A hermeneutic phenomenological investigation of adult nurses' concept of agency in clinical nursing care within hospital settings

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8HW006 DProfHW Thesis

A hermeneutic phenomenological investigation of adult nurses' concept of agency in clinical nursing care within hospital settings

A thesis submitted in partial fulfilment of the requirements of the University of Wolverhampton for the Professional Doctorate in Health and Wellbeing

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Faculty of Education Health and Wellbeing 24th October 2022

Declaration

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Abstract

A hermeneutic phenomenological investigation was undertaken to understand nurses' concept of agency, or power to act, in clinical nursing care within hospital settings. It examined how free or constrained nurses felt in nursing care within their scope of practice. There were questions of what constituted freedom in nursing care. Data was gathered using stories from nurses' experiences in clinical practice. A purposive homogeneous sample of twelve nurses was used in this study; all of whom were *insiders* as they were involved in clinical nursing care. This made it easier for them to understand the questions asked during their stories.

The main themes which emerged were experiences and responsibilities in nursing care, the ability to provide nursing care, constraints in nursing care and collaborative nursing care. The findings revealed that nursing care has changed over time, and nurses are now doing more clinical skills, but at a closer look, freedom appeared limited. Nurses were able to initiate and deliver basic nursing care; however, in some aspects of care, including extended roles, nurses needed approval from doctors first. When the findings were subjected to *poiesis*, the concept of agency was further compounded by the characteristics of power and authority, structuration, the cognitive empire, and colonialism. Findings were discussed against the backdrop of the existing literature and theories.

What made freedom an interesting concept in nursing care was that nurses could discuss their roles, responsibilities, and clinical nursing skills they had or did, but

they were unable to define nursing as it had various meanings to them. It was then difficult for them to say what was freedom. Freedom, however, was whatever the nurse saw as such. It was indicative that nurses should be allowed to develop their epistemic knowledges, deliver nursing care the way they saw appropriate and utilise clinical skills they were competent to perform.

Abbreviations

AACN – American Association of Colleges of Nursing

CASP – Critical Appraisal Skills Programme

CCU – Coronary Care Unit

CINAHL – Cumulative Index to Nursing and Allied Health

CO_2 – Carbon Dioxide

CPR – Cardiopulmonary Resuscitation

ECG – Electrocardiogram

ED – Emergency Department

EMU – Emergency Medical Unit

GDPR – General Data Protection Regulation

HCA – Health Care Assistant

ICU – Intensive Care Unit

IV – Intravenous

MDT – Multidisciplinary Team

MEDLINE – Medical Literature Analysis and Retrieval System Online

NHS – National Health Service

NMC – Nursing and Midwifery Council

$PaCO_2$ – Partial Pressure of Carbon Dioxide

pH – Power of Hydrogen

PIN – Professional Identification Number

RCN – Royal College of Nursing

Resus – Resuscitation

TPN – Total Parenteral Nutrition

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Introduction **Chapter One**

Nursing is a profession that has undergone many changes since its beginnings and continues to mature and evolve. The evolution of nursing is influenced by government policies, patients' changing needs and society in general (Leary and MacLaine, 2019; Benton, Ferguson and del Pulgar, 2020; Langer, 2021). There are claims that there is growing recognition from within nursing, healthcare policymakers and society at large for the need to analyse the contribution of nursing to health care (Schuurmans, 2013; Nutburn, 2016; Sultan, 2018; Gonçalves, Sampaio, Sequeira et al., 2020; Sharma, Vishwas and Jelly, 2020; Lukewich, Tranmer and Kirkland, 2019; Ryan, Talpur and Robertson, 2022). In my experience as a nurse and senior nurse lecturer, I could say that almost every health department or health professional relies on the nurse in patient care, yet nursing is still misunderstood or treated as less important than medicine (Blasdell, 2017; Jackson, Anderson and Maben, 2021). Considering this, I saw it necessary to start by discussing what nursing care is about, what the nursing role is, what clinical nursing skills and standards of proficiency are and how these play a role in this investigation. The relevant terms of concept and agency have been explored for the study's intelligibility. In any study, it is helpful to make it clear at the beginning what it is that is being investigated and what terms may be used within the study. Nelson Mandela suggests that if one talks to an individual in a language they understand, it goes to their head, and if one talks to them in their language, it goes to their heart (Mandela, 1995; 2011). Fanon (2008) points out that Piaget's remarkable studies have taught us to distinguish the various stages

in the mastery of language and says that some authors have shown us that the function of language is broken into periods and steps. The problem with language is that it is too basic to allow us to state it all the way we want to. Hand (1952) suggests that words or concepts are chameleons that reflect the colour of their environment. The situationality in this thesis is that words or concepts take their meaning from the context in which they are used (Wittgenstein, 1958).

1.1 Nursing care and the nursing role

Nursing is an umbrella term that means different things in different situations and to different individuals. The tendency to consider nurses as a homogeneous group is to mistake the scope of nursing practice (Sellman and Snelling, 2017). Nursing encompasses a wide range of activities, making it difficult to encapsulate what nurses do in a single statement; therefore, there is no simple definition of either what it means to be a nurse or what is understood by the term nursing (Loriol, 2018; Jackson et al., 2021). There was once a suggestion by Florence Nightingale that the elements of nursing are all but unknown (Royal College of Nursing (RCN), 2014). Some see nursing as associated with physical tasks such as keeping a patient safe, comfortable, nourished, and clean; some see it as assisting a doctor by carrying out tasks associated with medical treatment (Burns, 2019; Nunes and Szylit, 2021). The RCN (2014) highlights that the formal definition of nursing is probably that of Nightingale, which states that nature alone cures and that what nursing has to do is place the patient in a better position for nature to act upon them. The nurse's role is not specific, and there are varied definitions of the role. This is because various nursing roles have existed since the profession emerged.

It is reasonable to suggest that there are similarities in nursing roles and functions regardless of what they are (Scott, Matthews and Kirwan, 2014). In summary, the role of a nurse is to provide nursing care. My explanation in this study is that nursing care means assessing, monitoring or observing patients, treating them, and ensuring that all their activities of daily living (Roper, Logan and Tierney, 2000; Holland and Jenkins, 2019), physical, physiological, psychological, and social needs are met, and where appropriate, referring them to other health professions. The roles and tasks undertaken by nurses are diverse, as indicated in the diagram below.

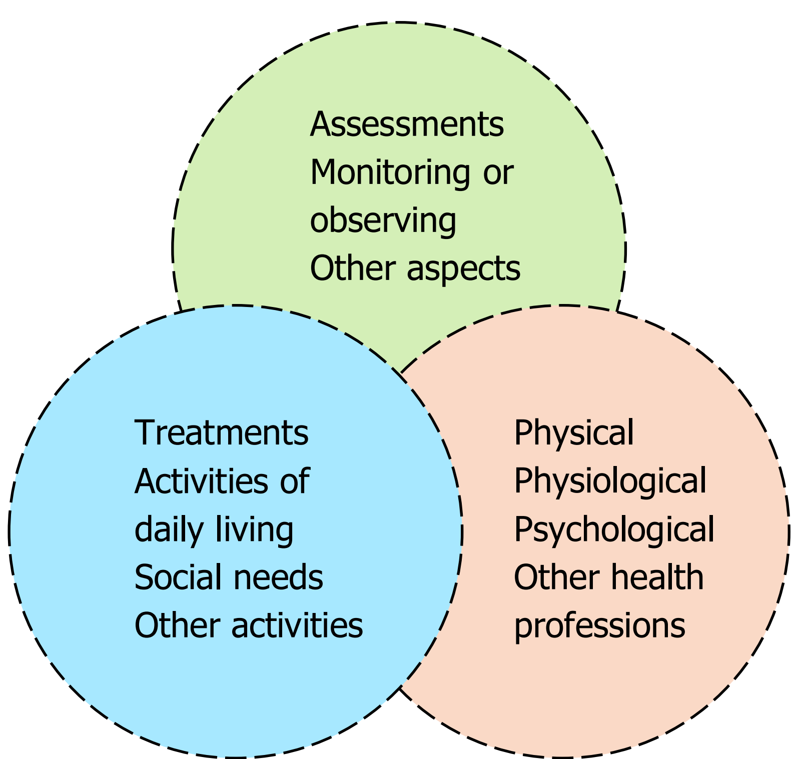

Figure 1: The diversity of nursing roles and tasks

Benner and Wrubel (2018) declare that nursing conceptualisations are found in the professional nursing rhetoric, literature, and educational texts that claim to place the centrality of care in nursing practice. The epistemology and ontology of

nursing practice are based on this literature and ideas (Welch, 2020). Morris, Matthews and Scott (2014) insist that the empirical work over the past years supports this conceptualisation of nursing practice which recognises a patient as a whole with psychological, social, and physical care requirements. Nursing is also about interacting and building trust with a patient. Gaining patient trust and confidence is related to personal factors in the practitioner, such as how one is in one's role (Scott et al., 2014; Xue and Heffernan, 2021). Seemingly, patients seek cues from the nurse regarding their level of interest in them as a person with their needs (Kane, 2012; Molina-Mula, Gallo-Estrada and Perelló-Campaner, 2018; Durkin, Usher and Jackson, 2019). It is claimed that patients' perceptions of their needs and good nursing are different from the nurses' perceptions of patients' needs and good nursing (Ozturk, Demirsoy, Sayligil and Florczak, 2020). From the patient's perspective, when feeling unwell and particularly vulnerable, receiving such care, human understanding, compassion, and support make nursing most valuable (Durkin et al., 2019). Martin (2018) says that nurses talk about their practice's reality and their desire to do a personally good satisfying job in an environment that sometimes seems to conspire against this goal. The literature states that nursing covers autonomous and collaborative care of individuals of all ages, families, groups, and communities, well or unwell, in all settings (Scott et al., 2014; Potter, Perry, Stockert et al., 2017). It adds that nursing includes health promotion, illness prevention, care of the ill, the disabled and the dying (Martin, 2018; Hinkle and Cheever, 2018). According to Henderson (1991), the role of a nurse is to assist individuals well or unwell without prejudice in the performance

of those activities contributing to health or its recovery or peaceful death, and that those individuals would perform those activities unaided if they had the will or knowledge, the necessary strength, and to do this in such a way as to help them gain independence as rapidly as possible, based on certain nursing skills and standards of proficiency (Nursing and Midwifery Council (NMC), 2018a).

1.2 Clinical nursing skills and standards of proficiency

Clinical nursing skills and standards of proficiency are significant in nursing care. The clinical nursing skills are administering medicines and fluids, pain management, wound dressings, monitoring, observing and evaluating patients' physical condition, meeting patients' activities of daily living (Holland and Jenkins, 2019), and other clinical skills (Scott et al., 2014). In addition to clinical skills, nurses must admit and discharge patients, document care, work and communicate with other health professionals regarding the care.

The nursing regulatory body, the NMC, identifies proficiency standards with seven platforms and two annexes that specify the knowledge and skills nurses must demonstrate when caring for people of all ages across all settings. These are being an accountable professional, promoting health and preventing ill-health, assessing needs and planning care, providing and evaluating care, leading and managing nursing care and working in teams, improving safety and quality of care, and coordinating care (NMC, 2018a). The two annexes are communication and relationship management skills and nursing procedures.

1.3 Concept and agency

It is essential to explore the terms of concept and agency within this study to acquaint the reader with the investigation's nature. A concept is a general idea, an understanding of something or an image held in mind (Elliot, 2020). The ontology of concepts begins with identifying mental representations, abilities, and abstract objects (Margolis and Laurence, 2015; 2021). It amounts to being able to discriminate something from something that it is not. Machery (2017) sees concepts as meanings or contents of words and phrases instead of mental objects or states. Margolis and Laurence (2021) assert that there is no reason why different views of concepts could not be combined in various ways. However, some theorists advocate concept *eliminativism* or believe there are no concepts (Johnson, 2010; Machery, 2009; 2017). In this thesis, the word concept refers to the nurse's understanding of their ability to deliver nursing care through cognition and practice.

Agency is the capacity of individuals or agents to act (take action) independently and make their own choices (Bai, 2006; Gillespie, 2010; Barker and Jane, 2016; Sunstein, 2017; Ferrero, 2021). It has been pointed out that human agency and freedom are fundamental tenets of Eurocentrism, Western thought, and civilisation (Lowe, 2008). An *agent* is an individual with the capacity to act, and agency denotes the exercise of this capacity (Schlosser, 2019). The term *agency* is used in a more specific sense to denote the performance of intentional actions (Wilson, 2016; Elliot, 2020). An act can be intentional in some circumstances and unintentional in others (Alvarez, 2010; Clarke, 2010; 2014). Searle (2001) and

Klima (2021) define intentionality as the capacity of mental states to be directed towards or related to something in the external world.

Orem (1983) discusses agency in her self-care deficit theory, but not in the context of this investigation. She sees nursing agency (collective nursing capabilities) as the complex attribute of an educated and well-trained nurse who allows the patient to understand and identify their therapeutic self-care demands and helps them meet their self-care agency (Younas, 2017; Ali, 2018; Gligor and Domnariu, 2020). Self-care is the practice of activities individuals initiate and perform on their behalf to maintain life, health, and well-being (Orem, 1991; Hartweg and Metcalfe, 2022). Self-care agency is the power of individuals to engage in self-care and their capabilities for self-care (Hartweg, 2015; Kumar and Soumya, 2017). Banfield (2011) sees nursing agency, from Orem's perspective, as the power or ability of the nurse to design and produce nursing systems of care. A nursing system of care is all actions and interactions of nurses and patients in nursing practice situations (Orem, 1983; Ali, 2018; Yip, 2021). It is about networking; in other words, it is about the nurse designing a plan of care that identifies what is to be done and by whom: the nurse, the patient, the carer or the family member (Hartweg, 2015). The actions of all involved in the care are collectively known as the nursing system (Carroll, 2019).

The term agency is rather slippery and is used differently based on the epistemological foundations and goals of scholars who utilise it (Dyson, 2020; Menzel, 2020). Agency discussed in this thesis is on nurses' actions or practices

(what they did or had to do) in nursing care; therefore, it is about the power to act or take action individually or collectively on the tasks, activities, or care delivered. It relates to how free they were in performing those tasks, activities or care delivered. In the context in which agency is used in this study, it means the nurse's ability to act or take action freely in delivering nursing care of preference (Pepper, 2019).

1.4 Purpose of the study

This study investigated nurses' concept of agency or power to act within their scope of practice in clinical nursing care within hospital settings. Nietzsche (1997) posits that if I wish to seek peace of mind and happiness, I should believe, but if I want to be a disciple of truth, then I must investigate. On the other hand, Sagittarius (2006) points out that I should be a free thinker and not accept everything I hear as truth; I need to be critical and evaluate what I believe. Nurses' concept of agency was chosen for personal and professional reasons. My reason for choice as a nurse and nurse lecturer is that I have always regarded nursing as rigid or not allowing freedom in nurses' actions in nursing care. Professionally, it is evident that nursing has evolved, and the nursing role is constantly changing; however, it is unclear if agency occurs in nursing care in this evolution and change (Leary and MacLaine, 2019).

In this study, I felt that I needed to find meaning in nurses' lives in clinical practice; in other words, understand that which had meaning to them and that which had meaning to me as a researcher. Nietzsche refers to this as meaning in

human existence (Nietzsche, 1969; 2005; 2014). This study highlights how nurses practised and seeks to understand if they delivered nursing care they felt was needed by their patients. Here I am gazing into the abyss to get some answers as Nietzsche (2002) believes that if I gaze long enough into the abyss, the abyss will gaze back into me. In doing this investigation, I anticipated living the full life of the mind in research, exhilarated by new ideas and intoxicated by the romance of the unusual (Hemingway, 2014).

Agency is important in today's nursing arena to fully appreciate the independent contributions of nursing to health care. It allows nurses to act freely in their actions or intentions and have a choice of preference in what they do. Nursing is seemingly progressing along the continuum of Benner's (1984; 2001) theory of novice to expert. Nurses have worked at a competence level, which means delivering nursing care successfully or efficiently (NMC, 2014). In 2018, nursing was moved along that continuum to proficiency or a high degree of skill or competence (NMC, 2018a) (see diagram below, and appendix 1 for Benner's detailed stages of clinical competence). On this basis, one would presume agency and professionalism in nursing care or at least a move towards.

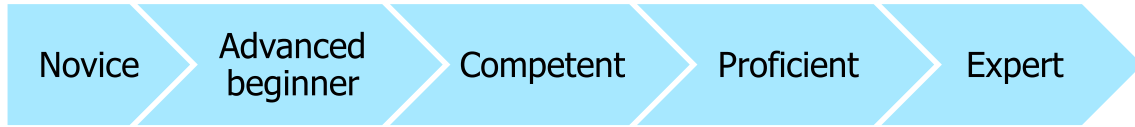

Figure 2: Benner's stages of clinical competence

The political and professional policy is to continually advance nursing practice and expand nurses' roles (Gray, 2016; NMC, 2014; 2016; 2018a; Griffiths and Carey,

2020; Ryder, Kitson, O'Brien, and Timmins, 2022). Nurses' roles and education have changed significantly to accommodate this (NMC, 2018a; 2018b; 2018c; 2018d; Watson, 2021). The resurfacing debate is on what nurses should be doing and how much of it as nursing is entangled with what other health professions do (Griffiths and Carey, 2020). There is an emphasis on nurses doing more in clinical practice, including adopting extended roles; however, there is no discussion of agency in what is emphasised (Kailainathan, Humble and Dawson, 2018; Mudgal, 2018; Michalowsky, Henning and Rädke, 2021). Indeed, nurses are doing more than they used to (Glaze, 2019; Griffiths, 2020). It is easier to suggest that nurses should be doing more in their role, but what is missed or not realised is the agency they should have in what they do.

I have worked as a nurse and senior lecturer for many years; within this time, I have witnessed major changes in nursing, such as the incorporation of extended roles or what used to be considered doctors' roles into the nursing role. It may be because nursing is based on the medical model, which suggests that the detection and identification of disease occur through a systematic process of observation, description, and differentiation, according to accepted clinical procedures, such as medical examinations, tests, or a set of symptom descriptions (Fawcett, 2017; Biesta and van Braak, 2020; Frechette and Carnevale, 2020). Historically and traditionally, nursing is based on monitoring patients and performing basic care (Fowler, 2017; Foth, Lange and Smith, 2018). Nursing has progressed to prescribing medicines, interpreting electrocardiograms, doing venepuncture, initiating medical investigations, and performing other relevant care aspects

(Johnson and Crilly, 2019; Gottlieb, 2022). The changes do not signify agency in what nurses do. Agency relates to other concepts such as the nursing role, autonomy, knowledge and professionalism due to their shared characteristics; the distinction between them is action; taking action is exercising agency (Gottlieb, Goottlieb and Bitzas, 2021).

The literature found on nurses' concept of agency in clinical nursing care within hospital settings is limited. It states that nurses are not empowered to be themselves in nursing care (Dubrosky, 2013; Friend and Sieloff, 2018; Young and Kwon, 2020). It is unclear what this means. The literature indicates that nurses are subordinated, subjugated, dominated, exploited, and oppressed (Mamayson, 2018). There is little discussion on how this occurs, hence the interest in understanding if nurses have the power to act. The expected outcomes were to understand the nurses' concept of agency, empower them with new knowledge, and contribute original knowledge on the subject area. In order to achieve this, I had to think deeply; I and me were always too deep in conversation.

A theoretical framework emerged as this investigation progressed. A theoretical framework is a structure or established ideas supporting a study theory (Garvey and Jones, 2021). It describes the theory that explains why the research problem under study exists (Miles, Huberman and Saldaña, 2020; Varpio, Paradis, Uijtdehaage and Young, 2020). There was a risk that using a theoretical framework here could stifle inductive reasoning or result in findings incongruent with the data (Kivunja, 2018, CohenMiller and Pate, 2019). I had to be reflexive,

revisit the theoretical framework and maintain a hermeneutic phenomenological fundamental of *dwelling* with the data (van Manen, 1990). The theoretical framework used in this investigation is that of structuration, meaning that where nurses work is highly structured and hierarchical. Nurses then find themselves situated in a lesser or invidious position. There is an overlap between them and other health professions. Rigidity or hard boundaries occur between health professions; nurses are subsequently denied agency and professionalism. Structure dictates agency, and as long as there is a power structure, there will always be a question of freedom.

It has taken time for nursing to be recognised as a profession, and nursing has struggled with its own identity and voice during this time (Burns, 2019). Professionalism would mean being characterised by autonomous evidence-based decision making by members of some occupation who share the same values and education and demonstrate and embrace accountability for their actions (NMC, 2016). On the other hand, the literature claims that nurses are now given powers or the ability to act in nursing care, but it is unclear if this enables them to decide freely what nursing care should be delivered. In this study, I expected to find autonomous nurses providing nursing care that they felt suited their patients, making independent decisions about the care, fully utilising clinical nursing skills they were competent in, and being responsible and accountable for their actions. I also expected to find some constraints or oppression in nursing care, but I was unsure what they would be. My experience as a nurse is that agency in nursing has always been limited; therefore, it is important to explore the developments in

nursing care. It could be that nurses have the power to act, and it might be that nurses do not have the power to do so. The literature does not portray a clear picture of what is going on. The water is muddied to make it seem deep (Nietzsche, 2014). This study aims to clear the muddy water to see what lies beneath rather than believe that the muddy water is deep without exploring it in its clear state.

It was anticipated that the nurses' experiences through storytelling in delivering nursing care would reveal agency insights into lived experiences within hospital settings and how this links to clinical practice (van Manen, 1997; 2007; 2016). The intention was to provide a sense of meaning to the experiences (Nietzsche, 1997; van Manen, 1997).

1.5 Overview of the thesis

This thesis has been structured in a traditional format which follows the research process and provides the theoretical justification of my journey. It is designed to attract various audiences and those with differing interests. The chapters have been summed up individually to indicate what has been covered.

Chapter two details the underpinning critical literature review that guided this study and paved the way to discuss the information contributing to nursing care knowledge. The information that has been presented is related to agency or clarifies some aspects needed for the study to be coherent. The literature review highlights the gaps in knowledge that the study has contributed to. It is here where the aims and objectives of the investigation are outlined.

Chapter three discusses the methodology and methods undertaken in this study in alignment with the study's aim and objectives. The considerations given in this chapter are philosophical concerns alongside the discussion, description, and debate of my epistemological and ontological fundamentals. It is also made clear how these connect with my positionality in the context of this enquiry. The chapter focuses on hermeneutic phenomenology and its background and why it is relevant to this study. Hermeneutic phenomenology is thoroughly examined, appraised, and linked to various philosophers and how they view it. There is also a discussion on the challenges encountered due to the methodology and methods used. Ethical considerations and other processes that were involved are discussed.

Chapter four explores the participants' experiential stories from clinical practice within hospital settings. There is information on how the stories were told, including how the nurses expressed themselves while telling the stories. This was considered as the study is a hermeneutic phenomenological design; therefore, if the information only addressed the experiential aspect of the story, it would not have been possible to fully capture the hermeneutic or interpretative element of the chosen methodology. It is suggestive that storytelling has strength in putting ideas to the world (McKee, 1999; Ober, 2017). Seemingly, individuals are their stories; they compress years of thought, emotion, and experience into a few compact narratives they convey to others (Pink, 2009; Palacios et al., 2015).

Chapter five detangles the findings and makes sense of the connection of the stories with the literature reviewed and the nurses' concept of agency. In this

chapter, a link back to the introduction and the critical literature review has been made for the connectivity of the inquiry. This is where the narrative from the stories is drawn together to make sense of the investigation.

Chapter six concludes the study and discusses the implications to practice and how these could inform and influence practice, the original contribution to knowledge that has emerged because of this investigation on nurses' concept of agency in nursing care, recommendations for further research, the strengths, and limitations of the study. This chapter marks the end of the beginning; what I call the beginning is the end, and to make an end is to make a beginning; the end is where I started from (Eliot, 1963; Green, Solomon and Spence, 2021). It feels like I have suddenly walked into a beautiful day; beautiful days do not just come to an individual; one must walk towards them (Rumi, 2018). I see this investigation as something beautiful. It is said that everything beautiful is made for the eye of the one who sees, and the human being has a remarkable potential for vision (Rumi, 2018).

1.6 Summary

In this chapter, I have justified the purpose of the study. The description and explanation of nursing care, the nursing role, clinical nursing skills and standards of proficiency, and the terms of concept and agency are discussed. The overview of chapters is encapsulated in summary. The critical literature review chapter follows from here. It discusses clinical nursing practice and provides a clear picture of agency and related aspects for continuing this doctoral journey.

This critical literature review aimed to show an in-depth grasp of the subject and to understand where my research fits into and adds to the body of knowledge (Boote and Beile, 2005; Boell and Cecez-Kecmanovic, 2014; Turner, 2018; Strnad, 2019) on nurses' concept of agency or the power to act in nursing care, indicating whether nurses have freedom or constraints within their scope of nursing practice. A review can identify future research, highlight gaps or discrepancies in the literature, expose unresolved issues and provide new perspectives (Imel, 2011, Nakano and Muniz, 2018; Williamson and Whittaker, 2019; Hiebl, 2021). Torraco (2016) explains that literature reviews are conducted for different purposes and take different forms for various audiences. Furthermore, a literature review provides the foundation for the study as part of a larger enquiry (Xiao and Watson, 2019; Greetham, 2021; Machi and McEvoy, 2022). In presenting the foundation for a larger study, a literature review sets the context of the study, setting boundaries on what is and what is not within the scope of the investigation with those decisions justified (Okoli, 2015; Snyder, 2019; Oerther, 2021; Turk, 2021).

Different types of literature reviews, such as the state-of-the-art, could have been used in this study (Cant and Cooper, 2017; Hart, 2018; Hendriks, Andreae, Agren et al., 2020). The state-of-the-art literature review predominantly addresses more current matters on a practice issue and may offer new perspectives or point out directions for further research (Grant and Booth, 2009; Snyder, 2019; Hendriks, Andreae, Agren et al., 2020). This review was not chosen as it is restricted to current matters and may have distorted the overall picture of developments in

nurses' concept of agency. Therefore, if some aspects of agency had been researched in the past but not currently, this would have fallen outside the time horizon of the review, making it imprecise (Richter, 2018). The critical literature review was chosen instead as it allows an in-depth discussion of the foundation literature considered for the investigation (Turner, 2018; Coughlan and Cronin, 2020; Wright and Michailova, 2022). In other words, it enables a deeper involvement in an academic debate. It requires what I see as a refusal to accept the conclusions of other authors without evaluating the arguments and evidence they provide (Jackson, McDowall, Mackenzie-Davey and Whiting, 2016; Efron and Ravid, 2019; Bettany-Saltikov, 2016; Strnad, 2019; Han, Yin, Wu et al., 2022). Interestingly, a critical literature review demonstrates that the reviewer has extensively researched the literature and critically evaluated its quality (Antony, Viles, Torres et al., 2020; Wright and Michailova, 2022). The literature on nurses' concept of agency in clinical nursing care within hospital settings is limited; however, some evidence emphasises the importance of empowering nurses and giving them freedom in clinical practice (Dubrosky, 2013; Munro and Hope, 2020). In this thesis, the term *clinical* means being directly involved in bedside observations and treatment of patients (Potter and Perry, 2014).

2.1 Background to the review topic

The topic of interest is adult nurses' concept of agency or the power to act (take action) with freedom in clinical nursing care. It might be that I am trying hard to relate the concept of agency and care. In Nietzsche's (2002; 2014) perspective, if one concentrates on something, it becomes what one wants it to be. This goes

well with hermeneutic phenomenology, which is concerned with the interpretation and tries to get beneath the subjective experience and find the genuine objective nature of things as realised by an individual (Kafle, 2011; Heinonen, 2015; Ramsook, 2018).

As a registered adult nurse and nurse lecturer, I have considered nursing care to have more constraints than freedom (Hemingway, 2013; Hoyle and Grant, 2015). Freedom means being free within a drawn boundary acceptable to an individual (Fanon, 1963). Freedom to a nurse would mean having power, authority and agency, upholding the professional duty of care and being autonomous in providing appropriate nursing care and making decisions free of interference or being vetoed by the institution or other professions in the institution's hierarchical structure (Coulter and Collins, 2011; Cassidy and McIntosh, 2014; Risjord, 2014). Freedom has its limitations. According to Baggani (2016), Sartre once wrote that the French were never freer than during the German occupation. Sartre believed that to be truly free as a human being requires more than the absence of constraints (Jones, 2015; Vassilicos, 2020). In freedom, individuals must use their capacity to make choices and accept responsibility for their decisions (Bell, 2013). It is sometimes difficult to say what it is to be free as there are many different conceptions of freedom (Yıkmış, 2020). In Kant's (1991) view, most people see freedom as safeguarding one's possibilities and capabilities in whatever commitment one may make and as the ability to choose and do as one pleases. Kleingeld (2015) believes that humans cannot only do what they want, but they can ponder their wants and question their preferences. Baggani (2016) urges that

the conception of freedom from which Hegel begins is what is called the classical liberal conception of freedom; I am free, on this account, when I can do as I please and others do not force me to do what I do not want to do. Others could well acknowledge that some restrictions need to be placed on freedom of choice for society or institutions to function properly (Armitage, 1995; Arneil, 1996; Coser, 2020). Nonetheless, the core liberal position is that society that maximises freedom maximises individual choice and that any limits or restrictions which might be placed on one's freedom to choose, however necessary, may always be experienced as restrictions (Magill, 1997; Kivelä, 2018; Thyssen and Wenmackers, 2021). The very meaning of freedom itself requires individuals to recognise that freedom is not simply found in unrestricted individual choice or in the unregulated pursuit of self-satisfaction, but in living by the law within a just political constitution (Northway, 1996; Montesquieu, 1989; Passini, 2017).

There are two types of freedom, and these are positive freedom and negative freedom (Bowring, 2015). Positive freedom entails people having a choice about their actions (Maccallum, 1967; Berlin, 2013). According to Berlin (2013), usually, what individuals choose to do is what they want to do, but this is not always the case as internalised attitudes to social duties may determine choices. It is about the right thing to do, linked with freedom of conscience (Tutor, 2018). Negative freedom is described as the absence of legal restrictions on one's freedom to act (Lazzeri, 2018; Frumer, 2020). The restrictions on freedom must not result from some natural incapacity or inability to achieve a goal (Hansen, 2015). In negative freedom, people are free to do whatever they desire so long as there is no law or

widely accepted standard of public behaviour forbidding them, but laws and customs must exist to provide some framework within which liberty might be enjoyed by all and not just by a few (Gray, 1984; Angelov, 2018; Francis, 2021).

In nursing, freedom must be by the code of professional conduct and the law (NMC, 2018e; 2020). Rousseau (2018) sees true freedom as obedience to the laws individuals have worked out for themselves. Freedom here refers to the ability to act or make change without constraint, meaning that a nurse would have freedom within their scope of practice to do things that would not be prevented by other forces in theory or practice (Harrison and Boyd, 2018). It is said that something is free if it can change easily and is not constrained (Friedman, 1973; Simhony, 2016; Westmoreland, 2020). Freedom means whatever the speaker wants it to be and can be used to conceal potential disputes regarding an issue of concern (Gloukhov, 2015; Coser, 2020). It seems that anyone can see freedom in anything regardless of their situation, even a prisoner who is allowed a day release might see that as freedom while someone might not see any freedom in it. Freedom requires self-discipline (Berlin, 2013). Plato saw freedom bound up with self-discipline and morality (Jowett, 2021). He doubted that the law could establish meaningful moral conditions in society without first having a moral impetus from within people themselves and had no objection to the principle of morality being enforced by the law (Cooper and Hutchinson, 1997; Nikiforova, 2020). Plato believed that without reason and self-discipline, individuals could not attain freedom; however, he doubted whether most people possessed these requisite qualities (Giouli, 2019; Jowett, 2020). Immanuel Kant links freedom with

making voluntary choices to do good (Kant, 2015; 2018; 2019; Ball, Dagger and O'Neill, 2021; Moggach, 2021). Nurses are always meant to work to do good; they have to work in the patients' best interest without harming them (NMC, 2018e).

2.2 Aims and objectives

This critical literature review aimed to identify and appraise research or literature on nurses' concept of agency or the power to act in clinical nursing care within hospital settings. The objectives were to explore and critically examine:

- The body of knowledge on nurses' concept of agency and other aspects related to it.
- How nurses deliver nursing care in clinical practice.
- How free or constrained nurses are within their scope of practice.

2.3 Search process, engines, and outcomes

A search strategy was done to complete this critical literature review. The search intended to highlight the available literature within the concept of agency, engage with it meaningfully, bringing my existing knowledge into play to co-create a new understanding from it (Dibley, Dickersson, Duffy and Vandermause, 2020). It is essential to note that the literature search is an important part of the research process, summarising current knowledge, informing future research, identifying what areas have already been investigated, highlighting new ways of investigating the problem and providing a theoretical basis of the research questions (Finlay, 2007; Aveyard, 2019; Rethlefsen, Kirtley, Waffenschmidt et al., 2021). Whilst it is

a time-consuming process, a properly constructed literature search ultimately saves energy and time, aids the researcher in avoiding design errors, identifies validated instruments that could be used and highlights data analysis methods (Finfgeld-Connett and Johnson, 2013; Bryman, 2016). It is emphasised that literature reviews must be selective and critical, and researchers must ensure this; simply producing a list of works with no evidence that they have been evaluated or are relevant to the study is a waste of the researcher's and reviewer's time (Atkinson and Cipriani, 2018; Aveyard, Preston and Payne, 2021).

The articles were found on databases, search engines and from various sources during the searches. The search began from the library catalogue or Summon, Medical Literature Analysis and Retrieval System Online (MEDLINE) and Cumulative Index to Nursing and Allied Health (CINAHL) using the terms and key phrases as follows; *nurses' concept of agency OR nurses' power to act in nursing care AND freedom of choice in actions in clinical practice within hospital settings; autonomy in nursing AND agency in nursing care; nursing roles and skills AND responsibilities in nursing care; decision-making in nursing care AND doctor-nurse game; structures in nursing OR hierarchy in nursing AND power and authority in nursing care; colonialism OR oppression AND devolution of power in nursing; influences in clinical nursing care AND nursing roles AND freedom and constraints of nurses in nursing care; nursing knowledge AND types of knowledge in nursing AND ways of knowing in nursing;* (see appendix 2 for keywords and phrases). All keywords and key phrases were also entered or used independently on the databases, search engines, and during hand searches. In addition, I searched for

relevant literature from books, journals, and the University library. I accessed other online sources, including Mendeley, ResearchGate, Academia.edu and Google Scholar, using the same keywords and phrases. The search yielded several core studies which were used in this review (see appendix 3 for the search outcomes). Some articles were cited in the found literature; subsequently, I looked for the primary sources instead of relying on what the authors had said as a third party, while some were stumbled upon by chance from other sources. The search uncovered the literature which formed the main themes (see appendix 4 for the themes and appendix 5 for their summary). In order to find the most relevant studies for this literature review, the search was narrowed down to make the results of the search manageable (Scells, Zuccon, Koopman and Clark, 2020). The Boolean operator was used to expand and limit the search. I added filters by using AND/OR, *open access* AND/OR *the time frame* of the publication to obtain the relevant research articles (Eriksen and Frandsen, 2018; Elston, 2020). Filters and time frames were removed at times to see whether these would help produce relevant research articles or written material. In hermeneutic phenomenology, it is recommended that the review should not be limited to any time or current literature; still, it is about how it challenges, changes the thinking, and informs the study (Dibley et al., 2020). The removal of filters and time frames produced any relevant literature related to the concept of agency in nursing care within hospital settings. While searching, some of the keywords and phrases led me to other aspects related to agency: knowledge, the doctor-nurse game, structures in nursing, oppression, colonialism and devolution of power. There were four stages

in the literature search process, and these were the identification of the relevant literature, screening, eligibility and inclusion. The literature search produced 5619 records which were narrowed down to 44 as per the diagram below.

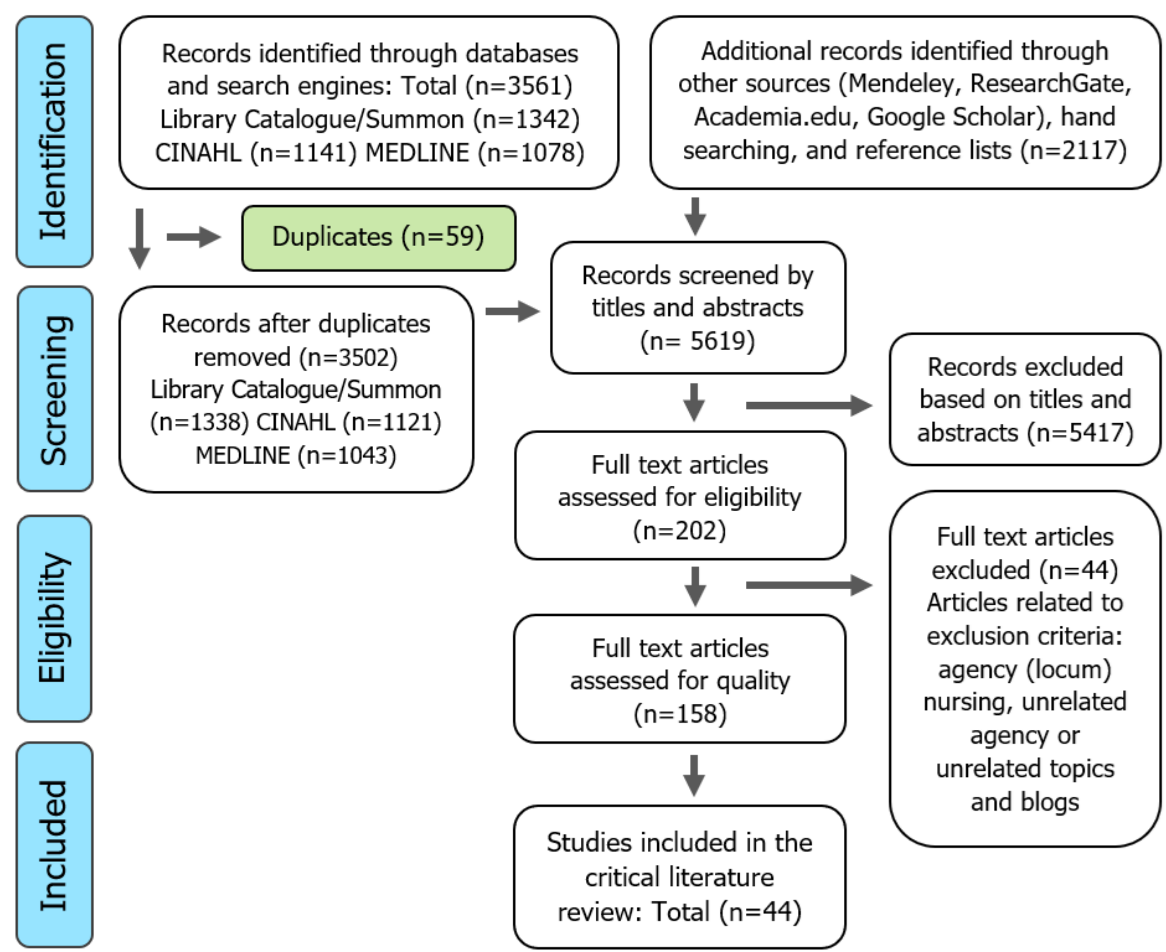

Figure 3: The screening process PRISMA (Moher et al., 2009)

2.4 Inclusion/exclusion criteria

The inclusion criteria were that all studies should be related to the concept of agency. All materials were included for this literature review except blogs, as some were opinions rather than scholarly material (Aveyard, 2019). The search was not limited to any country or date of publication; therefore, it included all relevant

studies from all over the world (see appendix 6 for the inclusion and exclusion criteria). The studies that were used related well to the research topic or had some important points that clarified what was being discussed in this study.

2.5 Overview of studies that form the outcomes

This literature overview identified relevant studies that address the research questions of the concept of agency in the now (van Manen, 2016). The main core studies identified for the critical review are presented in the appendix (see appendix 7 for the overview). The studies that have been considered are written in a scholarly manner and, to some extent, address the topic. The studies discussed the nursing background and how nursing is influenced (Sweet and Hawkins, 2015). Some studies touch on agency, but it is not referred to as agency in their context. The studies chosen for the literature overview came from various authors with varied backgrounds. I did not concentrate on nursing literature only; I also looked at other material with relevant information to better understand this topic (Okoli, 2021). It is important to say that the studies considered captured the topic from various perspectives. They provided a balanced view of perceptions and traits of the concept of agency.

2.6 Critical appraisal process and outcomes

This critical appraisal process reviews the studies identified for this investigation. It is important to ascertain the strengths and weaknesses of the literature chosen in a study (Atilano, 2018; Noble and Smith, 2018; Turk, 2021). Aveyard, Sharp and Woolliams' (2015) generic appraisal tool (see appendix 8) was chosen to

appraise the studies, including original research, literature reviews, and various types of articles. This tool allows most articles to be appraised, including research articles and any other articles. However, the tool needs an understanding of the methods of the chosen paper beforehand. The tool encourages the researcher to use a systematic approach in the appraisal and read in-depth about research or writing methods of any written material before the appraisal begins. Its weakness is that not all questions asked in the tool are always relevant to appraise some articles. On a positive note, this allows the researcher to incorporate their knowledge and skills in the appraisal. What seems to be beneficial about this tool is that it enhances the researcher's understanding of each paper and allows the researcher to consider the paper's relevance to their review, its strengths and weaknesses (Aveyard, 2019). Nonetheless, many more appraisal tools, including the Critical Appraisal Skills Programme (CASP) (2022), could have been used. Aveyard et al.'s (2015) tool appeared more appropriate in this case, as Aveyard (2019) states that it is appropriate for any evidence.

The literature reviewed suggests that nurses are now given more power and freedom in nursing care (Burns, 2019), but it is unclear what that power is. Power is described as the possession of authority, control, or influence by which a person or an organisation influences the actions of others, either by direct authority or by some other more intangible means (French and Raven, 1959; Petress, 2020). There are various types of power such as coercive, legitimate, referent, information and expert (French and Raven, 1959). It is worth providing some definitions of power which could relate to nursing practice. Coercive power is

about using fear to get things done with punishment being used if there is no compliance (Russell, 1969; Lukes, 2019). Legitimate power results from someone being elected, selected or appointed to a position of authority (Brinkmann, 2020). Authority is concerned with the right to give orders and the ability to exact obedience (Haugaard, 2018). This is to say that authority enables an individual to give orders and ensure that those orders are obeyed (Foucault, 1980; Petress, 2020). Referent power comes from a respected person the group accepts, identifies with, and are willing to follow (Raven, 1993; Cenkci, 2018). Information power occurs when an individual possesses knowledge that others need or want; usually, it is the information that others cannot get access to, while expert power is based on what one knows, the experience they have and the special skills or talents that they have (Hobbes, 2017).

Most of the literature discusses the current issues of how nurses practise in the present time. The literature also indicates that oppression occurs in nursing but sometimes does not go as far as how it exists (Dubrosky, 2013; Mendizábal, 2018; Leary, 2020). Some conclusions are based on theories or opinions, as they do not go into in-depth studies to determine this. Young (2011) discusses the five faces of oppression. Dubrosky (2013) applies the theories to nursing and discusses how these theories could be considered in nursing. The other articles discuss nursing care, influences in nursing practice, decision-making, autonomy, power, and authority in nursing care (McGibbon, Mulaudzi, Didham et al., 2014; Krishnan, 2018; Groenwald and Eldridge, 2020). The studies reviewed also highlight how nurses work or are dominated in healthcare.

2.7 Synthesis of research findings and critical discussion

The studies reviewed suggest that nurses could nurse patients the way they want to, while on the other hand, there are suggestions that nurses are oppressed. Significant changes have occurred in nursing over the years (Burns, 2019), yet nurses are seen as a colonised group or as displaying behaviours of the colonised (Farrell, 2001; Mendizábal, 2018; Waite and Nardi, 2017). Decision-making, the doctor-nurse game, agency, oppression and the devolution of power in nursing care are discussed as part of this review. The theme of influences in clinical nursing practice was considered the starting point in this synthesis of research findings and critical discussion.

2.7.1 Influences in clinical nursing practice

The literature points out that nursing has always been influenced by the medical model (Smith and Parker, 2015; Hajar, 2015). History tells us that the status and development of nurses' knowledge have been largely influenced by the dominance of medical power (Manias and Street, 2001; Feyereisen, McConnell, Thomas and Puro, 2021). This dominance has supported the view that medicine operates from a foundation of superior legitimated knowledge than the knowledge that forms the basis of nursing and other health professions (Kenny and Adamson, 1992; Prescott, 2017; Belrhiti, van Belle and Criel, 2021; Tybjerg, 2022). Knowledge is perceived as knowing that something is the case or how something is done (Boshoff, 2014). It is important to have the knowledge and utilise it or at least be on a pathway to utilising it; otherwise, it would not be worth having it

(Hashemiparast, Negarandeh and Theofanidis, 2019). There are several types of knowledge related to nursing: intuitive, legitimate, embodied, expert, authoritative, grounded knowledge, self-knowledge, and informed knowledge (Davis-Floyd and Davis, 1996; Kinchin, Möllits and Reiska, 2019; Béneker and van der Vaart, 2020). Authoritative knowledge is regarded as merely scientific knowledge and extends to empirical knowledge, which has been developed to the extent that all other knowledge patterns have been excluded from legitimacy (Chinn and Kramer, 2018). Nursing values scientific knowledge as legitimate knowledge and believes that more than one knower can be authoritative and arises from the fact that it matters to a profession (Draper, 2014; Masters, 2016). Intuitive knowledge is defined as inner knowing, common sense or gut feeling that is developed through holistic views involving spiritual, physical and psychic manifestations (Boshoff, 2014), and is considered inferior by the dominant medical paradigm for not being scientific (Chinn and Kramer, 2018). Intuition triggers a sense of alarm due to an uneasy feeling that something is wrong and enables the nurse to act or intervene in patient care to avoid an adverse situation without finding any indications objectively supporting that feeling (Chudnoff, 2013; Boshoff, 2014). It can also provide a sense of reassurance in what is not supported by legitimate scientific reasoning or the patient's diagnosis; this is risky as important facts can easily be overlooked (Drummond, 2015; Kump, 2022). Embodied knowledge is informal knowledge learned from personal experiences and observations of colleagues and is difficult to demonstrate as it emanates from an individual and includes the artistry of nursing learned through self-reflection

(Tanaka 2013; Koya, Anderson and Sice, 2017). Expert knowledge is extensive knowledge or ability based on research, experience and competence in nursing and is seen as a reliable source of technique and skill (Benner, 1984; 2001; Rodgers, 2012; O'Hagan, 2019; den Hertog and Niessen, 2021). Self-knowledge is an understanding of oneself and having an opinion on what one can do and then acting on those beliefs; grounded knowledge is the knowledge the nurse gains from the lived experiences of nursing patients, while informed knowledge is the knowledge that the nurse has learnt from a respected source such as books or lecturer (Potter et al., 2017; Decker and Hamilton, 2018; Schwengerer, 2019).

