

Nurses Participating in Healthcare Facility Redesign: A Qualitative  
Descriptive Study

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Descriptive Study

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# Nurses Participating in Healthcare Facility Redesign: A Qualitative Descriptive Study.

## **Abstract**

This study aims to reveal the experiences of senior nurses who have been expressly involved in healthcare facility and care redesign. This qualitative descriptive research describes the experiences of three senior nurses participating in hospital redesign at a New Zealand District Health Board (DHB). By examining their roles as project owners for facility and care redesign in project groups, we gain understanding of how such involvement currently exists, and what future recommendations might be formulated. Throughout New Zealand nurses have been involved in major hospital redevelopments, providing a unique opportunity to redesign facilities and systems of care. The participation of nurses in facility redesign projects contributes to a focus on the needs of key stakeholders, such as patient flow-through services, and reviewing current work practices and processes of care. Nurses demonstrate high levels of commitment to facility redesign projects holding key positions of representation. They seek to ensure integration with overall Ministry of Health strategic aims, service delivery requirements, client and population needs, and incorporating multidisciplinary healthcare concerns. Within this research paradigm the existing and apparent themes have been interpreted as *Representation; Leadership; Relationships; and Creativity*. These overarching themes were apparent in the data and thus provided important direction for the collation, presentation, and discussion of the related data and the findings. The subsequent recommendations focus on offering more support to enable senior nurses to be better equipped to fulfil this important role, with the aim being to ensure the new facility supports clients in a clinically safe environment.

## **Acknowledgements**

Thank you to the participants for generously disclosing the stories of their experiences.

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## **Attestation of Authorship**

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed:

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Julia Braid

## **Ethics Approval**

The application for ethical approval to AUTEC – AUT's Ethics Committee was completed in March 2010. The ethics application was referred to the Northern X Regional Ethics Committee.

Ethical approval was granted on 9 April 2010 by the Northern X Regional Ethics Committee.

Reference: NTX/10/EXP/050.

## **List of Abbreviations**

CNM - Clinical Nurse Manager.

DHB - District Health Board.

## **List of Definitions**

Healthcare facility - the hospital facility or environment (such as a patient ward, specialty department, or specialised clinical unit) where patients are cared for by multidisciplinary healthcare teams.

Facility redesign management group - a structure of senior management, with overall authority and responsibility for facility redesign project achievement.

Facility redesign project group - the working group established to provide clinical and operational knowledge to inform the redesign of a given healthcare facility. Consisting of a change manager and project owner (a senior nurse), and other key nurses, clinical and non-clinical staff.

Non-clinical staff - staff who are employed by the DHB in support services such as Procurement, Information Technology, food services, Orderlies and stores.

Senior nurse - the senior nurse within the project working group and whom acts in the role of project owner.

# **Chapter One**

## **The Research Context**

The aim of this dissertation is to describe the experience of nurses participating in healthcare facility redesign projects. The key assumption for this study is that investigating the experience of nurses involved in healthcare facility redesign will lead to some understanding of, and implications for, the resulting roles, processes, and outcomes. There is a growing body of nurses who have significant levels of involvement in the process of transforming hospital facilities and redesigning the way in which nurses and their counterparts deliver care in new or refurbished clinical areas. It is expected that investigating some of the nurses' experiences will lead to an understanding of their perspective from being within these redesign groups. Exploring the nurses' experiences through personal narratives will contribute to a deeper understanding of the nature of participating in healthcare facility redesign.

### **Background**

In the last decade nurses have had an opportunity to be involved in the redesign of public hospital facilities within New Zealand (e.g. Auckland City, Nelson, and Wellington, to name a few). During this period of hospital redevelopment there has been rapid and complex changes in healthcare demand and delivery. Nursing as a profession has been responsive to change and has expanded into new roles and areas of practice specialisation due to a range of factors such as technological, political, economic and social forces (Daly, Speedy, & Jackson, 2007).

Senior nurses in this study have been involved in recent and current facility redesign projects as members of *user groups*. Individual user groups were structured to focus redesign work on specific clinical areas such as in-patient wards, speciality units and departments, theatres, and surgical day-stay, and so forth. Nurses have held various positions of responsibility in facility

redesign user groups, directly influencing how the vision for patient care and service delivery is implemented in new facilities (X District Health Board, 2001b) User group project owners were selected from their role as the current cost centre manager of the ward, unit, or department, being redesigned. Medical staff were also represented in user groups in partnership with nursing. However, over a prolonged period of time clinical and other commitments often limited the medical staff's abilities to maintain an in-depth focus on project work. This resulted in the provision of consultation rather than sharing responsibilities of leadership for the group.

An example of a project brief states that facility design is informed by the purpose of the service and the services to be delivered (X DHB, 2001b). The project evolves through detailed and complex processes of decision-making, linking specific care pathways of clients to facility design and staff workflow. The *X District Health Board's* (2001a, p. 1) terms of reference for the user groups states that the nurses' function within such user groups is to:

- *review current work practices and recommend improvements;*
- *inform practice changes and relate these to impacts on facility design;*
- *research and visit other hospitals and recommend design options and learn from their ideas and experience;*
- *communicate with all key stakeholders.*

Senior nurses have collaborated in their user group roles with other healthcare workers, support service leaders, and industry consultants, to design healthcare facilities. Significant time, effort, commitment, and resources, have been required to sustain the nurses' involvement in these groups.

### **Researcher's Position**

I am a senior nurse within a New Zealand District Health Board (DHB), and have worked in this role for twelve years. As I attended various subject-related meetings and conferences I became interested in the stories of senior nurses participating in healthcare redesign projects from my own, and other, DHBs. I was yet to experience involvement in a user group myself, but I was hearing stories of the work being done, the involvement and investment of

nursing knowledge and expertise, the interpersonal relationships, the frustration of constraints, and the eventual outcomes of the redesign process. Then I read a letter to the editor in the *Kai Tiaki Nursing New Zealand* magazine (McCord, 2009), which was written by a nurse and midwife, stating that we should not be celebrating healthcare facility redesign because the reality for the end user is a compromised system. This sparked my interest in what was happening as nurses participated in user groups; '*What was their experience?*'. It seemed to me, that there was an untold story of nurses' experiences in healthcare facility redesign projects that needed to be described. Thus my research question emerged:

*'What are nurses' experiences of participating in healthcare facility redesign?'*

### **Research Significance**

The description of nurses' experiences in healthcare facility redesign may contribute to the body of nursing knowledge regarding how the nurses' influence, professionalism, and commitment impacts upon the development and outcomes of new healthcare environments.

The experiences described by nurses may also inform on the way in which nurses are prepared for accountabilities and responsibilities of leadership in healthcare facility redesign projects prior to taking on these roles.

It is hoped that this study will be useful to members of facility redesign project teams from industries such as architects and other involved consultants, so that they may have an understanding of the professional perspectives of senior nurses as they approach the processes of healthcare facility redesign.

### **Research Approach**

This is a small study, being only a part of a 60-point dissertation. My primary aim, having limited scope, was to listen to the stories of a small group of nurses who had been involved in healthcare facility redesign. The methodological approach is qualitative descriptive, seeking to reveal themes from which discussion and recommendations can be drawn.

## **Dissertation Structure**

This chapter has introduced the research question and significance. The following chapter presents a brief overview of relevant literature, noting that there is very limited writing on this topic. Chapter Three describes the research approach and methods, followed by a presentation of the findings in the fourth chapter. The final chapter offers a discussion, recommendations for practice, and ideas for further research. The scope of this research is narrow, but nevertheless the investigations have provided some vital insight into the research question at hand.

## **Chapter Two**

### **Literature Review**

#### **Review of the Nominal Literature**

The *keywords* used in the search for literature pertaining to healthcare facility redesign were: healthcare facility; healthcare redesign; facility redesign; nurses; facility design; hospital design.

Of the available literature, there were no identified qualitative research studies specifically relating to the *experiences* or *meaning* for nurses directly participating in an actual healthcare facility redesign project. However, there is an article authored by Lamb, Connor and Ossmann (2007) which describes their experience of participating in a unique educational course to design an innovative hospital room, from the vantage point of being nurses and nurse educators. The course included students from nursing, architecture, industrial design, systems engineering, and computer sciences, fields who worked together to design the *hospital room of the future* (Lamb, Connor, & Ossmann, 2007).

The authors state that the students' experiences "gave us [the authors] important insights into the role nurses play in educating healthcare design professionals about nursing practice and science, as well as the benefits of collaborating with designers" (Lamb, Connor, & Ossmann, 2007, p. 425).

In their study, Lamb, Connor, and Ossman (2007) sought to understand how to: merge diverse professional cultures and languages; define terminology and communicate values and measurements of success; and how this would lead to greater collaboration within a facility project team. The authors described the learning from their involvement in the course as the "importance of collaborative problem solving and the benefits of looking in new ways at common problems" (Lamb, Connor, & Ossmann, 2007, p. 426). The nurses involved in the course provided insights into the world of caring for patients as

they were able to *dissect their practice*, providing vital information for designers on how to solve problems and why it was necessary to do so. Nurses were able to inform the design team of the direct relationships of design problems to patient safety and quality outcomes (such as bathroom design and reduced falls risk). Another key part of the development of group solution generation was that professional differences were believed to be a critical part of the creative process, and that no one professional group or individual “had all of the pieces” (Lamb, Connor, & Ossmann, 2007, p. 428).

The study described three outcomes of successful healthcare facility design. Firstly, that facility design reflects the values and goals of its many stakeholders. Secondly, interdisciplinary processes may generate innovation and creativity. Thirdly, nurses found it “compelling to participate in the transformation of nursing and design knowledge into better designs for patient care” (Lamb, Connor, & Ossmann, 2007, p. 428).

One article written in an American nursing administrators journal identified that senior nurses participating in healthcare design projects, such as expanding or renovating hospitals, must extend their knowledge and capabilities in the field of healthcare facility (re)design (Stichler, 2007a). Stichler writes that it is essential the nurse is well-versed in evidence-based design processes to ensure that new healthcare facilities obtain “optimal patient outcomes [that] enhance the work environment for healthcare providers and improve organizational performance” (Stichler, 2007a, p. 527). The article discusses the roles of leadership that nurses can assume to ensure a successful facility development project. In recognising the issues inherent in hospital-based expansion or renovation programmes, one perspective is that these are opportunities or challenges for which senior nurses can assume leadership roles. These roles represent accountabilities and responsibilities to the organisation and a once in a lifetime opportunity of participation in a project that spans the gathering of project group members with initiation of the project, all the way to completion and post-occupancy evaluations (Stichler, 2007a, p. 527).

An editorial in *RN Magazine* encourages frontline nurses to become involved in executive decision-making within their organisation, whenever the opportunity arises (Veronesi, 2009). Correspondingly, nurses can seek

participation in major roles in healthcare facility redesign as recognition for their unique perspective of patient care, quality processes, and hospital operational knowledge.

In discussing how senior nurses may best influence and improve their involvement in healthcare facility redesign projects, Stichler (2007a) argues that project groups must be formed by inter-disciplinary team members and these interdisciplinary teams can be present at all stages of the project. The author states that there is compelling evidence such groups provide creative thinking, innovative ideas, and informed decision-making (Stichler, 2007a). Oftentimes senior nurses are given the highest leadership role within facility redesign groups as nurses are valued for their group process and facilitation skills, ability to lead small groups, ability to manage conflicting opinions whilst retaining insights into operational functioning, and importantly, for being able to place the patient at the centre of decision-making (Stichler, 2007a).

Working within a project structure improves the senior nurse's influence and involvement as it provides a clear pathway for communication and decision-making. Also in this article, Stichler states that leadership in nursing is demonstrated when nurses determine and articulate the "overreaching nursing and patient care philosophy and values that guide design" (Stichler, 2007a, p. 529). This is important as the care philosophy and model of care delivery informs the final design of the facility and whether it is successful in its aims.

