QUALITY NURSING CARE: AN EXPLORATION OF STUDENT NURSES' PERSPECTIVES

A DISSERTATION

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BY

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Date

To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a dissertation written by Robin A. Caldwell entitled "Quality Nursing Care: An Exploration of Student Nurses' Perspectives." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Health Education.

Eva D Doyle
Dr. Eva Doyle, Major Professor

We have read this dissertation
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Accepted: Leslie M Thompson
Associate Vice President for Research
and Dean of the Graduate School

DEDICATION

I dedicate this research to my two sons. I know that they are proud of my accomplishments. However, without their unwavering love, patience, and support, I would not have been able to complete this work.

To Kent and Krist: "You are my heroes and the wind beneath my wings."

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ABSTRACT

COMPLETED RESEARCH IN HEALTH SCIENCES
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The purpose of this qualitative study was to explore and describe the delivery of nursing care from the perspective of associate degree nursing (ADN) students. Actions and interactions attributed to quality care were explored as well as factors that enhance or inhibit the delivery of such care. Moreover, nursing students' perceptions of the significance of patient education as well as how they incorporate teaching into their practice were explored. A total of 26 students from a North Texas college Associate Degree Nursing (ADN) program volunteered to participate in this research study. All students participated in focus group discussions.

The premise for this research was the assumption that insights into students' perceptions can be gained from accounts of their lived experiences. Students provided significant insights into their experiences and the context of their responses was always considered.

Three separate focus groups were held in February 2000 at the hospital clinical facilities. Participants' perceptions of quality care and patient education were obtained through the use of focus groups. HyperResearch was used for data analysis. Qualitative analysis of focus group discussions revealed that quality nursing care was perceived to

relate to the degree to which patients' physical, psychosocial, spiritual, emotional, psychological, and educational needs were met. The consequences of quality care were interpreted as therapeutic effectiveness where the therapy provided by nurses was perceived to positively affect patient healing. This was gauged by the patients' psychosocial and physical response to illness, safety, and satisfaction. Quality care was facilitated by the development of positive relationships between students and staff nurses, competent practices, as well as a functional nursing team.

The problem of student nurses' inability to consistently provide quality care to all patients was identified. Insufficient time and nonsupport from nursing staff were perceived to be the major barriers to the delivery of quality care. Dissatisfaction and stress in student nurses was related to this problem. Moreover, concern was expressed that students were not being adequately prepared to successfully transition from the student role to the professional registered nurse (RN) role. Participants in this study recognized that nursing is facing the demand to produce a professional with abilities to function in the contemporary healthcare system. However, the frustration expressed by participants in this study as a result of unkind treatment by nursing colleagues and perceived deficiencies in their education raises serious concerns. Implications for nursing practice, education, and management are discussed, and directions for further research are provided.

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CHAPTER 1: INTRODUCTION

Quality care is a priority for health professionals as well as a topic central to nursing practice (Kozier, Erb, & Blais, 1992). Formal definitions of quality care are numerous as are approaches to measure this complex clinical phenomenon. Many health professionals consider patient outcomes to be the most valid indicators of quality care (Dansky & Brannon, 1996; Naylor, Munroe, & Brooten, 1991). Outcomes are the end results of care and focus directly on patients' health status, welfare, and satisfaction. (Kozier et al., 1992; Naylor et al., 1991).Nursing care has been associated with positive patient outcomes including increases in patients' knowledge, positive attitudes, recovery behavior, and satisfaction with care. (Joel, 1997; Miche, Ridout, & Johnston, 1996).

Nurses in the United States and abroad are challenged to maintain and improve quality care in the face of changing work patterns. The current healthcare environment has left many nurses frustrated at their reduced ability to consistently deliver quality care to all patients. Insufficient time due to lack of human and physical resources has often been identified as the greatest barrier to the delivery of quality care. Stress and dissatisfaction among nurses and threats to patient safety have become issues of concern (Lynn & McMillen, 1999; Ventura, 1999; Williams, 1998; Wolfe, 1999). Evidence exists that newly graduated nurses struggle the most with the problem of insufficient time and as a result are often the most vulnerable to feelings of frustration and stress (Williams, 1998). Furthermore, various studies indicate that nurses tend to cut short patient

education when time is restricted (Shindaul-Rothschild, Berry, & Middleton, 1996; Ventura, 1999; Wolfe, 1999). This is alarming because patient education is considered an integral component of qualtity care and vital to the nursing role (Babcock & Miller, 1993; Dansky & Brannon, 1996; Harrington, Smith & Spratt, 1996; Kozier et al., 1992; Lauer, Murphy, & Powers, 1982; Phillips & Heckelman, 1983; Pender, 1987). Effective education informs and empowers patients. An important predictor of patients' perceptions of overall quality is satisfaction with health education provided by nurses (Kozier et al., 1992; Lauer et al., 1982 Mahat, 1998; Mayer, 1987).

The indication that problems exist in the delivery of quality care warrants the need for further investigation. Further study is required to gain additional insight as to how nurses deliver quality care and which factors nurses perceive to affect the delivery of quality care. Documentation of strategies used by nurses to maintain quality care when conditions are adverse are few as is information indicating what circumstances are favorable to quality care provision and what constitutes the highest quality of nursing care.

This qualitative study evolved from the investigator's desire as both an educator and a nurse to explore the delivery of quality care and patient education from the perspective of student nurses. Faced with the challenge of preparing future nurses, educators have an obligation to patients to ensure that standards of care are upheld as well as a responsibility to students to impart the knowledge and skills required for the delivery of quality care and the provision of effective patient education.

This study was important for a number of reasons. First, by better understanding the process by which student nurses prioritize care, educators are better able to design successful strategies to improve patient outcomes and help these future nurses to function effectively in their practice. Second, before investigations can be attempted that seek to examine quality care, it is important to understand fully what quality care means to nursing students. Finally, there is a need for additional insight and understanding of the experiences that affect nurses' and student nurses' practice and the quality of their care. An exploration of students' perceptions of quality care and patient education will give educators a baseline upon which to build a foundation for imparting the skills and knowledge necessary for ensuring the delivery of quality care and thus facilitating positive patient outcomes.

Statement of the Purpose

The purpose of this study was be to explore and describe the delivery of nursing care from the perspective of associate degree nursing (ADN) students. Actions and interactions attributed to quality care were explored as well as factors that enhance or inhibit the delivery of such care. Moreover, nursing students' perceptions of the significance of patient education as well as how they incorporate teaching into their practice were explored. All students participated in focus group discussions. The premise for this research was the assumption that insights into students' perceptions can be gained from accounts of their lived experiences. Students provided significant insights into their experiences and the context of their responses was always considered.

The significance of this research was to ensure a relevant body of knowledge for the discipline of health education by offering further interpretations and explanations of the complex phenomenon of quality care. Results of this study contribute to efforts aimed at improving standards of care as well as assisting in the development of strategies to help both, the experienced nurse and the novice, as they confront the real world experiences affecting their practice and the delivery of quality care.

Research Questions

The broad research questions used to guide and frame this study were:

What does quality nursing care mean to nursing students?

How do nursing students prioritize care?

What factors enhance/inhibit nursing students' ability to deliver quality care?

How do nursing students rate the importance of patient education and to what extent do they incorporate teaching into their practice?

Definition of Terms

For the purposes of this study the following terms were defined:

Generic nursing students. Traditional nursing students enrolled in an associate degree nursing (ADN) program.

Licensed vocational nurse (LVN) transition students. LVN transition students are not required to take some of the first year ADN courses.

Nurses. Those licensed under the legal title of registered nurse (RN).

Nursing school. An associate degree nursing (ADN) program.

Nursing students. Students enrolled in an associate degree nursing (ADN) program.

Patient education. An independent nursing action which involves promoting, maintaining, and protecting health, as well as teaching about risk factors, increasing levels of wellness, and providing information about specific protective health measures (Kozier et al., 1992).

Patient outcomes. Changes in a patient's health status attributed to the delivery of health care services (Naylor et al., 1991). Outcomes focus on clients' health status, welfare, and satisfaction (Kozier et al., 1952).

Patients. Persons who are being treated by a doctor (Thorndike & Barnhart, 1988). Refers to recipients of nursing care and limited to individuals receiving services in acute care hospitals.

Quality nursing care. Therapeutically effective care that occurs when physical, psychological, and any extra needs of the client are met. Quality care facilitates positive patient outcomes (Williams, 1998).

Limitations/Delimitations

All studies are constrained by circumstances over which the researcher has little or no control. This study was no different. These limitations affect the interpretation and generalizability of findings. First, the participants represented only one geographic area/nursing school in the United States. Other factors such as rapport with the

interviewer, outside commitments, and degree of comfort with audiotaping must be considered when assessing limitations of the study.

Generalizability of results were restricted by the methodology as well as a lack of similar instruments and studies for comparison. The study was limited to those students who attended a North Texas ADN program and who volunteered to participate in the research. There was no exclusion of participants based on age, race, or gender. However, the majority of the students were white females between the ages of 25 and 45. The study sample was similar. The small nature of the study, lack of randomization, and the homogeneity of subjects prevented the findings of this study from being generalized to wider populations.

Background and Significance

While much has been written about the phenomenon of quality care, significant variations exist as to its interpretation and use. Qualitative research emerging over the past decade has provided greater insight into this complex clinical phenomenon (Williams, 1998). A few studies have examined the meaning of quality care from the nurse's perspective (Naylor et al., 1996; Williams, 1998; Wolf, Colahan, Warwick, Ambrose, & Giardino, 1998). Others have focused on the patients' or their family's perceptions (Dansky & Brannon, 1996; Iruita, 1993; Miche et al., 1996) and some have compared the perceptions of nurses and patients (Lauer et al., 1982; Lynn & McMillen, 1999; Rieman, 1986). Most studies found that quality care was usually perceived to be when the physical, psychological, and extra needs of the patient were met. Meeting extra

needs is denoted as an attitude of "nothing is too much trouble and treating the patient as an individual" (Williams, 1998, p. 811).

Increasingly it has been recognized that gaps exist between theory and practice. An understanding may exist among nurses as to what constitutes quality care. However, what occurs in practice under varying conditions often differs from the recognized standard (Joel, 1997; Williams, 1998). Nurses in Williams' study identified insufficient time to be the greatest barrier to the delivery of quality care and, subsequently, their greatest source of stress. Four contexts of time were identified which described the pace of work and workload from the nurses' perspectives. These were labeled abundant, sufficient, minimal, and insufficient. The contexts of time were related to the level of care delivered by nurses. Nurses observed it was the psychosocial and extra needs of patients which were omitted when time was minimal. Basic physical care was sometimes compromised when time was insufficient. Depending on time available, nurses were found to selectively focus on certain patients or on certain needs of patients to deliver quality care. The parameters of safety were indicated to be of utmost importance except when nurses experienced high and sustained levels of stress; then self preservation appeared to be the mode in which they functioned.

Stress is thought to reduce the positive attributes and competence of nurses and negatively impact the delivery of quality care (Miche et al., 1996; Ventura, 1999; Williams, 1998). Work related stress is more common among nurses than among many other occupational groups and the problem appears to be escalating (Miche et al.,1996).

Profound and often unwelcome changes in the health care delivery system have served to exacerbate nurses' stress and liability. These changes include the advent of managed care, corporate downsizing, budgetary cuts, increased patient acuity, increased work loads, and inadequate staffing (Joel, 1997; Shindaul-Rothschild, et al., 1996; Williams, 1998). These negative forces have a common and consistent theme regarding their impact on nursing; insufficient time to care for patients due to lack of physical and human resources. Nurses are often in a position of having to decide how to ration care: should equal care be given to all patients; only to those in greatest need; or give to those for whom he/she can do the most good? Choosing any one of these options implies that someone's care will be compromised (Williams, 1998). Furthermore, patients report feeling devalued and insecure when nursing care is delivered in a hurried and impersonal manner (Larson, 1984; Rieman, 1986; Wolfe, 1999).

Health education has been shown to enhance patients' sense of empowerment, comfort, and security, as well as facilitate adherence to treatment regimens (Babcock & Miller, 1993; Kozier et al., 1992; Lauer et al., 1982; Toscani & Patterson, 1995). Patient education is an integral component of nursing practice and competencies in patient education are weaved throughout nursing school curricula (Kozier, et al., 1992; Harrington et al., 1996). The fact that time constraints often force nurses to cut short patient education is alarming and has important implications for nurse educators. One of the most difficult challenges educators face today is how to prepare students for the realities of nursing (Williams, 1998; Mahat, 1998). Williams suggests that students may

benefit from creative and innovative strategies to most effectively use time and resources available. Mahat (1998) states that strategies emphasizing the value of patient education as well as renewed recognition of the stresses associated with nursing may be beneficial.

The suggestion that the delivery of quality care may be subject to variation and be influenced by different conditions indicates the need for further investigation. Few studies have explored the delivery of quality care from the perspective of practicing nurses and none were found to specifically focus on nursing students' perceptions.

The results of recent qualitative studies have laid important foundations for future research. A number of issues have been identified which require further exploration. Further research may lead to a more accurate measurement of the phenomenon of quality care as well as the development of strategies to assist nurses maintain and improve the delivery of quality care and patient education in the increasingly complex, and often chaotic contemporary health care environment.

According to Weiler (1988), "The empowerment of students means encouraging them to explore and analyze the forces acting upon their lives and respecting and legitimizing students' own voices" (p.152). The context of this qualitative research was founded on this concept. It is the investigator's opinion that the lived experiences of students must be heard before they can be educated and empowered.