Nurses in critical care environments such as the Emergency Department (ED) and Intensive Care Unit (ICU) have attempted to legitimise their knowledge by undertaking medical skills normally denied to general ward nurses (Manias and Street, 2001; Bryson, 2016; Adam, Osbourne and Welch, 2017; Woodrow, 2019; Sweet and Foley, 2020). The skills include venepuncture, cannulation, prescribing, and other related skills (Datton and Finch, 2018). This has not stopped nursing from being dominated by medicine (Balanon-Bocato, 2018). Hence, nursing has always been the eyes and ears of doctors and is an activity that enables male medical practitioners to gain power (Fletcher, 2006; Waite and Nardi, 2017). It is unclear how medical domination occurs in clinical practice or how it is associated with nursing care. However, what is discussed is that doctors are the ones who make decisions about patient care, but it is unclear what those decisions are (Smith and Parker, 2015). It is said that medical institutions and hospital

administrators exploit nursing by limiting nursing's scope of practice to serve the interests of the medical dominated industry (Rodwell and Demir, 2012).

Nursing has been predominantly viewed as a largely female occupation that is prey to sex-role stereotyping by dominant males; hence nursing has struggled to be identified as a profession (Farrell, 2001; Goodman, 2015; Mamayson, 2018). Farrell (2001) explains that the mother earth role depicts women as nurturing and caring, whereas the seductress role defines women as sex objects whose role is to titillate men at work. It is said that a lot has been achieved in this, but there are many instances where women are still marginalised or treated unfairly in comparison to men (Kohout and Singh, 2018; Attenborough, Reynolds and Nolan, 2019). This could be why nursing has been regarded as less in status to medicine, which has long been dominated by men (Sweet and Hawkins, 2015; Lee and Kim, 2020). This, however, does not explain how oppression or domination would exist in nursing care. Many men have joined the profession as years have gone by, and the numbers are increasing (Mott and Lee, 2018; Smith, Lane, Brackney and Horne, 2020; Smith, Rojo, Everett et al., 2021). This means that the way nursing is viewed should have changed by now if that was the major contributing factor. However, men who join nursing tend to end up in managerial roles (White, 2021). This brings the question of whether they further contribute to oppressive mannerisms; however, no research has been done to investigate this. On the other hand, nursing is a confusing term, as it is sometimes difficult to explain (Barrett, 2017). This could explain why nurses find it difficult to work with freedom

as nursing is unclearly understood. It could also make it easier for it to be oppressed (Lane, 2020; Balanon-Bocato, 2018).

The government, stakeholders, society, and regulatory bodies have continually influenced nursing (Hoyle and Grant, 2015). Despite these influences and changes, doctors are still likely to restrict nurses or allow them to do what they recommend. The insight into the influences of the medical profession lies in the fact that doctors are the ones who plan the care after diagnosis. It is said that some doctors are not comfortable with nurses doing more than what they do now (Goodin, 1987; Burns, 2019; Phillips, 2019). This could be an indication that nursing is not free to achieve its goals in patient care. What is not understood is how freedom or constraints exhibit themselves. It is indicative that the medical profession is the main player in influencing what nurses can do in clinical nursing care. This could easily be debated as nurses work alongside doctors and, as such, stand a chance of making decisions and influencing medicine (Webster, Ekers and Chew-Graham, 2016). There must be something that stops nurses from delivering nursing care in a way that they have been trained to do. It is unclear how the medical profession influences nursing decision-making. Do the decisions then lead to nurses being unable to deliver nursing care they feel is appropriate for patients?

2.7.2 Decision-making in nursing care

Decision-making is important in nursing if nurses are to deliver nursing care considered appropriate for patients (Dunger, Schnell and Bausewein, 2017; Abdelhadi, Drach-Zahavy and Srulovici, 2020). It is a process by which a person

or group identifies a choice or judgement to be made, gathers and evaluates information about alternatives and selects from among alternatives (Standing, 2020; Holland and Roberts, 2022). Various factors determine how decisions are made (Buka, 2020). The nurse's decision-making is based on their knowledge, education, experience, autonomy, power, authority, agency, understanding of patient status and situation awareness (Nibbelink and Brewer, 2017; Sholehah, Astari and Kapti, 2020). Gottlieb, Gottlieb and Bitzas (2021) posit that clinical decision-making results from clinical reasoning, having a clinical grasp of the situation, arriving at a clinical judgment of what is needed and then deciding what actions to take. Taking action is exercising agency (Schlosser, 2019). There is a need to produce a final choice in decision-making, which may or may not prompt action (Koubel, 2013). Decision-making in nursing is concerned with having preferences and choices that can best produce the best outcomes in the treatment and recovery of patients (Krishnan, 2018). Task complexity is a significant determinant in decision-making (Bucknall, 2003; Collen, 2017). Several studies have examined decision-making in the dynamic and complex clinical environments including critical care settings (Cohn, 2021; Cucchiara and Price, 2022). The environment has a major role in decision-making, as van Manen (1990; 1997; 2016) suggests that in hermeneutic phenomenology, the researcher needs to understand what the environment was like to understand the participants' experiences. Clinical environments are dynamic, complex, and inherently stressful (Kenny and Kaye, 2019; Nibbelink and Reed, 2019). The environment plays a significant role in agency, thus, if nurses are to deliver considered nursing care

(Cohn, 2021). Nurses must deal with increasing patient complexity, sophisticated technology (Wood, 2020; Rubeis, 2021), and often declining resources; as these are part of the nurse's environment, they impact decision-making (Bucknall, 1997; 2003; Davis, Morgans, Birks and Browning, 2016). Decision-making is not only based on the environment but also on rationalist approaches such as information processing and decision analysis (Nibbelink and Brewer, 2017). Clinical decisions are not cognitive events that occur in isolation but fit within a clinical paradigm with political, economic, ethical, legal, and social structures (Dowie and Elstein, 1997; Nibbelink and Reed, 2019).

Nursing decision-making has its challenges and difficulties in clinical practice. Improper decision-making endangers patients' lives; therefore, nurses need to think critically before making decisions (Stanley, 2016; Hosseini, Maleki, Gorgi et al., 2018). Bagnasco, Dasso, Rossi et al. (2020) and Abdelhadi, Drach-Zahavy and Srulovici (2020) warn that some nursing decision-making processes have contributed to missed or delayed nursing care. The difficulties nurses frequently encounter in decision-making are due to knowledge base, lack of time to make or implement decisions and personal value conflicts with other staff (Bucknall, 1997; Forman, 2020; Eekholm, Samuelson, Ahlström and Lindhardt, 2021). The challenge is that nurses can collaboratively discuss options for treatment that they cannot legally and independently perform, meaning that doctors end up making ultimate decisions (Bucknall, 2003; Nibbelink and Brewer, 2017). It seems decision-making has always been an issue somehow in nursing care.

Decision-making is a shared process in clinical environments; nurses have to consider the doctors and patients involved (Friesen-Storms, Bours, van der Weijden and Beurskens, 2015; Molina-Mula and Gallo-Estrada, 2020; Kuosmanen, Hupli, Ahtiluoto and Haavisto, 2021). In decision-making, nurses consistently describe disharmony with junior medical staff while not having similar issues with other health team members (Bucknall, 2003; Gonçalves et al., 2020). Nurses get distressed by junior doctors' lack of critical care knowledge, although less so if they are receptive to the nurses' advice and suggestions (Borrott, Kinney, Newall et al., 2017). Nonetheless, some doctors may lack critical care knowledge but still prefer to make final decisions (Trimble and Hamilton, 2016; Flannery, Peters and Ramjan, 2020). Nurses appreciate working with medical consultants who they respect their knowledge and attitudes and consider receptive to nurses' suggestions whilst controlling the working environment (Manias and Street, 2001; Chua, Legido-Quigley, Jones et al., 2020).

2.7.3 The doctor-nurse game

In the doctor-nurse interaction, Stein (1967) coined the doctor-nurse game. In the game, nurses were to be bold, have initiative and be responsible for making important recommendations, while at the same time, they had to look passive (Stein, 1967; Darbyshire and Thompson, 2018). In other words, they were to make recommendations, but these had to appear initiated by the physician. The physician traditionally and appropriately had total responsibility for making patient treatment decisions (Stein, 1967; Bârsu, 2017). The doctor-nurse game was later revisited by Stein, Watts and Howell (1990), who found that the game had

changed. The nurse had unilaterally decided to stop playing the game and instead was consciously and actively attempting to change both nursing and how nurses related to other health professionals. In the revisit, nurses were free to confront and even challenge physicians on patient care issues under the nurses' domain and make decisions about patients without consulting the physician. In 1990, nurses wanted nursing to be an autonomous profession with a well-defined area of expertise and work cooperatively as equal partners with other health professionals. Nurses' higher educational qualifications obtained from universities and other social changes were credited as drivers for change (Stein et al., 1990). Nursing has progressed to take on duties previously performed by doctors, such as taking blood, prescribing and consulting with patients; despite this, there are views that the game still exists (Holyoake, 2011; Tan, Zhou and Kelly, 2017). The two articles are empirical evidence verifying the truth, which corresponds with reality in clinical practice (Garrett, 2018). They could have been better being original research rather than theoretical to ascertain the reality of the game.

In 1967, it was implied that physicians were mostly men and nurses exclusively women. These game elements reinforced the stereotyped roles of male dominance and female passivity. In the revisit, the physicians were increasingly likely to be female. Health organisations in which doctors and nurses worked were very hierarchical and rigidly structured (Stein, 1967). Hierarchical leadership is a delineated chain of command from the lowest to the highest levels within an organisation (Fernandopulle, 2021). Structure refers to the recurrent patterned arrangements that influence or limit the choices and opportunities available

(Barker and Jane, 2016; Fox and Alldred, 2018). There is a consensus that nursing's origins were structured within an established hierarchy, and nurses continue to be oppressed by those practising medicine who are predominantly men who are placed at the top of the hierarchy (Rooddehghan, Yekta and Nasrabadi, 2015; Waite and Nardi, 2017). In Rooddehghan et al.'s (2015) view, in this hierarchy, the dominant group has the power to control and silence the other group, thereby promoting a systematic, pervasive, and recurring inequitable relationship.

In seeing that there were structures in most institutions and systems, Giddens (1979) conceived the structuration theory, which he says takes the position that social action cannot be fully explained by the structure or agency theories alone; instead, it recognises that actors operate within the context of rules produced by social structures, and only by acting in a compliant manner are these structures reinforced. The hospital's hierarchical structure of authority is a deterministic one, allowing few opportunities for actors to change and recreate their social relations (Svensson, 1996; Wellman, Applegate, Harlow et al., 2020). The hierarchical structure regards nurses as essentially powerless and able to exert influence only through indirect, manipulative strategies, which only reinforce prevailing power relations (Svensson, 1996; Fernandopulle, 2021). Doctors and nurses need to have a good relationship in clinical practice if quality care has to be delivered. The relationship between the two professions is a special one; there are few professions where the degree of mutual respect and cooperation between co-workers is as intense as that between doctors and nurses (Stein, 1967).

A few authors have looked at the doctor-nurse game from various perspectives since it was highlighted or revisited. Reeves and Zwarenstein (2008) reviewed the doctor-nurse game in the age of interprofessional care. They say the collaboration of medicine and nursing has led to task deregulation and role substitution and see the need for a new and much higher level of mutual trust, respect, and a more flexible form of collaboration between the two professional groups. Carryer (2011) explains that collaboration needs teamwork. She argues that teamwork is rhetoric because everyone thinks teamwork is important, yet very few nurses feel like part of a genuine team that respects and treats them as equals. According to Carryer (2011), there is a mentality of the *doctor is the captain of the ship* in clinical practice. This could mean that the game still exists in some form, even though there is denialism.

There are suggestions that the working relationships between doctors and nurses have made little progress in improving since the hierarchical doctor-nurse game was described 55 years ago (Tan, Zhou and Kelly, 2017; Darbyshire and Thompson, 2018; Greenlees, 2018; Brown, 2019; Liebe, Naumann and Tutic, 2019; Mertens, de Gendt, Deveugele et al., 2019). All authors agree that nurses at several levels are systematically dissuaded from and, as a group, are unable or unwilling to challenge or question a doctor's prescribing practices. In some cases, doctors ignore nurses in discussing patient care (Mertens, de Gendt, Deveugele et al., 2019). The view is that doctors and nurses can and must minimise or prevent the deadly doctor-nurse game from being played for another 50 years. Darbyshire and Thompson (2018) give an example of an airline pilot whose young

wife died in hospital after a relatively minor nasal surgery, who wrote of *nurses dancing around her care needs*, knowing full well that she was in danger. However, they could not state this explicitly to her doctors. The nurses were aware that things were going wrong but seemed unable to say anything. The consensus was that it was often not their place to speak up. Professionals rightly fear retribution, disapproval, career-limiting consequences, and worse if they dare to question or challenge colleagues in any discipline (Yalçın, Baykal and Türkmen, 2022). Seemingly, there is a need for a better approach to interpersonal relationships. It is emphasised that every registered health professional, from the new student to modern matron and consultant, must understand that it is essential that their practices and decisions will be discussed, questioned, and challenged by colleagues (Darbyshire and Thompson, 2018). This is seen as what the doctor-nurse game-changer could be. It is suggested that across the health service, there is a need to move away from hierarchical leadership to flat hierarchies (Fernandopulle, 2021), as the doctor-nurse game is seen as one of power dynamics, where doctors have the power, and that this dynamic may be reversed between transient junior doctors and senior nursing staff. A flat hierarchy is an organisational model with few or, most commonly, no middle management between frontline staff and decision-making executives (Fernandopulle, 2021). Brown (2019) wonders whether flat hierarchies could be achieved by enhancing the role of senior nurses on the ward to be in charge when senior doctors are not available and make the decisions to call the doctor team in the event of a deteriorating patient without junior doctors having to do this.

2.7.4 Agency in nursing care

In nursing, agency could be challenging as doctors seem to have a monopoly in holding power in the treatment of patients (Shutzberg, 2021). It seems nurses also find doctors intimidating; this could then affect how they deliver nursing care (Lee and Song, 2021). Nurses mainly take orders rather than make independent decisions. There is an indication that nurses rarely make decisions on their own on most aspects of care, rather, they constantly seek information and advice from their medical, nursing, and other colleagues on how to act when faced with uncertainty, and the introduction of protocols and clinical guidelines has not eliminated the need for such referrals (Trapani, Scholes and Cassar, 2016). Major decisions about treatment or care are traditionally within the domain of medicine; nurses often need to refer to and get some form of authorisation from a member of the medical profession when implementing specific care or interventions (Villa, Manara and Palese, 2012).

Trapani et al. (2016) explored dual agency in critical care nursing of balancing responsibilities towards colleagues and patients and seeking a deeper understanding of the complex and often tacit factors surrounding critical care nurses' decisions to seek help from doctors in clinical practice. They found that nurses' decisions to seek help from doctors involved weighing up several occasionally conflicting motivators, such as balancing their moral obligation to safeguard patients' interests with their duty to respect doctors' authority. What stems to mind is that health institutions adopt similar methods of assigning positions, duties, and responsibilities, just like political governments and militaries

who do so within their ranks (Dontigney, 2019). It is about members of that institution knowing whom they report to, who reports to them, who gives orders, and who takes them. The orders are meant to be obeyed even if there is disapproval, and it is made clear who does and does not possess the authority to assign or change tasks (Ku and Kim, 2020). In some way, this provides a clear chain of command with clearly defined sets of responsibilities. The division, responsibilities, and authority maintain discipline and situate those involved in dual agency (Saiti and Stefou, 2021). It seems nurses end up in a position of dual agency as they need to concurrently act as an agent to medical practitioners and patients (Trapani et al., 2016).

Nursing care seems regimented; as such, much of the nurses' work is centred around rules and tasks or time imperatives (Farrell, 2001; Durosaiye, Hadjri, Liyanage and Bennett, 2018). In nursing care, there is a time for washing patients, feeding them, administering medicines; the list is endless. It appears that nurses' daily work is task orientated (Burns, 2019). Farrell (2001) says that the notion of task or time imperatives in nurses' minds is so powerful that patients are sometimes seen as tasks and not as people. He critically analysed an extended literature review to develop a conceptual framework to account for interpersonal conflict. The review discusses various ways in which nurses are oppressed as well as being in a duality of oppression of gender and medical dominance, which is further worsened by what he sees as marginalised nurse managers, but it does not discuss agency. However, it provides the answers to the causes of interpersonal conflicts in nursing practice.

A recent publication noted that some hospital nurses were being trained to carry out hernia repairs and gynaecological operations (Phillips, 2019). The publication highlights resistance from some doctors about this and that there are long-standing and ongoing tensions between nurses and medical practitioners, with nurses wishing to increase their autonomy. Autonomy implies self-governance and self-rule without unnecessary inhibitions or bureaucracy and without having to gain permission or consent (Skår, 2009; Choi and Kim, 2019). In nursing, it is the freedom to exercise control over one's nursing practice, participate in decision-making, and influence working practices (Pursio, Kankkunen, Sanner-Stiehr and Kvist, 2021). It means working independently and having the ability to evaluate and implement nursing interventions based on competence, expert professional skill, and knowledge, but this does not mean agency (Oshodi, Bruneau, Crockett et al., 2019; Setoodegan, Gholamzadeh, Rakhshan and Peiravi, 2019; Munro and Hope, 2020; Peres, Paim and Brandão, 2020; Costa, Santos and Costa, 2021). It is identical to the Scottish, Welsh and Northern Irish governments, which have regional autonomy but have no agency in some issues such as independently conducting the referendum for independence or declaring independence (Mackinnon, 2015; Colomb and Tomaney, 2016; Katikireddi, Smith, Stuckler and McKee, 2017; Bradbury, 2021; Webb and van der Horst, 2021). In other words, Westminster holds the key to that agency. Agency is the highest form of empowerment (Gottlieb, Gottlieb and Bitzas, 2021).

Nursing care varies depending on where it is done. It has been said that nurses would soon be trained to do what doctors do (Brooker, 2013; Peate and Wild,

2018; Burns, 2019). Ending oppression is not about being allowed to do what doctors do; oppression occurs within what nurses can do. The medical profession determines what nurses do and how much they should do in practice. This is macro-oppression; micro-oppression remains hidden and needs to be unmasked (Mamayson, 2018; Leary, 2020). Autonomy is being granted slowly. This is because medicine holds the legally sanctioned monopoly over central tasks such as diagnosis and therapeutic measures (Flynn and Silva, 2021). It is said that many nurses are not comfortable with this large power disparity (McCoppin and Gardner, 1994; Purpora, 2012). It seems nursing organisations are all for the changes, saying that these are good ways of improving careers for nurses as this keeps them in the health service (Burns, 2019). Burns (2019) provides empirical evidence about nursing care, which discusses the history of nursing to where nursing is in the now. Nurses are now seen as leaders of care, taking on additional responsibilities in prescribing, performing minor surgery, implementing complex care interventions, and performing other invasive treatments (Burns, 2019). This is seen as signalling the end of tribalism in the health service (Phillips, 2019). However, Burns does not discuss agency they have in performing those activities.

Agency is infrequently studied in nursing; so much that when Gottlieb, Gottlieb and Bitzas (2021) examined the literature on it in nursing practice, they could only allocate two studies that linked nursing practice to agency. Gottlieb, Gottlieb and Bitzas (2021) point out that during the Covid-19 pandemic, nurses were placed in the spotlight because their knowledge and skills were desperately needed; they were encouraged to exercise their autonomy and agency. Instances where agency

could be exercised are not specified. It is claimed that agency contributes to job satisfaction and is seen as professional advancement and empowerment (Napper and Rao, 2019; Sarngadharan and Nandu, 2020). *Job satisfaction* has been defined as the favourableness or unfavourableness in which employees view their work and has been related to nurses feeling empowered to exercise autonomy and agency (de Simone, Planta and Cicotto, 2018). Autonomy and agency can be affected by nurses' managers' leadership styles; leaders are instrumental in setting the tone and creating the climate and culture that either values or devalues autonomy and agency (Möller, de Oliveira, Pai et al., 2021; de Simone, Planta and Cicotto, 2018; Napper and Rao, 2019; Sarngadharan and Nandu, 2020). When nurse managers and leaders create conditions that support and encourage nurses to exercise control over their practice, nurses feel they have a greater degree of agency (Gottlieb, Gottlieb and Bitzas, 2021). The studies briefly mention agency, as agency is not their main focus. It would be ideal for nurses to have agency and the freedom to deliver care that benefits patients rather than be restricted. It can be argued that nurses need to be restricted in what they do to protect patients, but some restrictions are unnecessary and impact patient care. In oppression, restrictions occur on top of restrictions, leaving a group disabled in what they can do (Moore, 2016).

2.7.5 Oppression in nursing

The literature indicates that various types of oppression occur in the modern world (Butt, 2012; Dotson, 2014; Baggani, 2016; Matthes, 2019; Roche, 2019; Drydyk, 2021). Oppression of people is not always political; it manifests itself in various

discreetly ways, hence the need to investigate it in the nursing profession and close the knowledge gap (Sweet and Hawkins, 2015; Giese, 2019; Maiese, 2022). Oppression is increasingly being used to describe the disadvantage and injustice which some social groups experience, not because they are subject to tyrannical powers but rather as the result of the everyday practices of a well-intentioned liberal society (Young, 2011). In the context of this research study, oppression means having no power to act or deliver nursing care that nurses feel is appropriate for patients (Aubert, Garrau and de Latour, 2019; Giese, 2019).

Oppression in nursing is sometimes seen as colonialism. In the original sense, colonialism is the establishment, exploitation, maintenance, acquisition, and expansion of a colony in one territory by a political power from another territory (Lu, 2011; 2017; Gilley, 2017). In Moore's (2016) perspective, there is no doubt that a central feature of colonialism is the subordination of one group by another, typically accompanied by replacing key elements of the subordinate group's culture with the concepts, categories, and ways of thinking of the dominant group. Said (1978) discusses orientalism and other colonial discourses and says that, in orientalism or colonialism, peoples are deemed incapable of representing or governing themselves. There is more than one model of colonialism; it can be direct or indirect (Gregory, 2004; Fanon, 1963; Said, 1978; 1993; Loomba, 2015; Gardner, 2020; Andrews, 2021). It is pointed out that the world involves relations of oppression under new names (d'Errico, 2011; Silverman, 2015; Moore, 2016; Lerche and Shah, 2018).

Several studies discuss colonialism, the colonising processes and practices in nursing practice (McGibbon, Mulaudzi, Didham et al., 2014; Valderama-Wallace and Apesoa-Varano, 2020; Waite and Nardi, 2017; Mendizábal, 2018). It is explained that nurses work in colonised healthcare, and there are different forms of oppression present in the nursing profession (Mendizábal, 2018; Waite and Nardi, 2017). The colonising processes and practices include the colonisation of nursing's intellectual development and its embedded colonising assumptions that sustain colonising thinking and action in the nursing profession (McGibbon et al., 2014; Valderama-Wallace and Apesoa-Varano, 2020). The Eurocentric knowledge systems, the dominance of Western epistemologies in nursing, embedded beliefs and assumptions, and outdated nursing theories formulated by those who worked diligently to advance knowledge in the context of the dominance of the medical profession are all seen as part of colonialism as they do not accommodate other alien processes and practices (Bhargava, 2007; McGibbon et al., 2014; Juanamasta, Iblasi, Aungsuroch et al., 2021). This has led to an argument for decolonisation (undoing of colonialism) which is said to be a path to urgently needed growth and transformation for the entire profession (Greaves, 2014; McGibbon et al., 2014; Waite and Nardi, 2017).

There is an indication that oppression in nursing may exist in various ways, but nurses themselves might be unaware of it (Dubrosky, 2013). Young (1990) compares this to someone who does not see a pane of glass, does not know that they do not see it, and someone being placed differently does see it but does not know that the other does not see it. Oppression occurs in various ways that may

be visible or invisible (Rodwell and Demir, 2012; Dubrosky, 2013; Dubeau, 2020). This suggests macro-oppression and micro-oppression, the oppression seen as an injustice to others or as institutional conditions that restrict individuals without them being aware (Vrousalis, 2013). Frye (1983) would say this is oppression; she likens oppression to a birdcage in that if one looks only at each wire, it is difficult to see why a bird cannot escape. She suggests that if one steps back and sees all the wires, one can understand immediately why the bird is inescapably caught.

There is a need to look at the concept of agency in-depth in nursing care as no researcher has ventured into this unexplored area. It might be that nurses are conscious or unconscious of it in their daily nursing care. In the general sense, all oppressed people suffer some inhibition of their ability to develop and exercise their capacities and to express their needs, thoughts, and feelings (Smyth, 2021). Above all this, oppressed people are limited or restricted in making independent decisions (Waldron, 1988; Patten, 2014; Rooddehghan, Yekta and Nasrabadi, 2015). Oppression also refers to systematic constraints on groups that are not necessarily the result of the intentions of the tyrant (McLaren, 2020). This is to say that oppression can be structural rather than a few people's choices (Dubeau, 2020). Its causes are embedded in unquestioned norms, habits, and symbols in institutional rules' assumptions and the collective consequences of following those rules (Frye, 1983; Scholz, 2017).

Structural oppression cannot be eliminated by eliminating the rulers or making new laws because oppressions are systematically reproduced in major economic, political, and cultural institutions (Young 1990; Milton, 2016). While structural oppression involves relations among groups, these relations do not always fit the paradigm of conscious and intentional oppression of one group by another (Ypi, 2013). It is suggested by Foucault (1977) that to understand the meaning and operation of power in modern society; one must look beyond the model of power as sovereignty, a dyadic relation of ruler and subject, and instead analyse the exercise of power as the effect of often liberal and humane practices of education, nursing, medicine, and any other factors. Foucault (1977) stresses that the conscious actions of many individuals contribute to maintaining and reproducing oppression daily, but those people are usually simply doing their jobs or living their lives and do not understand themselves as agents of oppression.

Young (1990) identifies what she calls the five faces of oppression. She does not relate them to nursing; however, Dubrosky (2013) does. These faces of oppression are exploitation, marginalisation, powerlessness, cultural imperialism, and violence (Roemer, 1985; Dubrosky, 2013). Young wrote a chapter to offer some explication of oppression as she understood its use on various groups of people oppressed differently. The chapter is empirical evidence combining various theories of oppression, enabling the reader to understand many ways of oppression under different names and how these can be applied to a situation where oppression exists regardless of the situation. Exploitation is the unfair treatment of one social group to benefit another (Mulkeen, 2021; Phipps, 2021).

In marginalisation, a whole category of people is expelled from useful participation in social life and are potentially subjected to severe material deprivation and even extermination; powerlessness designates a position in the division of labour and the concomitant social position that allows persons little opportunity to develop and exercise skills, cultural imperialism involves the universalisation of a dominant group's experience and culture, and its establishment as the norm, while violence refers to threats that are designed to damage, humiliate or destroy the person (Young, 2011; Milton, 2016). It is said that violence is systemic as it is directed at group members simply because they are members of that group (FitzMaurice, 2007; Purpora, 2012).

Dubrosky (2013) looks at the theory behind the behaviours of the oppressed, relating them to Young's five faces of oppression as applied to nursing. The article reads like an extended literature review, but this is not stated. However, it relates and gives answers to the five faces of oppression that may occur in nursing using existing literature. The author brings her knowledge as a nurse and clinical instructor but does not say her experiences. This could have been better if it was a research study. Nonetheless, it paints a picture of how nurses are oppressed. She highlights that nursing is a female-dominated profession and that this has led to oppression as nursing knowledge in part is based in a specific gendered defined occupation, leading to nursing being given very little value in society (Dubrosky, 2013; Merrick, Fry, Duffield and Stasa, 2015).

In Dubrosky (2013) and Goodwin's (2015) view, others often exploit nursing's work in the healthcare system. The exploitation mentioned is unclearly identified; however, from reading the literature, it appears to be referring to medicine as the dominating force in clinical practice. In exploitation, the power nurses have is diminished, which contributes to them suffering a loss of control and are therefore deprived of elements of self-respect (Krabbe, 2021). Goodwin (2015) says that nurses are marginalised because even if they are appointed as managers, they still fail to change the balance of power within the organisations in which they work. It is said that managers are chosen by those who hold oppressive powers such as doctors and administrators; this makes them more likely to promote the institution's agenda of meeting targets rather than the nursing agenda of delivering quality nursing care (Roberts, Demarco and Griffin, 2009; Dubrosky, 2013; Balanon-Bocato, 2018). Nurses appear to be unable to make significant changes because they hold onto the oppressed group's values (Matheson and Bobay, 2008; Rooddehghan et al., 2015). Matheson and Bobay (2008) state that if nurses themselves do not come forward to define what nursing is and to identify their contributions to healthcare and patient outcomes, then the medical profession and healthcare administrators will.

Nurses are powerless and marginalised in decision-making because of the status they occupy (Dubrosky, 2013; Juanamasta, Iblasi, Aungsuroch et al., 2021). The powerless find themselves situated to take orders and rarely have the right to give them (Dohal, 2022). Nurses are in this position of taking orders from doctors without any ability to do the same and with very little power to argue with the

doctor about the orders received (Juanamasta, Kusnanto and Yuwono, 2018; Darmayani, Findyartini, Widiasih et al., 2020). Many nurses are institutionally placed into roles of powerlessness and have been taught not to assert themselves either individually or as a collective (Dermarco and Roberts, 2003; Darmayani et al., 2020). Nurses find themselves having varying degrees of powerlessness depending on how they situate themselves (Bertero, 2010; Juanamasta et al., 2018). It is said that nurses want to believe that they are in charge, but they sense that they are not (Juanamasta et al., 2021). It is necessary to find out what makes nurses have feelings of powerlessness. It could be that nurses are oppressed, controlled, or restricted, hence feel this way.

Goodwin (2015) believes that cultural imperialism in nursing is riddled with medicine's dominant norms and culture, which have become the norm. Nursing has struggled with medicine's power as the normalising standard of healthcare (Fletcher, 2006). Doctors dominate the world of healthcare that, even when not present, represent a formidable authority (Dermarco and Roberts, 2003; Luetsch and Scuderi, 2020). Nurses who have experienced oppression have come to view medical dominance as the most significant reason for continuing oppression. Rodwell and Demir (2012) say that oppression in nursing also occurs as horizontal violence. Horizontal violence is described as the behaviour of oppressed people who cope with feelings of powerlessness by displaying negative emotions and aggressiveness onto each other rather than onto the dominant social group (Egues and Leinung, 2013; Tedone, 2020). The main aspect of horizontal violence occurs in the form of bullying (Taylor, 2016; Hartin, Birks and Lindsay, 2019).

Bullying is said to be the main issue in nursing, and it is believed that bullying contributes to nurses resigning from their posts (Johnson and Benham-Hutchins, 2020). There is a belief that the lack of self-esteem and self-hatred leads to the submissive, aggressive syndrome in which aggressive feelings towards the oppressor are misplaced as sabotaging behaviours against their group (Becher and Visovsky, 2012).

2.7.6 Devolution of power in nursing care

Nurses are now tasked with responsibilities that were once placed in the hands of doctors (Senior, 2008; Phillips, 2019). This is devolution of power and responsibilities, which is the undoing of oppression but does not necessarily undo all oppression depending on the degrees of freedom that come with that power (Hart, 1954; Dascal, 2007; Cruz and Sonn, 2010; Kohn and Keally, 2011; Greaves, 2014; Stilz, 2015; Katikireddi et al., 2017). McGibbon et al. (2014) point out that the concept of undoing oppression underscores the imperative to expose, resist, and transform oppressive processes' continuing presence and influence. Wilson and Yellow-Bird (2013) describe the undoing of oppression as the intelligent, calculated, and active resistance to the forces of oppression that perpetuate the subjugation or exploitation of minds, bodies and the ultimate purpose of overturning oppressive structures and realising liberation.

There is an acknowledgement that nurses should be allowed to do more clinical skills in care (Burns, 2019). In response to this, some nursing roles have changed, but this does not mean freedom. In oppression, the most powerful tool is the

mindset (Ford, 2010; Silverman, 2015). There are various ways of mind control, such as the colonisation of the mind or exposing individuals to what is deemed best for them. The colonisation of the mind is achieved when those colonised adopt the colonisers' epistemic principle of invidious comparison (Quinteros, 2015; Samier, 2017; Macías, 2019; Sieber, 2021; Kusumawardani, 2021). Sometimes mind control is done by giving incentives to the group. In nursing, this could occur by allowing the chosen few to perform certain extended roles. If the mind or group is controlled, they find themselves trapped without any route of escape, just like a bird in a cage (Moore, 2015). They find themselves powerless and without a voice (Tan, 2007; Gilley, 2017; Mignolo and Walsh, 2018). It could be argued that decolonising or changing the mindset is further oppression but in a different way. The group can get rid of oppression and adopt something else that some could view as oppression. It looks like a vicious cycle. This goes against the ultimate purpose of changing the mindset to overturn the oppressive structure and realise the group's liberation (Macías, 2019). When liberation has been achieved, oppressive habits remain in the mental state of individuals even though freedom or devolution of power has been granted (Cohen, 1979; Purpora, 2012). It looks like some elements of oppression or oppressive thinking can never be eliminated (Mignolo, 2021). This is the challenge that nursing faces long term. It seems that sometimes oppression is content in imposing its rule upon the present and the future of a dominated group (Mignolo, 2007; 2021).

Those who want to end oppression must change their way of thinking (Quijano, 2007; Heywood, 2021). Oppressive thinking and actions permeate the nursing

profession, from biomedical hegemony in the curriculum and practice to managerial efficiency models in nursing care (Britwum, 2017). The development of a consistent counter-narrative is necessary if nurses are to change their mindset of practices. Goodwin (2015) discusses the need to engage in critical self-reflection to understand the impact of many forms of oppression in nursing. This is because once oppressed; it is easy to perpetuate the conditions by striving to emulate and imitate the culture and ideas of the oppressors (Mills, 1991; Mengotti, Corradi-Dell'Acqua and Rumiati, 2011; Mengotti, Ticini, Waszak et al., 2012). It is important to change the mindset to rediscover the group's intimate selves and eliminate mental attitudes, complexes, and habits that made oppression trap them for a long time (Nandy, 1983). According to Mignolo (2021), an oppressive mindset continues the oppressive forms of domination after the end of oppressive administrations. Oppression is particularly present in the production, distribution, commodification and consumption of knowledge (Quinteros, 2015).

It seems bad habits die hard. Despite changing the mindset and responsibilities, arguably, oppressive elements remain with the group for a long time, if not forever. It is not possible to get rid of oppressive elements completely (Lu, 2011; 2017). This is the likelihood in nursing, it could be that nurses are free to decide how they deliver care to patients, but because all they have known is oppression, this might mean that they then find it difficult to work independently and with freedom. There is a need to make nurses aware of oppressive elements within the profession to move away from them. Oppressive mindset can only be eliminated if individuals change their thinking (Said, 1978; 1993). It is difficult to

suggest that a group can have the ability to think any other way if all they have known is being oppressed (Maiese, 2022). Can it be possible to think differently? This is difficult as an individual or group might not find ways to do so. Thinking outside the parameters is always challenging and requires careful consideration of the facts. Considering that it is unclear how some oppressive elements exist within nursing, thinking any other way could be a hard task (Koh, 2015).

2.7.7 Limitations of the critical literature review

The literature reviewed appears limited on the concept of agency in clinical nursing care within hospital settings. This topic has not been explored deeply in this field. However, some of the literature provides information related to the concept of agency. No original literature discusses nurses' concept of agency from my lens; as such, some of the literature is indirectly related to the topic. Therefore, I still had unanswered research questions after conducting this critical literature review.

2.7.8 The research questions

The questions which are being asked in this study are:

- Do nurses have the power to act in clinical nursing care within hospital settings?
- How free or constrained are nurses?
- What powers do nurses think they have?
- What do nurses think they should be doing?

2.7.9 Research aim

To investigate adult nurses' concept of agency in clinical nursing care within hospital settings from a hermeneutic phenomenological perspective.

2.7.10 Research objectives

- To find out how free or constrained nurses were in nursing care.
- To find out what powers they thought they had in nursing care.
- To find out what they thought they should be doing in nursing care.
- To contribute original knowledge on nurses' concept of agency in nursing care.

2.8 Summary

This chapter presented relevant literature in the now and in the now of the now, which is never the now and identifies gaps in the nurses' concept of agency in clinical nursing care. The literature on this topic is limited; however, the available literature discusses nursing practice, oppression, and nursing roles but does not detail how free or constrained nurses are in implementing the roles. The themes which emerged from the appraised literature were influences in clinical nursing practice, decision-making in nursing care, the doctor-nurse game, agency in nursing care, oppression in nursing and devolution of power in nursing care. The literature was inadequate to answer the research questions; hence, I outlined the above research questions, aims and objectives. The chapter that follows details the methodology and methods used in alignment with the study.

The methodology and methods are significant in a study and play a major role in aligning the whole investigation being undertaken. All research study sections determine what methods must be followed (McClean, Bray, de Viggiani et al., 2020). The chosen topic initially influences the researcher, the literature reviewed, and the questions being asked (Silverman, 2013; Robinson and McCartan, 2016). Some questions can only be answered in a certain manner. In answering the research questions, the choice of methods allows a specific study technique to discover new information about the phenomenon or to understand it (Bryman, 2016). In some instances, the methods are the ones that choose the researcher rather than the researcher choosing them. In other words, the context of the study automatically falls into certain research methods (Patton, 2015). Smythe (2012) confirms that even though a researcher may be drawn to the methodology and methods, it seems to just happen, as the methodology and methods choose the researcher.

This study naturally landed itself in the hermeneutic phenomenology methodology and methods (Babich and Ginev, 2014). The term *methodology* refers to how the study was done and its logical sequence (Hammond and Wellington, 2021; Gray and Grove, 2021), while *method* refers to the way or attitude of approaching a phenomenon (van Manen, 2016). I have always regarded myself as an interpretivist but had no zeal for hermeneutic phenomenology. I appreciate the genesis of meanings of things within one's stream of experiences and understanding the interpretive structures of experiences and how we understand

and engage things around us in our lifeworld, including ourselves and others (Moustakas, 1994; Suddick, Cross, Vuoskoski, Galvin and Stew, 2020). I do not believe that all valid information can always be obtained through reasoning and logical means, while, on the other hand, authoritative knowledge is not always an answer to every question (York and Clark, 2006). This study adopted a paradigm, epistemology, and ontology (Patton, 2015) as per the diagram below.

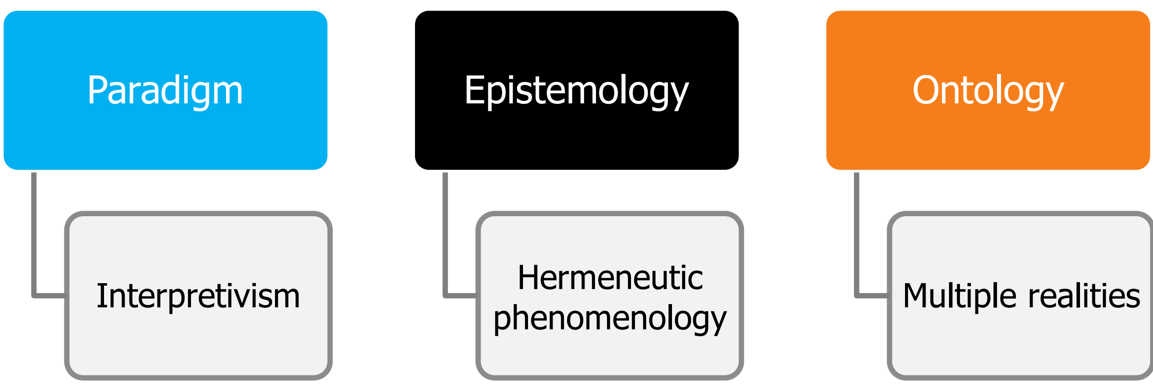

Figure 4: Paradigm, epistemology, and ontology

3.1 Interpretative research focus

Interpretivism appeared appropriate in this study as it enabled me to interpret elements of the inquiry and address the subjective meanings of those involved (Goldkuhl, 2012; Saunders, Lewis and Thornhill, 2012; Dudovskiy, 2018). Interpretivism refers to epistemologies or theories of gaining knowledge of peoples' lifeworld attached to their actions to understand the socially constructed reality (Chowdhury, 2014; Cresswell and Porth, 2018). It could be argued that the subjective nature of this approach allows room for bias on behalf of the researcher (Hobbs, 2021). The interpretivist views have different origins in different

disciplines and are often connected with the origins of the interpretivist paradigm (Atkinson, 1995; Denzin and Lincoln, 2011; 2018). Angen (2000) explains that the interpretivist paradigm was developed to critique positivism in the social sciences. In general, interpretivists assume that reality or relativist ontology, as it is known, is constructed intersubjectively through meanings or understandings developed socially or experimentally and is fluid (Denzin, 2001; Willis, 2007). According to Dibley et al. (2020), a deeper understanding of the lived experience of the phenomenon can change a person's reality and what it means to be human. Besides, a hermeneutic phenomenological view acknowledges that multiple realities exist and that this allows for several meanings to be derived from the same shared experience (Lipscomb, 2017; Dibley et al., 2020). Interpretivism also considers that we cannot completely exclude ourselves from what we know (Lincoln and Guba, 1990). The researcher and the object of investigation are linked such that who we are and how we understand the world is a central part of how we understand ourselves, others, and the world (Lincoln and Guba, 1985). This makes it possible to generate rich information that cannot be achieved by positivist means otherwise (Bryman, 2016).

3.2 Hermeneutic phenomenology

Hermeneutic phenomenology was used in this study as it allows an understanding of the participant's experiences and the researcher to interpret and reinterpret those experiences further (Ajjawi and Higgs, 2007; Dibley et al., 2020). In some way, it allowed me to be part of the participants' world and tell a story from what they experienced in clinical nursing practice. This study could have adopted

different versions of phenomenology or ethnography. An example could have been Husserl's phenomenology, which is concerned with understanding human beings at a deeper level of a given phenomenon (Husserl, 1970; 2013), or lived experiences of human beings at the conscious level of understanding (Wojnar and Swanson, 2007; Fochtman, 2008; Kakkori, 2009). His phenomenology gives wider meaning to the lived experiences under study, and by using his approach, a researcher uses *bracketing* (suspension of any preconceived ideas) as a taken for granted assumption in describing the natural way of the appearance of phenomena to gain insights into lived experiences and interpretation for meaning (Qutoshi, 2018). This type of phenomenology was not chosen as it could have detached me from the research, defying interpretivism, which encourages subjectivity or the researcher being part of the research. On the other hand, it is doubtful that researchers can negate their understanding of the world and look at situations without any preconceived ideas (Koch 1996; Dibley et al., 2020).

Ethnography is an interpretative methodology that studies the beliefs, social interactions, and behaviours of societies involving participation and observation over time and the interpretation of the data collected (Naidoo, 2012; Denzin and Lincoln, 2018). The advantage of ethnography is that the researcher, as a participant-observer, is immersed in the participants' culture over an extended period and is in a position to discover what is hidden (Naidoo, 2012). Ethnography was not chosen because there was no time for me to be immersed in the nurses' daily practices over an extended period. On the other hand, ethnography is linked

to the researcher's experiences (Naidoo, 2012); this would have gone against my focus which was specifically on nurses' experiences.

Hermeneutic phenomenology is made up of two research methods, thus hermeneutics and phenomenology. Hermeneutics is the art and science of interpretation and meaning (Finlay, 2007; Finlay and Evans, 2009; Ihde, 2020). However, interpretation can be limited by the absence of the researcher's own experience, while meaning is not a thing that is final and stable, but something that is continuously open to interpretation (Miles, Francis, Chapman et al, 2013). It has its roots in methods associated with the interpretation of biblical texts (Dubinina, 2020; Sarisky, 2021). Originally it was concerned with changing the unknowable to text and language that could be understood (Mueller-Vollmer, 1985; Grossmann, 2014). Hermeneutics aims to understand and articulate the common everyday practices and meanings of activities that seem obvious and taken for granted (Gadamer, 1976; Heidegger, 1977; Hall and Ritchie, 2011). In nursing, daily clinical practices sometimes become so familiar that they are either difficult to articulate or are hardly noticed (Kaufer and Chemero, 2015). Zahavi (2019a) sees phenomenology as a study of experience, particularly as it is lived and structured through consciousness. Consciousness here means being concerned with how it is like for an organism to be that organism (Nellhaus, 1998; 2004; Block, 2019; Perrotta, 2020; Frith, 2021). In other words, phenomenology studies conscious experience as experienced from the subjective first-person's viewpoint. In its tradition, phenomenology addresses the meaning things have in people's experiences, notably, the significance of objects, events, tools, the flow

of time, the self, and others, as these things are experienced in people's lifeworld (Moran, 2000; Pivčević, 2014; Qutoshi, 2018). Patočka (1996) explains that experience refers not so much to accumulated evidence or knowledge mastered by individuals; it is something that happens to individuals. It is important to understand the participant's experience of the phenomenon who is taking part in the study (Bryman, 2016). The researcher needs to try and understand how that participant's experience was like, including the environment in which that experience occurred (van Manen, 1997; Grossmann, 2014). In other words, the researcher must do the investigation as if it were an interrogation (van Manen, 1997; Kaufer and Chemero, 2015). Phenomenological reflection and intentionality are just as important as part of the investigation or as part of the discussion, as reflection or intention must be towards something (van Manen, 1997; 2016).