Finally, Stichler (2007a) conveys that senior nurses have many roles and opportunities to provide leadership within nursing and towards other healthcare professionals in facility redesign projects, such as: imparting specialist nursing knowledge; ensuring patient-friendly and staff efficient designs; facilitating and reviewing design work; managing relationships; and facilitating input. Stichler (2007a) argues that the greatest advantage for nurses having leadership roles in facility projects is an assurance that the design consistently reflects nursing philosophies and care delivery models.

An article by Cesario and Stichler (2009) discusses the necessity of preparing nurses to be design team members in the context of major hospital facility redesign. They argue that to have an informed voice, nursing needs to be educated - acquiring knowledge of the fundamentals of design features and

their subsequent impact on patients, staff, and organisational outcomes (Cesario & Stichler, 2009).

Other identified areas of difficulty for nurses are aspects of design work such as the language used, and being able to translate a two-dimensional drawing to how a space will look when completed (Stichler, 2007b). Cesario and Stichler (2009) suggest that in order to prepare nurses adequately, a graduate-level nursing course is required. This is expected to impart important evidence-based knowledge for role concepts, such as environmental and architectural design, and the relationship of individuals to their surroundings. Cesario and Stichler (2009) believe that nurses are the most knowledgeable about “design features that support optimal patient care” and that hands-on learning, and other learning methods, will provide essential resources and skills to nurses, thus maximising their involvement in healthcare facility projects (p. 328).

A New Zealand DHB that has conducted facility redesign, through a project of redeveloping facilities and systems of care, states within its project brief that the nurses’ participation in healthcare redesign projects provides an assurance that new patient environments can meet evidence-based standards for patient and staff safety and optimal operational functioning, and can incorporate technologies that are essential for best practice (X DHB, 2001b). These principles are consistent with Stichler’s (2007a) comments that nurses involved in facility redesign projects must assess the issues and needs of many stakeholders and integrate these into the design of healthcare facilities, as well as considering financial constraints and other existing issues.

Regarding literature that supports the utilisation of this type of evidence towards optimal healthcare facility redesign, an article from another North American nursing magazine informs that architects are utilising *evidence-based design* to develop new healthcare environments, and are correlating positive patient outcomes with decreasing the physical demands on the aging nursing workforce located in new facilities (Scott, 2006). Scott (2006) also highlights that listening to nurses, and providing opportunities for their critique of designs, has provided important feedback to project groups, as did acquiring knowledge from literature focused on evidence-based design. Scott (2006) has established that the involvement of nurses is instrumental in designing the “best environment possible to enhance their ability to care for their patients” (p. 12).

Examples of nursing leadership in facility redesigns were found in articles about innovative design for paediatric wards in San Diego and Florida in the United States. In *Health Facilities Management Magazine*, one feature article highlighted the collaboration of a construction company, design team, and hospital staff, that achieved the aims of providing patients and their families with a less fear-generating environment (Antonelli, 2000). Such results are similarly noted in a story from the web-based *Centre for Health Design*, which recounts how modifications to ward design achieved better interactions for children with the environment and staff, improving their overall experience (Ayesha, 2009).

Stichler (2007b) argues that nurse leadership roles in facility design projects require transformational leadership skills, clear articulation of a creative vision for the future, and an engagement of other healthcare professionals and colleagues in decision-making. Stichler (2007b) therefore recommends that nurses participating in healthcare facility design be informed of core competencies proposed by the *American Organization of Nurse Executives* and the *Healthcare Leadership Alliance for Nurse Executives*, as involvement in facility projects is deemed too complex for involvement without a structure to support the nurse facility project leadership roles. The proposed competencies are commonly-accepted skills of effective nursing leadership. The five specific domains are: “communication and relationship building, knowledge of the healthcare environment, leadership skills, business skills, and professionalism” (Stichler, 2007b, p. 111).

In redesigning a healthcare facility there is a flow-on effect for the care delivery processes within redesigned layouts, adding to the dimension of change. The redesign of care processes is highlighted by Haraden and Rutherford (2004), whom state that the rationale for work redesign is an attempt to change and promote systems of care to provide better outcomes for patients. Strategies to redesign clinical processes require innovation, and should be standardised to reduce variation, thereby enhancing teamwork and skill development (Haraden & Rutherford, 2004).

Poole, Stevenson, and George (1996) caution that when care processes are being redesigned, there is a risk of failure, and that redesigning healthcare processes involves much more than providing a modern facility and equipment. The organisation must be committed to its vision and values, understand how

staff perform in the workplace environment, and provide the support needed. Furthermore, the organisation needs to ensure staff are well-informed, and share information that is crucial to the facility redesign project's overall success (Poole, Stevenson, & George, 1996).

A letter to *Kai Tiaki Nursing New Zealand* (2009) questions the design of a major new hospital, claiming that the design is flawed and has resulted in inefficient and ineffective nursing systems and delivery of healthcare (McCord, 2009). The author of this letter is a nurse and midwife, and is perhaps representative of an end-user's experience working in a new environment. The issues raised identify legitimate concerns, and demonstrate the problems inherent in transforming abstract hospital design and nursing workflow processes into real-life situations. The author of the letter also indicates that patient care has become experimental, and lacks evidence for the nursing care model and design implemented. This article reflects the experiences of nurses as key stakeholders of new hospital facility systems. The meaning attributed relates to a perceived inability to deliver quality client care. The caution given by Stichler (2007) and Poole et al. (1996) echoes in the letter's comments that perhaps the vision and values for this project have not yet been transformed into practice within the new facility team and environment.

The literature search for qualitative studies describing nurses' perspectives and experiences of participating in facility redesign projects, or their experiences of achieving the valued components of redesign and care delivery, are limited. This research study aims to improve upon the available literature and data by directly investigating and documenting such descriptions of nurses' experiences in the many facets of participating in healthcare facility redesign projects.

## **Chapter Three**

### **Method and Methodology**

The methodology of this study follows a qualitative descriptive approach from which the methods are guided and outlined as specific to this study.

#### **Theoretical Perspective**

The epistemological theoretical framework of this qualitative descriptive study sits within the paradigm of *realism*. Qualitative research serves to uncover human truths that are realised through lived experience. These human truths are reached through inner subjectivity and the interaction of the person with their environment (Flood, 2010). Crotty (1998) states that social constructionism can be aligned with realist or relativist view-points, arguing that the realist view-point asserts that truths are socially constructed, in that the truth is formed through a set of social rules (which change as social power changes).

This study acknowledges that the participants' views of truth are composed of many local and specific realities that can only be subjectively perceived (Weaver & Olsen, 2006). Therefore, a realist approach allows the researcher to examine text or language for articulated meaning of an experience. Such an approach allows one to "theorise motivations, experience and meaning in a straightforward way, because a largely unidirectional relationship is assumed between meaning and experience" (Braun & Clarke, 2006, p. 85).

The qualitative research question seeks to understand the reality of human experience leading to more insight and thoughtfulness in practice. The final outcome of the research is well-described stories that the researcher has communicated effectively, achieving the advancement of our understanding (Koch, 1999).

The key assumptions of this descriptive study are that knowing any phenomenon or experience means that we need to know the specific stories in

their context regarding the phenomenon, and then work with those stories using an inductive approach. This means that fundamental qualitative description entails an accurate depiction of the experiences with minimal abstract application of the data. Any interpretation is *low-inference*, meaning the reader doesn't have to read between the lines, and thus the findings result in the likelihood of a consensus amongst the readership (Sandelowski, 2000). The stories of experiences may present as "ambiguous, complex and multiple forms" (Maggs-Rapport, 2001, p. 380) whereas the characteristics that descriptive inquiry conveys interprets this data as it shows itself.

The methodology of this descriptive study is to remain close to the participants' stories of their experiences so that the inquiry produces a description that provides an insight which is "a complete and valued end-product in itself" (Sandelowski, 2000, p. 335).

As the researcher, my role is an active one, seeking to identify themes within the data, selecting those of interest, and disclosing these to the reader (Braun & Clarke, 2006). In this way, the study utilises a fundamental qualitative approach of description for the purpose of exploring the participant's experiences of a project process (participation in a healthcare facility redesign project).

In this descriptive study, the participants' role is to describe or recount their experiences of being a nurse involved in a transformative process. Their stories are accepted as their construction of reality. As the researcher, I will describe their constructions (narrative) to the reader aiming to illuminate the specific phenomenon of participation. In the process of description there are no facts outside the particular context that give those facts meaning (Sandelowski, 2000).

Descriptive validity comes from accurately describing the events or experiences from the participants' interviews. As the researcher, I choose which events or experiences to describe. However, I am aware that it is essential to ensure events are conveyed and described in a way that remains close to the context, meaning, and significance, related by the participant. Furthermore, I acknowledge that "the description in qualitative descriptive studies entails the presentation of the facts of the case in everyday language" (Sandelowski, 2000, p. 336).

## **Thematic Analysis**

Thematic analysis is a qualitative research method that is compatible with qualitative descriptive inquiry, providing a rich and detailed account of participant data. It is useful for “identifying, analysing and reporting themes within data” (Braun & Clarke, 2006, p. 79). The participants’ interviews are described to reflect their reality and reveal the surface of reality for aspects of different experiences. In this qualitative descriptive study I have employed thematic analysis as the analytical method which “reports experiences, meanings and the reality of participants” (Braun & Clarke, 2006, p. 81), because this inductive approach permits the natural development of themes, comparatively, from the collective data.

In this research, a theme has been identified where collective data across the interview data captures something significant and analogous in relation to the participants’ experiences of *participation* in healthcare facility redesign. Thus, themes in this study have been developed from specific experiences or events that are significant to more than one participant.

A rich description of the participants’ interviews (dataset) has been written in the findings chapter to illuminate predominant themes. The process of inductive analysis involved the themes being strongly linked to the (comparable) data. The themes reflect the overall content of participant interviews thus providing a rich description of participation in healthcare facility redesign.

As the researcher, I approached the collection of participant data without preconceptions of what the participants would want to describe or what themes there might have been. The process of inductive analysis involved developing codes and themes based on significant and common premises, rather than trying to code to my, or any, pre-existing understandings. Braun and Clarke (2006) clarify that this form of thematic analysis is data-driven.

Having collected the interview data, the inductive approach meant that the text was read and re-read for themes related to participation without concern for finding congruence with previous research (of which there is very little).

Initial theme development involved a semantic approach of not looking for meaning beyond what the participants' had said, thereby allowing themes to be "identified within explicit or surface meanings" (Braun & Clarke, 2006, p. 84).

Next was the development of themes from description to interpretation, whereby themes were given significance and a broader meaning. The implications were considered with reference to their position in relation to previous literature (Braun & Clarke, 2006).

Braun and Clarke (2006) have a six-phase method of thematic analysis which I have employed as follows:

Familiarity with the data - I transcribed the interviews, and read and re-read the transcripts, making notes of my ideas as the participants stories presented the phenomenon based on their experience.

Generating initial codes - I found interesting codes that appeared across the entire dataset, and then grouped the corresponding stories with the codes that appeared to be relevant to each other. In finding codes and keeping the particular context of each story, I was able match specific stories with initial codes. In this way the selection of stories begins to feature and describe aspects of the participant's experience of the phenomenon.

Searching for themes - I then began collating codes into possible themes, and organised all data so that it related to the potential theme. The identification of the themes developed from the meanings the participants attributed to their experiences in the data and the actual words used (staying close to the surface of the data).

Reviewing themes - I reviewed the themes in relation to the coded extracts and the entire dataset. Some of the extracts could have been relevant to more than one code so I made a decision about where they seemed to fit best in relation to other extracts. The review of the themes entailed a reflexive and interactive process, where stories or data were reconsidered for new insights and relevance to theme.