Qualitative approaches are appropriate in situations where little research has been completed and allows for a rich description of a phenomenon (Morse & Field, 1995). Focus groups are particularly suited to gaining understanding about participants meanings

and ways of understanding. They are able to yield more in-depth information than quantitative methods, and as compared to one-on-one interviews, have the advantage of shortening data collection time (Lunt & Livingstone, 1996). The use of focus groups to research quality care in terms of student nurses' perspectives allowed exploration in terms of the current time, place, and culture, and gave insights into a topic central to nursing practice.

CHAPTER II: REVIEW OF LITERATURE

The related literature was used inductively as a frame for the research questions and became the basis for comparing and contrasting findings from this study with findings from others. Included is a review of research on the meaning of quality care, the consequences of quality care, the attributes of nurses deemed necessary for the delivery of quality care, and patient education as a component of quality care. An overview of literature is provided regarding changes in the health care system that have served to increase nurses' stress and impact the delivery of quality care. A description of the educator role of the nurse is provided. An overview of focus groups and qualitative research methodology is provided as well. This chapter is organized under the following headings (a) The meaning of quality care, (b) Quality care and patient outcomes, (c) Attributes of the nurse that contribute to quality care, (d) The current health care environment, (e) Nursing stress and quality care, (f) Patient education as a component of quality care, (g) The educator role of the nurse, (h) Focus groups, and (i) Summary

The Meaning of Quality Care

Nurses are directly concerned with the well being of patients and play a pivotal role in assuring the delivery of quality care (Kozier et al., 1992). While quality care has traditionally been considered a topic central to nursing practice, significant variations remain as to its interpretation and use. Attree (1993) asserts, "Unaware or undeterred by

the conceptual confusion, quality care continues to be assured , controlled, evaluated, and managed in the Health Care System today" (p. 355). Quality care has been studied from various perspectives using different methods. A number of quantitative studies have measured quality care from the perspective of patients and nurses. The Care-Q instrument developed by Larson (1984) was found to be used in several studies (Larson, 1984; Von Essen & Sjoden, 1995). This instrument assesses care using the subscales of: anticipates, comforts, trusting relationships, explains and facilitates, accessible, monitors, and follows through. Other questionnaires have been developed specifically for individual studies and have explored different aspects of the hospital experience focusing on patients' satisfaction with care and other nursing indicators (Cleary & McNeil, 1988; Strasser & Davis, 1991; Whiting, 1955).

Studies that have focused on the measurement of the quality of nursing care have highlighted the difficulties experienced with defining and measuring quality using such instruments. Williams (1998) suggests that these difficulties may be partially due to a basic lack of clarity as to what constitutes quality care. Donabedian (1988) contends that caution must be taken in the measurement of quality care as there is much in the interaction between the patient and the practitioner that is not yet fully understood.

Recent qualitative studies have provided greater insight into this complex clinical phenomenon. A few studies have examined the meaning of quality care from the nurses' perspectives (Naylor et al., 1996; Wolfe et al. , 1998; Williams, 1998). Others have focused on the patients' or their families' perceptions (Dansky & Brannon, 1996; Miche et

al., 1996; Iruita, 1993) and some have compared the perceptions of nurses and patients (Lauer et al., 1982; Lynn & McMillen, 1999; Rieman, 1986). While some differences between nurses' and patients' perceptions were found, most studies revealed that quality care was usually perceived by nurses and patients to be when physical, psychological, and extra needs of the patient were met. Meeting extra needs has been denoted as an attitude of "nothing is too much trouble"(Williams, 1998, p. 811). Patients often described high quality care with a particular value placed on nurses who treated them as individuals and provided factual information and personalized health education (Dansky & Brannon, 1996; Lauer et al., 1982; Lynn & McMillen, 1999). However, evidence exists that nurses tend to underestimate the value patients place on education. Lauer et al. (1982) explored oncology patients' and nurses' perceptions of important nursing behaviors. Patients in this study felt it was most important for them to have information regarding their diagnoses and management of their treatment regimens. Whereas nurses reported emotional support offered to patients as the most important nursing behavior. In a similar study, Mayer (1987) found that patients ranked health education, individualized care, and technical competence as the most important nursing attributes while nurses rated listening to patients and knowing when the patient needs comforting as most important.

Quality Care and Patient Outcomes

The consequences of quality care have been interpreted as "therapeutic effectiveness which in turn facilitates positive patient outcomes" (Williams, 1998, p. 811). The concept of outcomes focuses on what happened to the patient in terms of

control of illness, palliative care, or rehabilitation (Kozier et al., 1992; Naylor et al., 1991). According to Williams (1998), outcome measures closely influenced by nursing include functional status, mental status, stress, satisfaction with care, burden of care on families and caregivers, and cost of care.

The literature reveals the power nurses have to affect the lives of patients and their families. Rieman (1986) suggests that when patients are cared for in a positive way, they feel comfortable, secure, and relaxed. When they feel comfortable in a psychological sense and have feelings of self-worth, then healing can proceed. Rieman states that patients remember incidents of non-caring behaviors vividly, years after the event and contends that when there is a lack of positive caring "it makes patients even more vulnerable and helpless" (p.33).

Iruita (1993) found that the quality of nursing care delivered affected the patients' personal integrity. Iruita identified different levels of vulnerability from interviews with patients. The level of vulnerability experienced by patients was seen to be influenced by the amount of control they perceived themselves to have over their life at the time of ill health, as well as the level of risk to their integrity. Nurses were perceived to possess the means of preserving patients' integrity by the manner in which they interacted and the type of care they provided.

The idea that nursing care can influence healing is not a new concept, but in the past has "possibly been too obvious to be stated" (McMahon & Pearson, 1991, p. 1). Florence Nightingale described nursing interventions in 1860 which could create an

environment that assisted the body to heal itself (Kozier et al., 1992). Chiarella (1995) posits that the potential to heal is an integral part of the nurses' work. Chiarella further contends that the value and difficulty of nurses' work is often taken for granted by the public and other health care workers. Benner and Wrubel (1989) suggest that society undervalues nurses' work because hidden aspects of caring are not recognized.

Attributes of the Nurse that Contribute to Quality Care

A number of attributes possessed by nurses are deemed necessary for the provision of quality care. A review of the literature identified nursing competence, use of research, communication skills, time management, organization of workload, provision of health education and health promotion, creative thinking, reflection, and a caring attitude as elements of high quality care (Babcock & Miller, 1993; Benner & Wrubel, 1989; Dansky & Brannon, 1996; Iruita, 1993; Kozier et al., 1992; Lynn & McMillen, 1999; Rieman, 1986; Watson, 1979; Williams, 1998). A number of studies have equated the quality of nursing with the ability of the nurse to exhibit caring behaviors toward their patients. The caring approach of nurses has been related to a particular attitude which has been characterized by understanding, empathy, and acceptance of individual differences (Kozier et al., 1992; Williams, 1998). A caring approach has further been described as including the use of touch and anticipating the need for support from another person(Benner & Wrubel 1989; Watson, 1979). Whereas caring has been described as an important component of nursing care, exploratory research is lacking in the study of

factors which may influence the nurses' ability to exhibit caring behaviors under varying conditions and what additional factors may be involved in the delivery of quality care.

The Current Healthcare Environment

Ensuring and measuring quality care is a particularly difficult task in the current healthcare environment that is characterized by complexity, competition, and serious economic constraints. Nurses are challenged to maintain and improve quality care in the face of changing work patterns. Terms such as managed care, cost-effectiveness, cost containment, and shorter lengths of stay have become a part of the nursing lexicon (Hilton, 2000). Williams (1998) maintains "Although quality care is important to nurses and nurses are capable of delivering quality care and know what constitutes quality care, what happens in practice under varying conditions often differs from the recognized standard" (p. 812). The reality of nursing is that for a high proportion of the time they are struggling to reach their goal of quality care delivery to all patients (Williams,1998; Wolfe, 1999; Ventura, 1998; Hilton, 2000). Hilton (2000) poses the following question "When hospital nurses care for greater numbers of high-acuity patients or when home health nurses spend hours traveling between visits, how much time can they spend educating, listening, and providing a foundation for prevention and wellness?" (p.9). Sheridan-Gonzalez (2000) echoes similar concerns "Staff nurses and direct care providers struggle daily to negotiate with this chaotic system. Its not about cutting corners anymore. Its about neglecting basic needs" (p.13).

A clear and consistent theme across the literature is the problem of insufficient time to care for patients due to a lack of physical and human resources. A number of studies conducted in the U.S. and other countries identify a lack of control from the nurse's perspective in terms of quality care. In a recent survey, (Shindaul-Rothschild et al., 1996) 7560 nurses across the U.S. gave their views on health care and nursing practice. A common theme echoed by these beleaguered health professionals were feelings of disillusionment, exhaustion, and stress. One nurse was quoted as saying,"I can't stomach working under these conditions, I am very disheartened, I feel I run from patient to patient almost throwing their medications at them with time for nothing else" (p.30). Another nurse from the same survey stated "If I have only eight patients, only the sickest get reasonable care. Any patient close to discharge must be ignored ." Ventura (1998) surveyed 3,000 nurses across the U.S. and reported that 76% said time constraints have put their patients at increased risks/danger. Similarly, Wolfe (1999) surveyed 2,488 nurses and found that 82% said that short-staffing and increased workloads have forced them to provide care with which they were unsatisfied. In the United Kingdom, a recent study found nurses to be concerned at their inability to deliver care which had resulted from budgetary cuts. Increased workloads, reduced standards of care, and a lack of improvement in patient care were also said to be apparent (Scully, 1995).

Williams (1998) recently utilized grounded theory methodology to explore the delivery of quality care from the perspective of nurses in Western Australia. Williams states "Nurses have a vision of quality care, high standards and take pride and satisfaction

in their success. They also experience feelings of stress and dissatisfaction associated with nursing work" (p. 812). Frustration, guilt, and disillusionment were experienced when they were unable to provide the desired level of care. A lack of time was perceived to be the main reason for this. The availability of resources (human and physical) were seen to impact on the amount of time available for nursing care delivery. In order to manage heavy workloads, nurses employed certain strategies which depended on the time available. The safety of patients was the guiding parameter in prioritizing nursing care delivery.

The nature of nurses' work has traditionally been immense, overwhelming, and unpredictable. Skills in organization and time management are more important than ever if nurses are to function effectively in the present era of economic restrictions and insufficient time. Nurses must be prepared to prioritize and adjust their pace to ensure standards of care are met and quality care is provided (Kozier et al., 1992; Mahat, 1998; Williams, 1998). The skill mix of nurses and the competency of nurses have been identified as contributing to the amount of time available. Newly graduated nurses were often discussed in particular in relation to experiencing difficulties managing their time (Kozier et al., 1998; Mahat, 1998; Williams, 1998; Wolf, Boland, & Aukerman, 1994). Williams (1998) reports that more experienced nurses play a significant role in the supervision of less experienced nurses. Williams suggests that the mix of nurses to a particular ward needs to be carefully planned. "Adequate support for new nurses needs to

be ensured without taxing the experienced nurses by significantly reducing the amount of time available for them to spend with their own patients" (p. 814).

Williams (1998) found that the overall functioning as a team of a group of nurses in a particular area contributed greatly to the quality of nursing care. Characteristics of a functional team included effective communication between nurses, consensus of opinion about standards of care, maintenance of standards by peer review, nurses working together, and being flexible. Iruita (1993) contends that the relationship between nurses and other members of the health care team figures strongly in the delivery of quality care. "It is critical to have adequate nursing staff of the right quality and quantity and the same goes for the multi-disciplinary team as well. If you have low numbers of therapists or poor quality of nursing staff then the team will break down" (p.83).

Wolf et al. (1994) maintains that nurses tend to believe that the problems of quality care can be solved simply by employment of more staff. " However, more effective use of resources may prove to be the better option" (p.13). Wolf et al. also suggests that nurses need to review and change practices which are outdated in order to protect those elements valued as quality care .

Nursing Stress and Quality Care

Williams (1998) found that nurses' awareness of the effects of quality care on the well-being of patients appeared to produce a personal sense of responsibility. Because of the responsibility assumed by nurses for the well-being of patients, feelings of guilt and frustration were said to be experienced when nurses were unable to provide the care they

would like to provide. Ventura (1999) also discovered that feelings of dissatisfaction, frustration, and guilt resulted from nurses' inability to consistently provide quality care to all patients and these feelings led to stress.

A review of the literature reveals that high levels of stress experienced by nurses often affects their attitudes toward work, making it difficult for them to develop therapeutically conducive relationships with patients. Ventura (1999) reported that when nurses worked under high and sustained levels of stress they were said to develop negative attitudes toward patients. Nurses were less effective therapeutically as their normal behavior was altered because of stress. Wolfe (1999) also found nurses to recognize an inability in themselves to be caring toward all patients all the time because of the stress associated with nursing work. According to Williams (1998), the expectations nurses place upon themselves are often impossible to fulfill in the current context. Miche et al. (1996) found that pressures placed upon nurses in the workplace caused guilt, dissatisfaction, frustration, and fatigue, reducing their ability to care. Shindaul-Rothschild et al. (1996) contends that personal stress in nurses often prevents them from becoming involved with patients and doing little things for them. Other studies suggest that nursing stress may be associated with a higher rate of errors which is a major contributing factor to the quality of nursing care provided and thereby affects the health of patients (Joel, 1997; Lamendola, 1996; Wolf, 1998). Benner and Wrubel (1989) had this to say about the problem:

> The consequences of delivering inadequate care due to time constraints and work overload erodes the nurses' self-esteem and causes real anguish. Consequently a bad day is not experienced as just a bad day at work but a nightmare due to the human suffering and peril involved in inadequate care (p. 384).

