and four (66,7%) indicated that they did most of the time. No respondents indicated that the professional nurse practitioners often, seldom or never supported them. These data are reflected in Figure 6.43.

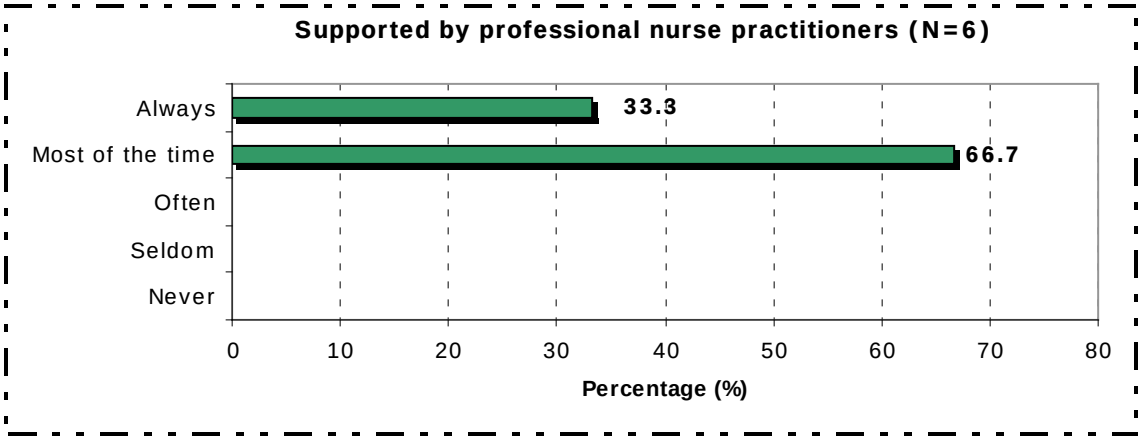


Figure 6.44: Supported by professional nurse practitioners

6.4.1.2 Summary of quantitative data obtained from the questionnaires of the A&E learners

Based on the findings obtained from the questionnaire, it is evident that the A&E learners perceived the A&E unit as an environment conducive to learning. The A&E learners indicated that they were supported by the clinical facilitator, the A&E nurse practitioners and the professional nurse practitioners while working in the A&E unit as part of the clinical component of the A&E programme.

6.4.2 Results and analysis of the accreditation reports

The two reports following the evaluation of the A&E unit by the Accreditation Committee of the Gauteng Department of Health in June 2005 and August 2006 were used as external evaluation.

Table 6.2: A&E unit: Summary of accreditation report (adapted from Accreditation Committee, Gauteng Department of Health: Summary of final report (2005 and 2006))

Standard		Compliance (%)	
		7 June 2005	6 August 2006
1	Reception and information	42	80
2	Comfort	65	75
3	Cleanliness	80	80
4	Waiting times	25	75
5	Patient rights	50	50
6	Availability of equipment and supplies	67	85
7	Reference and educational material	37	95
8	Emergency care	38	85
9	Staffing	92	95
10	Patient safety	50	75
11	Patient systems	75	75
Average		**56%**	**79%**

Based on the findings, it can be seen that the A&E unit's total score improved from 56 per cent to 79 per cent, thus reaching the target set by the PDG and nurse practitioners. All the aspects evaluated indicated an improvement except for cleanliness, patient's rights and patient systems for which the same previous mark was allocated.

The researcher informally discussed the findings obtained during the accreditation visit with the two members of the Accreditation Committee involved in the visits of June 2005 and August 2006, when she collected the documents. Both members confirmed that the second visit had been a positive experience. The following quotes confirmed this (Goba & Masondo 2007):

- *"… the practitioners (nurse practitioners) were proud to show us their unit (A&E unit) and looked us in the eye … they (nurse practitioners) almost fell over their own feet to show us everything they have implemented …"*
- *"… they (nurse practitioners) answered the questions we asked them and showed interest in our comments and suggestions to improvement …"*
- *"… it seemed as if they (practice leaders and unit manager) have taken ownership of their unit (A&E unit) in ensuring that it looked tidy and neat when*

we came … in 2005 they did not even bother to tidy the unit before we came, it was so untidy and patients were left unattended … it was quite the opposite this time round …"

- *"… the unit manager was also involved when we did our rounds and joined us … she too asked us questions and wanted to know exactly what we were evaluating and what she could do to improve her unit … it was wonderful to see this …"*
- *"… the unit (A&E unit) had great teamwork and each member on duty that day knew what was going on in their unit … they were so proud to show us their unit and what they have done in the unit …"*
- *"… they (practice leaders and nurse practitioners) even came to the final discussion of our findings, which amazed us all …"*

Regarding the second visit of the Accreditation Committee of the Gauteng Department of Health to the A&E unit, the unit manager reflected that:

> *… it was not like 2005 … [the professional nurse practitioners] came on their off day to make sure that the unit (A&E unit) is tidy and that everything is working … they (nurse practitioners) got everything right and prepared for three days before they (Accreditation Committee) came … everybody was wearing their uniforms with the correct shoes … if I remember how ashamed I felt the last time … I was proud now and I knew that they (nurse practitioners) will be able to answer the questions … the patients were neat and the stock was filled up … I was really proud …*

6.5 SUMMARY

In this chapter, both the insider and outsider evaluations, which were based on the criteria set by the PDG and the nurse practitioners, examining the worth of the AR for practitioners project, are discussed (see Section 3.6.1).

The barrier of the shortage of professional nurse practitioners was addressed although these shortages were not entirely resolved. The A&E unit has 74 per cent of the allocated number of nurse practitioners, but due to the shortages throughout the hospital, it remains a challenge to recruit nurse practitioners for this area.

However, the turnover of below one per cent was regarded as one of the successes of the project.

The toxic environment was changed into an enabling environment. The researcher as well as the practice leaders used a facilitation process, which included components of coaching, teaching, encouraging and supporting, to enable the nurse practitioners to reach a shared vision of 'emancipatory practice development'. The characteristics of the enabling environment included support, participation in the decision-making process, appreciation for the nurse practitioners' input, the nurse practitioners being trusted to plan and take action to change the practice, the enhancement of fairness regarding performance management, the provision of positive feedback, the availability of opportunities for CPD and the celebration of successes.

The majority of the respondents agreed that the priority one challenge, the professional development of the nurse practitioners, had been resolved. The involvement of the multidisciplinary team members in the professional development of the nurse practitioners was viewed as unresolved by approximately 26 per cent of the respondents. The scarce skills dilemma had been resolved, although this was not regarded as one of the objectives of the PDG. (See Section 3.5.2.1 and 5.5.2.1.) A&E nurse practitioners now receive scarce skills allowances as agreed to by the Gauteng Department of Health (Marais 2007).

Of the respondents 24 per cent indicated that the other multidisciplinary team members did not respect the nurse practitioners and 58,8 per cent felt that they were not supported by the multidisciplinary team. In addition, 27 per cent of the respondents disagreed that top management was supportive. Staff shortages remained a concern for 27 per cent of the nurse practitioners. Two challenges, namely the challenge concerning the psychiatric patients (see Figure 3.4; Section 3.5.2.2e) and lack of equipment (see Figure 3.6; Section 3.5.2.4), were not addressed during the project, as the PDG was of the opinion that these challenges would be resolved once the A&E unit moved to the new hospital. The respondents indicated that they felt that these two challenges had been resolved.

The priority two 'patient care' was viewed as having been resolved by the majority of respondents. However, 29 per cent felt that the amount of patient education

remained a concern. The time spent by patients waiting for specifically the specialists also remained a concern and will have to be assessed in future. The third priority 'structure' was also regarded as resolved. The two challenges that remained unresolved were the availability of protocols and the availability of standards to guide the nurse practitioners when performing procedures. The priority four 'equipment' and priority five 'research' were viewed as having been resolved.

Evidence of reaching the shared vision of 'emancipatory practice development' was based on the observed spin-offs of the project, which indicate that the nurse practitioners had started to move towards a patient-centred approach, implementing innovative and creative ways of enhancing the clinical practice.

The A&E learners and Accreditation Committee of the Gauteng Department of Health were involved as outsiders in the evaluation process. The A&E learners were asked to evaluate the A&E unit as a learning environment as well as the support they were given while working as learners in the unit.

The A&E learners viewed the A&E unit as an environment conducive to learning and indicated that the clinical facilitator, the A&E nurse practitioners and the professional nurse practitioners had supported them.

The report received from the Accreditation Committee indicated that the A&E unit had improved by 23 per cent. Most aspects evaluated received improved marks, with the exception of cleanliness, patient rights and patient systems, which all remained unchanged. An average of 79 per cent was obtained during the accreditation visit in August 2006, giving the A&E unit accreditation status.

The set outcomes for evaluating the worth of the AR for practitioners project had therefore been achieved.

7 Conclusions, lessons learnt and recommendations

When crossing a river, remove your sandals.
When crossing a border, remove your crown.

White Hmong Proverb

7.1 INTRODUCTION

In Chapter 3 to 6, the AR for practitioners project, and the insider and outsider evaluation of the worth of the project are discussed in detail. This chapter presents the conclusions drawn from the study, lessons learnt during the research and the recommendations for future research.

7.2 AIM AND OBJECTIVES

The overall aim of this research was to:
By means of AR, collaboratively plan a journey towards emancipatory practice development that would include both short-term and long-term solutions to address the emergency situation and enhance the possibility of creating a future for the nurse practitioners in the A&E unit.

In order to achieve this aim, the objectives and specific objectives of the research, which evolved as the AR for practitioners project continued, were, collaboratively, to:

- **Objective 1:** Enlighten the practice leaders, middle and top management, and the A&E lecturer about the situation in the A&E unit.
- **Objective 2:** Plan the proposal and obtain ethical consent.
- **Objective 3:** Initiate the journey towards emancipatory practice development in the A&E unit (key drivers: PDG, see Chapter 3):
  - Establish a PDG
  - Reach consensus regarding the barrier that exists that prohibits future action

- Address the barrier
- In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit
- Plan the roadmap for a journey towards emanicpatory practice development

o **Objective 4:** Address the challenges (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):

- Plan actions that could resolve the challenges
- Address the challenges, following the AR cyclic approach

o **Objective 5:** Explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):

- Plan long-term solutions
- Address the long-term solutions, following the AR cyclic approach

o **Objective 6:** Evaluate the worth of the journey towards emancipatory practice development undertaken in the A&E unit (Key driver: researcher/Chapter 6).

The realisation of these objectives is discussed below.

7.3 CONCLUSIONS

The findings obtained, the outcomes achieved and the evaluation of the worth of the journey of the AR for practitioners project are summarised and discussed below.

7.3.1 Objective 1: Enlighten the practice leaders, middle and top management and the A&E lecturer about the emergency situation in the A&E unit

This objective was reached by the nurse practitioners. Under the guidance of the researcher, the nurse practitioners working on a permanent basis in the A&E unit took the first step in the journey towards emancipatory practice development on 16 May 2005 by enlightening the practice leaders, middle and top management and the A&E lecturer of the emergency situation in the A&E unit.

During the emergency meeting, the nurse practitioners expressed their concerns regarding an emergency situation that had developed in the A&E unit (see Section 1.2 and Table 1.1). The nurse practitioners enlightened the practice leaders, middle and top management and the A&E lecturer about their frustrations, namely that they did not feel appreciated for their efforts in the A&E unit, were not supported by management and the other multidisciplinary team members in the A&E unit, and were not given opportunities to develop professionally.

Based on the events of the emergency meeting, the practice leaders, middle and top management and A&E lecturer (as the researcher) diagnosed the environment in which the nurse practitioners worked on a daily basis as a "*toxic environment"*, which had resulted in the resignation of highly skilled and experienced professional nurse practitioners.

In addition to the emergency meeting, the results of the Accreditation Committee of the Gauteng Department of Health were announced. These results confirmed the diagnosis of the emergency situation in which the A&E unit found itself and also contributed to the decision to initiate the AR for practitioners project in the A&E unit.

As a consequence of the enlightenment of the practice leaders, middle and top management and the A&E lecturer, a PDG, consisting of the researcher (external enabler) and practice leaders (internal enablers) was formed (see Section 3.3). These three members were regarded as the key drivers in addressing the challenges in the A&E unit.

7.3.2 Objective 2: Plan the proposal and obtain ethical consent

Following a reflective discussion, consensus was reached that the researcher could use the project as part of her doctoral thesis. The second objective of this research was therefore to plan, write and present a proposal to the Ethics Committee, in which the AR methodology that would be used to address the emergency situation in the A&E unit was discussed. The researcher obtained ethical approval from the relevant hospital as well as from the UNISA Research and Ethics Committee.