Naming and defining of themes - The naming of each theme involved reading around the codes and context of the stories. The definition of each theme, and identifying it by name, was a process of ongoing analysis in order to generate

and clarify each theme. Themes in this study represent central concepts of the phenomenon of participation in the redesign project process.

Producing the report - the discussion chapter includes the final analysis, which provides evidence from the data in themes that capture the meaning of the participants' experiences in their own terms. These are related back to the research question and literature.

### **Ethical Considerations**

As the researcher I acknowledge my responsibilities to adhere to ethical principles as they pertain to the participants and research integrity. In adhering to ethics protocol, ethical consent for this research was applied for and gained (refer to Appendix A).

*Anonymity* and *confidentiality*, the participants' rights to privacy and confidentiality through anonymity procedures, has occurred during all study procedures (Polit & Tatano-Beck, 2006). Participants were selected from a large DHB. They were contacted directly via a confidential and secure email system. A consent form (refer to Appendix B) was completed by each participant upon their decision to join the research study and are securely stored in a separate location from the audio and written materials. All audio tapes and written materials involving the participants do not carry the real identity of the participants.

Interviews were conducted in a private place, away from the participants immediate work area. An identifier (pseudonym by name) was given to each participant at the transcription stage, and I, alone, transcribed the audio tapes in my home office.

The process of writing the research report requires that the narrative remains in context but is not identifiable to the participant. This is a small study from within one DHB, so there is a risk that the participant could be identified. To reduce this risk, work areas have not been individually referred to as wards, units or departments. Using generic terms of workplace or work area reduces the likelihood of individual participant recognition.

### **Informed consent.**

To protect the participant, their right to autonomy involved obtaining informed consent (Polit & Tatano-Beck, 2006). This was accomplished through the provision of the Participant Information Sheet (refer to Appendix C) detailing all relevant study information. They were offered the opportunity to ask questions about the study, to fully discuss the research project and identify any concerns prior to any commitment to the study. When the participant contacted me and confirmed they wished to take part in the study, I then confirmed that they had full understanding of the study information. This discussion was repeated prior to the interview as we met to complete the consent process.

### **Beneficence.**

Actions that sought to minimise harm and maximise the benefits to the participant in this study included seeking information regarding workplace experiences of nurses (towards maximising good future experiences and minimising the negative through awareness and acknowledgment). Each participant was treated with dignity and respect by acknowledging their professionalism and contribution to healthcare in their respective roles.

### **Non maleficence.**

A fundamental ethical principle whereby avoiding harm is foremost. The participants in this study are asked to recall specific work-related experiences and the meaning these have for them. A process for providing an ethically safe environment for participants included open access to appropriate DHB resources for resolving personal or work-related problems, and keeping the participants professionally safeguarded. None of the participants have required this assistance.

### **Justice.**

This principle includes the participants' right to fair treatment. The Treaty of Waitangi assures Maori of protection, participation, and partnership in health research. While I had one participant who identified as Maori, it was equally appropriate that all participants were afforded these same rights as per the

ethical principles described in the *Guidelines on Ethics for Health Research Involving Maori* (2008).

Whilst research setting is within a DHB, the DHB as an employer is not the focus of the study. The Director of Nursing Practice at X DHB was informed of the research proposal, as a professional courtesy, and has acknowledged the presence of the study in the DHB by reply email.

## **Data Collection**

### **Participant sample.**

Each participant was purposively selected. My strategy was to hand-pick participants from the eligible group of nurses (one participant at a time was added to the study). The chosen participants were those who I thought would best contribute to the information needs of the study. As the context of the study is to describe nurses' experience of participating in healthcare redesign, an effort was made to include participants who would provide information rich in variation and dimension. Each participant received an informative email regarding the study, inviting them to read an attached participant information sheet (refer to Appendix B).

#### Inclusion criteria – reasons for participant selection included:

- *the participants being registered nurses in senior nursing roles;*
- *participants employed by one District Health Board;*
- *that each participant is/has been a member of a Project Group - a hospital facility redesign committee - that is governed by a project management structure;*
- *being a member of a project group has involved personal attendance/experience in the processes of healthcare facility redesign.*

#### Exclusion criteria - those excluded from this study were:

- *staff who were not registered nurses or in senior nurse roles;*
- *nurses who had not participated personally in the processes of project groups for facility redesign;*

- *nurses or employees from other DHB's were not offered participation in the study.*

I have interviewed three participants in this study. Two participants were of European descent, and one Maori. All held Clinical Nurse Manager (CNM) roles which they had been in, on average, for three years. The number of participants in this study directly relates to the large data contribution from a small number of people, as is often the case in qualitative research.

### **Interviews.**

Participants were interviewed separately and privately. The interview setting was a private office or place of the participant's choosing. The interview commenced with a single opening question of '*Tell me about your experience of being a senior nurse in a user group?*'. The participant talked freely, and few, if any, prompts were required. Where prompts were offered they were, for example, '*What was that experience like for you?*'. The interview was recorded on audio tape. The interview concluded when the participant had finished articulating what was on their mind.

### **Data analysis.**

Each interview was transcribed and checked against the audio tape for accuracy. A copy of the checked transcript was given to the participant. The participant had the opportunity to add, revise, or remove any content they desired. On returning the transcripts, each participant had only edited in a minor way, generally by adding a small clarifying statement to one or two sentences within the transcript.

Analysis of each participant's data commenced before the next interview. At this point, the aim was to get to know each entire text or narrative well through listening to the tape and transcribing into written words thereby embedding the context as given by the participant. At this time an holistic reading approach captured the fundamental experiences within, or main significance of, the narrative.

### **Rigour.**

To ensure trustworthiness in this qualitative descriptive study, the richness of the data is conveyed to the reader through unambiguously identifying the relationship between the themes and quotes (Streubert & Carpenter, 2007).

The criteria for trustworthiness was described in *Naturalistic Inquiry* as the judgment of the quality or goodness of qualitative inquiry (Lincoln & Guba, 1985). Trustworthiness can be defined by criteria that show the quality of a study and its findings.

Lincoln and Guba (1985) developed four criteria, which have been utilised in this research as follows:

Credibility - in this descriptive study I have provided assurances of congruence between the participant's views of their life experience and my reconstruction and representation of the same. I have described extracts of the stories as closely as possible to the context and meaning attributed by the participant so there is low inference (Tobin & Begley, 2004).

Dependability - in this study I have followed the process of qualitative inquiry, ensuring the study process can be followed by the reader. Dependability is reached when the researcher is able to demonstrate the credibility of the findings (LoBiondo-Wood & Haber, 2010).

Confirmability - establishes that the data and interpretations of the study are genuine. In this study there is a correlation of assertions, findings, and interpretations, to the data in a credible way. The process criterion for confirmability in this study is that there is evidence of the thought processes that lead to the conclusions (LoBiondo-Wood & Haber, 2010).

Transferability – this concerns the researcher's responsibility to provide the reader with sufficient information to enable them to establish the degree of similarity between the data, findings, and conclusions of the study, and a study to which findings might be transferred. Therefore in this study transferability refers to the potentiality for others in similar circumstances to find meaning in the research findings (LoBiondo-Wood & Haber, 2010).

The following chapter applies the methods and theories discussed in this chapter to the data collected as a means to analysing the findings.

## **Chapter Four**

### **Findings**

This chapter presents information disclosed by the participants regarding the various ways they experienced participation as senior nurses in user groups of facility redesign projects.

Nurses experience different dimensions of involvement as participants in facility redesign projects. Essentially they experience being achievers, but also experience having constant demands placed on them and being constrained in their capacity to make choices during the project process. They have challenging experiences of feeling opposing orientations to where they are placed in the project world. Sometimes this involves having a sense of equity, autonomy, and professional achievement, and at other times being silenced, disempowered, and feeling like they are professionally failing. This study of three nurses' experiences provides new understanding of senior nurses' participation in healthcare facility redesign.

The themes drawn from these experiences are illuminated through various modalities of participation. These are:

- *participation experienced through Representation;*
- *participation experienced through Leadership;*
- *participation experienced through Relationships;*
- *participation experienced through Creativity.*

#### **Participation Experienced Through Representation:**

The meaning of representation for senior nurses participating in healthcare facility redesign is explored through experiences of interactions and responsibilities. The senior nurses describe being involved in project groups as representing the central interests of their patients, specialty, or clinical service,

and keeping nursing concerns and clinical standards present in the redesign process.

The senior nurses have a unique awareness of the clinical world and organisation of hospital services, and therefore possess management and clinical skills along with human and leadership characteristics that are crucial to effective decision-making (Oroviogoicoechea, 1996). The participants, from herein referred to individually under the pseudonyms of *Kim*, *Alex*, and *Jordan*, experienced working in a systematic project of set objectives. *Kim* reveals how there was a necessity to refer back to nursing knowledge of hospital systems and processes to achieve a workable facility redesign. *Kim* recalls the constant recollection of the clinical world into the abstract world of the project:

*There are grey-areas where there is crossover of impacts from project facility work with hospital operational needs, I didn't have a clear demarcation line. As clinical staff, we merge them or are blending them. (Kim)*

As the facility redesign project advanced, *Kim*, *Alex*, and *Jordan* experienced involvement as integrating their nursing process knowledge and familiarity with the hospital environment into user group decision-making processes:

*To get a facility that is ultimately provided for patients to be cared in, and nurses to work in, I believe we have had to have people that are very familiar with working in the hospital environment and how it is occupied. I was able to put in my knowledge, experience, and judgement, on how things should flow. (Kim)*

*Kim* also gives an example of a sense of imbalance that occurred in having dual responsibilities of being a CNM and a project group member, where the capacity to focus on one role brings an awareness that the other role has receded from focus:

*You get so absorbed by this huge project that you lose track of your real job, it's really hard to do it all. (Kim)*

All of the participants experienced a feeling of being involved in a large project and becoming aware that the role of representation was present in being responsible for an increasing complexity of information, along with maintaining accuracy in redesign detail. *Alex* stated that she experienced the responsibility

to retain accurate information as developing her own system of accuracy, therefore she could account for the decisions she was making and for whom these decisions were important (e.g. staff, patients, the organisation). So she used the system of project documentation to her advantage by keeping accurate records and sending back incomplete documents. In this way Alex maintained a sense of valuing accuracy, keeping track, and being in control, whilst maintaining accountability to those she represented:

*There is a lot of paperwork, a lot of checklists were provided to us. I utilised these to my advantage to keep track. I kept versions, I poured over designs, highlighted and wrote notes. I sent back photocopies and showed the errors. Designs were always more incorrect than you were led to believe, nothing was ever represented as accurate [100%]. (Alex)*

Two participants experienced that the production of project documentation involved tracking of versions and corrections. They also noticed that they became involved as overseers checking that tasks were carried out. This added extra responsibilities to their roles. They experienced a sense of having to be constantly vigilant to ensure mistakes were not made:

*As clinical nurses we have had to check up on others' work throughout the project, they don't do what they say they are going to do. (Jordan)*

Alex stated that she experienced an instance when project work and her CNM role were competing for her attention and skill. In this circumstance she prioritised the urgency of managing the acute clinical service over the tasks of the facility redesign project. She was conscious of the investment on her part in having to decide which role to focus on and to be present with. The greater focus on the clinical role deferred facility redesign project priorities. She acknowledges the sense of tension between representing the project and the acute service needs, and this left her with a sense of dissatisfaction as it is difficult to perform in the two roles simultaneously:

*If we had our time again, we would have to think about the investment outlaid by the CNM so that more attention can be placed on the project role. (Alex)*

The dual-role nature of working as a CNM and being involved in the facility redesign project demanded the participants be fully engaged and

committed to multiple responsibilities for a prolonged period of time. Alex reflects on what she felt about the amount of work generated by the facility redesign project prior to moving to the new facility. Alex's experience is that she became overloaded with the expectations placed upon her, leading her to feel that she was being taken advantage of:

