The lived experiences of an advanced practice nurse in a rural New Zealand emergency department.

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A research project presented in partial fulfilment of the requirements for the degree of Master of Nursing.

Waikato Institute of Technology

2009

Abstract.

Advanced practice nursing signifies those roles encompassing a more complex level than traditionally accepted for a registered nurse (Sheer & Wong, 2008). They are distinguished by the autonomy to practice at the edges of the ever-expanding nursing role, grounded in the unique body of knowledge that is nursing. This goes far beyond the provision of complex technical skills to include the art of care. Consequently, advanced practice nursing is concerned with some of the most intimate occasions in human life and is vital for the wellbeing of the community being served.

A qualitative, phenomenological approach informed by van Manen (1997) is utilised to gain a deeper view of such practice. Excerpts from personal reflective exemplars and journal entries as an advanced practice nurse in a rural setting are given to profile emerging dimensions of compassion and caring, and conversation and listening. This process of exploring practice has resulted in a greater depth of insight into the already known facets of care.

Findings from this exploration incorporate the advanced practice nurses' response to complex situations. Recommendations are based on ways of developing recruitment and practice to value relational ability within the rural emergency department.

Acknowledgements

My sincere thanks to:

My family, especially Graeme, who has taken on the support roles of encourager, cook and housekeeper, and my grandson Matt who has not had as much fun time with me as we both would have liked.

My supervisor, Helen Nielsen, for her great skills in pointing me in the correct direction, and never-ending encouragement and support.

This District Health Board, for financial support through the Clinical Training Agency.

Cheryl Atherfold, Associate Director of Nursing, Professional Development Unit, for many years of encouragement, supervision and support.

The Wintec tutors, Patricia, Sallie, and Lesley

The librarians, Carolyn from Wintec, and Janet from the District Health Board.

Attestation of authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person, nor material of which a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements".

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Chapter One.

Introduction.

The art of nursing incorporates intuition grounded in my past experience and knowledge, and the sense of nursing that allows me to reach out to the patient and whanau when they are in a vulnerable and compromised position. For the last fifteen years this experience has been in a rural hospital emergency department, practicing the art of nursing when faced with situations that require the provision of often life altering care and treatment for acutely unwell patients. In tandem with this is my sense of nursing that incorporates the assistance and support that the patient and whanau require, and the in-depth interaction with the multi-disciplinary team.

My interest in writing about my lived experiences has been stimulated while practicing in this role. Excerpts from my exemplars and my personal journal will be utilised as a legitimate research product (Koch, 1998). These excerpts are my interpretations as an advanced practice nurse.

The aim of this research project is to describe and interpret my lived experiences as an advanced practice nurse in a rural emergency department. In this way I hope to contribute to the existing body of nursing knowledge. This research project asks about the lived experiences of an advanced practice nurse in a rural New Zealand emergency department.

Background.

Working in a rural emergency department as an advanced practice nurse has brought to my attention the importance of gaining a deeper understanding of my practice through the interpretation of my lived experiences (van Manen, 1987). This allows more accurate in-depth self-assessment, and assistance to other nurses in their progress towards becoming advanced practice nurses. It also demonstrates the care and compassion that can be offered to patients and their families, an aspect absent from existing frameworks used to measure advanced practice (Benner, 1984; Durie, 1998).

This research project is contextualised in a rural emergency department. Working in this department and living in this community for fifteen years brings much to my pre-understanding. The region includes a population of 36,000 swelling to 100,000 during school holidays and event weekends. There are two State Highways running through the district, three ski fields, adventure tourism activities, two prisons, three mountain ranges, a large lake and widespread rural populations. General Practitioner (GP) services are unavailable over night, and in the next largest centre, there are no GP services after hours.

In this region, the proportion of Maori is approximately 35% compared to 15% nationally (Minister of Health and Associate Minister of Health, (MOH) 2006). Maori under 25 years of age make up approximately half of the total District Health Board population. Maori life expectancy is significantly lower than for non-Maori, and is also lower than life expectancy for Maori throughout the rest of New Zealand (MOH, 2006). Maori are over represented in most negative social statistics such as prison population, unemployment, poor housing, low educational status, chronic disease and reduced length of life (Rochford, 2004). The consequence of these statistics means that emergency department presentations are increasingly Maori, and increasingly unwell, a context that suits the provision of advanced practice nursing.

The vision of a healthy community, and the mission to improve health for all, is a focus in this research project. The Treaty of Waitangi is the founding document of New Zealand Aotearoa. This District Health Board embraces the three principles of the Treaty of Waitangi. In practical terms this means:

Partnership; working together with iwi, hapu, whanau and Maori communities to develop strategies for improving the health status of Maori
Participation; involving Maori at all levels of the sector in planning, development and delivery of health and disability services that are put in place to improve the health status of Maori
Protection; ensuring Maori wellbeing is protected and improved as well as safeguarding Maori cultural concepts values and practices

The environment within which I work on a daily basis sees two registered nurses and one senior medical officer on duty. The base hospital is one hour away by road and the tertiary

hospital is two hours. One nurse is frequently out of the department for three to five hours on transfer. Retrieval team availability from the tertiary facility can take between two and twelve hours. The department does not have any administration staff, dedicated attendant or security staff in the department, and so by default many of these functions are completed by the nursing staff, concurrent to caring for patients and whanau.

Extensive life and nursing experience has developed many facets of my advanced practice nursing. These include the science of nursing that incorporates gaining and interpreting objective data and the consequential understanding of and response to the trends that this data provides (Benner, 1984). Equally important to these objective skills is the inclusion of the art of nursing; the caring and compassionate components (Hartrick Doane & Varcoe, 2005). These have the capacity to have the greatest effect through the betterment of the patient, the whanau and myself (Watson, 1985).

I reflect on situations that have been the most satisfying during the formal and informal reflections involved in self-assessment. I realise the importance to me of the responses patients and families have given, not only to the objective care but also to the subjective care that I deliver.

