

Discovering the Meaning of Quality Nursing Care  
Through the Lived Experience of Bedside Critical Care Nurses

Nicole Mascellaro

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## **Abstract**

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Nurses make up the largest human resource component of healthcare. With this in mind, understanding what quality care means to the nurses providing it becomes relevant. There have been numerous efforts made to understand, define, measure, and influence the phenomenon of quality nursing care. These efforts have reflected the perspectives of patients, nurses, and nursing leadership.

Bedside critical care nurses provide care in a dynamic, high-paced environment where patients have life-threatening conditions, may not be conscious of their care or condition, and outcomes including mortality are multifactorial, not always care-dependent. In such a scenario, outcome-based assessments of quality nursing care may result in inaccurate findings, making it difficult to create and institute improvement efforts.

This qualitative phenomenological study was designed to uncover the meaning of quality nursing care through the lived experiences of bedside critical care nurses. Twenty-two bedside critical care nurses were interviewed, and their responses analyzed using van Manen's method of phenomenology to uncover five essential themes that represent the meaning of quality nursing care: (a) It is not just taking care of the illness; (b) Being there for another, it's the little things; (c) It is knowing your stuff—bed bath, and beyond; (d) It is roles, not just responsibilities; and (e) It means having resources.

The results and discussion aim to clarify, through example, the meaning of quality nursing care differentiated from its definition. Findings of this study contribute to a large body of literature regarding quality nursing care. Furthermore, the results are relevant to nurses, educators, managers, and leadership to aid in assessment of quality nursing care and support its provision.

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## **Dedication**

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## Chapter 1: Introduction

*She was 15 years old and involved in a motor vehicle accident that would change the course of her life; a drunk driver speeding in his truck collided with the car she was in, destroying it on impact. She was extricated from the vehicle by first responders. They took her by ambulance to the hospital, and her injuries required admission. On the pediatric unit, she was very frightened and placed in a patient room, all alone, with only the call bell to get help. She expected a nurse willing to listen and help her until her parents arrived. To her this was the definition of quality. This was not what she received. Instead, the experience was far removed from her expectations. Her nurse may have been performing nursing tasks according to the quality expected by the institution or even the quality benchmarks of her direct supervisors. However, within the realm of this young patient's hospital encounter, the meaning of quality may not have been consistent. This young patient was me.*

*As a critical care nurse, my experience suggested that quality nursing care did not have a consistent meaning within the working parts of the healthcare system. Now, as a researcher, my goal is to perform an in-depth analysis using phenomenology to formally discover what "quality nursing care" means to critical care nurses. How does the critical care nurse experience quality? What does quality nursing care mean to them through their actions and observations? And finally, does their meaning differ from the definitions created by institutions and professional organizations? What better way to do this than to explore the lived experience of the bedside critical care nurse?*

In order to start on this journey, it is of the utmost importance to understand what phenomenology, as well as what the "lived meaning" of a phenomenon, is. In trying to

understand this, reading the explanation conveyed by Madjar and Walton (1999) in *Nursing and the Experience of Illness: Phenomenology in Practice* brought clarity to the researcher. A direct quote, while lengthy, was felt to be the best way to share this and give credit to the authors of what has been an instrumental piece for the foundation of this project.

Phenomenology is a way of thinking that allows us to get behind the shorthand, to reveal the experience as it is when it is lived through. Phenomenological thinking is a way of working towards seeing that which is essentially there but which labels and symbols often keep hidden. (pp. 8-9)

The authors use the example of a femoral arterial puncture to explain this further. As a procedure that is typically labeled as something that “hurts,” when the lived meaning to patients is explored, the words “pain or hurt” were not used to describe the experience. The patient’s lived experience instead described this as a procedure during which practitioners were jabbing and poking, harpooning, not being able to get blood, and fishing around for blood return. The patient would describe just having to lie there as though the procedure was not happening. The benefit of understanding this perspective lies in the providers of care reflecting on how to relate to and act during clinical interactions to potentially improve the experience for a patient (Madjar & Walden, 1999).

The *Oxford English Dictionary* (2021) defines quality as “the standard of something when it is compared to other things like it; how good or bad something is” (para. 1). Quality is associated with excellence, that the best service is experienced (Taylor & Haussmann, 1988). These definitions conceptually label the term *quality*. However, quality can have variable meanings to different actors in a particular setting. In the world of consumerism, for example, we encounter many components, including a consumer, a product, its manufacturer, the salesperson, and the reseller. Each may have their own meaning of what quality would be. One would expect that for an optimal experience, the meaning of quality for each of these components should, at

the least, overlap. In health care, the same holds true; there are multiple components of a health care encounter. The patient, health care providers, including the nurse, ancillary staff, and administration, are some key components of the overall interaction. Therefore, understanding what this means to these specific components independently can positively impact the shared experience of quality.