7.3.3 Objective 3: Initiate the journey towards emancipatory practice development

The third objective of this research was to initiate the journey towards 'emancipatory practice development' in the A&E unit and consisted of five specific objectives:

- Establish a PDG
- Reach consensus regarding the barrier that exists that prohibits future action
- Address the barrier
- In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit
- Plan the roadmap for the journey towards emancipatory practice development
  - Reach consensus on the criteria for determining the worth of the journey
  - Create a mind map of the planned AR for practitioners project

These specific objectives are discussed below.

The first three objectives concluded Phase 1 of the research and initiated Phase 2, namely the collaborative phase of the research.

7.3.3.1 Establish a practice development group

The PDG was established and consisted of the two practice leaders, namely the unit manager and clinical facilitator, and the researcher. Consensus was reached regarding the role of each member. The three members regarded themselves as professional development facilitators that would play an important role in leading and facilitating the development of the nurse practitioners, which would ultimately lead to patient focused changes in the clinical practice.

Consensus was reached amongst the PDG members regarding the activities and roles of each of the members, the ethical responsibilities of the group, as well as the shared vision and purpose of the project.

7.3.3.2 Reach consensus regarding the barrier that exists that prohibits future action

The emergency situation revealed two major barriers, namely the shortage of nurse practitioners and the toxic environment in which the nurse practitioners worked.

Consensus was reached amongst the PDG and nurse practitioners that the barrier of the shortage of nurse practitioners had to be addressed first.

7.3.3.3 Address the barrier

After the diagnosis of the emergency situation in the A&E unit, additional nurse practitioners, and specifically professional nurse practitioners, were appointed in the A&E unit. This was the first action implemented by the PDG and made use of a multidisciplinary approach, as the PDG, head of department and middle and top management were included. This barrier was addressed throughout the project and considered resolved, even though there remained a deficit of 17 nurse practitioners in the A&E unit. In Section 6.3.1, the outcomes of addressing the barrier of the shortage of nurse practitioners are discussed.

7.3.3.4 In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit

The NGT was used to explore the challenges that had to be overcome, as viewed by the nurse practitioners, in order to ensure a future for them in the A&E unit. In order of priority, these challenges were:

- Professional development
- Patient care
- Structure
- Equipment
- Research

7.3.3.5 Plan a roadmap for the journey

The PDG planned the roadmap for the journey, which included reflecting on a way forward, using mind maps (see Figure 3.8) and setting criteria to evaluate the worth of the project. The criteria and mind map were discussed with the nurse practitioners and, once consensus was reached, the journey started.

The criteria for the evaluation of the worth of the project, as agreed upon by the PDG and nurse practitioners, were:

- Insider evaluation:
  - resolve the barrier of the shortage of professional nurse practitioners (short-term)
  - change the toxic environment to an enabling environment (long-term)
  - address the challenges experienced in the A&E unit to such an extent that the majority of the nurse practitioners regard these challenges as resolved (short-term)
  - create an emancipatory practice development culture (long-term)
  - retain the nurse practitioners
- Outsider evaluation:
  - obtain positive feedback from the A&E learners regarding the A&E unit as a learning and supportive environment
  - obtain an average of 75 per cent or more from the Accreditation Committee of the Gauteng Department of Health, on their next visit to assess the accreditation status of the A&E unit

The realisation of these criteria is discussed in Chapter 6.

7.3.4 Objective 4: Address the challenges

The fourth objective was reached when the practice leaders planned actions to address the challenges described and explored during the NGM. A summary of these actions is provided in Table 3.3. Consensus was reached regarding who would take the responsibility for addressing each challenge. The practice leaders then worked independently, addressing the challenges as agreed and driving the processes.

7.3.4.1 The journey of the clinical facilitator

During the NGM, the clinical facilitator was enlightened regarding the need for professional development expressed by the nurse practitioners. The clinical facilitator was enabled in a supportive, motivating and learning environment to develop a role for an A&E clinical facilitator, and then plan and implement a professional development programme.

Once a role was developed, the clinical facilitator continued to address the priority one challenge, namely professional development, throughout Cycle 4, 5 and 6. The clinical facilitator took ownership of her new role and accepted the responsibility of implementing a professional development programme. In an enabling environment, the researcher facilitated the clinical facilitator's journey of planning and implementing a professional development programme as well as observing and reflecting on the outcomes thereof, thus continuing with the cyclic processes of AR.

Initially, the clinical facilitator focused on the in-service training programme (technical practice development), in which lectures were used as the main teaching strategy. Learning strategies utilised in the practice included collaborative and experiential learning as well as reflection. The clinical facilitator also used written tests to assess the nurse practitioners attending orientation programmes, but later used games such as 'hangman' to make the assessment fun.

Changes regarding the strategies used to facilitate the A&E learners' learning were observed. The clinical facilitator implemented on-the-spot teaching, focusing on emancipatory practice development. Role clarification, self-development and empowerment were evident as the clinical facilitator's self-esteem and self-efficacy increased and she took ownership of her new role as clinical facilitator.

Three important enabling partnerships were formed during the clinical facilitator's journey, namely with the lecturer of the A&E programme, the ICU clinical facilitators and the unit manager. These partnerships had not existed prior to the implementation of the project.

The clinical facilitator therefore acted as a change agent as she was actively involved in changing the toxic environment to a learning, and thus enabling, environment specifically suited to the adult learner.

During the facilitation process, the initial input of the researcher was extremely high (one to two hours per day). However, as the project evolved and the clinical facilitator developed, she became more independent. As her autonomy increased, the researcher's required input gradually decreased. The unit manager and the supervisor also supported the clinical facilitator throughout the project.

Important unforeseen spin-offs of the clinical facilitator's journey included the CPR champions programme, and the partnership formed between the researcher as A&E lecturer and the clinical facilitator, as well as the A&E nurse practitioners. Five professional nurse practitioners enrolled for the A&E programme in 2008, which was also regarded as a spin-off of her journey.

7.3.4.2 The journey of the unit manager

Concurrent to the clinical facilitator's journey, the unit manager addressed the remaining challenges during Cycle 7 of the project as planned. Recognising that addressing the challenges identified by the nurse practitioners (with the exception of the professional development programme) was a short-term solution, the PDG considered long-term solutions to creating an enabling environment.

7.3.5 Objective 5: Explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development

The long-term solutions planned in the A&E unit included changing the toxic environment into an enabling environment by:

- implementing a professional development programme, thus changing the A&E unit into a learning environment (clinical facilitator, see Chapter 4)
- changing the bureaucratic management style into a participative management style, thus providing the nurse practitioners with enabling opportunities to enhance further learning, and developing their leadership (unit manager, see Chapter 5)

In the process of changing the toxic environment into an enabling environment, the unit manager provided the professional nurse practitioners with learning opportunities by involving them in managerial tasks. The unit manager also involved the nurse practitioners in teamwork, again providing learning opportunities and enhancing enablement. She also fostered motivation by gaining the trust of the nurse practitioners. This was achieved through the implementation of the portfolios, which was perceived as an increase in fairness. The unit manager supported the nurse practitioners by having an open door policy and giving them the opportunity to consult her if they needed assistance. The unit manager valued the nurse practitioners' input. An example of this was the implementation of the shift leaders and team leaders, which was the nurse practitioners' initiative.

To enhance the empowerment process, the PDG reflected that participative management in the A&E unit was necessary. Therefore, a participative management style, which aimed to involve the nurse practitioners in various forms of decision-making, was adopted. As power is associated with autonomy and mastery, rather than domination and control (Armstrong & Laschinger 2006:124), it was important that the unit manager share her power and provide the nurse practitioners with the opportunity to participate in the management of and assume responsibility for the A&E unit (Kuokkanen & Leino-Kilpi 2000:237).

At the end of the project, the unit manager had a meeting with all the nurse practitioners and reflected on the positive outcomes of the project. She then asked them what challenges they perceived needed urgent attention in the A&E unit. The nurse practitioners reached consensus that the A&E unit lacked structure, which was described in terms of the storage of equipment and stock in the resuscitation bays, making it difficult to find the equipment or stock when urgently needed. The unit manager asked who was willing to form a task group to address the challenge and three nurse practitioners volunteered. This is evidence of both participative management and the provision of opportunities for enablement and job enrichment. This in turn showed that the unit manager's autonomy had increased and that she had a vision to continue with the project despite the withdrawal of the researcher.

The partnership and collaborative-type relationship that was established between the unit manager and clinical facilitator was a positive outcome of the project and facilitative processes used.

Thus, the unit manager can also be regarded as a change agent, as she not only changed the toxic environment to an enabling environment, but also changed the management style from bureaucratic to participative. It was evident that the unit manager took ownership of her new role as well as the responsibility of a change agent.

7.3.5.1 Empowerment of the nurse practitioners

The nurse practitioners were given enabling opportunities in the A&E unit. These included the professional development programme as well as the opportunity to develop their leadership through the participative management style adopted by the unit manager.

The empowerment and emancipation of the nurse practitioners were observed. Examples of these include:

- the nurse practitioners reflected that the in-service training programme enabled them to use the oxygen masks utilised in the A&E unit effectively (see Section 4.5.2.1)
- the nurse practitioners became aware of their specific learning needs regarding the nursing of ICU patients in the A&E unit and suggested specific topics to be addressed in the in-service training programme. The feedback obtained from the nurse practitioners indicated that they were empowered by the professional development programme as, for example, they were enabled to suction the ICU patients (see Section 4.6.2.1)
- the participative management approach empowered the nurse practitioners, as they were involved in problem solving and collaboration with members of the multidisciplinary team (see Section 5.3.2.3)
- the spin-offs of the project were also regarded as evidence of emancipation (see Section 6.3.4.1)

7.3.6 Objective 6: Evaluate the worth of the journey towards emancipatory practice development undertaken in the A&E unit

Objective 6 was reached when the set criteria were evaluated as reported in Chapter 6. This concluded the journey for the researcher.

7.4 LESSONS LEARNT

July 2007 marked the end of a two-year effort to resolve the emergency situation and challenges experienced in the A&E unit by implementing technical practice development followed by the shared vision of emancipatory practice development.

The PDG met in order to reflect on the lessons learnt and formulate a conclusion. These lessons focus on long-term solutions to reaching a shared vision.

7.4.1 Lesson 1: Promoting supportive partnerships

At the start of the project, the PDG was founded on the basis of collaboration, the most essential component of EAR. The researcher believed that the collaboration would be supportive and unproblematic, but this was not so. It was necessary for all three group members to learn about the challenges of collaboration while conducting the research.

At the beginning, the partnerships between the researcher and practice leaders were not always equal. Although the researcher aimed to facilitate the process through reflection, there were times when she planned actions that she thought would work based on personal experience without considering the opinions of the practice leaders. Then, because the practice leaders did not implement these actions, the researcher would became frustrated only to realise that it was her action plan and not a collaborative action plan. This could be because the researcher worked at a university, which could have been regarded by the practice leaders as an oppressive structure. Another possible reason could have been that the researcher wanted to ensure a 'successful' project for her doctoral degree by resolving the emergency situation and challenges, and achieving a 'successful' outcome.

Reading about principles of adult learning and empowerment gave the researcher insight into the dynamics of power in relationships, consciousness-raising and oppression, which in turn changed her values, to include collective autonomy and respect for other's values and assumptions in a participatory process. The researcher also realised that the focus of the project was long-term. In order to ensure a successful project, the emergency situation and challenges have to be

resolved, and the practice leaders enabled and empowered, so that they, in turn, could enable and empower the nurse practitioners to reach the PDG's shared vision of emancipatory practice development.

An important element of empowerment is *'not feeling alone … feeling part of a group'* (Chamberlin 1997:45). The project demonstrated that supportive partnerships evolve over time. The impetus of the project came from both the planned and unforeseen confluence of enthusiasm, and shared interest and vision. The three members of the PDG recognised the potential benefits of working together, whether these were short-lived or durable and continuous. The supportive partnership may have been preceded by mistrust and ignorance of each other's values and needs, but evolved over time as personal and organisational relationships solidified.

The partnership between the practice leaders developed from the point where each worked in the same environment, but had his/her own vision. This developed into a valuable and strong partnership as the project evolved. They collaborated, shared information, reflected on and monitored actions, and valued one another's inputs in order to reach the shared vision. One could reflect that the process of empowerment in terms of this partnership was successful.