*If I was in this position again, I would be more mentally prepared. CNM's really need to look after themselves through this kind of process because physically, mentally, and emotionally near the end it's hard, hard work. Sometimes I felt taken advantage of. (Alex)*

Kim also describes a time towards the end of her project when she became aware that she was focused on the detail of the facility redesign project, impending migration to the new facility, and maintaining the service operationally. At the same time, Kim's nursing team was experiencing anxieties regarding the changes to their workplace and work life. In this reflection Kim has felt the tension that representation brings when managing many interests at once. Ultimately, she was conscious of the need to support staff emotionally and professionally but the needs and responsibilities of the project dominated over her awareness of staff concerns. Kim is uncertain about whether or not she supported her staff well enough through the transition phase as the team experienced a state of disruption:

*There is a lot to be thinking about when involved in a project like this. Staff were preoccupied and worried about their workplace; they felt like their workplace had been thrown into chaos. Whereas I was more preoccupied with the move and keeping the service going. I don't know if I did that particularly well, I felt pulled in different directions at the time. You have to remember to support your staff, it was enormously disruptive to have the anxiety and disruption within the nursing team. (Kim)*

Jordan described how keeping close to professional and personal values led to her feeling that her participation in the project group was worthwhile and valued from her nursing team's perspective. The engagement of the nursing team is an experience of partnership, from which Jordan has seen the willingness of staff to be informed and involved. This is reflected as a sense of change and moving forward together as a nursing team:

*The things I value and ethics are instilled in this project. I feel a warm buzz out of that. Engaging the nurses, their willingness to be involved, makes my day. That's something really cool. (Jordan)*

Jordan experienced representing the values and standards of clinical care processes to the user group in an effort to balance the needs of the patient and the staff along with the practicalities of the redesign project:

*In my experience as the senior nurse on the project, I am the buffer between bureaucracy and the reality of nursing patients. (Jordan)*

The CNMs had no prior experience of healthcare facility development. Having little experience to draw on, they did not fully understand what being in a redesign project group would involve. The responsibilities, how the project would evolve, or what outcomes would be required of them, were not fully anticipated. Until the project started they had a sense that it was something that was going to happen but had little understanding of what it meant to be involved. Kim explained she felt surprised by the idea of being an integral part of the user group:

*Prior to this, the project had been something distant from my working day, it was out there but I hadn't understood how I might be directly involved with it. I had no idea of what that would involve at all. In fact, the whole thing took me by surprise. (Kim)*

Jordan experiences the moment of *knowing* validating her sense of professional credibility within the user group. This reinforces her sense of purpose in the role of representing nursing, being able to advise others of information that she knows is correct:

*It made me realise I have the information inside me, it was just amazing. So you realise you do know it, so that was really good. (Jordan)*

Here Jordan reflects on an experience that is in contrast with another experience of being listened to as a nursing authority. In this instance, Jordan's sense of being a nursing representative, and her influence, is altered and restricted by the administrative and management structure of the project:

*I have the leadership and management capability within my own department, but then I go to the project meetings and I feel totally disempowered, because they don't listen. I ask myself*

*'Why did you ask my opinion?'. What is the point of asking if you have already decided? (Jordan)*

Alex recalls instances when she experienced not being able to be representative of her service, when she felt not listened to, and felt that nursing did not have as much credibility without mandate from medical colleagues:

*The project team would tend not to listen to the nursing voice on its own. (Alex)*

Alex recalled that she changed her approach to user group meetings to improve her level of credibility for representing her service and relevant clinical issues. In this experience, she felt the difference in how nursing was viewed on its own, as opposed to an overtly united medical and nursing representation. Alex realised that in order to be able to participate fully she had to use the system to her advantage to get the identified outcomes from the meeting process:

*Prior to the project meeting, we would have our own meeting first and decide what point we were up to, and what we wanted to achieve and communicate. We would go to the user group meeting with a solid united front. If we needed more weight (credibility) for important decisions we would bring the Head of Department with us to meetings. We understood the power dynamic and we understood how to use it. (Alex)*

Alex noticed that working on aspects of facility redesign involved representation of the customer (patient), ensuring that clinically important issues and standards of care were upheld and defended by nursing and medical leadership. She recalls that in advocating for patients she made a conscious choice to work on facility redesign problems that directly involved clinical standards, rather than expend effort on less critical facility issues:

*My user group tried to stay true to the principles we wanted, and stay true to the standards we wanted to adhere to. We decided not to waste our energy on battles we knew we could not win. However, on the grounds of safety and clinical standards, and adhering to our own fraternity's standards, we fought hard and we won out in the end. And that feels really positive. (Alex)*

In representing the organisation, clinical standards, nursing, a multi-disciplinary team and patients, the participants have experienced the integration of many interests or agendas into their projects.

### Participation Experienced Through Leadership:

Kim, Jordan, and Alex have diverse experiences of leadership in different user groups within the healthcare facility redesign project.

Initially, for Jordan, being the senior nurse in the user group became an issue of retaining her own professional reputation. Jordan describes an experience of being overwhelmed by the expectation she would lead the user group as she began her new role as a CNM. She realised that, while she had the attributes and nursing experience to take on the role of CNM, she did not have the experience in leadership or project management that would give her the confidence to take ownership for leading the project. Knowing she had little leadership experience reinforced to Jordan that she had been thrown into a project role that she did not believe she would be competent at. Jordan recognised that there were many complex and considered decisions to be made in redesigning a facility and was aware that facility project decisions would have long term consequences:

*I had started a new CNM role I hadn't done before. I had no idea of anything about leading the facility redesign project or what it entailed - I was mortified. (Jordan)*

This led Jordan to strongly believe she did not have the ability to lead the project group on her own. Jordan preferred to be a part of the process but not lead it. The nurse leader agreed to take a greater role in the project which helped Jordan to not feel alone in her responsibility for the redesign project. At that time Jordan equated leadership with accountability and ultimately being blamed if aspects of the redesign were unsuitable. The experience of shared leadership supported Jordan in that she had someone to *bounce ideas off*, learn from, and collaborate with for decision-making:

*I was happy to be engaged in the process or be part of it, but not lead it...it made me feel a lot better to have the nurse leader with me at facility project meetings. I guess less blame could be aimed directly at me, the burden of responsibility of getting the decisions right was shared. (Jordan)*

Jordan was aware of the magnitude of the project and also the consequences of the decisions she was making for the organisation and the

community. It was a concern for her that present-day decisions would inform future possibilities for operational management and patient flow through the workplace. Jordan strived to aid the team to make decisions that incorporated opportunities for ongoing change to occur. She was aware that any service expansion or practice changes in the future would be affected by how the facility is redesigned at present:

*I am leading the project. I feel I still need support. I am making decisions that will impact the department, hospital, and patient community, for the next 50 years. I feel this is a huge responsibility. (Jordan)*

The participants realise that the design and care process work they are involved in is worked through theoretical planning and abstract thinking, utilising current knowledge and experience. They are cognisant of the fact that the new facility layout and work flows will not be tested until it is experienced as an actual working hospital environment. Jordan experienced anxiety in the form of being fearful of blame over these abstract and theoretical decisions. She stated she was aware that discourse about the success or failure of some decisions have already had an impact on previous CNMs involved in facility redesign. Jordan expressed a fear of this and in her view it is inevitable:

*At the end of the day, I've seen the other CNMs who have completed design projects before me receive blame. Blame about the whole design. The blame scares me tremendously because it's all going to come back to me. (Jordan)*

Jordan stated she anticipated fault to be found in the new facility by hospital staff. She was aware also that the responsibility for the project wouldn't end on move day, but rather that the leadership accountabilities she carried in the project will be present for some time after:

*I'm looking forward to when we move so that all the blame can occur and then we can get on with caring for patients and making the new system work well. (Jordan)*

Jordan describes the time she felt most overwhelmed by her role in the facility redesign project. Her role in the project becomes objectified as an expert from whom other parties need to glean understanding and information. A room full of experts on building facilities are present, and their gaze is on her. In this

experience, the idea of being the *expert from the hospital* has a gravity to it, and Jordan becomes aware of the unique expertise she holds. At this time, Jordan also expresses insights and doubts about her overall knowledge and ability. These thoughts undermine her confidence in being able to speak with authority about the aspects of the facility redesign necessary for a safe and effective hospital facility:

*Then the day I felt most overwhelmed was the day I walked into the room full of outside contractors such as architects and electrical engineers, fire consultants etc who look to you as the expert from the hospital. It was daunting, absolutely daunting, what if they ask me questions I don't know and I should know? What happens if I can't come up with any ideas? (Jordan)*

All of the participants at some point experienced being asked to attend project meetings, but were left feeling disempowered when their ideas and recommendations were not required. Jordan gives an example of a time when she struggled with the logic and effectiveness of the project meeting process when appearance at the meeting did not include autonomous input into the decision-making:

*I was uncomfortable because I felt disempowered (my ideas would not be heard). I appreciated that standards have to be met for the facility, but I didn't understand why I had to be involved in meetings where I could not add my expertise or an idea. Instead I could have gotten on with my other work. (Jordan)*

Alex describes experiencing leadership as feelings of being constrained and obligated to be responsible. The constant presence of constraint led her to be prepared for instances where she had to negotiate and compromise in order to achieve what she believed was the best result possible:

*I think that we were realistic about the financial constraints that the hospital faced, we know when you don't have money you don't have money. So we were prepared to negotiate a compromise on certain things, and we tried to stream the money available towards the things that meant the most clinically workable to make the facility the best it could be. (Alex)*

For Kim, the experience of leadership was being engaged in a balancing process that resulted in the achievement of a safe workable design. She felt that she retained sight of the big picture, and was able to help negotiate

compromises that retained the integrity of the design and achieve acceptable standards:

*We did get to do a whole lot of balancing input as people from their own specialty would want a specific and worthy focus, but we had to modify their expectations. The outsiders' perspective of what is ideal and the insiders' [user group's] perspective of what else needs to fit into the design. (Kim)*

Kim sums up her role of leadership in the facility redesign project with a reflection on what was accomplished:

*At the end of the project you have done a lot of hard work, you are getting to the end of the work, got a design, done the hard graft, there is a new ward that you can live with, afford, and move into. (Kim)*

In summary, Jordan's experience of being a leader is initially feeling inexperienced (incompetent), vulnerable, needing help, a burden of responsibility, and fear of blame. Alex's experience of leadership is of recognising the risks to the project if wrong decisions are made. Her leadership involves negotiating and taking control, advocating for key stakeholders and standards, and being able to analyse the project process and control it to maximise the likelihood of good clinical outcomes. She described an overall sense of accomplishment from maintaining professional integrity in holding the standard, and using the system to an advantage. Kim's experience of leadership was having a strong sense of team work, accountability, working within the process, and having a sense of accomplishment.

These senior nurses have described their experiences of participation in a leadership from feeling various amounts of professional competence, to that of being burdened by responsibility and being accountable as a key stakeholder.

#### Participation Experienced Through Relationships:

The staff involved in facility redesign were organised into mixed project groups of clinical and non-clinical staff. The experience of senior nurses in various working relationships within project groups is described in various ways.

In the following description, senior nurses reveal elements and dynamics of relationships they experienced while participating in project groups.

Kim's experience of working in a user group of predominantly nurses was mostly positive. She felt that the group functioned well because relationships had been established from prior working experiences, common understandings of patient care processes, and awareness of contemporary nursing issues. The level of understanding of what to contribute and how to contribute to the working relationship of the group influenced Kim's perception of how the group worked together:

*I had the benefit of working in a team. I found that the user group was beneficial because I worked alongside other nurses who were used to working together. (Kim)*

Being able to motivate and support members of the user group was an aspect of the working relationship that Kim also experienced as beneficial, as was the ability of the group dynamic to self-regulate and balance perspectives.