Quality has literal definitions as well as perceived meanings. Professional organizations and academic publications have presented works to conceptualize and create a framework of quality. These concepts may have ignored what quality means to the nurses providing bedside care. There are limited studies that have investigated nurse lived experience as it relates to defining quality nursing care (QNC). Furthermore, no studies have been published focusing on bedside critical care nurses (BCCNs) regarding the same. However, before delving into this very specific component within health care, it is important to summarize popular and institutional concepts of quality as it relates to health care.

The Institute of Medicine (IOM), now known as the National Academy of Medicine (NAM), has asserted that “quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr, 1990, p. 4). In addition, the NAM provided a framework to improve the quality of health care. This framework, consisting of six objectives, stated that health care should be (a) safe; (b) effective; (c) patient-centered; (d) timely; (e) efficient; and (f) equitable (IOM, 2001, pp. 39-40). Moreover, the World Health Organization (WHO, 2021) stated that “quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes” (para. 1). Furthermore, according to WHO

(2021), quality health care should not harm the patient, include the use of evidence-based practices, and be safe, effective, individualized, and centered on the patient.

As set forth by the American Nurses Association (ANA) in *Nursing: Scope and Standards of Practice* (2021), in the description of the standard of quality of practice, “the registered nurse: ensures that nursing practice is safe, effective, efficient, equitable, timely, and person-centered” (p. 101). This statement is more in line with the NAM’s six objectives of quality and the WHO’s definition of quality of care. By comparison, the American Association of Critical Care Nurses (AACN, 2019) defined quality of care as “a cooperative and collaborative process that combines the goals of professional standards of care with the defined expectations of the patient and family” (p. 38). This later definition distinguishes itself from the IOM definition by incorporating professional standards into what can otherwise be seen as outcome- and patient-focused.

The public expects excellence in health care. According to a poll created by researchers at the Harvard Opinion Research Program (HORP) and the Harvard T. H. Chan School of Public Health in partnership with the Robert Wood Johnson Foundation (RWJF) and National Public Radio (NPR):

Nearly 80 percent of Americans reflect positively on the health care they personally receive, but only a third (33%) says their care is excellent, while 46 percent rate it as good. When added to the 18 percent of adults in the U.S. who say their care is fair or poor, the data suggest the United States has a long way to go if it hopes to have one of the highest-quality health care systems in the world. (Harvard T. H. Chan School of Public Health, 2016, para. 5)

Despite an understanding of expectations regarding what is good care, institutional frameworks for its delivery, and health care expenditure exceeding that of any other industrialized nation, health care outcomes in the United States are inferior (Tikkanen & Abrams, 2020). In 2020, the United States spent approximately \$4.1 trillion of national funding

on health care goods and services (USA Facts, 2021, Noteworthy Data Section). Furthermore, in 2020, the U.S. health care expenditures of the gross domestic product (GDP) were 19.7% (USA Facts, 2021). Despite the significant amount of money spent on health care, Americans do not have the best outcomes. According to a report from The Commonwealth Fund that assessed the health care systems of 11 countries based on health care outcomes, administrative efficiency, equity, care process, and access, “the U.S. ranked last place among the 11 countries for health outcomes, equity and quality, despite having the highest per capita health earnings” (Cook, 2018, para. 2). Additionally, it should be noted that the United States had the highest rate of mortality that could be attributed to health care (Cook, 2018). This indicates that more Americans die from deficient quality of care than in any other country included in the study (Cook, 2018). This is not a new problem. According to The Commonwealth Fund (2017), throughout the past six similar reports, the United States has placed last in every single one. Life expectancy, numbers of chronic medical conditions, infant mortality, as well as maternal mortality, are worse than in most developed countries (National Academy of Medicine, 2021).

It has been two decades since the seminal reports *To Err Is Human: Building a Safer Health System* (2000) and *Crossing the Quality Chasm: A New Healthcare System for the 21st Century* (2001), produced by the Committee on Quality of Health Care in America and initiated by the IOM, identified strategies for improving health care quality for Americans. However, despite this research and awareness, health outcomes continue to decline. For example, the overall maternal mortality rate in 2020 was 23.8 deaths per 100,000 live births, an increase from 2019 (20.1 deaths per 100,000 live births) and 2018 (17.4 deaths per 100,00 live births) (Agency for Healthcare Research and Quality, 2022). The severe maternal morbidity rate, a measure of unexpected serious health outcomes during labor and delivery, increased by 11.1% (from 7.2 to

8.0 events per 1,000 deliveries) between 2016 and 2019 (Agency for Healthcare Research and Quality, 2022). Furthermore, the decline in life expectancy continues to worsen compared with any other industrialized nation, with the gap worsening for over four decades (Agency for Healthcare Research and Quality, 2022). As such, the quality of health care is a topic of concern for hospitals, the public, government, and regulatory organizations—an essential topic to address.