The literature reveals quality care to be a complex clinical phenomenon with possible discrepancies between theory and practice. The indication that problems exist in the delivery of quality care warrants further investigation. Further study is required to gain additional insight as to how nurses deliver quality care and which factors nurses perceive to affect the delivery of quality care in the context of the current health care environment

Patient Education as a Component of Quality Care

Patient education is considered an integral component of nursing practice and an important aspect of quality care (Kozier et al., 1992). In 1972, the American Hospital Association passed the Patient's Bill of Rights mandating patient education as a right to all patients. In addition, legislation relating to nursing frequently has included client teaching as a function of nursing, thereby making teaching a legal and professional responsibility (Kozier et al. 1992; Phillips & Heckelman, 1983). Nurses who fail to provide proper patient education not only increase their risk of civil liability, but more importantly are negligent in their nursing practice (Kozier et al., 1992).

Pender (1987) contends that illness prevention and health promotion through effective patient education are central to quality patient care. Babcock and Miller (1993)

state that teaching is communication that facilitates learning by providing a structure within which patients are encouraged to assume responsibility for improving their health through changes in their attitudes and behaviors. Kozier et al. (1992) maintains that patient education is multifaceted, involving promoting, protecting, and maintaining health. It involves increasing a person's level of wellness and providing information about specific protective health services. Lauer et al. (1982) asserts that patients will follow through with self-care more readily when they feel their concerns are understood, are taught about their illness and treatment, and are encouraged to participate in planning their own care. Evidence exists that patient education reduces the cost of health care which lowers the demand on the health care system by preventing illness or controlling illness (Toscani & Patterson, 1995). Toscani & Patterson point out that patients with chronic diseases can improve their coping skills and increase independence which may reduce the burden on their caregivers. In addition, education may increase patient awareness and facilitate earlier detection and earlier treatment if necessary.

According to Mahat (1998), effective education involves and empowers patients which may improve patient comprehension and compliance. Effective education can optimize nurses' contact time, improve clinical outcomes, and can minimize recurrent hospitalizations and unnecessary physician visits.

Babcock and Miller (1993) assert that nurses are the health professionals with the most continuous patient contact and are in an ideal position to reach patients at teachable moments. This view is consistent with the Health Belief Model (HBM). According to

the HBM individuals are motivated to change and engage in risk reducing behaviors when they perceive themselves to be at risk for disease and that the consequences of the disease are severe. Benefits of change must outweigh the barriers to change (Glanz, Lewis, & Rimer, 1997). Babcock and Miller state that when people are ill they feel more vulnerable, and thus may be more amenable to making healthy lifestyle changes. Babcock and Miller further contend that teaching is more important than ever.

> Because of shortened hospital stays every moment spent with the patient/family should become a teaching opportunity . Early assessment of patient education needs, identification of their preferred learning styles, and barriers to learning (pain, communication, anxiety) provide data for planning education (p. 12).

Moreover, Hohn (1998) states that as self care practices gain popularity and consumers become more knowledgeable, participatory relationships replace the once passive relationships that consumers had with healthcare providers. Hohn further posits that cost-containment practices have contributed to the consumers' increasing quest for health information regarding care, prevention, and health promotion. As consumers increasingly rely on multiple sources of health information, nurses and other health professionals must be prepared to utilize a number of teaching strategies and a wide variety of media to provide consumers with timely, relevant, and practical information. Jamieson (1998) reports that although it is still largely focused on illness and cure, managed care is beginning to shift our paradigm to keeping people out of the system. This provides an opportunity to focus on wellness, health education, disease prevention,

the management of disabilities, healthy coping, early intervention, and optimizing the assets of patients.

The literature reveals that nurses are challenged by the increasing demands of the work setting to meet their teaching responsibilities. In the midst of the current health care environment, many nurses feel called upon to care for too many patients, for too many hours. Increased workloads and diminished resources preclude anything more than basic and critical care. Nurses weighed down by such demands may be force to cut short patient teaching (Babcock & Miller, 1993; Ventura, 1999; Wolfe, 1999; Shindaul-Rothschild et al., 1996). Institutions that once enjoyed heavy endowments and rich funding now find it necessary to reorganize, streamline, and cut luxuries. Health teaching is often viewed as a luxury in such circumstances (Babcock & Miller, 1993). Babcock and Miller conclude that nurses may be tempted to take the position of the mountain villagers in the following excerpt:

> And it came to be with the story of the mountain villages..... their kind inhabitants labored day and night trying to resuscitate the large number of drowning people being continually swept down to them through the rapids of their turbulent river. A passing traveler asked them why they did not repair the bridge upstream. The answer he was told should be obvious. The daily care of the river's victims was already consuming much more time and effort than the village could afford (p. 177).

The Educator Role of the Nurse

The literature portrays patient education to be an integral component of nursing practice and vital to patients' well being and optimal functioning. Competencies in patient education are delineated throughout nursing schools' curricula (Kozier et al., 1992; Harrington, et al., 1996). Nursing students are prepared to assume the following three interrelated roles of the RN: 1. the provider of care, 2. the manager of care and, 3. member of the profession. The patient-teacher role has been integrated into these three roles (Harrington et al., 1996). Competencies of the RN graduate include the ability to foster a health-supportive environment, promoting rehabilitation potential, providing for physical and psychological safetey, and using communication techniques that assist patients with problem solving. Individualized patient centered care management and teaching plans are implemented, providing continuity of care and referrals as needed (Kozier et al., 1992; Harrington et al., 1996).

However, from most research into the congruence between nurses' and patients' perceptions, it has been concluded that nurses often underestimate the value patients place on education (Lauer et al., 1982; Mayer 1987). Furthermore, it is alarming that patient teaching is often cut short due to time constraints brought about in the contemporary health care environment. Such disturbing findings have important implications for nursing education. According to Williams (1998), students must be prepared for the realities of contemporary nursing practice. It has been suggested that students may benefit from creative strategies to most effectively use time and resources

available (Williams, 1998; Wolf et al., 1994). Strategies emphasizing the value of the nurse-patient relationship could be considered, together with a focus on the skills required for relationship development (Williams, 1998). Approaches to effective skills of time management could be reviewed (Williams, 1998; Wolf et al., 1994). Renewed recognition of the stresses associated with nursing could be considered, and directions provided concerning the management of those stresses (Williams, 1998; Mahat, 1998). Stronger emphasis on the value of patient education as well as skills for conducting effective patient teaching may benefit students (Mahat, 1998).

It is the investigator's opinion that educators must prepare future nurses to assume responsibility for bringing about an alteration in the health care delivery system. The well-being of patients, families, groups, and communities must be ensured. Creative and innovative strategies are needed to prepare students to meet the challenges and demands of nursing. An exploration of students' perceptions of quality care and the significance of patient education will provide a baseline upon which to build a foundation for empowering students to function as agents of change and thus "mend the bridge upstream."

Focus Groups

Qualitative researchers try to understand people from their own frame of reference. "For the qualitative researcher all perspectives are valuable. The researcher looks at settings and people holistically" (Morgan, 1988 p.7). Indeed qualitative approaches make valuable contributions in areas where little or no research has been

done, as theory testing can not occur if variables relevant to the concepts have not yet been identified (Chenitz & Swanson, 1986).

Focus groups are assembled to furnish in-depth answers through use of open ended questions and skilled facilitation . Focus groups are particularly useful when researchers seek to discover participant's meanings and ways of understanding (Lunt & Livingstone, 1996). The focus group is a special type of group in terms of purpose, size, composition, and procedures. A focus group is typically composed of 6-10 participants who are selected because they have certain characteristics in common that relate to the topic of interest. The researcher creates a permissive environment that nurtures different perceptions and points of view with out pressuring participants to vote, plan, or reach consensus. The group discussion is conducted several times with several types of participants to identify trends , themes, and patterns in perceptions. Careful and systematic analysis of the discussion provides clues and insights as to how a phenomenon is perceived (Krueger, 1994).

Krueger (1994) contends that the focus group interview works because it taps into human tendencies. Individuals do not form opinions in isolation. People often need to listen to opinions of others before they form their own personal opinions. Evidence form focus group interviews suggests that people do influence each other with comments and in the course of discussion the opinions of an individual may shift. As Krueger points out, "Although some opinions may be developed quickly and held with absolute certainty, other opinions and are malleable and dynamic" (Krueger, 1994, p.7)

Focus groups offer several advantages, including these: the technique is a socially oriented research method, capturing real-life data in a social environment, possessing flexibility, high face validity, relatively low cost, potentially speedy results, and the capacity to increase the size of a qualitative study (Krueger, 1994; Lunt & Livingstone, 1996; Morgan, 1988).

All techniques for gathering information have limitations, and focus group interviews are no exception. Limitations that may affect the quality of results include the following: focus groups afford the researcher less control than individual interviews, produce data that are hard to analyze, require special skills of the moderator, result in troublesome differences among groups, are based on groups that may be difficult to assemble, and must be in a conducive environment (Krueger, 1994; Morgan, 1988).

Summary

A review of the literature reveals that the delivery of quality care is important to nurses. Nurses understand the nature of quality care to be more than just efficient, regimented actions. This view of nursing care, where the care delivered has the potential to be therapeutically effective, is perceived by nurses to place them in an unique position of responsibility. Because of the personal responsibility assumed by nurses for the well being of patients, feelings of guilt, frustration, and stress are often experienced when they are unable to provide the desired level of care.

Working within the constraints of insufficient time repeatedly appears in the literature as a major factor influencing the type and amount of care provided. Insufficient

time appears to be central to nurses' reduced ability to consistently deliver quality care to all patients. Available time is often determined by workload, staffing, patient acuity, high turnover, shortened patient stays, and the availability of physical resources.

The problem of insufficient time to provide quality care frequently leads to feelings of stress and dissatisfaction among nurses. Threats to patients' safety become issues of concern. Stress is thought to reduce nurses' positive attributes and competence and so their ability to provide care that is therapeutically effective. The literature reveals that nurses often recognize an inability in themselves to be caring to all patients all the time because of insufficient time and the stress involved with nurses' work. The expectations that nurses place upon themselves are often impossible to fulfill in the context of the current health care environment.

Emerging qualitative studies have provided greater insights into the phenomenon of quality care and these studies have laid important foundations for further research. A number of issues have been identified which require further exploration. Further research into the conditions necessary for quality care delivery will be of assistance. Knowledge of the potential influence of such conditions may direct the focus of attention and resources on developing and strengthening those conditions identified. Nurses' perceptions of patient education as a component of quality care warrants further investigation as well.

A number of recommendations have been made from the findings of previous studies. From an educational focus, it has been recommended that educators assess

curricula and implement strategies to prepare students for nursing practice in the present era of complexity and cost containment. Teaching students to manage time, stress, and available resources may be the best approach to help them achieve a sense of control over their practice and facilitate the delivery of quality care. Stronger emphasis on patient education skills is also recommended.

It is the investigator's opinion that the issues identified in the literature need further research and refinement. Recent qualitative studies have described quality care from the perspective of practicing nurses. However, no studies have specifically focused on student nurses' perspectives. It is essential that the perceptions of student nurses be explored and comparisons made before further conclusions can be made concerning the quality of nursing care and effective strategies identified to prepare future nurses for the challenges and demands of contemporary nursing practice. An exploration of the students' perceptions will be the first step in a broad based assessment which may yield a rich foundation for educating and empowering them to function effectively in the current health care environment

This present qualitative study highlights the perceived importance of delivering quality care from the perspective of student nurses and provides insight into their lived experiences. The identification of factors affecting their ability to deliver quality care as well as their perceptions of the significance of quality care and patient education were explored. Results of this study may contribute to the development of strategies directed

at supporting student nurses in their education which ultimately may lead to a greater facilitation of quality nursing care to more patients.

CHAPTER III: DESIGN AND METHODOLOGY

Chapter III describes the methodology of this study and outlines the procedural steps used to collect and analyze the data. Ethical aspects are discussed as well as the strategies taken to ensure that issues of reliability and validity were met. A review of the literature revealed quality care to be a complex phenomenon with possible discrepancies between theory and practice. A qualitative approach to research was chosen to explore the phenomenon, in order to capture the reality of nursing care delivery from the student nurse's perspective.

Population and Sample Selection

At the time of the data collection for this study, the researcher was employed as an ADN Instructor at a North Texas College. The sample for this study was drawn from students at the same college. Access to participants was facilitated (following human subjects approval) by the researcher's occupational position and knowledge of the ADN program. Students selected for the study were 2nd year ADN students (those in their last 2 semesters of schooling). The sample was restricted to 2nd year students, because it was the investigator's opinion that upper level students have had sufficient clinical experiences and exposures to the realities or nursing. Other nursing faculty validated the investigator's opinion. It was felt that 1st year students needed a settling in period and more clinical exposures to feel comfortable and confident talking about their

practice. Participants also needed to be able to reflect on and be willing to share detailed experiential information about the phenomenon (Morgan, 1988).

A convenience sample was used for the focus group interviews. Three of the four 2nd year clinical groups were selected for the actual study and one group was assigned to the pilot study. Random assignment was conducted by placing the names of the four clinical instructors in a bowl. The first name drawn was delineated as the pilot study group. Students were not told to which group they had been assigned. There was no exclusion of participants based on age, race, or gender. However, the majority of students enrolled in the ADN program were white females between the ages of 25-45. Therefore the study sample across groups was similar.