In this instance, Kim describes how at different times nurses in the group were in need of support as their perspective changed in response to disappointments associated with being constrained:

*We were able to encourage each other over the obstacles. When one or two of the group were feeling deflated about the constraints and had a glass-half-empty perspective, the others retained the glass-half-full perspective. We ended up with a balancing dynamic going on within the people engaged in the project. (Kim)*

In getting to know the members of the user group, Alex found that her ability to understand others' perspectives improved. As these relationships developed it was easier to work within the scope and constraints of the project and to maintain good working relationships while achieving the group's goals and expectations. Being able to read and understand other user group members resulted in Alex having the experience of being able to 'navigate' through the process of managing essential relationships:

*I found that I got better at reading people, understanding the groups and parties I was working with. I could work within the constraints of the process I had to follow, that there was some way in which I could navigate. Building bridges, networking, and forging relationships became really important. (Alex)*

Having sustained good working relationships within the user group, Alex recalls a time when she was able to engage the group in looking at how they achieve tasks from another perspective:

*The user group membership included non-clinical support staff. They tended to come in and say 'this is the preordained plan and this is how you are going to do it'. I had to say to them 'our service has some points of difference, so actually the same approach may not work for this project'. So 'how can we do this differently?'. It took some talking and again the working good relationships benefited the project. (Alex)*

Jordan had a different experience in relationship-building with non-clinical members of the group. She experienced the dynamic of these relationships as *arduous and tortuous*. She found they were challenging to establish as staff were compelled to work together without being familiar with each other's working backgrounds. Jordan felt compelled to build relationships but was aware that they were constructed out of necessity rather than common professional perspectives, expectations, or understandings. Jordan encountered the arduous nature of building relationships as acting as an interpreter, moderator, and facilitator, so that user group members from different professional backgrounds could understand more clearly the important clinical aspects of the new facility, and contribute cohesively:

*Building relationships and making them work has been arduous and tortuous, particularly meeting and working with non-clinical staff and consultants who don't understand your core clinical business. (Jordan)*

In another example, the effort to sustain an individual working relationship involved Jordan modifying her own professional manner and behaviours. In this example, she reveals how she has had to change her professional self to reduce the risks to her integrity:

*I change the way I am, because of the history of our working relationship, because one day the project member will say something, and the next it's completely different. (Jordan)*

In contrast, Jordan then described another experience that was mutually constructive and rewarding. Participating in a group that consisted of mixed backgrounds became rewarding as she discovered the benefits of different

professional perspectives providing solutions to facility redesign. She felt that she was afforded equity as ideas for solutions were generated collectively and constructively:

*As the relationships between us got more comfortable, I could put my ideas out there, and no one would laugh (smirk) at me. The meeting became less uncomfortable for me because it became about putting your ideas out there for consideration [combining clinical expertise with industry expertise]. It's all about ideas. (Jordan)*

Jordan recognised that she could not represent nursing's perspectives on the facility redesign project alone. This large scale project would require input from her nursing team to find the best ideas, gain forward thinking, and ultimately a positive outlook for the outcomes of the project. Jordan thought it was vital that the nursing team felt that they were also part of the project.

Jordan's approach to participation included developing an empowering relationship with her nursing team. She was able to provide an environment where her staff could be involved in the generation of opinions, ideas, and decision-making. They experienced a sense of self-determination within their own workplace:

*I believe empowering people makes staff function and it makes a difference. Power makes people function. Nursing staff have had opportunities to have their say in some small ways; they have shown a greater commitment and sense of belonging. (Jordan)*

Jordan was aware that she has accountability to her nursing team as she represents them on the facility redesign project. She experienced insights about the need to highlight staff knowledge and fully involve them in project decision-making in a constructive and trusted manner. Being able to seek their views and to reciprocate by relating project information to staff gained their understanding and trust:

*Trust and relationship building has been key in the relationship with the nursing team. I know what is important to staff. I have an obligation to get the new facility right for them. The staff know their core business, therefore they have come up with the most amazing ideas. (Jordan)*

The participants described the experience of wanting to keep open relationships with staff by providing feedback to nursing teams on the progress of the facility redesign, but feeling frustrated when the opportunities for their nursing teams to re-engage did not stimulate the level of interest or satisfaction that they had anticipated:

*When taking information to staff, often it was fairly frustrating. It was hard to get them interested and engaged in something that they weren't actually involved in. (Kim)*

Kim also recognised that through the user group she had a sense of personal ownership and investment for the project, whereas the nursing staff felt that most decisions were beyond their influence. She had tried to include the nursing team by providing as much decision-making detail as possible. However, her frustration as a result of the lack of engagement leads her to feel that she would get mad if the new facility was criticised. Kim also recognised that in her relationship with the nursing team she had empathy and understanding for the reasons they might question aspects of the facility redesign:

*The hardest part for me was when the building was finished, I knew that I was going to get really mad when people criticised it. I knew what had gone into the project and knew how hard we had tried to think of every eventuality and possibility. I knew every compromise we had to make. (Kim)*

*It was perfectly understandable that staff that had no involvement in the project would ask questions – (e.g.) ‘Why did they do that?’. (Kim)*

The previous extracts describe evolving relationships of senior nurses throughout their time of participation in healthcare facility redesign projects. The following extracts describe relationship influences that concerned the participants in some way.

Firstly Alex describes that as an employee and member of the user group project she assumed that her cultural world view of valuing consultation under the Treaty of Waitangi was not present within the framework of the project. Alex became aware of a contrast in how user group members were treated as opposed to her usual experience of working relationships. In this

experience, Alex felt the foundations of partnership, protection, and participation were not distinctly *there*, leading her to believe that individuals and team members were not in an equitable relationship with project management:

*It amuses me greatly that we are in a health service where we profess to adhere to the rights of the Treaty of Waitangi for our patients, but we are not afforded that as employees. All of the 3 P's were not adhered to in the project process. I felt quite passionate that we were being downplayed in terms of our voice and our ability to decide our destiny. (Alex)*

The approach to mutually solving issues often involved both clinical and non-clinical staff. Alex recalls a meeting where there was a division of the membership. She experienced this as a power struggle regarding what the clinical membership believed to be important, which was in opposition to the priorities of the non-clinical membership. This event happened as the number of staff and professional credibility of staff attending the meeting, grew on both sides. In this particular instance, the relational approach was to outnumber the opposition in order to prove a case and get a desired result. Alex experienced having to refer to clinical standards of practice, and utilising the credibility of the Head of Department, in order to preserve the argument for the clinical layout of the facility:

*We had a meeting where we brought the Head of Department to a meeting, then a whole room of project people turned up. We all sat round the table and it's an 'us' versus 'them' situation. We argued the standard from our specialty medical college standard. Then there was all this haggling about clinical areas of the facility. They disputed the clinical standard for the facility. Then we gave clinical scenarios to prove our case. Then they went along with us. (Alex)*

There were other times when Alex became aware that some members of project management appeared to be reserved in the way they consulted or released information regarding the facility redesign process - they determined when information would be made available to the wider user group. Alex felt certain information was not disclosed as an invisible measure to control user group perspectives and expectations:

*There were times I felt things were unsaid by other user group members, bits of the puzzle were missing. You seemed to be drip fed information at certain times. I could see information*

*was being withheld as well. That became quite frustrating as we progressed along that journey. (Alex)*

Jordan, Kim, and Alex all experienced meetings where the relationships became strained due to feelings of imbalance in power and influence within the group. Kim recalls an instance of not being listened to because an alternate agenda (priority of another group member) dominated the discussion:

*Sometimes I found it was tense when discussing this issue; sometimes I was not being heard or understood because there were other priorities in the room. (Kim)*

Whilst assuming that participating in a user group implies partnership and equity, there are instances where partnership and collective view is not consistently applied. Alex's example demonstrates what it was like to experience relationship inequity in the absence of partnership in the user group. Alex's request for more information is received as a challenge of authority. Alex experiences this as being dominated, played out in the behaviours of not being listened to and not being able to engage in a discussion:

*Depending on who you were challenging, there was a personal reaction to it; there was one person who did not like to be challenged at all, and wanted to perceive themselves to be this all-knowing entity that guides the hospital through everything and create this wonderful world. They weren't really listening. They refused to listen because in their mind they had a preconceived idea about how it was all going to turn out. (Alex)*

Alex then became aware that the members of the project group that were from her service began to feel like they were difficult to work with because of their desire to be consulted and informed more fully. The reactions from the project members seemed to reflect that they were difficult to deal with and were not entitled to the level of consultation desired:

*When I began to ask more questions that they clearly didn't have answers to, you were cut short, and meetings were adjourned. We began to feel in our user group that we were basically being labelled the 'black sheep' of the process: "oh here comes that team again with all of these questions", that team that is difficult to please, who won't take no for an answer, who want more consultation than is allowed. I found that quite frustrating. A design process, no matter if it is in a workplace or in your own personal life, the design principle, is one of consultation, and that was left out. (Alex)*

### Participation Experienced Through Creativity:

There are creative experiences within this redesign project whereby Alex, Jordan, and Kim participated in a process of design work that required constant integration of their background in nursing with clinical facility requirements to further develop concepts and ideas. There were also instances of constraints, causing frustrations that were overcome as creative thinking led to compromise. The participants experienced informal and formal modes of creativity within their respective nursing teams and user group meetings. Being able to envisage, and critically think, led to questioning their own thinking, and this enabled the nurses to share the problems with others, stretch beyond the currently possible, and experience the freedom to think expansively.

Jordan describes how the team experienced a simple cognitive technique, which took away barriers of thinking, to expand and create new possibilities. When the words '*imagine*' or '*why can't we?*' were used, current thinking was put aside and it was safe for nurses to make suggestions, which made it possible to consider ideas from new or different perspectives:

*In my sharing with a staff member a problem, the staff member said 'imagine if' and, a new good idea was made. A different approach to a problem, simple, straightforward, saves one hundred thousand dollars. The words, 'imagine' and 'why can't we?'. (Jordan)*

The participants were aware throughout the project that ideas for improvements of facility design would come from a range of sources. Nurses were assigned responsibility for utilising their experience and seeking new facility ideas to have a positive effect on the facility redesign. Jordan had an experience of acknowledging her own creative limitations. Being conscientious, she wanted to contribute to the project to the best of her ability. However, she felt her own professional inexperience was a limiting factor:

*I know our thinking is limited to only knowing the current facility. Our ideas are based on our own imagination and desire for good standards and workflow. I was refused the opportunity to go and see other departments to see how they work and compare facility layout. (Jordan)*

The process of redesign of the facility and workflows is based on what she currently knows. Jordan believes that her participation in the project would have benefited from learning from the experience of other hospitals. Being able to compare and discuss with others who have lived through the experience of facility redesign would have added to Jordan's sense of credibility in her role as the senior nurse within the user group. In being denied this opportunity to learn from the experience of others, Jordan is left with some anxiety for *only knowing the current facility*. For the project to utilise her as a resource, Jordan knows that her ideas are created from *imagination and desire for good standards* rather than a broader experience and knowledge of other healthcare facilities design.