Technical knowledge constructs and frames the illness experience in terms of specific clinical discourse, such as reliance on objective data and clinically verifiable facts (Holroyd, 2007; Hudson & Marshall, 2008). These technical and complex skills that I bring as an advanced practice nurse are readily visible, but the interpretation of the art of advanced practice nursing are not (Bailey & Tilley, 2002; Benner, 2001). These invisible acts are not charted, yet are the most comforting parts of nursing care for the patient (Benner, 2004) and also for myself.

Advanced practice nursing.

The Health Practitioners Competency Assurance Act came into law in 2003 (Ministry of Health (MOH), 2007). Professional Development Recognition Programme (PDRP) requirements were developed nationally from the New Zealand Nursing Council (NZNC) competencies (2005 & 2007) for continuing competence, and embraced by District Health Boards. The NZNC competency & PDRP domains include professional responsibility,

management of nursing care, interpersonal relationships, and inter-professional health care and quality improvement. My advanced practice nursing position is described by the competencies in the Expert Nurse and Senior Nurse programmes, and my Position Descriptions.

The New Zealand Nurses Organisation Position Statement (2000) defines an expert nurse as having extensive experience, and accepting more delegated medical tasks and technical procedures, allowing a unified and consistent approach in New Zealand. It differs from that of a proficient registered nurse through more advanced practice and a wider sphere of influence, and the application and utilisation of advanced nursing knowledge. Scopes of practice issued by the New Zealand Nursing Council cover nurse assistant, enrolled nurse, registered nurse and nurse practitioner. Advanced practice in roles other than Nurse Practitioner currently sits within the registered nurse scope in the New Zealand context. New Zealand Nursing Council (2009) are currently looking at either extending the scope of the registered nurse, developing a credentialing model with professional organisations, developing individual authorisations, or developing a new scope of practice. These scopes of practice do not take into account the aspect of practice that is important to me, that is the art of nursing.

Evaluation of advanced practice nursing involves assessing clinical skills and using an interpretive approach to describe practice, utilizing the timing, meanings, and intentions of particular situations (Benner, 1984). However, these competencies are primarily associated with objective behavioural outcomes, and do not adequately describe the subjective experiences of those behaviours. Models that place emphasis on clinical experience such as that presented by Benner (1996) are an example of a linear developmental process. Such models do not always take into account the broader understanding of non-clinical experience in the development of nursing expertise (Arbon, 2003). My unique characteristics as an individual practitioner are due in part to my non-clinical experience, my personality and my character (Arbon, 2003).

Outside of competency measures, as an advanced practice nurse I practice within the scope of the Registered Nurse as defined by the NZNC (2005). Advanced practice nursing in a rural New Zealand emergency department adds further dimensions to the context of my practice.

Advanced practice nursing has been used as an umbrella term to signify those roles that describe practice of a more complex level than traditionally accepted for a registered nurse (Sheer & Wong, 2008). In New Zealand there has been some learning from the international experience, resulting in an increased understanding of defined advanced practice roles. Specific roles have been differentiated, including nurse practitioner and clinical nurse specialist (Sheer & Wong, 2008). The first New Zealand Nurse Practitioner Programme received recognition in 2000. The NZNC regulates the title of Nurse Practitioner, and applicants are academically prepared at the Masters level. Clinical Nurse Specialist roles have also developed, but there is no consistency in New Zealand, with the scope of practice being developed by individual District Health Boards. The District Health Board where I am employed clearly outlines a commitment to enhancing patient care and includes progressing nursing in advanced roles.

Development of advanced practice nursing has occurred through the continual evolution of the registered nurse scope of practice, the change from apprentice training to an education institution, the impact of cultural feminism and professional identity, and more recently with the introduction of the Health Practitioners Competency Assurance Act (2003) (Jacobs & Boddy, 2008). These developments have been related to the readiness of individual nurses and the nursing profession itself to advance to a higher level of practice through education and experience (Sheer & Wong, 2008), and the need to provide a responsive, efficient and collaborative means to provide care and services in the current and future environment (Forero & Hillman, 2007).

Advanced practice nursing in New Zealand is distinguished by the autonomy to practice at the edges of the ever-expanding nursing role, and is firmly grounded in the unique body of knowledge that is nursing (Benner, 1984). I utilise scientific theories drawn from nursing and other disciplines, as well as current research to enable the articulation of sound rationale for the selection of my nursing actions. This results in a growing recognition of increased autonomy in decision-making, and patient and whanau management (Elsom & Happell, 2006; Hudson & Marshall, 2008). My role offers a higher level of skill, knowledge and interpretation of experiences resulting in critical analysis, problem solving, accurate decision-making and a deeper understanding of whanau and patient, self and team (Hudson & Marshall, 2008; Sheer & Wong, 2008). Advantages in employing advanced practice nurses are seen by Hudson & Marshall (2008) as improving staff to patient ratio, providing greater

clinical experience, decreased wait times, increased job satisfaction, improved quality of care, increased patient satisfaction, better use of resources, more holistic care, and improved continuity of care.

Emergency nursing has developed considerably over the last decade with increasing use of technology, increasing presentations, and patients presenting with higher acuity conditions. These changes can have an impact on the ability to provide the art of nursing to the emergency department population.

Rurality.

This research project is contextualised within a rural New Zealand emergency department. The need to develop and maintain advanced practice nursing is vitally important for front line practitioners. (Roadside to Bedside, 1999; Ministry of Health Rural Health Policy, 1999). Searle (2008) discusses the shifting professional boundaries of nurse practitioner candidates, particularly in rural and regional areas, identifying that nurses are seen as the most stable and consistent workforce outside of metropolitan areas. Practitioners in rural areas need to have a wider range of skills than their city counterparts to meet community health care needs. Advanced practitioners have a critical effect on the health of the rural population. Lower population densities and less infrastructure result in diseconomies of scale and extra costs associated with goods and services, including health services (Bidwell, 2001).