Students were invited to participate by the researcher and their clinical instructors. Volunteers were sought during lecture classes 2 days prior to the pilot-study. This was to allow students ample time to make a decision regarding participation. Students were assured by the investigator, the ADN director, and their clinical instructors that participation was voluntary, and neither their decision about participation or their responses if they did participate would affect their grades or academic status. Students were informed that focus group sessions would be conducted at the end of the clinical day and those wishing to participate would assemble in a pre designated conference room in another part of the hospital. This was to allow those not wishing to participate the opportunity to leave the clinical facility without undue pressure or embarrassment. All eligible students agreed to participate. Seven students participated in the pilot study and their responses were not used in data analysis. There were 7 students in focus group A, 9

students in focus group B, and 10 students in focus group C, making a total of 26 participants. Focus groups were held on the following days: the pilot study and one focus group session on February 17, one session on February 18, and the final session on February 24, 2000.

Setting

This study was implemented at two of the ADN programs' hospital clinical sites. According to Patton, "An important source of qualitative evaluation data is direct, first hand observation of the program. This means going to the place where the program takes place" (Patton, 1987, p.70). The pilot study group and 1 focus group were day shift (7am-3pm) clinical groups. The remaining 2 focus groups were evening shifts (3pm-11pm). Focus group interviews were conducted at the end of the clinical shifts and after the students had been dismissed for the day by their instructors.

Procedure

Data were collected through tape-recorded semi-structured interviews (Appendix F). A questionnaire was used for quantitative purposes (Appendix E). Focus group interviews took place in private venues within the hospital away from the clinical setting, where the risks of interruptions were anticipated as being minimal. The pilot study interview took place in a conference room, as did the first focus group session. The remaining two interviews were conducted in hospital classrooms. The rooms were booked prior to the arranged time. Before participants arrived for the interviews, the researcher and assistant checked the setup of the room, arranged chairs in a comfortable manner, and adjusted the room temperature as necessary. None of the interviews were

interrupted. However, during the pilot study, one student left the room (excusing herself to go to the restroom) and came back. During another interview, one student briefly left the room to give an important message concerning her patient to the primary nurse. She had forgotten to relay the message prior to coming to the focus group session. When these distractions occurred, the researcher refocused the groups by repeating what had been said and by asking participants to continue.

At the time of the interviews, the researcher was known by the participants to be employed as a 1st year clinical instructor in the ADN program, a position which consisted of teaching two didactic courses and one clinical course. The interview sessions commenced with some informal small talk between the researcher and the participants. This informal communication time varied, but continued until such time that the researcher felt that the participants were at ease with the situation. The researcher then talked about the research and its purpose, explaining the content, and formally asking permission to proceed. Following the signing of consent forms (Appendix B), demographic and questionnaire data were collected (Appendix E). Students were instructed not to put their names on the forms. Fifteen minutes were allowed for completion, however all participants finished the forms in 5 minutes or less. The assistant distributed forms and pencils and then collected the completed forms. The assistant then tested the tape recorder and turned it on as the interviews commenced. The interviews varied in time between 45 minutes to 1 hour and 15 minutes.

Interview questions were constructed using the objectives of the study to guide, not structure the interviews. The interview technique used allowed detailed exploration

of different aspects of the topic using probes such as how, what, where, when, and could you explain that? Examples were also requested. Participants were informed that the session would be audio taped in order to record all comments. Participants were encouraged to talk freely, but to talk only one at a time. The investigator emphasized that there were no right or wrong answers, and that it was important that each person's view be shared, even if it was different from that of others. Each interview commenced with the question "what does quality nursing care mean to you?" Participants tended to respond to this question tentatively (as this was their first question) with broad answers that were then explored in more detail. For example the following excerpt is taken from the beginning of the first focus group interview:

> **Res (Researcher):** *Now I wonder if you could tell me what quality care means to you?*
>
> **S1 (Student interview #1):** *To me its meeting all of the needs of the patient.*
>
> **Res:** *What sort of needs would these be?*
>
> **S1:** *Holistic needs ... I mean beyond just physical ... including the emotional, spiritual, and psychosocial needs as well.*
>
> **S2 (Student interview # 2):** *Yes... looking at the whole patient and including their family as well. Treating people as individuals.. not just a diagnosis or a room number.*

Once a topic had been explored in full, another question from the interview guide was used. Although an attempt was made to introduce questions in essentially the same order, there was variation between groups in how the moderator introduced questions and how much discussion was devoted to any one point in the guidelines. This flexibility was

maintained to permit free discussion of issues and unsolicited opinions. Due to the dynamics of the members, some groups were more talkative than others.

During each focus group session, the investigator and assistant made observations of the processes in the classroom and recorded them in a field notebook. These observations included: (a) number of participants in the group, (b) comments made during the sessions, (c) body language and other non-verbal communication, (d) degree of interaction among group members, and (e) general mood and comfort level of participants. The main objective of these observations was to verify data obtained by interview and to record the general ambiance. The demographic sheets/questionnaires were used as descriptive data. One week after the final focus group session, the investigator provided students with refreshments and token gifts (less than $5.00 value) during lecture courses. This time and setting was chosen so as to allow all students access to the reward plan regardless of study participation.

Instrumentation

The researcher developed the semi-structured interview guide (Appendix F) and questionnaire (Appendix E). The focus group instrument consisted of four broad questions. Standard prompts were also included. The questionnaire included four closed-ended and one open-ended question. Age, gender, ethnicity, and student classification were included as demographic data. Four nursing instructors reviewed and provided feedback on content validity of instruments prior to pilot testing. Only minor amendments were suggested. The focus-group questions were designed to elicit rich in-depth information regarding students' perceptions, attitudes, beliefs, and feelings

regarding quality care and the significance of patient education as a component of quality care. The general, open-ended questions were:

1. What does quality nursing care mean to you?
2. What factors enhance/hinder your ability to deliver quality care?
3. What are some of the important aspects to consider in the delivery of quality care and can these be prioritized?
4. How do you rate the significance of patient education and how do you incorporate teaching into your practice?

Ethical Considerations

The research was approved for implementation by the Texas Woman's University Human Subjects Review Committee on February 1, 2000 (appendix A). Consent was solicited and obtained from the director of the ADN program on January 13, 2000 (Appendices C & D). Each participant was informed verbally and in writing of the purpose of the study. Protection of anonymity and freedom of choice regarding participation was explained. Students were provided the opportunity to ask questions about the study.

Once participants were satisfied with the requirements of the study, consent forms were signed (Appendix B). The consent outlined the purpose of the study, benefits and risks of participating in the study, and the assurance of anonymity. The students were advised that participation was voluntary and of their right to withdraw at anytime without penalty or undue attention. Consent to audio tape during focus group discussions was included in the general consent form. All participants received copies of their signed

consent form. The investigator offered to report the findings of the study at a later date. The researcher explained to the participants that no identification of individual participants would be made. Participants were told that the tapes would be erased as soon as the transcriptions were made, and that the transcriptions along with other participant information and responses would be kept in a locked file cabinet in the investigator's home and destroyed after three years by shredding and recycling.

Participants were informed that they could contact the researcher or the researcher's advisor at anytime and contact numbers were provided. No one chose to withdraw from the focus group sessions although students were allowed the opportunity to decline. Focus group participants were identified on the interview transcripts by a numerical code. Any identifying data was deleted from the transcripts in order to protect participants.

Treatment of data

All the collected information, demographic profiles, and the transcripts of the audio tape recordings were treated as data. Each focus group interview was reviewed in a timely manner following the session to maximize recall of content, observations, and discussion climate. Each interview was transcribed verbatim on a word processor by the investigator. Data were then organized and managed for analysis using HyperResearch computer software. This program is useful for recognizing keywords, phrases, and general themes. It facilitates the constant, comparative review process. The transcription of the pilot study group and three study groups took approximately 9 hours.

Handwritten field notes from the investigator and assistant were included to supplement the audio transcriptions and identify significant themes and general ambiance. Using guidelines established by Morse & Field (1995), data were coded in a systematic procedure using unique symbols to identify concepts. Initial major coding was developed by grouping responses to questions. Subcoding within the major code was used to further develop analysis. Both thematic analysis to analyze for themes and content analysis to identify categories, constructs, and domains were used (Morse & Field, 1995).

The interview transcripts were first coded line by line, sentence by sentence to identify and label common themes and categories. This was done by extensively reading the data, listening to the tapes, and noting thoughts (in the form of memos) as they occurred in the data. The steps in coding as recommended by Morse & Field (1995) are: (1) develop an initial set of codes corresponding to each item in the focus group set of guidelines, (2) create additional codes for topics that arise and are of special interest, (3) develop nonsubstantive codes that will be of particular help in the analysis and write up phases, and (4) develop subsequent detailed codes to use for analysis of specific topics.

To begin the interpretive part of the analysis, the codes were transferred to a matrix to provide an overview of relationships among items (Morse & Field, 1995). Based on the transcriptions, particular words and phrases used by the participants to describe experiences were coded on note cards. These were then listed and grouped together by similarities. Content was analyzed by coding to identify recurrent themes in the discussions and by counting the frequency of statements made per theme group.

Data entry and analysis of data using HyperResearch took approximately 8 hours. Fifteen general themes were identified as data saturation occurred. The transcripts were continually referred to throughout the analysis of data. The transcripts of the pilot study were manually coded and compared with the study findings. These transcripts were not entered into the HyperResearch program, but their analysis confirmed the saturation of categories identified in the data set. A thorough analysis was achieved by using both HyperResearch and the coding method as described by Morse & Field (1995).

Data from the questionnaire/demographic survey were used to describe the sample using frequencies and measure of central tendency. Data from participants in each focus group session were analyzed separately for a composite analysis. Data from the instrument were entered and compiled using the computer program, Statistical Package for the Social Sciences (SPSS).

Reliability and Validity

In qualitative research, differences in the type of data collected necessitate a different approach to issues of reliability and validity than that taken in quantitative research. Data needs to be assessed in terms of the way it accurately represents the truth; it needs to be presented in a way that people with similar experiences would immediately relate to it (Sandelowski, 1986). Silverman, Ricci, & Gunter (1990) state, "The quantitative researcher's concern for ensuring validity and reliability is comparable to the qualitative researcher's concern for data accuracy, verification, and validation" (p. 59).

A number of strategies were employed throughout the study to ensure that the data collection and interpretation accurately reflected the phenomenon. These are described as follows: .To avoid bias in the data collection and analysis, the researcher (who possesses current personal knowledge of nursing in a hospital setting) raised awareness of her own preconceptions and bias to the topic. This was achieved by being interviewed by another faculty member using the interview guide, before commencing the interview with the participants. The researcher avoided imposing these preconceptions on the data collection/analysis. Rosenbaum (1988) discusses the concept of the researcher as an instrument in quality research, potentially bringing personal biases to the findings, "Researchers must be aware, through every phase of the research, of their own likes, dislikes, and prejudices as they relate to the participants or phenomenon being studied" (p. 56). Interviews were transcribed verbatim and transcripts were checked for accuracy by listening to the tape recordings. The process of data collection and analysis was clearly described so that researchers wishing to replicate the study could do so and could confirm the reliability of the findings (Silverman et al., 1990). Once the description of the phenomenon was complete, it was returned for validation to one participant from each of the three focus groups. The students were asked to read the description and to see if it made sense to them in terms of their own experience. They were asked to look particularly at quotes within the categories and whether or not they agreed with the choice of categories. All three students agreed with the interpretations with no amendments suggested. Guba (1981) describes this strategy as a test of credibility, a way of assuring validity.

Summary

The researcher used qualitative methodology to explore and describe the delivery of quality care from the perspective of students. Actions and interactions were examined as well as the identification of enhancing and inhibiting factors in the delivery of quality care. The significance of patient education as a component of quality care was also explored. The analysis of data lead to increased insight that explained the delivery of quality care from the students' perspectives.

A total of 26 students from three intact clinical groups were interviewed. A semi-structured, tape-recorded interview technique was used. A questionnaire was used for quantitative purposes. Participant observation and field notes were also used as additional data sources. Data were organized for analysis using the HyperResearch software and analysis using the coding method of constant comparative analysis. Strategies were taken by the researcher to ensure that the human rights of the participants were protected and that issues of reliability and were addressed.

CHAPTER IV: FINDINGS

In this chapter, the investigator presents analysis of the data collected during the study. The results are organized in the following sequence: (a) Descriptive Analysis of Demographic Statistics, (b) Descriptive Analysis of Instrument Responses, (c) Analysis of Focus Group Responses, (d) Themes, and (e) Summary.

Descriptive Analysis of Demographic Characteristics

The gender of participants (N=26) was 96.2% female (n=25) and 3.8% male (n=1). Table 1 summarizes the number and gender of focus group participants.

Table 1
Number and Gender of Participants in Focus Groups (N=26)

Focus Group	Subjects	Women	Men
A	7	7	0
B	9	8	1
C	10	10	0
Total Subjects	26	25	1

The age of participants (N=26) in this study ranged from 22 to 53 years with a mean age of 34.7 years, a range of 31 years, and a standard deviation of 8.6 years. Participants in focus group A (n=7) had a mean age of 36.6 years, participants in focus

group B (n=9) had a mean age of 36.8 years, and the participants in focus group C had a mean age of 30.8 years. Table 2 summarizes ungrouped demographic data by age.

Table 2
Summary of Raw Data by Age of Participants (N=26)

Variable	Group	N	Range (min-max)	M	SD
Age	A	7	29 (23-52)	36.6	9.6
	B	9	31 (22-53)	36.8	9.7
	C	10	20 (22-42)	30.8	6.4

The ethnicity of participants (N=26) was reported to be 69.2% White (n=18), 15.4% Black (n=4), 3.8% Hispanic (n=1), 3.8% Asian (n=1), 3.8% Native American (n=1), and 3.8% reported as other (n=1). Twenty-three percent of the participants (n=6) reported their employment status as full time. Forty-two percent of the participants (n=11) were employed on a part-time basis, and 34.6% (n=9) were unemployed. Table 3 summarizes ethnicity and Table 4 illustrates the employment status of participants.