The researcher now understands the importance and value of training clinical facilitators. Manias and Aitken (2005:76) suggest a clinical orientation programme for clinical facilitators involved in the clinical teaching of learners enrolled in postgraduate programmes. This is essential as it supports the clinical facilitators in their new role. This is an initiative that the researcher will implement at the tertiary institution at which she is lecturer of the A&E programme. A preliminary programme, which aims to ensure more effective partnerships between the university, clinical facilitators and A&E learners, will be developed and adapted according to the needs of the clinical facilitators, thus ensuring that the clinical learning needs of the A&E learners are addressed.

7.4.2 Lesson 2: Learn from successes and mistakes

One mistake the research made was in the situation, mentioned in Section 7.4.1, in which she planned actions without the collaboration of the practice leaders due to the influence of her own agendas.

The researcher, practice leaders and nurse practitioners can learn from their mistakes, and it is vital that they are honest with themselves and learn these lessons. This project did not always go smoothly, but, throughout the process, the PDG emphasised honesty. By using a reflective journal, analysing the processes as well as their role in it and being honest about the successes and the failures, individuals can use the lessons learnt to become more effective facilitators.

7.4.3 Lesson 3: Research-minded practice

Nurse practitioners might not sufficiently use research findings to inform their work (Hart & Bond 1995:212). AR has the potential to narrow the gap between theory and practice.

In this study, a partnership was formed between the researcher as lecturer at a tertiary institution and the clinical practice. Initially, this partnership mainly involved the practice leaders, but, as the project continued, the researcher often held reflective conversations with both the practice leaders and the nurse practitioners. These conversations raised questions about the clinical practice, which were addressed, leading to emancipatory practice development. During the two-year period of the study, the clinical facilitator and two nurse practitioners enrolled for masters degrees and the unit manager plans to enrol for a masters degree in 2008.

The AR project therefore has the possibility of encouraging research-minded practice, which could enhance emancipated practice development and a decrease in the theory-practice gap.

7.4.4 Lesson 4: Both appreciative and constructive feedback is needed

Appreciative feedback leads to the repetition of the behaviour addressed (Turner 2006:141). Constructive feedback, given in the spirit of development, can also lead to and encourage changed behaviour. Some of the most effective feedback can be self-generated by asking the questions “What do you think worked well and why?” and “How could we improve?” Questions such as “What went wrong?”

were not asked, as this could lead to blame or guilt instead of innovation and continued improvement.

7.4.5 Lesson 5: Trust them and believe in them

To the researcher, this lesson was possibly the most important of all the lessons learnt. Trusting people and believing in their abilities creates opportunities for empowerment and emancipation. However, a positive attitude, coaching and support were essential ingredients for the success of the project.

7.4.6 Lesson 6: Sustainability

The project was initiated in June 2005 following the visit of the Accreditation Committee to the A&E unit. Initially, the nurse practitioners were enthusiastic about the project when they realised that the practice leaders were fulfilling their commitment to act. However, the sustainability of the project will be determined by the enthusiasm and commitment of the practice leaders' sustained efforts. However, this was not the purpose or objective of the research. It is therefore important to observe and reflect upon the sustainability of the project once the research has been completed.

The practice leaders shared valuable lessons. Firstly, they indicated that working as a group with a shared vision and an action plan motivated and encouraged them to implement the actions. According to them, the shared vision "*gave us something to work for*" and, by planning the actions in collaboration with the nurse practitioners, they ensured the ownership of the nurse practitioners in the project.

During the project, the PDG members provided support and encouragement to each other, which all three members valued. The PDG members also confirmed that having an action plan provided structure and that this in turn made it possible to work more productively.

Reflecting with the members of the PDG as well as nurse practitioners made it possible to determine their views and suggestions regarding certain concerns. This ensured the buy-in of those involved. This is in line with a bottom-up

approach rather than a top-down approach. The practice leaders indicated that they did not realise how important it was to collaborate and work together. In the course of the project, they formed a partnership, which they regard as the most valuable aspect gained during the project.

These lessons may prove valuable for other units or wards seeking to resolve emergency situations and challenges experienced in their environment.

7.5 Limitations

The limitations of this research were as follows:

- This research was conducted in only one A&E unit of a Level III tertiary hospital in Gauteng. The results do not involve a more comprehensive group of units or hospitals.
- The research involved only a limited number of participants and can therefore not be applied to the broader nursing community.
- The project aimed only to improve the environment of the nurse practitioners working in the A&E unit. Personal problems, personality types and other aspects that could have influenced the values and motivation of the team members were not taken into account, as this was not within the scope of the research.
- The research was conducted over a period of only two years. This is a limitation, as the long-term objectives of this research could not be explored.

7.6 FURTHER RESEARCH

The following topics could be considered for future research:

- Correlate nurse practitioner recruitment and retention by shaping an enabling environment that enhances patient outcomes
- Develop healthcare teams that are able to sustain evidence-based quality patient care in an enabling environment
- Evaluate and assess the effectiveness of the role of the clinical facilitator in practice development
- Evaluate the role of the clinical facilitator in emancipatory practice development
- Investigate the learning culture of the multidisciplinary team in the A&E unit

- Evaluate the role of practice developers, their authority to affect change in practice and their sphere of accountability

7.7 CLOSING REFLECTION

Learn from the people
Plan with the people…
When the task is accomplished
The people all remark
We have done it ourselves

Lao-tzu

It was difficult to demonstrate the consequences of the journey towards emancipatory practice development undertaken in the A&E unit. The complexity of the environment in which the journey took place and the interdependence of so many underlying factors meant that relating processes to outcomes was difficult.

Timing played a vital role in the initiation of the AR for practitioners project. It was of the utmost importance that the emergency situation and challenges should be addressed, and long-term solutions planned and implemented to ensure a future for the nurse practitioners in the A&E unit. The A&E unit is the 'front door' of the hospital and the first direct contact with the community (patients and their families) on a daily basis.

Action research in its various forms is still relatively new in nursing research, and its validity and appropriateness as a 'scientific' method of conducting investigations are only just being established (Lathean 1996:32). In this study, it was used effectively to bring about change in practice, specifically with regards to the environment. This resulted in the initiation of the emancipatory process through making the practice leaders and nurse practitioners aware of the emergency situation they were facing. The enablement, empowerment and emancipation of the practice leaders and nurse practitioners led to emancipatory practice development. This in turn benefited not only the hospital, but also the patients and their families, and the community at large.

The AR for practitioners project did not solve all the challenges and did not establish its sustainability. However, the researcher felt fortunate to have been

asked to assist the practice leaders and nurse practitioners working in the A&E unit to resolve the emergency situation. The researcher found an unselfish commitment on the part of the practice leaders and nurse practitioners, despite working under difficult conditions and moving to the new hospital during this project, to realising the shared vision of 'emancipatory practice development'.

Annexure A

Ethical approval to conduct the research

A.1 Department of Health Sciences (UNISA)

Annexure A

Ethical approval to conduct the research

A.2 The Hospital

Annexure B

Informed consent

B.1 Participation leaflet and informed consent: action research for practitioners' project: practice leaders

Annexure B

Informed consent

B.2 Participation leaflet and informed consent: action research for practitioners' project: nurse practitioners

Annexure B

Informed consent

B.3 Participation leaflet and informed consent: action research for practitioners' project: nominal group meeting

Annexure C

A&E unit: adapted statistics

Table C1	A&E unit: Adapted statistics 'old A&E unit' (January to June 2003/January to June 2005)
Table C2	A&E unit: Adapted statistics 'new A&E unit' (January to June 2007)

Annexure D

Challenges as prioritised during the nominal group meeting: comparing the nurse practitioner categories

Annexure E

A comparison between the 2005 and 2006 reports of the Accreditation Committee, Gauteng Department of Health

Annexure F

Journey of the clinical facilitator

F.1 Clinical accompaniment of the first-year A&E learners

Annexure F

Journey of the clinical facilitator

F.2 Clinical accompaniment of the second-year A&E learners

Annexure F

Journey of the clinical facilitator

F.3 Job description: clinical facilitator: A&E unit

Annexure F

Journey of the clinical facilitator

F.4 A&E programme study guide: week 3

Annexure F

Journey of the clinical facilitator

F.5 In-service training programme (2006-2007)

Annexure F

Journey of the clinical facilitator

F.6 Certificate of attendance

Annexure F

Journey of the clinical facilitator

F.7 A&E unit: record of on-the-spot teaching

Annexure F

Journey of the clinical facilitator

F.8 Cardiopulmonary resuscitation (CPR) record tool

Annexure G

Example of performance evaluation form

Annexure H

Questionnaires

H.1 Questionnaire 1: nurse practitioners

Annexure H

Questionnaires

H.2 Questionnaire 2: A&E learners

Annexure I

Roadmap towards emancipatory practice development

Participation leaflet and informed consent

Action research for practitioners project: Practice leaders

Dear Colleague

You are invited to participate in the "action research for practitioners project" that will take place over a period of two years within the accident and emergency (A&E) unit. This information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher at any time.

TITLE OF STUDY

A journey towards emancipatory practice development

1) The purpose and objectives of the study

You are requested to take part in a research study. Your participation will be as practice leader working within the A&E unit of the [redacted].

On 17 May 2005 the nurse practitioners held an emergency meeting in the A&E unit. One of the concerns expressed by the nurse practitioners was the fact that nurse practitioners were leaving the A&E unit at a rapid rate. Following a visit by the Accreditation Committee in June 2005, the researcher was requested by the practice leaders to assist in resolving the perceived emergency situation in the A&E unit and address the challenges experienced in the unit.

The aim of this study is to by means of AR, collaboratively plan a journey towards emancipatory practice development that would include both short-term and long-term solutions to address the emergency situation and enhance the possibility of creating a future for the nurse practitioners in the A&E unit.

In order to achieve this aim, the objectives and specific objectives of the research, which evolved as the AR for practitioners project continued, were, collaboratively, to:

- **Objective 1:** Enlighten the practice leaders, middle and top management, and the A&E lecturer about the situation in the A&E unit.

- **Objective 2:** Plan the proposal and obtain ethical consent.
- **Objective 3:** Initiate the journey towards emancipatory practice development in the A&E unit (key drivers: PDG, see Chapter 3):
  - Establish a PDG
  - Reach consensus regarding the barrier that exists that prohibits future action
  - Address the barrier
  - In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit
  - Plan the roadmap for a journey towards emanicpatory practice development
- **Objective 4:** Address the challenges (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):
  - Plan actions that could resolve the challenges
  - Address the challenges, following the AR cyclic approach
- **Objective 5:** Explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):
  - Plan long-term solutions
  - Address the long-term solutions, following the AR cyclic approach
- **Objective 6:** Evaluate the worth of the journey towards emancipatory practice development undertaken in the A&E unit (Key driver: researcher/Chapter 6).

2) Explanation of procedures to be followed

You as practice leader are requested to participate in a collaborative effort to plan actions that would resolve the emergency situation in the A&E unit, facilitate these actions in collaboration with the nurse practitioners, monitor and reflect on the actions and then re-plan actions if appropriate.

3) Risk and discomfort involved

As a participating practice leader, you will experience no discomfort. There is also no risk involved in this study. However, your input into this project will require a lot of time and effort.

4) Benefits of the study

The emergency situation and the challenges experienced in the A&E unit could be resolved if a collaborative effort is made involving not only the practice leaders but

also the nurse practitioners. By enabling the practice leaders to resolve the emergency situation and challenges, and by enabling the nurse practitioners to develop their own and collective emancipated practices, this project could potentially create a better future for nurse practitioners and the A&E unit.

If the outcomes of this study are positive, the principles utilised could assist other practice leaders to address similar issues of concern.

5) Voluntary participation in and withdrawal from the study

Participation occurs on a voluntary basis, and you can withdraw from the project without stating any reason should you no longer wish to take part.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of South Africa, as well as the [redacted], has granted written approval for this study.

7) Additional information

If you have any questions about your participation in this action research project, you should contact the researcher, Ms Tanya Heyns –

Work telephone: (012) 354-2125
Cellphone: 083 287 3929
Email address: tanya.heyns@up.ac.za

8) Confidentiality

Your input into this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

9) Consent to participate in this study

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

I have read the above information leaflet and fully understand what is expected of me. Its content and meaning have been explained to me. I have been given the opportunity to ask questions and received satisfactory answers. I hereby volunteer to take part in this research.

_____ _____

Participant's signature **Date**

_____ _____

Person obtaining informed consent **Date**

_____ _____

Witness **Date**

……..