Hermeneutics and phenomenology are well suited together or along with each other. Ricoeur (1991) affirms a mutual belonging in the simple opposition between phenomenology and hermeneutics. It is impossible to study experience without simultaneously inquiring into its meaning, and it is impossible to study meaning without experiential grounding (Friesen, Henriksson and Saevi, 2012; Davidson and Vallée, 2016). On the other hand, language is also inextricably involved in this mutual dependency of meaning and experience (Ricoeur, 1991; 2004; Friesen et al., 2012). I see the experience as something that has already been interpreted; otherwise, it would be meaningless to say that it is an experience without it being interpreted. Hermeneutic phenomenology, then, is an interpretive approach that studies experiences together with their meanings (Dibley et al., 2020).

Hermeneutic phenomenology is concerned with the participants' everyday worlds from their perspectives of experiencing a particular phenomenon (Keshavarz, 2020; Furtak and Barnard, 2021). The emphasis in hermeneutic phenomenology is on the individual lifeworld, inclusive of how the life has been socially constructed and the experiences of the individual relating, interpreted, and situated within their lifeworld (Dreyfus, 1994). Dreyfus considers hermeneutic phenomenology as an interpretation of human beings as essentially self-interpreting, thereby showing that interpretation is an appropriate method for studying human beings. This means that it is open to revision and reinterpretation. Its emphasis on the interpretation and reinterpretation of meaning rejects any transcendental claim to the meaning or any research conclusions that are fixed once and for all (Crowther and Thomson, 2020). It does not study objects or phenomena as objective but as necessarily meaningful (Friesen et al., 2012; Ramsook, 2018). Dreyfus (1994) explains a phenomenon as that which shows itself directly or that which shows itself in itself. In a way, the subject of phenomenology could be something that does not show itself but can be made to show itself (Dreyfus, 1994; Zahavi, 2019a; 2019b). The researcher is encouraged to look beyond the face value of the everyday experiences of life and uncover the hidden meanings of phenomena (Miles et al., 2013). Bernstein (1983) believes that interpretation has always involved dispute and clashes of authority. No text completely determines its interpretation. It seems that a text can mean anything depending on who is interpreting it. Bernstein (1983) insists that in some instances, meaning is not derived from a text but brought to it, and that initial meaning will in great measure

determine the interpretation of the text regardless of what the text might be thought to mean to others. It looks like the text is the real-world in which hermeneutic phenomenology anchors. Nietzsche (2014) warns that everything lacks meaning; thus, the untenability of one interpretation of the world, upon which a tremendous amount of energy has been lavished, awakens the suspicion that *all* interpretations of the world are false. It is a wake-up call to any researcher to be careful when interpreting, as anything interpreted does not necessarily mean that it is true (Schrift, 2009; Boadu, 2021). In the hermeneutic phenomenological sense, the perception of social reality or understanding of reality is shaped by the interpretation of events as seen by one person and only one person (Friesen et al., 2012; Zahavi, 2019a; 2019b), and that person is me.

Hermeneutic phenomenology is not just about understanding and interpreting what is being said as the lived experience; it further involves the art of understanding and interpreting both verbal and non-verbal expressions, including their prior aspects influencing communications (Laverty, 2003; Dangal and Joshi, 2020). It is important to bear in mind the complexity of that experience and that sometimes it is not always easy to understand the experience. Pellauer (2021) points out that, while philosophical language continually aims at univocal concepts, used language is always polysemic; it can have more than one meaning, more than one translation, so all language uses necessarily call for interpretation. Littlejohn and Foss (2016) describe communication as the vehicle by which meaning is assigned to the experience. Merleau-Ponty (2014) notes that the tenet

of hermeneutic phenomenology is that an individual's most fundamental experience of the world is already full of meaning.

van Manen's (1990) version of hermeneutic phenomenology was utilised in this investigation. He says that hermeneutic phenomenological text succeeds when it lets the researcher see that which shines through but tends to hide itself (van Manen, 1997). van Manen approaches hermeneutic phenomenology with fluidity. He does not introduce a rigid structure to it, allowing the researcher to incorporate their own hermeneutic phenomenological ideas. This suggests that my version of hermeneutic phenomenology can never be exactly the same as any other, and there are indications that there are as many versions of it as the number of researchers who have used it (Patton, 2015; Dibley et al., 2020). Significantly, the basic idea of hermeneutic phenomenology is critical reflection and interpretation of the lived experiences (Paley, 2018; Zahavi, 2019a). van Manen's hermeneutic phenomenology seeks to understand what it was like or how it was like, the mood, feelings, emotions, what the environment was like and any other aspects. In asking these questions, the researcher must interrogate the participant to understand the experience and obtain the necessary information to clarify the phenomena (van Manen, 1990; 2017b). There is no restriction on what other questions can be asked by the researcher as long as the intention is to clarify the participants' lived experiences and anything else the participants have to deal with in their everyday life practices (van Manen, 2016). Hermeneutic phenomenology helps in reflecting on the now. However, van Manen (2016) points out that trying to grasp the now is never possible because it is always too late each time a

researcher does so. In some way, he questions what we call the now. What we consider as the now is always in the past regardless of the time span; even though we might consider it as in the now, it could never be in the now.

In using van Manen's (1990) hermeneutic phenomenology, I realised that it works well when used with other aspects of hermeneutic phenomenology alongside it. Heidegger's hermeneutic aspects (Capobianco, 2015) were incorporated into van Manen's hermeneutic phenomenology. Phenomenology becomes hermeneutical when the method is interpretive and not purely descriptive (Sloan and Bowe, 2014; Zahavi and Martiny, 2019; Traini, Stewart and Velez, 2021). In using Heidegger's (1962) and other philosophers' ideas on hermeneutic phenomenology, I saw this as fused hermeneutic phenomenology (Dibley et al., 2020). Fused here infers to blended aspects of hermeneutic phenomenology being expressed as a singular entity. Heidegger is primarily concerned with Dasein or existence and intentionality (that which is towards) (Heidegger, 1962). My positionality is that existence on its own is an experience that has its focus on intentionality. Dasein is a way of life shared by some community members (Heidegger, 2018). Here the members of that community were nurses who worked and shared experiences in clinical nursing care. It would seem that a way of life provides that experience as human beings lead their lives. It is viewed that to be Dasein is about Being or to be there (Dreyfus, 1994). In Dasein, an individual ineluctably finds themself being in the world or a world that matters to them in some way or another (Dreyfus, 1994; Heidegger, 2018; George, 2020).

The stories and informal discussions were about how it was like being in the world or being there experiencing the phenomenon of clinical nursing care and how it was done around them. I became part of their world as I was engrossed in their lifeworld. Heidegger emphasises that a researcher should take an ordinary experience as its point of departure, but which, through a careful and sensitive examination of that experience, aims to reveal a priori, transcendental conditions that shape and structure it (Heidegger, 2018; Bordogna, 2021). An interesting aspect of Heidegger's hermeneutic phenomenology is poiesis (Heidegger, 1962). Poiesis is a process of revealing and was done in data analysis. Poietic events are acts of unconcealment in which entities can show themselves, and this does not imply that what is revealed is something independent of human involvement (Wheeler, 2020).

3.3 The research participants

The sample consisted of 12 qualified NMC registered adult nurses (1 male and 11 females aged between 28 to 54 years old) on post-registration courses at the University, namely the bachelor’s and master’s nursing degrees, prescribing, and working within hospital wards, Emergency Departments (ED), Emergency Medical Units (EMU), Intensive Care Units (ICU), Coronary Care Units (CCU) and from various healthcare institutions. They were working as band 5 to 7 as per NHS (2021) agenda for change, and their nursing experiences ranged from 4 to 34 years. The participants were identified through the courses they were doing. A letter was then posted on their online course page. Any qualified nurse who worked clinically in hospital settings willing to participate was invited to participate

in the study. However, nurses who worked in other settings or were not qualified were excluded from the study as they did not have the needed characteristics (Etikan, Musa and Alkassim, 2016). The participants were considered to have the characteristics that could enable the research questions to be answered. I could have gone to clinical practice to find alternative participants, but they would have had similar characteristics as those doing post-registration courses.

3.4 The sampling technique

Purposive sampling was used in the selection of participants. This type of sampling is a nonprobability sampling technique also known as judgmental, selective, or subjective sampling (Patton, 2015; Terry, 2018). The weakness of nonprobability sampling is that it is rarely representative of the researcher’s target population. It means that not every element or segments in the population have a chance of being included or represented in the sample. The main goal of purposive sampling is to focus on particular population characteristics that best enable the researcher to answer the research questions (Polit and Beck, 2018). Participants were selected based on the study purpose, expecting each participant to provide unique and rich information of value to the study. Purposive sampling methods place initial emphasis on saturation, a core concept in interpretative research, meaning until no new relevant information emerges with additional interviews (Etikan et al., 2016). There are arguments on whether data saturation can be achieved (Fusch and Ness, 2015; Fofana, Bazeley and Regnault, 2020). Data collection, however, was done until I had enough information to answer the research questions.

There are various types of purposive sampling, each with different goals. The homogeneous sampling method was adopted as I aimed to have a sample with very similar characteristics or traits, such as being in the same nursing field and having similar knowledge, expertise, or experiences (Bryman, 2016). A homogeneous sample is often chosen when the research question being addressed is specific to the characteristics of a particular group or subgroup of interest, which is subsequently examined in detail (Patton, 2015; Etikan et al., 2016). It is considered that only a small fraction of the characteristics in which nurse researchers are interested are sufficiently homogeneous to render sampling bias an irrelevant consideration (Patton, 2015).

3.5 Data collection procedures

The data was collected by storytelling which included informal discussions with the participants describing their experiences in clinical practice (van Manen, 1990). The words story or stories include an experiential conversational discussion with the researcher (Crowther, Ironside, Spence and Smythe, 2017). Nurses were asked to tell me stories of their choice of incidents where they were involved in nursing care (van Manen, 2016). The limitation of a story is its verification. Informed consent was obtained from the participants before the stories were told, and a consent form was signed simultaneously (see appendix 9 for the consent form) (Bryman, 2016). The stories and all discussions were audio-recorded with permission from the participants. Prompts and questions were used during storytelling to understand the experiences and the concept of agency in nursing care (see appendix 10 for the storytelling prompts).

The data was collected within the University settings, and these were voice recorded for the purposes of data analysis. The data was only used for the purposes of the doctoral study. The stories from nurses were obtained during the nurse's free time. This was before or after lectures. Data collected was verified with the participants in person and stored in a secure place and destroyed within a certain time when it was no longer needed (Miller, Birch, Mauthner and Jessop, 2012). The potential risks in this study during data collection could have been the identification of nursing malpractice. This was going to be dealt with in accordance with the NMC (2019) guidelines.

The nurses had the right to refuse to participate in the research study without giving any reasons. They could withdraw from participating in the study anytime they liked without explaining; the information then could not be used in the study (McClean et al., 2020). The use of information could also have been stopped before it was anonymised if the participant decided they no longer wanted it to be used.

The data collection occurred within the University campus chosen by the participant. This was the site that was easily accessible to them. The discussion with the participant happened in a suitable quiet room within the University. The room for the storytelling was booked in advance. I did not expect any safety issues or risks during data collection as per the risk assessment I did for the study (see appendix 11 for the risk assessment form). However, the discussion or storytelling could easily have been interrupted by members of staff or students. Given this, I

had to put signs on the door stating that an interview was in progress and not to disturb. The participant was told that the story would last between 45 to 60 minutes, including prompts to understand their story. They were shown the facilities, including fire exits they could use while within the University if needed. I then went through the ethical prompts, which can be found in the ethics form as my checklist.

3.6 Data analysis procedures

The literature suggests that information gathered subjectively and textually from individuals presents an opportunity to understand the meaning of human experience (Dilthey, 1989). In hermeneutic phenomenology, it is recommended that data should be processed, uncovering the thematic aspects (van Manen, 1997; 2017a; Grbich, 2013; Järvinen and Mik-Meyer, 2020). In this study, the data analysis was done using van Manen's (1997) six research activities for data analysis aided by the hermeneutic cycle in understanding the stories (van Manen, 1997; Miles et al., 2013). The six steps involve turning to a phenomenon of interest and the lifeworld, investigating the experience as lived by the participants, reflecting on the essential themes which characterise the phenomenon, describing the phenomenon through the art of writing and rewriting, maintaining a strong and orientated relation to the phenomenon, and balancing the research context by considering the parts and the whole (van Manen, 1990). I had to listen to the stories over and over again. They were then transcribed word for word (see appendix 12 for the story transcript).

Using van Manen's (1990) six research activities, I first explored agency in nursing care within the stories as my area of interest; therefore, I tried to understand if nurses could deliver nursing care the way they wanted to execute it. This allowed me to be part of the study and bring my experience as a nurse and senior lecturer into the research process. Secondly, I investigated the lived experiences of nurses as told by them in the stories rather than through concepts (van Manen, 1990). Thirdly, I reflected on the meanings of the stories to identify and characterise agency within them. Here I had to *dwell* with the data, allowing ideas and thoughts to *bubble up,* questioning and revealing what was concealed (Dibley et al., 2020). It meant examining all of the original data and letting it sit in my mind *stewing* (van Manen, 1990). Fourthly, the development of themes emerged when I started describing the concept of agency within the stories and writing interpretive statements through writing and rewriting (see appendix 13 for the writing and rewriting, and 14 and 15 for the story themes) (van Manen, 1997). van Manen (2016) says that in exploring themes and insights, the researcher can treat texts as sources of meaning at the level of the whole story, the level of the separate paragraph and the level of the sentence, phrase, expression, or single word. Fifthly, I had to maintain a strong link to the concept of agency and the research questions being asked. I had to consider that which was concerned with agency during storytelling and in examining the stories and transcripts. It made me not to get side-tracked, wander unfocused, indulge in wishy-washy speculations, or equally settle for preconceived conceptions (van Manen, 1990; 2017a). Sixthly, I had to consider when to stop accumulating the data analysed

and interpreted as I had to constantly check for its relevance to the hermeneutic phenomenological methodology, as van Manen (1990) asserts that one needs to constantly measure the overall design of the study or text against the significance that the parts must play in the whole textual structure.

van Manen's (2016) three-level approach was followed in examining the story or stories as a whole, paragraphs, sentences, and individual words, giving me an insight into nurses' concept of agency in clinical practice. Here I captured the phenomenological meaning or significance of the text in parts and as a whole. This continued to the selective approach where I had to repeatedly revisit and listen to the audio recordings or read transcribed texts several times to see what statements or phrases revealed agency. The statements were highlighted before they were included in the themes that were considered for the study. I then progressed to a detailed reading approach where I looked at every sentence to see what it revealed about agency in nursing care and how the nurses delivered it. During data analysis, I also examined other factors such as the tone of voice of the participants, hesitation, their emotions and anything related. This allowed me to capture the true picture of what was being said or was going on.

The hermeneutic circle was used in the interpretation stage by moving forward and backwards circularly and spirally with the data. It encompasses reading, reflective writing, and interpretation in an extremely thorough and careful manner (Laverty, 2003). The text was read carefully to guarantee familiarity. I listened and relistened to the audio recordings and read and re-read the transcripts

dwelling with the data (van Manen, 1990). I highlighted important ideas, text, and meanings on each transcript, then combined them to understand the parts and the whole, demonstrating my awareness of the parts and the whole (van Manen, 1990; 1997). However, when I incorporated the hermeneutic circle as part of my data analysis, it was incomplete or did not capture the whole meaning. Considering this, I expanded the hermeneutic circle by adding poiesis to it. Poiesis in this study means an activity in which I could bring into being that which did not exist before (see appendix 16 for poiesis themes). Poiesis was specifically meant to discover what was otherwise than meaning by deriving it from the text or by bringing it to the text. van Manen (2016) sees this as genesis. My positionality is that interpretation goes beyond the final stage of interpreting to incorporate poiesis in the hermeneutic circle. This means that other realities can be revealed beyond interpretation as per diagram below.

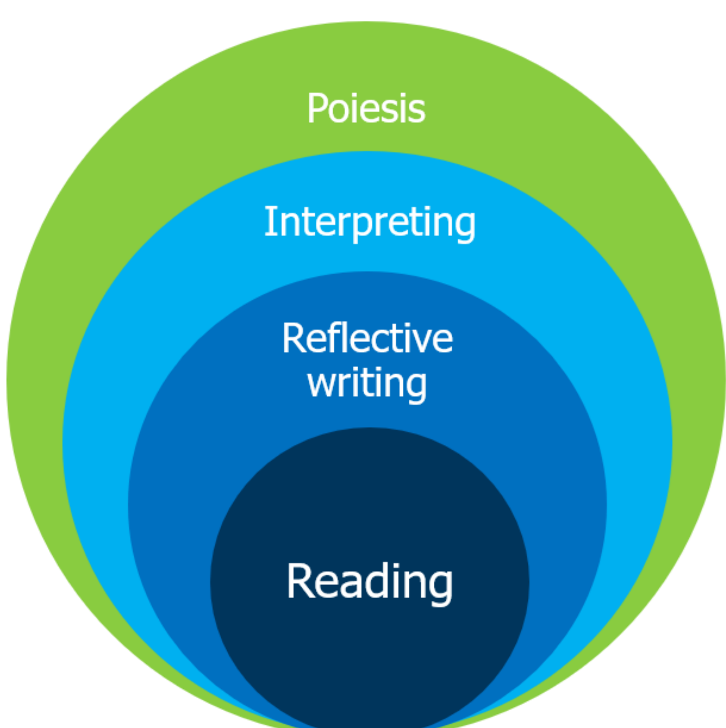

Figure 5: The hermeneutic circle (Kafle, 2011)

3.7 The rigour or trustworthiness considerations

In hermeneutic phenomenological research, there are contesting opinions on quality issues about this type of research (Kafle, 2011). In the interpretive paradigm, four standards of consideration address rigour. These being credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985; Harley and Cornelissen, 2022). According to van Manen (1997), the above standards do not fit well with a hermeneutic phenomenological inquiry, instead, he recommends four rigour criteria of orientation, strength, richness, and depth in addressing major trustworthiness quality concerns. The criteria are vital in pedagogic textuality where research involves the consideration of texts that explicate the lifeworld stories of the research participants (van Manen, 1997; 2017b).

According to van Manen (1990), orientation is the researcher's involvement in the world of the research participants and their stories. This started when I talked to the participants about my study, listening to their stories and having informal discussions with them, which allowed my involvement. I also had the privilege to witness their mannerisms during discussions and relate to what they were saying. I was the sole story transcriber and interpreter of what they were saying, this allowed me to be deeply involved. Strength refers to the convincing capacity of the text to represent the core intention of understanding the inherent meanings as expressed by participants through their stories (van Manen, 1990). Richness is intended to serve the aesthetic quality of the text that narrates meanings as perceived by the participants (van Manen 1997). In response to strength and richness, I used direct quotes which were in participants' own words. The

participants verified the transcribed data before direct quotes were extracted. Kafle (2011) suggests that participant feedback is another quality trail that hermeneutic phenomenological research must pass before reaching its audience since it helps to represent best what is intended by the participants. Similarly, Langdridge (2007) proposes persuasive accounts and participant feedback as major components determining quality in a hermeneutic phenomenological inquiry as part of analytical rigour. Analytical rigour addresses the attitude displayed by the researcher to pay attention to every case that either confirms or disconfirms the theme (van Manen, 1990). It seems that no taken for granted attitude is permitted during the hermeneutic phenomenological analysis. In addressing analytical rigour, all stories were considered as parts and a whole. Every story was transcribed word for word and listened to from the start to the end regardless of whether the information confirmed or disconfirmed emergent themes to make sense of what the participants were saying. A persuasive account refers to the quality of convincing the reader and the appeal this has on their personal experience in light of what they have read, while depth is the ability of the research text to penetrate down and express the best of the intentions of the participants (van Manen, 1997; 2016). In the persuasive account, I wrote everything the way it was said by the participants and how they viewed their lifeworld and how it was related to clinical practice and the concept of agency. In addressing depth, I listened to the stories and read the scripts repeatedly to make sure that I captured what was said. I progressed to reflective writings, interpretations and to incorporate poiesis into the findings.

3.8 Subjectivity

Interpretivism allows subjectivity (Simandan, 2016), which some researchers consider a weakness (Strazzoni, 2015). In this study, I was subjective. Subjectivity was adopted as I wanted to reveal or unmask myself as a nurse and nurse lecturer. It would have been unjust to pretend that I did not know anything about nursing practice, as I have knowledge, beliefs, and views about it. Subjectivism is metaphysical entrenchment in something based on personal perceptions, beliefs, feelings or the individual's figment of their imaginations without reference to reality (Drapeau, 2002; Schulting, 2017; Farber, 2021). Nevertheless, subjectivity does not require the elimination of objectivity; therefore, the notion of objectivism (external/objective truth) still pertains (Fritzson, 2018; Hier, 2019; Barrett, 2022). In the context in which the word subjectivity is used here, it means to relate to an idea, situation, or a material thing considered only true from the perspective of an individual (Allen, 2002; Simandan, 2016). It also refers to an individual who possesses experiences such as in nursing that could be in the form of feelings, perspectives, desires, and beliefs (AlWadi, 2013; Rahimi, 2015). Subjectivism allows the researcher to be part of that research and feel that they somehow own it (Bernstein, 1983). The strength of interpretive research lies in its ability to engage the researcher's subjectivities and seek to understand why they occur, which needs to be appreciated (Solomon, 2005; Simandan, 2013; Silverman, 2014; Rahimi, 2015; Mackey and Gass, 2021). Nonetheless, to provide a balanced discussion and keep my thoughts in perspective, I had to be reflexive in my discussion and thinking.

3.9 Reflexivity

Reflexivity allowed me to be self-aware of the observer effect, hence, reflective and, for this reason, reflexive throughout this study. This was self-engagement with an *other* as the *other* and involved looking at my inside and my outside as the researcher (Merleau-Ponty, 2014). Merleau-Ponty believes that a human being has an inside and the outside; the inside is the outside, and the outside is the inside (Merleau-Ponty, 1969; 2014). In other words, I became critical of myself and was reflexive from various perspectives rather than solely being subjective (Archer, 2013; Finlay and Gough, 2003; Hunt and Sampson, 2006). In this study, reflexivity, therefore, comes to mean an act of self-reference where examination or action bends back on, refers to and affects the entity instigating the action or examination (O'Brien, 2014).

In my understanding, the principle of reflexivity was perhaps first enunciated in sociology, implicating that the situations that man define as true become true for them (Derrida, 1978; Peirce, 1998; Vandenberghe, 2007). Bourdieu believed that social scientists are inherently laden with biases, and only by becoming reflexively aware of those biases can they free themselves from them and aspire to realism (Bourdieu, 1977; 1984; 1990; 2008; Bourdieu and Wacquant, 1992). This requires an immediate dynamic continuous self-awareness (Williams, 1976; Wilshire, 1982; Goffman, 1956; Nellhaus, 2010; 2017). It involves not getting rid of the self but doubling the self, distancing the self from the self to a greater or lesser extent to have a sense of standing outside the self and observing what one is doing and thinking (Hunt and Sampson, 2006). There are no clear models of reflexivity; as

a result, I decided to create and consider the main points identified in the diagram.

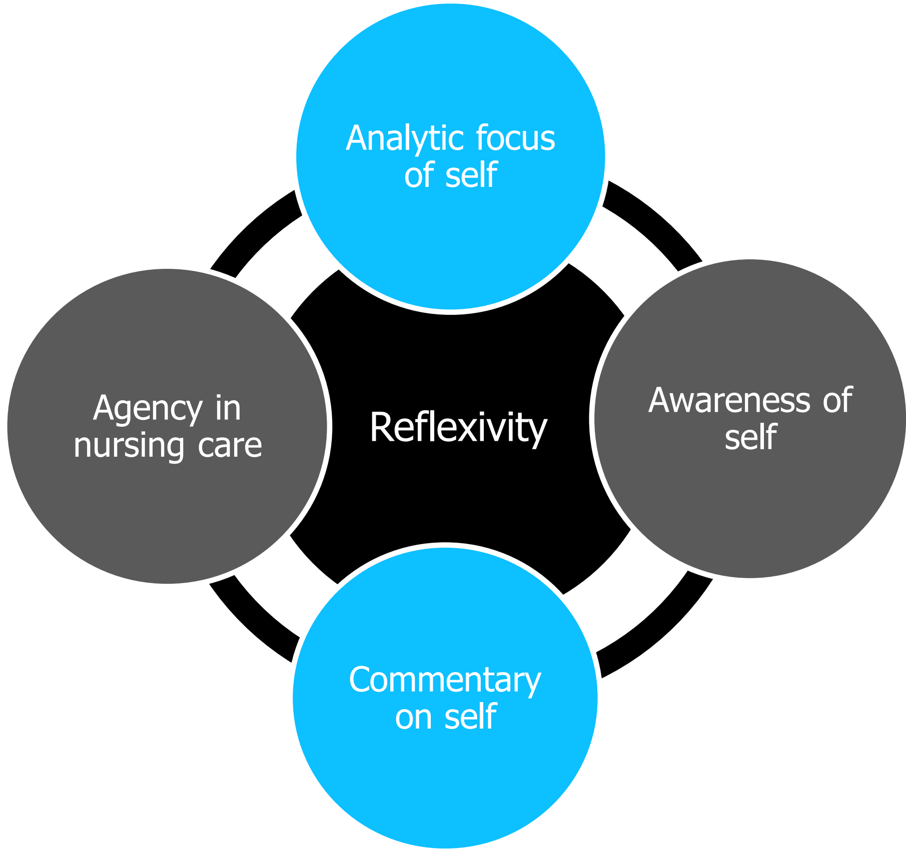

Figure 6: The reflexivity model

This reflexivity model was created to make sense of my thoughts and self (Lakoff and Johnson, 1999; Alejandro, 2021). The main points I addressed in reflexivity are the analytic focus, consciousness or awareness and the commentary on self (Bhaskar, 1978). The analytic focus is concerned with the topic of discussion, the consciousness deals with self-awareness and thinking about the thinking, while the commentary on self and knowledge is based on discussing me as an individual and how I see myself being in the lifeworld (Bernstein, 1983; Johnson and Duberley, 2003; Nellhaus, 2017). In this thesis, I have addressed the main aspects of reflexivity as they naturally occur in the discussion. I have grasped that the process of engaging in reflexivity is perilous, and I understand that researchers

must negotiate the swamp of interminable self-analysis and self-disclosure (Finlay, 2002; Lee, 2007; Berger, 2015; Alejandro, 2021).

3.10 Ethical considerations

The permission to conduct the study was obtained from the University (see appendix 17 for the letter to the University and appendix 18 for the approval), the Dean of the Faculty (see appendix 19 for the letter to the Dean and appendix 20 for approval from the Faculty), the University Ethics Committee (see appendix 21 for the ethics application form and appendix 22 for ethics approval), and from the participants. Informed consent and a signed consent form were obtained from the participants before data collection (Bryman, 2016). The diagram below details sequential steps taken to gain ethical approval in this study.

Step	Description
Step 1	Request for approval from the University Permission granted by the University
Step 2	Request for approval from the Dean of Faculty Permission granted by the Dean of Faculty
Step 3	Request for approval from the University Ethics Committee Permission granted by the University Ethics Committee
Step 4	Informed consent gained from the participants Consent form signed by each participant and the researcher Stories including conversational discussions occurred

Figure 7: Sequential steps taken to gain ethical approval

The participants were fully informed of the risks and benefits of participating and of their right to refuse participation or to withdraw from the research at any time (Polit and Beck, 2018). This was done by giving them an information letter and information sheet (see appendix 23 for the information sheet), which fully stated the risks and benefits of participating in the study. The letter (see appendix 24) and the consent form clearly stated that the participant had the right to refuse to participate in the study and had the right to withdraw from the study at any time without any explanation (Love, 2012; Kara, 2018). Nurses were reassured that I was a researching colleague, and whatever decision they took was respected and did not affect any relationship with the researcher (Dodd, 2020). They were also informed that the information would be confidential and anonymised and would only be shared with the supervisors for the purposes of the study (Kara, 2018). It was also stated that they could stop the use of the information they had given before it was anonymised and that this action would not affect them or their relationship with the researcher (Banks and Brydon-Miller, 2019). All the above information was also given to them verbally before the collection of data began. The data collected from the participants was only used for the purposes of this doctoral study. Data was stored in a secure University laptop I used at work which was encrypted and protected with passwords. The data was destroyed when it was no longer needed for the study, as suggested by Miller et al. (2012).

Confidentiality and anonymity were maintained, and therefore, no individuals or specific places were mentioned by name (Beauchamp and Childress, 2019). Participants were given a pseudonym, and their names were not used or included

anywhere in the study (Miller et al., 2012; Cardinal, 2017). The University where the participants studied or their place of work was not disclosed; this was referred to *as the University, the department or area of clinical practice.* This was intended to make it difficult to identify any of the participants. It is important to say that some readers might be able to guess where the study was done. However, due to the use of pseudonyms to identify the participants in the study, it is unlikely that any individual participant could be identified. During the study, if anything could have breached the code of professional conduct for nurses (NMC, 2018e), this could have been referred to the University or the healthcare institution concerned. This was unlikely to happen as the focus was on the concept of agency; nonetheless, any untoward story incidents discussed had already been escalated and resolved in clinical practice.

The data remained confidential within the limits of the law and the nursing regulatory body's professional code of conduct (NMC, 2018e) and I was the only one who had access to it. It was only shared with my supervisors, examiners, and the participants for the purposes of the study. Such personnel could not link the data to participants, as the data was anonymised so that no individual participant was identifiable (Gordon, 2019). Any quotes used in the research used a pseudonym rather than the participant's name. The only time that confidentiality could have been breached was if something that caused concern was raised or if there was a concern that someone could be at risk of harm (Surmiak, 2020). The participants were shown the transcribed scripts in person for verification rather than via email to prevent the data from being accessed by those not intended for.

All data was destroyed once the study was completed and when it was no longer needed, this was within two years of the study (Kanza and Knight, 2022). The information could have been kept for longer than two years had the study gone beyond that or was needed to be reviewed by the University.

This study complied with the General Data Protection Regulation (GDPR), encompassing seven requirements (Wray, 2017). The GDPR states that the terms of consent must make clear that, if a security breach occurs, this has to be reported within 72 hours to the participants and the University, if the participants request their existing data profile, this needs to be served to them with a fully detailed and free electronic copy of the data which has been collected about them, once the original purpose or use of the participant data has been realised, the participants have the right to request that their personal data is totally erased; the participants must be able to obtain their data from the researcher and reuse that same data in different environments outside of the University, the University must have proper security protocols in place from the start and should have a data protection officer (Denly, Foulsham and Hitchen, 2019; Dibble, 2020). The contact details were given to the participants for the Dean of Research as the independent person in the case of complaints and the details of the Data Protection Officer in the participant information sheet, which is a standard requirement (Dibble, 2020). A data protection officer is responsible for overseeing the University's data protection strategy and its implementation to ensure compliance with GDPR requirements.

3.11 Summary

This chapter justifies the use of hermeneutic phenomenology as a methodology and method and further details relevant methods used, which align with this study. It further explains how data was collected using stories and what they entailed. Furthermore, this chapter specifies how data were analysed using van Manen's (1990) steps of data analysis aided by the hermeneutic circle. It also discusses the four rigour criteria of orientation, strength, richness, and depth and their relevance. There is the provision of information on why I had to be subjective and reflexive simultaneously where pertinent. The study setting, participants, purposive homogeneous sampling, and ethical issues are also discussed. The following chapter provides a synopsis of the stories that were told by the participants and discusses how the stories were told to understand agency within nursing care.

The Stories — Chapter Four

This chapter presents the findings which determine if nurses had freedom or constraints in clinical nursing care. In them, the stories tell the concept of agency within hospital settings. I felt that providing a clear picture of the participants' experiences and understanding their interpretations before my interpretation would allow a detailed understanding of the concept of agency. The stories had already been interpreted somehow, as van Manen (1990; 1997; 2007; 2016; 2017a; 2017b) declares that anything with meaning has already been interpreted. This suggests that a story to be a story means it already has a meaning to be understood as telling something. The stories provided information on how nurses delivered nursing care and that which contributed to how they delivered it. Illustrative quotes extracted from the stories are used to reveal the participants' exact language in this chapter. The quotes are written in a different font and have a participant's pseudonym at the end. The themes that emerged were experiences and responsibilities in nursing care, the ability to deliver nursing care, constraints, and collaborative nursing care. These themes have subthemes as structured in this chapter.

4.1 Experiences and responsibilities in nursing care

This theme discusses what nurses did, their involvement, experiences, and responsibilities in care. The theme proceeds to explore nurses' feelings, their views of nursing care and what influenced them to work the way they did.

4.1.1 Everyday nursing care

Nurses talked about nursing care but were not always clear about what they meant by this. They had a varied range of what they considered nursing care. They assessed patients, administered medication, monitored patients' progress during treatment, did observations or vital signs, dressed wounds, and helped patients with activities of daily living. They articulated accounts of what they did every day as part of their nursing role.

> On a daily basis, nursing is about providing nursing care to patients, giving them their drugs in the morning, doing drug rounds, doing all the vital signs, doing their wound dressings, looking after them and turning them in bed so that they don't get pressure sores (Eliana).

Nursing care to them was not just about meeting patients' physical needs, such as pain management or assessing and monitoring them. While nurses acknowledged that there was more to nursing than what they did in practice, they were aware that they were not addressing all aspects of nursing care as they should.

> It's really hard, because there isn't a definition of a nurse, it's so wide ranging; nursing is probably about meeting the patients' holistic needs, making sure they are physically okay, mentally okay, emotionally okay, attending to daily activities of living, addressing all those needs in one really, which is difficult; it's also about supporting relatives and significant others (Emerald).

They worked with other health professionals, primarily doctors. Doctors initiated the care, and without doctors' input, nursing care would have been limited to basic care, observations, and minimal interventions. Doctors were unavailable occasionally to attend to patients immediately. This required nurses to do roles meant for doctors, such as cannulation or taking blood for investigations. These

were seen as extended roles. Nurses also implied that their role involved keeping track of what was happening to patients; they were the *eyes and ears* of the doctor. In other words, they had to make sure that patients were progressing well in recovery, and if a doctor needed any information, the nurse was the first port of call for all the information regarding patients.

> We had to tell the doctor what happened, but they are so busy, they just say keep an eye on him and let me know if there are any changes. We had to check his vital signs, his ECG, we monitored him for any effects, we just kept an eye on everything, we were constantly looking at the monitors to see if there were any changes and report them (Eliana).

Nursing care has improved, and nurses now do more, but a minimal change was noted compared to what nursing care has always been. There was an indication that nursing care was mainly based on basic physical needs. Daily nursing care was primarily about meeting the patients' physical needs, and everything related to it stemmed from there.

4.1.2 Priorities

Some nursing care was done as a priority rather than how nurses would if they had a choice. Priorities were those aspects needed most by patients and were essential, meaning that patients could not do without. Some priorities included nursing critically ill patients; this impacted the nursing care given to others.

> I was looking after the men’s side, another nurse was looking after the ladies’ side, on both sides we had very poorly patients each to look after, we could not give all patients equal care (Sapphire).

Nurses saw medication as another priority. Medication is important as part of managing patients. It is well known that if medication is not administered, it could lead to patients getting worse or not recovering.

You must think of the time, and if I am going to give the medication to patients at the right time (Petal).

The timing of medication is important due to various factors such as gut motility, pharmacokinetics, pharmacodynamics, drug metabolism, specificity, absorption, bioavailability, and efficacy (Venables and Gunnell, 2019). On the other hand, some drugs such as insulin are important if blood glucose levels are to be maintained within range. Another priority was that of assessing patients for nursing and medical problems. The assessment is important as it leads to diagnosis and identification of care that patients require.

It is important that we do their assessments, daily monitoring, their observations and monitor their condition (Diamond).

Nurses were vague, though, about what they meant by assessments. An assessment is not just based on the patient's observations; there are varied ways of assessing patients. It involves the use of various contemporary assessment tools. However, when nurses talked about patients' assessments, they were brief about it in their discussion. It could be that they thought I knew all the assessments; therefore, there was no need for them to go into detail. I wanted them to tell me explicitly about the assessments, but this did not prove easy. It might have been that they were not familiar with all the available assessments in clinical practice, and therefore, it was better not to mention them.

4.1.3 Nursing care plans and care pathways

Nurses mentioned nursing care plans and pathways that they used. They viewed them as an integral part of nursing. Traditionally, nurses write care plans, but some are computer-generated or pre-planned for some conditions that patients may present with. These are automatically selected when the diagnosis of a patient is entered. The disadvantage of pre-planned care plans is that they do not consider that patients are individuals and have specific individual needs. In contrast, care plans written by nurses are specific to individual needs. The nurse using the pre-planned care plan might not tailor the care according to each patient's needs; the nurse follows what is written down for them. This, in turn, leads the nurse to deliver nursing care that they did not intend to deliver in the first place. In some instances, nurses believed that the patient's nursing care was appropriate following the pre-planned electronic care plan. Misty saw the care plan as a guide to nursing care given.

> Looking back and reflecting, the pre-planned care plans were there; we delivered what was there; I think more could have been done, maybe spiritually or emotionally, to support her (Misty).

The care plan provided direction for nursing care that the patient received; however, Misty felt that even though the nursing care given to the patient was appropriate, there was still more that nurses could have done. It might be that the care plan considered did not allow this to occur. The care could have been done differently if the nurse had the opportunity to do so. Care pathways were used in some situations instead of care plans. A care pathway is a pre-planned care plan specific to procedural processes in managing certain conditions. The

care pathway tends to be problematic because it does not always favour patient-centred care, just like a pre-planned care plan. It can be said that care pathways help provide basic standard uniform nursing care for all patients assigned to it.

> We started the sepsis 6 pathway, got him into a gown and made him feel comfortable. We use so many care pathways within the department, everyone could be blasé about sepsis (Emerald).

Some nurses said that besides nursing care plans and pathways, they were being introduced to medical models in the assessment and care of patients. Sapphire was surprised that she was doing a course that enabled her to use medical assessment models during her consultation with patients. Knowing medical assessment models made her feel that nursing had changed as the models she was exposed to were only privileged to doctors in the past.

> The health assessment module I am doing is opening my eyes, nursing has changed quite a lot, we have been talking about what medical models we can use when doing a consultation, this is something that we couldn't have done many years ago as nurses, this has always been done by doctors (Sapphire).

It was unclear what models she was referring to or how she saw them helpful. She saw the use of models in consulting patients as allowing her freedom. In her view, this enabled her to do extended roles with some degree of independence. She appreciated stepping into a doctor's shoes rather than a nurse's and wanted to do more than what nurses do.

4.1.4 Feelings about nursing care

Nurses expressed different feelings about how it was like nursing patients. The feelings were a significant indicator of whether they were satisfied with nursing care and helped them understand what went on in clinical practice. Some feelings

were about nursing care, while some were about how they worked with their colleagues and other health professionals. Their views were that the care they gave could have been different, while some felt that they could not have done more due to limitations. Some limitations were within what was in their remit, while others were not within. Sapphire described how she looked after a myocardial infarcted patient who later had a cardiac arrest and was said to be at a stage where nothing else could be done. The intervention she mentioned was an angiogram which, according to her, was to see the extent of the damage to the heart. An angiogram is not what a nurse can do or request in practice. This information did not make sense because if the patient had already been diagnosed with a myocardial infarction, the best option would have been a stent or thrombolysis. The nurse demonstrated her knowledge of when to initiate Cardiopulmonary Resuscitation (CPR) when the patient had a cardiac arrest. However, during the cardiac arrest, she fractured the patient's ribs.

The patient I looked after came in having had an acute myocardial infarction, there was really no point of doing an angiogram to see the extent of the blockage. He then has a cardiac arrest, I started the CPR, I cracked his ribs, thus all I could think about, I actually went and locked myself in the cupboard somewhere and cried, he had died (Sapphire).

Fracturing the ribs made her upset. It could have been a natural reaction of any nurse when they are stressed and things are not going well, or it could have been a sense of guilt. It is unclear whether she fractured ribs because of a lack of knowledge or due to an underlying disease that the patient might have had. There was a look of fear in her when she told me her story. She was not the only one who expressed fear. Some nurses feared being disciplined or losing their Professional Identification Number (PIN) when or if anything went wrong. In

another story, Eliana administered a drug with a colleague via an infusion pump, only to realise that the drug had infused through quicker than the time scale it was meant to. What was going through her mind was not that the drug had gone through quicker than it should have but was fearful of the consequences that could have followed, such as the side effects of the drug and being disciplined.

I was anxious; my palms were sweaty because I thought I'd made a mistake; because I was the second checker, had we made a mistake, probably we would have had to re-do our drugs and got disciplined (Eliana).

It is possible that if nurses were fearful in clinical practice, including the fear of administering drugs or performing some clinical skills, then this could easily have stopped them from feeling free to nurse patients. On the other hand, this could have acted as a deterrent in preventing untoward incidents from occurring. Besides fear, nurses voiced their frustration of working in clinical practice. The frustration stemmed from palavering with other health professionals who were involved in the care. In one incident, Gemini was frustrated with tissue viability nurses who were meant to give a plan of care for a patient, but they were unclear about it. They were meant to see the patient and dress the wound as stipulated in the local guidelines, but they did not. This meant that the nurse could not dress the wound until tissue viability nurses had decided on the treatment. It took days before they eventually instructed her to dress the wound.

It was frustrating; you are agitated, you can't deliver the care that you want, that's irritating, agitating, agitates me (Gemini).

The nurse was frustrated because she could dress the wound but was not allowed to as the guidelines required tissue viability to manage the wound. She had the

knowledge to do so, but the guidelines restricted her. Wound care was placed under another speciality.

4.1.5 Views of what nurses should be doing in nursing care

During discussions, I wanted to understand how nurses wanted to work, so I questioned them to see how they wanted nursing care done. I was hoping that they would discuss how they envisaged nursing. Similarly, I wanted them to paint a picture of how they saw current nursing care, whether it needed to be maintained the way it was or changed. This was the hardest part for them to answer. They saw nursing varied from one environment to another. According to them, nursing was not the same in different hospital settings. There were skills they felt they should be doing. Misty mentioned that nurses had several nursing skills, but those skills were not used; as a result, they were eventually lost. Her view was that those skills should be utilised. I asked what those skills were, but they would say it was a range of skills without specifying which ones. I was eager for them to say more, but they acted as if I knew what they were referring to.

> How I see it is that what is a competent nurse all round on one ward, if you put them in a different place, it's not going to be the same, so we have this big number of skills we all need to do, to look at the whole health of the patient and the whole well-being of the patient but we don't use them (Misty).

On the same question, some felt that nurses should be doing less in practice. Abigail's view was that nurses were doing far too much, and she believed they were not recognised for it. She argued that nurses were the ones who looked after patients and implemented treatment. In her view, the doctor prescribed the care but did not know the patient as much as the nurse.

I think nurses should be doctors, I think we nurse our patients back to health, we give them the treatment prescribed by the doctor, we look after them if they have pressure sores, we talk to their families quite a lot to say how they are getting on and we are the closest people to the patient when they are hospitalised (Abigail).

In response to the same question, Sapphire thought there was a big shift in nursing and that nursing had somehow changed from what it was. She stated that nurses had taken some activities from the medical staff.

I think there is a big shift on what nurses used to do and what nurses are doing now, we have taken over some activities from medical staff compared to what we used to do. However, medical staff do phlebotomy, cannulation, and things like that (Sapphire).

Interestingly, Sapphire said that phlebotomy and cannulation were done by medical staff. Obtaining blood and cannulation has long been done by nurses in clinical practice. Primarily this is what doctors used to do as part of their investigations, but nurses have been known to cannulate patients and take blood. It might be that this was new to her, or it might easily have been that she had had no opportunity to do so before. I could have asked her further questions on this, but she was reluctant to provide further information.

4.2 Ability to deliver nursing care

This theme discusses how nurses were able to deliver the nursing care they intended for patients. It illuminates and illustrates how nurses had the power to act in nursing care.

4.2.1 Freedom in nursing care

There were times when nurses believed that they worked independently within their scope of practice in accordance with their role specifications. What fascinated

me was that while they could tell me that they worked independently, sometimes it was unclear what they did independently.

> We do lots of things independently. I think we are working within our limitations and under competencies, so things that I do independently are things that I am competent in, and I know my limitations (Sapphire).

They could take blood gases, check the Power of Hydrogen (pH), the Partial Pressure of Carbon Dioxide ($PaCO_2$) and understood what was going on physiologically within the patient. Even though they could take blood, take blood gases, and administer appropriate medication, they were not authorised to interpret results. They were able to initiate processes, but they were not permitted to initiate the treatment. This was despite their belief that they were capable of doing so.

> Where I work, as soon as we take blood gases, we have to understand the pH, the $PaCO_2$, we have to understand if the patient is compensating, and when we see the potassium level, we ask the doctor to prescribe it, and we know what needs to be done. We know what to do, but we are not allowed to (Eliana).

It is worth pointing out that nurses have always done blood gases in most clinical settings. Experienced nurses have usually done this. Another highlighted constraint was the inability to prescribe medicines unless otherwise approved by the doctor beforehand.

Additionally, nurses said they could do skills such as looking after central lines and administering Total Parenteral Nutrition (TPN) to patients. They had to have some training and observe specialist nutritional nurses in action to do this. They were given the required knowledge to carry out those aspects of nursing care. If patients needed blood cultures done, they would do this without asking the doctor

for permission. The downside to this is that they were not permitted to request any investigations.

If I thought the patient was unwell, I wouldn't have to say, doctor can I take blood cultures; I'd just do it, but I am not permitted to sign the form for requesting investigations (Misty).

In telling me about their ability to do blood cultures, they implicated that they could do more and make decisions without doctors being involved. This indicated that nurses could have had agency if permitted. What came across here was that nurses valued undertaking the doctor's role. It made them value themselves and see themselves as capable of doing what doctors do. They talked about their capability of managing patients independently without any interventions from other health professionals, such as in wound dressing.