Table 3
Summary of Ethnicity

n	Group	Ethnicity					
		White	Black	Hispanic	Asian	Native-American	Other
7	A	4	1		1		1
9	B	5	2	1		1	
10	C	9	1				

Table 4
Summary of Employment Status

n	Group	Employment Status		
		FT	PT	Unemployed
7	A	1	4	2
9	B	3	2	4
10	C	2	5	3

Twenty of the participants (76.9%) reported having previous healthcare work experience. Eight of the participants (30.8%) were classified as LVN transition students, while the remaining 18 (69.2%) were classified as generic students. Of the participants who reported having previous healthcare work experience, one was a paramedic, one was an emergency medical technician (EMT), one was employed as a phlebobimist, eight

were certified nursing assistants (CNAs), and eight were currently employed as licensed vocational nurses (LVNs). Table 5 summarizes healthcare work experience and student classification.

Table 5
Healthcare Work Experience and Student Classification

n	Group	Previous Healthcare work experience		% of Healthcare Work Experience	Student Classification	
		Yes	No		LVN Transition	Generic
7	A	5	2	71%	2	5
9	B	7	2	78%	4	5
10	C	8	2	80%	2	8

Descriptive Analysis of Instrument Responses

All participants (N=26) rated the provision of quality nursing care to be very important to positive patient outcomes. However, no one reported that they were "always" able to deliver quality care. Nine of participants (34.6%) reported they have an ability to deliver quality care "frequently", while 14 (53.8%) reported they were able to deliver quality care "sometimes." Three students (11.5%) reported that they were "rarely" able to deliver quality care. No participants reported that they were "never" able to deliver quality care to patients.

Participants responded to the one open ended question on the questionnaire "What impedes your ability to always deliver quality care?" with a variety of comments. Eleven participants made a general statement of "not enough time." Other participants were specific in their responses. Three participants cited "charting and too much paperwork" as their major barriers. Four participants mentioned lack of knowledge and time management skills. Inadequate staffing, patient acuity and workload were cited 12 times. The absence of teamwork and lack of support from staff nurses was reported 9 times as key factors that impeded students' ability to "always" deliver quality care to patients.

Table 6 summarizes the importance of quality care and Table 7 show the frequency participants were able to deliver quality care.

Table 6
The Importance of Quality Care

n	Group	Importance				
		very important	important	somewhat important	somewhat unimportant	unimportant
7	A	7				
9	B	9				
10	C	10				

Table 7
The Frequency Participants were able to Deliver Quality Care

n	Group	Frequency				
		always	frequently	sometimes	Rarely	never
7	A		2	5		
9	B		3	4	2	
10	C		4	5	1	

Patient education was rated as a "very important" component of quality care by 84.6% of participants (n=22). The remaining 15.4% of participants (n=4) rated patient education as "important" to quality care. No participants rated patient education to be "somewhat important," "somewhat unimportant," or "unimportant." Fourteen participants (53.8%) reported that they "always" incorporate teaching into their practice, while 12 participants (46.2%) reported that they "frequently" incorporate patient education into their practice. None of the participants reported that they "sometimes," "rarely," or "never" incorporate education into their care. Table 8 summarizes the significance of patient education and Table 9 illustrates the frequency with which patient education was delivered.

Table 8
The Significance of Patient Education

n	Group	Significance				
		very important	Important	somewhat important	somewhat unimportant	unimportant
7	A	6	1			
9	B	8	1			
10	C	8	2			

Table 9
The Frequency of Patient Education

n	Group	Frequency				
		always	frequently	sometimes	rarely	never
7	A	3	4			
9	B	6	3			
10	C	5	5			

Analysis of Focus Group Responses

The investigator conducted focus groups to elicit rich in-depth responses revealing attitudes and beliefs about quality care, as well as the significance of patient education. Three separate focus groups were conducted at various times to obtain a more

representative sample of ADN students. Each focus group was conducted in the same manner with an overview of the project, obtaining subject consent, the questionnaire/ demographic survey, followed by the focus group discussion. The interview questions were posed in the same order with standard probes used, but each focus group was comprised of different individuals so that the dynamics of each group were unique.

As reported in chapter III, 15 general themes emerged from the research questions as data saturation occurred. The following pages will present areas of interest within the themes and categories. Table 10 illustrates response interpretations made by the investigator during the coding process. Responses include verbal communication recorded by audio tape and nonverbal communication from field observations. Many of the participants used nonverbal communication such as shaking one's head instead of verbally responding with yes or no. Field notes were especially helpful in deciphering general opinions where the audio tape was silent or indecipherable.

Table 10
Keywords and Responses

Affirmative Responses	
1. yes	4. usually
2. I agree	5. most of the time
3. some	6. nods head yes
Negative Responses	
1. no	4. never
3. rarely	6. rolls eyes
Neutral Responses	
1. Don't know	3. silent
2. shrugs shoulders	

Research Questions and Themes

Question 1: What Does Quality Nursing Care Mean to Nursing Students?

Question 1 focused on students' perception of quality nursing care. Each focus group began with same question "What does quality nursing care mean to you?" Participants mentioned treating patients as individuals, providing holistic care, meeting all the needs of the patient, including their family, and providing patient education as elements of high quality care. It was frequently reported that quality care included meeting the physical, psychological, psychosocial, emotional, and spiritual needs of

patients. Six participants reported that quality care meant providing the level of care that they would desire for themselves or their loved ones. One student commented "It's the Golden Rule, treat patients the way you would want to be treated or your mother or grandmother." Another student added, " They're not just another diagnosis or another cow in the herd." Spending time with patients was deemed a necessary condition for the delivery of quality care. Students mentioned "taking time to do little extra things for the patient," " taking the time to follow through," "taking the time to give 100% and do a good job," and "spending one-on-one time with patients" as elements of quality care. At least five students stated that quality care occurred when nurses took time to listen to patients and provide individualized patient education. The importance of devoting the time required for quality care delivery was cited by participants at least 15 times. Participants referred to meeting patients needs in a comprehensive manner 14 times and on 13 occasions participants described the concept of the Golden Rule as their definition, of quality care.

Four students described how being able to deliver quality care affected their own feelings. One student remarked, "It's going home at night knowing you did your best, things weren't left undone. You did something to help your patient and brighten their day." Three students stated that nursing knowledge and competency were prerequisites for the delivery of quality care. One participant from the first focus group stated, "It takes knowledge... so much of it. Quality care is when you have the knowledge and skills and then apply them to the situation." Table 11 illustrates themes and categories related to research question 1.

Table 11
Emerging Themes and Categories for Research Question 1: What Does Quality Care Mean to Nursing Students?

Quality care means taking time

1. Take the time to follow through
2. Do a good job – give 100%
3. Spend one-on-one time
4. Take time to do little extra things

Quality care means meeting patients needs

1. Whole patient
2. holistic care
3. Beyond physical
4. Physical, psychosocial, spiritual, emotional needs
5. Teaching patients
6. Include their families
7. listening to patients

Quality Means the Golden Rule

1. Individualized care
2. The way you would want to be treated
3. The care you'd provide for loved ones
4. They're not just another diagnosis
5. It's the Golden Rule
6. Show respect, care

Question 2: How Do Nursing Students Prioritize Care?

Question 2 related to how students' prioritize care. Patient safety and medications were referred to most frequently as participants' overriding concerns when deciding how care should be prioritized. Several participants mentioned patient acuity. One participant said, "Maslow, I think of Maslow (referring to Abraham Maslow's Hierarchy of Human Needs). You know, you have to take care of the physical needs, the

basic needs, the life-threatening needs before you can think of higher level needs, like self actualization." Several students nodded in agreement to this statement. Another participant added, "I agree with [another student], if my patient is bleeding or has unstable vital signs, then that's my first priority as opposed to another patient who is stable or close to discharge." Several others in the group voiced their agreement to these comments. Patient safety was mentioned on at least 14 occasions as the guiding parameter for prioritizing care. In addition, several participants commented that excellent assessment and critical thinking skills are paramount to nurses' ability to prioritize care effectively. One participant stated, "You can't always go by the medical diagnosis or even what you get in the report (referring to the change of shift report), even though that helps, you have to accurately assess your patients and the situation and go from there." To this comment another student added, "You must be able to assess patients… identify those who are sickest, have multiple needs. It's sad to say, but sometimes you can't give the care you would like to all of your patients. Those who can do for themselves or are close to discharge are sometimes put on auto-pilot. It shouldn't be that way, but that's the real world." Others in the group agreed with this commentary. One participant from the second focus group remarked that the legal aspects of care were his top priority, "That patient's safety is my safety… I always consider what I can be taken to court over." No other participants made similar comments.

Twelve participants cited medications as an indicator of how nursing care should be prioritized. A participant from the first focus group said, "You have to give your medications on time, no matter what. I look at how many medications a patient has and

what time they're due. I then plan my day around that." A participant from the third focus group commented, "There's no flexibility with medications. Medications are usually my first consideration. What kind, how many, what time. You have to give 'em on time and give 'em right." Another student added, "I agree with her. I don't want to be responsible for a medication error." Others in the group expressed agreement to these statements. Table 12 illustrates emerging themes and categories related to research question 2.

Table 12
Emerging Themes and Categories for Research Question 2: How Do Nursing Students Prioritize Care?

Prioritizing Care to Ensure Patient Safety

1 Accurate assessment of patient and situation

2. Identify high acuity patients

3. Prioritize according to Maslow. Basic needs first

4. Life threatening needs before self actualization needs

Medications are a Priority

1. No flexibility with medications

2. Plan day around medication schedule

3. Avoid medication errors

Prioritize According to Time

1. There's not always enough time to give quality care to all patients

2. Stable patients or those close to discharge may go on auto-pilot

3. It's sad to say, but that's the real world

Question 3: What Factors Enhance/Inhibit Nursing Students Ability to Deliver Quality Care?

Question 3 addressed the conditions deemed necessary for the delivery of quality care. Sufficient time to deliver care, the presence of a strong supportive team, and the possession of vital nursing skills were important to participants in this study.

Participants in all groups reported that having ample time to spend with patients was of vital, and this was mentioned on at least 26 occasions. It was reported that workload, acuity of patients, and the number and type of staff available were factors that affected the time students had to spend with patients. One student from the second focus group remarked "When patients can help themselves, go to the bathroom by themselves or feed themselves, that helps, but when you have 2 or 3 that are total care you can get behind fast." In response to this statement, another participant said, "...and you have to have adequate staffing... and it needs to be consistent. Not like, 'Oh, okay, today I have help but what about tomorrow?'" Another participant from the third focus group stated, "When you have adequate help you can adjust your time and prioritize... not just fly by the seat of your pants."

The presence of teamwork and a supportive nursing staff were cited as being critical factors influencing students' ability to provide quality care. A participant from the first focus group echoed the sentiments of others in her group, "When you have a good team it doesn't matter how busy you are, you just pull together and patients are consistently taken care of." Another participant added, "Yeah, and its not just nursing. All members of the healthcare team need to work together... lab, physical therapy,

pharmacy, nurses, techs, everyone." One participant reported that there must be teamwork among all shifts, "You know when nurse from previous shifts leave things undone, like empty IV bags or dressing changes, that should have been done on their shift."

Skills in time management and organization were mentioned by at least 6 participants as important for the delivery of quality care. One student remarked, "You really have to be good with time, you don't survive in nursing today without excellent time management… as students, I don't feel this is being emphasized enough… we need to be taught more in the way of how to manage time." Several participants in the group nodded in agreement to these statements. The possession of astute assessment skills, skills with the technical aspects of care (handling equipment, knowing procedures), communication, and leadership skills were also mentioned by students in all groups as positive nursing attributes that facilitated quality care delivery. One participant commented, "It helps when the instructor is with you… you get to do more (referring to skills)." Others in her group agreed.

The barriers to care were voiced many times, often at length and in great detail. Insufficient time to deliver care, unfriendly and non-supportive nursing staff, and the student role were reported by participants as factors that hindered their ability to deliver quality care. Insufficient time to provide care was cited at least 18 times. Heavy workloads, high acuity patients, inadequate staffing, the absence of teamwork, time spent on paperwork/charting, time spent on non nursing duties, and students lack of knowledge

and skills were mentioned as factors contributing to the basic problem of insufficient time to provide quality care to all patients.

One participant made the following comment regarding working within the constraints of insufficient time, "… sometimes you just feel like you are running from patient to patient, throwing their medications at them." Another student added, "Yeah, and when that happens you feel like crap." A participant from the second focus group expressed her concern, "I will actually miss being a student, at least now we have more time to spend with the patients. When I'm a real RN things will be different. I see how they struggle with time. The other day [another student]and I were helping this nurse with her patients and she was just running around in circles, throwing her arms up saying that she just couldn't do it all."

Lack of teamwork and unfriendly nursing staff were mentioned at least 17 times as a problem for students. Comments frequently made to describe staff nurses were "unfriendly," " mean," " burned out," and "rude." One participant from the third focus group stated, "Some of these nurses act like they were never students. You ask for help and they look at you like you're stupid and walk off." In response to this comment another participant added, "It's true, nurses really do eat their young." A participant form the second focus group reported that staff nurses have humiliated her in front of patients "… it's so embarrassing. They correct you or reprimand you in front of patients. It makes you feel awful and incompetent, and patients lose confidence in you." Another statement reflecting participants views regarding staff nurses was, "…if they are so unhappy or burned out they need to get out of nursing. They affect everyone with their

bad attitudes, including patients. They need to go flip burgers somewhere and quit dealing with human life."