Two of the participants did however experience the opportunity to visit other hospitals to learn from other redesign ideas. Site visits were specifically looking for opportunities to replicate, create, or merge ideas. Kim describes a time when she experienced a sense of opportunity to bring back a solution, and to be creative and contribute to innovations within the redesign of a ward setting:

*We visited another DHB, we saw how they managed the clinical notes and x-rays on the ward. It was a good solution for privacy of clinical notes, writing documentation, with accessible and safe storage. (Kim)*

Kim describes the feeling of being most engaged with the project when working on the details of patient care processes. In knowing patient care process well, Kim's confidence led to greater engagement and a feeling of a meaningful outcome:

*The project group that I was involved with, that I feel I had the most effect and engaged with the most had the best and most tangible outcome. (Kim)*

Kim felt her work was most meaningful when the architectural drawings of the new facility were in front of her. She felt a sense of engagement, of being drawn in and being involved with the drawings. For Kim, the presence of the drawings translated abstract ideas into a feel for the reality of the future facility:

*The part of the facility redesign project where it starts to feel more meaningful is seeing the drawings on paper. That's the part I*

*felt my involvement was meaningful, seeing our ideas are taking shape and taking shape in the form of something visible that you can see drawn out in a plan. I felt myself becoming more engaged, because I wasn't just talking a 'language' about a 'concept' or possibilities anymore I was able to talk about real rooms and spaces. You begin to see it. (Kim)*

The above experiences of being engaged and innovative contrast to other recollections of user group participation by all three participants. They also experienced times of frustration in instances where creative ideas were not able to be progressed due to limiting factors of the building footprint and budget constraints. Kim describes that it was hard to witness creativity, in the form of ideas that had already been transformed into solutions or '*what we would like*', being culled from the design:

*It was also hard. Our team had worked out what we would like on the basis of all the background research, site visits, and talked about great ideas. But when I saw the detail design drawing, I had to see these fantastic ideas be whittled down because of practicalities, what is workable and affordable. (Kim)*

Although there were frustrations as ideas and decisions were shelved for different reasons, Kim also describes the sense that participation in the project held positive experiences as they worked towards the final stages of a redesigned facility:

*It is exciting and hard at the same time. It is frustrating to go to a meeting one week and come up with fantastic ideas that you know will benefit patients and give nurses a better work environment. Then you find out you can't have it because it is too costly or some other infrastructure has to occupy that space. (Kim)*

All of the participants experienced disappointment and frustration at not being able to incorporate some of their creative solutions into the projects. They experienced the process of trying to find compromises. In essence, their experience was to persevere, as solutions needed to be found:

*Some decisions went out the window, because the reasons not to have them could not be overcome. It was incredibly disappointing and frustrating to have to sit and listen to the list of constraints of why things can't be done, because we had really good rationale of patient needs of why it should be done. We went round and round. I guess you just work away at finding compromise for the things that you can't have. (Kim)*

In the example above, decisions are moderated by constraints. However, Kim experiences the desire to continue to work to improve the outcome of the facility redesign. The affects of the compromises result in some innovations being sidelined, and more time and energy spent in further researching and debating or *going round and round* to try to accommodate a different innovation.

In participating in user group decision-making, participants also experienced having the process of expressing creative ideas as facilitated by a change manager. The experience highlights that having an environment that one can be respectfully heard also ensures ideas are critically thought through:

*I saw that having a good change manager was an advantage to facilitate the balancing of priorities and made sure that people had the opportunity to be heard. There was robust discussion rather than deterioration into an unproductive discussion. (Kim)*

The participants have experienced a process of creativity in redesigning wards, units, and departments for patients and staff. The creativity experienced by the participants has been to use each other as a resource, use their imagination, and participate in robust discussion, looking for learning from other institutions and awareness of the moderating effect of compromise, to locate solutions for design. Kim's experience is an example of this:

*I had great idealistic things I thought were going to be best for our service and patients but I ended up constantly modifying and balancing my expectations along with all the parties involved. At the end of the day I have a sense of achievement after my work in the project. (Kim)*

From this realisation at the ending of the project, there seems to be a *coming to terms* with the entity of the project as an experience of having creative licence and being constrained.

In this chapter, four themes of participation experienced as *Representation; Leadership; Relationships; and Creativity*, have been discussed. The discussion under each of these four themes was directed and supported through summaries and excerpts from the research participants'

experiences. The next chapter discusses in greater depth the meaning within these interrelated themes and goes on to make associated recommendations.

## **Chapter Five**

### **The Results - A Discussion**

This chapter is dedicated to the study findings, which will be discussed within the themes of participation defined earlier as *Representation, Leadership, Relationships, and Creativity*.

#### **Representation**

The findings suggest that senior nurses' participation in healthcare redesign involved not only representing a nursing perspective but also representation of multiple interests for other stakeholders (the DHB, specific standards of care delivery, healthcare services, patients, and other healthcare professionals). In representing key stakeholders, the senior nurses were present as a professional authority (representative of nursing expertise and knowledge). They facilitated the patient-care world, and the working world of clinicians, into the abstract redesign world by integrating practice knowledge and clinical standards into all aspects of redesign.

Having no prior experience of healthcare facility redesign, the senior nurses' experienced what it meant to act as representatives of stakeholders and to act as a resource within a new context and management structure. In adapting to the challenge of working in a facility redesign project, the senior nurses' point of reference was their prior nursing roles, practice, and knowledge of hospital facility environments. Cessario and Stichler (2009) state that it is critical that nurses be given roles in evaluating and designing hospitals, to ensure that completed facilities provide the users with safe and healing environments and staff with a facility that supports technology and best practice.

In the theme of representation, it was described that there was little distinction between the actions of representing key stakeholders as a CNM of a clinical area or representing stakeholders as a member of the facility redesign project group. This suggests that for senior nurses the mantle of representation

was present and was described as merging and blending the needs of the project and its design impacts with reference to the needs of the clinical setting.

The impacts of decisions on patients and other key stakeholders required consideration for standards, values, and needs of key stakeholders. Therefore, nurses' participation in decision-making for systems of caregiving and conditions of work are linked to positive patient and organisation benefits (Anthony, 1999).

Senior nurses' representation of patients could also be seen as integration of nursing attributes such as clinical expertise, experience, and judgement, translating into redesign concepts. It may be said that the nursing process framework is similar to project management techniques (Overgaard, 2010), in that the nursing process provides a systematic approach and set of skills which are fundamental to both. Successful project management includes "project initiation, planning, execution, monitoring and closing" (Overgaard, 2010, p. 53). Hence senior nurses may be successful in their approach to the complexities of representation in facility redesign projects from the paradigm of the nursing process (assessment, diagnosis, planning implementation, and evaluation).

There were aspects of representation that were described as difficult professionally. The recollection of an experience related to the nursing voice not being listened to on its own, gave the senior nurse a sense of not having a mandate for representation - either for nursing in its own right or for medical colleagues, and the individual clinical service that they represented. The senior nurse perceived this as being disregarded as a professional authority, when in fact expertise and mandate were present. This finding reveals incongruence with representation and meaningful engagement as a project group member, suggestive of a lack of recognition for the professional authority inherent in the senior nurse. The nature of the CNM role is described as being wide-ranging, with responsibilities including "managing compliance, professional regulatory rules, organisational policies, procedures and quality assurance systems" (McCallin & Frankson, 2010, p. 320). These responsibilities contribute to senior nurses' expertise and therefore their purpose in participating in healthcare facility redesign projects as representatives of professional authority.

In order to achieve representation one strategy was to alter communication and working group approaches in order to be listened to. As required, medical and nursing members contributed group work in partnership, improving decisional involvement and establishing for project management that in fact the medical and nursing voice was united. In this study the theme of representation was displayed in the experience of *decisional involvement*.

Decisional involvement has been described as the concept of making a choice to be involved in the *processes* that affect nurses practice in a hospital setting, where there is complex collaboration between nursing staff and the organisation (Kowalik & Yoder, 2010). Through the underpinning theme of representation, the senior nurses in this study have recognised that provision of a quality redesign project directly relates to nurses having a voice and being heard as professional authorities. They have strived to have decisional involvement regarding their work environment and practice.

Collaboration with nursing staff from within services also enabled valued contributions to the project. Kowalik and Yoder (2010) discuss the presence of collaborative relationships between senior nurses and nursing staff as encouraging decisional involvement within the nursing team. In this study the senior nurse actions of representation were in-turn reciprocated by staff. The nursing team became engaged along with the senior nurse, adopting an attitude of partnership and adding to the generation of ideas and problem solving.

The theme of representation also includes the senior nurse making conscious choices, and sometimes compromises, due to constraints of building layout or funding. The focus or priority in these circumstances became non-compromise of core professional values of advocacy for patient safety and maintenance of an environment that meets clinical standards, rather than less critical facility issues such as infrastructure that were beyond the sphere of influence. Often, nurses choose patient care as their highest value (Brown, 2002). In this study it appears that the senior nurse has indeed focused nursing influence on the redesign of the clinical setting to promote patient safety and standards of care in the presence of constraints.

An aspect of representing key stakeholders was also ensuring that vast amounts of complex project information and documentation was accurate and accounted for. To do this, the senior nurses utilised the documentation system

to their advantage. They felt that they had to constantly keep track of versions of documents relating to procedure, infrastructure, other facility details, and commitments. The driver for this level of vigilance was representation of the interests of stakeholders to ensure that important decisions were incorporated and not forgotten - the implications being that every detail of the project is known and related to creating a quality environment for patient care.

The senior nurses were required to incorporate project work into their everyday roles of managing patient clinical areas over a prolonged period of time. The absorption of a major facility redesign project into an already busy CNM role resulted in time and focus on the project displacing some of the usual work place responsibilities and vice versa. The findings reveal that for senior nurses working in dual roles this resulted in some degree of role overload. The implications, as some deferment of project priorities occurred, were of the senior nurse being left with a sense of dissatisfaction. It appears in this study that it was difficult to perform these two roles simultaneously.

The concept of role overload of CNMs new to nurse management was explored by McCallin and Frankson (2010). Their study found that CNMs were inadequately prepared for charge nurse manager roles. Their findings may be transferable to the experience of CNMs new to leadership roles in facility redesign project groups. In this study senior nurses reported having difficulty being able to manage two roles at once and feeling that effective representation was at times reduced because of this. This study revealed that the presence of role overload was experienced as *preoccupation* and *uncertainty* resulting in feelings of inadequacy.

## **Leadership**

The theme of leadership explores the experiences of accountability and responsibility described by senior nurses while participating in the facility redesign project.

Providing leadership was experienced from varying backgrounds of leadership expertise. The scope of the senior nurse role is described by McCallin and Frankson (2010) as being complex, ambiguous and demanding, suggesting that senior nurses need to be well-supported as there are deficits in the way they are prepared for senior nurse roles.

The senior nurses perceived that their leadership role within the project was crucial to project success and would have major influences on outcomes of the facility redesign project. Inexperience in the CNM role was, though, perceived as being insufficient for the accountabilities and responsibilities of project leadership, creating a sense of burden and vulnerability, and fear of making the wrong decisions and being blamed. For the senior nurse, the experience of feeling ill-prepared and inexperienced led to a feeling of mortification. The fear of failure has been stated as deriving from the need for perfection, an intolerance of mistakes, and a belief that *I can't handle it* (Yoder-Wise & Kowalski, 2006). These mindsets are prevalent in healthcare as the reality of errors are reinforced to healthcare workers by reports of adverse outcomes (Yoder-Wise & Kowalski, 2006).

This premise that senior nurses can positively or negatively influence outcomes for organisations, patients, and healthcare providers, is congruent with the work of Cummings, Lee, MacGregor, Davey, Wong, Paul, and Stafford (2008), who defined leadership as a “process whereby an individual influences a group of individuals to achieve a common goal” (p. 241) and that nursing leadership can be developed through specific educational activities, by modelling and practicing leadership competencies (p. 241).

The concept of professional integrity or reputation was intertwined with leadership competence and responsibility, leading a senior nurse to seek shared leadership of the project group with the nurse leader. In this study, a senior nurse shared leadership responsibilities with the line manager which enabled emulation (experiential learning from practice example). Therefore, support and an educative environment was available to the senior nurse through modelling and participating in leadership competencies (Cummings et al., 2008) within the context of project group work. For the senior nurse this provided some measure of safety for professional integrity, in that the opportunity for mistakes to occur could be minimised and that blame for mistakes could also be shared.

In this study, the greater the length of time in a CNM role prior to participating in the redesign project the greater sense of leadership competence and reduced expression of anxiety about performance as a leader. The absence of leadership skills was not described by the more experienced senior

nurses. In the review of literature conducted by Cummings et al. (2008) they found that “previous leadership experience was related to higher reports of a leader’s skills and practices” (p. 244).