I knew what dressing to put on, I put aquaucel and made a decision to review it in 48 hours, and after about a week, we changed to jelonet, and it was brilliant (Gemini).

Nurses independently decided what dressing to use and when to change it and knew which dressings to use as an alternative at different stages of wound healing.

4.2.2 Teamwork

Teamwork was important to nurses as it enabled them to deliver what they saw as better and organised care. They said the teams were good, but they would contradict themselves.

I think we did have a nice team, it was just intense at times, so teamwork was really important, team dynamics were different on some days (Misty).

Misty said she worked in a good team but then said the atmosphere was sometimes intense. This indicated that things were not as rosy as portrayed. She enjoyed working on some days, while on others, she could not wait to get home. However, they appreciated the team effort as it is where they felt they supported each other. Most nurses placed teamwork at the epicentre of their work. They believed that to deliver quality care, they had to work together to achieve this.

We worked as a team providing the best care for patients, absolutely supporting each other as a team, making sure that we used the best resources possible (Ruby).

We worked as a team, we had one person scribing and one person looking at the time, one person doing CPR, one person giving medication, we were a full team looking after this patient, we obviously had a rapport, but we also made sure that other jobs were done (Emerald).

Teamwork was not just about nurses working in unison; it also had a meaning to them. It meant working with other health professionals, such as doctors. When nurses talked about doctors, they referred to junior doctors, and when they talked about medical consultants, they referred to them as consultants. Nurses preferred working cooperatively with doctors and valuing each other's input in care. They expressed the need to be listened to and respected in a team, especially by doctors. Some doctors were said to exclude nurses in decision-making and discussions about care. This made them feel as if they were not part of the team. However, consultants were seen as friendly and able to listen to nurses and involve them in decision-making and discussions of patient care. This made nurses appreciate working with them.

Working with consultants was so good, because they normally consulted the nurse also, if you suggested something to them, they would listen, they wanted you to feel

as part of the team, they never looked down upon you, they would ask for your opinion, some doctors and nurse managers would look down upon you (Ralph).

It was unclear why doctors were seen as uncooperative or not allowing nurses to participate equally in care. There was a struggle for dominance between nurses and doctors. Another struggle was between nurses and nurse managers. Managers were seen as hindering teamwork by not listening to nurses. They felt that managers were in a position to boost teamwork, but this was not always the case. They said that if managers respected them, this would make them enthusiastically deliver nursing care. Managers were seen as responsible for causing chaos in nursing care regularly. It was because managers were regarded as doing whatever suited them rather than considering those involved in the care. Some of the reasons were that managers would ask nurses to do other tasks instead of allowing them to nurse patients how they wanted to. They were seen as not allowing nurses to make independent decisions where they could. Another issue was that the managers would sometimes move nurses from one setting to another, causing anxiety among them as they were made to work in unfamiliar environments in which they had no relevant skills.

I work within my competencies and limitations, but I get sent to places like surgery; I am not a surgical nurse; matrons would say, you need to go there, just wash the patients, do observations, give them tablets and do the basics (Misty).

Sending nurses to unfamiliar settings without relevant nursing skills was seen as problematic as it only allowed nurses to deliver basic nursing care. Misty believed they should perform relevant skills related to that speciality rather than just providing basic care when asked how nurses would have wanted to work when they were sent to other settings. She saw the provision of basic care as potentially

dangerous. Providing basic care contributed to important aspects of care being missed or not attended to accordingly. Managers were said to be oblivious to the code of professional conduct, which states that nurses should be aware of their limitations and competencies in practice (NMC, 2018e). Ralph's view was that a manager should understand and work with nurses and not interfere in what nurses do. He saw an excellent manager as someone who believed in nurses and helped them by boosting their morale. According to Ralph, this was good for building nurses' confidence. He saw some managers as inhibiting good nursing care, while some were good at working with nurses and appreciating what they did. Some were seen as unable to improve staff morale by not allowing nurses to be themselves. He suggested that nurses should be authorised to provide the care they saw fit for patients, ensuring nurses felt valued for their contribution.

Communication was essential between nurses, doctors, and managers in building a team. Nurses associated good communication with good quality care given to patients. The communication nurses concentrated on most was between them and doctors as they felt it enabled continuity of care. However, the interchange was limited, doctors were seen as lacking communication skills.

> Doctors do not communicate very well with us, so from experience of witnessing poor communication between nurses and doctors in certain situations, there is a need for more training and respecting each other’s opinions (Ruby).

This might have been why they felt doctors were not engaging in discussing patient care with them. However, it was unclear what made nurses believe that doctors lacked communication skills. Some of the information raised about doctors’ interpersonal skills appeared to be personal opinions. Ruby had attended

a communication course, and she felt that it made her communicate better. On the contrary, she suggested that she probably needed more training to handle doctors. This could have been an admission that she was questioning her communication skills. She also talked about how difficult it was to override what the consultant had recommended. It was unlikely that this was due to communication skills. It might have been down to her role limitation and the overall responsibility and authority held by the consultant.

In addition to communication, nurses said they needed support from others in implementing nursing care. The support they needed from their colleagues was physical support. Doctors were providing professional support in guiding on how to care for patients rather than providing physical help. Nurses regarded support from colleagues and doctors as equally important.

> I felt supported on my ward by nurses, doctors and by my manager, it made all the difference (Petal).

They saw themselves working better when supported. They felt abandoned or lost when they were left to work alone without anyone around them. They were happy to be given help or instructions as they worked. When help was not there, it made some of them anxious or stressed. In some instances, support was limited, especially from other nurses. They said that helping each other was on tribal lines and excluded some. In those instances, they saw themselves as outsiders and isolated. Diamond described some nurses as a group of them. This group of nurses excluded anyone else from their circle.

There is a very face fit culture, there are people that would be a group of them, they work together, they would support each other but not others, they would even make sure that they all have breaks properly (Diamond).

The group mentioned were said to be against being challenged or questioned for excluding others. It was said that they made life difficult for those who expressed their views about their work practices. The nurses in a group arranged to work in a way that suited themselves rather than the whole workforce. This affected how others worked or delivered care.

4.2.3 Competence and knowledge

During discussions, an issue of competence and knowledge among nurses arose. Abigail told me about a patient who was originally admitted with diabetic ketoacidosis. She said that the patient was unresponsive when he was admitted, had raised Carbon Dioxide (CO_2), abnormal pH, and low oxygen saturations. In addition to this, the patient had undiagnosed prostate cancer and was not passing urine. The patient was confused and refusing treatment. Abigail did not seem to understand why her patient was refusing treatment and investigations. She saw refusal to comply as being stubborn and not cooperating. She was aware that the patient was confused but did not consider that her patient might have been hypoxic; therefore, this might have contributed to his behaviour change.

He was very forceful, there was no reason for him to behave that way, when he didn't want something, he would just say no, I don't want it. When we needed to do a blood test from his wrist, he wouldn't let anyone do that, I felt like giving up (Abigail).

It would seem that the patient was acutely ill and was refusing medical interventions because he was at the end of life. There was a need for the nurse

to understand the effects of the disease and how this contributed to the patient's lack of capacity. The nurse did not demonstrate knowledge of pathophysiology and the underlying pathophysiology of the signs and symptoms. Given this, it is likely that there was a limitation in how the nurse would care for the patient. It might have been that the nurse did not have the relevant knowledge to deal with the patient, or there was nothing more she could have done. Interpersonal skills could have been used to persuade the patient to cooperate even though they were confused. The nurse seemed to give up easily without trying.

Most nurses said that they had current nursing knowledge as they had done additional courses since qualifying. Some went to the extent of criticising University nurse education, saying nursing care was nothing but common sense.

> What we do is common sense, rather than apply what you have learnt at University, not being disrespectful, but I always say to my students go to University because you have to, but probably 90% of the job is common sense. Probably would just be easier to train them on the job than go to University (Gemini).

The course they valued most was nurse prescribing, which enabled them to prescribe medication, predominantly paracetamol. Most prescribed medications were non-prescription medicine which still required the doctor's authorisation in advance. This meant that most of the prescribing were done by doctors. It sounded as if the medication prescribed was prescribed by the doctor indirectly. The only difference was that it was the nurse who signed against the prescription. They knew what medication was required in certain conditions but had no authority to prescribe that medication. However, they said they could get doctors to prescribe any medicines if they wanted to.

I could recommend the administration of potassium, I haven't got the prescribing qualification, I know what doses are prescribed, sometimes I will say straight away, can you give 20mmols, I need it right now (Eliana).

Nurses saw themselves as knowledgeable in prescribing medicines but felt restricted by doctors who were thought to be above them. They believed that they did not know as much as doctors. They placed short courses as the basis for their knowledge. It is unclear what brought the thought of doctors knowing more and in what context this was seen. Nurses' view was that they could deliver care but could not make independent decisions as this was placed in the doctors' hands. A doctor has always had authority over nurses. Nurses constantly compared their authority and knowledge to that of doctors. There were complaints of feeling restricted in what nurses could do. They were concerned that they regarded themselves as knowing how to deliver the care patients needed but were held back even though they knew what treatment the patient would have.

They give me lots of knowledge on the best way to work, and then they make decisions that I can only use certain skills, so they are giving me knowledge but then pulling me back (Maya).

It was unclear what a *lot* of knowledge Maya had. She argued that she had enough experience and knowledge and could work alone without guidance. Despite this, she was not given opportunities to make independent decisions. The decisions which could have been made were unclear. She said decisions were made for her, and she had no power to work autonomously. In her view, she followed orders and had no freedom as a professional. Decisions made for her made her feel as if her knowledge was not acknowledged or valued. It was unclear who made

decisions for her. This is something I wanted to understand, but the information was limited.

4.2.4 Resources

Resources played a vital role in nursing care. Some nurses said they had all the resources needed to nurse patients, while others said the resources were limited or not fit for purpose. They were not always specific about what they meant when they said whatever they needed was available.

I think everything we needed was there, we had adequate resources (Sapphire).

Nurses who were concerned about resources raised an issue of quality and the selection available. They said materials were of lower quality than they would have wanted.

I think I have seen a decline in equipment in the National Health Service (NHS), such as dressings, aprons, gloves, and catheters. There is a limited selection of dressings; good dressings of choice are not there. It feels like they just provide cheap stuff (Misty).

The dressings which were regarded as appropriate for certain wounds were not always supplied. They did not see the replacement dressings as the best alternative. They were disappointed that they had no say in what dressings they should use. They knew suitable wound dressings, but they were not given their preferred choice. In addition, they said some equipment was not always working properly or was faulty. Eliana told a story where she had to use an infusion pump to administer potassium chloride. The infusion pump delivered all the potassium chloride within a few minutes due to it being faulty. This was dangerous because

potassium is an electrolyte and, if given very quickly, can cause cardiac arrhythmias, cardiac arrest, or death.

We checked potassium, she attached it to the infusion pump, when she went back to the patient, she came back to me and said the whole syringe has gone through, we did not make a mistake, the investigation concluded that there was a fault with the pump (Eliana).

When Eliana told her story, she was frightened and worried about what could have happened. She was certain that a similar incident could happen again in future. This could have been an isolated incident; however, there was a concern that the equipment was not always working in accordance. It meant that lack of equipment slowed nurses in delivering nursing care.

4.2.5 The environment

The clinical settings were divided into manageable units, which were seen as appropriate for different levels of care. This could be questioned as it might have been that nurses had never known anything different. The setup enabled them to care for patients accordingly.

The unit I worked on was only nine beds, we had the men's side and the ladies' side, the nursing stations were close to one another, we could see patients from the nursing station (Sapphire).

Nurses found the environment comfortable to work in even though they described it as very intense at times. It required more input than what they could provide. Misty felt that there were too many patients from different specialties mixed up together, such as alcoholics, gastroenterology patients and any other from any speciality who required extra nursing care. A few nurses thought the environmental setup could have been improved by collectively grouping patients

with similar conditions together. Diamond said that having patients together meant that she could provide equal nursing care to all of them. Separating patients with similar conditions did not allow uniform nursing care.

Nurses prioritised care where necessary. Sapphire mentioned a patient who had to be allocated a bed close to where nurses could easily monitor him. It meant that by being near the nursing staff base, it was easier to provide care. Emerald also echoed something similar to what Sapphire said. In her case, she discussed a patient who needed monitoring in the resuscitation (Resus) bay. The patient was critically ill and needed urgent attention; the resuscitation area was specifically designed for critically ill patients. It was where all the required resources were located.

> We looked after the patient in resus, resus has four beds, all the things we needed were there. I think it was in the best resus cubicle, because it had a lot more things there, like the Lucas, for example (Emerald).

Prioritising care enabled nurses to meet patients' different requirements and different levels of care simultaneously. Some clinical environments were well controlled, while others were busy depending on the patients they had.

4.3 Constraints in nursing care

Additionally, constraints identified included the workload, staffing levels, difficult patients, seriously ill patients, aggressive patients, time, policies, guidelines and protocols, and conflict with other health professionals.

4.3.1 Workload and staffing levels

The workload and staffing levels concerned nurses as they saw themselves having too much to do. What contributed to increased workloads was reduced staffing levels. Nurses had to look after several patients, mostly on their own, without help available. It restricted them to doing basic care for each of them.

> It was a big responsibility to look after 14 patients alone and to do the very basic for each of them, so there was a sense of feeling the pressure (Petal).

Nurses talked of having *bucketful lists* of things to do every day. This was interpreted as an outcry against the immense workload they had. In addition to their workload, they had patients who needed specific attention. Ralph said he would have about ten patients on his ward who needed logrolling due to spinal cord compression. Those patients needed at least three nurses to logroll. When there were fewer nurses on duty, it was not easy to do so. It was unclear how those patients were turned when they were short-staffed. There was a potential that those patients could have been turned inappropriately. However, there was no evidence to suggest so.

Nurses were aware that having fewer nursing staff on the wards hindered them from providing nursing care. According to Eliana, there were fewer nurses because nursing posts were being reduced, leaving a few responsible for the care. Eliana felt that some patients were not getting adequate care as a result. She referred to staffing levels as better where she worked. The word better denotes that it was not as severe but was somehow similar to other settings. The reduced number of nurses was further complicated by some nurses calling in sick.

On the wards, they always have staff shortages, it has a big impact on the patient because the patient is not getting the proper care, it is not the nurses' fault, but if they are short staffed, they can only do what they can, they haven't even got time to educate patients, sometimes somebody rings in off-sick, I have seen many things (Eliana).

Eliana further said that she had seen many things; this implied that there was more to what she was saying but would rather not say. It sounded worse than how it was pictured. According to her, nursing care was done but took longer. Sapphire gave an example of what happened in her department when they were short-staffed.

I worked in Coronary Care Unit (CCU) on a night shift; there was only a sister, me, as a staff nurse and a nursing care assistant. Staffing wasn't good enough; I couldn't give my immediate time to patients, nobody could help us, staff shortages are not just in nursing; they are across the hospital (Sapphire).

Sapphire said that staffing levels were good on most shifts. Despite this, where she worked was not immune to staff shortages. It is safe to say that overall, staffing levels were a major concern in nursing care. Ruby pointed out that staffing was never good where she worked, and when they were short-staffed, there was no action taken to address it. Ruby felt they needed to employ more nurses or draft additional nurses to deal with an increased workload. Agency (locum) or bank nurses were used to cover shifts. There were feelings among nurses that agency nurses were not prioritising nursing care.

We have a lot of agency nurses that work on our ward because we have vacancies. Some agency nurses don't care, they are happy throwing drugs out three times a day and thus it, so when it comes to nursing skills, they don't want to know (Gemini).

It was claimed that they only provided basic nursing care and administered medication. While they contributed to the number of nurses needed to deliver required nursing care, they were blamed for being ineffective. It was unclear why

agency nurses were not appreciated as they were also qualified and competent. Everyone was overwhelmed with the workload, and they needed to be appreciated rather than blamed. The information from the stories indicated that nurses were regularly doing work meant for several people. Emerald had to coordinate the care in her department and delegate some duties to care assistants. She stated that she was doing most of the work as care assistants were not qualified and could not perform some skills meant for qualified nurses.

I was coordinating minors because I was the only nurse on that night shift, so the best thing we could do was do as best as we could; we needed at least one charge nurse coordinating, two staff nurses and two Health Care Assistants (HCAs) ideally (Emerald).

Short staffing hindered Emerald from prioritising patient care, but also, she could not spend time with patients. She gave an example of patients being taken to the wards from ED without having been fully assessed. Short staffing contributed to high levels of stress among nurses. In addition to reduced staffing, nurses were required to deal with what they saw as excessive paperwork, which took them away from patient care. The paperwork was related to nursing care, fluid balance and incontinence. They stated that even when some patients were independent and not at risk of developing pressure sores, they were still required to be checked. This was done and documented hourly. Nurses felt compelled to do so even though they did not see the necessity. Abigail felt that they should have had a choice in documenting what they considered relevant in the care. She knew that documentation and fluid balance were part of her role. Fluid balance is important as its core is homeostasis. Patients need to be hydrated to reduce further complications during hospitalisation.

4.3.2 Patients

Nurses looked after varied patients who indirectly hindered the nursing care of others. Patients who hindered others' care were either difficult, violent, or critically ill. Critically ill patients took most of the nurses' time. This was because they needed constant nursing care individually. The violent or difficult patients were a security risk for staff and other patients. This led to some patients being deprived of nursing care.

> We had two very poorly patients, one each to look after, so they were a priority over anything else (Sapphire).

When Sapphire described the patients as very poorly, it meant they were not just critically ill but needed more care, constant close monitoring, and reassurance. These patients can deteriorate quickly, so the nurse needs to be able to detect any slight changes that can occur in seconds and take appropriate action. The nurse must constantly be by the patient's bedside. Unfortunately, this means that the nurse might not have as much time to attend to other patients who also need nursing care.

Some patients were admitted to environments that did not suit their medical needs. Sapphire gave an example of a mentally ill patient who was paranoid and perceived nurses as a threat.

> We had a patient in CCU who was having mental health issues, decided to lash out and chase us around the ward on a night shift, thinking we were a threat to him, he actually started being aggressive with us (Sapphire).

The mentally ill patient had to be a priority in this case. Sapphire ensured that he received appropriate care and that other patients were not harmed as he was

aggressive. It is unclear what he did that made Sapphire say he was aggressive. She expressed disappointment that she could not give all the patients the care they needed. Aggressive patients tended to be alcoholics, while some were aggressive for no specific reasons. This had an impact on the care patients received. When nurses spoke about nursing care, they also talked about medical interventions as if they were nursing care. They were not discriminating between nursing care and medical interventions.

4.3.3 Time

Nurses valued time in nursing care, but it was not always available to fully address patients' care needs. They wanted time to talk to patients, to understand their feelings, care needs, and expectations. Nurses said they had lots of other things to do; this meant they spent less time with patients than they would have wanted.

> There is not enough time to nurse patients the way nurses want to. I would like to actually go to the patient and spend a good ten minutes talking to them, getting to know them and their needs (Emerald).

> I think nurses don't spend enough time with patients because of staff shortage, and if it's full capacity on the ward, it's very difficult, so I still think that the big thing is staffing levels (Ralph).

They did not stop working during their shifts. There were times when they could not even have a drink or attend to their own basic needs. They felt that they had a duty of care to patients; hence, they kept working. It can also be said that they had no choice as they had no other means. There were indications that nurses were constantly working, and even though they were doing so, the work they did was never-ending. This led them to complete their shifts hours late. Time played

a fundamental part in nursing care, yet nurses could not have it on shifts. The reduction in staff numbers contributed to excessive workloads. This, in turn, did not allow nurses to spend time with patients or have enough time to deliver the care they intended. It made nurses feel detached from the very patients they wanted to feel close to.

4.3.4 Policies, guidelines, and protocols

Policies, guidelines, and protocols were regularly discussed. Nurses said they followed policies, guidelines and protocols when delivering nursing care. These were favoured by some, while some viewed them as prescriptive and restrictive. Those who favoured them said they provided step by step guidance on how to provide care, while those who did not appreciate them said they restricted them from making independent decisions. Gemini stated that policies made her feel restricted and unable to care for patients freely.

> I feel as if I can't care for a patient from my own nursing professional perspective because am tied to policies, you've got your own professional opinion for a particular thing when caring for a patient but then there is a policy that will stop you, that's what I struggle with (Gemini).

Nurses felt that policies were not always what they should be. They were intended to benefit nurses; instead, they made nurses' work difficult. One of the negative aspects of the policies was that nurses could take blood for investigations, but they were not allowed to request investigations or review the results. They could look at the results and tell the doctor what they were, but they were not allowed to act even though they understood what those results meant. The policies gave

power to the doctor and stipulated that requesting blood investigations or reviewing the results was a doctor's role.

Gemini talked about a patient who was admitted with leg ulcers and needed dressings changed. However, she could not change dressings as the policy stated that only tissue viability nurses could change them. She knew what dressing could be used but was not allowed to do so due to policy restrictions. She eventually changed dressings as tissue viability could not see the patient. The wound healed well under her instructions and interventions. The patient was later discharged without any complications. This demonstrated that Gemini and her nursing team had the knowledge to manage the leg ulcers but were hindered by policies.

On the other hand, some nurses were happy to have policies, procedures, and protocols as they provided a routine. They saw routine as a guide to nursing care.

We have protocols to follow and then deliver the nursing care in accordance, I think it's good, you need to follow certain procedures and policies on how to deal with certain patients, so imagine if we didn't have that? (Amber).

Policies give me routine. I like routine when am working. Routine, routine, yeah, having a good routine, when you are having a routine, you watch your priorities (Emerald).

Emerald appreciated a routine as she thought it allowed her to deliver nursing care systematically. Routine meant doing different activities in sequence as a world order for them. It appeared to be a fixed way of working to meet patients' needs every day. It could be that it worked for them, and they could deliver the nursing care they thought was needed. It was difficult to understand how this took into consideration the individuality of each patient.

4.3.5 Conflict

Nurses said that it was not always easy working with some colleagues. They dreaded going to work because they did not feel appreciated by them. Initially, nurses were reluctant to talk about their colleagues. It took them a while to go into detail about how they worked with them as this was a sensitive issue. A few individual nurses were said to be hostile to colleagues.

> Sometimes people you work with can be a challenge, you dread going to work because you feel like you are not appreciated by your colleagues (Misty).

It sounded like infighting or even bullying that occurred among themselves. Diamond said that it was a very tense environment at times. The conclusion was that group dynamics were in question. The conflict did not just occur among nurses but also between nurses and other health professionals. Petal said doctors saw themselves as *gods* and viewed nurses as nothing. Nurses wanted to be more involved in decision-making about treatment; however, they saw things differently from doctors. Petal said that she was the nurse who sat with patients and families. She talked to them and was more involved than doctors. It made her believe that she should be allowed to have a say in patient care. Another example where conflict existed was between biomedical scientists and nurses. Biomedical scientists made recommendations about care and carried out scientific and laboratory investigations for diagnostic and treatment purposes. Sapphire pointed out that biomedical scientists had no clinical background, and therefore, they were not in a better position to understand patient care than them. She said nurses were very holistic in care, whereas biomedical scientists were research-focused rather than hands-on.

I have biomedical scientists who aren't clinical; I can have a little bit of annoyance when they do not understand what I am doing with my patients (Sapphire).

It was clear how the role of biomedical scientists differed from that of nurses. However, other health professionals shared similar roles as nurses, for example, tissue viability, who were made up of nurses. This caused conflict as there were different views on how patients should be managed. There was an impasse between tissue viability and nurses in some cases, which meant that the patient's treatment was delayed. Nurses could not treat the patient until they had had permission from tissue viability. Managers were also seen as unhelpful in patient care; they were accused of interfering. They were said to be telling nurses what to do rather than allow them to prioritise the care the way they saw appropriate and make decisions independently. This meant that they were not able to deliver nursing care the way they intended to.

They need to ban managers; if the medical team and the nursing team worked together, nurses would feel fine (Ralph).

On other occasions, managers were not acting when nurses were short-staffed. This did not allow nurses to deliver what they called quality care.

4.4 Collaborative nursing care

Nurses worked in collaboration with other health professions in implementing care. Collaboration here means the involvement of more than two parties working together. I saw it relevant to look at how nurses worked with other health professionals, viewed themselves among them, and saw those who collaborated with them. This would indicate if they had agency in nursing care.

4.4.1 Nurses' self-view

Nurses saw themselves as inseparable from doctors, and when they referred to patient care, they used the term *we.* There was an indication that they saw themselves equally involved in care, just like doctors were and had a sense of belonging to the same group. Sapphire implied that she was treated as an equal in decision-making; however, some saw the doctor as in charge and responsible for making decisions about patient care. They claimed doctors were not always more knowledgeable as they would sometimes teach them patient care. In contrast, some saw themselves as *just a nurse.* They saw themselves as having a lesser status than doctors. They felt that nurses' responsibility was to escalate to doctors when they had concerns about the patient.

The doctor in charge made decisions about what needed to be done, I am just a nurse, it is the duty of a nurse to escalate to the doctor if the patient is deteriorating (Emerald).

Some nurses did not value their status and contribution to patient care when they said they were just nurses; I saw this as acceptance of inferiority. It emphasised a belief that nurses were lower in status and less important than doctors. It could have meant that they questioned their capability to work as equals with doctors. This suggests that nurses saw themselves as nobody in care. They also said doctors did not respect their opinions. The word opinion denotes that there were no scientific facts to back the nurses' views. They thought doctors perceived them as lacking knowledge because of being a nurse. When asked why they thought doctors did not respect nurses, Ruby said doctors respected nurses but were generally not respected.

I think doctors sometimes perceive nurses as lacking knowledge because of being a nurse. I am not saying doctors don't respect us, but the way they would override you, they see their training as superior to nurses' (Ruby).

Ruby explained that she was aware that doctors had the final say and overall responsibility; hence they would sometimes overrule nurses when making decisions. Nurses viewed themselves as valuable and believed that all nurses should be appreciated. They admitted, however, that doctors were trained in more depth than them and that they understood more. This could have enabled doctors to take whatever course of action they wanted without being challenged by nurses. There was an indication that power and authority were tilted to one side, to the doctors' side. Nurses wanted to have a voice, be listened to, and be valued. They did not see this happening in practice. They were frustrated that they had knowledge and experience, but this was not always considered by other health professionals and in general. Nurses felt that a negative image was always depicted despite them playing a vital role in care.

4.4.2 Doctors as seen by nurses

Doctors were viewed as the elite or superior in knowledge and status compared to nurses. Superiority is about power; for someone to think they are superior or are seen as such, they have to compare themselves to something (Mignolo, 2021). Nurses claimed that doctors ruled the place, and they had the ultimate power in patient care.

Doctors rule the place, they don't necessarily do a good job of it, but the power always lands with them, doesn't it? The doctor stops us being a nurse, the doctor always overrules us whenever they want (Abigail).

There was an impression that they had no voice and doctors did what they liked. They alleged that they had to consult doctors regularly, whether be it for prescribing, prescribing errors or when they wanted them to write something. On some occasions, doctors were found hindering nurses from delivering nursing care by not accepting what nurses suggested.

When nurses were implementing nursing care, they noted that doctors instructed them on what to do even when they knew what they were doing. They saw doctors as not acknowledging that they had a good knowledge of what they were doing. It sounded as if doctors were not allowing nurses to work independently. Nurses expressed that they had no choice except to follow doctors' orders. They said that if they did not follow the doctors' orders, the doctors *would go mad,* as they were protective of their patients post-operatively, which meant nurses had to follow what was instructed strictly.

If we didn't follow his orders, the doctor would just go mad, they are very protective of their patients. If they have performed heart surgery on that patient, you have to follow strictly what they want. Sometimes they just raise their voices when they get stressed or angry (Eliana).

It was also said that sometimes doctors would raise their voices to nurses when they got stressed or angry. The nurse appeared to get upset when she spoke about this. They believed that they had to implement whatever plan of care was put in place by doctors. Some nurses said they would challenge doctors if they did not agree with the plan of care, while others said it was not worth challenging doctors because the likelihood of them changing the plan of care was minimal.

The plan of care was put out by medics, and so I was to do whatever was on the plan of care, such as giving intravenous (IV) fluids. I think doctors feel they are gods and see nurses as nothing; I have to do what they tell me (Petal).

The consultants, however, were regarded as the most approachable in discussing patient care. They listened to nurses' views and were more likely to listen, while some doctors were considered difficult to talk to. Abigail said that she had to bypass doctors and talk to consultants if she had concerns. This was to get them to listen or implement intended care.

4.4.3 Related professions

The health professionals who delivered the care were part of the Multidisciplinary Team (MDT). Professionals involved included doctors, nurse specialists and other professions. Some of the care provided by other health professions was seen as being part of nursing care. Nurses said that when they cared for patients, it was not just about what they thought the patient needed; they had to consider the input of the MDT in the process. The care had to be agreed upon by the MDT rather than by nurses alone.

When I care for patients, it is not just about what I think; we multidiscipline the care we give, we must agree the care with other members of the MDT (Petal).

Nurses said that having the MDT was beneficial in allowing patients to receive care from different perspectives; however, there were limits on what nurses could do in some aspects of care. Nurses were not always comfortable telling me their whole stories. They would ask me to pause the recordings on some occasions so that some stories were not captured. They felt that the information was too

sensitive to be recorded. The information which was discussed while the recordings were paused was not included in the study.

4.5 Summary

This chapter describes, discusses, and presents the findings from the stories as told by the participants. It also brings in what I understood as the researcher and provides a deeper meaning of what was captured and explored. The interpretation involved understanding stories and what they were telling individually and as a whole. The themes that emerged were experiences and responsibilities in nursing care, the ability to deliver nursing care, constraints in nursing care and collaborative nursing care together with subthemes as presented in this chapter. Nurses were able to identify areas where they saw themselves free as well as constrained in nursing care. The next chapter provides a deeper meaning, interpretation and poiesis of what emerged from the stories.

This chapter presents key constitutive themes that emerged from the stories through interpretation and poiesis. There are two ways of interpretation; the first is bent on discerning and deciphering the meaning, and the second is bent on inventing new meanings and effects that are otherwise than meaning; poiesis is that which is otherwise than meaning (Heidegger, 1962; Saum-Pascual, 2020). My positionality is that it is necessary to step back and forth within ways of interpretation if poiesis has to manifest itself. It seems that interpretation is always conducted in the space between interpretations of interpretation (Ricoeur, 2004; Caputo, 2018). In other words, this chapter clarifies the participants' experiences, the meanings of what the stories revealed, and invents new meanings and effects not thought of before. The themes that emerged in poiesis were nursing in clinical practice, characteristics of power and authority, structuration, the cognitive empire, and colonialism.

5.1 Nursing in clinical practice

The stories revealed that the role of a nurse in hospital settings focused on assessing and monitoring patients, doing vital signs, administering drugs, providing basic nursing care based on the activities of daily living, referring patients to other health professions, wound dressings, and documentation of nursing care. This is within the nursing role specification, but nursing care should not be limited to these aspects only (Hemingway, 2013). In wound dressing, policies dictated that this was tissue viability nurses' responsibility. Health

promotion, preventing disease, spiritual support, knowledge development and other varied aspects of care were not usually addressed (RCN, 2014). Therefore, nurses could deliver some aspects of nursing care, while some were not considered. There is an emphasis that nursing care should focus on the whole person rather than on a particular aspect of the person or a particular pathological condition (Hinkle and Cheever, 2018). Additionally, nurses performed extended roles on an ad hoc basis; these included taking blood, cannulation, and prescribing medications; however, not all nurses could do so. Performing extended roles was probably occurring to help doctors speed up patients' treatments, as not doing so could have slowed it down. Extended roles are what has been traditionally done by doctors, and these had limitations, even though they were part of nursing care.

The evolution, change and advancement in nursing seems to be the inclusion of extended roles in the nurse's role. The participants, however, were unable to perform other extended roles such as minor surgery, complex care interventions or other invasive treatments, nor were they competent to do so, in contrast to Burns (2019) and Philips (2019), who say nurses now perform these. It might be that nurses in other roles within the hospital did so, but the participants did not mention this. This position would not necessarily have enabled agency in nursing care. Nurses had diverse roles and tasks, as suggested in the literature (Scott et al., 2014), and even if they had agency, it would not have been easy to implement them all as they were too many to consider at any given time. In other words, having diverse roles and tasks impeded agency (de Simone et al., 2018; Vassilicos, 2020; Gottlieb et al., 2021). The agency they had was on implementing basic

tasks as it is where they had independence rather than in treatment and extended roles. It is fair to say that agency was extremely limited or non-existent in some cases in nursing care. Considering that the NMC (2018a) has moved nursing from competence to proficiency, one is inclined to expect nurses to have agency in nursing care. However, it could be questioned what is meant by proficiency. The NMC does not make it clear either whether being proficient entails agency.

5.1.1 The power to act in nursing care

The participants saw the ability to deliver nursing care as crucial in clinical practice. Nursing care started mainly after the doctor had prescribed pivotal care that the patient needed during their hospital admission. Nurses were not seen as autonomous equal partners with doctors in care provision (Carryer, 2011; Oshodi et al., 2019; Burns, 2019), nor did they have a well-defined area of expertise they intended to have when Stein et al. (1990) revisited the doctor-nurse game. It was evident that nurses did not have as much power to act as they wanted (Fox and Alldred, 2018; Brown, 2019). They could only give basic care and complete relevant documentation before the doctor's assessment (Farrell, 2001; Burns, 2019). They had prescribed roles and responsibilities that limited them to the nursing care they delivered. Some nurses saw this as having freedom in delivering care within certain specifications.

The first freedom was freedom under the law (Harrison and Boyd, 2018), and the second was working under the code of professional conduct (NMC, 2018e; Vassilicos, 2020). The code of conduct seemingly has two elements to it. Firstly,

it is for action; secondly, it is for inaction. Nietzsche (2017) says that the ancient Sceptics said that they must act; therefore, a code of conduct was necessary for them, while the Buddhists said that one must not act, and they devised a code of conduct by which one detached oneself from the action. Both freedoms require nurses to recognise the limits of their competencies. Some might say that working within the law or the code of professional conduct is not freedom (Berlin, 2013, Baggani, 2016). The absence of restrictions would be problematic in nursing as the safety of patients is paramount. It is about patient safety versus agency. Patients are there to be protected; however, it could be said that nothing untoward would be expected as nurses work within their competencies and in the patient's best interests. The agency discussed, however, was within nurses' prescribed roles and responsibilities, the professional code of conduct and the law. Nurses were free in some aspects of nursing care, but their ability to act was constrained by factors within which they were free to act on. They had what was seen as individual freedom (Harrison and Boyd, 2018). Individual freedom was that which enabled them to decide when to do something as an initiated act, such as administering a drug. It occurred as part of the daily nursing activities that nurses do. The nurse did not need to be told what to do but initiated the nursing care they knew the patient needed or had been prescribed by the doctor. They could deliver certain aspects of nursing care but could not fully act on them because, somehow, they had restrictions or limitations on their actions.

Gottlieb et al.'s (2021) positionality are worth bearing in mind, as during the Covid-19 pandemic, nurses were placed in the spotlight because their knowledge

and skills were desperately needed; they were encouraged to exercise agency. It implies that nurses could have had the ability to take responsibility for the management of the patient independently, guided by their knowledge and skills, without being instructed by the doctor. Gottlieb et al. (2021) do not detail the tasks in which nurses could have had agency. In this study, the agency nurses could have had would have been the ability to initiate care, including extended roles, assess the patient, make decisions about the care they were competent in, and implement that care independently without consulting others in other professions first. In other words, nurses' agency would have meant using their skills and knowledge independently, implementing tasks and taking action with freedom, and having power and authority to deliver care within their scope of practice without asking the doctor or waiting for the doctor to act, for example, and having unnecessary limits. It would seem that this is what nurses want.

5.1.2 The restrictions in nursing care

Several factors restricted nurses in nursing care. Firstly, the restrictions were within what they could do. An example was prescribing drugs, they could prescribe some common drugs such as paracetamol, but they were not allowed to prescribe drugs such as potassium chloride even though they could request the doctor to prescribe it. In circumstances where they could prescribe, the doctor had to approve it first. I saw this as a signature exercise as the nurse signed the drug chart on behalf of or in the absence of the doctor. It felt like an act designed to save the doctor's time rather than agency to the nurse (Costa et al., 2021; Eekholm et al., 2021; Pursio et al., 2021; Setoodegan et al., 2019). This confirms

that major decisions about treatment or care are traditionally within the domain of medicine; nurses often need to refer to and get some form of authorisation from a member of the medical profession when implementing specific care or interventions (Villa et al., 2012; Bagnasco et al., 2020). In their stories, nurses had to go to doctors for something, whether it be prescribing, prescribing errors or if they wanted the doctor to write something. It confirmed that the doctor is still the ship's captain (Carryer, 2011); it seems the doctor rules. It meant that nurses looked up to the doctor to make decisions and take action in patient care. However, it was unclear if doctors hindered agency in nursing tasks and actions. Secondly, they could take blood for investigations from patients, but they were not allowed to request the investigations or interpret the results when they received them, even though they could do so. They could tell the doctor what the blood results were, but they were not allowed to analyse them. Thirdly, nurses only assessed patients for nursing problems. Even if they identified them, they could not decide what nursing care or interventions the patient would need until the doctor medically examined them and decided what care they needed. Fourthly, nurses were mainly able to provide nursing care that doctors prescribed. Fifthly, nurses were competent in many aspects of care but were not allowed to implement the care despite being competent. It meant that they had to leave those aspects to other professionals such as doctors to do them. Sixthly, some resources provided to nurses were not of good quality or their own choice.

The care delivery systems such as care plans, care pathways, policies and guidelines put in place guided nurses as well as restricted or constrained them in

what they did. It seemed as if nurses were free to deliver nursing care required by patients, but at a closer look, freedom was limited. There is a talk of nursing evolving and nurses being able to do more. According to Burns (2019), the nurse's role has extended, and nurses are now significant partners with other health professionals and service users in care provision. Nurses might now be doing more, but they were unable to do so unless doctors approved. I do not see freedom as the literature seems to claim. Maybe, in theory, nurses have freedom but, it does not seem so. It brings to mind Joshua Nkomo, who once said that the hardest lesson in his life was that he did not realise that a nation could win freedom without its people becoming free (Nkomo, 2001). It feels as if nurses had freedom in principle but not in practice. It is important to say that I am not suggesting that nurses should be unrestricted. Here I am pointing out that in some cases, nurses were restricted excessively to the extent that it prohibited the performance of some of the skills they were competent in. Maybe here I see this from my lenses. It reminds me of a quote that is claimed to be from Nietzsche, which says that those who were seen dancing were thought to be insane by those who could not hear the music. I hope here I am not in my fantasy world, and those reading this can also hear the music. On the other hand, it might be that I am saying something that can be frowned upon. On this, Nietzsche (2014) says that we often refuse to accept an idea merely because the tone of the voice in which it has been expressed is unsympathetic to us. Nevertheless, I am hopeful that there is some sense in what I am saying.

Nurses raised a few issues, such as short staffing levels and lack of time in nursing care. According to them, if something adverse happened due to short staffing, short staffing was not considered as a contributing factor by managers. They feared being disciplined regardless. The disciplinary action they were mostly concerned about was losing the right to practice as nurses. It is worth remembering that the NMC (2020) takes action to deal with individual nurses whose integrity or ability to provide safe care is questioned to maintain quality and standards of care. This affected how nurses performed some nursing skills that could have benefitted their patients. It led me to ask them what they thought nursing care should be like.

5.1.3 Rethinking unthinking thinking in nursing care

I see this as reconsidering nursing care in thought with the view to adjusting it and the reversal of held thoughts, attitudes, knowledge, and beliefs, and relearning that which has meaning (Koh, 2015; Mpofu and Ndlovu-Gatsheni, 2019). Goodwin (2015) suggests critical self-reflection but stops short of discussing rethinking unthinking thinking in nursing care. Nurses voiced that they did not see themselves as having the ability to deliver nursing care needed by patients at times. However, when asked what they felt they should be doing, they talked about the need to spending more time with patients (Eekholm et al., 2021). There was nothing new mentioned which could have had a new meaning in nursing. I was expecting at least some thought on the direction that they felt nursing should take. I had anticipated something new and unique that nurses felt should be incorporated into nursing care. When important new evidence

undermines the old and predictions do not hold, individuals or groups must rethink their premises (Wallerstein, 1991). What is missing is the rethinking unthinking thinking of the purpose of nursing or questioning what nursing is or what direction it should take other than incorporating extended roles. Nurses suggested that they should be spending more time with patients to get to know them. Some thought that they should perform extended roles rather than other aspects of the nursing role. It may be because nursing is based on the medical model (Frechette and Carnevale, 2020); therefore, there is a notion that nursing should mirror medicine. In other words, nurses could only think along medicine's epistemic knowledges. They were unsure what nursing was nor what the role should be besides what they did daily as a routine (Farrell, 2001; Burns, 2019). They found it difficult to suggest how nursing should be developed. It might be, at least in part, because they had difficulty in saying what nursing is. I am not saying that nurses have no thoughts or suggestions; here, I am trying to encourage the search for a new paradigm that would take considerable time and effort to construct. In rethinking unthinking thinking, there is a need to introduce or deal with new ideas and issues needed in nursing care. There might be a need to learn to unlearn to relearn in nursing.

Even though nursing is regarded as a profession that has evolved and continues to evolve, it seems that some aspects have changed, but others have not. It could be the new visibility which is the old. Merleau-Ponty (1969) believes that what is visible in the painted self like a painted mountain is new visibility at most tracing out the old. Nursing appears to be tracing out the old into the new, the new which

is clouded. Nurses seem to be looking themselves in the mirror, but the mirror is invisible (Merleau-Ponty, 1969). This is to say that nurses might have an image of themselves that is not what it is. What seems to be happening is that nurses want to lean towards the doctor's role of treating patients rather than the nursing one of providing care. Nurses are nurses, not doctors; therefore, it might be that there is a need to refocus on nursing, understand what nursing is and how it can be developed further. Nursing has always been taught and practised similarly since it began. This investigation points to an epistemic crisis or epistemicide in nursing. Sartre (1963) would say that this is walking a lie, meaning that nursing is no longer what it should be or what it was, hence the need to rethink and unthink thinking in nursing.

The literature emphasises the importance of including extended roles in nursing care instead of challenging this ideology (Burns, 2019; Phillips, 2019). When there is a belief in something, individuals are tempted to note only the evidence that supports it and avoid or dismiss any pointing another way (Henderson, 2013). It seems nurses are happy to go with extended roles as a focus to developing the nursing role. It could be suggested that maybe there is a need to reflect and adjust to contemporary nursing rather than mirror other professions. The issue which keeps resurfacing is that there is no clear definition of what nursing is. This could mean that the nursing role is unclearly defined, and as a result, nurses have no power to define their role and responsibilities and work the way they feel they should.

5.2 Characteristics of power and authority in nursing care

In the healthcare system, like in any other institution, power and authority have a role in care delivery. Nurses raised issues that were related to the characteristics of power and authority in nursing care. Power is a commodity that can be utilised to secure intended goals when possessed by individuals or a group (Hobbes, 2017). The power and authority that nurses talked about were what they had or wanted to have or other professions' and the institution's power.

5.2.1 Power and authority in nursing care

Power is an organised hierarchical coordinated cluster of relations and, in the substantive sense, does not exist (Foucault, 1980). However, some form of power and authority exists where there is a structure. The term *power* here refers to nurses' ability to control and influence the actions of others and other health professionals, give orders, and have those orders obeyed with legitimacy. Nurses are professionals and should have powerful influence and authority in their field. Nurses implied that they had limited power and authority. It was so because doctors made independent decisions about medical treatment while nurses assisted patients and provided a supportive role for doctors, as suggested by Manias and Street (2001). Doctors were a dominant group as per Rooddehghan et al’s (2015) position that in a hierarchical system, the dominant group has the power to control and silence the other group, promoting a systematic, pervasive, and recurring inequitable relationship.

Doctors were said to overrule nurses whenever they wanted to, and they ruled the place. In other words, they were able to do as they pleased. This indicated that doctors had power and authority over nurses. It could have also meant that doctors could dictate whatever they wanted nurses to do in care. The power nurses had was diminished, which contributed to them suffering a loss of control and therefore deprived of elements of self-respect (Krabbe, 2021). Doctors have always had the privilege of making decisions and instructing nurses about the care patients need. It is important to say that doctors have a statutory duty to maintain and continuously improve clinical standards through clinical governance (Burns, 2019).

The hierarchical structure regarded nurses as essentially powerless and able to exert influence only through indirect, manipulative strategies, which only reinforced prevailing power relations (Fernandopulle, 2021; Friesen-Storms et al., 2015). Nurses preferred a flat hierarchy instead of a structured hierarchy to have freedom in nursing care or to have the ability to deliver and make decisions about the care they felt their patients needed, even though they did not directly say so. While nurses said they made care decisions, they had limited decision-making powers granted to them. Even if nurses made any decisions, those decisions could easily be reversed by doctors whenever they wanted. Any care that nurses would have liked to be given to patients could have been stopped at any moment. Nurses were powerless and marginalised in decision-making because of the status they occupied (Juanamasta et al., 2021; Sholehah et al., 2020). It confirmed that the powerless find themselves situated to take orders and rarely have the right to give

them (Dohal, 2022). Nurses were in this position of taking orders from doctors without any ability to do the same and with very little power to argue with the doctor about the orders received (Juanamasta et al., 2018; Darmayani et al., 2020). Nurses were institutionally placed into roles of powerlessness, and they did not assert themselves either individually or as a collective. They found themselves having varying degrees of powerlessness depending on how they situated themselves (Bertero, 2010). Nurses wanted to believe that they were in charge, but they also sensed that they were not (Juanamasta et al., 2021). It led to nurses not being bothered to make decisions that they knew could be ignored, hence why they probably felt that something was stopping them from delivering the nursing care the way they wanted to. They said that there was something unspecific making them hold back. The reason could be the power and the authority that doctors and the system held. On the other hand, nurses were restricted by policies, guidelines, the professional code of conduct, to name but a few. These could be some of the reasons that stopped nurses from delivering nursing care the way they desired.