Participants expressed a desire for staff nurses to be more supportive of them. Several students stated that nurses should be "role models" or "mentors." One participant reported, "As students we have so much to learn and these nurses could help us so much… I mean we are the future of nursing… some nurses are great but some of them have an attitude like, well you know, 'I was treated bad, so now I am going to treat you bad.'"

On at least 8 occasions participants reported that being a student was often a barrier to the delivery of quality care. One participant made the following comment "You have to wait for your instructor to be with you before you can do a skill. There's only one instructor and she can't be everywhere at the same time." Another said, "We are being held back from learning and getting to do so many things because we have to wait for our instructor." Participants with and without previous healthcare experience mentioned lack of knowledge and skills as barriers to the provision of quality nursing care. One participant echoed the opinion of her classmates, "It takes so much experience to become proficient… I just guess for now we need to make sure we are safe practitioners and the more sophisticated skills will come in time."

Participants were concerned with what they perceived as deficiencies in their education. Eight participants reported that they were not being adequately prepared to transition from the student role to the RN role. One student from the first focus group remarked, "We do paperwork, but we aren't applying what we learn in the clinical

setting. We need to have more meaningful hands-on learning experiences." A student from the second focus group made a similar comment, "... in our last semester we should be given more opportunities to work as real nurses... internships... to transition us from student to nurse role." One participant from the third focus group remarked, "There are humongous gaps as big as the Grand Canyon in what we learn in class and what we need to know to be real RNs."

Participants discussed strategies for improvement. Several participants mentioned smaller clinical groups, internships, and preceptor courses. Other suggestions included revising curriculum to reflect increased emphasis on time management, leadership, communication, and patient education. One participant from the third focus group echoed the general feelings of the others, "These are skills we need to survive in the real world." Table 13 illustrates the following themes and categories.

Table 13
Emerging Themes and Categories for Research Question 3: What Factors Enhance/Inhibit Nursing Students' Ability to Deliver Quality Care?

Teamwork as a Helping Factor	
1. It takes a good team of nurses	3. Helpful nurses
2. Everyone pulling together	4. All departments... not just nursing
Sufficient Time as a Helping Factor	
1. Adequate staffing	3. Stable patients
2. Consistent staffing	4. Manageable workloads

Table 13 continued
Emerging Themes and Categories for Research Question 3: What Factors Enhance/Inhibit Nursing Students' Ability to Deliver Quality Care?

Knowledge/Skills as a Helping Factor

1. Assessment skills
2. Skills proficiency
3. Time management
4. Organization
5. Communication
6. Can do more when instructor present

Lack of Support Inhibits

1. No teamwork
2. Other shifts leave things undone
3. Burned out nurses affect everyone with their attitudes
4. Unfriendly nurses
5. Nurses ignore you

Insufficient Time inhibits

1. Inadequate staffing
2. Heavy Workloads
3. Time spent on other non-nursing duties, answering the phone
4. High acuity patients
5. time spent on paperwork

The Problem of Being a Student

1. Too much paperwork
2. Gaps in education
3. Having to wait for the instructor holds you back
4. It takes so much knowledge. We're still learning
5. Not being prepared to transition from student role to RN role
6. Need skills to survive in real world
7. Lack of time management skills
8. Need more hands on experiences

Question 4: How Do Nursing Students Rate the Importance of Patient Education and to What Extent Do They Incorporate Teaching Into Their Practice?

Question 4 focused on the significance of patient education. Participants were fairly universal in their responses. Overall, patient education was reported to be an integral component of quality care as well as an important nursing responsibility. When asked to explain their views on patient education, several participants provided examples from their own experiences. A participant from the first focus group recalled how she witnessed an improvement in a patient's vital signs after having provided patient education. "I actually saw her pulse and blood pressure come down to a more normal level… I could see an overall physical, as well emotional, improvement. She had been so anxious, really worked up, but afterwards she was calm and more in control." Several participants specifically mentioned that patient education helped patients to feel "secure," "safe," "calm," and "in control." Two participants reported that education "empowers patients." A participant from the second focus group stated that education "… helps patients get well and stay well. It's a win-win situation. They are healthier and happier… it also decreases costs on the healthcare system." Another student replied, "Yeah, and it frees you (nurses) up. When patients know what to do, what to expect, they don't need you as much…. It keeps you out of their room."

The sophistication of patients and the availability of health information currently available from a variety of sources were discussed. Four participants in various focus groups reported that many patients today are no longer passive recipients of healthcare,

but instead are active participants in their healthcare regimens. In addition to the sophistication of patients, participants mentioned that an important responsibility of nurses is to help patients sort through the overwhelming amount of information currently available from a variety of sources. One participant commented, " We have to teach. That's what we're here for. Patients get so much information, some good and some bad… or sometimes they get just enough information to hit the high spots. We have to make sure they get complete and accurate information." Another student added, "Look at the Internet for example. There's all kinds of information out there. Some is credible, but there is also a lot of garbage out there."

A participant from the first focus group provided and example that illustrated the informed status of many patients. She recalled a recent incident in which a patient prevented her from making a medication error. "… and she(the patient) asked 'What's this pink pill? I've never taken this before.' Then she told me exactly what routine medications she took. She knew correct dosages and all. I double-checked, and sure enough, it was the wrong medicine. I was so embarrassed, but I'd rather be embarrassed than make a medication error."

Participants reported that they routinely incorporated patient education into their practice. One participant remarked, "Teaching should be personalized, not something you just read out of a book. Every time you go in a room you should teach them something." At least five participants commented that teaching should be individualized or relevant to the patient's situation.

Several participants from each focus group commented that they were not confident in their ability to conduct effective patient education. It was reported that students lacked sufficient opportunities to apply their newly learned skills in the clinical setting. One participant voiced the sentiments of her colleagues, "We turn in teaching plans during the semester. They're major paperwork assignments, but what we need is more time and guidance at the bedside to practice." Others in her group agreed. Two well-received suggestions came from a participant in the second focus group. She recommended that 1 hour at the end of the clinical day be set aside for formal patient education or specific clinical days be designated as patient education days. As she explained "These could be a time to focus exclusively on teaching. No direct patient care, just education." Table 14 illustrates emerging themes and categories related to research question 4.

Table 14

Emerging Themes and Categories for Research Question 4: How Do Nursing Students Rate the Importance of Patient Education and to What Extent Do They Incorporate Teaching Into Their Practice?

The Value of Patient Education

1. Empowers patients
2. Patients feel safe, calm secure
3. Improved physical, psychological, emotional, and functional status
4. Patients don't need you so much
5. Patients are more in control

The Nurses' Role in Patient Education

1. It's an important part of what we do. That's what we're here for.
2. Every time you go in the room teach something
3. It should be personalized, not just read out of a book
4. Patients today know more. It's a challenge for nurses to stay current
5. There's a lot of information out there. Some is credible, some garbage
6. Nurses must make sure patients get accurate information

Students' Perceptions of their Teaching

1. I don't feel comfortable with my teaching skills
2. Need more practice teaching in the clinical setting
3. We do teaching plans, paperwork, but we need more hands-on.

Summary

Demographic data regarding the sample were provided along with the results of the focus group interviews. Analysis of focus group data revealed 15 major themes related to the 4 broad research questions. Chapter V presents a discussion and

interpretation of the data. Implications for nursing management, education, and research are discussed, as well as conclusions and recommendations for further research.

CHAPTER V: DISCUSSION, CONCLUSIONS, RECOMMENDATIONS

The final chapter of this dissertation draws the findings together and outlines the insights gained into the phenomenon of quality care and patient education as a result of this study. The findings are discussed, conclusions drawn, and recommendations made relating to the specific significance of this study for nursing practice.

Discussion of Findings

The quality of nursing care delivered from the perspective of the students interviewed for this study was found to consist of varying levels. The level of quality care was determined by the degree to which patients' needs were met, Where physical psychosocial, spiritual, emotional, and psychological needs were met, nursing was interpreted as being of highest quality. Low quality care was delivered when only physical needs were met or partially met.

Meeting patients' needs was found to be central to students' perceptions of quality care delivery. The provision of patient education was viewed as an important component of quality care. When patients' needs were met and when effective health education had been provided, patients were said to be facilitated in achieving a condition that was conducive to healing (positive patient outcomes).

Quality nursing care was found to occur when students had time to spend with patients. As one student commented, "It is that one-on-one time spent listening to

patients, finding out their stories, teaching them, and meeting all their needs... beyond just the physical." In addition to this, the presence of positive attributes in students (the ability to manage time and organize workloads, knowledge and competency with skills, and a caring attitude), support from staff nurses, and a functional team were all important conditions deemed necessary for quality care delivery. When nursing care was of low quality there was insufficient time, negative nursing attributes, non-support from staff, and a dysfunctional team.

Time available to deliver care was found to vary, and because of this, students assessed the amount of time available for care delivery. Factors affecting time availability were identified as workload, acuity of patients, number and type of staff available, time spent on charting and other paperwork, the ability to prioritize and manage time as well as factors inherent to the student role (inexperience, waiting for the instructor). When students worked within the context of insufficient time, they became frustrated and dissatisfied with their work. Several students questioned their decision to enter nursing. One student stated, "I thought it would be different than this... It's bad enough as a student but I see the nursing staff struggling and going around in circles because they can't do it all... I wonder what I've got myself into..."

As reported in Chapter IV, five dominant themes emerged in the analysis of the focus group data. General interpretations of the focus group responses are best made by analyzing the connections between and interrelationships among themes and by comparing findings from this study with findings from previous research.

The findings of this study endorse the findings of previous qualitative studies on the phenomenon of quality care, as well as contributing additional interpretations and explanations. The evolving theme of quality nursing care in this study, as in previous studies, was assessed by nursing students in terms of meeting patients needs (Dansky & Brannon, 1996: Iruita, 1993; Lauer et al., 1982; Lynn & Mcmillen, 1999; Miche et al., 1996; Naylor et al., 1996; Rieman, 1986; Shindaul-Rothschild et al., 1996; Ventura, 1998; Williams, 1998; Wolfe, 1999; Wolf et al., 1998). These needs were referred to as psychosocial, psychological, emotional, and spiritual care needs, as well as the more obvious physical needs. As in previous studies, the delivery of such holistic care was further reported to consist of providing health education, communicating, caring, advocating, as well as providing care for meeting patients' family and social needs (Babcock & Miller, 1993; Benner & Wrubel, 1989; Dansky & Brannon, 1996; Iruita, 1993; Kozier et al., 1992; Lynn & Mcmillen, 1999; Rieman, 1986; Watson, 1979; Williams, 1998).

There were a number of similarities in the findings of this study to the findings of other studies which have explored the quality of care from the nurses' perspective (Naylor et al., 1996; Williams, 1998; Wolf et al., 1998). These studies identified the meeting of patients' needs as quality nursing care. The facilitating conditions of the nurses' positive attributes, nursing competency, and a functional team were identified as well. The problem of nurses experiencing insufficient time to consistently deliver quality care was mentioned in previous studies along with the dissatisfaction and stress caused by the reduced ability to deliver quality care (Shindaul-Rothschild et al., 1996; Ventura,

1998; Williams, 1998; Wolfe ,1999). However, previous studies have not described the delivery of quality nursing care from student nurses' perspectives. Furthermore, the relationship between quality care and the degree to which patients' educational needs were met, is not as apparent in these studies.

Comparison of the findings from this study with the findings of studies exploring the meaning of quality care from the patient's perspective also reveal similarities (Dansky & Brannon, 1996; Iruita, 1993; Miche et al., 1996) as do comparisons with studies exploring perceptions of both nurses and patients (Lynn & McMillen, 1999; Lauer et al., 1982; Rieman, 1986). Findings from these studies identified the importance placed by patients on the meeting of their needs by nursing care delivery, and in particular, the meeting of psychosocial and individualized care needs. Rieman (1986) found that the absence of such care was viewed by patients as non-caring. The provision of physical care only in an impersonal manner was perceived by patients as a devaluation of their individual concerns.

Patient education as a component of high quality nursing care was a dominant theme across all groups. These findings were consistent with the literature (Babcock & Miller, 1993; Harrington et al., 1996; Jamieson, 1998; Kozier et al., 1992; Lauer et al., 1982; Mahat, 1998; Pender, 1987; Phillips & Heckelman, 1983). Participants placed a great emphasis on meeting patients' individualized educational needs and described the care of these needs in greater detail than care for physical needs. Students reported that despite time constraints and difficulties delivering quality care, they always or frequently incorporate teaching into their practice. Students drew from their own experiences and

provided rich descriptions of the significance of patient education, citing improvements in patients' physical, emotional, and functional status. It was reported that if nurses provided the patient with education, then the impact of compromises in quality care was often reduced. One student explained this concept, "If they understand, know what to do, know what to expect, then they can help themselves.... they are in control, empowered. They don't need you so much because they know what to do." Students reported that patients expect and value education given by nurses.

Participants recognized that many patients today are no longer passive recipients of health care, but insist on the right to be informed and participate in their care. This coupled with their increased accessibility to information (Internet, television, radio, and other media) increases nurses' responsibility to provide patients with correct, complete, and factual information, as well as to help patients evaluate the credibility of information obtained from other sources. Hohn (1998) points out that consumers increasingly rely on multiple sources of health information. Health professionals must be prepared to utilize a number of innovative teaching strategies and a wide variety of media to provide consumers with timely, relevant, and practical health information. Students in all groups identified the need for improved teaching skills as well as increased opportunity to apply those skills in the clinical setting.