In my experience, advanced practice nursing in rural emergency departments requires nurses who are multi-faceted and have their practice grounded in nursing, with aspects of their practice that extend beyond their responsibilities. Within this context, nurse leaders and managers see advanced practice nursing as a positive and effective way to address the changing complexity and composition of health care services in order to respond to current health needs (Elsom & Happell, 2006; Roadside to Bedside, 1999). Rural multi-disciplinary health teams need to be flexible, adaptable, multi-skilled and have a sense of belonging to both the team and the community (Grimwood & London, 2003).

The Ministry of Health Rural Health Policy, (1999) advises that once an advanced practice nurse position is appointed, the need to continue professional development remains. This

ensures safety of practice and reduces issues around professional isolation. The "specialist generalist" role (O'Malley & Fearley, 2007) is most suitable for rural advanced practice nurses. This is because the relatively small number of staff need to be able to work across a wide range of clinical functions to cover the needs of patients and whanau presenting to the emergency department. This role in a rural context is part of the lived experiences that will be interpreted from my perspective as I practice in a unique way in response to the health environment in which I am immersed (Siegloff, 2009). This rural population has strong Maori demographics, an understanding of which will provide the context to advanced practice nursing, interpreted through exemplars and personal reflective diaries.

Personal and nursing identity.

Reflexivity is the thoughtful self-aware evaluation of the dynamics between the researched topic and myself. This involves critical self-reflection of how my background, assumptions, positioning and behaviour impact on the research process (Findlay, 2008). It is a two-sided phenomenon, referring to my ability to take responsibility for what I say and, simultaneously, my ability to say something substantial about my advanced nursing practice (Findlay, 2008). In this research project that object of enquiry is myself. Consequently my existing knowledge, values and assumptions are taken into account as part of the research process (Atkinson & Hammersley, 1995; Yin, 1994). Using a self-aware stance enables me to challenge my own assumptions, relationships, and the role I play in nursing. The interpretation of my experiences will be shaped by this reflexivity.

I perceive myself to be a reasonably outgoing person, friendly and accepting of others. I am excited by the diversity in my team, and enjoy working with others to make things happen. I bring openness and realism to my work and personal life. I endeavour to be flexible and honest, valuing empathy and optimism as important aspects of who I am.

Delivering advanced practice nursing requires me to undertake reflection on my own cultural identity and to recognize the impact that my personal, historical, political and social context have on my professional practice (van Manen, 1997). Understanding that there is a difference in everyone else's context in which they exist is a vital component of my cultural safety.

My nursing identity has been shaped by many experiences. My genealogy forms my culture and is part of whom I am, and has been developing from the moment of my birth (Davies, 2005). This included growing up as a daughter in a nuclear family in rural South Island, and becoming a wife, mother and grandmother. It brings an understanding to every situation that I encounter, and offers "the power to grasp one's own possibilities for being-in-the-world" (van Manen, 1997, p180). Interpretation is a product of my situatedness in the world, as a New Zealand European woman, wife, and nurse as I understand the world before I begin to think about it (Holroyd, 2007).

My progress from hospital trained novice to expert and senior nurse (Benner, 1984) has taken many years. Beginning with a role as a junior staff nurse in a general medical ward, through coronary care and intensive care, practice nurse, acute surgical ward, operating theatre and on to emergency department nursing. My background has influenced my current roles as a clinical leader, senior nurse as defined in the PDRP, and expert nurse as defined in the PDRP, and Benner (1984). I strive to continue to develop my empathetic, nurturing and valuing leadership style that encourages staff diversity, growth and development in the delivery of care. I am not a Nurse Practitioner as defined by the NZNC that describes competencies relating to this specific role (NZNC, 2008). However there are many nurses working in advanced practice nursing roles in New Zealand who are not nurse practitioners (NZNC, 2009).

Throughout my nursing career, valuable lessons have been learned while listening to, watching and reading about others' advanced practice nursing experiences, and incorporating many into my practice (Arbon, 2003). Personal and professional experiences in this context have had a profound impact on me as an advanced practice nurse.

Offering compassion and caring in an advanced practice nursing role are vital components in the provision of my nursing care. Being an integral part of an amazing team of nursing provides me with great personal satisfaction. I take a part in role modelling the environmental and human factors that allow for the provision of best nursing practice.

Organization of the project.

This chapter has introduced the idea of the research project and why it is important. Rurality and advanced practice nursing have been defined, and information given around personal and professional experiences that have shaped my nursing identity.

Chapter two contains the theoretical framing, the framework construction, the interpretive concepts used to inform the research project, data collection and justification, data analysis, and ethics.

Chapter three contains the data analysis and findings supported by the literature.

Chapter four contains the significance of the findings, recommendations for practice, and suggestions for ongoing research.

Chapter Two.

Introduction.

Some phenomena such as the art of nursing cannot be measured with quantitative research; consequently this project uses the phenomenological approach. It investigates the way in which I interpret and want to understand my world. For the purpose of this research project, the distinction between description and interpretation is arbitrary. "The meaning of phenomenological description as a method lies in the interpretation" (van Manen, 1997, p.25), and as a consequence I will be interpreting my lived experiences.

Phenomenology offers nurses a way of thinking about their practice that is at once simple and familiar, and yet which brings forth understandings that are often novel and complex. The understandings made possible through phenomenological inquiry help to put meaning into my everyday world of practice and human interaction. Given that nursing is concerned with some of the most intimate occasions in human life, it does not seem surprising that phenomenology, which allows nurses to reflect meaning of their work, should be attractive to

clinicians and researchers alike. “It offers a way to the soul of nursing” (Madjar & Walton, 1999, p.3).

There are many common threads that bind nursing and phenomenology. The views of nursing and phenomenology show that I am a whole being, and that I actively create my own meanings. I am a “subjective being-in-the-world and my life is experienced in a particular context” (Walters, 1994, p.137).