Nursing is the nation's dominant profession providing health care, with over 4.2 million registered nurses in the United States (American Association Colleges of Nursing, 2022; Smiley et al., 2021). Nurses are on the front line and in contact with patients 24 hours a day and 7 days a week in many environments. To make progress in quality improvement, understanding what QNC means to the nurse would seem essential. Thus, nurses are in an ideal position to affect the quality of health care that patients receive and have a positive impact on patient outcomes.

According to the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine (IOM, 2011), “a promising field of evidence links nursing care to high quality of care for patients, including protecting their safety” (p. 3). Nurses are uniquely qualified to help improve the quality of health care (National Academies of Science, Engineering, and Medicine et al., 2021). The Nursing Alliance for Quality Care (NAQC), managed by the ANA, includes in its mission that “nurses actively advocate and are accountable for consumer-centered, high quality health care” (American Nurses Association, n.d., mission section).

Nursing care quality has direct implications on health care outcomes and correlates with patient safety and satisfaction. (Cho & Han, 2018; Mendes de Jesus, 2014; Stalpers et. al, 2016). One would expect that nursing interventions are performed with excellence and quality in mind.

The definition of quality used to determine successful nursing interventions may be purely institutional in nature. The question arises: What does quality mean to the nurses who provide direct patient care? More specifically, critical care nurses managing gravely ill patients in a clinically demanding setting may have unique beliefs, definitions, and understanding of the meaning of QNC compared to those held by their institutions, patients, and professional organizations. This being said, the definition of QNC is not consistent, making it challenging for nurses themselves to come to an understanding of what represents QNC (Grimley, 2017).

### **Aim of the Study**

The aim of this study is to discover the meaning of QNC by exploring the lived experience of the BCCN in the United States. The goal of this study is to illustrate a deeper understanding of the meaning of QNC among BCCNs as it is perceived in the critical care environment. This research is meant to contribute to the body of knowledge regarding QNC within healthcare literature.

### **Phenomenon of Interest**

A phenomenon is “something (such as an interesting fact or event) that can be observed and studied and that typically is unusual or difficult to understand or explain fully” (*The Britannica Dictionary*, 2022, para. 1). According to Gutierrez (2014), a phenomenon is an event based on human perceptions that is observed and can be explained. The purpose of phenomenology is to describe subjective components of lived experiences (Fain, 2013). The phenomenon of interest to be studied here is the lived experience of quality among BCCNs in the United States. Through this study, the goal is to discover the meaning of QNC for this subset of clinical nurses.

Ambiguity arises in the existing definitions of QNC, as the experiences of nurses have not historically been included, as previously mentioned. In addition, some models or frameworks used to define the concept of QNC are borrowed from disciplines outside of the nursing profession. For example, Donabedian (1988) described quality as it relates to the structure, process, and outcome that have been used in nursing as the building blocks to define QNC.

In order to understand the phenomenon of QNC in a manner that will be meaningful to the nursing profession, the description needs to incorporate the expressions of nurses themselves. Ryan et al. (2017) asserted that given the wide variation in perceptions, it is hard to assist nurses in delivering QNC according to their own standards and those of the organization. Input from the bedside nurses concerning their lived experience of QNC may enhance the existing definitions of QNC, enabling its delivery and measurement with greater relevance. Lynn et al. (2007) noted that “AN ESSENTIAL ELEMENT [sic] in defining the quality of nursing care is the provider of the care—the nurse” (p. 328).

A positive patient outcome is undeniably the goal of hospital admission. However, the quality of the care, inclusive of bedside nursing care within the admission, can be inconsistent. Thus, it would seem that establishing a universally accepted definition of QNC may be meaningful. However, the conundrum in creating such a definition is an issue that has spanned over six decades, as evidenced in works as far back as 1988, where Taylor and Haussmann reported difficulties even 20 years before their report.

In more contemporary literature, Mhlanga et al. (2016) reported that QNC is a concept used commonly in health care with vagueness. Furthermore, Juanamasta et al. (2021) conveyed that there is no clear definition of QNC; rather, the concept is complex and ambiguous. There have been efforts to understand this concept through the experiences of nurses, however limited.

Despite this decades-old issue, the research dedicated to elucidating nurses' perceptions regarding QNC is limited. Lynn et al. (2007) stated, "Limited research has been conducted on nurses' definition and perceptions of quality nursing care" (p. 180). Ten years later, Ryan et al. (2017) similarly asserted that only a limited number of studies have been performed on the definition and views of QNC from the nurses themselves. Since their report, only two studies have investigated this issue. Stavropoulou et al. (2022), through interviews with open-ended questions, explored the same concept in Greece. Nyelisani et al. (2023) studied nurses' understanding of quality care in the setting of limited resources and declining patient care and outcomes in South Africa. The latter two studies further demonstrate that the lack of consensus is not limited to the United States but affects health care globally.