It was evident that nurses did not hold as much power as they would have wanted. The powers that were at play were coercive, legitimate, referent and information power. In coercive power, nurses feared being punished through internal disciplinary procedures or the code of conduct. They did not challenge the code of professional conduct as they felt it protected patients from harm. What was of concern to them was losing their right to practice, which meant that they were apprehensive about performing some nursing skills. The institutions,

managers and doctors were believed to possess legitimate power while nurses were subordinate. Some nurses appreciated the leadership, while others thought that managers were not helpful in workload allocation. Nurses were regularly moved from their usual working environments to work somewhere else (Bucknall, 2003). It meant that they could not use some of their nursing skills in unfamiliar environments where they had to work (Möller et al., 2021). They also felt that managers were not listening to them; this, in turn, caused low morale to staff who were then disgruntled to work. Nurses felt that they had no say or had no voice in the care that patients needed at times. In referent power, nurses felt that some in the management were on their side and supported them in getting the work done. The medical consultants were said to provide the support that every nurse needed, and they listened to them, while junior doctors did not seem interested in listening to nurses. In information and expert power, nurses saw themselves as less informed than doctors. It made them regard doctors as the most appropriate individuals to make decisions about the care that patients needed. It simply meant that nurses stepped back in some decision-making about patient care.

The legal authority appeared to be enforced through the code of professional conduct. It was not direct authority but was there to remind nurses of their responsibilities and how to conduct themselves as professionals. Nurses had charismatic authority, which they used to charm their way through while working with other health professionals. It might be because nurses were trained in interpersonal skills, but nursing is also about compassion and empathy. While a

discussion on authority could continue, the information that has been discussed provides a snapshot of how nurses worked and what power and authority they had or what power and authority affected them. Overall, it could be said that nurses had limited power and authority in nursing care. However, Dahl's (2005) pluralist view is that many different groups exert power and that no one all-powerful elite exists. Nurses took instructions or orders from doctors, and they rarely gave them. This restricted nurses from delivering the nursing care they may have wished. Some of the restrictions appeared influenced by the nurses' knowledge base.

5.2.2 Knowledge and knowledgeability in nursing care

Power, authority, and knowledge are sometimes related; a prime source of power is the possession of knowledge (Foucault, 1980; Lukes, 2019). A person with knowledge is often seen as having the ability to influence the actions of others directly or indirectly (Mann, 2012). Nurses indicated that they had less knowledge than doctors. It meant that they could not deliver some aspects of care or get involved in some decision-making about the care. The status and development of nurses' knowledge have been largely influenced by the dominance of medical power (Feyereisen et al., 2021). There is the view that medicine operates from a foundation of superior legitimated knowledge than the knowledge that forms the basis of nursing and other health professions (Prescott, 2017). Nurses made their decisions based on their knowledge or on decision-making models, which were structured (Nibbelink and Brewer, 2017). The structure of the models focused on information collected about the patient, the medical diagnosis, nursing

assessment, interventions, and the evaluation of those interventions (Gonçalves et al., 2020). Nurses were restricted to those specified aspects and could not deliver nursing carefreely. There are various ways in which decision-making is done in clinical practice, such as unproblematic subordination, the doctor-nurse game, informal and formal overt decision-making (Manias and Street, 2001). In unproblematic subordination, doctors made independent decisions about patient treatment while nurses assisted patients and supported doctors.

It was clear that the doctor-nurse game was well and alive (Darbyshire and Thompson, 2018; Greenlees, 2018; Brown, 2019; Tan et al., 2017). It is year 2022 now, and the doctor-nurse game still exists with different colours from when Stein (1967) described it. When this study was done, nurses made recommendations openly in collaboration with doctors in patient care, but they were not always welcome to do so with open arms. They were not encouraged to make recommendations either, and when they did, they felt unacknowledged and undervalued. In some instances, they could only watch doctors making decisions about the care. The structure, knowledge, roles, and responsibilities made it difficult for nurses to make independent decisions. They had taken roles once reserved for doctors, but they could only perform those roles after consulting with a doctor, with the doctor seemingly making recommendations. My position is that if doctors remain elite, the game will continue in one form or another.

According to Hagell (1989), one's distinct knowledge base should be specific to a profession. This is because each profession has its corpus of knowledge;

therefore, it is important for nursing to develop its own body of knowledge specific to the nursing profession. The stories revealed that nurses applied different types of knowledge in their daily nursing practices. The knowledge was mainly acquired for specific skills or practice they performed (Boshoff, 2014). They said that they relied on the knowledge that they had gained from courses and practice. They also valued intuitive knowledge, which was based on gut feeling. This type of knowledge is regarded as weak due to a lack of scientific evidence backing it. It seemed that nurses struggled to pursue and refine a body of knowledge unique to and congruent with their profession. It was unclear whether the knowledge nurses used enabled agency and, if so, how; there is a need for this to be explored further. The investigation was concerned with agency and did not detail the knowledge nurses used or how it affected agency. Synthesising or pulling together the knowledge gained from other types of knowing could allow nurses to understand the patient better, make decisions and provide higher quality care (Peate and Wild, 2018; Boshoff, 2014; Molina-Mula and Gallo-Estrada, 2020).

When asked what nurses should be doing in clinical practice, there was no mention of theory or research behind what they did, nor did they suggest a need for more knowledge to perform their nursing skills. Medical knowledge appeared to be what they based their nursing knowledge on. It seemed as if they were kept in their place by their knowledge. Nurses said they were trained to perform skills such as wound dressings, communication, and other skills, rather than being educated to develop their epistemic knowledges. It indicated epistemic crisis or exhaustion. Even if nurses could develop their epistemic knowledges, this could

be challenging for them as they struggled to use some skills that they were competent in. Nurses could only do what was prescribed to them.

Nurses' knowledge was mainly that of understanding and carrying out clinical skills they performed. They did not consider theory, research, or critical thinking. Critical thinking should be a focus in nursing. There is a need to consider scholarship to move away from what has always been said, practised, taught, or known. Scholarship in nursing is those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry (American Association of Colleges of Nursing (AACN), 2018). Nursing needs a rethink or to consider different types of epistemic knowledges. A unique body of knowledge is a foundation for attaining society's respect, recognition, and power to a fully developed profession and scientific discipline (Butcher, 2006). It could be suggested that nursing should balance research, theory, and practice to enable this (Masters, 2016).

It is important to remember that theories do not tell nurses what they must do or how they must do something; rather, they are abstract guides. While I expected nurses to tell me about theories and research on daily practice, this did not occur. Nurses seemed interested in discussing their clinical practice skills rather than the theories and research relevant to their nursing practice. It could be suggested that there is a need for a change in nursing to enable nurses to be critical thinkers who do not just base their knowledges on nursing skills. It seems important to independently understand and apply theories and research to clinical practice, as

stipulated by Boshoff (2014). Harrison and Graham (2021) say that knowledge workers recognise that change is inevitable and that the best approach is to be ready for change and view it as an opportunity for learning and improvement.

5.3 Structuration in nursing care

The stories revealed that nurses worked in structured and hierarchical institutions. Stein (1967) says that doctors and nurses work in hierarchical and rigidly structured health organisations but does not detail this. There is a consensus that nursing's origins were structured within an established hierarchy, and nurses continue to be oppressed by those practising medicine who are predominantly placed at the top of the hierarchy (Rooddehghan et al., 2015; Waite and Nardi, 2017). It seems that this has always been the case in clinical practice. The structure here means being arranged in certain related ways (Giddens, 1976; 1984). Nurses knowingly or unknowingly produced and reproduced structures via routines and rituals, often through taken for granted or unquestioned norms. Nurses were not the only ones producing and reproducing structures; the institution was doing so by allocating some nursing roles to other health professions such as clinical scientists and specialist nurses; this meant that nurses had to readjust and relinquish some of their nursing roles to those professions. This impacted agency (de Simone et al., 2018). It is likely that the production and reproduction of structures also occurred in other professions within the institute or due to other reasons, meaning that nurses had to adapt to their changing roles and responsibilities constantly. Nurses were driven by the fact that they wanted to deliver high quality and timely nursing care, act professionally, being a team

player, working in collaboration with others and delivering nursing care through doing. Even though this reinforces both enabling and constraining features of the social system already existing, social structures are always subject to change because of people's intentional or unintentional actions (Hardcastle et al., 2005).

In everyday life, nurses' working practices shape their practice. They saw nursing care as common sense at times in their views. In doing so, they had their ways of nursing patients in mind. They had something that guided them in nursing care, even though they did not say it. Some said they knew patients needed to be looked after, fed, kept clean, and given their deserved care. In understanding how nurses produce and reproduce structures, there is a potential for changing them. It is said that structuration theory can be employed to explore how nurses produce, reproduce, and transform nursing practice through social interaction that shapes their practice across time and space (Fernandopulle, 2021; Hardcastle et al., 2005).

Trapani et al. (2016) discuss the duality of doctor and patient in care. It seems that this is not the only duality that exists; there were multiple dualities identified in this study; namely, nurse and doctor, the nurses and managers, nursing knowledge and medical knowledge, nursing clinical skills and medical clinical skills, and roles and responsibilities which equalled to nursing practice. According to Giddens (1984), the theory of structuration is a theory of social action, which claims that society should be understood in terms of action and structure, a duality rather than two separate entities. Nurses were agents or actors within a structure

in nursing practice. Kaspersen (2000) refers to this as social practice. The institution itself was a structure and a resource in which nurses worked. It could be argued that the nursing profession was designed to be within a structure for it to function the way it was intended to. However, structure and agency seemingly, do not complement each other; where there is a hierarchical structure, there is limited freedom or no freedom as the role and responsibilities of a nurse are prescribed. Nursing care occurred within the duality of the structure described by Giddens (1984) and Kaspersen (2000) as per the diagram below.

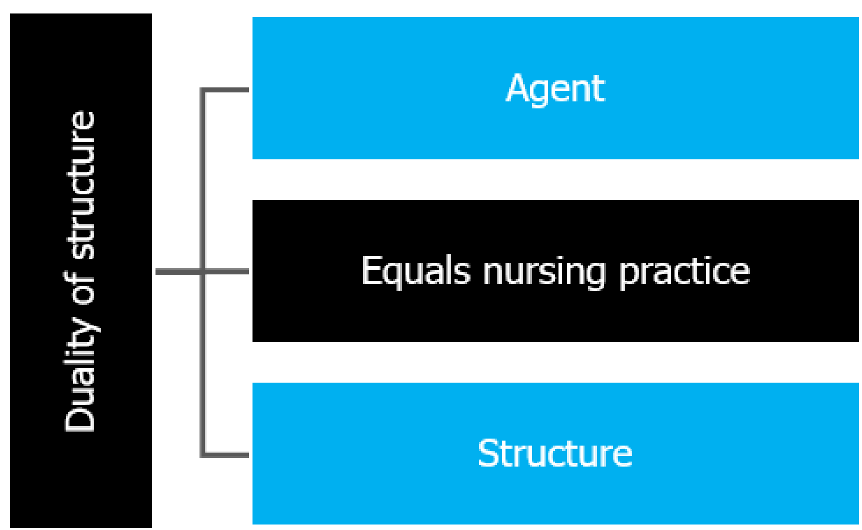

Figure 8: Agency-structure duality

The institution, with its resources, enabled nurses to deliver nursing care dictated by those resources while protocols and procedures constrained nurses from acting independently. Giddens (1984) resisted individualism in social practice and suggested that structures are not inimical to agency but are essential to it. The institution, in some way, is a *system.* The term *system* refers to how an institution enabled or constrained nurses in what they did daily. Nurses sometimes used

terms such as *they* or *them* to refer to something. However, it was unclear if *they* referred to an institution, other actors, structures, or simply something they could not pinpoint. Seemingly, structures occur individually within institutions or other structures (Fox and Alldred, 2018). Nursing occurred within an institution but also had its separate structures within various ranks within nursing itself. However, the institution had a composition that made hierarchical structures. The structures were made of the institution itself, managers, doctors, nurses, other professions, self-formed groups, and patients as per the diagram below.

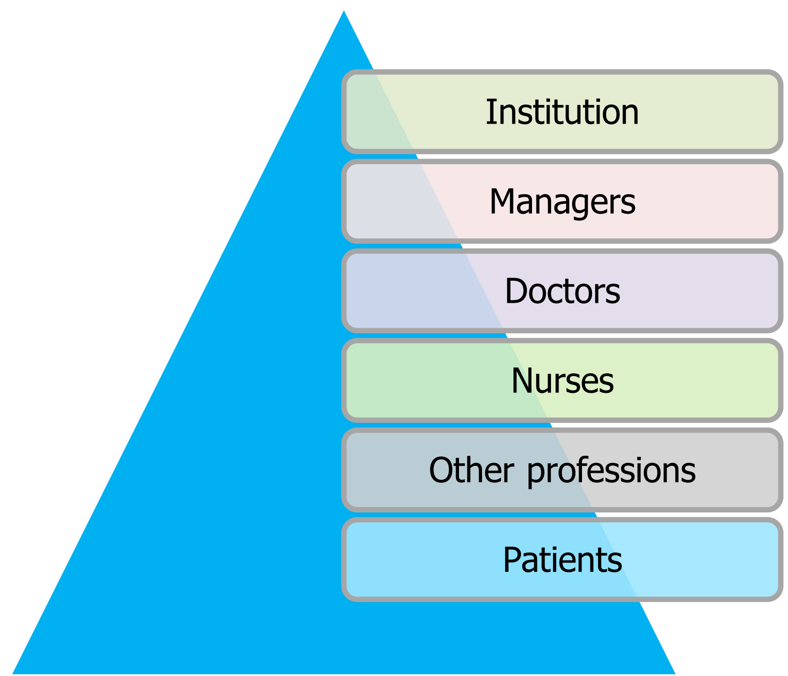

Figure 9: Institutional structures

Nurses had to work with or in collaboration with others in delivering nursing care within the hospital settings. This had an impact on how nurses cared for patients. Doctors were said to instruct nurses in clinical practice, while nurses did not have enough room to question their instructions. It made nurses care for patients in a way determined by others, leaving them to make partial decisions on nursing care

rather than fully to allow other health professions' input. An example was when a nurse consulted tissue viability nurses on wound dressings that she was competent to do. The structures in nursing care were based on the defined roles and responsibilities placed on the nurse. Nurses were further instructed by their nurse managers on how to deliver nursing care. Nurses also influenced each other on how to care for patients through interactions that occurred at the hospital, ward, or departmental level. This was part of an organisational culture within nursing care.

5.3.1 Organisational culture

In this investigation, organisational culture stemming from the structured and hierarchical system (Rooddehghan et al., 2015; Waite and Nardi, 2017) was identified, meaning a group's shared pattern of basic assumptions acquired over time to successfully cope with internal and external organisationally relevant issues (Schein, 1990; Cancialosi, 2017). In the context in which the word is used here, it means how the institutions do things or how things are done around here (Schein and Schein, 2019). In Stein's (1967; 1990) doctor-nurse game, some interaction was based on the organisational culture. There is a debate about what organisational culture is (Watkins, 2013). There is, however, an agreement that it exists and plays a crucial role in any institution. Nurses said the institution's expectations were good quality care and positive patient experiences. Nurses felt that to achieve this, they needed to be supported. My interpretation was that, firstly, nurses needed someone to help them physically to deliver nursing care when they were talking of support. Secondly, they wanted guidance or

instructions to achieve this. Thirdly, they needed supervision by someone they felt knew better than they did. Doing so meant they would not implement nursing care independently or freely. On the other hand, this could have helped them deliver the care they felt the patient needed. In their view, support was not available as much as they would have wanted it to be. In some way, the institutions where nurses worked seemed to favour what worked for them as an institution rather than what worked for nurses. Nurses felt that the health institutions did not place the care they valued and staff morale at the core of their values. It is also said that an organisation's culture encapsulates what it has been good at and what has worked in the past (O'Donnell and Boyle, 2008; Schuldt and Gomes, 2020).

In this investigation, it was identified that, in an organisational culture and structure, individuals or groups are limited to specific roles and boundaries. This means that they can only implement what is within a specified scope of practice. In other words, this requires them to do what is asked of them within an institution and to exclude anything else that is not within that specification. It could be said that sometimes having specific roles and boundaries helps nurses to deliver nursing care that is very specific to patients. Nurses followed instructions from the institution as their employer. Being employed had an impact on agency. Nurses were guided by policies, guidelines, protocols, procedures and by direct interference from the managers. This changed the role of a nurse to something else rather than what the nurse felt was trained to do. They became individuals who took orders or instructions from the institute. They were made to feel that

their training or education and knowledge and skills were irrelevant to their role. One nurse felt that her University education did not contribute to her being a good nurse; she felt that being a nurse was common sense. It indicated that nurses did not find room to apply their knowledge and skills gained during their nurse training. This led to them becoming unsatisfied with their nursing role, which led to reduced staff morale.

Nurses said they worked in small groups of friends in their clinical areas rather than as a whole group. This caused conflicts between those so-called small groups. One nurse described small groups as cliquey groups. This meant that grouping themselves reduced the interaction in nursing care delivery. This was a constraint. Some nurses felt excluded in nursing care due to group dynamics. They needed a sense of belonging where they worked, but this was sometimes hindered; as a result, I saw the need for extra-structuration agency.

5.3.2 Extra-structuration agency

In my frame of mind, I wanted to explore issues beyond structuration and structures; hence I termed this extra-structuration agency. Extra-structuration agency is the thinking beyond structures or that which does not exist or has ever existed in the functionality of an institution other than in structures. Here I am not writing in some fancy language, nor am I going to try, but I am writing in a way that I want to be understood. Sartre (1965) says I do not need to write in flowery language; I must let my pen run on without searching for words.

In the extra-structuration frame of thought, nurses felt a need to get rid of managers. They felt that managers contributed to what they saw as chaos in nursing care. The reasons were that managers allocated unreasonable shifts and moved nurses from their specialist areas to work elsewhere. Whilst managers were expected to help the institution provide equal care to all patients, nurses felt prevented from delivering nursing care the way they wanted to as they did not have the skills or knowledge needed to do so in some areas where they were allocated work short term. They were sometimes not happy with the use of policies, guidelines, protocols, and procedures as they felt that those were restrictive somehow. They said that these were helpful at times but had more negative aspects than positive. In their view, extra-structuration agency within clinical areas would have meant delivering nursing care guided by the knowledge and skills they possessed rather than by managers. This would have meant freedom for them. Sartre (1943; 1965) would say that this is pure being. Sartre describes how ordinary objects lose their meaning until he encounters pure being at the foot of a chestnut tree, and at that moment recovers his sense of his freedom. In this freedom, nurses saw the foot of a chestnut tree as nursing practice that valued a knowledgeable and skilled nurse who delivered care independently without fear of repercussions.

In extra-structuration agency, it becomes apparent that the nurse or I as a researcher need to think deeply to find solutions, but this is not an easy task. It is not easy to find alternatives or supplement current structures within the institutions. Nurses based their thoughts on what they had always known. This

restricted them from thinking beyond the structures that existed. There are unexplored areas in nursing care, including philosophical and critical thinking, which could enable extra-structuration agency. It might be that nurses could easily work without any structures in clinical practice, but they did not suggest this. On the other hand, they talked about the characteristics of structures in clinical practice, but they were not aware of the nature of structures. In addition to structures, there was an existence of what I saw as the cognitive empire.

5.4 The cognitive empire in clinical practice

The cognitive empire is not physical; it is a world of cognition or *mental state* (Santos, 2018). In the literal sense, an empire is a major political unit having a territory of great extent or several territories or peoples under a single sovereign authority (Mehta, 1999; Kumar, 2021). In this context, cognitive empire means the act of having, thinking and acquiring knowledge in the world of healthcare. I see the cognitive empire as a *metaphysical empire* related to attitudes, beliefs or thinking in acquiring knowledge. It is about who gets what type of knowledge. It is worth remembering that Manias and Street (2001) and Feyereisen et al. (2021) say that the status and development of nurses' knowledge has been largely influenced and dominated by the so-called legitimated superior medical knowledge and power. There is the view that medicine operates from a foundation of superior legitimated knowledge than the knowledge that forms the basis of nursing and other health professions (Prescott, 2017). Nurses had nursing knowledge that confined them to their scope of practice and saw themselves as *just nurses* and viewed doctors as superior to them professionally and in

knowledge. In some way, they automatically cognitively declared themselves powerless. The likelihood is that if doctors were seen as superior, then nurses would do as they were told; this reduced their agency.

Nurses were in a position that allowed gaining of knowledge through experience and training. They did not talk of the need to be educated to be independent critical thinkers to generate epistemic knowledges that allowed them to develop nursing care. They asserted that their experiences in clinical practice should be considered and be appreciated as it contributed to shaping care. In this cognitive empire, nurses saw the need to be trained and educated similarly to doctors, possibly to have power, authority and agency. They said that they should be doctors or should become doctors. This indicated that they felt a need to develop and change nursing, but they could only think of changing it to something they saw in medical practice. On the other hand, nurses valued their in-house courses; hence some viewed themselves as more knowledgeable than doctors as a result; for example, one nurse who had done a communication course felt that she knew more about communication than doctors and that doctors should also undergo the same training if they were to understand patients and how nurses made decisions. It was interesting to note that every nurse's story mentioned doctors. It was clear that nursing depended on medical practice. Nursing could never be independent of medical practice; hence nurses were conflicted about their role and responsibilities. Nurses saw medicine as an alternative or an equally attractive option to nursing, if not more attractive. Nurses had to find some ways of resolving this conflict by leaning towards medicine. In adopting medical knowledge, nurses

emulated or imitated doctors as some felt that they should be doctors. However, they saw themselves as having knowledge that needed to be valued. They said that they were knowledgeable in their field like any other professional, yet they felt unable to utilise all their knowledge in practice.

Nurses constantly viewed medical knowledge as far superior to theirs and thought doctors understood diagnosis and treatment more than they did. When asked what knowledge this was, they said that doctors understood diagnosis and treatment more than they did. Nurses wanted to resolve this imbalance by gaining medical knowledge. The knowledge was gained through interaction with doctors and undertaking further training. In addition, nurses resorted to doing extended roles such as prescribing medicines, which were considered a doctor's role. While nurses could provide provisional nursing diagnoses and suggest treatment, they had no power to make decisions or to initiate treatment. In some cases, doctors would contradict what nurses suggested; nurses would then challenge doctors. Goodman (2014) suggests that a nurse would challenge a treatment option not by invoking better or different scientific knowledge or status, which would not be seen as equal. This might have been due to cognitively drawn boundaries. Nurses felt that they could not become what they wanted to become (Nietzsche, 1979). This resonated with what I term *colonialism*.

5.5 Colonialism in nursing care

In this investigation, I identified attributes or characteristics of colonialism and coloniality. I uncovered ways of working and oppression I saw as colonialism, just

like Heidegger (1982), who came face to face with an apple tree in his garden. Instead of coming face to face with an apple tree, I came face to face with colonialism. It is important to make my positionality clear here. I was born in a colonised country where I witnessed how people were oppressed or controlled. In colonialism, control is done by various means or by other means (Said, 1978). Despite independence, it would appear that colonialism continues overtly or covertly. I see freedom as a myth. Oppression in nursing goes beyond five faces of oppression, and indeed above nurses resembling a colonised group (Farrell; 2001; Young, 1990; Dubrosky, 2013; Rubeis, 2021). My explanation is that colonialism in nursing care is a practice of domination or control of individuals or of a group of people in a way that resembles colonialism (Tan, 2007). In other words, colonialism occurs in multiple ways, systematic processes or systems that oppress and control nurses. Heidegger (1982) believes that people can choose to relate themselves to something or objects if they want to, and they can choose not to relate themselves if they choose not to. He relates himself to an apple tree at one point and brings this idea of a thinker standing face-to-face with a tree (Heidegger, 1982; Marder, 2014; Smith, 2015). Marder (2014) claims that what makes a full-fledged relation to the apple tree possible is that we share being, meaning the state of being alive with it, even though a human and a tree have distinct styles of existence at their disposal.

Several studies discuss colonialism, the colonising processes and practices in nursing practice (McGibbon et al., 2014; Valderama-Wallace and Apesoa-Varano, 2020; Waite and Nardi, 2017; Mendizábal, 2018). It is explained that nurses work

in colonised healthcare, and different forms of oppression are present in the nursing profession. The colonising processes and practices discussed include the colonisation of nursing's intellectual development and its embedded colonising assumptions that sustain colonising thinking and action in the nursing profession. The dominance of Eurocentric and Western epistemologies in nursing, embedded beliefs and assumptions, and outdated nursing theories are part of colonialism as they do not accommodate other alien processes and practices (Juanamasta et al., 2021). However, there is more to colonialism than what is discussed in the nursing literature, as indicated in this chapter.

In this colonial system, nurses viewed doctors as above them and possessing knowledge, power, and authority in care. This suggested that doctors could be colonisers; however, this might not have been the case as doctors could have been colonised too or used as colonial accessories. It was also indicative that control could be institutional. It became difficult to identify the colonisers and those who were part of colonialism and their role. In colonialism, there is an oppressor and the oppressed; the oppressed are prevented from exercising collective self-determination. There is a suggestion that *colonialism* is a fact of life in the world at large, within nations, communities, families, tribes, corporations, organisations, universities, political groups, and any other human organisation (d'Errico, 2011). Nursing is no exception. Colonialism in clinical practice is a system that demands the labour and resources of another profession without allowing that profession equality and freedom within its scope of practice to

practice their skills fully. It seems that nursing is colonised by systems, individuals or groups that have powers.

Colonialism manifested itself in nurses' knowledge, epistemic knowledges, the roles and responsibilities, the thinking, beliefs, attitudes, routine, education, the curriculum, the position in which nursing is situated in the institution's structure and other related aspects. This determined what freedom or constraints nurses had. Nurses also seemed to have what I saw as colonised minds by seeing themselves as being *just* nurses. I see this as self-colonisation. In other words, they were saying that they had no power and authority, but others or the system had power and authority over them. This would, to some extent, indicate that a nurse is reduced to nothing but a professional who takes orders and has no agency. In self-colonisation, nurses accepted that they had no power and authority and, therefore, they were in a submissive role. My explanation of self-colonisation is that it is about self-restriction or acceptance of domination, subjugation or self-oppressing practices that do not allow the group or individuals self-determination or to practice freely within their scope of practice or defined parameters.

Colonialism occurs in numerous ways that may be visible or invisible (Dubrosky, 2013; Krabbe, 2021). This is to say that colonialism occurs as macro as well as micro. It can be an injustice to others or institutional conditions that are restrictive without nurses being aware (Vrousalis, 2013). Policies, guidelines, procures and protocols, the knowledge nurses possessed, the role specifications and

responsibilities seemed to be accessories of colonialism in the nurses' stories. Colonialism seems to occur over time, and once it is implanted into a group cognitively, it gets accepted by any member that joins them; colonialism then becomes the norm (Mignolo, 2007; 2021). In other words, colonialism or oppression is what they have always known; that is why they cannot find any other way of doing things differently or with freedom (McGibbon et al., 2014). What an outsider sees as an option for freedom can easily be something against the group's norms, culture, or colonial matrix of power (MacLeod and Nhamo-Murire, 2016).

5.5.1 Colonial matrix of power

The colonial matrix of power is about how individuals or groups function in the world order; it is about who has power and who is above whom (Young 1990; Mignolo, 2021). Nurses worked within hierarchical structures that made up that world order. The world order seemed to be about nurses taking orders from doctors, managers, and the institution rather than nurses themselves structuring the nursing care the way they saw necessary. When asked if they could deliver nursing care the way they wanted, nurses said that doctors ruled the place and had to do whatever doctors ordered them to do. It seemed that the colonial matrix of power in nursing situated doctors above nurses in care. This meant that agency did not fully occur due to this world order.

Nurses felt that they were able at times to challenge and engage doctors in the care of patients. However, being able to challenge doctors is different from having

the authority to make decisions. Doctors had overall authority and power to make decisions in general. Nurses regarded doctors as the main decision-makers, and even if they challenged them, there was nothing much they could change as doctors would still do whatever they wanted. Fanon (1963) likens this to dogs that bark but do not bite. In other words, nurses could challenge doctors, but whatever they said did not change the course of action that doctors took or wanted to take. It is likely that, to some extent, doctors took into consideration what nurses said, but nurses felt unacknowledged. Nurses said that some doctors listened to them while others did not, especially junior doctors. Nurses wanted to play a more significant role in patient care, but this was not happening; there was a need for decolonisation for change to occur.

5.5.2 Decolonisation in nursing care

The literature indicates that decolonisation is needed where there is colonialism or coloniality to enable collective empowerment and liberation (Mignolo, 2007; 2021; Munro and Hope, 2020). Decolonisation is viewed as a path to urgently needed growth and transformation for the entire nursing profession (Greaves, 2014; McGibbon et al., 2014; Waite and Nardi, 2017). It would mean making changes that would give nurses the power to act per their role specifications. Nurses suggested that their prescribed roles and responsibilities were restricted. In decolonisation, it is important to identify colonialism within the practice in the first place. Decolonisation does not only refer to the complete removal of dominating forces within the geographical space of the colonised, but it also refers to the decolonising of the mind from the systems or colonisers' ideas that made

the colonised feel inferior in the first place (Quijano, 2007; Cruz and Sonn, 2010). Nurses indicated that the inferiority came from being powerless and less valued than doctors and being treated as such. It would seem that the concept of decolonisation underscores the postcolonial imperative to expose, resist and transform the continuing presence and influence of colonial processes (McGibbon et al., 2014). Decolonising should be an intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation or exploitation of minds, bodies, and the scope of practice with the ultimate purpose of overturning colonial structures and realising group liberation (McGibbon et al., 2014; Wilson, 2016).

Decolonisation in nursing care is occurring but is slow (Senior, 2008). Changing roles and responsibilities do not seem adequate; there is more to decolonisation. Decolonisation is about changing practice, education, the curriculum, knowledge, thinking, beliefs, attitudes, roles and responsibilities, structures, the system, the mindset, colonisers' minds, colonising systems, and other aspects. Doing so means that nurses can develop nursing practice and create new epistemic knowledges specifically suited to contemporary nursing practice. Nurses are now tasked with responsibilities that were once placed in doctors’ hands. They could prescribe some medicines, but this was done as a supplement in the absence of doctors. It is documented that there are shortages of doctors in some specialties; as a result, nurses provide some services that would be provided by doctors otherwise (Burns, 2019).

Nurses compared their knowledge with that of doctors. Nursing might have lost its meaning; there is a need to reconsider what makes nursing what it is or what it should be. Nurses need to reconsider that which is nursing knowledge rather than medical knowledge. It might be difficult to separate the two as nursing is based on a medical model. Nursing might as well change its name and adopt a different name that would incorporate medical practice rather than nursing on its own. On the other hand, I see the need for nurses to stop relying on medicine and comparing nursing to medicine. However, this raises the issue of what is medicine and what is nursing. The introduction was unclear about what nursing is, and nurses in this investigation did not know it either.

Nurses were unclear about what it was that they would want to see themselves doing. They mentioned that they should be spending more time with patients. However, nurses must think beyond what nurses do now. There is a need to think about new horizons and bring something new that would change or give nursing its unique identity. However, this can be challenging due to coloniality.

5.5.3 Coloniality in nursing

Coloniality is that which remains cognitively when decolonisation has occurred; it is a continuation of the colonial forms of domination after the end of colonial administrations (Cohen, 1979). However, it is difficult to teach an old dog a new trick. Eradicating colonial mentality is challenging, as some elements of colonialism or coloniality can never be eliminated (Bhabha, 1994; Quijano, 2007). Those who want to end colonialism must change their ways of thinking.

Sometimes colonialism is content in imposing its rule upon the present and the future of a dominated group (Mignolo, 2021). This is the challenge that nursing faces long term. When nurses were asked about changes, they wanted to see in nursing, they did not suggest anything new. They appreciated what they were doing and believed that they needed more time to do it better. Their minds were anchored on what they had always known. In other words, I saw this as colonising thinking. Colonising thinking and actions permeate the nursing profession, from biomedical hegemony in the curriculum and practice to managerial efficiency models in nursing care (Britwum, 2017).

The development of a consistent counter-narrative is necessary if nurses are to work towards decolonising practices. There is a need to engage in critical self-reflection to understand the impact of the many forms of colonisation. Once colonised, it is easy to perpetuate the conditions by striving to emulate and imitate the culture and ideas of the oppressors. It is important to rediscover the group's intimate selves in coloniality and eliminate mental attitudes, complexes, and habits that made colonisation trap them for a long time (Mignolo, 2021). The colonised mind does not have any agency in constructing its subjectivities, representations, and desires (Quinteros, 2015). It explains the systemic organisation of globalism, knowledge, social and behavioural interactions between axial definitions of the global patterns between hegemonic power and the subordinate subaltern global consumer, the colonised (Taylor, 2004; Alexander, 2021).

Coloniality would persist as nurses did not see the existence of colonialism in the first place. They blamed themselves rather than the system that appeared to control or colonise them. In coloniality, it is difficult to change the mindset of individuals. In discussions with the participants, I was not intending to change their thinking but wanted to understand how they saw clinical practice within hospital settings. I allowed them to reflect on the freedom and constraints in their clinical practice areas to free themselves. In their reflection, they also mentioned what I saw as colonial violence in nursing care.

5.5.4 Colonial violence in nursing

The stories indicated that there was violence in clinical practice. Violence was not limited to horizontal or lateral violence only (Young, 1990; Farrell, 2001; Dubrosky, 2013). Two types of colonial violence were uncovered, these being symbolic and horizontal violence. Symbolic violence is non-physical violence manifested in the power differential between social groups (Bourdieu, 1977; 1998; Dowding, 2011). Besides, nurses said doctors would be angry with them if they did not do what they wanted. They would raise their voices if they were not happy with the nurse, or the care given. Some said that doctors would look them in the eye and tell them that they were the doctor. An example of symbolic violence is the mental knowledge that the doctor can dictate what a nurse can do. This impedes nursing agency and causes the nurse to work in a controlled way. It is said that being colonised or controlled frustrates nurses, and this leads to horizontal violence. In other words, this causes nurses to turn against each other.

Horizontal violence between nurses is aggression perpetrated by one colleague toward another colleague (Bourdieu, 1998). Nurses said that other nurses were unfriendly towards them. In some cases, nurses wanted things done their way by other nurses. There was evidence of nurses wanting to dominate others. The nurses said that they worked with *clique* groups who worked together and supported each other within their groups. They excluded others from being part of those groups. Nurses felt they could not deliver the care patients needed by being excluded from the groups. It is said that although horizontal violence is usually verbal or emotional abuse, it can also include physical abuse and may be subtle or overt (Dubrosky, 2013). Repeated acts of horizontal violence against another are often referred to as bullying (Sherman, 2012).

Horizontal violence is intimidation and unacceptable behaviour, including condescending language, impatience, angry outbursts, reluctance, or refusal to answer questions, threatening body language and physical contact (Rodwell and Demir, 2012). Nurses said that the horizontal violence they experienced was verbal and psychological rather than physical. Some complained of being looked down upon by others who talked to them as if they were nothing. This was regarded as offensive behaviour, and it disrupted the delivery of nursing care. The institution *(they)* and managers disciplined and forcibly moved nurses to other unfamiliar settings or required them to work in areas they were not familiar with or comfortable working in, with nurses given no choices or a say.

5.6 Summary

In this chapter, I have presented the key constitutive themes that emerged from poiesis. The constitutive themes are nursing in clinical practice, characteristics of power and authority in nursing care, structuration in nursing care, the cognitive empire in clinical practice and colonialism in nursing care. This chapter links the introduction, literature review and findings, concentrates on what has meaning in the stories and brings what did not exist before into existence. Agency in nursing is not just about freedom or constraints; other related issues influence clinical nursing practice. The next and last chapter concludes the study and brings together what I found. In some way, it provides a summary of the study. It is where the implications to practice, contribution to knowledge, recommendations for further research, and strengths and limitations of the study are discussed.

This chapter concludes the study and gives an impression of how the purpose of the investigation was achieved. It is worth restating what this study intended to answer. The study aimed to investigate nurses' concept of agency in nursing care using their stories from clinical experiences. The questions were: Do nurses have the power to act in clinical nursing care within hospital settings? How free or constrained are nurses? What powers do nurses think they have? What do nurses think they should be doing?

The hermeneutic phenomenological investigation succeeded in letting that which tends to hide itself shine through (van Manen, 1990; 1997). It revealed that nurses had the power to act on basic nursing care or on what was concerned with activities of daily living. However, in other aspects of care, such as prescribing, nurses were constrained on what they could do by policies and guidelines, and they could not prescribe drugs without approval beforehand from a doctor. When delivering care, nurses had to consider the input of other professions even though they could go it alone in principle. Nurses could also take blood, but they could not request investigations on it. On the other hand, they were competent in various nursing skills but could not perform them due to imposed restrictions. There were protocols, pre-planned care plans and care pathways that nurses had to adhere to, among other things. They also felt that they needed to utilise their nursing skills fully and be allocated reasonable workloads so that they could deliver intended nursing care. Another restriction was that nurses were allocated work by nurse managers in clinical settings where they had no knowledge or

nursing skills to utilise. Nurses thought they should spend more time with patients, addressing spirituality, mental health needs and other aspects other than physical nursing care, but this was not always possible.

It was clear that some nursing care was done as a priority or as what nurses felt patients needed most or urgently. In some instances, nurses wanted the nursing care to be different but there were limitations in what nurses could do. Conflict with colleagues and other health professionals sometimes prevented nurses from delivering the nursing care they intended. However, there was a sense of teamwork among nurses and other health professionals' involvement in the care. In addition, there were limited resources which constrained the nursing care given. The increased workload and reduced staffing levels meant that it was not always possible to deliver the care patients needed. Some patients were admitted to environments which did not suit their care needs.

In knowledge and knowledgeability, nurses did not always have the same knowledge, agency or power and authority, and privilege in decision making as doctors. They also lacked information power to execute agency. It seems that nursing knowledge kept nurses in their place. Nurses did not always have knowledge in pathophysiology or disease management. Furthermore, nurses could not see nursing in any other way or suggest anything new or a different direction in which nursing should take. Extra-structuration agency was considered but was confined to power structures; nurses wanted flat rather than hierarchical structures.

Structures played a part in clinical practice; they subjected nurses to specific or prescribed roles and responsibilities; sometimes, this restricted them from being the nurses they wanted to be. Nurses had an invidious position in the hierarchical power structures. Structures also occurred within nursing itself; nurses produced and reproduced structures and substructures within their groups. Besides structures, nurses worked within an organisational culture that demanded them to work in certain ways which were not always their preferred choice. The organisational culture further compounded agency as nurses had to do what they were told rather than nurse patients the way they wanted. They saw themselves as just nurses and viewed doctors as superior to them, even though they saw themselves as inseparable from them; as such, they had limited power and authority. Nurses were doing more in nursing care; however, doctors had a monopoly in holding power in the diagnosis and treatment of patients. Nurses also saw themselves as having different ways of thinking and having different epistemologies in comparison to doctors. This tells the story of nurses who did not know who they were anymore. Some even said nurses should be doctors or should train as doctors. This could be seen as losing that which has meaning. Nurses willingly emulated or imitated doctors rather than being themselves. They wanted to have power, authority and agency to mirror medicine.

There were indications that nurses were colonised, dominated, subordinated, subjugated, and controlled as they were not always free to self-determine their destiny, ranging from decision-making to the education they needed in the world order of clinical practice. The colonised cannot exercise agency or freely exercise

agency. Colonialism is not always a politically oppressive system; it is a systematic process or system with traits of colonialism that manifest in various ways. Colonialism manifested itself in the nurses' thinking, beliefs, prescribed roles and responsibilities and ways of doing things. Colonialism is present in every social context and social structure. This colonial system had a colonial matrix of power and decolonisation. Decolonisation allowed nurses to do other skills or practices they were not previously allowed to do, such as prescribing. They still saw themselves as less valuable than doctors despite decolonisation.

6.1 Implications to practice

This study discussed important information on adult nurses' experiences and the concept of agency in clinical nursing care and provided significant findings that had implications for practice. This study was important as it highlighted where nurses had agency in clinical nursing care, as well as the challenges they experienced, and the limitations placed on them which impeded agency. It is indicative that nurses were not in a position to deliver the nursing care they wanted to deliver despite being capable to do so. It seems nurses want to be able to have the ability to deliver nursing care with minimal constraints or no constraints. My recommendations are that nursing care could be improved if nurses had agency, the freedom to care for patients, and the power and authority to make decisions and use their nursing knowledge and skills independently. Nurses need the freedom to deliver nursing care the way they see appropriate to benefit patients. There is a need to define what nursing and the nursing role are as nurses tend to do extended roles, bringing the nursing role to crossroads.

Nurses should be empowered or enabled to be in a position where they can deliver nursing care to all patients without having to prioritise other patients as a norm. The nursing role, responsibilities, care plans and pathways should not be prescriptive to allow nurses to use their knowledge and skills. Nurse managers should consider how nurses want to work and give them opportunities to make independent decisions about patient care. They should allocate duties and shifts where nurses are competent and have the necessary nursing skills and knowledge to practice. The resources allocated to nurses should be appropriate as nurses said some of them were not of good quality or were faulty and should be given a choice of resources they want to use. The workload given to nurses should be equivalent to staff ratios, and where possible, there should be a reduction of unnecessary nursing tasks. There should be an increased number of nurses working in clinical practice as nurses work in reduced numbers most of the time. Nurses should be given enough time to give patients all aspects of care and the support they require. Nurses should be given roles and responsibilities that do not conflict with that of other health professions. Patients should be admitted to appropriate settings to receive appropriate care. Policies, guidelines, and protocols should be designed to allow nurses flexibility, allowing them to use their knowledge and skills not covered in the policies, guidelines, and protocols.

There is a need to show nurses that they are valued like any other health professional by allowing them to make major care decisions. Nurses could be allowed to prescribe medication within their scope of practice if they are competent to do so without first gaining approval from the doctor. It could be

recommended that unnecessary restrictions be removed so that nurses can practice freely using the knowledge and skills they already possess. They could be given the power to treat and nurse patients the way they see appropriate if they have the knowledge and skills. Nurses' knowledge needs development to allow them autonomous practice and agency. There is a need for multiple epistemologies on nursing knowledge which should encompass critical thinking, research, theory and practice, not just clinical practice. The structures and organisational culture that nurses work in need to be reviewed, and necessary modifications made to allow nurses freedom. Nurses need an education that allows them to be highly competent and have a valued identity. Colonialism needs to be addressed, and nurses need to be aware of its existence in clinical practice. Colonialism would be identifiable if nurses were aware of what it is. This would enable them to change their mindset, empower themselves, and have a powerful voice in clinical practice. Colonialism would only be got rid of if there was decolonisation. The likelihood is that coloniality would remain after decolonisation. This could be addressed through nurse education or the nursing curriculum and other epistemologies.

6.2 Contribution to knowledge

This study contributes to knowledge in various ways. The contribution starts from the research title to the introduction, critical literature review, study design and protocols, the stories, interpretation, poiesis and discussion, and the conclusion to its overall presentation. In the *title,* adult nurses' concept of agency in clinical nursing care within hospital settings has not been looked at before; this is the first

time this has been investigated. In the *introduction,* the role and responsibilities of a nurse are outlined, and agency in nursing care has been defined or explained in the context of this investigation. It is indicated how the agency discussed here varies from that of others. The purpose of this study to investigate nurses' power to act within their scope of practice is the first of its kind; no other investigation has considered this. It also brings to life the meaning of nurses' lives concerning the concept of agency. In the *critical literature review,* the review is an addition to what is little known about agency in the context of this study, as the nurses' concept of agency within hospital settings is limited. The review highlighted the available literature within nurses' concept of agency and brought my existing knowledge into play to co-create a new understanding from it. It does not look at the topic from the nursing perspective only, but it also looks at other fields afar to better understand agency. It would seem that there are other aspects related to or affect agency that have contributed to the understanding of this topic. Thus, it contributes to the concept of agency, critically examines the literature that directly or indirectly discusses agency and clarifies how some concepts relate to the concept of agency. In the *study design and protocols,* there is a contribution to hermeneutic phenomenology as it is said that there are as many versions of hermeneutic phenomenology as researchers who write it, so mine can never be the same as the other. In this study, the hermeneutic cycle had to be adapted to suit the way the investigation was done, and in doing so, I added poiesis to it to enable the discovery of new aspects related to agency that have never been thought of before. On the other hand, the investigation led to the creation of a

new reflexivity model. In the *stories,* the study contributes to an understanding of experiences and the concept of agency using stories as told by participants. It addresses why or how nurses work and their freedom and constraints in clinical practice. On the other hand, stories have not been used before as a data collection tool in investigating adult nurses' concept of agency in the context of this study. In *interpretation, poiesis and discussion,* the contributions include how the characteristics of power and authority in nursing care, the organisational culture, structuration, and extra-structuration agency play a major role in the concept of agency. This study highlights and brings new concepts to nursing such as colonialism, the colonial matrix of power, decolonisation, coloniality and colonial violence in nursing and how they further compounded nurses' ability to deliver nursing care. In the *conclusion,* it is evident that nurses had the power to act on basic nursing care or on what was concerned with activities of daily living; however, in other aspects of care such as the extended roles, treatment and decision-making, nurses were constrained on what they could do. In the *overall presentation or investigation,* this investigation adds to an understanding of nursing agency in clinical practice within hospital settings. Agency in nursing is either misunderstood or under researched; therefore, this study considers how it could occur and clarifies the term's meaning concerning nursing practice. The thesis has added to the body of knowledge by illustrating that nursing is still evolving or developing; it is yet to achieve its full potential in agency and patient care and needs to be recognised for its independent contribution to health care. It looks at agency from a clinical practice perspective, highlights freedom that

nurses have as well as oppression that occurs in clinical practice. It identifies and adds knowledge in nursing that has not been considered before and identifies a path which nursing knowledge should take as well as the need to consider agency if nurses are to have the ability to deliver nursing care that they see appropriate for their patients. The study contributes to wider nursing literature on agency in that it brings something new into the domain that has not been considered before by other authors or researchers. Despite the fact that this study had a small and focused homogenous sample, it identifies issues that affect nursing practice in clinical practice within hospital settings. Having a small sample did not necessarily mean that the findings were insignificant. Nurses had prescribed roles and responsibilities, and this limited agency. It would appear that where roles and responsibilities are prescribed, there is a question of freedom and agency. In other words, the nurse has to do what they are required to do and nothing else. It is clear that nurses were not equal autonomous partners with doctors in care provision; they were taking orders, rendering them powerless. In this powerless structure, rethinking, unthinking thinking and questioning what direction nursing should take was limited; the medical knowledge seemed to be at play. Nurses knowingly or unknowingly produced and reproduced structures via routines and rituals often taken for granted, seemingly to accommodate agency. What further complicated agency was the duality of structures. There were many dualities, including the doctor and the nurse, medical treatment and nursing care which affected agency. Restrictions occurred within what nurses could do, even when they were competent to do those tasks or skills. In addition, daily nursing care

was impossible to achieve as nurses had long lists of things they needed to do, yet alone agency. In addition, there was epistemicide in nursing knowledge, and therefore, nurses based their knowledge of understanding how to carry out clinical skills they performed based on medical knowledge. Oppression showed itself in hierarchical structures, organisational culture, as colonialism, colonial matrix of power, coloniality, colonial violence and the cognitive empire. The actions that seem to be needed in nursing care were extra-structuration agency and various forms of decolonisation.