The pattern of patient education identified in this study differs from that found in studies where nurses were reported to underestimate the value patients place on education (Lauer et al., 1982; Mayer, 1987), and from studies where nurses were found to cut short patient education when time was restricted (Babcock & Miller, 1993; Shindaul-

Rothschild et al., 1996; Ventura, 1999; Wolfe, 1999). A possible explanation for these differences is that perhaps for student nurses faced with learning new responsibilities, and facing uncertain clinical challenges, it is paramount to embrace and apply the ideals learned in school that are not always possible to achieve or maintain in everyday nursing practice. It is also possible that students answered in a socially acceptable manner, that is answering the question as they felt it should be answered, rather than as they honestly wanted to. However, students appeared open and candid during focus group sessions, and several participants specifically commented that they welcomed the opportunity to "vent" their feelings. This issue will require exploration in future studies.

Major themes in relation to quality care were factors that enhanced or hindered the delivery of care. Together with the need for sufficient time to provide care, the nursing team was seen to play a vital role in maintaining standards for quality care delivery as well as providing a support mechanism for students. Relationships with staff nurses were clearly of importance to the participants. However, not all nurses were seen as nurturing, positive role models. One student echoed the sentiments of others in her group, "It's true, nurses really do eat their young." Overall, students' morale was low as a result of negative relationships with practicing nurses. Several participants expressed the desire for nurses to be more understanding and supportive of them.

The competency of students was discussed as contributing to their ability to deliver quality care. Participants identified the need for astute assessment skills and expertise with technical aspects of care. In addition to these traditional nursing skills, it was reported that student nurses require skills in time management, leadership, and

communication. These findings confirm the perceptions of Mahat (1998), Williams (1998), and Wolf et al. (1994). These researchers contend that if nurses are to be successful in their practice, they must be equipped with the skills to most effectively utilize the resources available in the current healthcare environment. However, participants in this study generally perceived their education to be deficient in these areas.

Students identified charting and other paperwork as time consuming tasks that took away from patient care. One student commented, "It seems that at least ½ your time is taken up with all this paperwork. We do so much that could be delegated to someone else.. it takes away from time with patients." Others in her group agreed. These findings are supported in the professional literature. Hendrickson et al. (1990) conducted an observational study as to how nurses use their time and found that nurses spend only 31% of their time with patients. The majority of nurses' time was found to be concerned with paperwork and other activities other that direct patient care.

The identification of a perceived inability to consistently provide high quality care to all patients and the resulting evidence of dissatisfaction in this small sample of nursing students was of particular note. Previous research has indicated that nurses do suffer from high levels of work related stress (Benner & Wrubel, 1989; Joel, 1997; Lamendola, 1996; Miche et al., 1996; Shindaul-Rothschild et al., 1996; Ventura. 1999; Williams, 1998; Wolf, 1998; Wolfe, 1999), and in one study (Hutchinson, 1987), it was suggested that more support should be given to nurses to assist them in coping with the stresses encountered in their work. The strategies suggested were enhancing the relationship between nurses and supervisors by educating nursing administrators to provide the kind

of support which best assists nurses to cope; team building and improvements in communication skills. Hutchinson identified strategies that could be used by nurses to enhance self-care. These strategies included the socializing outside work of nurses who worked together to strengthen relationships and develop an effective team. According to Hutchinson, "When self-care is effective, nurses have a sense of well-being and a feeling of control over themselves and their practice" (p.196). Mahat (1998) found the clinical setting to be stressful for students. Problems in the nurse-student relationship were identified as a major cause of this stress. Mahat maintains that a certain degree of stress is unavoidable due to the nature of the experience and it is sometimes necessary to challenge students to learn, but too much stress hinders learning. In light of previous research and findings of this present study it would appear that nurse educators and nurse administrators could collaborate to minimize stress among staff nurses and students by promoting the team building strategies suggested by Hutchinson (1987). Indeed, findings from this study clearly indicate that the staff nurse-student relationship demands special attention.

The emerging theme of how student nurses prioritize care is consistent with Williams' (1998) notion of selective focusing. Depending on time available, students were found to focus on certain needs of patients to deliver quality care. This resulted in the omission of nursing care or nursing care needs of some of the patients. However, the parameters of patient safety were found to be of the utmost importance. The level of safety was said to guide students' choices and priority of actions. Situations and resources were assessed and work was planned and carried out accordingly. Some

activities, such as assessments and medications, were said to be undertaken immediately, while others were left to a more convenient time. Individual patient needs were continually assessed by students and then placed in the context of other needs that may be present, as well as with the needs of other patients in their care. Like nurses in Williams' (1998) investigation, participants in this study indicated they disliked having to prioritize their work and felt frustrated when they were unable to provide the care they would have liked to provided. Findings from this study provide support for Williams' position that within the current context of limited time and resources, it would seem necessary to concentrate efforts on the identification of patients in most need of high quality care. Selection of specific patients may be determined by such factors as their dependence on nursing care for meeting their needs, their level of vulnerability, and level of family support. Standards should also be put in place to ensure that these patients not focused on do not receive compromised or unsafe care.

Additional Analysis

Analysis of the focus group transcripts revealed additional issues that were of concern to the participants or of interest to the investigator. This section further explores focus group responses under the headings: (a) Comparison of the Demographics of the Participants with other ADN programs, (b) Context of the Focus groups, and (c) Attitudes Towards Nursing School.

Comparison of the Demographics of the Participants with other ADN Programs

The investigator noted an unexpected item of interest in the demographics. A comparison of the study group is not consistent with the male-female ratio typical of most

Texas ADN programs. Of the 26 participants in this study, only 1 was male. While nursing has been and continues to be a female dominated profession, the number of men entering nursing has steadily increased over the past 2 decades. Approximately 8.5% of RNs in the state of Texas are male (Board of Nurse Examiners for the State of Texas, 1999). According to the director of the program, approximately 10% of current nursing students in the state are male (Patrick Lilley, personal communication, February 28, 2000). The director of the ADN program reported that the current under representation of males is an unusual occurrence and that the demographics of the ADN program generally reflects that of typical ADN student bodies across the state.

Context of Focus Groups

The same format was used for each focus group. One group appeared slightly rushed at the end due to worsening weather conditions. One improvement was implemented as a result from an evaluation of the pilot test. Initially, the tape recorder was situated in a corner of the room, so as not to distract the participants. However, the researcher decided to place the recorder on the table and arrange chairs in a closer seating pattern during subsequent sessions to improve voice pick-up. An initial concern was that the tape recorder would distract participants or inhibit their comments. However, students did not seem to mind having the recorder in clear view.

Another interesting point, was the enthusiasm participants displayed for the study. Once the investigator explained the purpose of the study and emphasized that she was interested in what they had to say, students were eager to participate. The participants seemed pleased that the investigator was interested in their perceptions and their

experiences. Upon completion of each focus group session, several students thanked the researcher for being interested in hearing their views and for allowing them to "vent" their feelings. Three or four students remarked that they hoped changes would be made to the nursing program as a result of this research. The investigator was cautious in replying so that false assumptions or expectations were not given.

The dynamics of each focus group were different. Some groups were more talkative than others. All groups were comprised of individuals with and without previous healthcare work experience. Eight of the participants (31%) were classified as LVN transition students. The nursing program in this study, along with most ADN programs across the United States, offers a transition program that allows individuals who are licensed vocational nurses (LVNs) to enter the 2nd year of the ADN program after completing pre-requisite courses. The researcher was interested to find there was little variation in student responses regardless of previous health care experience.

Overall, responses were similar across all groups. However, when the topic of prioritizing care was mentioned, one student in the 2nd group spoke at length, stating that he prioritized nursing care according to legal ramifications. "What I can be taken to court for." No other students made similar comments.

Attitudes Towards Nursing School

The fact that problems associated with the student role were voiced many times was of particular interest and concern to the investigator. Overall, students reported feeling discouraged as a result of unkind treatment from the nursing staff. On several occasions, concern was expressed that students were not being prepared to successfully

transition from the student role to the professional RN role. Participants reported that they needed more "hands-on" clinical experiences rather than many of the classroom assignments that they felt had little application to "real-world" nursing practice. As one student stated, "We need the skills to help us function in the real world… not all this paperwork… We are getting ready to graduate and I don't feel prepared." Several students suggested that the last semester of school should be spent in internships. One student said, "Let us work as real nurses. Help us make the leap from student to nurse. When we graduate we are going to be expected to hit the ground running. We're not ready." Smaller clinical groups to allow the instructor more one-on-one time with students and preceptor experiences were mentioned several times as well.

Students in all groups identified the need for a stronger emphasis on time management, communication, leadership, and patient education skills. One LVN transition student expressed her unhappiness, "I didn't think it would be like this. I thought we would learn to communicate with patients, teach them, be a leader…learn things a professional is supposed to know. All we do is paperwork in class and change beds and handout bed-pans in clinical."

Participants in this study recognized that nursing is facing the demand to produce a professional with abilities to function in the complex contemporary healthcare system. However, the frustration expressed by these students regarding treatment by nursing colleagues and perceived deficiencies in their education raises serious concerns.

Conclusions and Recommendations

Research Questions

The following research questions were addressed using the data from the focus group discussions:

1. What does quality nursing care mean to nursing students? Focus group responses revealed that students have a vision of quality care. They understand quality care to be more than just efficient, regimented actions. Participants reported positive nursing attributes, provision of individualized, holistic care, and health education as elements of high quality nursing care. Quality care was said to occur when the physical, psychosocial, psychological, emotional, and spiritual needs of the patient were met. Participants expressed pride and satisfaction in their work when they were able to deliver quality care. However, they also expressed frustration when they were unable to consistently provide quality care to all patients.

2. What factors enhance/inhibit nursing students' ability to deliver quality care? The importance of "time," teamwork," and "support from staff nurses" were voiced many times. Having sufficient time to spend with patients was mentioned every time the topic was introduced. The ability to manage time, think critically, solve problems, and communicate were perceived as paramount to nurses ability to provide quality care. The importance of teamwork and support from nursing staff was mentioned at least 17 times as necessary for the provision of quality care.

Overall, time constraints and lack of support from staff nurses were reported to be the key barriers to the delivery of quality care from the student nurses' perspectives. The

majority of students perceived support from practicing RNs to be minimal. Staff nurses were seen to possess the ability to facilitate students learning experiences. However, it was reported that nurses were frequently unkind. Students identified factors inherent to the student role as inhibiting their ability to deliver quality care at times. It was reported that, as novices, they often lack sufficient knowledge and skills. Students also reported feeling, at times, held back because they had to wait for their instructor before performing many skills. Participants discussed perceived gaps in their education and they identified the need for an increased emphasis on time management, organization, communication, leadership, and patient education skills.

3. How do nursing students prioritize care? Focus group responses revealed that patient safety along with medication administration issues were the most important criteria to consider when prioritizing nursing care. It was suggested that when time was limited, the patients in most need were focused upon and others were provided care within the parameters of safety.

4. How do nursing students rate the importance of patient education, and to what extent do they incorporate education into their practice? Participants consistently identified patient education to be an important component of quality care as well as an integral nursing responsibility. It was reported that effective health education empowers patients and helps them to achieve and maintain an optimal level of wellness. Furthermore, students recognized that many patients expect to be active participants in their healthcare regimens. Participants remarked that nurses have a responsibility to help patients evaluate the credibility of health information currently available. Students

reported that they consistently incorporate teaching into their practice (53.8% always, 46.2 % frequently). However, several participants in this study reported a lack of confidence in their ability to conduct effective patient education and verbalized the desire for increased opportunities to conduct formal patient education in the clinical setting.

Implications for Nursing

The premise for this research was the assumption that insights into students' experiences in providing quality care and patient education can be gained from accounts of their own lived experiences. By listening to the narrative of nursing students it was possible to experience their emotions, beliefs, and philosophies. Through the use of inductive methods, common meanings embedded in the experiences of these students were revealed. The remembrance, analysis, and synthesis of the phenomenon representing the experience of providing care for patients are examples of real-world clinical scholarship, and they have implications for the nursing profession in the education, practice, and research arenas.

Findings from this present study add to the growing body of evidence that the actualization of quality nursing care is becoming increasing difficult and deficient. The current unstable economic environment and the focus on cost-effectiveness aspects of care have major implications for nursing as well as other health professions. It is the investigator's opinion that nurses must be engaged in the restructuring and innovative rethinking of priorities related to delivery and management of patient care. It is imperative that nurses develop skills in taking a proactive and accountable position to ensure standards of care are maintained and the delivery of quality care to all patients is

ensured. Indeed, the results of this study highlight the problems and challenges that student nurses face today. But what are the answers to these dilemmas? It appears that the solutions are not simple, easily put in place, or even complete. However, it would serve us well to develop a heightened sensitivity to situations that cause student nurses concern. If nursing is to maintain the highest level of professional practice, educators, administrators, and staff nurses must re-examine their interactions with students and novice nurses. Students are nursing's future. Without them, professional extinction beckons. It is the investigator's opinion that particular attention should be paid to the development and implementation of strategies to support students in their education.

Nurse educators must rise to the occasion of preparing a cadre of nurses suited to the chaos and complexity of the future. There is a need to re-examine nursing school curricula. With the rapid changes in the healthcare system and the shifts toward cost containment, students must be taught the strategies necessary to most effectively use resources available. The focus of attention onto effective methods to incorporate patient education into their practice would be an essential part of this process. Strategies to allow students increased time to conduct patient education could be considered. Emerging technology could be utilized (video-conferencing, computers, etc.) to encourage the development of critical thinking skills and increase the participation of students in the learning process. Students could use information technology in the development of patient education projects with an emphasis on proactive health promotion rather than on reaction to crisis.