Phenomenology is the study of essences (van Manen, 1997). It allows me to acknowledge the context of experiences that are being described to enhance the development of my nursing knowledge and practice (van Manen, 1997). The term essence is derived from the Greek word *ousia* meaning the inner essential nature of a thing, its characteristic structures or behaviours which define its being (Heidegger, 1962). A good interpretation that constitutes the essence reveals the lived experience in a new way so that it can be understood (van Manen, 1997). As an advanced practice nurse in a rural emergency department I strive to uncover the essence of my lived experiences.

In the course of my nursing work I identify personal and professional experiences that engender strong emotional responses. To explore and analyse these often-painful lived experiences is truly a phenomenological approach. Such research is a way of investigating questions. The method is informed by the question itself, what are the lived experiences of an advanced practice nurse in a rural New Zealand emergency department.

This research project is informed by phenomenology as described by van Manen (1997). Facets of his phenomenological approach that I have found helpful during the life of this project are the writing and rewriting, self-interpretation, the taken for grantedness of everyday life, and the use of journal entries and reflection. Van Manen (1997, p.78) emphasises that “To do human research is to be involved in the crafting of a text” and this supports the approach I am taking of being the participant in this research project.

Writing and reflection has been therapeutic for me, as the interpretation of experiences uncovered deep feelings and layers of meaning in my lived experiences allowing me to see the deeper significance of those experiences (Koch, 1998). My writings are defined by my worldview, and make aspects of my nursing practice visible and valued (Koch, 1998). The

quality of this phenomenological writing allows others as the reader(s) to see the deeper significance of my lived experiences (van Manen, 1997).

Phenomenology allows me to be self-interpreting, and to understand a situation directly, according to the meaning it has for me (Levin, 1999). I attempt to interpret what is already understood, the taken for granted of the everydayness of my practice as an advanced practice nurse in a rural emergency department. The things of the world speak for themselves (van Manen, 1997). In the process of interpreting, I am attuned to the situations that I want to speak about (Fox & Chelsea, 2006).

Method.

Phenomenology endeavours to ward off any predetermined set of fixed procedures, techniques and concepts, but it does have "a way" (van Manen, 1989, p.29). This way is discovered in response to the question and the method maintains a harmony with the interest. While there is no fixed method in phenomenological research, there is "a tradition, a body of knowledge and insights, a history of lives of thinkers and authors….that constitute both a source and a methodological ground" (van Manen, 1997, p.30). I have not used a predetermined set of fixed procedures to govern this research project, but my phenomenological reflection aims to show, clarify or reveal the essential nature of my lived experiences (van Manen, 1997). Writing and reflecting is my method, with the method invented as a response to the way the question is articulated, and the type of debating between the method and the question (van Manen, 1997, p.124). My lived experiences were obtained through experience documented in exemplars and personal journal entries.

Van Manen (1997) introduces six methodological themes that I have utilised as practical approaches to this research project. This utilization is shown in the following ways. I have chosen the topic of advanced practice nursing in a rural emergency department, a topic that I am committed to. I describe and interpret my lived experiences. I engage in phenomenological reflection on the emerging themes, and consult the literature to give insight. I engage in phenomenological writing, using writing and rewriting to develop a rich and true text. I am mindful that no single interpretation of my lived experiences will exhaust the possibilities of yet another captivating and deeper description. I attempt to maintain a strong focus on the phenomenon, to avoid distraction. I balance the research context by

moving between my thoughts, exemplars and personal journal, reflecting on how each part fits in the lived experience of my advanced practice nursing.

Data collection.

Data gathering and analysis are not really separable, and are seen as part of the same process (van Manen, 1997). Data in the form of exemplars and a personal journal describe my reflections that are sources of insight into my lived experiences (Walters, 1994). Writing forced me into the reflective attitude required for phenomenological research (van Manen, 1997; Johns, 2006).

My data collection utilizes practice examples from a variety of relational experiences rather than one specific example. This is to maintain patient and whanau confidentiality in a small community. Values and perspectives that are intrinsic in my personal and therefore professional life will position me in the practice context.

This research project is written in the first person "to enhance the evocative value of a truth experience expressed in this way" and to show that I recognise "that one's own experiences are the possible experiences of others, and also that the experiences of others are the possible experiences of oneself" (van Manen, 1997, p.57). Writing in the first person will consequently position me in this research project.

Thematic analysis.

Lived experience descriptions are appropriate sources for uncovering thematic aspects (van Manen, 1997). Van Manen suggests that there are three approaches to identifying themes. Firstly, the holistic or sententious approach, looking at the text as a whole, to identify a sententious phrase that captures the fundamental meaning. Secondly, the selective or highlighting approach by re-reading the text several times to identify a statement or phrase that seems particularly revealing about the experience. Thirdly, the detailed line-by-line approach where each sentence and paragraph is examined for the meaning they hold about the experience. In this research project I have used the first two approaches.

Data analysis.

Excerpts from my exemplars and personal journal are provided, allowing more self-reflection to interpret the lived experiences (Johns, 2006; Koch, 1998; van Manen, 1997). The literature will be searched to support the themes.

The themes will be examined, articulated, re-interpreted, omitted, added or re-formulated as the writing and re-writing proceeds (van Manen, 1997). My lived experiences in the identified themes will be interpreted to constitute the immense complexity of my lifeworld (van Manen, 1997).

Ethical considerations.

This is an ethical project, in that the body of knowledge gained in this context is critiqued, and needs to be respected and acknowledged (Atkin, 2008). The interpretation of advanced practice nursing in a rural emergency department in this research project has been developed from my personal and professional experiences.

Validity is achieved through description and explanation, and whether or not the explanation fits the description, "is the explanation credible?" (Denzin & Lincoln, 2000, p.393). I have had a prolonged engagement with the data, and taken part in peer debriefing through presentations to the group, with feedback being incorporated. Supervision has been an ongoing process throughout the life of the project. I have met monthly with my supervisor who was appointed during the course of this research project. I have also met twice monthly with my supervisor within the District Health Board where I am employed.

Confidentiality will be maintained throughout, with data collection utilizing practice examples from a variety of relational experiences rather than one specific example. Details have been anonymised to assist in maintaining confidentiality in a small rural community. Although I have taken these measures to maintain confidentiality, there is always the possibility that somebody could recognise a patient.