The lack of consensus regarding the definition and perception of QNC within the nursing profession, institutions, organizations, and literature demonstrates a need to further investigate, discover, and explore what is known about this multi-faceted phenomenon.

### **Context of the Phenomenon**

The context of a phenomenon is the setting in which the occurrence can be understood. Clinically complex patients are cared for in the critical care unit (CCU) by specialty-trained nurses, usually referred to as critical care nurses. Patients in the CCU may require intricate devices, treatments, and complex care to preserve their lives. It is here that attention to detail is critical to the outcome of the patient. Assessing the patient's status and the need to adjust their care is always required. The BCCNs who care for these patients should possess critical thinking and reasoning skills beyond the skill set and practice level of nurses on non-critical units.

BCCNs provide continuous care to the patients in the CCU and are usually responsible for one or two patients during their shifts. Their roles may include assessing minute-to-minute

changes in their patient, titration of infusions, administration of blood products, monitoring of vital signs, maintenance of supportive equipment, turning and positioning of the patient, care of surgical incisions and wounds, and maintenance of invasive intravenous vascular access devices, to name a few.

Qualitative studies using phenomenology to discover and explore the lived experience and meaning of QNC in the CCU are limited. Also, there is a paucity of research on the meaning of QNC from the nurses' experience, particularly in the CCU. Illuminating this complex phenomenon in the context of BCCNs in the CCU using the qualitative hermeneutic phenomenological method will add to this body of knowledge.

### **Justification for the Study**

An essential responsibility of nurses involved in patient care is to make sure QNC is provided to the patient, as their responsibilities extend around the clock (Laschinger & Fida, 2015). Logically, then, the essence of QNC should emerge from nurses who are the hands-on providers of the care measured and evaluated for patients. Thus, it becomes relevant to discover and explore the essential elements and values nurses describe and define as QNC.

Grimley (2015) reported that the majority of attempts to describe QNC have concentrated on elements affecting the quality of nursing care—namely, “nurse workload, nurse turnover, nurse-sensitive clinical outcomes, or local nursing shortages” (p. 3). According to Grimley, only minor consideration has been given to the nurses' perspectives of what represents quality care. Moreover, Burhans and Alligood (2010) reported that most of the literature on the measurement of QNC has focused on patient satisfaction and patient outcomes. Ryan et al. (2017) similarly asserted that only a limited number of studies have been performed on the definition and views

of QNC from the nurses themselves. Burhans and Alligood (2010) added that there has been little research relating to what QNC is, how it is defined, and how it is perceived.

Currently, QNC is evaluated and measured by nurses, patients, professional organizations, and institutions using various modalities. One method in which the quality of nursing care is measured and evaluated is through the satisfaction of the patients or consumers themselves. For example, the Centers for Medicare and Medicaid Services (CMS, 2017) uses the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to measure patients' perceptions of their hospital experience. HCAHPS is a 32-item survey sent to random patients to measure their perceptions of their hospital experience (CMS, 2017). It contains some questions that relate to "care from nurses." However, this begs the question: Do the surveys provided to patients by such accrediting bodies take into account the nurses' own definition of QNC, or are they merely representing the "consumers" experience as a surrogate of quality? Understanding how BCCNs value, define, and experience QNC provides a deeper meaning of what quality is beyond the measures currently used.

Bedside nurses are observed during their delivery of QNC by their peers, colleagues, and leadership teams, as well as by other disciplines; however, they are rarely involved in the development of the surveys or instruments used to measure QNC (Burhans & Alligood, 2010). Understanding QNC through the lived experience of nurses and using those definitions instead of surrogate measures may lead to more meaningful self-assessments and peer and supervisor evaluations.

Patient outcome is another method by which nursing care is evaluated and measured. For example, pressure injury prevalence, patient falls with injury, and other hospital-acquired conditions are measured as indicators to evaluate nursing care. The National Database of Nursing

Quality Indicators™ (NDNQI®), operated by Press Ganey, is the oldest national nursing database that provides benchmarking information derived from unit-level data reporting over 600 measures pertinent to nursing performance, patient experience, nurse experience, and patient outcomes (Madaris, 2023). However, are the measurements used to evaluate nursing care on the unit level representative of what a bedside nurse embraces as QNC? Or are there other values that bedside nurses find essential to measure and evaluate QNC?

It is the right of every patient to receive high-quality care, and it is the responsibility of every nurse to provide it (Elayan & Ahmad, 2017; Hogston, 1995a; Idvall & Rooke, 1998; Redfern & Norman, 1990). Since nursing has been acknowledged as the most honest and trusted profession by society (Reinhart, 2020), it is a professional responsibility to maintain that trust and accountability by delivering QNC to all patients. While understanding what QNC means to bedside nurses does not ensure that QNC is delivered on a system level, this understanding may facilitate professional development, improve delivery, and then subsequently evaluate the performance of QNC.