Additionally, as Williams (1998) suggests, students may benefit from skills in time management, organization, and communication. Consideration should also be given to Mahat's (1998) position that renewed emphasis on the stresses associated with nursing, along with directions for effective management for those stresses should be provided. Moreover, it is the investigator's opinion that educators must guard against assigning unrealistic study loads that may have little relationship to clinical practice.

Multidisciplinary collaboration among all members of the healthcare team is important. Student nurses may benefit from clinical rotations conducted with other health professionals, including preceptored experiences with health educators. This would provide student nurses the opportunity to learn sophisticated and effective patient education skills.

From a nursing management perspective, the introduction of strategies to assist novice nurses successfully make the transition from school to the practice setting, would appear important. While downsizing and cost-cutting have taken a toll on nursing budgets, it is imperative that administrators push for effective orientation, preceptor, and education programs for novice RNs. It is the investigator's opinion that nurse administrators who do not support their novice's rights to beginner status contribute heavily to burnout, frustration, and dropout of nursing's young.

The introduction of staffing strategies to facilitate positive relationships between experienced nurses and novice nurses is recommended. As Willliams (1998) maintains, the number and skill mix of nurses to a particular ward should be carefully allocated.

Students and new graduates should be supported without taxing the more experienced nurses who may already be overburdened with a heavy workload.

Indeed, the nurse-student relationship demands special attention. Participants in this study were clearly frustrated by the lack of care and concern shown by the staff nurses. Having worked hard to reach their goals, they were hurt when they were ignored or treated condescendingly. Students realized they have much to learn and expressed a desire for mentors who will help them understand the system and function in it,

The researcher recognizes from her own personal experience, and as indicated by previous studies, today's staff nurse is often frustrated and may be close to burnout herself. Nurses may be tempted to think they don't have the time or energy to help a novice develop skills. However, this is a self-defeating attitude. It doesn't make the nurses position more secure or help patients. On the other hand, by supporting and mentoring a novice nurse, experienced nurses can reap the rewards of gaining a capable colleague to help with heavy caseloads.

Teamwork is essential for the delivery of quality care. By identifying the needs of students and using the appropriate strategies, educators and clinicians should be able to positively affect patient care as well as staff nurses' and student nurses' satisfaction.

Directions for Future Research

The delivery of quality care and patient education as described in this study has not been previously identified. This study can not be generalized to wider populations of student nurses at this stage because the methodology and the context in which the data were collected limit them. Confirmation of these findings in a wider range of settings

would need to be researched further. However, this study represents a first and necessary step in understanding student nurses' perceptions of the complex clinical phenomenon of quality care and patient education as a component of such care.

There are many possibilities for future research on the topic of quality care and the significance of patient education from student nurses' perspectives. A few suggestions are itemized as follows:

1. Conduct a similar study on a wider scale to increase generalizability.

2. Replicate this study with more male students. Although nurses and nursing students are predominantly female, study result using a more equal proportion of males and females may affect study results.

3. Conduct a longitudinal analysis of students' perceptions of quality care and patient education. A 6-month and 1 year follow-up after graduation may be appropriate to determine if perceptions differ over time.

4. Continued research into the quality of nursing care and patient education in wider contexts including the nurses' and patients' perceptions.

Summary

This study highlights the perceived importance of patient education and the perceptions of quality care from student nurses' perspectives and provides insights into the realities faced daily by students. The identification of the inability of students to consistently deliver quality care to all patients, the recognition of limiting factors, and the application of strategies directed at supporting students in the education could lead to a greater facilitation of quality care to more patients. A number of issues were identified in

this study which require further exploration and continuation of research in this area is strongly recommended.

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APPENDICES

APPENDIX A

Human Subjects Review Committee
Consent to Conduct Research

TEXAS WOMAN'S
UNIVERSITY
DENTON · DALLAS · HOUSTON

HUMAN SUBJECTS
REVIEW COMMITTEE
P.O. Box 425619
Denton, TX 76204-5619
Phone: 940/898-3377
Fax: 940/898-3416

February 1, 2000

Ms. Robin Caldwell
119 RiverBoat Drive
Denison, TX 75021

Dear Ms. Caldwell:

Re: Quality Nursing Care: An Exploration of Student Nurses' Perspectives

The above referenced study has been reviewed by a committee of the Human Subjects Review Committee and appears to meet our requirements in regard to protection of individuals' rights.

If applicable, agency approval letters obtained should be submitted to the HSRC upon receipt prior to any data collection at that agency. The signed consent forms and an annual/final report (attached) are to be filed with the Human Subjects Review Committee at the completion of the study.

This approval is valid one year from the date of this letter. Furthermore, according to HHS regulations, another review by the Committee is required if your project changes. If you have any questions, please feel free to call the Human Subjects Review Committee at the phone number listed above.

Sincerely,

Dr. Linda Rubin, Chair
Human Subjects Review Committee - Denton

cc. Dr. Susan Ward, Department of Health Studies
Dr. Eva Doyle, Department of Health Studies
Graduate School

APPENDIX B

Subject Consent to
Participate in Research

Texas Woman's University

Subject consent to
participate in research

Quality Nursing Care: An Exploration of Student Nurses' Perspectives

Researchers: Robin Caldwell, MS, RN, CNS, 940-668-4264
Eva Doyle, Ph. D., C.H.E.S., 940-898-2841

I am being invited to participate in a research study which involves my participation in a focus group. The focus group is a group of 8-10 people that discuss their feelings about specific topics under the direction of a leader. The purpose of this study is to gather information about my views as a student nurse regarding quality nursing care, and the significance of patient education. The focus group will take about 45 minutes of my time. Before the focus group interview I will be asked to complete a short questionnaire which asks questions related to the interview topic. The questionnaire will take about 15 minutes of my time. My total involvement will take about 1½-2 hours.

During the focus group, the trained leader will ask me and the other participants some general questions about my definition of quality care, and what factors affect my ability to provide quality care. I will also be asked how I rate the importance of patient education.

Prior to and at the end of the group I will be able to ask any questions I might have about this research or the procedures involved. I understand that the focus group will be audiotaped so that my comments will be transcribed by the investigator. My name will not be associated with the comments once they are taken from the audiotape. My name will not appear on the questionnaire at any time. Audiotapes will be erased after the comments are transcribed. All transcripts and questionnaires will be destroyed within 3 years of completion of the study.

Possible risks of participating in the study are as follows: It is possible I might feel some embarrassment, intimidation, stress, or loss of privacy during this research. In addition to the group leader, 1-2 research assistants may be present in the room in order to assist the leader. Several measures are in place to protect my rights and to minimize these risks. They are as follows: the group leader and assistants have been trained in running groups and protecting my rights, I am free to refuse to answer any question I choose, and I may stop participating at any time without consequence. Data associated with the study will be locked in the investigator's home and I will not be mentioned by name in any reports or articles written about this research. Portions of transcripts may be shared with the researcher's dissertation committee. No names or identifying remarks will be used.

Participant's Initials

Confidentiality will be protected to the extent that is allowed by law.

I may benefit from this study by learning about the realities of nursing and how to better help patients and function more effectively in the clinical setting. I will receive refreshments and a token gift.

If I have any questions about the research or my rights as a subject, I should ask the researchers: their phone numbers are at the top of this form. If I have questions later, or I wish to report a problem, I may call the researchers or Ms. Tracy Lindsay in the office of Research and Grant Administration at 940-898-3377.

The researchers will try to prevent any problem that could happen because of this research. I should let the researchers know at once if there is a problem and they will help me. I understand, however, that TWU does not provide medical services or financial assistance for injuries that might happen because I am taking part in this research.

My participation is voluntary and I may withdraw from the research at anytime. Withdrawal or refusal to participate will involve no penalty and will not affect my grades or academic status. I have been given the opportunity to have my questions answered. I will be given a copy of the dated and signal consent form to keep.

_____ _____

Signature of Participant Date

The above form was read, discussed and signed in my presence. In my opinion the person signing said consent form did so freely and with full knowledge and understanding of its content.

_____ _____

Representative of Texas Woman's University Date

APPENDIX C

Letter Requesting Permission
From Director of ADN Program to
Conduct Research

Jan 4, 2000
Mr. Patrick Lilley RN, MBA, MSN
Director of Associate Degree Nursing

Dear Mr. Lilley,

I am a doctoral candidate in the Department of Health Studies, Texas Woman's University. I am preparing to conduct a research study to fulfill the requirements for my doctoral degree under the supervision of my major advisor, Dr. Eva Doyle. I am proposing to study student nurses' perceptions of quality care, and the significance of patient education. I would like to include associate degree nursing students in my study population. As you may recall from our conversation on Jan 3, 2000, I would like to conduct focus group interviews with 2nd year students at the clinical settings between mid-February and early March, 2000. Students will be advised that participation is voluntary and neither their decision to participate nor their responses if they do participate will affect their grades. A copy of my prospectus, the interview instrument and questionnaire/ demographic data sheet is enclosed for your consideration.

Following your consideration of these proposed procedures and the enclosed materials, please indicate in writing that I have your permission to conduct the study procedures outlined above. If you have any questions please do not hesitate to call me at (903) 463-6461 or Dr. Doyle at (940) 898-2841.

With my sincere thanks ,

Robin Caldwell
MS, RN, CNS

APPENDIX D

ADN Program Permission

Texas Woman's University
Health Studies Program Permission
for conducting student focus groups

The [illegible] Associate Degree Nursing program, [illegible], grants to Robin Caldwell, MS, RN, CNS, a doctoral candidate in the department of Health Studies at Texas Woman's University, the limited use of its facilities in order to study the following:

Quality Nursing Care: An Exploration of Student Nurses' Perspectives

This study involves holding 3 focus groups following a pilot study at clinical facilities during the months of Feb.- March 2000. Each student will be given a consent form to sign before participation. Participation is on a voluntary basis and may be discontinued at any time without consequence. There will be absolutely no coercion of any kind used to persuade students to participate.

Please read each item and circle and initial the appropriate parenthesis. You may fill in additional conditions if you wish. The conditions mutually agreed upon are as follows:

1. The institution (may) (may not) be identified in the report.
2. The names of consultive or administrative personnel in the [illegible] ADN program (may) (may not) to be identified in the final report.
3. The institution (wants) (does not want) a conference with the student when the report is completed.
4. Other (please fill in):

_____

_____

[illegible] MSN MBA
Agency Representative

1-13-00
Date

Robin Caldwell 1-13-00
Student Signature, Date

APPENDIX E

Questionnaire/Demographic Survey

Questionnaire/Demographic Data Sheet

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1. How important do you consider quality nursing care to be to positive patient outcomes?
   1. very important
   2. important
   3. somewhat important
   4. somewhat unimportant
   5. unimportant

2. How often do you feel you are able to provide quality care to your patients?
   1. always
   2. frequently
   3. sometimes
   4. rarely
   5. never

   *If your answer was other than "always," define what impedes your delivery of quality care?_____

3. How important is patient education to quality care?
   1. very important
   2. important
   3. somewhat important
   4. somewhat unimportant
   5. unimportant

4. How often do you include patient education in your practice?
   1. always
   2. frequently
   3. sometimes
   4. rarely
   5. never

Demographic Survey

1. Age_____
2. Gender: male___ female___
3. Ethnicity
   - ___Caucasian
   - ___African American
   - ___Hispanic
   - ___Asian
   - ___Native American
   - ___Other
4. Current Employment Status
   - ___Full-time
   - ___Part-time
   - ___Unemployed
5. Previous or current health-care work related experience
   - ___yes
   - ___no

   *If "yes," state when and in what capacity: _____
6. Student Classification
   - ___Generic student
   - ___LVN transition student

APPENDIX F

Focus Group Interview Guide

Transcript of Focus Group
Interview Guide

1. Introduction and Purpose:
    1. Thank you for coming
    2. I am interested in what you have to say.

    3. You will participate in a focus group. I will be asking you some general questions and would like for you to tell me what you think. There is no right or wrong answer. You do not have to agree with each other. You are free to refuse to answer any questions you choose.
    4. The information you give will be used to help improve quality nursing care.

2. Procedure:
    1. Before the focus group interview you will be asked to complete a short questionnaire. Do not put your name on the form. Your answers will be kept confidential.
    2. We will be using a tape recorder during the interviews so that we can record what you say. Your comments are confidential, and will be used for research study.
    3. We will be meeting with 3 other groups like this one, and be asking the same questions to each group.
    4. You do not have to wait to be called upon to talk. It is easier
    5. if you talk one at a time so that the tape recorder and note taker can get everything you say - please do not use your name or other people□s names in order to preserve confidentiality.
    6. I will be asking several questions. Please stop if there is anything that you want to add before we move on to another area.
    7. We will pass out questionnaires and allow 15 minutes to complete the forms. We will collect the forms and I will then start the focus group - which should take no longer than 45 minutes.
    8. The following focus group questions will be asked. Standard prompts follow.

        1. What does quality nursing care mean to you?

        2. What factors enhance/hinder your ability to deliver quality nursing care?

3. What are some of the most important aspects to consider in the delivery of quality care? Can these be prioritized?

4. How do you rate the significance of patient education and how do you incorporate teaching into your practice?

Standard Prompts

1. What are some characteristics of high quality/low quality care?

2. What helps you?-Can you think of a time when you felt you were able/unable to

3. How do you decide what is top/low priority as you organize your day/nursing care? How do you decide what takes priority?

4. How important is it for nurses to teach patients? Give and example of a situation

3. Closure

1. If there is anything that you want to add before we end?
2. Thank you for telling me what you think. The information from all of the groups will be summarized and used to improve the delivery of quality care and help nurses function more effectively.
3. Once again thank you for your opinions.
4. You may call the number on the consent form for future questions/concerns.

You may review your groups audiotape.

You will be welcome to findings of this study.