Being a culturally safe practitioner requires self-awareness as a pre-requisite, and understanding that there is a difference amongst people (Ramsden, 2005). Delivering advanced practice nursing care, and in relation to this project, requires that I continue to undertake reflection on my own cultural identity and to recognize the impact that my personal historical, political and social processes have on my professional practice. Understanding and accepting that there is a difference in everyone's emotional, social, economic and political context in which people exist is a vital component of my cultural safety.

Assisting in the development of my context and informing this project, I have endeavoured to incorporate Maori concepts appropriately. These include: Mana (self esteem) is a Maori concept that is developed through a relationship with the Te reo (tribal language), Te whanau (extended family), Te wairua (spirit), Te whenua (the land), Te hinengaro (emotions and thoughts) and Te tinana (the physical being) (Durie, 1998). Mana cannot be claimed by an individual, but is bestowed by others (Bolstad, 2004; McKinney & Smith, 2005). Maori are the indigenous peoples of New Zealand. However, their voices have often been subsumed within the dominant group. This has resulted in Maori being further marginalised, oppressed and disempowered (Johnson, 1998).

To make this research project ethical, it needs to be truthful and reasonable, and allows readers to draw their own conclusions. Trustworthiness is addressed through reliability and believability (Priest, 2002). Believability is important in this research project as I am interpreting my own experiences (Denzin & Lincoln, 2000). Ethical integrity of the research project is maintained through researcher reflexivity (Koch, 1998). All experiences described in this research project are real examples of my own practice and are further informed by reflection and reflexivity (Johns, 2006; Koch, 1998).

The aim of this research project is to gain an understanding of my lived experiences of an advanced practice nurse in a rural New Zealand emergency department. It has the potential to bring about beneficial change in an area of nursing that is difficult to quantify. Articulating these invisible arts will bring them forward for discussion and renewal, and encourage others through education and motivation (Benner, 2004; Johns, 2006; Lindsay, 2003).

This chapter has discussed the choice of phenomenology informed by van Manen (1997) for the research project; methods of data collection and analysis; situating myself in the project, and ethical considerations.

Chapter three will profile the data as examples from my practice and reflective journal. These examples will be explored in themes and supported by literature to further understand their meaning.

Chapter Three.

Introduction.

Advanced practice nurses in a rural emergency department are vital for the health of the community they service. This chapter presents the findings and data analysis of the lived experiences of an advanced practice nurse in a rural New Zealand emergency department.

Relational concepts in nursing have been consolidated by descriptions of mutuality, narrative, relationship and caring (Larkin, de Casterle & Schotsman, 2008; Hartrick Doane & Varcoe, 2005). They offer me a meaningful way to interpret my nursing practice. Relational commitment is a basic principle of a relational ethic. I utilise the dimensions of engagement (requires a dialogue that enables rational and emotional aspects of peoples lives to be visible) mutual respect (that acknowledges individuality and difference enabling a broad understanding of culture and language), embodiment (reflects the connection between people so that interactions are meaningful) and environment (encapsulates the breadth of a relationship by seeking to understand relations) (Larkin, de Casterle & Schotsmans, 2008; Hartrick Doane & Varcoe, 2005).

I immersed myself in the data by reading and re-reading the exemplars and personal journal using a holistic approach. From this emerged frequently occurring thoughts and sententious phrases involving care and compassion, and listening and conversation. These themes link strongly to those of relational concepts and the interpretation of the heart / art of my practice.

Themes.

In this research project I have used the selective and detailed approaches as described by van Manen (1997), to identify and discuss the two main themes emerging in the data from my exemplars and personal journal. I selected the text that kept recurring in my thoughts as the themes emerged. These are compassion and caring, and conversation and listening. In analysing these themes, I utilised the literature to be able to come to a better understanding of the deeper meaning of my lived experiences, and to become more experienced myself (van Manen, 1997). There is some overlapping content in the themes as they are complementary in nature. Excerpts that are presented in italics are taken from several personal exemplars and my reflective journal. These excerpts cover a variety of practice situations and enable the reader to have insight in order to gain understanding about what I am describing and interpreting.

I address the phenomenological meanings of the themes of compassion and caring, listening and conversation, prior to examining the literature so that it is easier to write about my understandings (van Manen, 1997). The purpose of reviewing relevant literature during the development of this project is to place it within the context of existing knowledge. Insights that have been gathered by others on the themes of compassion and caring, and listening and conversation are captured and critically analysed and integrated where appropriate to allow me to get a better grasp on my lived experiences (Booth, Colomb & Williams, 1995; Denscombe, 2003; van Manen, 1997; van Manen, 2002, Koch, 1998). My personal reflections are the sources of insight into my lived experiences relating to those themes (van Manen, 1990), and make aspects of them reflectively understandable and intelligible (van Manen, 1997; Johns, 2006; Koch, 1998).

It is not possible to separate out the technical and compassionate aspects of advanced practice nursing, so excerpts from my exemplar and personal journal will acknowledge my technical skills while at the same time looking at my lived experiences within the themes. "In the human encounter everything is unique; although seemingly familiar nothing is certain. The moment is always a mystery. Hence reflection is the exploration of uncertainty and narrative

the revelation of mystery" (Johns, 2006, p.ix). Previous understanding cannot be eliminated; consequently I endeavour to be as aware as possible of that, and account for my personal interpretive influences (Davies, 2005).

The theme of compassion and caring

Compassion is described by Wilde, (2000), Bond, Mandleco & Warnick, (2004) as a deep recognition of the connection that exists between ourselves and others—that their suffering is our own, and to suffer with, in patient care, experiences and nursing practice. Caring is described as being connected by fusing thought, feeling and action, knowing and being (Benner, 2003). This notion of caring and compassion occurred frequently throughout my interpretive journey.