In the role of leaders, the senior nurses stated there were inconsistencies that they didn’t understand and whereby their mandate within the structure of the project group was at times reduced as dictated by project management. They felt there was a lack of autonomy in the role of leader, sometimes causing frustration and feelings of disempowerment. In these circumstances they were excluded from discussion or decision-making. The senior nurses described this as leaving them wondering what their purpose was in the project group.

In writing about empowerment, Yoder-Wise (2007) states that empowerment is the process by which “we facilitate partnership of others in decision making and taking action within an environment where they are free to exercise power” (p. 174). In the above example of disempowerment, it appears that the ambiguity of the role occurred in an environment where the senior nurse was denied freedom to exercise power.

Leadership responsibilities as senior nurses within the project included having to be an expert from the hospital. Cesario and Stichler (2009) describe nurses as being crucial to leadership roles in facility redesign groups as they are the most “knowledgeable about the specific design features needed to support optimal patient care” (p. 324) as they are the largest group of healthcare workers in healthcare facilities (p. 324). The sense of having a unique knowledge to impart also caused reflection on what this expertise actually is and the certainty, validity, and depth of nursing knowledge held.

The attributes of an expert nurse are many - being experienced, intuitive, flexible and highly proficient; and a nurse that uses analytic ability in new situations, able to change course quickly and able to visualise future possibilities (Benner, 1984). These attributes appear within the study data, as senior nurses have imparted nursing perspectives and knowledge whilst participating in healthcare facility redesign as leaders of nurses.

Leadership involved communicating the ultimate vision and maintaining a big-picture perspective for members of the project group. The senior nurse identified ideal outcomes for healthcare facility redesign and provided detailed information for each specific group or individual so that their area of expertise

was focused, ensuring a cohesive approach within the group. Being engaged in balancing the expectations of all stakeholders through a process of negotiation resulted in the reported achievement of a safe and acceptable facility.

Feldman and Greenberg (2005) express that effective communication in group settings involves the leader engendering cooperation and influencing the group dynamic, thus leading the group toward cohesion and performing to achieve the group's goals (Feldman & Greenberg, 2005). The communication actions of senior nurses in identifying the goals of the project, balancing perspectives and expectations, and negotiating input, achieved cohesion and a productive group environment.

The obligations of this leadership role included being responsible for finding solutions when constraints were in place. The presence of constraints was seen as part of the reality of redesigning a new facility within an existing hospital infrastructure and fiscal responsibility. Leadership from the senior nurses included demonstration of a willingness to negotiate and compromise when necessary to obtain the goal of safe and effective solutions. The senior nurses in this study appeared to feel accountable for the outcomes of solutions that involved compromises, even if the constraint and subsequent compromise was not in their control.

Marquis and Huston (2009) describe accountability as an internalised responsibility whereby one feels morally responsible for the consequences of one's actions. As a result, the senior nurses were being accountable for the actions and outcomes of the project group, which is fundamentally acting on concepts such as leadership, accomplishment, choice and professionalism, and concern for improved quality of patient care (Hood & Leddy, 2003).

## **Relationships**

The theme of participation experienced through project group relationships is described using Tuckman's model of small group development – *Forming, Storming, Norming, and Performing* (Tuckman & Jensen, 1977).

The utilisation of this model will help the reader to come to an understanding of the experiences of project group relationships described in the data. The following discussion using Tuckman's model is intended to provide an image of facility redesign group relationships only, and is not intended as a

chronological or linear description. The project group relationships described were uniquely formed in separate project groups.

As groups are formed, the group participants first meet each other, establish individual identities, establish rules and the scope of work, and finally perform the work of the group (Marquis & Huston, 1998). The work of Tuckman and Jensen (1977) includes the dynamics of group communication and the process each group goes through before work is accomplished.

They defined the following four stages of group process which is described by Smith (2005):

Forming – is when individuals first come together they mostly orientate themselves to others and the work to be done, creating a degree of interdependence. Behaviour is driven by the desire to be accepted by others and to avoid conflict.

Storming - Storming is characterised by conflict and polarisation around interpersonal issues and may relate to the work of the group roles and responsibilities. The behaviours include suppressing conflict, feelings of winning or losing battles, and looking for rules to prevent conflict from progressing.

Norming – when resistance is overcome and a cohesive group dynamic occurs leading to the development of in-group standards, tasks, and roles. Group members are able to express opinions, come to an understanding, and appreciate the skills and experience of group members.

Performing – Performing is characterised by group members being interdependent and flexible in their behaviours, resulting in functional and trusted activity, and team members being task-orientated. Roles and responsibilities seamlessly change, and the energy in the group is focused on the achievement of tasks.

### **Relationship forming.**

The groups established by project management were predominantly formed by nursing and non-clinical hospital staff. The study revealed that there were some challenges in establishing and maintaining working relationships in project groups - particularly those in which a shared work history or prior understanding of each other's professional backgrounds was absent.

### **Relationship storming.**

The relationship that project management had with senior nurses was described as lacking a framework of consultation from the view point of the *Treaty of Waitangi*. There was an assumption and expectation by senior nurses that they would be involved in the facility redesign project under the same relationship framework of participation, protection, and partnership that other DHB consultative processes would follow.

In practice, cultural safety is respectful of Maori worldviews, recognises culturally driven differences and protocols, and “understands historical, contemporary socio-cultural and political reality” (Wilson & Neville, 2009, p. 69). It appears that in this relationship structure there was insufficient consultation process in terms of the *Treaty of Waitangi*. This was described as diminishing the voice and ability to decide outcomes as they relate to Maori opinion and destiny. It appears that described in this experience is a power differential, manifesting as a limited agenda for project management to genuinely participate in meaningful consultation acceptable to Maori.

In another experience a senior nurse became aware of the arduous nature of being in a project group relationship as interpersonal, role, and responsibility issues appeared to be generated by a lack of understanding and appreciation of core clinical perspectives. The senior nurse made a conscious decision to ‘*change self*’, thus protecting the working relationship. The instigator for this recognised need for change was the necessity to progress the project and act in the best interests of the collective good (rather than jeopardise the process as an individual).

### **Relationship norming.**

One perception of the project groups formed predominantly by nurses was that they were easily established as a team. This was experienced as beneficial because working together from a shared professional background overcame the necessity to initiate new working relationships with group members from other backgrounds. Positive and cohesive experiences of working relationships were developed from a base of pre-established common understandings of contemporary nursing issues.

Also described were the benefits of having different professional backgrounds within the project groups as a wide range of perspectives contributed to effective problem-solving. When non-clinical staff had preordained plans that conflicted with other methods or objectives, the senior nurses described that having the presence of good working relationships benefited the project as they were able to achieve changes in perspectives. Being able to motivate and support members of the user group was beneficial to relationships. In this dynamic, the expression of ideas and opinions leads to new understanding and appreciation of group members as the group finds a common way forward (Smith, 2005).

Shared experiences resulted in group cohesion, and this led to the group understanding each other, each other's expectations and concerns, and over time, learning to read each other. Networking and building relationships was described as a way to navigate relationships. A relationship pattern was also described as emerging and naturally occurring where negative thinking (caused by constraints or obstacles) was balanced with optimistic viewpoints.

### **Relationship performing.**

As working relationships developed, the group found it easier to achieve the goals and expectations they were tasked with (cohesion). In relating to non-clinical group members, actions enhancing working relationships and completion of tasks included providing opportunities for meaningful contributions of non-clinical team members, moderating group interactions and facilitating inclusion in meaningful discussions. Good leadership within a project will have a significant and positive effect on the performance of the group (Anderson, 2010). Likewise, the climate of the group can be influenced by the leader, thus when feeling empowered group members feel energy and are able to accomplish their aims (Brown, 2002).

The senior nurse's positive relationship with the nursing team (stakeholders) empowered the team to participate in the project, creating an environment of self-determination and respect for the input of staff into the project and within the workplace. Anderson (2010) in writing about project management leadership identified that in valuing others we "accomplish effective team development, appreciate the needs of the team and validate

effective approaches to leadership styles" (p. 63). This was reflected in the relationship of the senior nurse with the nursing team as reciprocation in the relationship gained understanding and trust, and enabled nurses to feel involved.

In acknowledging staff expertise, a constructive relationship with the nursing team was maintained. The understanding of the CNM/senior nurse in building relationships through valuing nursing team members resulted in the experience and knowledge of the nursing team contributing positively to the project.

### Creativity

The senior nurses participating in this research have been involved in a *once-in-a-career opportunity* to be involved in a project that redesigns a DHB healthcare facility, and to contribute to changes in nursing care delivery within new facilities.

This study found that in order for nurses to be innovative, and make changes, they acknowledged their own life-world limitations, looked for external sources of opportunity, encouraged imagination to generate ideas and broaden thinking, and experienced constraints and compromises as limiting factors. Through such complex process they came up with alternative innovations.

In the theme of creativity, the use of imagination to stimulate ideas to solve problems of design came from relaxed and informal conversations with staff. The experience of nurses asking each other '*why can't we?*' or '*imagine*', set the stage for the removal of barriers to thinking and created an environment for considering new perspectives. This stretching of ideas beyond what was already known resulted in a sense of wonderment and led to the emergence of ideas for solutions.

The senior nurse's strategy in sharing a redesign problem with staff ensured that the innovations of the nursing world were integrated into the project. This is echoed by Richer, Ritchie, and Marchionni (2009) as they describe the process of staff meeting and sharing their innovative ideas about care delivery as an appreciative inquiry process that enables the emergence and adoption of creative ideas. This premise of interpersonal relationships between CNM and staff establishing a creative environment for ideas and

cooperation is also echoed by Roussel (2006). Roussel (2006, p. 70) states that the “acceptance of differing behaviours and ideas, and a willingness to listen” are fundamental to processes of problem resolution leading to creativity.

Knowledge limitations were described in two ways. Firstly, being new to the senior nurse role was experienced as a limiting factor, as was having limited employment experience in other DHBs from which to draw on. An awareness of having limited senior nurse experience implies that nurses need time to settle into their CNM role (to create experience, history, and knowledge) before they can be effective agents of change in a healthcare facility redesign project. In environments such as healthcare, staff accumulate and produce knowledge that contributes to change, enabling them to be viewed as ‘*agents of change*’ (Richer, Ritchie, & Marchionni, 2009). However, the perceived inexperience was viewed as a lack of knowledge undermining an ability to be creative and affect change.

The preparation of CNMs for participation in the facility redesign project did not take into account any limitations in work-life history. It appears that there was an assumption that being a CNM was in itself an appropriate level of knowledge that would contribute to creativity within the project.

The senior nurses had a strong desire to not simply reproduce their current facility in the new facility, but to make changes in design that were innovative, evidence-based, and forward-thinking. They recognised that any personal limitations could be overcome through learning from nurses and design teams from other healthcare settings and DHBs. However when denied the opportunity to visit and learn from other health providers, relying on nursing values, current knowledge, and imagination, formed the basis of design ideas.

Sources of opportunity included the learning and experience of other DHBs which had a positive impact on creativity within project groups. The visualisation of solutions in the real world of patient care delivery at other hospitals provided opportunities to replicate, create, and merge ideas. Being able to see and experience a working facility, and discuss the learning from other healthcare workers, allows comparison of conceptual ideas between the abstract and the tangible clinical world.

At times, having to make compromises impacted on the creative process and was experienced as difficult because of financial and practical constraints.

The senior nurses participated in the creative process through finding out what was possible by researching other New Zealand hospital facilities. Some made site visits to other hospitals and developed ideas through discussion. They found it exciting and at the same time challenging as ideas beneficial to healthcare delivery could not all be incorporated into the designs. The nurses describe feeling frustrated and disappointed when creative solutions could not be incorporated and compromises had to be found. The senior nurses experienced having to persevere with creative ideas to overcome constraints and find compromises that were safe and effective solutions.