Tanya Heyns

Researcher

Participation leaflet and informed consent

Action research for practitioners project: Nurse practitioner

Dear Colleague

You are invited to participate in the "action research for practitioners project" that will take place over a period of two years within the accident and emergency (A&E) unit. This information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher at any time.

TITLE OF STUDY

A journey towards emancipatory practice development

1) The purpose and objectives of the study

You are requested to take part in this research study. Your participation will be as nurse practitioner working in the A&E unit of the [redacted].

On 17 May 2005 the nurse practitioners held an emergency meeting in the A&E unit. One of the concerns expressed by the nurse practitioners was the fact that nurse practitioners were leaving the A&E unit at a rapid rate. Following a visit by the Accreditation Committee in June 2005, the researcher was requested by the practice leaders to assist in resolving the perceived emergency situation in the A&E unit and address the challenges experienced in the unit.

The aim of this study is to by means of AR, collaboratively plan a journey towards emancipatory practice development that would include both short-term and long-term solutions to address the emergency situation and enhance the possibility of creating a future for the nurse practitioners in the A&E unit.

In order to achieve this aim, the objectives and specific objectives of the research, which evolved as the AR for practitioners project continued, were, collaboratively, to:

- **Objective 1:** Enlighten the practice leaders, middle and top management, and the A&E lecturer about the situation in the A&E unit.

- **Objective 2:** Plan the proposal and obtain ethical consent.
- **Objective 3:** Initiate the journey towards emancipatory practice development in the A&E unit (key drivers: PDG, see Chapter 3):
  - Establish a PDG
  - Reach consensus regarding the barrier that exists that prohibits future action
  - Address the barrier
  - In collaboration with the nurse practitioners, explore the challenges that need to be overcome in order to create a future for them in the A&E unit
  - Plan the roadmap for a journey towards emanicpatory practice development
- **Objective 4:** Address the challenges (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):
  - Plan actions that could resolve the challenges
  - Address the challenges, following the AR cyclic approach
- **Objective 5:** Explore possible long-term actions that could be implemented to reach a shared vision of emancipatory practice development (Key drivers: clinical facilitator/Chapter 4 and unit manager/Chapter 5):
  - Plan long-term solutions
  - Address the long-term solutions, following the AR cyclic approach
- **Objective 6:** Evaluate the worth of the journey towards emancipatory practice development undertaken in the A&E unit (Key driver: researcher/Chapter 6).

2) Explanation of procedures to be followed

You as a nurse practitioner are requested to participate in a collaborative effort to plan actions that would address the challenges experienced in the A&E unit, monitor and reflect on the actions and re-plan if appropriate.

3) Risk and discomfort involved

As a participating nurse practitioner, you will experience no discomfort. There is also no risk involved in this study. However, your input into this project will require a lot of time and effort.

4) Benefits of the study

The emergency situation and the challenges experienced in the A&E unit could be resolved if a collaborative effort is made involving not only the practice leaders but also the nurse practitioners. By enabling the nurse practitioners to develop their

own and collective emancipated practices, this project could create a better future for them and the A&E unit.

If the outcomes of this study are positive, the principles utilised could assist other nurse practitioners to address similar issues of concern.

5) Voluntary participation in and withdrawal from the study

Participation in the action research takes place on a voluntary basis, and you can withdraw from the study without stating any reason should you no longer wish to take part.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of South Africa, as well as the [redacted], has granted written approval for this study.

7) Additional information

If you have any questions about your participation in this action research project, you should contact the researcher, Ms Tanya Heyns –

Work telephone: (012) 354-2125
Cellphone: 083 287 3929
Email address: tanya.heyns@up.ac.za

8) Confidentiality

Your input into this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain unidentifiable.

9) Consent to participate in this study

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

I have read the above information leaflet and fully understand what is expected of me. Its content and meaning have been explained to me. I have been given the opportunity to ask questions and received satisfactory answers. I hereby volunteer to take part in this research.

_____ _____

Participant's signature **Date**

_____ _____

Person obtaining informed consent **Date**

_____ _____

Witness **Date**

……..

Tanya Heyns

Researcher

Participation leaflet and informed consent

Nominal group meeting

Dear Participant

You are invited to participate in a nominal group meeting that will be held on 17 August 2005 in the accident and emergency (A&E) unit. This information leaflet contains information that will help you understand your role in this meeting. If there is any need for further clarification, please feel free to contact the researcher at any time.

TITLE OF STUDY

A journey towards emancipatory practice development

1) The purpose and objectives of the study

You are requested to take part in a nominal group meeting. You will participate as a nurse practitioner working in the A&E unit of the [redacted].

On 17 May 2005 the nurse practitioners held an emergency meeting in the A&E unit. One of the concerns expressed by the nurse practitioners was the fact that professional nurse practitioners were leaving the A&E unit at a rapid rate. Following a visit by the Accreditation Committee in June 2005, the researcher was requested by the practice leaders to assist in resolving the perceived emergency situation in the A&E unit. The practice leaders and researcher have planned actions based on your inputs during the emergency meeting and are currently addressing the issue.

In order to create a future for the nurse practitioners and A&E unit, it is important to explore the views of nurse practitioners concerning the challenges experienced in the unit. The nominal group technique is a method that can be used to explore and prioritise these challenges. Based on these challenges, collaborative actions will be planned to attempt to not only resolve these challenges, but also create a better future for nurse practitioners and the A&E unit.

The purpose of the nominal group meeting therefore is to –
Explore and describe the views of nurse practitioners concerning the challenges that need to be overcome in order to create a better future for them and the A&E unit

2) Explanation of procedures to be followed

You as a nurse practitioner and an expert working in the A&E unit are requested to participate collaboratively to explore the challenges experienced in the A&E unit. The single nominal group session and will take up approximately two to four hours of your time. The exact steps will be explained to you at the meeting. Even though exploring and prioritising the challenges is a group effort, everybody will get an equal opportunity to provide their input.

3) Risk and discomfort involved

As a participating nurse practitioner, you will experience no discomfort. There is also no risk involved in this study. However, your input into this project will require a lot of time and effort.

4) Benefits of the study

The emergency situation and the challenges experienced in the A&E unit could be resolved if a collaborative effort is made involving not only the practice leaders but also the nurse practitioners. By enabling the nurse practitioners to develop their own and collective emancipated practices, a future could be created for the A&E unit.

If the outcomes of this study are positive, the principles utilised could assist other nurse practitioners and practice leaders to address similar issues of concern.

5) Voluntary participation and withdrawing from study

Participation occurs on a voluntary basis, and you can withdraw at any time without stating a reason.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of South Africa, as well as the [redacted], has granted written approval for this study.

7) Additional information

If you have any questions concerning your participation in the nominal group meeting, you should contact Ms Tanya Heyns –

Work telephone: (012) 354-2125
Cellphone: 083 287 3929
Email address: tanya.heyns@up.ac.za

8) Confidentiality

Your input at this meeting will be kept confidential. Results will be published and presented in such a manner that you as a participant cannot be identified.

9) Consent to participate in this study

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

I have read the above information leaflet and fully understand what is expected of me. Its content and meaning have been explained to me. I have been given the opportunity to ask questions and received satisfactory answers. I hereby volunteer to take part in this research.

_____ _____

Participant's signature **Date**

_____ _____

Person obtaining informed consent **Date**

_____ _____

Witness **Date**

……..

Tanya Heyns

Researcher

Table C1 – A&E unit: Adapted statistics 'old A&E unit' (January to June 2003/January to June 2005)

Period	Total (Jan – June)		January		February		March		April		May		June	
Year	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005	2003	2005
Priority 1	583	581	93	104	86	94	98	89	115	81	111	97	80	116
Priority 2	832	6 006	213	1 143	122	408	136	1 148	65	1 055	212	1 110	84	1 142
Priority 3	19 734	16 131	3 269	2 419	3 271	2 647	3 239	2 617	3 368	2 578	3 504	2 616	3 083	3 254
Total	21 149	22 718	3 575	3 666	3 479	3 149	3 473	3 854	3 548	3 714	3 827	3 823	3 247	3 935
Admission (wards)	7 076	6 664	1 210	1 200	1 177	950	1 110	1 186	1 104	1 069	1 267	1 119	1 208	1 140
Admission (ICUs)	355	388	72	63	44	51	59	46	28	48	78	48	54	54
Patients admitted to A&E unit > 4 h	6 389	5 422	598	834	1 037	936	1 277	907	1 508	908	996	889	973	948

Adapted from: THE HOSPITAL: A&E unit. 2003, 2005. Statistics. Unpublished.

Priority 1 (P1): Patients admitted with life-threatening injuries or medical emergencies, such as airway, breathing and/or circulation problems. These patients are so severely injured or critically ill that they will die should they not receive immediate medical interventions.

Priority 2 (P2): Patients admitted with potentially life-threatening injuries or medical emergencies. Although their conditions are less serious than those of P1s and they are stable for the moment, they require watching by trained personnel and frequent re-triage, as the possibility exists for rapid deterioration.

Priority 3 (P3): These patients are often referred to as the 'walking wounded' and do not require immediate management. These patients have minor injuries or medical conditions and following their management, will usually be discharged from hospital.

Priority 4 (P4): These patients are either dead on arrival or unsalvageable when admitted in the A&E unit.

Table C2 – A&E unit: Adapted statistics 'new A&E unit' (January to June 2007)

Priorities	Total (Jan – June)		January		February		March		April		May		June	
Priority 1	1 284		357		366		428		542		488		441	
Priority 2	8 476		1 655		1 522		1 654		1 498		1 195		1 352	
Triage	2 488		719		290		449		348		359		323	
	Admit	***Refer***	***Admit***	***Refer***	***Admit***	***Refer***	***Admit***	***Refer***	***Admit***	***Refer***	***Admit***	***Refer***	***Admit***	***Refer***
	821	*1 667*	*432*	*287*	*53*	*237*	*143*	*306*	*63*	*285*	*71*	*288*	*59*	*264*
Total admitted to A&E unit	11 498		2 012		1 888		2 082		2 040		1 683		1 793	
Patients admitted to A&E unit > 4 h	6 663		1 026		1 032		1 235		1 152		1 023		1 195	

Adapted from: THE HOSPITAL: A&E unit. 2007. Statistics. Unpublished.

Priority 1 (P1): Patients admitted with life-threatening injuries or medical emergencies, such as airway, breathing and/or circulation problems. These patients are so severely injured or critically ill that they will die should they not receive immediate medical interventions.

Priority 2 (P2): Patients admitted with potentially life-threatening injuries or medical emergencies. Although their conditions are less serious than those of P1s and they are stable for the moment, they require watching by trained personnel and frequent re-triage, as the possibility exists for rapid deterioration.

Priority 3 (P3): These patients are often referred to as the 'walking wounded' and do not require immediate management. These patients have minor injuries or medical conditions and following their management will usually be discharged from hospital.

Triage: Patients triaged in the A&E unit. If the patient is classified as P1 or P2, he/she is admitted to the A&E unit. If the patient is classified as P3, he/she is transferred to a relevant clinic. The South African Triage Score is used.

***Note**: Because of a shortage of hospital beds, patients remain in the A&E unit from anything between two hours to 14 days. Every day between two and eight critical care patients are nursed in the A&E unit because of the shortage of beds.*

A comparison between the 2005 and 2006 reports of the Accreditation Committee, Gauteng Department of Health

Standard		Compliance (%)	
		7 June 2005	6 August 2006
1	Reception and information	42	80
2	Comfort	65	75
3	Cleanliness	80	80
4	Waiting times	25	75
5	Patient rights	50	50
6	Availability of equipment and supplies	67	85
7	Reference and educational material	37	95
8	Emergency care	38	85
9	Staffing	92	95
10	Patient safety	50	75
11	Patient systems	75	75
	Average	**56**	**79**

Compiled from the 2005 and 2006 reports of the Accreditation Committee, Gauteng Department of Health

Challenges as prioritised during the nominal group meeting: comparing the nurse practitioner categories

Nurse practitioners (n=14)							
Participants (n=14) **Final vote**	**Professional nurse practitioners (n=11)**						**Auxiliary nurse practitioners (n=3)**
	Professional nurse practitioner (n=4)	A&E nurse practitioner (n=2)	A&E learner (n=2)	Critical care nurse practitioner (n=1)	Clinical facilitator (n=1)	A&E and critical care nurse practitioner (n=1)	
Priority 1: Professional development	Professional development	Professional development	Professional development	Professional development	Structure	Professional development	Professional development
Priority 2: Patient care	Patient care	Patient care	Patient care	Patient care	Patient care	Patient care	Equipment
Priority 3: Structure	Structure	Structure	Structure	Structure	Professional development	Structure	Patient care
Priority 4: Equipment	Equipment	Equipment	Equipment	Equipment	Equipment	Equipment	Research
Priority 5: Research	Research	Research	Research	Research	Research	Research	Structure

Equal votes indicated:

APPLICATION TO CONDUCT A RESEARCH STUDY

Faculty of Health Sciences Research Ethics Committee
University of Pretoria
Pretoria
Pretoria Academic Hospital
Tel: (012) 339 8612
Fax: (012) 339 8587
E Mail: manda@med.up.ac.zza - Main Committee
E Mail: dbehari@med.up.ac.za - Student Committee

GENERAL INFORMATION AND AGREEMENT BY APPLICANT

APPLICANTS

Ms Tanya Heyns
Department of Nursing Science
Faculty of Health Sciences
PO Box X667
Pretoria
0001
Tel: (012) 354 2125

Prof SP Hattingh (Study leader)
PO Box 392
UNISA
0003
Tel: (012) 429 6543

Prof VJ Ehlers
PO Box 392
UNISA
0003
Tel: (012) 429 6543

FULL TITLE OF THE STUDY

A journey towards emancipatory practice development

ARE ANY SPECIAL PRECAUTIONARY MEASURES TO BE TAKEN AND BY WHOM?