Inseparable from the technical aspects of my own practice is being caring and compassionate, which suggests that my nursing is not so much a kind of doing as a kind of being; being present in a moment of crisis and need; a kind of being there (Benner, 1996; Benner, 2003; Mooney, 2009). By staying close in this way I can offer a supportive relationship (van Manen, 2002).

I was faced with an acute situation today where I needed to develop that initial relationship to reduce anxiety in the patient and family whilst concurrently performing vital assessments and interventions, where minutes are vital.

The word 'presence' is of Latin and French origin. It derives from the words praesen from prae, meaning in front, and sens, meaning being. The same word as a verb, praesentare, means to place before, to hold out, to offer, from which the nouns gift and present evolved. I define my nursing presence as an intersubjective encounter between myself and a patient and their whanau who are unique human beings in a unique situation (Benner, 2004; Doona, Haggerty & Chase, 1997; Finfgeld-Connett, 2006; Melnechenko, 2007). I am there, and I offer to be with them. It is the nature of my contact, and the *nearness of the grandmother in a child's resuscitation* that reveals presence and caring (Finfgeld-Connett; Melnechenko; Leight, 2002; van Manen, 1997). To be authentically present to a patient and their whanau, I maintain an open stance, recognising that I do not know the patient or their subjective world

(Madjar & Walton, 1999). For me, an open stance is represented by my posture, by not looking busy or sidetracked, and being interested and encouraging.

The grandmother was the first relative to come into the resuscitation room where her young grandchild was being resuscitated. She was guided to the head of the bed where I was giving ventilatory support to the child. I put my arm around her for support.

My presence in acute situations appears to be supportive to the team patients and whanau. I feel this is so as I am often the first person the team contacts in high acuity emergencies, bringing leadership, support and confidence. When I enter the room, I notice the sigh or look of relief as people look to me for guidance and direction. Within my leadership I bring my clinical expertise and caring to the situation (Benner, 1984).

My phone rang today, a baby with a respiratory arrest. As I headed to resus, my first thoughts were asthma? Drowning? On arrival I went to the head of the bed, taking over ventilation from the resuscitation leader so she could function more effectively in her role. A great position for me to be able to see, hear and feel all that is happening, and respond accordingly.

As well as the leadership of the team I am aware that as New Zealand is a bicultural nation, I have the privilege of walking alongside Maori as they incorporate spiritual values and ceremonies in their everyday culture. Being able to practice in this bi-cultural context gives me permission to be myself. I express my own spiritual nature as a nurse, and see deeper meaning in my work through caring and compassion (Benner, 2003; Durie, 1998; Tarlier, 2004; Youngson, 2009).

I encouraged the Maori family to reach out and touch their loved one, to feel they were with the critically ill person, and an important part of the care offered.

Touch is the contact of one human being with another, the different type of touch that has a unique experiential quality for the recipient. Touch is an action that I use every day as long as that touch is accepted (Benner, 2004; Hawley, 2009; Leight, 2002; Yonge 2009). This kind of contact with another person is an important source of comfort and reassurance not only for the patient or family, but also for myself (Benner, 2004). My hand touches the body of a

living person. This caring hand is guided by my knowledge of a sensitive kind, a knowledge that has as its end thoughtful, caring action (Hawley & Jensen, 2007; van Manen, 1989). My touch conveys confidence, support and comfort, and an understanding of another's pain, It conveys my nearness to the other person, and the caring that I reveal with my skilful touch that is guided by my technical knowledge of nursing (Benner 1984; Hawley & Jensen, 2007; Hawley, 2009; van Manen, 1989).

I encouraged grandma to touch her grandchild, and to speak to him. She stroked his arm and spoke to him for much of the rest of his time in our department.

By acknowledging the emotional and spiritual lives of patients, families and the multi-disciplinary team I have the sense of becoming more humane and compassionate. I know that this was a part of my practice before, but this insight has enabled me to be more conscious of what I bring in these moments confirming that caring and compassion are integral parts of my practice (Youngson, 2009).

It is always more difficult when children are involved. Aside from the whanau, I know the staff were upset today, as was I. We took time out to be together, to engage and respect each other's feelings. Our connections with this child and in fact all children were apparent. Being in the emergency department team is what I love, enjoy and value. This aspect of being connected in what can be a celebration or grieving of life is intuitive and comes from the trust we have in each other.

I build trust in an intuitive way by consciously attending to what is happening for each team member, how I respond to their individual needs, and their responsiveness to me. That is the foundation for shared meaning and the unwavering intention for healing or the inevitable ending of life. I take care to mean well, and with an open heart I ask how I can help, or show that I am willing to help, I find that these small acts of care and compassion may surprise patients and their family. I often see this through non-verbal indicators, such as a thankful glance or a sense of relief of the pressure and burden. This enhances the quality of our relationship (Taylor, 2000; Youngson, 2009).

Sometimes the family need me more than the patient does, to provide a listening ear, hold their hand, and acknowledge what they are going through.

As a nurse, I often find myself in the position of feeling emotionally involved when bad news is given to patients or whanau. I am not able to limit or regulate this emotional caring stance in my nursing, and neither would I wish to. It is embedded in my personal cultural meanings and commitments (Patterson & Zderad, 1976; van Manen, 1997). My acts of caring cannot be controlled but may be understood through my writing.

It's not too often that I verge on loosing control, but today, I was really upset when it looked like this baby was going to die. Tears appeared, and I held my breath to keep the sob hidden, when the healing hand of our Maori Health team member was placed on my arm. I was so grateful, she was saying through her touch that she was there, that she heard me.

It was believed for many years that it was important for nurses to remain emotionally detached from their patients, to ensure professional practice could be carried out successfully, and to prevent burn-out. However, recent research has shown the opposite to be true (Hartrick Doane & Varcoe, 2005; Titchen, 2003; Yonge 2009). Caring can be defined and recognized as a unique scientific quality that is realized, understood and accepted within professional nursing (Cronqvist, Theorell, Burns & Lutzen, 2004; Tarlier, 2004; Taylor, 2000).