In this chapter, the discussion has linked the description of experiences to the findings and previous literature. The theme of representation describes the complex nature of maintaining the interests of key stakeholders as senior nurses have acted with professional authority. The theme of leadership is illuminated in experiences of professional integrity described as accountabilities and responsibilities, control and compromises. The theme of relationships was described using Tuckman's model of small project group dynamics to provide some insights into senior nurses' experiences of group work and communication. Finally, creativity was expressed through individual and group imagination and described from the desire to do the best possible within constraints and compromises.

The final chapter, Chapter Six, puts forth some recommendations based on the research findings, towards better understanding and improving the experiences of those involved in healthcare (re)design projects, and towards fostering positive future experiences and outcomes for healthcare facility (re)design projects and their user group members.

## **Chapter Six**

### **Recommendations**

#### **Recommendations for Organisations**

The allocation of senior nursing staff to large facility redesign projects is essential to the safe and successful design of healthcare facilities. Senior nurses contribute majorly to the integration of design and care processes that are able to meet the needs of patients and staff in the rapidly changing healthcare setting. Facility redesign projects may only happen once in a career, so there is an investment required for preparing nurses for leadership roles in facility redesign groups, as are supportive systems required to relieve senior nurses of their CNM roles at times when achievement of crucial project tasks or objectives is required.

This research highlights the importance of initiating protective strategies to prevent burden and role-overload. The calibre of nurses involved in this work is of such value to the organisation that resources need to be invested which both encourages nurses to take on such roles and ensures their clinical responsibilities are appropriately supported through the duration of the project. The organisation must be aware of the consultative process employed by any project management structure in place, and ensure that consultation does adhere to the principles of the *Treaty of Waitangi*, and seek feedback from Maori that this has been satisfied.

#### **Implications for Individuals**

This study has generated a number of insights into the experiences of senior nurses participating in user groups. It can be said that participation in a facility redesign project group requires senior nurses to learn and develop new knowledge and skills of design work whilst integrating nursing knowledge of patient care and hospital systems into a new design. Ever-present is the fundamental desire of nurses to keep the patient and the quality of care delivery

central to the project. There are a myriad of tasks, accountabilities, and responsibilities for which the senior nurse needs to prepare for.

### **General Specific Recommendations**

I recommend that senior nurses/nurses:

- *continue to be seen as essential members of facility redesign projects, imparting and representing nursing knowledge of innovative patient care systems and best practice standards.*
- *are supported to take leadership roles within healthcare facility redesign groups by receiving training in project management, communication, and to develop knowledge of industry facility design processes.*
- *have mentorship provided through their initial experience of being part of such a project.*
- *have their regular workload monitored throughout the duration of the project with additional staffing support put in place as needed.*
- *whom have developed expertise in facility redesign projects have a mechanism of sharing their insights with others through professional networks.*

### **Suggestions for Further Research**

A larger qualitative study of the experiences of nurses in healthcare facility redesign may bring forth further understandings of their influence in modern hospital design. An online survey aimed at an international audience could reveal common tensions and strategies.

A case study of a facility redesign that interviewed all stakeholders would provide valuable insight from perspectives additional to nursing. It would also be interesting to interview nurses who had been part of a redesign team one year following the move to a new facility to hear their impression of success.

### **Limitations of this Study**

This study described the experiences of three participants from one DHB. Being a qualitative study, the research data collected from the small group was rich in detail. The participants all had various lengths of time employed as CNMs prior to their involvement with project groups. One

participant had completed participation in user groups, while the other two were concluding or still involved in participation.

Each of the three study participants was female, two were of European descent and one was Maori. The study's findings do not necessarily reflect the experiences of any other nurse or male nurses. The descriptions in this study do not account for the understandings derived from people of other ethnic groups.

## **Conclusion**

In this study the senior nurses' experiences through their participation in healthcare facility redesign has been described within four themes of participation: *Representation; Leadership; Relationships; and Creativity*.

*Representation* was present in the way in which senior nurses have represented many stakeholders as they acted as a professional authority of nursing knowledge and expertise. They performed an essential and unique role within facility redesign project groups. Their presence integrated the perspectives of stakeholders, nursing values, goals, and concerns into the abstract world of healthcare facility redesign. *Leadership* experiences of demonstrating professional integrity were found in the ability of the senior nurses to influence facility redesign outcomes and were described as achievements. However, accountabilities and responsibilities were at times experienced as a burden, which created vulnerability.

*Relationships* were experienced in user group dynamics and instances of communication through stages of group development. Senior nurses experienced establishing the group, conflict and resolution, benefits of sharing and moderating perspectives, and achieving group tasks. *Creativity* was described as opportunities found in new ideas generated by self, nursing team, or project group. The experiences of being constrained or limited led to compromises, which in turn sometimes generated innovation.

The experience of senior nurses in healthcare facility redesign processes has been described through many challenges and constraints with a merging and blending of the clinical world into healthcare redesign. Senior nurses have

led the way forward, retaining a focus on the patient and clinical standards, and have sought to be innovative and seek opportunity to improve the facility and care process for patients and staff.

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Some identifiers within the reference information have been withheld to protect individual and organisation identities. Obtaining information regarding identifiers may only be authorised by contacting the author through Auckland University of Technology.

## Appendix A: Ethics Approval Letter



### Northern X Regional Ethics Committee

Ministry of Health  
3rd Floor, Unisys Building  
650 Great South Road, Penrose  
Private Bag 92 522  
Wellesley Street, Auckland  
Phone (09) 580 9105  
Fax (09) 580 9001

9 April 2010

Ms Julia Braid



**Postal:**  
Private Bag 92 522  
Wellesley Street  
Auckland 1141  
**Phone:**  
(09) 580 9063  
**Email:**  
cheh\_chua@moh.govt.nz

Dear Julia

Ethics ref: **NTX/10/EXP/050**  
Study title: Nurses participating in healthcare redesign: an interpretive study  
Investigator: Ms Julia Braid  
Supervisor: A/Prof Liz Smythe  
Localities: Auckland University of Technology, [redacted] District Health Board

Thank you for your application received 7 April 2010. The above study has been given ethical approval by the Deputy Chairperson of the **Northern X Regional Ethics Committee** under delegated authority.

#### Approved Documents

- Information Sheet dated 1/6/2009 Please insert version number with the date and place it as footer on the information sheet
- Consent Form: undated. Please provide same version number and date as information sheet and place as footer on consent form.

#### Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

#### Final Report

The study is approved until **9 April 2011**. A final report is required at the end of the study and a form to assist with this is available at <http://www.ethicscommittees.health.govt.nz>. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

#### Amendments

It is also a condition of approval that the Committee is advised if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

**Please quote the above ethics committee reference number in all correspondence.**

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study

Yours sincerely

A handwritten signature in black ink, appearing to read "Cheh".

Cheh Chua(Ms)  
Assistant Administrator  
Northern X Regional Ethics Committee

## **Appendix B: Consent Form**



### **Consent Form**

For use when interviews are involved.

*Project Title:* Nurses Participating in Healthcare Facility Redesign: An Interpretive Phenomenological (Hermeneutic) Study.

*Project Supervisor: Liz Smythe*

*Researcher: Julia Braid*

- I have read and understood the information provided about this research project in the Information Sheet dated 01/06/2009.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one):  
Yes No

Participant's Signature:

.....

Participant's Name:

.....

Participant's Contact Details (if appropriate):

.....

Date:

**Approved by Northern X Region Ethics Committee on April 9 2010, HandDEC**  
**Reference number NTX/10/EXP/050.** Note: The Participant should retain a copy of this form.

## **Appendix C: Participant Information Sheet**



### **Participant Information Sheet**

Date Information Sheet Produced: 01/06/2009

**Project Title:** Nurses Participating in Healthcare Facility Redesign: An Interpretive Phenomenological Study.

#### **An Invitation**

You are invited to take part in a research project exploring the experiences of nurses participating in healthcare facility redesign. Your participation in this research project is voluntary (of your own choosing). You may choose to withdraw from the project at anytime. Withdrawal from the project will not have any influence on your employment or workplace in any way. The information you provide will be part of a study that will be written as part of a Master's qualification.

#### **What is the Purpose of this Research?**

The purpose of this research is to provide a way of articulating, appreciating and making visible the voices and experiences of nurses who have participated in Project A User Groups at X DHB. The information from the study will provide insights into the meaning of participating in healthcare facility redesign. It is hoped this will prove useful for other nurses participating in healthcare facility redesign within the region and nationally.

#### **What Happens to the Information I Provide?**

The information obtained from the interviews will be used to explore and define the meaning and significance of events, interactions, and experiences disclosed by the participant. The report findings will be written as the dissertation for a Master's Degree. It is planned that the results will be published in an appropriate nursing journal and as a presentation at a nursing conference. You will not be identified as a participant in the research project or in any of the written reports.

#### **How was I Chosen for this Invitation?**

Nurses from X DHB who participated in user groups have been invited to participate in this research project. If you respond to this invitation you will be in direct contact with the researcher. The research project will contain a specific number of participants due to the limited timeframe available for the study.

#### **What will Happen in this Research?**

The project involves interviews with nurses who have participated in user groups. Participants will be asked to talk about their experiences of participating in user groups with the researcher, in an audio-taped interview. The interview will take one to two hours.

#### **What are the Discomforts and Risks?**

You may recall work related experiences that are stressful or in some way unsatisfactory. If this happens, there is a possibility that you may feel uncomfortable revealing this information.

**How will these Discomforts and Risks be Alleviated?**

As the participant, it is your choice what experiences you reveal and convey to the researcher. You will have the opportunity to withdraw any part of the information you give. You will be given a summary of the interview which you can modify. You can choose to withdraw from the interview and/or the study at any time prior to the completion of data collection. You may choose to access free staff services from X DHB (e.g. Employee Assistance Programme (EAP), Staff Wellness Coordinator, Clinical supervision and Coaching).

**What are the Benefits?**

In time, there will be a contribution to nursing knowledge regarding the experience of nurses' participation in the many facets of healthcare redesign, from which others may draw new insights and understanding.

**What Compensation is Available for Injury or Negligence?**

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

**How will my Privacy be Protected?**

Your participation in the study and interview will be kept confidential to the researcher (no other person or the organisation you work for will know of your involvement). You will not be identified in any transcripts or written materials and the recording of your interview will be held in a secure locked place. The interview will take place in a location of your choosing and will be held so that it cannot be overheard.

**What are the Costs of Participating in this Research?**

There are no direct costs to you the participant. You choose the time you give voluntarily for the interview. Any reasonable cost (travel) in relation to being interviewed will be agreed upon by both parties and you will be reimbursed. All costs associated with the study are the responsibility of the researcher.

**What Opportunity do I have to Consider this Invitation?**

You have 14 days to consider participating in the study and to respond to the invitation.

**How do I Agree to Participate in this Research?**

Contact the researcher directly using the contact details below.

You will be asked if you understand what is involved in being a participant in this study and to sign a Consent Form which the researcher will give you prior to the interview.

**Will I Receive Feedback on the Results of this Research?**

Yes.

You will receive a copy of the transcript from your interview.

You may also choose to have a copy of the final written study.

**What do I do if I have Concerns about this Research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, [madeline.banda@aut.ac.nz](mailto:madeline.banda@aut.ac.nz), Tel. 921-9999 ext. 8044.

**Whom do I Contact for Further Information about this Research?**

Researcher Contact Details:

*Julia Braid RN*

*Post Graduate Student, Health and Environmental Studies, AUT.*

Project Supervisor Contact Details:

*Liz Smythe*

*Associate Professor AUT*

*Approved by Northern X Region Ethics Committee on April 9 2010, HandDEC  
Reference number NTX/10/EXP/050.*