In this study an approach will be planned, initiated and evaluated by the nurse practitioners working within the accident and emergency (A&E) unit in order to resolve the "emergency situation" experienced within the unit. Voluntary participants will be known to each other during the entire study and therefore subject anonymity will not be possible. Anonymity pertaining to the participants will be ensured during the data capturing and data analysis. Publications will not contain any information that will link the hospital or the participants to the study.

INDICATE EXPECTED DATE OF REPORT

DAY	**MONTH**	**YEAR**
31	January	2008

INDICATE NUMBER OF STAFF INVOLVED

STAFF	**TOTAL**
Area 4 manager	1
The nurse leaders within the A&E unit	2
All the nurse practitioners working full time within the A&E unit	Currently: 29

THE NAME OF THE HEAD OF DEPARTMENT

Dr A Engelbrecht

AGREEMENT BY APPLICANTS

- To conduct the study recorded in and under the conditions set out in this application form
- To conduct this study at no additional expenses to the Gauteng Department of Health whatsoever
- To inform the Superintendent General: Gauteng Department of Health and other relevant authorities should it be deemed necessary to deviate from the protocol or stop the study
- To make available without delay all the results of this study to the Superintendent General: Gauteng Department of Health
- We understand that the Superintendent General, Gauteng Department of Health, places himself or herself or the Gauteng Department of Health under no obligation whatsoever and to leave the final choice of the institution where the trial/evaluation will be conducted to the Superintendent General, Gauteng Department of Health.

THE APPLICANTS MUST SIGN HERE

APPLICANTS		
NAMES	**SIGNATURES**	**DATE**
Ms T Heyns		24 June 2005

INITIAL CONSENT BY DEPARTMENTAL HEAD

THE HEAD 0F THE DEPARTMENT MUST SIGN HERE

APPROVAL BY HOSPITAL CHIEF EXECUTIVE OFFICER

LETTER OF INTENT

Prof JR Snyman
Chair: University of Pretoria
Faculty of Health Sciences Research Ethics Committee
University of Pretoria
Pretoria
Pretoria Academic Hospital
Tel: (012) 339 8612
Fax: (012) 339 8587
E Mail: manda@med.up.ac.zza - Main Committee
E Mail: dbehari@med.up.ac.za - Student Committee

Dear Prof JR Snyman

SUBMISSION OF PROTOCOL FOR EXPEDITED REVIEW

NAME OF PROTOCOL

NATURE OF STUDY

In this study an approach will be planned, initiated and evaluated by the nurse practitioners working within the accident and emergency (A&E) unit in order to resolve the "emergency situation" experienced within the unit. Voluntary participants will be known to each other during the entire study and therefore subject anonymity will not be possible. Anonymity pertaining to the participants will be ensured during the data capturing and data analysis. Publications will not contain any information that will link the hospital or the participants to the study.

CONTRACT RESEARCH NO

ARE SUFFICIENT FUNDS AVAILABLE TO COMPLETE STUDY YES

PATIENTS/VOLUNTEERS/FILES/SAMPLES

The Area 4 manager, two practice leaders (unit manager and clinical facilitator) and all the nurse practitioners (n=29) working within the A&E unit will be approached to participate in the study.

IN WHICH DEPARTMENT WILL THE RESEARCH BE CONDUCTED?

The accident and emergency unit of the Pretoria Academic Hospital

SIGNATURE OF THE HEAD OF DEPARTMENT

SIGNATURE OF RESEARCHER INVOLVED

_____ 24 June 2005

Signature **Date**

Ms T Heyns
Department of Nursing Science
University of Pretoria
Tel: (012) 354 2125
Fax: (012) 354 1490
E Mail: tanya.heyns@up.ac.za

Clinical accompaniment of first-year A&E learners

Compiled by: [redacted] (September 2005)

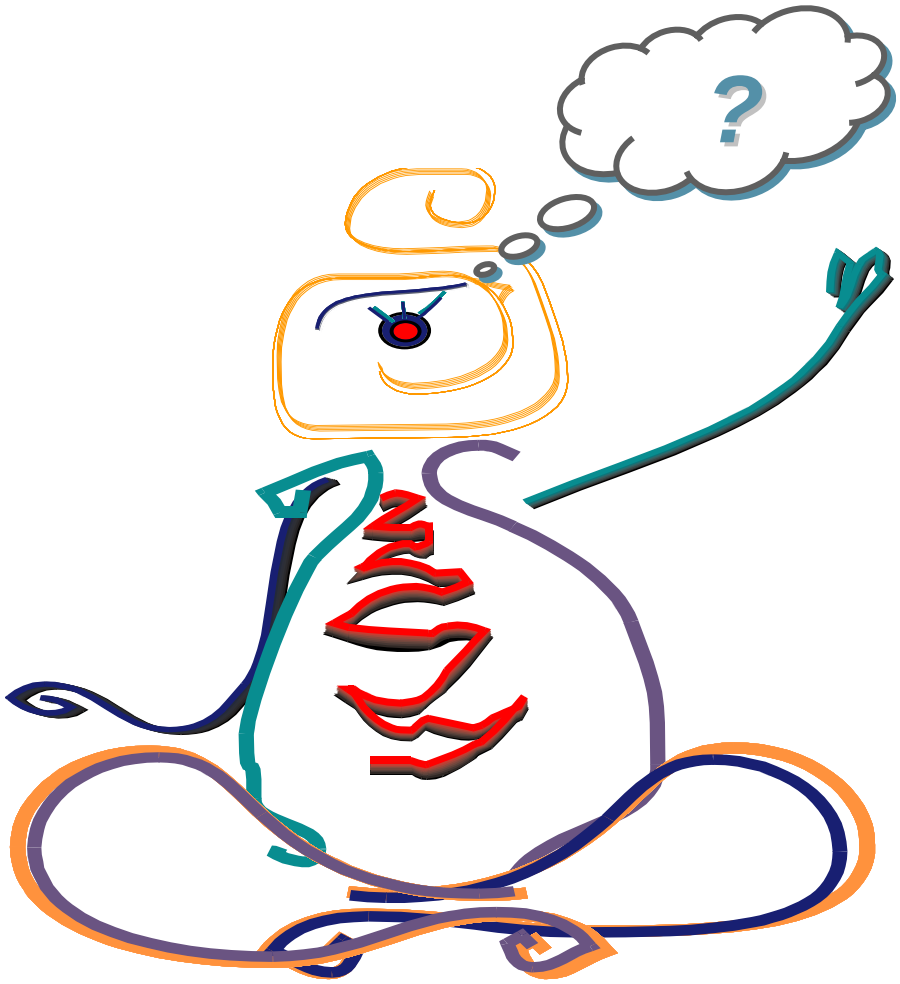
February / March	April / May / June	July / August	September / October
Knowledge			
Anatomy o Cardiovascular system (heart/conduction) o Respiratory system (lungs)	Anatomy o Neurovascular system Arterial blood gases o Respiratory status o Metabolic status o Oxygenation status →		
Maintenance of blood pressure →			
			Antibiotics
Skills			
Basic CPR →			
Oxygen masks →			
Bag-valve-mask ventilation →			
Defibrillator →		Basic principles of mechanical ventilation →	
		Chest X-ray interpretation →	
← **Scope of practice** →			

February / March	April / May / June	July / August	September / October
Assessment			
Assessment of patient Overall assessment →			
Assessment of patient Focus on – o Haemodynamic monitoring →			
	Assessment of patient Focus on – o Shock and shock syndromes →		
	Assessment of patient Focus on – o Cardiovascular system • Inotropes o Respiratory system • Atrovent • Berotec • Combivent • ABG	Assessment of patient Focus on – o Neurological system (↑ ICP) • *Mannitol* • Decadron • Valium • Epanutin o Gastro-intestinal system (Renal/liver) • Albumin	

February / March	April / May / June	July / August	September / October
Assessment (cont.)			
		Assessment of patient Focus on – o Fluid and electrolyte balance • Crystalloids • Colloids • Maintenance fluid	
	Normal ECG	ECGs – atrial arrhythmias	ECGs – ventricular arrhythmias
Planning			
	Prioritise problems and indicate specific nursing interventions		
← **Implementation** →			
			Infection control measures
← **Evaluation** →			
← **Record keeping** →			

Clinical accompaniment of second-year A&E learners

Clinical facilitation



	January	February	March
Knowledge		**Week 1 to 4** o Orientation to programme (1) o Shock emergencies and mechanisms of injury (2) o Nursing process (3) o Cardiovascular emergencies (4)	**Week 5 to 8** o Cardiovascular emergencies (5) o Respiratory emergencies (6) o Test (7) o Respiratory emergencies (8)
Skills	**Day 1** (22 February)		**Day 2** (1 March) **Day 3** (13 March)

	April	May	June
Knowledge	**Week 9 to 11** o Neurological emergencies (9) o Neurological emergencies (10) o Organ donation (11)	**Week 12 to 15** o Analgesia and anaesthesia (12) o Test (13) o Case studies (14) o Case studies (15)	**Examination**
Skills		**Day 4** (8 May)	

	July	August	September
Knowledge	**Week 1 and 3** o Genitourinary emergencies (1) o HIV/AIDS(2) o Paediatric emergencies (3)	**Week 4 to 7** o Abdominal emergencies (4) o Endocrine emergencies (5) o Orthopaedic emergencies (6) o Test (Week 7)	**Week 8 to 11** o Wounds and emergencies (8) o Obstetrical and gynaecological (9) o Toxicological emergencies (10) o Maxillofacial, ocular and environmental emergencies (11)
Skills	**Day 5** (24 July)	**Day 6** (7 August)	Preparation for clinical examination

	October	November	December
Knowledge	**Week 12 to 14** o Test (Week 12) o The multiple trauma patient and stabilisation and transport (13) o Case studies (14)	**Examination**	
Skills	**REVISION**		

Compiled by: [redacted] **(September 2005)**

[redacted]