Today a patient with acute coronary syndrome was near death, not responding to treatment. The shocked whanau was told there was nothing more that could be done for him medically. I held his hand as the news was conveyed. As usual, I shed a few tears; the caring that is my nursing is heartfelt for me.

I show through my body language, actions and words that 'I am here, I hear you'. My words arise from the sharing of a feeling, a seeing and feeling with the other. The concern is visible in my eyes and conveys warmth in both verbal and body language to the patient and the whanau, who often say or show how they appreciate my being there, often at their most private moments (Notting, 1984; Yonge, 2009).

It continually amazes me when I show I am there for patients and families, what a privilege it is to have them share their private lives with me. Being with them.

In 1974 van den Berg wrote that familiar words are comforting to many, and possess a special tone and rhythm; however it is not those comforting words in themselves that are important, but rather, what I am revealing through those words. Today in my own practice, thirty-five years later, little has changed. Compassion and caring as discussed remain an integral part of my practice, as are conversation and listening, which are discussed next.

The theme of listening and conversation.

Listening and conversing are integral components of my nursing practice. Listening is making an effort to hear something, to hear what is said while paying attention. Conversation is the communication of thoughts between two or more people. As a nurse I utilise these social processes to develop rapport with patients and whanau during stressful and crisis situations. This reflects the everyday situations in which my nursing occurs. I make a difference to patient outcomes by showing care and providing emotional support, through the use of listening in an engaged and empathetic way (Madjar & Walton, 1999).

Grandma arrived in the room accompanied by the manager, explaining that I would be able to help her understand what was happening. Grandma came up to the bed beside me. I moved my monitoring equipment into a place that would enable me to see Grandma, while maintaining a watch on the vital signs monitor. It was important to me to communicate effectively with Grandma who obviously cared deeply for this baby. I explained to Grandma what we were doing and why, supporting her, and seeing that she understood.

Listening is something that I enter into, emerging from my occupation with others, and with their meanings. Listening has much in common with "attention." As described by Hawley (2009), attention is the manner in which I relate myself to people on the basis of the meaning they have for me. Attention is a form of 'pregnant' contact, something that I am expecting or anticipating from the contact. I can never separate attention from being occupied with the things and from the meaning within my field of action. So it still is with listening today (Hawley, 2009).

Today's experience was very special as Grandma confided her inner most thoughts to me.

My ability to understand encounters with others is directed by the fusion of my own life world and the unfamiliar life world of the other person (Holroyd, 2007; van Manen, 1997). I am reflective, insightful and sensitive to language to ensure that I am open to experiences in an unbiased a manner as possible. I listen through being physically and emotionally present allowing patients and families to express themselves in their way (Cornwell & Goodrich, 2009; Titchen, 2003). Within a short space of time there was another similar case recorded in my reflective journal.

Another case of child abuse today. Members of the whanau needed to talk about their suspicions, and I needed to listen in a non-judgemental way, giving the best possible care to the child.

As I talk with other nurses I share my experiences, using stories that show the art of my nursing. In this way we share, laugh, cry and support each other, as we in turn support patients and whanau (Bond, Mandleco & Warnick, 2004).

Today's informal debrief at the end of the shift allowed me time to discuss with the others what had happened for me, and how I felt about it. Hearing their stories of the event helped me put my own feelings and actions in context.

I listen with my ears and mind and body because listening is an activity of all of my senses, attuned to the text, tone and mannerisms of the conversation, the talker and the context. I also listen with my eyes, my touch, my stomach, and my body, bringing the collected weight of my experience to emerging understandings (Davis, 2008; Hartrick Doane & Varcoe, 2005). This involves using my eyes for observation to verify the truth of the conversation, and to show that I am listening and taking an active part in the conversation. My touch involves the provision of a physical link with the person to convey that I am here for you, and my body feels the stress involved through tension. For me, listening is a human endeavour that evokes physical and emotional responses in me. As Merleau-Ponty (1962, p.234) suggests, "I echo the vibration of the sound with my whole sensory being".

Ron (pseudonym), an elderly gentleman, was in the department visiting his wife today. When their daughter arrived, Ron and I went to the whanau room. He seemed desperate for a talk. I sat with him, just waiting for a couple of minutes, then out it all came.

I show my openness, my receptivity, and my availability to engage in a genuine encounter. I do this by responding at the moment it is apparent during my presence as described in compassion and caring, when the need is revealed even though it is not verbal my response is with open posture and an undistracted focus despite all that I am aware of that is happening in the emergency department. This indication of availability implies my being at the patient's disposal and being with them with the whole of myself. I experience this through physical, emotional, spiritual and family dimensions. As with compassion and caring I also reveal myself as being fully "present" through a glance, a touch, or a tone of voice (Benner, 2004; Doona, Haggerty & Chase, 1997; Finfgeld-Connett, 2006; Melnechenko, 2007). In-attention or lack of focused listening can communicate that I am not listening or participating in the conversation, where as a commitment to being present protects against this (Benner, 2004; Doona, Haggerty & Chase 1997; Finfgeld-Connett, 2006; Melnechenko, 2007). These non-verbal indications are communicated by me to Ron, and from Ron to me, the direct and unmistakable revealing of that glance, touch, tone of voice, involves reciprocity. This availability extends to the whanau as an extension of the patient (Durie, 1998).

Involving whanau and the Kaumatua in the planning of Ron's wife's care made a huge difference to everyone today. They were so grateful to be an important part of the care. Whanau are vitally important in the care of a patient, and I could feel the difference it made.