Research has pointed out that the capacity of nurses to provide QNC to patients has been connected to their workplace satisfaction (Stalpers et al., 2017). Throughout recent history, there has been a repeated theme in which nurses perceived that inability to deliver what they felt was quality care leads to professional dissatisfaction. When a nurse does not have the ability to deliver QNC, stress and dissatisfaction with their work may result (Williams, 1998). Nurse dissatisfaction and stress result in staff turnover, nurses leaving the profession, and nurse burnout. Nursing burnout has been linked to the quality of nursing care. In their study, Poghosyan et al. (2010) explored the relationship between ratings of quality of care and burnout among 53,846 nurses in six countries. Findings showed that higher levels of nurse burnout

correlate with nurses' characterizing quality of care as fair/poor. Jun et al. (2021) concluded in their systematic review of the literature that "nurse burnout is associated with worsening safety and quality of care, decreased patient satisfaction, and nurses' organizational commitment and productivity" (p. 1).

Nurses' professional satisfaction can, in turn, have significant impacts on the healthcare system. Nurse turnover is costly, adding to staffing, recruitment, and training costs. A number of researchers have attempted to ascertain the cost of turnover. A 2023 survey of 273 facilities in the United States compared 2021 data to 2022 data for nurse turnover and demonstrated that "the average cost of turnover for a bedside RN is \$52,350, a 13.5% increase, resulting in the average hospital losing between \$6.6m–\$10.5m. Each percent change in RN turnover will cost/save the average hospital an additional \$380,600/yr" (NSI Nursing Solutions, 2023, p. 1). With the number of experienced nurses declining, the delivery of healthcare systems and population health are negatively impacted (Halter et al., 2017). Understanding what a bedside nurse perceives is important to deliver and define QNC may improve staff retention, decrease nurse turnover, and improve the work environment.

Three groups participate in and/or potentially benefit from an understanding of what QNC means as well as the delivery of QNC: nurse managers (NMs), nurse educators (NEs), and nurse executives (NEXs). NMs have the responsibility to make certain that their staff delivers QNC to patients on the unit and are accountable for the QNC delivered to those patients. NMs are responsible for creating and supporting an environment that attracts and retains professional nurses as part of providing quality care. NMs are responsible for supporting clinical nurses in ensuring quality patient care, patient safety, and enhanced overall performance (Nantsupawat et al., 2022). The work environment has been directly correlated with the quality of care in

nursing (Amaliyah & Tukimin, 2021). As an NM, understanding how bedside nurses define QNC may help lead to strategies that facilitate a more engaging and positive work environment, thus ensuring high-quality care (Laschinger & Frida, 2015). In addition to using set criteria, incorporating aspects of what bedside nurses feel represents QNC may lead to an inclusive evaluation process.

As another vital group involved in health care, NEs are charged with making certain that nurses can develop professionally and understand the significance of providing QNC to patients. An understanding of the essential elements that a bedside nurse values in QNC would help NEs develop teaching modalities to facilitate the professional development of nurses in this area. The information gleaned from this research could be incorporated into nursing curricula to ensure that nursing students have the opportunity to develop a deeper understanding of QNC and its significance on nurse satisfaction, the patient's experience, and, most importantly, patient outcomes.

Nursing leadership has a responsibility to improve the quality of nursing care. Understanding the factors nurses attribute to QNC can lead to better services within institutions. Using more encompassing definitions of QNC, NEXs can develop structures, processes, and outcomes that support a model for the delivery of nursing care and provide bedside nurses with opportunities to deliver QNC. NEXs are accountable for the financial implications of providing an environment where nurses feel they can provide QNC. Developing an environment where clinical nurses can provide QNC may ultimately help decrease costs associated with the delivery of care through reduced hospital-acquired infections (HAIs), reduced length of stay, and decreased turnover.

In March 2020, SARS-CoV-2 (a novel coronavirus named COVID-19 by the WHO) became a pandemic (WHO, 2020). Being a nurse manager during this time I had firsthand exposure to the struggles faced by the hospital I worked for. There was a shortage of personal protective equipment, staff, medical and non-medical supplies, and even physical beds for patients. Nurses in particular bore the brunt of the increase in patient care workload related to these admissions. Studies evaluating nursing burnout during this time have shown that burnout positively correlated with adverse events as well as self-perceived deficiencies in the quality of administered care (Kakemam et al., 2021). The correlation between perceived deficiencies in administering QNC and burnout demonstrate the personal and professional relevance nurses place on being able to provide care that they feel is of quality.

### **Assumptions and Biases**

In this chapter, I disclose my assumptions and biases for purposes of self-awareness and to make the reader aware of possible influences. An assumption is defined as “something that you accept as true without question or proof” (*Cambridge Dictionary*, n.d., para. 1). Since assumptions and biases can impact one’s research, it is important to be aware of their potential influence in all phases, including planning, data collection, and analysis. With this in mind, I was cognizant of these assumptions and acknowledged my biases as I gathered and interpreted my data.