Job Description
Clinical Facilitator
A&E unit

Job title: Clinical Facilitator

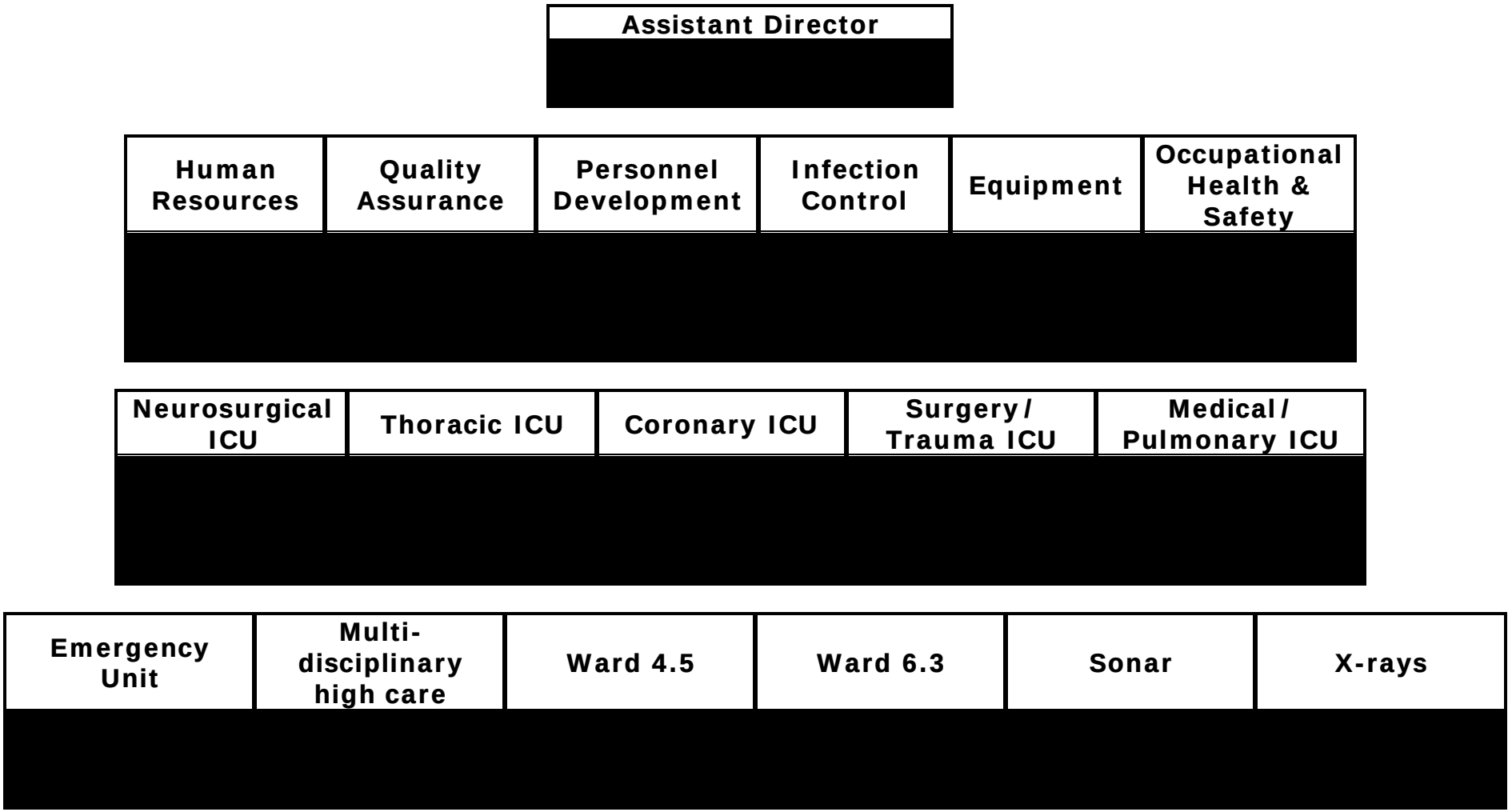
Job base: [redacted]

Accountable to: Assistant Director, Area 4

Qualifications: Diploma/Degree in Accident and Emergency Care Nursing, Diploma in Nursing Education

Working hours: 40 hours per week

Organisational Structure: Area 4



1. Summary of job description

The functions of the clinical facilitator are –

- Education
- Patient care
- Management
- Research

2. General knowledge and skills required

The order of priority as seen by the clinical facilitator is as follows:

2.1 Education

The main function of the clinical facilitator is to ensure that learning takes place in the accident and emergency (A&E) unit. To be able to ensure that adequate learning takes place, the clinical facilitator needs the following knowledge and skills -

- Knowledge -
    - basic knowledge pertaining to general nursing science, midwifery, psychiatric nursing and community health nursing
    - advanced theoretical knowledge pertaining to A&E nursing
    - basic knowledge regarding the pre-hospital environment and personnel requirements
    - evidence-based practice concerning A&E nursing
- Skills -
    - advanced, up-to-date clinical skills
    - good interpersonal skills
    - excellent teaching/training skills
    - management skills
    - communication skills at all levels
    - computer skills
    - innovative skills
    - critical, analytical thinking skill

The above knowledge and skills will empower the clinical facilitator to effectively perform her primary and secondary function in the A&E unit.

2.1.1 Primary function

- To start and facilitate a professional development programme for all staff working in the unit by means of -
    - an in-service training programme and assessment thereof
    - on-the-spot teaching
    - reflection-on-action
    - keeping of records about continuing education taking place outside health service

2.1.2 Secondary function

- To be available to other health categories in the hospital environment in order to -
    - facilitate training in, and train, staff in the hospital's CPR programme
    - support all categories of learners visiting or rotating through the A&E unit, e.g. BCur pre-graduate learners, ICU post-basic learners, paramedics and community health nurses
    - give ad hoc lectures as part of the hospital's in-service tranining and post upgrading programmes

For an overview see the graphical job description on page 7.

2.2 Patient care

The second function is the nursing care of patients. This entails -

- general and advanced nursing care when the need arises within the A&E unit, e.g. inadequate trained staff, staff shortages or when the unit is extremely busy and staff members cannot cope with the patient load

- acting as expert A&E nurse practitioner and role model in the field of A&E nursing
- acting as patient advocate

2.3 Management

The third function as seen by the clinical facilitator is managing her own professional development and that of nurses working in the unit, including the A&E learners.

- Concerning the professional development of the clinical facilitator
    - plan to attend relevant congresses, in-service training sessions, training sessions on morbidity and mortality, lectures, etc.
- Concerning all categories of nurses working in the emergency unit –
    - plan and implement a relevant professional development programme
    - plan and implement an induction programme for newly appointed nursing staff
    - represent the A&E unit at different meetings, e.g. ICU task team meeting, Area meeting, and Accreditation meeting
    - participate in problem solving when appropriate
- Concerning the A&E learners
    - ensure the signing of study contracts with all learners
    - negotiate a learning contract with each learner
    - plan a rotation roster
    - plan annual leave
    - manage PMS
    - plan suitable clinical sessions with learners, including the first and second-year learners
    - evaluate the learning progress made by each individual learner and plan appropriate interventions

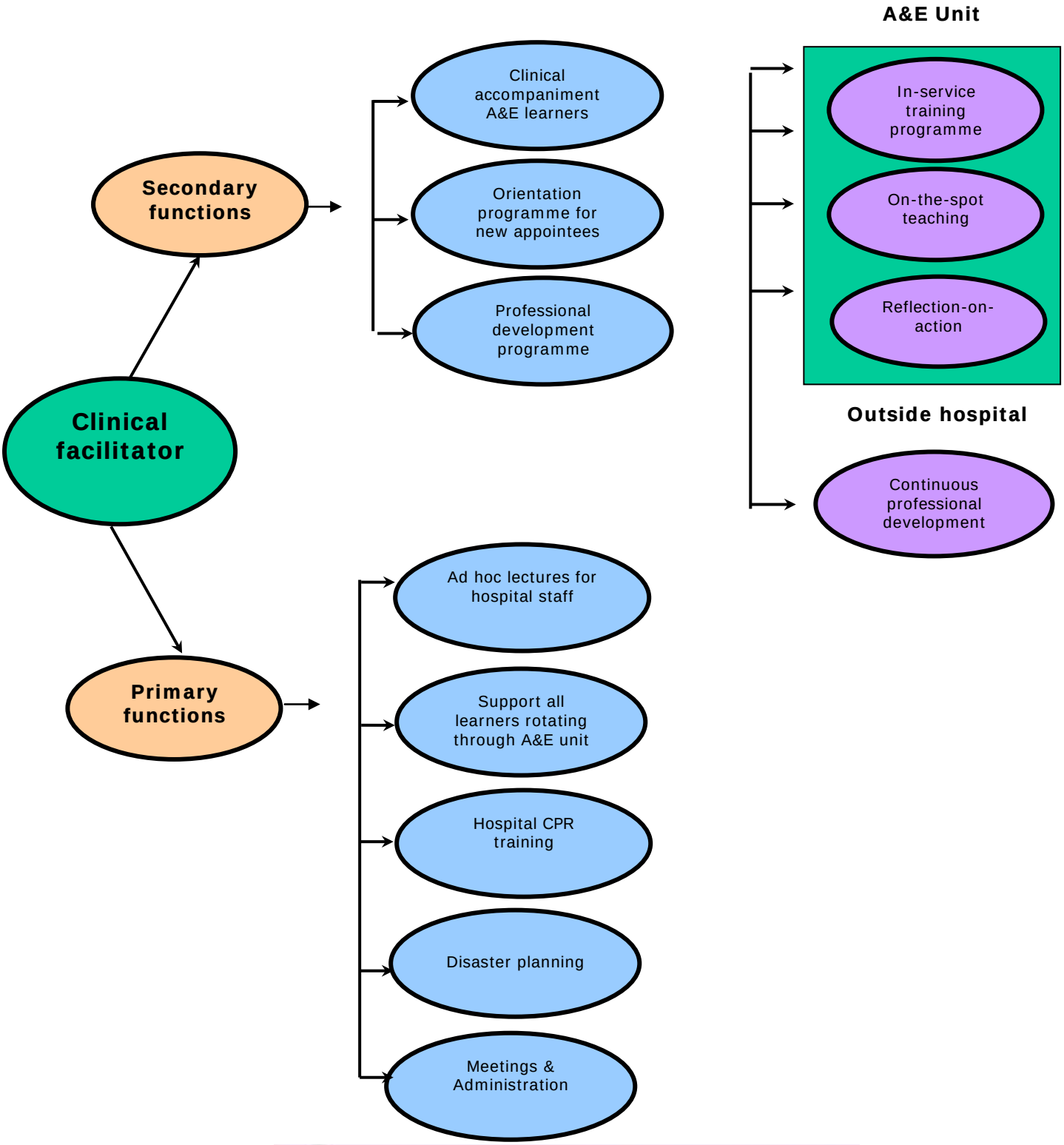
2.4 Research

The fourth function of the clinical facilitator is research. This entails -

- reading relevant research articles that will keep her up to date on evidence-based A&E nursing
- attending congresses that will keep her up to date on new developments in the fields of speciality
- informing nursing staff of new developments in the fields of speciality
- initiating and facilitating research projects

Figure 1 - Schematic representation of job description

Clinical facilitator (A&E unit)



Compiled by: [redacted] **(November 2005)**

A&E programme study guide: week 3

Week 3: Cardiovascular emergencies

Critical outcome

On completion of this unit the learner should be able to –

Delineate the nursing process in the management of a patient with coronary artery disease (CAD) and/or myocardial infarction and/or heart failure and/or cardiogenic shock

Specific outcomes

- Specific emergencies to be discussed in this unit (make use of the given guidelines to prepare) –
  - Angina
  - CAD
  - Acute myocardial infarction (AMI)
  - Congestive heart failure (forward and backward; systolic and diastolic; acute and chronic)
  - Pulmonary oedema
- **Differentiate** between cardiogenic and non-cardiogenic pulmonary oedema.
- **Describe** the age-related aspects one would consider in the emergency environment.
- With regard to the emergency nurse, **explain** the medico-legal aspects that apply to cardiovascular emergencies.
- **Apply** the above knowledge when analysing a case scenario (paper based and real-life scenarios).
- **Describe** the assessment of the cardiovascular system.
- **List** the drugs used in your A&E unit for managing the above-mentioned conditions.
- **Delineate** the nursing process in the management of a patient with any of the above-mentioned conditions.

NB: Give special attention to the ***differential diagnosis*** that can be made in the presence of chest pain.

Learner activities

- **Bring** at least two AMI ECGs to class.
- **Differentiate** between a STEMI and non-STEMI *and* **indicate** the significance of differentiating between them.
- **MONA** – what does this medical acronym stand for and how will it be used in the clinical setting?
- **OPQRST** – this nursing/medical abbreviation is often used when chest pain is evaluated. Do you know what each letter of the alphabet stands for? How can this be used effectively in the clinical setting?
- **Differentiate** between the types of angina (tabulate your answer).
- **Differentiate** between the types of AMI (tabulate your answer).