Gadamer, Weinsheimer & Marshall's (2000) formulation describes the conversation as a triad involving me, the speaker and the topic or subject matter. The subject matter exists only in the conversation - neither in them nor in me, but between us, and we are conducted by it. Through the conversation I attempt to incorporate the insights of the speaker, moving toward a consensus or "fusing of horizons" (p. 387). This allows me to gain a better understanding of that person and their world (Virani & Sofer, 2003; Youngson, 2008). And so the communicative relationship is an intimate one. Real listening is very personal and takes me as a nurse into a somewhat intimate place in peoples lives where we are walking with them,

standing with them, for this part of their journey. An idea echoed by Merleau-Ponty (1962) suggests that human interaction involves a merging or intercorporeality: [As I listen to another, my body] "Discovers in that other body a miraculous prolongation of my intentions, a familiar way of dealing with the world. Henceforth, as the parts of my body together comprise a system, so my body and the other person's are one whole, two sides of one and the same phenomenon, and the anonymous existence of which my body is the ever-renewed trace henceforth inhabits both bodies simultaneously" (Merleau-Ponty, 1962, p.354). This intercorporeality is seen as a merging or interweaving of between myself and the other person. The way we relate and respond to each other involves two sides of the one phenomenon. As I listen to that another person, I sense that our intentions are similar.

Consequently I am joined in the conversation with that person, a theme that is common in Merleau-Ponty's writings (1962). I am sensitive of the behaviour and undertones while listening, and in the conversation, and perceive, observe, hear and sense that person, using the gained knowledge to further the conversation. I become capable of greater insight and deeper understanding, capable even of cutting beneath the conscious intent of the speaker (Glass & Cluxton, 2004; Merleau-Ponty, 1962). A goal of my conversation is to deepen my understanding of the other person, and interpreting the notion that has stimulated it (van Manen, 1990). The key to my sense making, which enables the interpretation, is my ability to listen. Levin (1989) describes being sensitive to the subtle undertones of language is a true listener. I feel able to listen and converse, because I can help make a difference. However I am conscious of being the one that a patient or whanau member has chosen to speak to or converse with, and I feel privileged. An overwhelming sense I have is that of the responsibility to carry the information, concerns and perspective with integrity.

End of life conversations are an example of those that can be hard to have, but very rewarding for everyone involved if the listening and conversation consists of effective communication. (Cornwell & Goodrich, 2009; Larson & Tobin, 2000).

A patient was dying when I arrived at work. He was restless, and the whanau seemed unaware of what was happening. I held his hand and spoke to him and the whanau about what was happening. I gave charted analgesia, answered many questions, and gave the whanau time to decide how to manage the situation. The patient was transferred to the ward, and it was rewarding to see the way the

whanau was able to support each other when they had the full information, and the patient much more settled.

Hermeneutic phenomenology requires an ability to be reflective, insightful, sensitive to language, and constantly open to experience in as unbiased manner as possible. No one can quite see and feel like someone else does, it is through the collectivity of language that some understanding can happen (van Manen, 1997). It is the art of my being sensitive to the subtle undertones of language. When I use patient centred communication I am able to enhance the patient experience (McCabe, 2004).

This chapter has profiled data from my practice exemplars and reflective journal, bringing further understanding through application of the literature. The identified themes of compassion and caring, listening and conversation have been developed and supported by the literature.

Chapter four will make recommendations for practice from the project, and draw conclusions.

Chapter Four.

This chapter draws together significant findings and proposes recommendations from the study that can be used to positively impact practice within the rural emergency department setting.

Utilizing a phenomenological approach that has been informed by van Manen (1997) has allowed me to investigate the way in which I interpret and understand my world, and help put meaning in my everyday life. It has allowed me to study the essence of my practice. However, the phenomenological approach has also bought to the fore some strong emotional responses as I examined my exemplars and reflective journal. This has resulted in personal growth.

A basic tenet of advanced practice nursing is cultural sensitivity. This required an understanding of historical events, my personal history, and personal self-awareness. The face-to-face communication that occurs in the rural emergency department offers the opportunity to integrate the requirements of the Treaty of Waitangi into nursing care.

The research project has highlighted the relational aspects of advanced practice nursing and their contribution made to a busy and challenging work environment. Compassion and caring, conversation and listening are the corner stones of this relational contribution. They weave together the overtly expert clinical tasks and the less visible intuitive communications to positively impact on my clinical judgement and application of care. In examining and analysing my reflective exemplars and journal against the literature I am sometimes overwhelmed by the value that a simple touch or a caring approach brings to the patient and whanau in a difficult moment. During the process of developing this research project I have often needed to take time to feel the impact of the associated emotions. The subsequent task of articulating this into the project has been challenging and I would note that my ability as a novice researcher has been in conflict at times with my experience as an advanced practice nurse.

The relational aspects included in the art of my advanced practice nursing have bought beneficial change in an area of nursing that is difficult to quantify. Articulating these invisible arts has brought them forward for discussion and renewal, and enabled me to encourage others through education, support and motivation (Benner, 2004; Johns, 2006; Lindsay, 2003). There is potential to bring increased benefits to both the emergency department population, the staff and the District Health Board. Recommendations from the project link to the two themes that emerged: compassion and caring, conversation and listening. They apply directly to my own practice environment however they also apply to all other nursing contexts. As a consequence of this project, the following recommendations are made, and are reflective of the outcomes.

The first recommendation is to apply recruitment processes that capture relational ability and team fit as priorities in employment. This can be achieved by utilizing the tools associated with behavioural interviewing. It is perceived to be considerably easier to teach staff clinical skills than it is to teach them to be relational, so attention to this would strengthen the value and application within practice.

The second recommendation is that relational aspects of practice are profiled and incorporated as valuable within practice development. This occurs informally but consciousness raising around these aspects can be intentionally facilitated using both informal and structured reflection in our department (Titchen, 2003; Johns, 2006).

The third recommendation is to further equip staff who are already identified with relational ability, with the facilitation skills required to enable them to impart these to others.

The fourth recommendation is highlighting the important aspects of relational practice within existing structures such as the Nursing Council, College of Emergency Nurses, New Zealand Nurses Organization, and Rural Nurses Network will allow an equal focus on caring and compassion, conversation and listening, with the more overtly clinical focus that will support solutions to other rural health care barriers.

In conclusion, this research project has been one of discovery and development of a greater level of self-awareness regarding the value of compassion and caring, and conversation and listening as cornerstones of my advanced practice nursing. The application of these attributes and the associated skills of communication and facilitation are included as hallmarks of my advanced practice nursing.

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