My assumptions are based on my experiences as a BCCN, critical care nurse educator, and, subsequently, a nurse manager of an intensive care unit. First and foremost, I believe bedside nurses come to work to give the best care possible to their patients. As an NM, my assumption was and remains that BCCNs want to provide QNC to all patients. Throughout my work experience and discussions with BCCNs, I have understood that BCCNs have varied

perceptions regarding quality. I have observed that clinical nurses rationalize how different aspects of nursing care are more important than others. In my experience, I believe that what QNC meant to me as an NM was different from the meaning held by BCCNs. Furthermore, from my experience, I believe that BCCNs define QNC differently than their NEs, and NEXs. Having been an NM, I have experienced that my beliefs of what QNC meant as a manager were not always mirrored in the beliefs of BCCNs. I assume that NMs operate from a different perspective where QNC is concerned. This assumption arises from the understanding that institutional expectations are that providing QNC requires the incorporation of a number of recognized benchmarks and metrics, including: HCAHP scores, NDNQI® metrics, patient satisfaction, nurse satisfaction, nurse vacancy rates, and budgetary requirements.

In addition, through my lived experience as a BCCN and later through discussions with BCCNs, I assume that BCCNs believe policies are unrealistic if the input is lacking from the bedside nursing staff. My experience with the COVID-19 pandemic created an understanding within myself as to why hospital policies exist and the importance of involving the BCCN in the development of innovative models of care delivery. During this time of crisis, I saw BCCNs develop solutions or what some considered to be workarounds for delivering care while maintaining patient safety. Workarounds are created to solve challenges that arise when a nurse is trying to complete a task or a nursing intervention that is necessary for quality patient care. Workarounds can develop as nurses are providing care to a patient, and they work around the “normal” way of carrying out tasks (Hughes, 2018). Workarounds are used to solve a block in a workflow, usually related to a structure in the system (Debono et al., 2013). The goal of performing a nursing workaround is to provide quality and safe care, to improve efficiency and system design; however, doing so and deviating from a standardized process may result in

unintentionally compromised patient care (McCord et al., 2022). This leads me to foster my assumption that nurses' involvement in clinical policy-making is essential.

My conviction is that stress and dissatisfaction may impact the nurses' perceptions of QNC. This contemporary assumption, while not necessitating proof to maintain, has been a historical theme in nursing. It just might be that stress, frustration, and dissatisfaction occur if bedside nurses do not have the tools, support, and resources to provide the nursing care they believe is required. I presume that bedside nurses leave the organization, and possibly the profession, when they get frustrated, dissatisfied, stressed, and believe they cannot make a difference in their patients' care.

As a BCCN and in reviewing feedback as an NM, I developed the notion that BCCNs feel their nursing care is underappreciated by NMs or peers, which may lead to frustration and lack of engagement. With no clear understanding or perception of QNC, nurses may be expected to adapt their manager's definition, which is more often associated with outcomes and not actual bedside care.

In addition, I assume that many BCCNs experience "burnout," a situation further exacerbated due to the unprecedented impact of the pandemic. This has been supported by pandemic-related literature in which nurses caring for COVID-19 patients demonstrated high chronic fatigue, poor quality of care, low work satisfaction, and higher intention to leave their organizations (Labrague et al., 2022). Having managed staff during COVID-19, I witnessed BCCNs having increased workloads. I dealt with diminished staffing due to illness, nurses leaving their organization to take other positions, nurses transferring to non-clinical or non-CCUs, nurses retiring early or leaving the profession altogether, and COVID-related deaths.

Through this experience, I have developed the belief that nurse turnover leaves the least experienced nurses working on the unit, thus potentially impacting the provision of QNC.

I consider that the clinical environment impacts the ability of the BCCN to provide QNC. Throughout my career thus far in nursing, I have witnessed a lack of staffing, supplies, supportive peer relationships, nursing leadership, professional development, recognition, and empowerment resulting in BCCNs becoming dissatisfied with work as well as developing a sentiment that they are unable to provide QNC. Others have explored these assumptions in nursing literature. Andrews et al. (2011) conducted a study on 106 medical-surgical nurses using a narrative analysis of their comments regarding their work-related experience. They found that “comments by respondents in this study suggest that nurses who feel that the work environment neither empowers them to act effectively on behalf of their patient nor enhances their self-concept may lead to compromised patient care quality” (p. 76). I have experienced the CCU to be a fast-paced, high-stress, and intense working environment. It may be that certain types of nurses are successful in this area of nursing. I have concluded through my interactions with BCCNs that nurses in this health care environment enjoy the clinical challenges and intellectual involvement that come with the patient care associated with this level of acuity.