In-service training programme (2006–2007)				
Theme	**Airway**	**Breathing**	**Circulation**	**Disability, drugs, defibrillation and environmental control**
Month	**April - June**	**July - September**	**October - December**	**January – March**
Topic	**Basic life support** o Oxygen masks and nebulisation therapy • Using the correct mask and determining the correct oxygen flow • Drugs used for nebulisation therapy o Airway manoeuvres (adult and paediatric patient) o Use of and insertion of an oral airway o Cervical spine immobilisation **Advanced life support** o Endotracheal intubation • Assist and prepare for endotracheal intubation • *Perform an endotracheal intubation (manikin/patient) ***Note*** o *All nurse practitioners were involved in the basic life support topics* o *Only the professional nurse practitioners were involved in the advanced life support topics* o *Topics indicated with an * were included in the CPD of the A&E learners*	**Basic life support** o Positioning the dyspnoeic patient • Pulse oximetry • Peak flow measurement o Bag-valve-mask ventilation and applying cricoid pressure • Adult patient • Paediatric patient **Advanced life support** o Ventilation and taking of arterial blood gas (ABG) • *Manipulation of ventilation according to ABG (scenarios)	**Basic life support** o Haemodynamic monitoring (blood pressure, heart rate, respiratory rate, urine output, level of consciousness and blood glucose) • Normal values for adult • Normal values for child o Intravenous access and appropriate fluid therapy **Advanced life support** o Basic analysis of ECG strip o *Analyse ECG strips: life-threatening arrhythmias o *Analyse ECG strips: potentially life-threatening arrhythmias	**Basic life support** o Neurological assessment • AVPU Scale • Glasgow coma scale (GCS) o Automated external defibrillator (AED) • Checking the equipment • Using AED during cardiac arrest **Advanced life support** o Defibrillation and cardioversion • Checking the equipment • *Recognising life-threatening and potentially life-threatening arrhythmias (too fast and too slow, wide and narrow complexes) o Drugs used during cardiac arrest o *External pacing and drugs o *Drugs used during the management of potentially life-threatening arrhythmias

[redacted] Hospital

Accident and Emergency Unit

In-service Training Programme

This is to certify that

_____

has attended in-service training

Topic _____

Presented by _____

_____ _____

Signature Date

A&E unit: Record of on-the-spot teaching

Learner_____

Topics reflected on and discussed

_____ _____ _____ _____

Signature (Facilitator) **Signature (Learner)** **Date** **Time**

Learner_____

Topics reflected on and discussed

_____ _____ _____ _____

Signature (Facilitator) **Signature (Learner)** **Date** **Time**

Learner_____

Topics reflected on and discussed

_____ _____ _____ _____

Signature (Facilitator) **Signature (Learner)** **Date** **Time**

THE HOSPITAL
CARDIOPULMONARY RESUSCITATION (CPR) RECORD TOOL
To be completed by the resuscitation team

Ward:._____

Date:_____

Time cardiac arrest diagnosed:_____

Time CPR started:_____ **Time ended:**_____

Time resuscitation team arrived:_____

Family contacted by:_____ **Time:**_____

Patient Sticker

Clinical assessment and management

Airway	**Type**	**Size Tube**	**Time**	**Type**		**Time**
	Endotracheal intubation			Surgical crich	Yes / No	
	Laryngeal mask			Oropharyngeal airway	Yes / No	
Breathing	**Type**			**Time started**		**Time ended**
	BVM (Synchronised)					
	Manual ventilation (Unsynchronised: 1 every 8 sec)					
Circulation	**Type of line**	**Area**	**Time Inserted**	**Type of line**	**Area**	**Time Inserted**
	Peripheral lines inserted	1.		Other lines	1.	
		2.			2.	
	Intra-osseous line inserted	1.		Central venous line	1.	
	Jugular vein line inserted	1.		Femoral line	1.	
Intravenous fluids	**Crystalloids**	**Colloids**	**Plasma**	**Blood**	**Others**	
	1.	1.	1.	1.	1.	
	2.	2.	2.	2.	2.	
	3.	3.	3.	3.	3.	
	4.	4.	4.	4.	4.	
	5.	5.	5.	5.	5.	
Total						
Manual compressions	Yes / No	Adult / Paeds / Neonatal			Synchronised ratio: _____ : ____	

Defibrillation	Time									
	Rhythm									
	Joules									
Drugs	Adrenaline	Time							**Signature:** Doctor	**Signature:** Professional nurse practitioner
		Dose								
		Route								
	Amiodarone	Time								
		Dose								
		Route								
	Atropine	Time								
		Dose								
		Route								
	Sodium Bicarbonate	Time								
		Dose								
		Route								
	Calcium chloride	Time								
		Dose								
		Route								
		Time								
		Dose								
		Route								

CPR team members

	Name	Signature		Name	Signature
Doctors	1.		**Nurse practitioners**	1.	
	2.			2.	

Comments

Compiled by [redacted]

Team leader / Clinical specialist

(GRADE 7 – 10)

Performance Evaluation Form

Job title	
Primary purpose or role	
Full name and surname	
Persal number (or ID if no Persal number)	
Department	
Directorate / Institution / District	
Date	
Full name & surname of supervisor / Unit manager	
Persal number: Manager/Supervisor	

Performance Dimension

PD1: Locate work in a public service context

Definition

Locate work in a public service context.

People who meet this standard are able to -

- Locate the roles of the GPG and SA government
- Locate the role of their own department in the GPG
- Locate the role of their work team in their department
- Locate the role of their work team and own job in the delivery of department objectives

Performance Dimension

PD2: Plan and organise work to achieve objectives that meet service standards

Definition

Plan and organise work to achieve objectives that meet service standards.

People who meet this standard are able to -

- Plan and organise the work of a work group to achieve objectives
- Ensure that work is on time and up to standard

Performance Dimension

PD3: Lead a team to solve workplace problems and conflict

Definition

Lead a team to solve workplace problems and conflict.

People who meet this standard are able to -

- Apply a structured problem-solving technique to a problem
- Describe a solution
- Implement the solution
- Evaluate the results of any actions taken

Performance Dimension

PD4: Identify performance requirements and improve work team performance

Definition

Identify performance requirements and improve work team performance.

People who meet this standard are able to –

- Analyse work content and identify performance requirements of work roles in a work group
- Use job analysis information to define workplace requirements for job descriptions and person specifications
- Produce selection criteria for recruitment in the work group
- Identify the development needs of individual work group members
- Coach and provide for the formal development of individuals
- Evaluate the effectiveness of development activities (including training) in the performance of work duties

Performance Dimension

PD5: Manage own performance and development

Definition

Manage own performance and development.

People who meet this standard are able to -

- Develop their own work plans
- Contribute to group work plans
- Implement own work plans
- Review their own and the work teams' work plans against service level requirements
- Proactively look for and participate in development opportunities

Performance Dimension

PD6: Communicate in the workplace and work team

Definition

Communicate in the workplace and work team.

People who meet this standard are able to -

- Present a formal written report on a workplace topic
- Hold effective meetings
- Counsel employees
- Report back on task

Performance Dimension

PD7: Lead change in the work team in the workplace

Definition

Lead change in the work team in the workplace

People who meet this standard are able to -

- Anticipate and identify the effects of change in the workplace
- Adapt to the effects of change processes in the context of work
- Review the effects of change processes in the context of work

Performance Dimension

PD8: Produce data and analyse statistics for workplace operations in the department

Definition

Produce data and analyse statistics for workplace operations in the department.

People who meet this standard are able to -

- Measure and monitor workplace performance
- Complete calculations required to analyse and interpret workplace performance
- Present the outputs to different audiences in an easily comprehended form

Performance Dimension

PD9 Deliver and monitor client service

Definition

Deliver and monitor client service.

People who meet this standard are able to -

- Provide services to clients that meet the standards laid down in the department
- Monitor feedback on client satisfaction, with service provision
- Initiate adjustments in team performance, and monitor these, to ensure department service level requirements are met

Performance Dimension

PD10: Secure and allocate resources and draw up a budget to achieve workplace objectives

Definition

Secure and allocate resources and draw up a budget to achieve workplace objectives.

People who meet this standard are able to -

- Secure resources and a budget to achieve workplace objectives
- Allocate resources and a budget to achieve workplace objectives
- Monitor use of resources and replace shortages or deal with discrepancies, as required (note: resources include physical, materials but exclude human resources)

Performance Dimension

PD11: Maintain physical and/or electronic information records

Definition

Maintain physical and/or electronic information records.

People who meet this standard are able to -

- Apply departmental procedures and standards for the storage of physical or electronic information
- Ensure that all members of the work group enter information into and extract information from records efficiently

Performance Dimension

PD12: Use computers and/or equipment to achieve work team objectives

Definition

Use computers and/or equipment to achieve work team objectives.

People who meet this standard are able to use computers and/or equipment efficiently to achieve workplace objectives.

Participation leaflet, informed consent and questionnaire

Questionnaire 1: Nurse practitioners

Dear Colleague

You are invited to participate in the evaluation phase of the research study that has been conducted in the accident and emergency (A&E) unit for the past two years. The information leaflet that follows contains information that will help you understand your role in the final cycle of the research. If there is any information that needs to be clarified, please feel free to contact the researcher at any time.

TITLE OF STUDY

A journey towards emancipatory practice development

1) The nature and purpose of the questionnaire

You are being asked to take part in a research study. Your participation will be as nurse practitioner working in the A&E unit of the [redacted].

In May 2005, the A&E unit was faced with an "emergency situation". Some of you may have been involved in a group session organised in August 2005 in which the challenges experienced in the A&E unit by the nurse practitioners were pinpointed and prioritised. These challenges (in order of priority) were –

- **Priority 1**: Professional development
- **Priority 2**: Patient care
- **Priority 3**: Structure
- **Priority 4**: Equipment
- **Priority 5**: Research

An action plan was planned and implemented in order to resolve these challenges and, after two years, it is time to re-look the relevance and priority of these challenges. The data obtained will be used to amend the action plan if required.

2) Explanation of procedures to be followed

You are asked (as nurse practitioner) to participate in completing a questionnaire which aims to obtain your view as nurse practitioner as to what degree the challenges expressed in August 2005 by your colleagues have been resolved or not.

3) Risk and discomfort involved

There are no risks or discomfort involved in this study for you as the participant.

4) Benefits of the questionnaire

The data obtained will be provided to the unit manager and clinical facilitator to review. These practice leaders will then be able to amend the current action plan in order to address the unresolved challenges as viewed by you as nurse practitioner.

The data will also be used in the research project to evaluate the action plan implemented in the A&E unit.

5) Voluntary participation in and withdrawal from study

Participation in completing the questionnaire is completely voluntary and you as participant can withdraw at any given time without stating a reason.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of South Africa, as well as the [redacted], has granted written approval for this study.

7) Additional information

If you have any questions concerning this questionnaire, you should contact Ms Tanya Heyns at –

- Work telephone: (012) 354-2125
- Cellphone: (083) 287 3929
- Email address: tanya.heyns@up.ac.za

8) Confidentiality

All input obtained from the questionnaire and written comments will be regarded as confidential. Results will be published or presented in such a fashion that you as a participant will remain unidentifiable.

CONSENT TO PARTICIPATE IN THIS STUDY

I understand that my participation in this research is voluntary and that I can refuse to participate or stop at any time without stating a reason. ***The implication of completing the questionnaire is that informed consent has been obtained from me.***

……..

Tanya Heyns

Researcher

Instructions for completing the questionnaire

1. In this questionnaire the abbreviation A&E unit refers to the **Accident and Emergency Unit**.

2. The term **nurse practitioner** refer to all nurses (regardless of the category) working in the A&E unit

3. The term **professional nurse practitioner** refers to registered nurses working in the A&E unit.

4. Answer each question by indicating your chosen option with a cross (✘) in the appropriate box or fill in the information asked for in the space provided. **Remember that your recommendations and suggestions are important**.

5. **PLEASE WRITE CLEARLY, USING CAPITAL LETTERS.**

6. You are welcome to include **comments** at the end of each question.

7. If you require any **assistance** regarding this questionnaire, you are most welcome to contact Ms Tanya Heyns (012) 354-2125 or 083 287 3929.

8. It will take approximately **20 minutes** to complete the questionnaire.

9. The questionnaire consists of the following five (5) sections and you are requested to complete **all** the sections.

Section A – Priority 1: Professional development
Section B – Priority 2: Patient care
Section C – Priority 3: Structure
Section D – Priority 4: Equipment
Section E – Priority 5: Research

Please continue >

QUESTIONNAIRE: Evaluating the challenges experienced in the A&E unit

Section A – Priority 1: Professional development

This section focuses on professional development, which was indicated as the first priority that needed to be addressed in the A&E unit.

By means of the following five-point scale, indicate to which extent you agree or disagree that the items of priority 1 "professional development" have been resolved in the A&E unit.