This study's first impact is that it is thought-provoking and allows those who read it to look deeper into daily nursing activities that occur without much thought put into it. Secondly, its impact is on policy. It is indicative that the policy should consider nursing agency or nurses being given more agency or the freedom to deliver nursing care in every aspect or task as long as the nurse is competent to do so. Agency could include freedom in the treatment and diagnosis of patients as long as nurses have the relevant knowledge, education and theory relevant to their extended roles and responsibilities. This raises the following questions: Can nurses be trusted with agency? Can they operate or function without a doctor? The answer is 'yes they can', as long as they are competent, have the necessary education, knowledge and skills needed to do so. This indicates that the goal of nursing practice development needs clarification; and there is a need to encourage the inclusion of agency in patient care as it is currently limited in the evolution, development and advancement of nursing. Nursing practice, knowledge and theory need to be advanced at the same pace to allow agency and the

evolution, development and advancement of nursing practice. Thirdly, this study challenges the cognitive empire in medical and nursing education. It is suggestive that nurses should be educated to standards that enable agency rather than depend on medical knowledge. Their education should mirror their expanded roles and responsibilities in clinical practice. Fourthly, it seeks and challenges the nature of agency in nursing practice to appreciate the independent contribution of nursing to healthcare. It also identifies that agency is very limited in nursing practice as nurses do not have the power and authority to deliver the nursing care they see as appropriate. Fifthly, it exposes the gaps in nursing theory and illuminates the need to review the epistemologies in nursing. It is also suggestive that there is a need to review nursing theory and update it to accommodate agency and freedom. It would seem that nursing practice theory is based on theories that somehow are no longer relevant to modern-day nursing where nurses are meant to contribute to health care independently, with freedom and agency. It becomes clearer that nursing theory should not be based on medical knowledge only as it somehow hinders new nursing epistemologies. Nursing science needed by nurses should be designed to meet contemporary patient care needs and enable agency. There is a need for a clear sphere of operation for nurses. Nursing needs continuous updating and professionalisation, and the nursing domain should be redefined and continuously refined.

It is worth stating that this study was received with enthusiasm at the University of Wolverhampton Annual Research Conference in June 2020, July 2021, and June 2022, and as the Doctoral College keynote presentation in January 2022. The

findings have been disseminated to the participants, and the intention is to publish this study in reputable sources as my contribution to existing nursing knowledge and present it in conferences. This study provides a platform for nurses to challenge that which prohibits the development of nursing care and helps them strengthen that which benefits nursing in general. It is unlikely that my study alone can change the world; however, it is worth saying that it should help in making others see what I see in this investigation. This study provided me with an opportunity to suggest recommendations for further research.

6.3 Recommendations for further research

This study investigated nurses' concept of agency in clinical practice within hospital settings, but it did not investigate this from other health professions' perspectives. In future, there might be a need to investigate this and understand how they see nurses and the role they play in clinical practice. Another investigation could include all fields and backgrounds of nursing to see their concept of agency in nursing care as this investigation involved a homogenous group of nurses in clinical practice within hospital settings. It is worth to say that it is unclear overall which tasks nurses have agency in and how much agency nurses need to have; therefore, it is important that this is understood by conducting further research. The data was collected using stories which did not directly ask questions on agency; therefore, there is a need to have a specific study that directly questions agency. It was unclear if nurses understood agency. It could be interesting to find out nurses' understanding of agency and how they would want to see it in clinical nursing practice or how it could improve nursing

care. Hierarchical structures had a role to play in agency; this study did not examine structures in detail; another study could be better designed to investigate how the structures specifically impact or affect agency. It is clear that hierarchical structures hinder agency, but this is not understood in depth. There is a need to look deeper into how structures impact agency in nursing care. What is not understood is what leads to the production and reproduction of structures and to what extent these impede or affect agency and nursing care. The topic of agency is not well researched in nursing, therefore, there is a need to investigate or consider various aspects of it in nursing. It is also important to understand how agency would benefit patients, nurses, other health professionals, health institutions and health care as this was not looked at in depth in this investigation. It would seem that where there are power structures, there is a question of agency and freedom. It is clear that as long as nursing remains within hierarchical structures and overlapping with other health care professionals and professions, it is unlikely that agency can fully occur as these restrict and impact agency. Power was seen as contributing to constraints in nursing care, but it was not fully understood how it affects agency and other health professions. There is a need for research into the nursing aspects where nurses should have agency. Nurses seemed to think that doctors and the health care institution held power, but it was unclear who exactly held that power. Nurses used the terms *they* and *them;* these are ambiguous and need to be explored. Colonialism needs further investigation to find how it manifests itself in clinical practice. Health professionals seem to be accessories of colonialism or oppression that limits care delivery, but

this has not been independently verified by research. Another investigation that could be done could be finding out if there are other factors affecting agency in nursing care other than those discussed in this thesis.

6.4 Strengths and limitations of the study

The strength of this study was in its ability to yield vast amounts of data revealing how nurses worked within hospital settings and how much freedom or constraints they had. Its nature of interpretivism allowed me to understand the deeper meaning of nursing practice and agency. The literature review was a limitation in that some of it was not discussing topics that were openly agency. It meant that, at times, I had to read and interpret some of the information related to agency. There were times I had to think of other terms to get to some elements of agency within nursing care. Hermeneutic phenomenology had strength in that it allowed me to understand the participants' experiences and how they interpreted them and allowed me as a researcher to provide further interpretation and clarification of the participants' accounts. Interpretation has its limitations in that sometimes, other researchers and the audience might not share the author's positionality. Hermeneutic phenomenology, however, allowed an in-depth scrutiny of what participants said and how they said it. Participants contributed to the strength of this study as they all worked in clinical practice within hospital settings. This meant that they had rich knowledge and understanding of nursing care. What the participants said could not be disputed as it was what they said they experienced. The hindrance was that what the participants said could not be independently verified. The participant characteristics I was interested in were sufficiently

homogeneous to render sampling bias an irrelevant consideration. On the contrary, the participants were post-registration students and might have felt obliged to participate as I was a lecturer within the University even though I was not teaching them. The study cannot be generalised as it only considered a small specific sample of the nursing population. However, the sample provided significant issues related to the concept of agency within clinical practice. The extent in which agency could improve nursing care was not fully explored, therefore, it is necessary to explore the contributions of agency further. The .investigation was set to let the concept of agency shine through the stories rather than investigate the concept of agency directly. The study's timescale was a limitation as this doctorate was four years and funded to a maximum of five. There was a race against time to finish the study within that time. Ethical restrictions and approval were other limitations, it took longer to gain ethics approval, and I could not proceed within that time. The final hurdle was the word limit of 40 000 words which meant less room for manoeuvre than in a traditional PhD. Overall, this was an enjoyable study that got me excited all the way. I am still excited.

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Benner's (2001) Stages of Clinical Competence — Appendix One

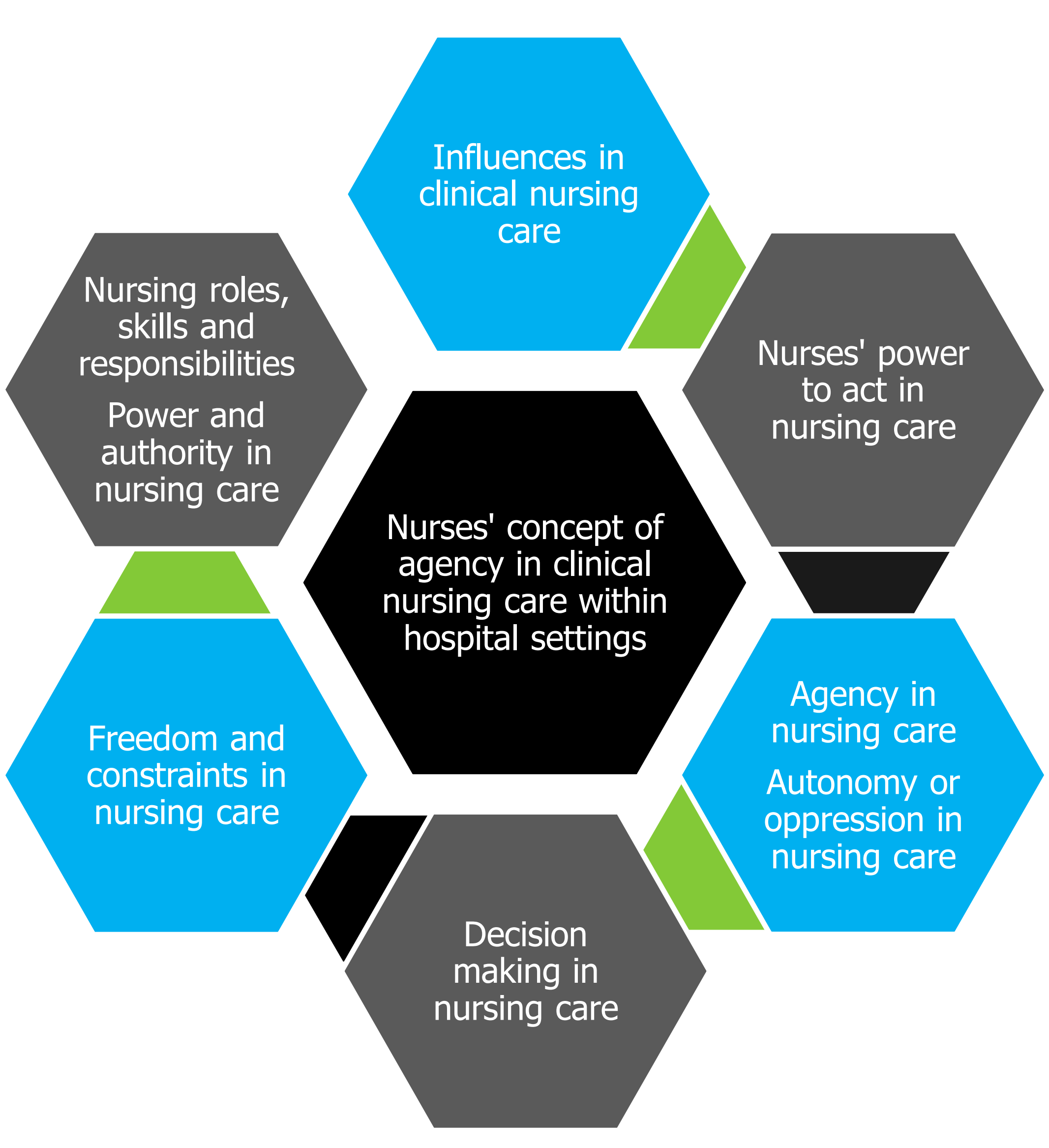
In the acquisition and development of a skill, a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert.

Novice
The *novice* or *beginner* has no experience in the situations in which they are expected to perform. The novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. Practice is within a prolonged time period and the nurse is unable to use discretionary judgement.
Advanced beginner
Advanced beginners demonstrate marginally acceptable performance because they have had prior experience in actual situations. They are efficient and skilful in parts of the practice area, requiring occasional supportive cues. May or may not be within a delayed time period. Knowledge is developing.
Competent
Competence is demonstrated by the nurse who has been on the job in the similar situations for two to three years. The nurse is able to demonstrate efficiency, is coordinated and has confidence in their actions. For the competent nurse, a plan establishes a perspective, and the plan is based on considerate conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation. Care is competent within a suitable time frame without supporting cues.
Proficient
The *proficient* nurse perceives situations as wholes rather than in terms of chopped up parts or aspects. Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long-term goals. The proficient nurse learns from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The proficient nurse can now recognise when the expected normal picture does not materialise. This holistic understanding improves the proficient nurse's decision making, it becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones.
The expert
The *expert* nurse has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of untruthful, alternative diagnoses and situations. The expert operates from a deep understanding of the total situation. Their performance becomes fluid and flexible and highly proficient. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience.

The Mapping of Keywords and Key Phrases Considered

Appendix Two

Phase One



Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Nurses' concept of agency OR nurses' power to act in nursing care AND freedom of choice in actions in clinical practice within hospital settings*	All results ✔ Full text English language Scholarly and peer reviewed Open access e/Books References available Abstract available Journals	89 ✔ 103 102	2 ✘ 1 1	88 ✘ 101 98	Burns, (2019). Costa, Santos, and Costa, (2021). de Simone, Planta and Cicotto, (2018). Gottlieb, Gottlieb and Bitzas, (2021). Phillips, (2019).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✔ Full text e/Books Abstract available Journals	64 ✔ 58 62 60	1 ✘ 1 1 0	62 ✘ 58 62 59	Molina-Mula and Gallo-Estrada, (2020). Möller, de Oliveira, Pai, Azzolin et al., (2021). Munro and Hope, (2020). Rubeis, (2021).

Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Autonomy in nursing AND agency in nursing care*	Full text ✔ Medicine Public health Journal article Scholarly and peer reviewed Open access e/Books English language Abstract available	288 ✔ 131 147	1 ✘ 2 2	287 ✘ 131 146	Costa, Santos, and Costa, (2021). de Simone, Planta and Cicotto, (2018). Gottlieb, Gottlieb and Bitzas, (2021). Phillips, (2019). Trapani et al., 2016).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✔ Full text e/Books Abstract available Journals	61 ✔ 63 59 64	2 ✘ 1 1 1	60 ✘ 63 59 63	Molina-Mula and Gallo-Estrada, (2020). Munro and Hope, (2020). Oshodi et al., (2019). Pursio et al., (2021). Setoodegan et al., 2019). Vassilicos, (2020).

Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Nursing roles and skills AND responsibilities in nursing care*	Full text ✓ Medicine Public health Journal article Scholarly and peer reviewed e/Books English language Abstract available	58 ✓ 174 129	3 ✗ 1 1	57 ✗ 173 129	Burns, (2019). Gonçalves, Sampaio, Sequeira et al., (2020). Phillips, (2019).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✓ Full text e/Books Abstract available Journals	56 ✓ 43 71 67	1 ✗ 0 0 1	55 ✗ 42 71 67	Bucknall, (2003). Gonçalves, Sampaio, Sequeira et al., (2020). Friesen-Storms, Bours, van der Weijden et al., (2015). Möller et al., (2021). Munro and Hope, (2020).

Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Decision-making in nursing care AND doctor-nurse game*	Full texts ✓ English language Scholarly and reviewed e/Books Open access Medicine References available Abstract available Journals	185 ✓ 151 145	2 ✗ 1 1	184 ✗ 151 145	Bagnasco et al., (2020). Brown, (2019). Bucknall, (2003). Carryer, (2011). Darbyshire and Thompson, (2018). Greenlees, 2018). Stein, (1967). Stein, (1990).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✓ Full text e/Books Abstract available Journals	68 ✓ 55 63 69	3 ✗ 0 1 0	67 ✗ 54 63 69	Friesen-Storms, Bours, van der Weijden et al., (2015). Mendizábal, (2018). Nibbelink and Brewer, (2017). Sholehah et al., (2020). Tan, Zhou and Kelly, (2017).

Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Structures in nursing OR hierarchy in nursing AND power and authority in nursing care*	All results ✓ English language Full text online Scholarly and reviewed e/Books Open access Physical items References available Abstract available Journals	172 ✓ 167 157	0 ✗ 1 0	171 ✗ 166 157	Carryer, (2011). Darbyshire and Thompson, (2018). Eekholm, Samuelson, Ahlström et al., (2021). Fernandopulle, (2021). Fox and Alldred, (2018). Stein, (1967) Stein et al., (1990).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✓ Full text e/Books Abstract available Journals	63 ✓ 68 53 49	2 ✗ 1 1 0	62 ✗ 68 52 49	Eekholm, Samuelson, Ahlström et al., (2021). Fernandopulle, (2021). Fox and Alldred, (2018). Giddens, (1984).

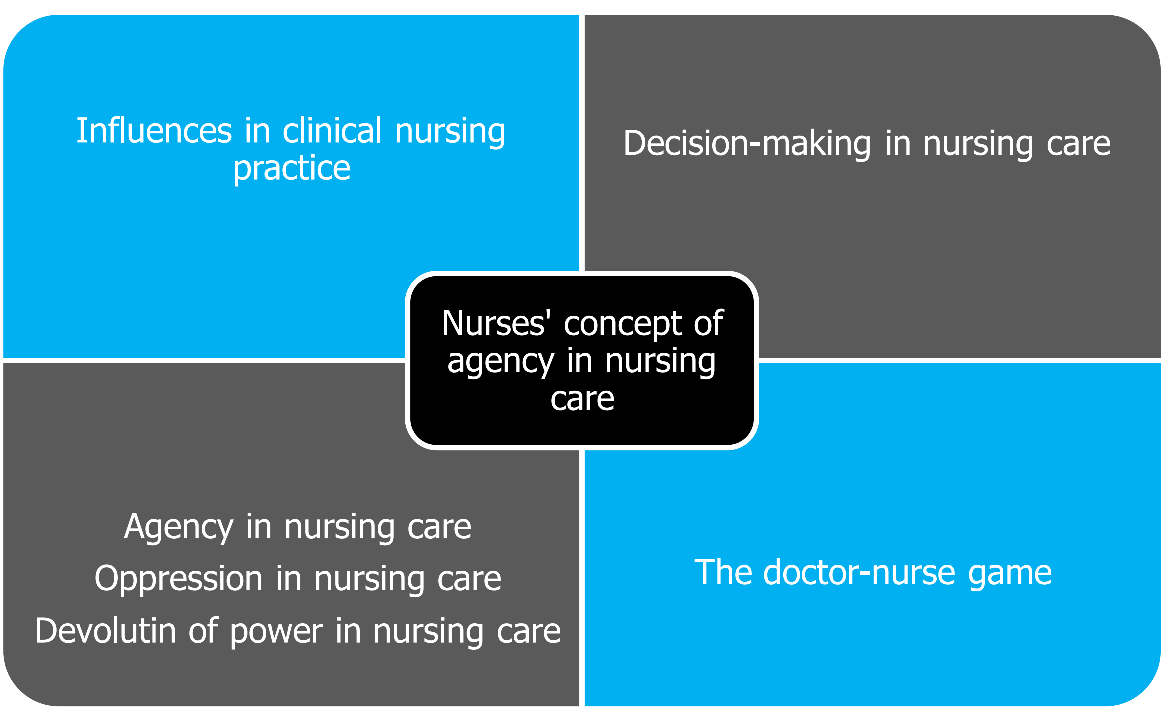
Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Colonialism OR oppression AND devolution of power in nursing*	All results ✔ Full texts Scholarly and peer review Open access References available e/Books Abstract available Journals	191 ✔ 173 119	0 ✘ 0 0	191 ✘ 173 118	Burns, (2019). Dubrosky, (2013). Farrell, (2001). McGibbon et al., (2014). Phillips, (2019). Rodwell and Demir, (2012). Rooddehghan et al., (2015). Young, (1990).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✔ Full text e/Books Abstract available Journals	63 ✔ 61 65 60	2 ✘ 1 0 3	61 ✘ 61 65 60	Juanamasta, Iblasi, Aungsuroch et al., (2021). Mendizábal, (2018). Said, (1978). Valderama-Wallace et al., (2020). Waite and Nardi, (2017).

Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Influences in clinical nursing care AND nursing roles AND freedom and constraints of nurses in nursing care*	All results ✔ Full text Scholarly and peer review Open access e/Books English language References available Abstract available Journals	234 ✔ 107 123	2 ✘ 2 1	233 ✘ 107 122	Bagnasco, Dasso, Rossi et al., (2020). Manias and Street, (2001). Munro and Hope, (2020).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✔ Full text e/Books Abstract available Journals	63 ✔ 62 59 73	1 ✘ 1 1 1	62 ✘ 61 59 72	Bagnasco, Dasso, Rossi et al., (2020). Juanamasta, Iblasi, Aungsuroch et al., (2021). McGibbon et al., (2014). Mendizábal, (2018).

Search Process, Engines and Outcomes						
Database	**Search terms**	**Limiters**	**Hits**	**Duplicates**	**Rejected**	**Selected**
Library catalogue CINAHL MEDLINE	*Nursing knowledge AND types of knowledge AND ways of knowing in nursing*	Full text ✔ Scholarly and peer review Open access e/Books References available Abstract available Journals	121 ✔ 115 121	1 ✘ 0 1	120 ✘ 114 121	Boshoff, (2014).
Mendeley ResearchGate Academia.edu Google Scholar	*Same keywords and phrases as above entered separately*	All results ✔ Full text e/Books Abstract available Journals	64 ✔ 67 41 73	1 ✘ 1 1 1	63 ✘ 67 41 72	Boshoff, (2014).
Hand Searching Physical Items Reference Lists	*All keywords and phrases guided the search*	Books ✔ Journals e/Books Any other written material	64 ✔ 62 24	0 ✘ 0 2	63 ✘ 62 18	Burns, (2019). Giddens, (1984). Nasrabadi, (2015). Said, (1978). Setoodegan et al., (2019). Young, (1990).

The Mapping of the Emergent Themes from the Literature

Phase Two Themes **Appendix Four**



The Critical Literature Review Main Focus

Thematic Summary of the Concept of Agency in Nursing Care

Appendix Five

Theme	Summary
Influences in clinical nursing practice	Influence is anything which makes an impact or changes how nursing is done. It would appear that the role of a nurse has evolved and incorporated other aspects that were once not considered as part of nursing. This theme discusses how nursing has been influenced by various factors such politics, history, society, patient needs, epistemic knowledges, power dynamics and gender influence. Medicine has always and seems to influence much of what nurses do, this suggests that nursing is dominated by medicine.

Theme	Summary
Decision-making in nursing care	Decision-making about patient care seems to be the battle ground in clinical practice, as it is where care is decided for the patient. There are various factors which need to be considered in order for effective decisions to be taken. The patient situation, resources, interpersonal relationships between staff, the role, and responsibilities of the professional, patients and families play a major role in decision-making.

Thematic Summary of the Concept of Agency in Nursing Care

Theme	Summary
The doctor-nurse game	The doctor-nurse game highlights how doctors and nurses have interacted in clinical practice, but also highlights nurses involvement in indirectly decision-making or in recommending patient care in the midst of doctors. Nurses were expected to behave as if they were giving doctors clues about patient care rather than directly making those decisions or recommendations. However, since then the game has changed, and nurses have openly made contributions on decision-making or care recommendations. Some authors have written about how things have changed since then. The question now is, does the doctor-nurse game still exists?

Theme	Summary
Agency in nursing care	Agency is at the core of this thesis, and here, the theme discusses how nurses work, what their role and responsibilities are. According to the literature, nurses seem to work under instructions from doctors, however, there is an indication that autonomy in nursing exists in principle, even though it is granted slowly. It is said that nurses are now tasked with extended roles. Nurses are independent or free in addressing activities of daily living such as washing patients, feeding them, dressing them and so forth.

Thematic Summary of the Concept of Agency in Nursing Care

Theme	Summary
Oppression in nursing care	The literature indicates that there are various forms of oppression that could be or are occurring in nursing. It would appear that where there is oppression, needless to say, there is no freedom. This paints a dark cloud on what is seen as nurses' autonomy in clinical practice if there is any. The faces of oppression that are discussed or seen as related to nursing are, exploitation, marginalisation, powerlessness, cultural imperialism, and violence. There is a discussion that nurses might be aware of oppression in nursing, or they might not be aware of it. However, those who are objective might be able to see it.

Theme	Summary
Devolution of power in nursing care	This concerns giving nurses more power to be able to deliver nursing care they see appropriate for their patients. It is said that doctors hold monopoly on power in clinical practice and it is acknowledged that nurses should be allowed to do more. In response to this, it is said that nursing roles have changed. The question is, how much change has occurred, and how much more change is needed? It would seem that a few chosen nurses are allowed to do extended roles, but this does not apply the whole group. It is suggested that for change to occur, there is a need to change the mindset and epistemic knowledges in nursing.

Inclusion and Exclusion Criteria	
Inclusion Criteria	Exclusion Criteria
Positivist and interpretivist primary and secondary research worldwide. Any material connected with the concept of agency in nursing care. Empirical evidence or data. Full text and peer reviewed. English written material only. No date limit in order to understand the background and history of the nurses' concept of agency to the now in nursing care. Focused on nurses' concept of agency in clinical nursing care. Manually selected materials on nurses' concept of agency in nursing practices. Tutor or peer recommended research articles. Materials from any other country. Published or unpublished material.	Agency (locum) in nursing care. Literature discussing nursing care from unqualified nurses. Literature discussing nursing care from student nurses. Non-English written research articles or material. Literature addressing the concept of agency in unrelated professions or professionals. Literature which was seen as blogs or personal opinions. News bulletins. Material intended for commercial usage.

Overview of Studies that Form the Review **Appendix Seven**

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Bagnasco, A., Dasso, N., Rossi, S., Timmins, F., Aleo, G., Catania, G., Zanini, M. and Sasso, L. (2020). A qualitative descriptive inquiry of the influences on nurses' missed care decision making processes in acute hospital paediatric care. *Journal of Nursing Management,* 28 1929 – 1939).	The aim was to explore influences on nurses' missed care decision-making processes in acute hospital paediatric care.	The study is a qualitative descriptive inquiry which was conducted using semi-structured interviews with paediatric nurses (n = 20) from one paediatric hospital. The interviews were transcribed verbatim, field notes were integrated into the transcription. A thematic analysis was then conducted. The inclusion of participants' quotations added trustworthiness to the data.	The four themes which emerged were nurses' value system: hospital logistics, structures and resources, prioritisation processes, and the informal caregiver's role. The themes identified revealed the factors that influenced the paediatric nurses' decision-making processes related to missed care actions when delivering and planning nursing care.	The design chosen achieved its goal. Steps were taken to ensure methodological rigour. A semi-structured interview schedule was developed using the literature on the topic; it could have been better to be unstructured to allow participants to speak freely. The rich data collection was obtained through interviews and observations to gain a deeper understanding of individual participants, including their opinions, perspectives, and attitudes.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Boshoff, N. (2014). Types of knowledge in science-based practices. *Journal of Science Communication,* 13 (3) 1 – 16.	This theoretical paper focusses on the *knowledge* part of knowledge utilisation and provides a conceptual framework to distinguish between different types of knowledge in science-based practice.	This is a theoretical paper which examines empirical evidence on knowledge utilisation and the distinguishing features between different types of knowledge in science-based practice, including nursing. The paper further provides a theoretical framework that can be used to distinguish between different types of knowledge in practice. It is unclear what type of review the paper is, nor is it stated how the literature used was retrieved.	The study found that the practitioner's knowledge store is a dense set of personal knowledge, consisting of procedural knowledge, factual knowledge, potential factual knowledge and opinions or beliefs; the totality of which is continuously refined through more experiences and additional information received from people, documents or events.	The paper looks at various types of knowledge from those whose activities are informed by the outputs of science, e.g., doctors, nurses and winemakers and those whose task is to produce science, such as molecular biologists. It could have been better to choose one profession rather than all those whose knowledge is science-based. It can be argued that professions do not apply science similarly as practice elements are not the same. The call for evidence-based practice is more strongly felt in health care practitioners.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Brown, JS. (2019). Ending the doctor-nurse game by enhancing the role of the ward nurse. *BMJ,* 364.	An extended discussion on Greenlees' (2018) essay on professional hierarchies or doctor nurse-game by enhancing the role of the ward nurse.	A review or critique article written in response to Greenlees' essay which is based on Darbyshire and Thompson's (2018) essay. It is empirical evidence that discusses ending the doctor-nurse game.	There are no findings as this is not original research. It says a longstanding error in medicine is putting the most inexperienced members of the doctor team in the most vulnerable and important situations when patients need expert decisions and management. It calls for the need to enhance the role of senior nurses on the ward to be in charge and decide to call the doctor team in the event of a deteriorating patient.	The article is not original research and only concludes with one article as its reference. However, it suggests that the junior doctor trainee at the hospital has less experience and knowledge than the nursing team and must spend valuable time assessing the patient. This prolongs the time before a doctor with appropriate training is called. It is suggested that after receiving sufficient training, the nurses should be considered more senior and would be integral contributors to the team, therefore, make decisions.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Bucknall, T. (2003). The clinical landscape of critical care: Nurses' decision-making. *Journal of Advanced Nursing,* 43 (3) 310 – 319.	The study investigated environmental influences on nurses' real decisions in the critical care setting.	The study was interpretative, or a naturalistic design and it used naturalistic observations and semi-structured interviews with 18 critical care nurses. Content analysis was performed on the behavioural observation and interview data. The outcomes were that there were three categories on decision making; patient situation, resources availability and interpersonal relationships.	Clinical decisions were influenced by the context in which the decision was made. There were three environmental influences. These being the patient situation, resource availability and interpersonal relationships. Time and risk guided all clinical decisions. Nurses established the state of the situation, the time constraints on decisions and the risk involved for both patient and nurse.	The use of a naturalistic inquiry was appropriate for the study but does not fit in very well with the use of observations in influences and is unclearly justified. There is no discussion of what naturalistic inquiry is. However, the semi-structured interview questions are best suited for the study to understand the influences from the nurses' perspectives.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Burns, D. (2019). *Foundations of Adult Nursing.* 2nd edition. London. SAGE Publications.	This is a book written to address adult nursing practice. It addresses how nursing has developed from when it began to where it is now. It precisely details how nursing was developed by famous nurses such as Florence Nightingale and how it has developed to the present day.	This is a book which is empirical evidence that is based on available literature and research in nursing that has been done over the years. It describes various aspects of nursing which could be claimed to be up to date.	There are no major findings, but the book discusses current nursing, the role of the nurse, skills, and responsibilities. It also discusses extended roles which are now done by nurses and suggests which roles could done by nurses in future.	The book is presented very well, and it provides excellent information on essentials of nursing such as values, knowledge, skills, and practice. It has everything about nursing practice including medicines management, clinical decision making, leadership and management. Its strongest point is that it is diverse and addresses all aspects of current nursing in depth.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Carryer, J. (2011). Collaboration between doctors and nurses. *Journal of Primary Healthcare,* 3 (1) 77 – 79.	The article examines collaboration between doctors and nurses that influence or affect clinical practice, indicating that there has been a significant pleasure to sense the small but growing and more genuine collaboration at the team and practice level, however, the article questions how this could be fully achieved.	This is an article which discusses the author's viewpoint on doctor and nurse collaboration using empirical evidence.	In this article, it was found that the increase in the prevalence of long-term conditions and the persistence of poverty, deprivation and the subsequently increased need for all types of care has raised the issue of collaboration between health professionals and brought it to the forefront of health professionals' thinking. It seems so much has been written about the importance and value of collaboration, but it has proved such a challenge to achieve.	The article is not original research or a clearly defined literature review. It could have been better positioned as a literature review or original research to address reality in practice. It is referred to as a viewpoint and uses two articles to justify the author's viewpoint on the topic. The article could have discussed the background of the issue of concern first, but this was not done. There was a need to say how the literature used was obtained and screened.

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Costa, RLM., Santos, RM. and Costa, LMC. (2021). The professional autonomy of nursing in pandemic times. *Revista Gaucha de Enfermagem,* 42 e20200404.	The study reflects on the exercise of nursing's professional autonomy during the pandemic.	This is a theoretical-reflexive study under the light of the sociology of professions proposed by Eliot Freidson, using the concepts of professional autonomy, status, expertise, and self-regulation. The author chose the sociological approach due to the good reception Freidson's work has had among Brazilian researchers in the last decade.	It was found that although there are obstacles in nurses' work, autonomous practice contributes satisfactorily to the performance of nurses by revealing all the potential and leadership they have, it allows their professional autonomy to be legitimised. The reflection clarified the importance of nurses putting their autonomy into practice to achieve greater recognition and social appreciation of their work in times of pandemics.	This theoretical study uses Freidson's concepts to understand nurses' professional autonomy. It is good as it relates to the current situation by relating the author's knowledge with theory. Theory can easily be inaccurate; therefore, the study could have benefited by being a research study with participants sharing their experiences. The current literature is used in the study and discusses the Covid-19 pandemic and how it has highlighted the need for autonomy.

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Darbyshire, P. and Thompson, D. (2018). Gosport must be a tipping point for professional hierarchies in healthcare: An essay by Phillip Darbyshire and David Thompson. *BMJ,* 363.	The essay discusses professional hierarchies and the doctor-nurse game in healthcare and how they contributed to the 600 patient deaths at Gosport War Memorial Hospital and avoidable deaths at Mid Staffordshire NHS Trust, which led to the Francis report and the Morecambe Bay report on avoidable deaths at the maternity department of Furness General Hospital.	This essay based on available empirical evidence related to professional hierarchies and the doctor-nurse game. The measured outcome was on how some game elements still exist or impact the daily interaction of nurses and doctors in clinical practice. The interventions discussed are the proposal of ending the game. It is emphasised that action is needed; otherwise, if nurses and doctors do not take action, the game will continue for another 50 years.	The doctor-nurse game, lethal silence, dancing around care needs and professional imperative were seen as major issues in the professional hierarchies. Nurses cannot question prescribed care; there is lethal silence and dancing around patients' care needs. Doctors and nurses have made little progress in improving working relationships since the game was described. There is a need to question and challenge practices.	The essay considers existing evidence and how it relates to hierarchies and the doctor-nurse game. This evidence is where the challenges in clinical practice are drawn from. The essay is not original research; therefore, it cannot be ascertained that the conclusions made are the reality in clinical practice. It would have been better as a study, possibly ethnographical, to ascertain the discussion and conclusions made.

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de Simone, S., Planta, A. and Cicotto, C. (2018). The role of job satisfaction, work engagement, self-efficacy and agentic capacities on nurses' turnover intention and patient satisfaction. *Applied Nursing Research,* 39 130 – 140.	This research explores and explains nurses' voluntary turnover by analysing the role of self-efficacy, agentic capacities, job satisfaction, and work engagement on hospital turnover intention and studying the relationships between these variables and patient satisfaction.	This is a survey which gathered data from 194 nurses and 181 patients from 22 inpatient wards at two hospitals in southern Italy.	Correlation analysis revealed that job satisfaction, work engagement, self-efficacy and agentic capacities were positively interrelated and negatively correlated with turnover intention. Path analysis showed that self-efficacy, some agentic capacities (anticipation and self-regulation), job satisfaction, and work engagement had direct or indirect effects on nurses' turnover intention.	The study is a survey, but it is not explicitly stated; it becomes evident that it is a survey after reading it. It involved nurses and patients and examined nurses' voluntary turnover from different perspectives. The study could have involved other health professions in contributing to the information they obtained from nurses and patients to understand the situation fully.

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Dubrosky, R. (2013). Iris Young's five faces of oppression applied to nursing. *Nursing Forum,* 48 (3) 205 – 210.	The purpose of the review was to explore Iris Young's five faces of oppression as a framework for understanding oppression of nurses.	This is a literature review which was done to explore the five faces of oppression and how these can be applied to nursing. The measured outcome was that of understanding the five faces of oppression as a framework in comprehending oppression of nurses.	There are no findings in this extended literature review. However, this is related well to nursing and explores how nurses could be oppressed. It certainly provides an insight into how nurses are or could be oppressed.	The review is good as it looks at oppression and relates it well to nursing, but it is unclear why nursing was related to the five faces of oppression in the first place. The article reads more like an extended literature with fives faces of oppression linked to nursing and justification supported by existing literature. She makes it clear why she believes nursing is oppressed by answering what she is questioning using published material.

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Eekholm, S., Samuelson, K., Ahlström, G. and Lindhardt, T. (2021). Stolen time: Delivering nursing at the bottom of a hierarchy: An ethnographic study of barriers and facilitators for evidence-based nursing for patients (BFEBNP) with community-acquired pneumonia. *Healthcare (Switzerland),* 9 (11) 1524 – 1541.	The aim of this study was to describe the barriers and facilitators influencing registered nurses' (RNs') adherence to evidence-based guideline (EBG) recommendations for nursing care (NC) for older patients admitted with community-acquired pneumonia (CAP).	Semi-structured focus group interviews (n = 2), field observations (n = 14), and individual follow-up interviews (n = 10) were conducted in three medical units and analysed by a qualitative content analysis. This study identified central factors that may help RNs to understand the underlying dynamics in a healthcare setting hindering and facilitating the performance of NC and make them better equipped for changing practices.	The study found main themes of stolen time, delivering nursing at the bottom of a hierarchy, under the dominance of stronger paradigms, the loss of professional identity, and the power of leadership. These themes comprised subthemes, illustrating that RNs' adherence to EBG recommendations was strongly influenced by RNs' professionalism and identity, contextual barriers, including organisational structure, culture, and evaluation of the NC.	It is clearly stated that this is an ethnographic study of barriers and facilitators for evidence-based nursing for patients with community-acquired pneumonia. The methodology is appropriate as it allowed a deeper understanding of BFEBNP. The study wanders into nursing professionalism and identity, the contextual barriers, including organisational structure, culture, and evaluation of the nursing care.

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Farrell, GA. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing,* 35 (1) 26 – 33.	To develop a conceptual framework to account for interpersonal conflict in nursing. To extend the boundaries of debate on the causes of interpersonal conflict in nursing.	A critical analysis of an extended literature review adapted from a doctoral dissertation.	It is contented that it is not only the alleged misogyny intrinsic to oppression theory that shackles and impedes nurses but nurses themselves who in their everyday work and interpersonal interactions, act as insidious gatekeepers to an iniquitous status quo.	The critical analysis of the extended literature is written well and discusses oppression and feminist perspectives in detail. This study implies that nurses are a colonised group, but it does not discuss how. The study looks at oppression from different perspectives but sometimes the information provided is very brief and does not go into detail about what is discussed.

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Fernandopulle, N. (2021). To what extent does hierarchical leadership affect health care outcomes? *Medical Journal of the Islamic Republic of Iran,* 35 (1) 1 – 4.	The purpose of the study is to understand to what extent hierarchical leadership affects health care outcomes.	This is a literature review which looks at hierarchical leadership in clinical practice starting from ward rounds. It draws viewpoints from different sources that have looked at leadership and hierarchical structures in health care and suggests alternatives.	The study found that hierarchical leadership is an antiquated practice in health care, whereby strictly defined roles and their importance are overemphasised. This has unintended negative consequences in a pressurised environment. In contrast, flat hierarchies are gaining popularity, as they afford the flexibility and equality vital in practice, where no one should be afraid to raise concerns and voice their opinions.	The literature review looks at the commonly used hierarchical leadership styles in health care. The limitation is that only two types of leadership are discussed. The author seems to favour the flat hierarchies over the hierarchical leadership style. It is unclear what type of literature review this. This literature review would have benefited from looking at various leadership styles, engaging in a debate and being a systematic review.

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Fox, NJ. and Alldred, P. (2018). Social structures, power and resistance in monist sociology: (New) materialist insights. *Journal of Sociology,* 54 (3) 315 – 330.	The literature review examines social structures, power and resistance in monist sociology. It considers two monistic sociologies: Bruno Latour's 'sociology of associations' and DeLanda's ontology of assemblages. Understandings of social processes in terms of structures, systems or mechanisms are replaced with a focus upon the micropolitics of events and interactions.	This is a literature review which discusses structures and how mainstream sociological theory has been founded within dualisms such as structure/agency, nature/culture, and mind/matter, a thread within sociology dating back to Spencer and Tarde favoured a monist ontology that cut across such dualistic categories.	The study found that power is a flux of forces fully immanent within events, while resistance is similarly an effective flow in events producing micropolitical effects contrary to power or control. The findings conclude that the relationality of the world is operationalised via an understanding of agency that no longer privileges human action.	The literature review is well-written and discusses power and other related discourses. There is a mention of patriarchy, colonialism, homophobia and caste systems, the scapegoating of foreigners and the anthropocentrism that underpins activities which occur in society. This study is not in nursing but relates to the power structure in clinical practice. It could be said that this is a universal study which applies to any field.

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Friesen-Storms, JHHM., Bours, GJJW., van der Weijden, T. and Beurskens, AJHM. (2015). Shared decision-making in chronic care in the context of evidence-based practice in nursing. *International Journal of Nursing Studies,* 52 393 – 402.	This literature review discusses shared decision-making in chronic care in the context of evidence-based practice in nursing. This paper discusses the relevance of shared decision making in chronic care and to suggest how it can be integrated with evidence-based practice in nursing. The discussion is primarily relevant to countries in which advance practice nursing and team-based practice is within nursing's scope of practice.	This study is a literature review. It did not intend to provide a systematic and complete review of the literature. However, the CINAHL and PubMed digital databases were searched. A network of experts on evidence-based practice and shared decision-making was consulted to include the most relevant papers that underpin the discussion based on previous literature and ensure that key points had not already been published elsewhere.	The study found that patients' willingness to participate in shared decision-making, the clinical expertise of the nurse, and the context in which the decision making takes place affect the shared decision-making process. A knowledgeable and skilled nurse with a positive attitude towards shared decision-making integrated with evidence-based practice can facilitate the shared decision-making process.	The study discusses influences on decision-making from various perspectives. It makes it clear that the patient plays a significant role in decision-making and is the main focus. This study focuses mainly on nurses and patients and does not consider other health professions. It discusses the impact on the patient, the nurse, and the context of shared decision-making. Finally, the nursing implications are addressed.

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Giddens, A. (1984). *The Constitution of Society:* Outline of the theory of structuration. California. University of California Press.	This book discusses the constitution of society and outlines the theory of structuration, a theory of social action, which claims that society should be understood in terms of action and structure, a duality rather than two separate entities. The book also set up an approach to social theory of a very definite type, combining a sophisticated version of functionalism and a naturalistic conception of sociology.	This book is empirical evidence based on available literature and research on structuration that has been done over the years. It seeks to establish an approach to social science that differs substantially from existing traditions of social thought. The book provides a summation of previous writings, setting them in what is a developed coherent manner of the structuration theory.	There are no major findings; the book addresses the constitution of society and structuration. It is argued that there should be action and structure for society to function coherently. The structuration theory is related to other theories such as functionalism, hermeneutics, phenomenology and interpretative traditions, as these strongly connect to sociology.	The book is presented very well and provides excellent information on the structuration theory. Its strongest point is that it is diverse and addresses everything related to the structuration theory. Theories from other theorists are incorporated or looked at in detail concerning the discussed theory. This is a bible in understanding society's functionality.

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Gonçalves, PDB., Sampaio, FMC., Sequeira, CAC. and Paiva e Silva, MATC. (2020). Data, diagnoses, and interventions addressing the nursing focus delusion: A scoping review. *Perspectives in Psychiatric Care,* 56 175 – 187.	The purpose of this study was to explore and synthesize literature related to the nursing process addressing the focus *delusion*.	This literature review is integrated with a scoping study framework. From the total 252 papers found, 39 were selected. This scoping review is the first to explore the nursing process addressing the focus delusion. In this way, information about diagnostic activities and relevant data, diagnostic hypotheses, and nursing interventions related to the focus delusion have been described.	Relevant data and diagnostic activities, hypothetic nursing diagnoses, and interventions addressing the focus *delusion* were identified*,* based on the steps of the nursing process identified. This clinical data model may contribute towards improving nursing clinical decision-making and nursing care quality in relation to a client suffering from delusion as well as producing more reliable nursing-sensitive indicators.	It is clearly stated that the literature review is a scoping review. A strength of this literature review is that the search included English, Spanish, and Portuguese language papers. On the other hand, there are certain limitations which are inherent to a scoping review approach: (a) the considerable quantity of data generated and (b) the absence of synthesis, i.e., the relative weight analysis of the evidence found.

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Gottlieb, LN., Gottlieb, B. and Bitzas, V. (2021). Creating empowering conditions for nurses with workplace autonomy and agency: How healthcare leaders could be guided by Strengths-Based Nursing and Healthcare Leadership (SBNH-L). *Journal of Healthcare Leadership,* 13 169 – 181.	The purpose of this paper is three-fold: First, to describe the concepts of agency, autonomy, and structural and psychological empowerment; Second, to examine leadership styles that contribute to nurses' autonomy and empowerment; Third, to propose a value-driven leadership framework, namely, (SBNH-L), to guide nurse and healthcare leaders to create empowering conditions for nurses to encourage autonomy and exercise their agency.	This is a literature review concerned with nurses' knowledge and skills desperately needed during the Covid-19 pandemic. It measured how leaders are instrumental in setting the tone and creating the climate and culture that either values or devalues autonomy and agency.	The study highlights that job satisfaction has been related to nurses feeling empowered to exercise autonomy over their practice and having agency. Leadership is integral to creating conditions that permit nurses to work in environments where they feel empowered to be autonomous and exercise their agency.	This literature review is well-written; however, it is not stated what type of literature review this is. The focus is clear as it is on various aspects of the concepts of agency, autonomy, structural, psychological empowerment, leadership styles, empowerment and agency. This review could have been better being original research to ascertain the reality of what is discussed. On the other hand, it examines extensive studies to make sense of the current situation.