### **Relevance to Nursing**

An essential aspect of the BCCN’s function is to provide QNC for every patient. However, it has not been elucidated if the ones providing this care have a meaning of QNC that differs from those established. In a time of high levels of professional dissatisfaction among nurses, high rates of resignation, and low recruitment, the importance of understanding BCCNs’ meaning of QNC has relevance. Literature has supported a sentiment favoring shared governance. Shared governance is a partnership among bedside clinical nurses and nurse

managers that empowers bedside clinical nurses to participate in decision-making regarding the clinical unit (Ott & Ross, 2014). According to Ott and Ross, “fulfillment and empowerment occur when job duties are defined, input is solicited, work is made easier and the staff nurses are content” (p. 766). To embark on a path of shared governance, understanding nurses’ perceptions of the meaning of QNC is of the utmost importance.

### **Summary**

This chapter reviewed the phenomenon of the study, justification, context for the study, assumptions, biases, significance, and relevance of the study to nursing. In the next chapter, I explore the evolution of the study, including the historical and theoretical context for QNC. Additionally, I discuss the experiential background and literature review.

## **Chapter 2: Evolution of the Study**

It will take 150 years for the world to see the kind of nursing I envision....  
(Florence Nightingale, 1870, in Dent, 2022, p. 71)

This chapter serves as a primer for understanding the phenomenon of quality nursing care (QNC) through a literature review. I begin with the historical context of QNC, followed by a general discussion of the phenomenon, including proposed definitions and mechanisms of measurement. The chapter concludes with an experiential context to offer insight into the researcher's reasons for studying the phenomenon of QNC, specifically through the experiences of bedside critical care nurses (BCCNs).

### **Historical Context**

The modern history of quality in nursing practice can be traced back to Florence Nightingale, who, over 150 years ago, critically evaluated problems she encountered, proposed solutions, and prolifically shared her experiences (Hogston, 1995b). While she did not use the term "Quality Nursing Care," at least to the knowledge of the researcher, her efforts to improve outcomes through improved practices are equated to "quality improvement" by many.

Previously referenced literature suggested that quality practice results in better outcomes. As a result of this association, many measures of healthcare quality, and specifically QNC used presently, are outcome-dependent. Reasoning would lead one to understand that quality cannot improve unless the components of care leading to the outcome are understood and can be influenced. Jones (2016) stated that:

improving outcomes without knowledge of specific process failures is analogous to treating a disease of unknown etiology and can result in misdirected and/or delayed

corrective action. Therefore, quality assessment is best achieved through a set of measures that include outcomes and associated structures and processes. (para. 9)

### **Quality and Nursing Care**

QNC is a term specifically associated with nursing (Juanamasta et al., 2021). Despite being profession-specific, QNC has been reported on from a variety of perspectives due to the diversity of concepts and stakeholders associated with it, including patients, their loved ones, administrators, the public, and nurses themselves. There are no precise definitions of QNC, and the existing ones vary (Juanamasta et al., 2021). There are reports describing patient outcomes as defining QNC, as well as studies defining QNC through the perspectives of patients and nurses. The findings of the studies have come to varying conclusions. Nurses who have performed the research, as well as nurses who were subjects of research, have reported that patient-focused factors such as fulfilling a patient's needs define QNC. Yet others have reported nurse-specific structure and process components to be what represents QNC.

Over two decades ago, Hogston (1995b) performed a qualitative research study in England to develop a definition of quality based on nurses' perceptions of QNC. In this grounded theory study of 18 practicing nurses, three categories emerged, namely: structure, process, and outcome. Structure related to human and physical resources, process related to holistic and patient-centered care by competent nurses, and outcome related to patient satisfaction and meeting the patient's needs.

Taylor and Haussman (1988) discussed the difficulty of defining QNC for many years. The authors proposed that a definition of QNC should include indicators of caring and standards of nursing care. A more detailed description of the aspect of caring as defining QNC can be found in a contemporaneous Australian study. Williams (1998) reported that QNC was meeting the psychosocial, physical, and extra care needs of the patients. This grounded theory study was

conducted utilizing interviews of practicing nurses at an acute-care hospital in Western Australia. A similar patient-centered meaning of QNC was also reported by Thai nurses who were interviewed for the purpose of creating a definition of QNC (Kunaviktikul et al., 2001). The findings suggested that QNC should include a patient's physical, psychological, emotional, and spiritual dimensions, as well as considering patient satisfaction. In the same study, additional stakeholders, specifically hospital administrators and patients, were interviewed with a similar purpose. Administrators defined QNC as made up of standards, efficiency of work, and patient satisfaction. Patients, however, reported QNC to be represented by the qualifications of the nurses providing care.