(1) Strongly disagree (2) Disagree (3) Unsure (4) Agree (5) Strongly agree

Priority 1: Professional development items	**Strongly disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly agree**
An in-service training programme is in place	**1**	**2**	**3**	**4**	**5**
There is multidisciplinary team involvement in the in-service training programme	**1**	**2**	**3**	**4**	**5**
Sponsored Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Paediatric Advanced Life Support (PALS) courses are taking place	**1**	**2**	**3**	**4**	**5**
There is an increased number of professional nurse practitioners specialising in accident and emergency nursing	**1**	**2**	**3**	**4**	**5**
I do get an opportunity to get exposure to other units in this hospital	**1**	**2**	**3**	**4**	**5**
The scarce skills dilemma has been resolved	**1**	**2**	**3**	**4**	**5**
There is continued disrespect amongst the nurse practitioners for one another in the A&E unit	**1**	**2**	**3**	**4**	**5**
There is continued disrespect from the multidisciplinary team members toward the nurse practitioners	**1**	**2**	**3**	**4**	**5**
There is continued disrespect in the A&E unit toward the patients and their families visiting the unit	**1**	**2**	**3**	**4**	**5**
The stock used in the A&E unit is filled up on a regular basis	**1**	**2**	**3**	**4**	**5**
All the different categories of nurse practitioners are working within their scope of practice	**1**	**2**	**3**	**4**	**5**
Nurse practitioners are accepting accountability and responsibility	**1**	**2**	**3**	**4**	**5**
The nurse practitioners are supporting each other in the unit	**1**	**2**	**3**	**4**	**5**

Priority 1: Professional development items *(continued)*	**Strongly disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly agree**
The nurse practitioners are not supported by the multidisciplinary team members	**1**	**2**	**3**	**4**	**5**
The nurses are supported by top management	**1**	**2**	**3**	**4**	**5**
The nurses are supported by the support staff (e.g. porters, security, cleaners, administration clerks)	**1**	**2**	**3**	**4**	**5**
The nurse practitioners are experiencing problems with transporting patients to different hospitals or facilities	**1**	**2**	**3**	**4**	**5**
There is no socialisation between the nurse practitioners	**1**	**2**	**3**	**4**	**5**
There is no socialisation between the nurse practitioners and other multidisciplinary team members	**1**	**2**	**3**	**4**	**5**

Do you have any remarks to add?

Section B – Priority 2: Patient care

This section focuses on patient care, which was indicated as the second priority that needed to be addressed in the A&E unit.

By means of the following five-point scale, indicate to which extent you agree or disagree that the items of priority 2 "patient care" have been resolved in the A&E unit.

(1) Strongly disagree (2) Disagree (3) Unsure (4) Agree (5) Strongly agree

Priority 2: Patient care items	**Strongly disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly agree**
There are an adequate number of permanent nurse practitioners in the A&E unit to ensure optimal patient care	**1**	**2**	**3**	**4**	**5**
Preference to overtime within the unit is not given to permanent nurse practitioners	**1**	**2**	**3**	**4**	**5**
Basic nursing care to patients is not up to standard	**1**	**2**	**3**	**4**	**5**
As nurse practitioners, we show respect to the patients admitted to the A&E unit	**1**	**2**	**3**	**4**	**5**
As nurse practitioners, we show respect to the families of patients admitted to the A&E unit	**1**	**2**	**3**	**4**	**5**
Patient education is provided to all patients	**1**	**2**	**3**	**4**	**5**
Patients' time spent waiting to be seen by the nurse practitioners has decreased	**1**	**2**	**3**	**4**	**5**
Patients' time spent waiting to be seen by the unit's doctors has decreased	**1**	**2**	**3**	**4**	**5**
Patients' time spent waiting to be seen by the specialists has decreased	**1**	**2**	**3**	**4**	**5**
Psychiatric patients are staying in the A&E unit for long periods of time for observation before being transferred to appropriate facilities	**1**	**2**	**3**	**4**	**5**
Pharmacy is available to patients 24 hours a day	**1**	**2**	**3**	**4**	**5**
Patients are able to obtain their prescribed medication 24 hours a day (pharmacy or A&E unit)	**1**	**2**	**3**	**4**	**5**
Do you have any remarks to add?					

Section C – Priority 3: Structure

This section focuses on structure, which was indicated as the third priority that needed to be addressed in the A&E unit.

By means of the following five-point scale, indicate to which extent you agree or disagree that the items of priority 3 "structure" have been resolved in the A&E unit.

(1) Strongly disagree (2) Disagree (3) Unsure (4) Agree (5) Strongly agree

Priority 3: Structure items	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
There are adequate rules in the A&E unit that nurse practitioners should adhere to (e.g. tea time, lunch time)	1	2	3	4	5
There are adequate rules in the A&E unit that the medical students should adhere to	1	2	3	4	5
Protocols are available in the A&E unit to guide nurse practitioners in the management of patients	1	2	3	4	5
Standards are available in the A&E unit to guide nurse practitioners when performing procedures on patients	1	2	3	4	5

Do you have any remarks to add?

Section D – Priority 4: Equipment

This section focuses on equipment, which was indicated as the fourth priority that needed to be addressed in the A&E unit.

By means of the following five-point scale, indicate to which extent you agree or disagree that the items of priority 4 "equipment" have been resolved in the A&E unit.

(1) Strongly disagree (2) Disagree (3) Unsure (4) Agree (5) Strongly agree

Priority 4: Equipment items	**Strongly disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly agree**
There is adequate equipment available in the unit to ensure appropriate patient care	**1**	**2**	**3**	**4**	**5**
The nurse practitioners know how the equipment works	**1**	**2**	**3**	**4**	**5**
The nurse practitioners are not taking care of the equipment	**1**	**2**	**3**	**4**	**5**

Do you have any remarks to add?

Section E – Priority 5: Research

This section focuses on research which was indicated as the fifth priority that needed to be addressed in the A&E unit.

By means of the following five-point scale, indicate to which extent you agree or disagree that the items of priority 5 "research" have been resolved in the A&E unit.

(1) Strongly disagree (2) Disagree (3) Unsure (4) Agree (5) Strongly agree

Priority 5: Research item	**Strongly disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly agree**
The nurse practitioners are informed of the patient statistics on a monthly basis	**1**	**2**	**3**	**4**	**5**
Do you have any remarks to add?					

Thank you for participating and sharing your views with the unit manager, clinical facilitator and myself as researcher. Your input is valued and plays an import role in the final evaluation of the project. It not only increases the validity of the project, but also includes important information that will be used to amend the action plan and create a future for YOU in the A&E unit.

Participation leaflet, informed consent and questionnaire

Questionnaire 2: A&E learners

Dear A&E learner

You are invited to participate in the evaluation phase of the research study that has been conducted in the accident and emergency (A&E) unit for the past two years. The information leaflet that follows contains information that will help you understand your role in the final cycle of the research. If there is any information that needs to be clarified, please feel free to contact the researcher at any time.

TITLE OF STUDY

A journey towards emancipatory practice development

1) The nature and purpose of the questionnaire

You are being asked to take part in a research study. Your participation will be as A&E learner working in the A&E unit of the [redacted].

On 17 May 2005, the nurse practitioners held an emergency meeting in the A&E unit. Amongst other concerns raised at this meeting, the nurse practitioners indicated that the A&E unit was not conducive to learning and did not support the A&E learners who were working in the A&E unit while completing the clinical component of the A&E programme. An action plan was planned, implemented and monitored in order to resolve the emergency situation and challenges experienced by the nurse practitioners.

The purpose of this questionnaire is to obtain your view as A&E learner of the A&E unit as a learning environment as well as of the support you receive while working in the unit.

2) Explanation of procedures to be followed

You are asked (as A&E learner) to complete a questionnaire which aims to obtain your view regarding the degree to which the A&E unit could be regarded as a learning environment and the extent to which you feel supported in the A&E unit.

3) Risk and discomfort involved

There are no risks or discomfort involved in this study for you as the participant.

4) Benefits of the questionnaire

The data obtained will be provided to the unit manager and clinical facilitator to review. These practice leaders will then be able to evaluate the actions implemented to facilitate learning for A&E learners in the A&E unit.

The data will also be used in the research project to evaluate the action plan implemented in the A&E unit.

5) Voluntary participation and withdrawing from study

Participation in the study in terms of completing the questionnaire is completely voluntary and you as participant can withdraw at any given time without stating a reason.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of South Africa, as well as the [redacted], has granted written approval for this study.

7) Additional information

If you have any questions concerning this questionnaire, you should contact Ms Tanya Heyns at –

- Work telephone: (012) 354-2125
- Cellphone: (083) 287-3929
- Email address: tanya.heyns@up.ac.za

8) Confidentiality

All input obtained from the questionnaire and written comments will be regarded as confidential. Results will be published or presented in such a fashion that you as a participant will remain unidentifiable.

CONSENT TO PARTICIPATE IN THIS STUDY

I understand that my participation in this research is voluntary and that I can refuse to participate or stop at any time without stating a reason. ***The implication of completing the questionnaire is that informed consent has been obtained from me.***

……..

Tanya Heyns

Researcher

Instructions for completing the questionnaire

1. In this questionnaire the abbreviation A&E unit refers to the **Accident and Emergency Unit**.

2. The term **professional nurse practitioner** refers to the registered nurses working in the A&E unit.

3. Answer each question by indicating your chosen option with a cross (✘) in the appropriate box or fill in the information asked for in the space provided. **Remember that your recommendations, suggestions and comments are important**.

4. **PLEASE WRITE CLEARLY, USING CAPITAL LETTERS.**

5. You are welcome to include **comments** at the end of each question.

6. If you require any **assistance** regarding this questionnaire, you are most welcome to contact Ms Tanya Heyns (012) 354-2125 or 083 287 3929.

7. It will take approximately **15 minutes** to complete this questionnaire.

8. The questionnaire consists of four (4) questions and you are requested to complete **all** the sections.

A&E unit as learning environment

1. Indicate with an "X" on the following 5-point Likert scale how you perceive the A&E unit as an environment conducive to learning.

Always	Most of the time	Often	Seldom	Never
5	4	3	2	1
Comments:				

2. Indicate to which extent the **clinical facilitator** supported you during the clinical component of the A&E programme.

Always	Most of the time	Often	Seldom	Never
5	4	3	2	1
Comments:				

3. Indicate to which extent the **A&E practitioners** supported you during the clinical component of the A&E programme.

Always	Most of the time	Often	Seldom	Never
5	4	3	2	1
Comments:				

4. Indicate to which extent the **professional nurse practitioners** supported you during the clinical component of the A&E programme.

Always	Most of the time	Often	Seldom	Never
5	4	3	2	1
Comments:				

Thank you for sharing your views with the unit manager, clinical facilitator and myself as researcher. Your input is valued and plays an import role in the final evaluation of the project. It not only increases the validity of the project, but also includes important information that will be used to amend the action plan and create a future for YOU as A&E learner in the A&E unit.

Roadmap towards emancipatory practice development

The rapid changes in the healthcare environment increase the need for nurse practitioners to be motivated, knowledgeable and skilled in order to ensure quality patient care. This cannot be realised in a toxic environment, as dissatisfied nurse practitioners negatively influence the functioning of the entire unit, hospital and care to the community they serve.

Nurse practitioners should work in an enabling environment in which they can be motivated and their skills, knowledge and critical thinking developed with the intention of enhancing innovative and creative ideas to develop their own professional growth and emancipated practice. For this to realise, the following guidelines should be adhered to:

Initiating a journey towards emancipatory practice development

- It is crucial that the nurse practitioners and/or practice leaders working in the toxic environment should **recognise** that they are working in a toxic environment
- The nurse practitioners and/or practice leaders should **initiate** the journey to enhance the ownership thereof
- The nurse practitioners should take the **responsibility** to enlighten middle and top management of the toxic environment they perceive within their clinical setting

The journey

- A **practice development group**, consisting of **willing** practice leaders and/or nurse practitioners, should take the responsibility of driving and facilitating the journey towards emancipatory practice development
- **Explore** and **prioritise** the **challenges** as perceived by the nurse practitioners for the specific context
- The practice development group, in collaboration with the nurse practitioners, should agree on a **shared vision** for the journey
- The **route** towards the shared vision should be planned collaboratively

- The practice development group should use **facilitation** as well as **Socratic questioning**, both formally or informally, to enhance the nurse practitioners' ability to think laterally as well as raising questions about thoughts, feelings and behaviour
- Throughout the journey towards emancipatory practice development, it is important that there should be continuous **observing** and **reflecting** on actions taken
- Based on the observations and reflections **amended action plans** are planned and implemented, giving it the unique characteristics of the action research cyclic process
- The action research cyclic process is **continuous** where empowerment and emancipation are strived for

Evaluating the worth of the journey

- During the planning process, criteria should be developed collaboratively to **evaluate the worth** of the journey
- The development of individuals and teams within an unit enables the delivery of **evidence-based practice**
- The use of emancipatory learning processes can result in changes in the clinical setting, thus changing the environment from a **toxic to an emancipatory environment**