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Greenlees, GC. (2018). Transience and hierarchy: Ending the doctor-nurse game. *BMJ,* 363.	An extended discussion on Darbyshire and Thompson's (2018) essay on professional hierarchies or the doctor-nurse game.	A review or critique article was written in response to Darbyshire and Thompson's essay. It is empirical evidence that also brings into consideration medical power in clinical practice and the role of medical students in the doctor-nurse game.	There are no findings as this is not original research. The article adds that there are power dynamics within clinical practice. It also mentions that medical students often have little experience of clinical responsibility, with some saying they are treated as little more than an annoyance by senior doctors and other ward staff; junior doctors must feel supported and heard in raising concerns about culture and hierarchy to stop the game continuing.	The article is strong in adding more to what is in the main domain. It looks at the power and hierarchies that exist within clinical practice. The culture, structure and hierarchies mainly influence the doctor-nurse game. It is suggested that most in clinical practice do not challenge the culture; they leave it for someone else to endure. It suggests that everyone needs to feel supported and heard in raising issues of concern about the culture and hierarchy.

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Juanamasta, I., Iblasi, AS. Aungsuroch, Y. and Yunibhand, J. (2021). Nursing development in Indonesia: Colonialism, after independence and Nursing Act. *SAGE Open Nursing,* 7 1 – 10.	The purpose of this literature review was to look at nursing developments in Indonesia. This is because stereotyping of nurses still occurs nowadays in Indonesia. Society and healthcare think nursing is a doctor helper service. The public image of a nurse as a doctor's helper is hard to erase. The authors felt that the nursing development in Indonesia needs to be explored in describing the stereotyping and the nursing conditions in the current situation.	This is a literature review detailing the developments in nursing practice in Indonesia which will increase autonomy and dignity. The study used a narrative review with 45 sources analysed and extracted. Increasing education curricula, practice competency, and research impact will change the perspective of society with the support of recognition and education from the nursing organisation.	The findings are that nursing education has developed since colonialism. It brought nurses into the professionalism of healthcare which the Indonesian government recognised. However, nurses' practice culture did not change for a long time because of a lack of research and literature evaluated from 1990 to 2010. Then, nurses have faced new problems, including practice and education gaps. There is still colonialism in nursing practice.	This narrative review is structured and well discussed. The colonialism discussed is that of politics; however, it is clear how some elements of colonialism or oppression exist in nursing. The history of nurse development is detailed; however, the review's aims and objectives are unclear. There is no researchers' positionality on this chosen topic. Nevertheless, the study relates well to oppression in nursing.

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Manias, E. and Street, A. (2001). The interplay of knowledge and decision making between nurses and doctors in critical care. *International Journal of Nursing Studies,* 38 (2001) 129 – 140.	The study explored the complex relationships between knowledge and decision making as nurses and doctors interacted with each other in a critical care unit which included a cardiothoracic unit.	This study used a critical ethnographic design and involved a research group of six nurses who worked in the unit. The sampling method is not made clear. It is likely that this was a purposive or convenient sampling. Data collection was done by journaling, observations, individual and focus group interviews. Data analysis was done by frequent readings of the transcripts to increase the researchers' familiarity with them.	Nurses differentially valued their knowledge, depending on the situation, experience, and level of medical input. They were also involved in decision-making based on their differential visibility in the process. Nurses' specialist knowledge of the critical care unit played a major role in influencing how they interacted during decision making. However, it is unclear how this was so.	The study's strong points are that it used critical ethnography which enabled the researcher to triangulate data collection and understand the study from various perspectives. It would have been beneficial to discuss the sampling used, this appears missing, and it is unclear what relationship the researchers had with the participants. They could have said what kind of participant observations they did.

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McGibbon, E., Mulaudzi, FM., Didham, P., Burton, S. and Sochan, A. (2014). Toward decolonising nursing: The colonisation of nursing and strategies for increasing the counter-narrative. *Nursing Inquiry,* 21 (3) 179 – 191.	The goals of this discussion article are to underscore the urgent need to further articulate postcolonial theory in nursing and to contribute to nursing knowledge about paths to work toward decolonising the profession.	This discussion article examines nursing's participation in colonising processes and practices which have not taken hold in nursing's consciousness or political agenda. Based on examining politics and the power of the structural determinants of health, critical analyses continue to be marginalised in the profession.	It is said that colonialism is imbued with many foundational beliefs and assumptions based on nurses' careers in the nursing profession over many years. One of the strongest beliefs driving the persistence of colonial thinking and practices in nursing is that colonialism is a thing of the past. Because it happened long ago, nurses have nothing to do with it, and it must be over. Colonialism in nursing is encapsulated in discrete events.	The review is written well and bases its discussion on relevant literature. Processes involved in the colonisation of nursing are described in detail, including the colonisation of nursing's intellectual development and the white privilege and racism that sustain colonising thinking and action in nursing. It is unclear how decolonisation can be achieved. The review could have been better, original research to ascertain reality in nursing practice.

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Mendizábal, JA. (2018). The democratic care in Argentine nursing: Historical and social aspects unveiled by gender perspective. *Cultura de Los Cuidados,* 50 58 – 67.	The purpose of the review was to identify the grammar of interaction, the subjectivities that cross it and the different forms of coloniality present in the profession through the gender matrix to account for the lines of care that threaten or promote sovereignty with plurality.	A historiographical study of theoretical analysis. The theoretical analysis is based on the existing literature.	The findings were that different historical periods in nursing had shown the possibility of unequally expanding or restricting the profession's citizenship. The recognition of autonomy is a historical political and social turning point of small symbolic capitalisation. The practice continues to be influenced by oppressive historical burdens by weaving care that becomes undemocratic.	The historiographical study of theoretical analysis is detailed and identifies the grammar of interaction, the subjectivities that cross it and the different forms of coloniality present in the profession. However, it is unclear what it is that has contributed to coloniality. Coloniality is a product of colonialism. It would have been great to discuss colonialism and its nature in nursing practice before discussing coloniality to better understand this historiographical study of theoretical analysis.

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Molina-Mula, J. and Gallo-Estrada, J. (2020). Impact of nurse-patient relationships on quality of care and patient autonomy in decision making. International *Journal of Environmental Research and Public Health,* 17 (3) 835 – 852.	The aim of this study is to analyse the nurse-patient relationship and explore their implications for clinical practice, the impact on quality of care, and the decision-making capacity of patients.	A phenomenological qualitative study was conducted to analyse the nurse-patient relationship and explore its implications for clinical practice and the decision-making capacity of patients. Thirteen in-depth interviews with nurses and 61,484 nursing records from internal medicine and specialties departments from 2015 – 2016 were used. Discourse analysis and triangulation were conducted.	The analysis of the interviews resulted in a category defined as *patient as a passive object.* These elements describe the current situation in a hospital setting and the ability of the patient to make decisions regarding the kind of care they want from the perspective of the nurse. This study reveals that the patient is not autonomous in making decisions about their care due to the characteristics of the nurse's relationships with the patient.	This phenomenological study is written well, and the participants' experiences are presented with direct quotes from the participants. The study concentrates on patient decision-making rather than the nurse's decision-making. However, within the study, it is clear that the nurse is limited in making decisions with or for the patient as decision-making involves other professions rather than the nurse and the patient only.

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Möller, G., de Oliveira, JLC., Pai, DD., Azzolin, K. and de Magalhães, AMM. (2021). Nursing practice environment in intensive care unit and professional burnout*. *Revista Da Escola de Enfermagem,* 55 1 – 8.	The study evaluated and compared the nursing practice environments in Intensive Care Units (ICU) of public and private hospitals and the prevalence of burnout among nursing professionals.	The study is a cross-sectional, descriptive study with a quantitative approach to the data. The data collection was carried out through a questionnaire with socio-occupational variables and metrics of intensity. We included professionals with at least six months of employment. The sample consisted of 296 professionals.	The study found favourable environments in both institutions; however, low results in the subscales autonomy, control and organisational support in the private hospital. The prevalence of burnout among nurses was 2.5% in the public hospital and 9.1% in the private hospital, and among nursing technicians, it was 9.5% and 8.5%, respectively.	The study mainly discusses practice environments and burnout among nurses. However, it mentions autonomy as it reduces burnout among nurses. Nonetheless, the control of the environment, autonomy and support were considered critical points, referring to the importance of assessing institutions factors that can improve the working conditions for the nursing team.

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Munro, CL. and Hope, AA. (2020). Empowering nurses in 2020, the year of the nurse. *American Journal of Critical Care,* 29 (3) 165 – 167.	The purpose of this article is to empower nurses by emphasising how nursing should progress in its development. It looks at how investing in and empowering nursing can yield tangible benefits.	This is an editorial paper calling on all countries to invest in nurses and midwives as part of their commitment to health for all.	There are no findings, but it is emphasised that every professional in critical care should be empowered and encouraged to use their knowledge, skills, and judgment to practice to the full extent of their education and training. This is the essence of full practice authority and should be the norm. Nurses and others should contribute their full capabilities in working together to provide care for critically ill patients.	The article brings a thought that is worth considering in nursing and globally. The article has a collection of ideas from empirical evidence to current issues in the public domain. Its weakness is that it is not original research; therefore, some of the information could be personal rather than evidence based. It also uses a few sources of evidence to base its discussion. The article does not mention agency or autonomy; however, what is proposed resonates with the two.

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Nibbelink, CW. and Brewer, BB. (2017). Decision-making in nursing practice: An integrative literature review. *Journal of Clinical Nursing,* 27 917 – 928.	The purpose of the review was to identify and summarise factors and processes related to registered nurses' patient care decision-making in medical–surgical environments. A secondary goal of this literature review was to determine whether medical–surgical decision-making literature included factors that appeared to be similar to concepts and factors in naturalistic decision making (NDM).	An integrative review was conducted to include various research methodologies. PubMed and CINAHL databases were searched, and research meeting criteria were included. Data were identified from all included articles, and themes were developed based on these data. Thematic analysis was used to synthesise and summarise factors and processes that emerged from the literature.	Key findings in this review included nursing experience and associated factors; organisation and unit culture influences decision-making; education; understanding of patient status; situation awareness; and autonomy. Incorporating evidence into acute care nursing practice continues to be a struggle for acute care nurses. Experience was the most commonly identified theme.	This review provides new information on research on nurse decision-making in medical-surgical settings. Despite the broad focus of the search, this review had limitations. While autonomy influences decision-making in nursing, how autonomous nurses differ from nonautonomous nurses is unclear. In addition, how nurses developed the skills necessary for understanding patient status and situation awareness is not clarified.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Oshodi, TO., Bruneau, B., Crockett, R., Kinchington, F., Nayar, S. and West, E. (2019. Registered nurses' perceptions and experiences of autonomy: A descriptive phenomenological study. *BMC Nursing,* 18 51 – 64.	This qualitative study aimed to explore the understanding and experiences of autonomy of nurses working in England. Professional autonomy is a key concept in understanding nurses' roles in delivering patient care. Recent research exploring the role of autonomy in the nursing work environment indicated that English and American nurses had differing perceptions of autonomy.	A phenomenological approach was employed to understand the perceptions and experiences of autonomy of nurses in England. A descriptive phenomenological analysis of data from 48 semi-structured interviews with registered nurses from two National Health Service (NHS) hospitals (purposive sample) was used to explore the concept of autonomy.	Six themes were identified: working independently; working in a team; having professional skills and knowledge; involvement in autonomy, boundaries around autonomy, and developing autonomy requires support. Nurses related autonomy to their clinical work and the immediate work environment of their ward rather than to a wider professional context.	This study was conducted in two NHS hospitals in the Southeast of England. This makes it difficult to say how typical they are of all acute trusts in England and may limit the generalisability of the findings. The fact that the study's sample was predominantly women could be a limitation, as findings might have differed if there were more male participants. The study solely discusses autonomy rather than agency, with is the main focus of this thesis.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Phillips, H. (2019). Training nurses to do surgery. *Royal College of Surgeons Review.*	The purpose of the review was to look at nurses who were being trained to carry out surgery, including hernia and gynaecological operations.	This review looked at the development of the nursing role in various clinical institutions. It also considered agencies such as the National Association of Theatre Nurses and The Royal College of Nursing tasked with this development. It also involved health professionals involved in voicing their views. The outcomes measured were how to achieve the nurse competencies needed for further development of the nursing role.	It was found that nurses are now being trained to carry out surgery, including hernia and gynaecological operations. Other surgical areas now being tackled by healthcare workers from nursing and support backgrounds include vascular surgery, orthopaedics, ophthalmology and gynaecology. It is said that these are a good way of improving nurses' careers and keeping nurses in the NHS.	This review provides current information and indicates the direction of future nursing. It implies that the future of nursing is based on extended roles. It does not seem to question what nursing is or should be. It is more sided with making nurses mini doctors than independent professionals. Nevertheless, it seems nursing is dependent on medicine, and as such, it continues to overlap with what doctors do in clinical practice.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Pursio, K., Kankkunen, P., Sanner-Stiehr, E. and Kvist, T. (2021). Professional autonomy in nursing: An integrative review. *Journal of Nursing Management,* 29 1565 – 1577.	The purpose of this review was to summarise knowledge of professional autonomy in nursing. Professional autonomy is associated with experienced meaningfulness of the work. This refers to participation in decision-making and the ability to influence working practices.	In this integrative review, relevant studies were retrieved from four databases. The search identified 27 relevant studies which were conducted in 17 countries and published between 2000 and 2019. Quality was systematically evaluated using critical appraisal tools. PRISMA guidelines were followed. Inductive content analysis was used to analyse current knowledge of the focal subject.	**Findings:** The freedom to make care decisions and work independently is crucial as it reportedly allows full utilisation of nurses' knowledge and abilities. Important aspects of professional autonomy and associated advantages that are widely recognised in the reviewed studies include having authority over oneself, freedom to make clinical decisions, with accountability, and act in accordance with the decisions.	The review is written well; however, some studies may have been missed. The included studies were highly heterogeneous. They had widely varying designs, applied 10 different instruments and had widely varying numbers of participants. This complicated the combination of results and synthesis of findings. Additionally, researchers still have differing views on how the concept of professional autonomy should be defined and understood.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Rodwell, J. and Demir, D. (2012). Oppression and exposure as differentiating predictors of types of workplace violence for nurses. *Journal of Clinical Nursing,* 21 2296 – 2305.	To extend a model of the antecedents of workplace bullying to apply to a wider range of types of workplace aggression, including bullying and several types of violence, among nurses.	This study is a cross-sectional design. A validated questionnaire was sent to the work addresses of all nursing and midwifery staff in a medium-to-large hospital in Australia. A total of 273 nurses and midwives returned their completed questionnaires. Ordinal regressions were conducted to assess the antecedents of workplace aggression across bullying and violence.	**Findings:** Aspects of job tenure significantly predicted particular forms of violence, while negative affectivity and work schedule were significant for bullying. The results suggest key mechanisms that characterise certain forms of violence and distinguish between bullying and types of violence across the range of workplace aggression. In particular, oppression and exposure appear to differentiate types of workplace violence.	The type of study could have been more specific by saying it is quantitative. The study results are interpreted in light of the limitations of cross-sectional study designs and self-report measures. The study's cross-sectional nature impacts the authors' ability to draw conclusions about the causality of the antecedents of workplace aggression. The study's response rate was relatively low, with 37.1% of nurses and midwives participating.

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Rooddehghan, Z., Yekta, ZP. and Nasrabadi, AN. (2015). Nurses, the oppressed oppressors: A qualitative study. *Global Journal of Health Science,* 7 (5) 239 – 245.	The study aimed to explain the nurses' experiences of equity in healthcare provision. In the absence of comprehensive research to assess equity in healthcare, the dimensions of this crucial phenomenon in the country had remained unexplored.	A qualitative study described the experiences of 18 clinical nurses and nurse managers selected through purposive sampling. The inclusion criteria were the nurses' familiarity with the subject of the study and willingness to participate. The data were collected through in-depth, unstructured, face-to-face interviews. Interviews were recorded, transcribed word by word, and then analysed using thematic analysis.	The study found that since people tend to firmly resist being labelled as oppressive or oppressed, they may try to simultaneously fit in both groups, i.e., they may be oppressors from one perspective and oppressed from another. The studied nurses fluctuated between states of oppression and submissiveness in the provision of equal care. The submissiveness of nurses led to their oppression.	The study is qualitative, but it is unclear what methodology or research approach was used. The study is weak in the methods. It is said that oppression, a phenomenon experienced and reported by most nurses worldwide, occurs when a dominant group develops a series of norms and regards outsiders as inferior, but is not confirmed by the data. It is characterised by unfair behaviour, ignoring others' rights, and disrespecting their dignity.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Rubeis, G. (2021). Guardians of humanity? The challenges of nursing practice in the digital age. *Nursing Philosophy,* 22 (2) e12331.	This paper aims to analyse the potential challenges of nursing practice in the digital age. As an alternative to this outdated role, nurses should be included in technology design and policymaking processes. Enabling nursing professionals to shape the circumstances of a digitally enhanced holistic practice may empower their status within the healthcare system and benefit the patient by contributing to more person-centred care.	The analysis is conducted through the lens of new materialism, a set of theoretical models that understand the relationship between humans and technology as dynamic and performative. According to this view, there is no prefixed essence of technology. Rather, the meaning of technology is enacted in concrete practice.	The analysis shows that in past debates on technology use in nursing, the nurses' role has been defined as guardians of humanity, defending the patient against the dehumanising effects of technology. This role has been transferred to the digital age, where nurses must cushion the negative effects of digital technology.	The analysis is written fairly well, but it fails to address the technology that nurses already use and build the discussion and argument from there to say how the potential challenges of nursing practice in the digital age have occurred. The flaw of this model is obvious. It lies in the perpetuation of the false dichotomy between humanity and technology. It builds on the classical role of nurses as guardians of humanity and transports it to the digital age.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Said, E. (1978). *Orientalism.* London. Routledge.	This book addresses orientalism and other discourses of oppression in the modern world.	The book is empirical evidence based on available literature and research on oppression. It describes various aspects of oppression and is very specific to orientalism.	**Summary:** Orientalism is the imitation or depiction of aspects of the Eastern world and the idea that Western society is developed, rational, flexible, and superior. It emphasises that Western learning and Empires are superior to any other. It refers to a general patronising Western attitude towards Middle Eastern, Asian, and North African societies. In orientalism, peoples are deemed incapable of representing or governing themselves.	The book is presented very well and provides excellent information on oppression. Its strongest point is that it is diverse and addresses everything related to orientalism. Theories from other theorists are incorporated or looked at in detail concerning the discussed theory. The book provides a detailed description of orientalism and how the Western world depicts it, yet they imitate it and make some aspects look like their original ideas. It is some form of epistemic exploitation.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Setoodegan, E., Gholamzadeh, S., Rakhshan, M. and Peiravi, H. (2019). Nurses' lived experiences of professional autonomy in Iran. *International Journal of Nursing Sciences,* 6 315 – 321.	The study aimed to assess nurses' lived experiences of professional autonomy. Nurses' autonomy is a complex and multi-dimensional concept that has often been overlooked. Although many studies have addressed patients' autonomy, there has been no assessment of nurses' experience of professional autonomy.	This qualitative study's target population were nursing professionals employed by various hospitals. The experiences of the participants were assessed through 14 in-depth semi-structured interviews. The response of the participants was analysed using Van Manen's 6-step approach for interpretive phenomenology.	**Findings:** The participating nurses indicated that patient rights support is of prime importance. They believed that the rights of the patients and nurses are intertwined. Violation of nurses' rights would, in turn, negatively affect the patients' rights. The participants considered direct involvement in the decision-making process, in terms of both the macro-and micro-level healthcare, as an integral part of professional autonomy.	The study is said to be qualitative, but it is unclear what type it is. The authors say the participants' responses were analysed using Van Manen's 6-step approach for interpretive phenomenology. They use the term interpretive phenomenology, but van Manen does not call his methodology interpretive phenomenology. The word qualitative is generic, and it would have been better to use hermeneutic phenomenology per van Manen's methodology.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Sholehah, B., Astari, AM. and Kapti, RE. (2020). Factors influencing in clinical decision making of nurses: A systematic review. *International Journal of Science and Society,* 2 (3) 135 – 145.	This study aimed to examine factors influencing nurses' clinical decision-making using a systematic review.	This systematic review was compiled using ProQuest, Science Direct and PubMed databases. A total of 564 articles from ProQuest, 219 articles from Science Direct and 216 articles from PubMed. 13 articles were selected for use in accordance with inclusion criteria.	**Findings:** Decision making is important for nurses to do. Improper clinical decision-making can have fatal consequences for patients. It is a complex process consisting of careful assessment of medical conditions, the use of nursing knowledge and learning based on critical thinking experiences. Nurses' clinical decision-making is important due to the risks patients face; thus, the nurses should think critically.	This systematic review is appropriate for information; however, the information it provides is sometimes vague. The study uses 13 articles. It could have benefited from having more articles and an in-depth discussion. It might not have achieved this as it was part of a Masters dissertation.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Stein, LL. (1967). The doctor-nurse game. *Archives of General Psychiatry,* 16 699 – 703. Stein, LL. et al. (1990). Sounding board: The doctor nurse-game revisited. *The New England Journal of Medicine,* 322 546 – 549.	The purpose of the study was to discuss how nurses interacted with doctors. This generated the theory of doctor-nurse game. The study was about how decisions or recommendations were made between nurses and doctors in clinical practice. This was later revisited in 1990 to see if the doctor-nurse game had changed, hence the inclusion of the two articles together as they discuss the same thing.	This was an empirical study which was based on what the author coined and later with other authors revisited or reviewed the game. The population considered was that of nurses and doctors, but this was not an original research study which had a specific design and methods. The article achieved a theory of the doctor-nurse game, but also came to conclude that nurses were not independently making decisions in both articles.	In the first article nurses were to be bold, have initiative and be responsible for making important recommendations, while at the same time they had to look passive. Nurses were to make recommendations, but these had to appear to be initiated by the physician. In the second article, nurses had decided to stop playing the game, and they wanted to change both nursing and how they related to other professionals.	The first article is unclear what it is, it has some elements of a literature review without this being acknowledged, the information discussed is not backed by evidence but is applicable to nursing. It also reads as if it was an observation of some kind, but this is not detailed. Both studies use scenarios, making them read like an interpretative study but it is not made clear if these were real life scenarios.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Tan, TC., Zhou, H. and Kelly, M. (2017). Nurse-physician communication: An integrated review. *Journal of Clinical Nursing,* 26 3974 – 3989.	The purpose of this paper was to present a comprehensive review of current evidence on the factors which impact on nurse–physician communication and interventions developed to improve the communication.	An integrative review was conducted following a five-stage process: problem identification, literature search, data evaluation, data analysis and presentation. Five electronic databases were searched in five electronic databases including the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PubMed, Science Direct and Scopus.	This integrative review suggests that nurse-physician communication remains ineffective. A total of 22 studies were included in the review. Four themes emerged from the data synthesis: communication styles; factors that facilitate nurse-physician communication; barriers to effective nurse-physician communication; and interventions to improve nurse-physician communication.	The integrative review on nurse-physician communication is suited to the topic. The majority of the interventional studies on nurse-physician communication in this review were nonexperimental designs, so the causal relationships of phenomena cannot be determined.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Trapani, J., Scholes, J. and Casser, M. (2016). Dual agency in critical care nursing: Balancing responsibilities towards colleagues and patients. *Journal of Advanced Nursing,* 72 (10) 2468 – 2481.	The purpose of the study was to explore critical care nurses' decisions to seek help from doctors. It is pointed out that nurses rarely take decisions about patients' treatment modalities on their own and constantly need to seek advice or authorisation for their clinical decisions, even for protocol-guided actions.	This study adopted grounded theory. Data was collected in the general intensive care unit involving ten nurses who were selected through purposive and theoretical sampling. Participant observations, interviews, focus groups were used. Data analysis was done using the dimensional data analysis which involved dimensionalising, differentiation and integration.	Nurses' decisions to seek help from doctors involved weighing up several occasionally conflicting motivators. They had to balance their moral obligation to safeguard patients' interests with their duty to respect doctors' authority. Subsequently, nurses ended up in a position of dual agency as they needed to concurrently act as an agent to medical practitioners and patients.	The study uses grounded theory which allows new theories to emerge from the data, however, it feels like the researcher already knew the answer. The data is analysed using dimensional data analysis, but it is unclear how themes came about in the findings. There is a mention of focus groups and theoretical saturation, but this is not convincing. A researcher can simply stop looking for new ideas and claim saturation.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Valderama-Wallace, CP. and Apesoa-Varano, EC. (2020). The problem of the colour line: Faculty approaches to teaching social justice in baccalaureate nursing programs. *Nursing Inquiry,* 27 (3) 1 – 12.	The purpose of this study was to explore how faculty teach social justice in theory courses in Baccalaureate programs. The study contributes to the long-standing and growing call to interrogate and address colonialism and whiteness in nursing.	This qualitative study utilised constructivist grounded theory methods to examine processes informing participants' teaching. Participants deploy specific strategies, varying largely by race, educational background, and nursing speciality. A background in social sciences supports pedagogy that interrogates health inequities rather than merely raising awareness about disparities.	Findings reveal that anti-oppression efforts are needed across education, research, clinical practice, and policy, including sustained commitment to address colonialism and whiteness in every institution that defines, promotes, and claims to advance nursing so that responsibility can be fulfilled to address unjust systems and structures to serve all communities.	The constructivist grounded theory methods allowed a deeper and thorough investigation into how faculty teach social justice in theory courses in Baccalaureate programs. The constructivist grounded theory approach shaped this qualitative study to gain a critical understanding of participants' pedagogical approaches. It is an original study which enabled the causal relationships of phenomena to be determined.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Vassilicos, B. (2020). The freedom(s) within collective agency: Tuomela and Sartre. *Bulletin D'analyse Phénoménologique,* XVI (11) 112 – 137.	This review aimed to investigate the nature of freedom enjoyed by participants in collective agency. It aimed to address the following questions: In what respects are participants in collective agency able to exercise freedom in some weaker or stronger sense? In what ways is such collective or common freedom distinct from the freedom ascribed to individuals? Might there be different freedoms involved in and tolerated by collective agency?	This review addresses the nature of freedom enjoyed by participants in collective agency. The review looks at a vast collection of literature discussing or investigating collective agency.	**Findings:** Clarification of what freedom may involve and how it subsists within collective agency is not only important for being able to demonstrate the instrumental value of social ontology to contemporary political debates; its clarification is undertaken via a comparison to the notions of freedom at stake in the respective accounts of sociality and collective agency.	This article is well written and uses theories and philosophical underpinnings relevant to collective agency. It is not stated what type of literature this is. It reads more like a book chapter even though it has an abstract. Given the varied and sometimes incompatible current theories of what unites or is shared by collective agents, it seems natural that most attention would be given to how individuals are bound or united in agency.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Waite, R. and Nardi, D. (2017). Nursing colonialism in America: Implications for nursing leadership. *Journal of Professional Nursing,* 35 (1) 18 – 25.	The purpose of this paper is to explore the nurse leader's role in understanding the impact of colonialism, specifically racism, a product of colonialism, as a key determinant in shaping the education of nursing students and its influence on practising nurses.	This review addresses the nature of colonialism and oppression in nursing. The study looks at a vast collection of literature discussing oppression in nursing.	**Findings:** The nursing profession is not ahistorical; this is critical to understanding the persistence of colonialism as a factor that impacts nursing education and practices today. In decolonisation, it is pivotal to not discard the deleterious effects of colonisation very quickly without dealing with encompassing tentacles that have locked onto human consciousness.	This article is well written and uses theories underpinnings relevant to nursing colonialism. It is not stated what type of literature this is. However, nursing colonialism and kinds of oppression are discussed. It is clearly stated that the nursing profession has developed and progressed within the context of colonialism, offering a basis for colonising intellectual growth in nursing. Racism and white privilege sustain colonialism in nursing.

Article	Purpose of study or review	Design and methods, sampling method, population, sample size, description of interventions (if any), instruments used, and outcomes measured	Major findings and findings relevant to the project	Critique of study or review of the project (What makes it strong or weak evidence)
Young, I. (1990). Five faces of oppression, from *Justice and the Politics of Difference.* Princeton. Princeton University Press.	The chapter details the five faces of oppression. The oppression discussed in this chapter is about different races in America who were oppressed. This is not research based but looks at how individuals or groups are oppressed.	The chapter appears to be theoretical based. There are no findings, but it is recommended that these could be applied to settings where oppression could be occurring. There were no outcomes being measured.	Unfortunately, there are no major findings as this is not a research study. However, the chapter provides guidance of what to look for where there is oppression.	The chapter seems to be well written and proposes an enabling conception of justice where there is oppression. The five faces of oppression could easily be used as a framework in other situations such as in clinical practice. The only thing is that they are only restricted to oppression and the aspects that could be contributing to it are overlooked.

Six questions for critical thinking

Where did you find the information?

- Did you just 'come across' it?
- Or did you access it through a systematic search?

How do you know it is of good quality?

- Is their line of reasoning logical and understandable?
- If it is research or a review of research, how was it carried out, was it done well, and do the conclusions reflect the findings?

When was this written/said?

- Older key information may still be valid, but you need to check if there has been more recent work.

What is it and **what** are the key messages or results/findings?

- Is it a research study, professional opinion, discussion, website or other?
- What are the key messages/results/findings?

Who has written/said this?

- Is it the author/speaker an organisation or individual?
- Are they an expert on the topic?
- Could they be biased?
- How do you know?

Why has this been written/said?

- Who is the information aimed at – professionals or patient/client groups?
- What is the aim of the information?

Aveyard (2019)

Consent Form **Appendix Nine**

Title of Project: An investigation of adult nurses' concept of agency in nursing care within hospital settings.

Name of Researcher: Mr Nkosilathi Moyo

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 6th March 2019 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication ☐

4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐

5. I agree for my interview to be audio recorded and for the data to be used for the purpose of this study. ☐

6. I agree to take part in the above study. ☐

....	....	....
Name	Date	Signature
....	....	....
Researcher	Date	Signature

Storytelling Prompts **Appendix Ten**

Tell me a story or an anecdote where you have had to care for a patient in a hospital setting.

Prompts

I want you to reflect on the incident and tell me why you nursed the patient the way you did.

How was it like nursing your patient?

What powers, freedom, or constraints within your scope of practice did you have in the nursing care?

What do you think nurses should be doing in nursing care?

Could you have done anything differently in the care of your patient?

What was the mood, feelings, emotions, state of mind, and so forth?

What was the environment like?

(van Manen, 1997; 2016)

Signed: *Nkosilathi Moyo*

Nkosilathi Moyo
Professional Doctorate in Health and Wellbeing Student
Senior Lecturer in Adult Nursing

Research Ethics Risk Assessment **Appendix Eleven**

Identified Risks	Likelihood	Potential Impact/Outcome	Risk Management/Mitigating Factors
Identify the risks/ hazards present	High/Medium/Low	Who might be harmed and how?	Evaluate the risks and decide on the precautions, e.g., Health and Safety
Travel risks to location of research project: Road accident Physical assault	Low	Researcher: Physical injury Psychological harm	Awareness of options for travelling Awareness of physical environment Researcher aware of health and safety policies or research location
Discussion of a sensitive topic in an interview has potential to cause distress to participant	Low	Participant: Psychological stress Researcher: Anxiety about dealing with a complex situation	Offer to cease interview Signpost participant to internal or external support services
Whistleblowing	Low	Participant: Emotional distress from disclosing the event Bias/prejudice as a result of disclosure	Inform participants of limits to confidentiality in participant information sheet At the time of disclosure, cease interview Have identified person to pass on details of the event
Data collection with individual participants	Low	Disagreement or conflicts between the researcher and participants	Confirm researcher experience and skill in interview facilitation
Data collection taking place in an unfamiliar location with people not known to the researcher	Low	Researcher: Physical injury or psychological harm	Visit location prior to data collection to assess possible risks associated with built and social environment Use this information to plan session Identify back up location Allow extra time to familiarise participants with research and environment

Identified Risks	Likelihood	Potential Impact/Outcome	Risk Management/Mitigating Factors
Disclosure of information about poor practice	Low	Immediate, urgent, or prompt response may be required from service providers	Ensure all verbal and written information about research indicates possible researcher response to disclosure
Identify the risks/ hazards present	High/Medium/Low	Who might be harmed and how?	Evaluate the risks and decide on the precautions, e.g., Health and Safety
Disclosure of unmet health or social care needs	Low	Immediate, urgent, or prompt response may be required from service providers	Ensure all verbal and written information about research indicates possible researcher response to disclosure
Research participant in danger of harm to self or others	Low	Immediate or urgent response may be required from service providers or emergency services	Ensure all verbal and written information about the research indicates possible researcher response to indication of danger to self or others
The risk assessment has not identified any significant risks for the study			

This was a story with a conversational discussion between the researcher and the participant who had a pseudonym of **Gemini**.

Nkosilathi: Our conversational discussion will start by you telling me about your experience in form of a story where you had to nurse a patient and how you nursed that patient.

I will now ask you to tell me a story where you had to nurse a patient in a hospital setting when you are ready, it's a conversation rather than an interview and I will ask you some questions where necessary in order to understand the story.

Gemini: Oh Nkosi, I can't think of anything in particular at the moment, but as a nurse, as a senior nurse, I feel as if you can't care for a patient from your own nursing professionalism because you are tied to policies, even if policies aren't always what you think they should be. Does that make sense?

Nkosilathi: Tell me more.

Gemini: So, you are, you are tied, you have got your own professional opinion for a particular thing for care for a patient but then there is a policy that will stop you, thus the only thing that I struggle with.

Nkosilathi: How do the policies stop you?

Gemini: Yeah, well it depends though, I don't know about other Trusts, but ours, I can't request bloods, I can take bloods, but I can't put them on the system to request bloods, even though I know that those bloods need to be ordered. Does it make sense?

Nkosilathi: It makes sense. So, if you took bloods, what happened?

Gemini: So, our policy now is saying, the doctors have to order it, I can take it, they can take it, nurse can take it, but whoever orders it takes responsibility for reviewing the bloods, you think as a nurse we are not qualified to review bloods, we can look at them and understand them to a certain extent, but we are not really trained to.

Nkosilathi: What does understanding them to a certain extent mean?

Gemini: Real competent, I am competent, but to review bloods and tell the patient and then tell the doctor, potassium is low, high, you know, so doing whatever.

Nkosilathi: So, who can request blood tests?

Gemini: Doctors. Yeah. They rule the place, don't necessarily do a good job about it, but the power always lands with them, doesn't it? We always have to go the doctors for something, whether it be prescribing, prescribing errors, we find an error we ask them to prescribe again, we write or whatever.

Nkosilathi: Can you not do that yourself?

Gemini: Thus right, yeah. You are hand tied as a nurse, you know, any doctor will tell you that when they first qualify, they rely on us to save them and guide them.

Nkosilathi: So, is there anything which could be done differently?

Gemini: They (nurses) should at least be able to order some bloods, but it is still under the doctor then to read the results, and it's a doctor's decision whether be an MDT's decision thus different but.

Nkosilathi: Are there any other people who have an impact on the way nursing care is done?

Gemini: I don't know.

Nkosilathi: I would like to ask you gain if you looked after a patient and say why you looked after them the way you did? I wanted to hear about your experiences.

Gemini: I think everything comes down to policies, like if you want to go on about a leg ulcer admitted from home, seeing district nurses and known in the community, comes to me, I took the dressings down which were horrendous, really bad, and I thought tissue viability should look really, but the reply I got was I saw her in August, this is now September, things can change, give me advice of what dressing, I know the dressing I would put on it, but I am governed by the tissue viability team, aren't I? So really you should be coming down looking at this wound and directing me, but she wouldn't come down, they wouldn't come down, so I took it down myself, touch wood, she went home yesterday, she was thriving, but it might not have been that easy, so you might say again that you are governed by the policies, everything you do is governed by policies, because you want to do one particular thing, like I say that I knew what dressing I wanted to put on it, but someone is going to say, actually you have got to follow this team, it is their decisions.

Nkosilathi: How did you feel about it?

Gemini: Yeah, common sense, rather than apply what you have learnt at University, not being disrespectful, but I always say to my students go to University because you have to, but probably 90% of the job is common sense. Probably would just be easier to train them on the job.

Nkosilathi: You say you had to take down and put on a new dressing, so where did that idea come from, to say you had to put a certain dressing, do you know what you put on?

Gemini: I know what dressing I put on, but I don't know what dressing I took down, because it was very disgusting, it was runny.

Nkosilathi: Tell me more. So, what dressings did you put on?

Gemini: So, the dressings were soaked. I put aquaucel, flat on it, and I decided to review it in 48 hours, and then after about a week, we changed to jelonet, and it was brilliant.

Nkosilathi: How was it like looking after the patient, how did it feel like?

Gemini: She didn't come in with the leg ulcer, she came in with a fractured femur, obviously thus, it was difficult when she came in because we couldn't put her on traction, skin traction, because of the ulcer, so obviously the lower leg was too painful, so we struggled, luckily, she did not have to wait long before we could take her to theatre for the femur but obviously her leg ulcers, probably took more of nursing skills than the femur itself, obviously when it was fixed it was fixed. So, yeah, it's been hard, she has been in two months, more for the fact that she had an ulcer rather than the social side of it, a couple of nurses we found that they were not doing the dressings on alternate days, so then the patient suffered because of pain, but noticed from day one comparing to now, that she was not in pain anymore, because of the depth of the wound was now getting better, even though it was superficial, the pain was worse, does that make sense? Obviously because of nerve endings, we'd done a good job; I can certainly hope that community continue.

Nkosilathi: Tell me about these 2 nurses.

Gemini: Couple of nurses, several if you want to say that we have a lot of agency nurses that work on our ward because we have vacancies. I think the ward is very busy and if they feel as if, well would rather concentrate on this, they must have prioritised their care, this is my excuse for them, but I suppose prioritised their care and the dressing was one of their priorities, but seeing that lady for the last 2 months, and looking at that dressing at least twice a week, it was one of my priorities.

Nkosilathi: Did you have freedom looking after this patient, or were you constrained?

Gemini: I felt freedom once tissue viability didn't want to come and review, that was my decision, wasn't it? I had freedom as a professional to make decisions, but prior, on that first day she came, when I took the dressings down, I hadn't got

freedom, did I? I was controlled by policies in speaking to specialists, but as soon as the specialists said they didn't want to come or they don't need to come, then I felt the freedom to be able to nurse to my standards, does that make sense?

Nkosilathi: Yes, it does. Did you deliver the nursing care your patient needed? Considering this scenario, what do you think nurses should be doing in nursing care?

Gemini: I did eventually, once they had given me the no. Maybe some nurses are scared to ask for advice and some help, whereas I am quiet, even as a senior nurse, quite happy say I don't know this, you know. I need some help, but maybe, do they stay away from doing the dressing because they don't understand, they haven't got the education regarding the dressing we offer, or do they stay away, because actually that's going to time you for 20 minutes, but I could be doing this, isn't it, I don't know.

Nkosilathi: You said you always ask for advice, but some nurses don't, why do you think some nurses do not ask for advice?

Gemini: Maybe, I don't know, because I am not that kind of person, I'd rather ask more than getting something wrong, do they not ask because they are scared of somebody thinking they are silly, or thick or they don't ask because they feel they can do without any input, do they think they are too good to ask for advice. But why would anybody not ask for advice? I have only been qualified for 6 years, I feel still pretty new, obviously as a sister I manage, but I could manage at the age of 21 or 41, but the skill as a nurse and the skills that we learn and then being able to teach others, and I am a person that can quite happily hold my hands up and say I need help here. Some people don't do that, some people are scared to do that.

Nkosilathi: What was your state of mind when you nursed the patient, what was going in your mind when you were looking after that patient?

Gemini: Initially? It was frustrating, isn't it, you are agitated, you can't deliver the care that you want because you feel as if someone is going to come and give you that information, but then is someone says no we can't come, we saw her a month ago, thus irritating, agitated, agitates me, because I think, actually things can change in a month, why are you not coming to see her? And then I am thinking, well, what's the point of having you as a service in the hospital if you are not going to come and see this poor patient, so then when I knew, they were not coming, then I can say actually it doesn't matter because I can work forward with this, I can manage this lady, and manage all the other staff to make sure that this leg is managed, does that make sense?

Nkosilathi: It does. So, what made you decide to use that though?

Gemini: Because of the wound bed and the slough, it was runny, I don't know if it was because the dressing, the lady couldn't identify when the dressing was last done, so, but it was pouring. So, it was because of the slough, I swabbed the wound and just put the aquaucel on, like I say 48 hours, then you can review, that first decision is the hardest, isn't it, which dressing you put on, you know, but it was gross, a runny slough rather than a thick stuck on the wound bed so I didn't need actiform to lift it, because it was lifty, probably the dressing had not been done for a week or something, a work's worth sitting there.

Nkosilathi: If you had to comment about the care, what would you say?

Gemini: Obviously, it was a job well done, because of how the wound improved, like I say, I hope the community continued it to do that, but there was only a handful of nurses that would do the dressing, me and the ward manager have looked back and seen where it's not alternate days, and it's gone 3 days, 4 days, because if I am off for 4 days, it doesn't get done sometimes.

Nkosilathi: You said there were 2 nurses involved, were there other people involved besides the tissue viability?

Gemini: No. The ward manager would always have a look, the ward manager is very hands on, she is happy to look and give her advice.

Nkosilathi: Did you tell anyone how you looked after your patient; tell your friends, other nurses, or anyone about it?

Gemini: We had several discussions regarding that lady.

Nkosilathi: So, what was the reaction you got?

Gemini: Some nurses don't care, they don't, a dressing is a hindrance to them; some nurses are happy throwing drugs out 3 times a day and thus it, so when it comes to dressings, the nursing skills, some nurses don't do it, long pause.

Nkosilathi: Is there anything else you would like to tell me?

Gemini: We have to follow policies, but 99% of our job is common sense, isn't it? You care for them how you want to be cared for or how your relatives want to be cared for, and you want to do a good job, you want someone to go home, and they have had a good experience.

Nkosilathi: Anything else you want to add.

Gemini: No.

Nkosilathi: Thank you for coming and for participating in this study.

Gemini: Oh Nkosi, I can't think of anything in particular at the moment, but as a nurse, as a senior nurse, I feel as if you can't care for a patient from your own nursing professionalism because you are tied to policies, even if policies aren't always what you think they should be. Does that make sense?

Gemini: So, you are, you are tied, you have got your own professional opinion for a particular thing for care for a patient but then there is a policy that will stop you, thus the only thing that I struggle with.

Gemini: Yeah, well it depends though, I don't know about other Trusts, but ours, I can't request bloods, I can take bloods, but I can't put them on the system to request bloods, even though I know that those bloods need to be ordered. Does it make sense?

Gemini: So, our policy now is saying, the doctors have to order it, I can take it, they can take it, nurse can take it, but whoever orders it takes responsibility for reviewing the bloods, you think as a nurse we are not qualified to review bloods, we can look at them and understand them to a certain extent, but we are not really trained to.

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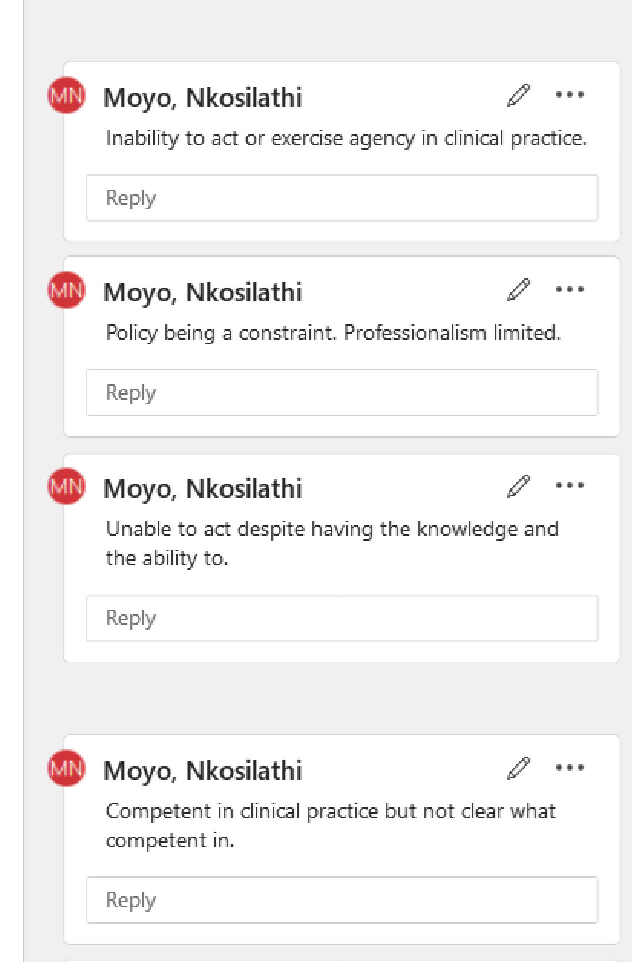

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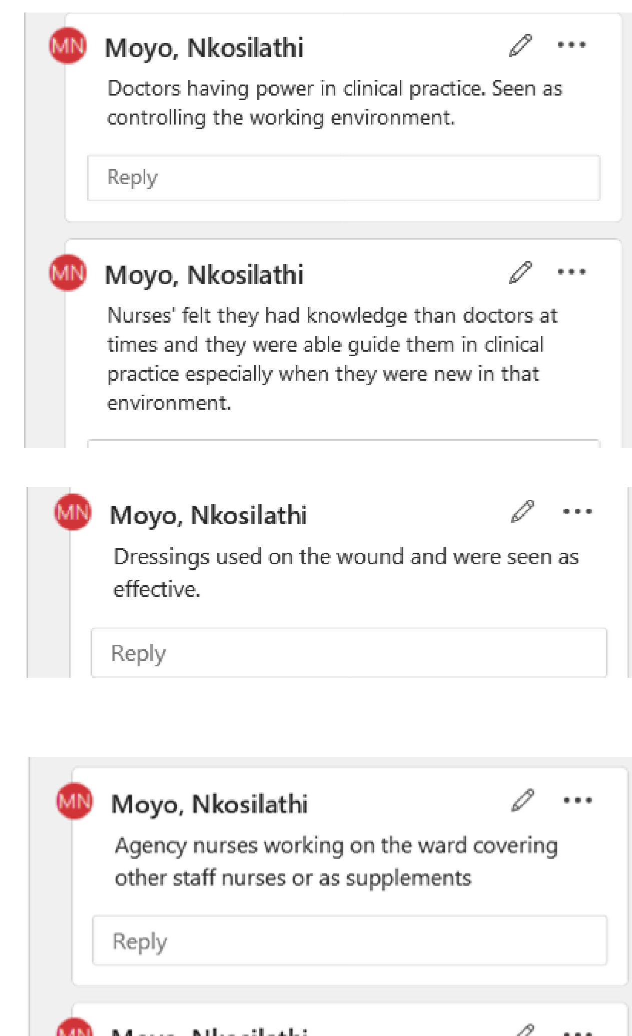

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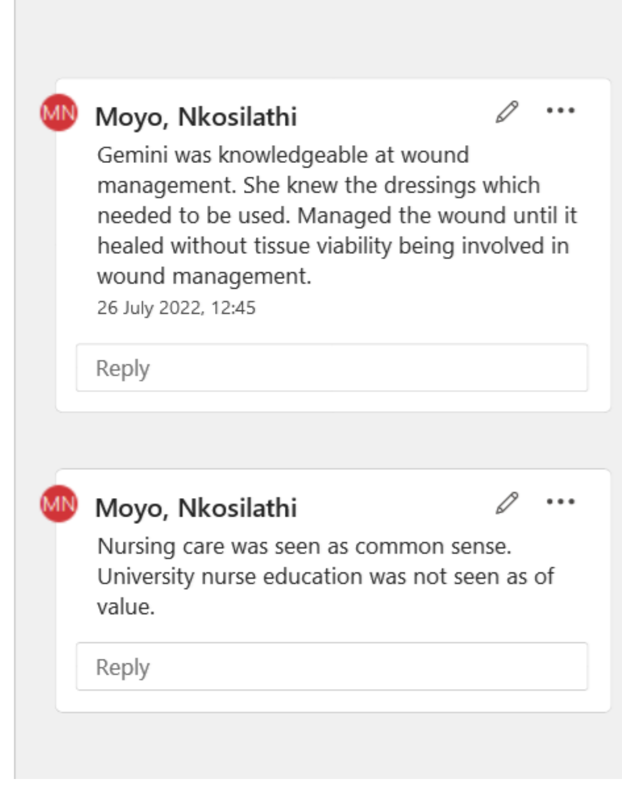

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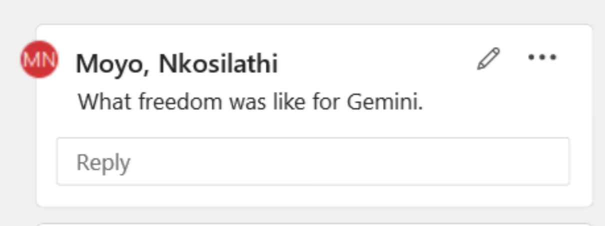

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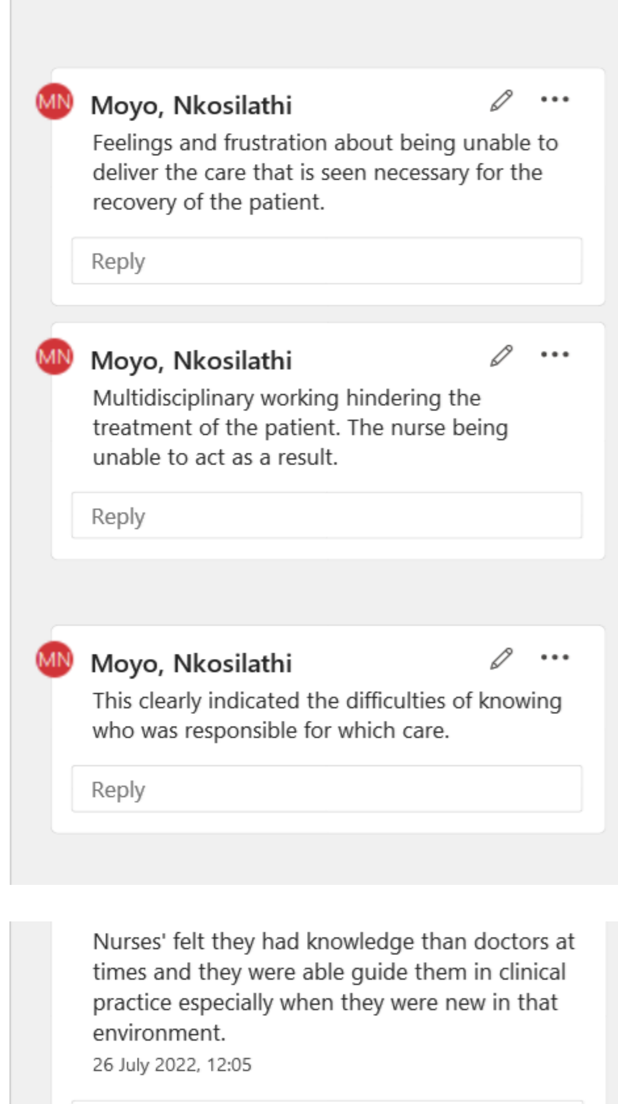

Interpretation, meanings, phrases and words emerging from stories	Theme
Exhausting Blaming self Helplessness and stressed Fear to be disciplined Anxious, frustrated, feeling not valued	Feelings
Bays Side rooms	Environment
Allocated patients Doing what's not their speciality	Workload
Advice Directions Instructions	Doctors' role
Two nurses doing the work of few nurses Agency nurses	Short staffing
Poorly patients Mental health patients Different conditions together Aggressive and violent patients	Patients
Time with patients Observations Drug administration Spirituality Emotionally Physically	Nurses' role
Not allowed to request investigations	Limitations

Interpretation, meanings, phrases and words emerging from stories	**Theme**
Nurses' knowledge Education and influence Non-metaphysical and metaphysical cognition Lack of research, theory, and practice No rethinking of nursing epistemic knowledges No progression	Knowledge or oppression
Consultants Drs junior Consultant Matron Specialist nurses Nurses Other professions and teamwork	Multi-disciplinary team
Lack of power and authority Not allowed to do other things Conflict or institution Colonialism Policies, protocols, and guidelines Care plans and care pathways	Constraints or oppression
Attending to patients' activities of daily living Nursing assessments Drug administration Referrals/documentation Wound dressings Vital signs	Freedom
Nurses doing more now Prescribing	Competencies or competency
Limited catheters Cheap equipment Faulty equipment Dressings, just what's there, not suitable	Resources

Interpretation, meanings, phrases and words emerging from stories	**Theme**
New doctors Scientists Pethidine given while not needed	Conflict
Nurses' views not always considered	Disrespected by doctors
Having to work longer on shifts Other nurses not doing their work Difficult colleagues Interference	Experience
Interpersonal skills with other health professionals Drs not listening to nurses Consultants do Junior doctors do not Patients refusing nursing care	Communication
Too many of them Routine	Nursing pathways
Working alone Dressing wounds Medication and patients	Freedom and priorities
Hands tied Documentation of patient care and regular patient checks	Guidelines, protocols, and policies
Doctors and managers Litigation and losing registration Support and lack of it from managers and from each other	Fear and support

Themes and subthemes	**Summary**
Experiences and responsibilities in nursing care Everyday nursing care Priorities Nursing care plans and care pathways Feelings about nursing care Views of what nurses should be doing in nursing care	This theme discusses how nurses were involved in nursing care and what was expected of them. Nurses assessed and monitored patients, did vital signs, dressed wounds, helped patients with activities of daily living and worked with other health professions. The nursing care that they delivered was according to priorities. Nursing care plans and care pathways were used as a guide to nursing care. They were able to say how they felt about the nursing care that they provided. The feelings were mixed, some were happy about the care they delivered, while others felt that it could have been delivered better. Some nurses felt that their role should involve extended roles. They were not sure how nursing could be developed or improved as such.

Themes and subthemes	**Summary**
Ability to deliver nursing care Freedom in nursing care Teamwork Competence and knowledge Resources The environment	Nurses felt that they were at times able to deliver nursing care that was needed by patients. Some felt that they worked independently yet it was unclear what that independence was as doctors were overall responsible for the care delivered. Nurses valued and worked in teams as a way of delivering intended care collectively. There were issues of competence and knowledge such as using cardiac monitors and applying scientific knowledge related to nursing care. Sometimes the care that was given was affected by the environment and the resources available.

Themes and subthemes	**Summary**
Constraints in nursing care Workload and staffing levels Patients Time Policies, guidelines, and protocols Conflict	There were varied constraints in nursing care such as the workload and staffing levels. Nurses felt that these were not always addressed, and they had to do work which was intended for a much bigger workforce. Some patients needed more care than others, and this took much of their time that they needed to deliver nursing care to other patients. They further felt restricted by policies, guidelines, and protocols that they followed in the delivery of nursing care. There were conflicts between nurses, managers, and doctors that they felt constrained them on how they delivered nursing care.

Themes and subthemes	**Summary**
Collaborative nursing care Nurses' self-view Doctors as seen by nurses Related professions	Nurses worked in collaboration with other health professions in most cases, and this meant that some nursing care could not be implemented unless or until other professions were involved. In this collaboration, nurses saw themselves as inseparable from doctors. They saw themselves as belonging to the same group, however, the majority of them saw themselves as less in status and not respected like doctors. In other words, doctors were seen as superior to them. This implied that in their role they were taking instructions or orders from doctors and rarely giving them. They were other health professions or health professionals that were involved in the delivery of care. This led to some of the skills that nurses did as part of nurses to be given to other professions. This was problematic in that even if nurses were able to perform those tasks or skills, they had to ask other professions to be involved even when they were competent to implement them.

Themes and subthemes	**Summary**
Nursing in clinical practice The power to act in nursing care Restrictions in nursing care Rethinking unthinking thinking in nursing care	Nurses were able to do some aspects of nursing care, but this was what I saw as basic nursing care. They delivered nursing care in accordance with competences and limitations as specified by the NMC. The care that they delivered, was that which was recommended by doctors after they had assessed the patient for medical problems. Nurses were restricted in what they could do despite having the skills to perform the tasks or skills which needed to be implemented. This meant that they had to leave those tasks to other professions even though they were competent to do them. These were issues which seemed relevant to suggest that there was a need to rethink unthinking thinking in nursing care. However, nurses seemed to lean towards the doctors' role. There were no suggestions of anything new such as critical thinking, research, or theories in nursing. Nurses seemed to be task orientated.

Themes and subthemes	**Summary**
Characteristics of power and authority in nursing care Power and authority in nursing care Knowledge and knowledgeability	There were indications that there were characteristics of power and authority in nursing care. There were powers which nurses had or wanted to have in practice. It seems that nurses had limited power and authority in comparison to doctors. Doctors were seen to dictate what nurses had to do or what nurses did. It seems that what made doctors have this power and authority was because it was legally granted to them. They also possessed medical or authoritative knowledge which nurses did not have.

Themes and subthemes	**Summary**
Structuration in nursing Organisational culture Extra-structuration agency	In working with doctors and other health professions, nurses were in a structure which detected the roles and responsibilities they had. The structure they worked in was complex, nurses referred to the structure or the system they worked in as they. This indicated that they were not sure about the whole structure that they were in. In the institution there was an organisational culture that changed the way they delivered nursing care. Nursing was done in a way that suited the health institution rather than the nursing knowledge and skills they possessed. This made nurses recreate structures that they worked in. This gave a feeling that there should be extra-structuration agency in nursing, a need to think beyond structures. While they did not specifically mention extra-structuration agency, they believed in getting rid of managers to make the care given to patients better. They preferred doctors and nurses working together without any managers.

Themes and subthemes	**Summary**
The cognitive empire in clinical practice Epistemic crisis or exhaustion	Knowledge was important in clinical practice; it was about who had which epistemic knowledges or gained which knowledges. It made it difficult for nurses to deliver some aspects of care as they had no relevant knowledge to do so. However, nurses ended up wanting to do skills that were once considered to be under a doctor's role. Nurses were conflicted between medicine and nursing. They wanted to choose between the two attractive role options, there was an epistemic crisis.

Themes and subthemes	**Summary**
Colonialism in nursing care Colonial matrix of power Decolonisation in nursing care Coloniality in nursing Colonial violence in nursing	Oppression manifested itself as what I saw as colonialism in nursing care. This chapter discusses the nature of colonialism and coloniality within healthcare and nursing. I was born in a former colony where I have witnessed how people were controlled or oppressed and how that oppression continues overtly and covertly today. In this investigation, I identified some traits of colonialism and coloniality in clinical practice. In colonialism, control is done by various means such as in allocation of roles and responsibilities, structures, education, policies, cognitively, the curriculum and various other means. This means that a group or individuals find themselves powerless and unable to self-determine the path of their own profession. What also seemed to be the stumbling block to self-determination was power and authority which was held by the health institution and other professions such as medicine. Nurses felt powerless in some aspects of care such as in decision making, but they were being allowed to do extended roles which were once a privilege to doctors. This is what I saw as decolonisation. Decolonisation is the undoing of colonialism or oppression. In the midst of decolonisation, nurses still held beliefs that doctors were superior to them. It would seem that where there has been colonialism, coloniality remains. Coloniality is about holding to colonial mannerisms and beliefs. In addition, there was colonial violence, nurses turned on each other. In colonialism, those who are oppressed blame each other rather than the oppressors. Nurses worked in clique groups who did not always appreciate each other.

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June 2018

Dear Sir/Madam

I am a nurse and senior lecturer at this University, and I am writing to you to ask if you would be kind enough to allow me to undertake a research study which aims to investigate what influences nurses in the delivery of care. I am currently doing my professional doctorate in health and wellbeing, and I am now at the final stage of the course. In my doctoral thesis I want to understand if there is some form of control in what nurses do in delivering nursing care. The topic for my thesis is entitled, an investigation of nurses' concept of agency in nursing care within hospital settings. I intend to understand this by asking nurses who are doing post registration courses within the University to tell me a story or an anecdote where they have had to care for a patient in a hospital setting. I hope that by exploring this topic I will understand how nurses work and how free or constrained nurses are in the delivery of nursing care.

Please be reassured that all information given in response to this request by the participants will be confidential and shall be used for the sole purpose of this research project. The participants will have the right to refuse to participate in this

study. They will also be able to withdraw from participating in this study at any time they like and the information they have provide would not be used in the study.

I look forward to hearing from you.

Yours sincerely: *Nkosilathi Moyo*

Nkosilathi Moyo
Professional Doctorate in Health and Wellbeing Student
Senior Lecturer in Adult Nursing

Dean of the Faculty of Education Health and Wellbeing

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09/07/2018

Dear Mr Moyo

Your research proposal has been received and we are happy to confirm that you may go ahead with your studies.

The supervisors that will be a part of your research journey are as follows:
David Matheson
Dean Holyoake

We wish you all the best throughout your studies with us.

Best Wishes,

Academic Support Administrator
Faculty of Education, Health and Wellbeing (FEHW)
Samuel Johnson Building
Walsall Campus – WS1 3BD
University of Wolverhampton

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THE UNIVERSITY OF OPPORTUNITY

Letter to the Dean of Faculty **Appendix Nineteen**

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Switchboard:

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11/09/2018 13:50

Dear Nkosilathi

I am happy to approve your request to carry out the research, as described in your proposal, subject to ethics approval.

Kind regards

Director of the Institute of Health
Faculty of Education, Health and Wellbeing
University of Wolverhampton
Samuel Johnson Building| Gorway Road
Walsall | WS1 3BD

Email:
Telephone:
Personal Assistant:
Telephone:

THE UNIVERSITY OF OPPORTUNITY

Ethics Application Form **Appendix Twenty-One**

Ethical Approval Form

Please complete and submit the five components, which together make up the ethical approval form document – (i) The Investigator, Supervisor & Research project details; (ii) Researcher Check List (iii) Ethical Consideration Prompts (iv) University Ethics Form; (v) if appropriate your Protocol.

Investigator, Supervisor & Research Project details

Investigator's Details (Must be completed)

Title: Mr
Forename: Nkosilathi
Surname: Moyo
Position: Senior Lecturer
Qualifications/Expertise of the investigator relevant to the submission: Doctorate student and Senior Lecturer in Adult Nursing.
Email address:
Address:
Postcode:
Telephone number:
Alternative contact number:
Supervisor's Name & Contact details: Dr David Matheson.
Are you as the Investigator or is your Supervisor a member of the ethics committee?: No ✓

Title of the Research:
Please indicate the type of submission (See Section 3 for Guidance):

- ☐ Category 0 Undergraduate project self-certification
- ✓ Category A
- ☐ Category B

Please indicate whether the study is:

- ☐ Staff Research (Externally funded) - Dept./Institute:
- ✓ Staff Research (University funded) - Dept./Institute: Health
- ✓ Postgraduate student Project
  Programme of study: Professional Doctorate in Health and Wellbeing **(DProfHW)**
- ☐ Undergraduate student project - Programme of study:
  Programme of study:

How many words is your protocol: 1500 words.
If your proposal is significantly longer than 1500 words please provide a justification here:
Key Words: Freedom; constraints; power to act; colonialism; delivery of nursing care.

Please LIST below the major ethical issues you have discussed in the attached research protocol. • Identification of malpractice. • Maintaining confidentiality.

Researcher Check Lists

Once you have answered all the questions below and the relevant documents have been included please send this to your supervisor for submission.

Procedural Aspects Prompts This is the first researcher checklist and aims to help ensure you have addressed all the salient procedural aspects of the ethical approval process. It should be submitted completed as part of your ethics application form. If you answer No to any of the items below, your submission is likely to be returned to you without being reviewed.			
1. Have you completed and included all three parts of the submission document? i. Researcher Checklists ii. Researcher, Supervisor & Research Project details iii. Your Research Protocol with Appendices	Yes ✓	No ☐	N/A ☐
2. Does your project protocol include an electronic signature from your supervisor? (For supervised projects only)	Yes ✓	No ☐	N/A ☐
3. Is your protocol 1,500 words (+ or – 10%)?	Yes ✓	No ☐	N/A ☐
4. Have you included ALL necessary Appendices documents?	Yes ✓	No ☐	N/A ☐
i. Original letter of access and/or approval letter or some other form of approval in principle from organisation	Yes ✓	No ☐	N/A ☐
ii. Letter/Email Inviting participants to take part Note: University rather than personal contact details should be used in documentation	Yes ✓	No ☐	N/A ☐
iii. Consent form	Yes ✓	No ☐	N/A ☐
Iv Consent form involving access to medical records	Yes ☐	No ☐	N/A ✓
v. Participant information sheet	Yes ✓	No ☐	N/A ☐
vi. Debrief sheet	Yes ☐	No ☐	N/A ✓
vii. Data Collection Materials & Procedures (e.g. questionnaires, interview schedules, training/intervention details etc.)	Yes ✓	No ☐	N/A ☐

Ethical Consideration Prompts This is the second researcher checklist and aims to help ensure you have addressed all the salient ethical issues. It also aims to help you to decide if your study is a category A or category B project. It should be submitted completed as part of your ethics application form			
1. Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	Yes ✓	No ☐	N/A ☐
2. Will you tell participants that their participation is voluntary?	Yes ✓	No ☐	N/A ☐
3. Will you obtain written consent for participation?	Yes ✓	No ☐	N/A ☐
4. Will you avoid coercion?	Yes ✓	No ☐	N/A ☐
5. If the study involves observational data collection, will you ask participants for their consent to being observed?	Yes ☐	No ☐	N/A ✓
6. Will you tell participants that they may withdraw from the research at any time without giving a reason and with no repercussions?	Yes ✓	No ☐	N/A ☐
7. With questionnaires, will you give participants the option of omitting questions they do not want to answer?	Yes ✓	No ☐	N/A ☐
8. Will you tell participants who will have access to their data?	Yes ✓	No ☐	N/A ☐
9. Will you tell participants that their data will be treated with full confidentiality (detailing data protection and storage procedures) and that, if published, data will be anonymised? If you cannot guarantee full confidentiality (e.g. due to potential safeguarding issues). Select No but explain this fully in the protocol.	Yes ✓	No ☐	N/A ☐
10. Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study).	Yes ✓	No ☐	N/A ☐
11. Will you provide participants with the option of receiving a lay summary of the main findings?	Yes ✓	No ☐	N/A ☐

Question		Yes	No	N/A
12. Will your study involve deliberately misleading participants in any way? (Category B)		Yes ☐	No ✓	N/A ☐
13. Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details in the ethical issues section of in Part B and/or in your Protocol (Part C) and state how this will be handled (e.g. who the participant can contact for help). (Category B)		Yes ☐	No ✓	N/A ☐
14. Does your study involve work with animals? (Category B)		Yes ☐	No ✓	N/A ☐
15. Do participants fall into any of the following special groups? (Category B) Note that you may also need to obtain satisfactory CRB clearance (or equivalent for overseas students).	Schoolchildren (under 18 years of age)	Yes ☐	No ✓	N/A ☐
	People with learning or communication difficulties	Yes ☐	No ✓	N/A ☐
	Patients/Clients (including people with diagnosed psychological or health conditions)	Yes ☐	No ✓	N/A ☐
	People in custody or offenders	Yes ☐	No ✓	N/A ☐
	Other vulnerable groups (e.g. crime victims, homeless people, substance misusers etc.)	Yes ☐	No ✓	N/A ☐
16. Does your study involve collecting sensitive secondary data (e.g. records regarding cause of death, abuse, neglect etc.) (Category B)		Yes ☐	No ✓	N/A ☐
17. Is this study going to an external ethical review committee (e.g. IRAS, REC, NOMS etc.), if so please give details below.		Yes ☐	No ✓	N/A ☐
External Approval will be sought from:				

The next section contains the University Ethics form which must be submitted to the committee.

Ethics Submission Form
Faculty of Education, Health and Well-being

- *You must complete all sections of this form in as much detail as possible (word counts are given if necessary). If your form is incomplete, it will be returned to you to resubmit.*
- *You must be given approval for your research project from the University before you can begin.*
- *Applications should be submitted by 1st Monday of each month to* FEHWEthics@wlv.ac.uk

Section One

1. Enter Your First Name and Surname Below:	
First Name	Mr Nkosilathi
Surname	Moyo

2. Enter your University Student/ Number

3. Enter your University e mail address (e.g. M.Name@wlv.ac.uk)

4. Enter your daytime contact telephone number in case we need to contact you.

5. Enter the name of your Project Supervisor, Director of Studies, or Principal Investigator.
Dr David Matheson

6. Which subject area is your research / project located? Please ✓ all that apply

		✓
1	FEHW	✓
2	Education	
3	Health	✓
4	Sport	
5	Psychology	
6	FSE	
7	FOSS	
8	FOA	
9	COLT	
10	Cross University Project	
	Other – Please give details below:	

7 Please indicate if this study is	
	✓
Staff Research (Externally funded)	
Staff Research (University funded)	✓

8. Which Category of Project Are You Applying For? Categories are outlined in the handbook from the RPU (www.wlv.ac.uk/rpu) Please tick ✓					
Category A	✓	Category B		Category 0	

9. Give details of service user involvement
Not applicable

Section Two

10. What is the title of your project?
An investigation of nurses' concept of agency in nursing care within hospital settings.

11. Give details of any proposed research questions/hypothesis
Do nurses have power to act in the delivery of nursing care in hospital settings?

12. Briefly outline your project, stating the rationale, aims and expected outcomes. (300 words)
The study aims to investigate nurses' concept of agency within their area of clinical practice within hospital settings. In simplicity, the study aims to investigate if nurses have the power to deliver the nursing care they consider appropriate for the patient within their scope of nursing practice. This investigation will also aim to shade the light on what nurses think they should be doing in the delivery of nursing care. The study aims to contribute to new knowledge in nursing practice. **Aim** – An investigation of nurses' concept of agency within their scope of practice in nursing care within hospital settings. **Objectives:** To find out how free or constrained nurses are in the delivery of nursing care. To find out what powers nurses think they have in the delivery of nursing care. To find out what nurses think they should be doing in the delivery of nursing care. To contribute original knowledge on nurses' concept of agency in nursing care. The literature found on nurses' concept of agency in their area of clinical practice is limited. It states that nurses are not empowered to be themselves in nursing care (Dubrosky 2013). It is not clear what is meant by this. The information appears to be a collection of thoughts and theories which are not backed by research. The literature goes on to say that nurses are subordinated, subjugated, dominated, exploited and oppressed in clinical practice (Farrell 2001; Tan 2007). There is no clarification on how this is known nor is there any discussion on the extent of this within clinical nursing care. I am interested in finding out what influences the nursing care delivered to patients and to understand if nurses themselves have the power to act in delivering the nursing care. The expected outcomes are to understand the nurses' concept of agency within their scope of practice in nursing care within hospital settings and to empower nurses with new knowledge and to contribute original knowledge in clinical practice.

13. How will your research be conducted? (750 words max.)
Describe the methods so that it can be easily understood by the ethics committee.
Please ensure you clearly explain any acronyms and subject specific terminology.

Hermeneutics phenomenology has been chosen for the research study (van Manen, 2016). The goal of hermeneutics is to understand and articulate the common practices and meanings of activities that seem obvious and taken for granted (Gadamer, 1976; Hall and Ritchie, 2011). In nursing, daily clinical practices or nursing care sometimes become so familiar that they are either difficult to articulate or are hardly noticed (Kaufer and Chemero, 2015). Hermeneutics inquiry suggests that the way to understand the world is through the everyday practical involvement that people have with their world (Heidegger, 1977). Hermeneutics phenomenology has its roots in methods associated with the interpretation of biblical texts (Mueller-Vollmer, 1985). Hermeneutics means interpretation and originates from Greek (Finlay, 2007; Finlay and Evans, 2009). Originally it was concerned with changing the unknowable to text and language that people could understand (Grossman, 2014).
The reason why phenomenology has been chosen is that it studies the phenomena or appearance of things, things as they appear in our experience or the way we experience things, thus the meanings things have in our experience (Cerbone, 2014). The structure of an experience is its intentionality, its being directed toward something as if it is an experience of or about some object (van Manen, 2016). It is also important to understand the experience of the participant who is taking part in the study regarding what is being investigated (Bryman, 2015). The researcher needs to try and understand how that experience of the participant was like (Grossman, 2014). In other words, the researcher has to do the investigation as if it was an interrogation (Kaufer and Chemero, 2015). The participant needs to discuss what their mood, feelings, emotions and state of mind was in the identified incident (van Manen, 2016). Phenomenological reflection as well as intentionality are also important as part of the investigation or as part of the discussion (Moran, 2000).
The data will be collected by story-telling and anecdotes from the participants. Participation will be voluntary. Nurses will be asked to tell me stories and anecdotes of their choice that describe incidents where they have had to deliver nursing care (van Manen, 2016). The data will only be used for the purposes of the doctoral study. The stories and all conversations will be audio recorded. Data collected will be verified with the participants and it will then be stored in a secure place and destroyed when it is no longer needed for the study, or needed by the University (Beauchamp and Childress, 2009). Informed consent will be obtained from participants and a consent form will be used (Bryman, 2015). Confidentiality and anonymity will be maintained, therefore, no names or specific places will be mentioned by name, pseudonyms will be used instead (Beauchamp and Childress, 2009). Permission to conduct the study will be obtained from the Dean of the Faculty and the University Ethics Committee.

14. How will your data be analysed?

In hermeneutic phenomenology, it is recommended that data should be processed uncovering the thematic aspects (van Manen, 1997). In the study, the data analysis will be done using van Manen's (1997) four research activities for data analysis aided by the hermeneutic cycle in understanding the stories that were told by nurses (van Manen, 1997; Miles, Huberman and Saldana, 2013).The stories and the anecdotes will be transcribed word for word. However, during analysis the tone of the voice of the participant, hesitation; the emotions etc will be taken into account as these will enable me to understand the true picture of what is being said. The information will then be grouped into patterns. The analysis will enable categories and themes to emerge from the stories and the anecdotes.

15. Is ethical approval required by an external agency? (e.g. NHS, company, other university, outside organisation, etc.)

1. NO ✓
2. YES - but ethical approval has not yet been obtained

External Approval will be sought from:

3. YES - see contact details below of person who can verify that ethical approval has been obtained)

16. What in your view are the ethical considerations involved in this project? (e.g. confidentiality, consent, risk, physical or psychological harm, etc.) Please explain in full sentences. Do not simply list the issues. You should also make it clear how you are going to deal with issues with regard to your own welfare and safety.

Areas	✓	Intervention
Confidentiality	✓	Will be maintained by not mentioning names of the participants or their place of work. Numbers or pseudonyms will be used to identify participants.
Consent	✓	Informed consent will be obtained and all participants will sign a consent form.
Participants Under 18	✓	Participants will all be qualified nurses who are over the age of 18. It is unlikely that there will be any harm as a result of the study as nurses will be telling me what they do on a daily basis.
	✓	Where necessary participants will be given support by the researcher as well as the University counselling service. I do not expect any issues regarding the participants' welfare and safety nor my own welfare and safety. Any unexpected issues arising will be handled following the University, NHS Trust and NMC guidelines or policies.

17. Have participants been/will participants be, fully informed of the risks and benefits of participating and of their right to refuse participation or withdraw from the research at any time?

1. YES (Outline your procedures for informing participants in the space below.) ✓
2. NO (Use the space below to explain why)
3. Not applicable - There are no participants in this study

This will be done by giving participants an information letter which fully states the risks and benefits of participating on the study. The letter and the consent form will clearly state that the participant has the right to refuse to participate in the study and has the right to withdraw from the research study at any time without any explanation given. Nurses who are known to the researcher will be reassured that I am doing the research as a colleague and whatever decision they take will be respected and this will not affect the relationship with the researcher. They will also be informed that the information will be confidential and anonymised and will only be shared with the supervisors for the purposes of the study. It will also be stated that they can stop the use of the information they have given before it is anonymised and that this action will not affect them or their relationship with the researcher. All the above information will also be given to them verbally before the collection of data begins.

18. How will you ensure that the identity of your participants is protected (See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for guidance on anonymity)
The participants will be given a pseudonym and their names will not be used or included anywhere in the study. In the study, the pseudonym or number allocated to the participants will be used instead of the name of the participant. The university where the participants study or the area of practice where the participants work will not be disclosed, this will be referred to as the university, the department or area of clinical practice. This will make it impossible to identify any of the participants.

19. How will you ensure that data remains confidential ((See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for definition of confidentiality)
The data will remain confidential to within the limits of the law and the nursing regulatory body's professional code of conduct, and I will be the only one who has access to it; the data will only be shared with my supervisors, examiners, and the participants for the purposes of the study. The only time that confidentiality could be breached is when something that causes concern is raised or if there is a concern that someone could be at risk of harm. The data will be anonymised so that no individual participant will be identified. The participants will be shown the collected data in person to verify it rather than via mail or email to prevent the data being seen by those that it is not intended for. All the data will be destroyed once the study has been completed and when it is no longer needed, this is likely to be within two years of the study. The information might be kept for longer than two years if the study goes beyond two years or is needed to be reviewed by the University.

20. How will you store your data during and after the project? (See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for definition of and guidance on data protection and storage).
The data will be stored on the university computer and laptop that I use at work which are encrypted and protected with a password. When the data is used at home, it will also be accessed via my personal computer which is encrypted as well as protected with a password. The information stored on portable devices will be stored on my portable drive which is also encrypted as well as protected by a password.

SECTION THREE

The following questions must be answered otherwise your form will not be reviewed and it will need to be resubmitted to the panel at a later date.

21. Does Your Research Involve Children Under 18 years of Age? Please delete and leave your response below
1. No ✓
If Yes, Do you have an Enhanced Disclosure Certificate from the Criminal Records Bureau/Disclosure and Barring Service (DBS)?
2. Yes/No

22. Are participants in your study going to be recruited from a potentially vulnerable group? (See RPU website (www.wlv.ac.uk/rpu) and follow link to Ethical Guidance pages for definition of vulnerable groups)

1. YES (Describe below which groups and what measures you will take to respect their rights and safeguard them)
2. NO ✓

23. Does your research fit into any of the following security-sensitive categories? (For definition of security sensitive categories see RPU webpages (www.wlv.ac.uk/rpu) follow links to Ethical Guidance). If so please complete questions 22-26

	Security Sensitive Categories	If YES, please tick below. ✓	If NO, please tick below. ✓
1	Commissioned by the military		✓
2	Commissioned under an EU security call		✓
3	Involve the acquisition of security clearances		✓
4	Concerns terrorist or extreme groups		✓

24. Does your research involve the storage on a computer of any records, statements or other documents that can be interpreted as promoting or endorsing terrorist acts?
Please delete and leave your response below.

1. NO ✓

25. Will your research involve the electronic transmission (e.g. as an email attachment) of any records or statements that can be interpreted as promoting or endorsing terrorist acts? Please delete and leave your response below.

1. NO ✓

26. Do you agree to store electronically on a secure University file store any records or statements that can be interpreted as promoting or endorsing terrorist acts. Do you also agree to scan and upload any paper documents with the same sort of content? Access to this file store will be protected by a password unique to you.
Please confirm you understand and agree to these conditions.

1. YES I understand and agree to the conditions ✓
2. NO (please explain below)
3. I do not understand the conditions

27. Do you agree NOT to transmit electronically to any third party documents in the University secure document store?
1. YES I agree ✓
2. NO I don't agree

28. Will your research involve visits to websites that might be associated with extreme, or terrorist, organisations? (for definition of extreme or terrorist organisations see RPU webpages (www.wlv.ac.uk/rpu) and follow links to Ethical Guidance.
1. YES (Please outline which websites and why you consider this necessary)
2. NO ✓

29. You are advised that visits to websites that might be associated with extreme or terrorist organisations may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Do you understand this risk?
1. YES I understand ✓
2. NO I don't understand

30. Appendices (All submissions) Please list the items that you are submitting with this document. (These will need to be submitted to FEHWEthics@wlv.ac.uk. You may want to include additional information that will help the panel with their decision such as your proposal. You need to provide examples of research instruments, recruitment posters and leaflets, information sheets (age appropriate) assent forms (for children), consent forms, risk assessment if research is carried out abroad .
Letter to participants Consent form Participant information sheet Research ethics risk assessment Interview/conversation guide Letter to the Dean of Faculty Letter of research approval from the Dean Letter of approval from the University

Section 4

CONFIRMATION OF ETHICAL APPROVAL AND FEEDBACK ON SUBMISSION

TO BE COMPLETED AS INDICATED, BY MODULE LEADER, SUPERVISOR AND/OR HEAD OF ETHICS PANEL

Office Use Only:	
Submission Number	
Date of Review	
Identified Category	

On behalf of members of staff and students

I confirm that the proposal for research being made by above student/member of staff is

Category 0	
Category A	
Category B	Checklist of submissions required for Category B proposals:

Checklist item	
Outline summary: rationale and expected benefits from the study, with a statement of what the researcher is proposing to do and how	
Explanation of the methodology to be used	
An information sheet and copy of a consent form to be used with subjects	
Details of how information will be kept	
Details of how results will be fed back to participants	
Letter of consent from any collaborating institutions	
Letter of consent from head of institution wherein any research activity will take place	

Decision
Approved: **I confirm that the proposal for research being made by the above student/member of staff is a category A proposal and that s/he may now continue with the proposed research activity.** **I confirm that the proposal for research being made by above student/member of staff is a category B proposal and that all requirements for category B proposals have been met.** The applicant can continue with the study as detailed in the proposal. However, any subsequent changes should be submitted to the Ethics Committee.
Approved subject to conditions. Make minor/major amendments as detailed in comments and feedback.
Not Approved – Substantial re-write required Resubmit as new application

Comments and Feedback	
Proposed Actions	
Date of Further Review	
For a student's proposal – **Name of module leader or supervisor giving approval**	
For a member of staff's proposal – name of Head of Ethics panel giving approval	
Signed **(This form must have a valid signature)**	
Date	

Dean of the Faculty of Education Health and Wellbeing

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Switchboard:
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17/06/2019

Mr Nkosilathi Moyo/Dr David Matheson

University of Wolverhampton FEHW

Dear Nkosilathi

Re: Do nurses have the power to act in the delivery of nursing care in hospital settings? submitted to the Chair Faculty of Education, Health and Wellbeing Ethics Sub-panel (Health Professions, Psychology, Social Care & Social Work)

Upon review by the Chair of the Ethics Sub-panel your Resubmitted Research Proposal was passed and given full approval (**Code 1 - Pass**). You are free to continue with your study. We would like to wish you every success with the project.

Yours sincerely

Ethics Chair
Chair – Ethics Panel

THE UNIVERSITY OF OPPORTUNITY

Participant Information Sheet **Appendix Twenty-Three**

29/03/2019 Version 1

I am a nurse as well as a senior nurse lecturer at the University of Wolverhampton and I lecture in pathophysiology, anatomy and physiology, research methods, clinical nursing practice, moving and handling, cardiopulmonary resuscitation, to name but a few. I am currently doing my doctorate in health and wellbeing, and I am now at the final stage of the course. I have always had an interest in improving clinical nursing care. In my doctoral thesis I want to investigate and understand if nurses have freedom or constraints in delivering nursing care in clinical settings within their scope of practice. In doing so, I hope to understand if nurses have the power to act in nursing care. I intend to understand this by asking you as a nurse to tell me a story or an anecdote where you have had to care for a patient in a hospital setting. The topic for my thesis is entitled *an investigation of nurses' concept of agency in nursing care within hospital settings.* I hope that by exploring this topic I will understand if nurses have power to act in nursing care. This in turn will allow me to explore some ideas and to provide some information that should enable nurses to empower themselves in improving clinical nursing practice in future.

In the study I want the participants to be nurses who work in clinical practice within hospital settings. I intend to include or involve all nurses who work in hospital settings regardless of their experience. The stories from nurses will be obtained during the nurse's free time. This will be before or after lectures. The data will be collected within the University settings, and this will be digitally recorded for the purposes of data analysis. The information collected for the research study will be confidential and shall be used for the sole purpose of the research study. The information collected for this study will be destroyed when the study has been completed. The nurses have the right to refuse to participate in the research study without the need to give any reasons. The participants will be able withdraw from participating in the study at any time they like without giving an explanation. The use of collected information from the participant could be stopped before it is anonymised if the participant decides that they do no longer want it to be used.

When the data has been transcribed and analysed word for word, I intend to have it verified by the participant to make sure that it represents what they have said or meant. During the data analysis, the sound of the voice, pause, expression etc by the participant will also be considered as this will help me understand what is being said by the participant. There will be a consent form to be signed before the data is collected in accordance with ethical guidelines. The risks in this study during data collection could be identification of nursing malpractice. This study is aimed at benefitting nursing long term in that it will enable a debate on how nursing should

be improved as well as the development of nursing care in future. I am looking forward to working with you on my research study and to hear how you nurse your patients in clinical practice.

Please see the following detailed information about the study

Study title

An investigation of nurses' concept of agency in the delivery of nursing care within hospital settings.

Invitation Paragraph

You are being invited to take part in a research study. Participation in the study is voluntary and you have no obligation to do so. In other words, you can participate in this study only if you are happy to, otherwise you do not have to participate if you are not happy to, and your refusal to participate will not affect you in any way. It is suggested that before you decide whether to participate or not to participate in this study; it is important for you to understand why this research is being done and what it will involve. Please take time to read the following information carefully and discuss it with your nursing colleagues, friends, or relatives. You are encouraged to ask us if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part. If you need clarification about this study, please email Nkosilathi Moyo. Thank you for reading this.

What is the purpose of the study?

The research study is intended to understand how much freedom or constraints nurses have in nursing care within their scope of nursing practice. In other words, I want to understand if nurses have the power to act in the delivery of clinical nursing care.

I have always had an interest in understanding the role of a nurse in the delivery of nursing care within clinical practice. On the other hand, I want to understand what nurses think they should be doing when it comes to nursing patients. This study will enable me to understand how nurses see themselves or their role in nursing care.

The aim of the study is to investigate nurses' concept of agency or power to act in their own area of clinical practice within hospital settings. The objectives are to find out how free or constrained nurses are in the delivery of nursing care in hospital settings within their scope of practice, to find out what power nurses think they have in the delivery of nursing care, to find out what nurses think they should be doing in the delivery of nursing care and to contribute to original knowledge on nurses' concept of agency in nursing care.

This study is aimed to be completed by September 2019; however, the collection of the data is likely to be completed within two months from the day of approval by the Ethics Committee.

Why have I been chosen?

You have been chosen for this study because you are a qualified nurse who works with patients on a daily basis in hospital settings and you are in a position to understand a nurse's role and the powers nurses have in nursing care. You have been identified as suitable to take part in the study through our postgraduate courses offered by the University. It is anticipated that this study will involve ten to twelve participants in order for the study to be undertaken. This study will offer me an opportunity to investigate and understand how nurses work, how much freedom or constraints they have in nursing care and what powers nurses feel they should have in nursing care within hospital settings.

Do I have to take part?

It is up to you to decide whether to take part or not to take part in the research study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form to participate in the study of which you will also be given a signed copy to keep as part of the data collection procedure. You are free to withdraw at any time and without giving a reason. If you withdraw before data analysis has begun, your data will not be used. Once the data analysis has begun, your data will have been anonymised and can no longer be withdrawn. It is important to let me know as soon as you can if you decide to change your mind about participating in the study.

What will happen if I decide to take part?

The information or data collection needed for the research will be collected from you from any of the campuses of the University, depending on your preference. The researcher will travel to the Campus of your choice. You will be asked to tell a story or an anecdote where you had to nurse a patient, and how you nursed them. You will then be asked to reflect on the incident or the anecdote you have chosen to discuss by looking at why you delivered the nursing care the way you did to the patient. The researcher will be interested in understanding how free or constrained you were when you were delivering the nursing care in your chosen story or anecdote. In other words, I want to understand if you had any powers or had no powers to act in the nursing care. During the storytelling prompts rather than questions will be used in order to help me understand the story being told.

The storytelling including prompts for more information is expected to last for forty-five to sixty minutes but no more than an hour. However, if the story being told is brief, it might last less than the time specified, and this will still be acceptable as stories vary in length.

What are the potential benefits and risks of taking part?

Though there are no direct benefits for you if you take part, by taking part you will help us to find out about how nurses deliver nursing, and this may improve nursing knowledge in the future.

There are no risks to you in taking part outside of those you would experience in everyday life. However, by taking part, you may remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected.

Will my taking part in the study be kept confidential?

Yes, if you take part in this study, this will be kept confidential. Confidentiality in the study will be maintained in accordance with the General Data Protection Regulation (GDPR) and the University policies on handling general sensitive data. All the information about your participation in this study will be kept confidential. The only time that confidentiality will be breached is when something that causes concern is raised or if there is a concern that someone could be at risk of harm. The transcription of your interview will be stored on a password protected computer or encrypted hard drive in a locked office. Only the researchers working on the project will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed. It is important to say that if anything is raised during the interview that indicates that either the participant or someone else is at risk of harm, then these concerns will have to be taken further to the University or the healthcare institution. However, it is unlikely that there will be a risk of harm being identified as you are expected to talk about what you do in nursing care on a daily basis within your scope of practice. If you have a concern regarding the use of the data you are going to give or you have given as part of this research study, please contact the Data Protection Officer.

What will happen at the end of the research study?

The findings will be disseminated in various ways at the end of the study. This will be done by giving each of the participants the findings of the study once they have been analysed, then the findings will be available in the University library in form of the thesis once this has been written, lastly the findings will be published in nursing journals as part of my journey on this doctorate. The findings will also be published online, and a link will be given or sent to the participant. In every stage of the research the results will be made available to all participants through the researcher should they wish to see them.

What if I have a problem or concern?

If you have a concern or you are not happy about any aspect of this study at any stage, you should ask to speak with the researcher Mr N. Moyo who will do his best to answer your questions. However, you can also contact the supervisors Dr David Matheson and Dr Dean Holyoake within the University if you feel appropriate to do so. You can also contact the Dean of Research as the independent person in the case of a complaint. All the above individuals can also be reached by telephone via switchboard.

Who has reviewed the study?

The Research Ethics Committee of the University has reviewed this study in accordance with the University guidelines. In addition to the Research Ethics Committee, the research supervisors have also reviewed this study to ensure that it is conducted appropriately.

Contact for further information

Please contact me at the University via telephone or via email for further information. I can also be contacted via the main University switchboard number.

I would like to take this opportunity to thank you for taking part in this study. It is much appreciated; I look forward to completing my doctoral journey with you on board. Your participation plays a major part; without your involvement, this study would be impossible.

Additional information:

Please remember to keep the participant information sheet and a signed consent for future reference. During the study you might be contacted for an update on the study or the results; if you would want this or again you would not want this, please inform the researcher during the interview.

Letter to Participants **Appendix Twenty-Four**

Dear Colleague

I am writing to invite you to participate in a research project, which I am conducting as part of a Professional Doctorate course in Health and Wellbeing at the University of Wolverhampton. I enclose an information sheet, which explains the title and aims of the project and what taking part will involve.

If you are willing to be interviewed, the interview would take between 45 and 60 minutes. Confidentiality will be maintained to within the limits of the law and the nursing regulatory body's professional code of conduct and guidelines. The only time that confidentiality would be breached is when something that causes concern is raised or if there is a concern that someone could be at risk of harm. The data will only be shared with those involved in the study, such as the research supervisors and examiners. Such personnel will be unable to link the data to participants, as the data will be anonymised by using pseudonyms or numbers only on the interview transcripts. Any quotes used in the research will use a pseudonym or number rather than the participant's name. Place names and any other identifiable information will also be changed to preserve anonymity. Data will be protected by keeping transcripts and interview recordings in a secure facility, accessibly only to the researcher. The data from the study will be stored for 2 years or until the end of the study and then it will be destroyed confidentially. The interview would take place at Wolverhampton City, Walsall or Burton campuses at a time that is convenient to you. In the thesis pseudonyms will replace all names so that you cannot be identified.

If you feel that you would like to be interviewed, please indicate on the attached sheet, and email it to me. If you would prefer not to be involved, please ignore this letter. If you decide not to be involved, I would like to assure you that your relationship with the researcher or the University will not be affected in any way.

Yours sincerely,

Signed: *Nkosilathi Moyo*

Nkosilathi Moyo
Professional Doctorate in Health and Wellbeing Student
Senior Lecturer in Adult Nursing