Descriptions of QNC centered on nurse-specific factors and professional aspects of nursing exist elsewhere as well. Glen (1998) proposed that QNC can be viewed as a developmental continuum based on the following nursing perspectives: nursing as a labor, craft, profession, and art. Furthermore, Glen asserted that each view of nursing is a stage of professional development. Nurses develop along this continuum, beginning with a minimal level of competency and advancing to excellence. Along the same lines, Gunther and Alligood (2002) reviewed the literature to establish a framework for defining quality of care. They maintained that high-quality nursing care requires using knowledge from the nursing profession's theories and conceptual models. Therefore, high-quality nursing care equals competence in the psychomotor, affective, and cognitive domains (Gunther & Alligood, 2002).

QNC has also been defined through a patient-nurse relationship. Carroll (2005), reported that QNC involves the component of a nurse listening to and connecting with the patient. Moreover, Carroll asserted that recognizing mutual human connections and being present in the nurse-patient relationship are the essence of QNC.

Tafreshi et al. (2007) defined QNC from the perspective of clinical nurses as well as nursing experts. This qualitative study from Iran concluded that QNC is “the delivery of safety care based on nursing standards which eventuates patient satisfaction” (p. 320). Reporting on the interviews of 20 medical surgical floor nurses in the United States, Lynn et al. (2007) concluded that nurses providing quality care focus on both the patient’s needs and their vigilance and advocacy responsibilities, in addition to focusing on their relationships with patients. A few years later, Burhans and Alligood (2010) performed a qualitative phenomenological research study among practicing nurses in the U.S. to study the meaning of QNC. They reported the meaning of QNC to be meeting patients’ human needs. The essence of QNC included the following: responsibility, caring, intentionality, empathy, respect, and advocacy (Burhans & Alligood, 2010).

More recent works have further explored QNC through concept analysis. The first concept analysis on QNC was completed in 2016. Mhlanga et al. (2016) reported that “quality nursing care entails meeting client needs and expectations, through conformance to relevant standards/requirements and comprehensive implementation of care through the nursing process” (p. 29). A second and more contemporary concept analysis was performed by Juanamasta et al. (2021). The authors evaluated the term QNC and concluded that QNC was conceptually related to standards of care as well as “meeting patient needs.” The authors further discussed the consequences of QNC, including decreased levels of burnout and increased job satisfaction for nurses who provide QNC (Juanamasta et al., 2021). Lastly, this concept analysis found that health outcomes and patient satisfaction were impacted by QNC.

In a qualitative descriptive study among nurses in Saudi Arabia, Alsufyani et al. (2020) asserted that empathy, advocacy, and caring are essential elements of QNC and should be

incorporated into a nurse's practice to improve QNC. More recent work studying QNC as a phenomenon has been published by international researchers. Stavropoulou et al. (2022) explored how clinical nurses perceived and defined the concept of QNC in adult medical patients in Athens, Greece. This research was performed using a qualitative descriptive approach since, according to the authors, there was minimal knowledge about the phenomenon. Participants were asked to define what quality of care means. Stavropoulou et al. reported that they "defined quality as a holistic approach to patient care, involving issues of communication, best patient outcome, competency, knowledge, satisfaction, and meeting the patient's needs" (p. 473).

The need to understand nurses' perspectives has been mirrored by Nyelisani et al. (2023). The authors noted that "nursing care quality can be improved by understanding specific factors influencing nurses' 'perceived quality'" (p. 2). This led them to conduct a qualitative exploratory-descriptive study in Limpopo Province, South Africa, among nurses working in public hospitals to describe nurses' understanding of, views, or perspectives on QNC. This study included 35 participants. Nyelisani et al. reported findings that QNC "means meeting patients' needs through advocacy, empathy, fulfillment of patient's needs, good interpersonal relationships and teamwork" (p. 1).

### **Patient and Nurse Perceptions of Quality (Comparative Studies)**

Several studies attempted to explore and compare perceptions of QNC from the patient and nurse simultaneously. As far back as 1999, Redfern and Norman conducted a research study to identify indicators of QNC and assess the similarity between the perceptions of patients and their nurses. Redfern and Norman reported that significant indicators of quality of nursing care related to thorough, therapeutic, and psychosocial care according to the 96 patients and 80 nurses interviewed in the United Kingdom.

In 2008, Zhao et al. conducted a descriptive comparative study of 221 nurses and 383 patients in non-ICU units in China. The goal of this study was to explore and compare patients' and nurses' perceptions of QNC using the Perception of Quality Nursing Care Scale. According to the results from Zhao et al., patients and nurses had different perceptions of QNC.

Almost a decade later, a qualitative descriptive study with 25 surgical unit nurses and 25 patients from those same units was performed to compare perceptions of QNC. Grimley (2017) reported the shared description of QNC that emerged from patients' and nurses' interviews as follows: nursing vigilance, raising patient awareness, nurse approach to work, rapport, caring behavior, staying one step ahead, having enough time, nurses are knowledgeable, isolated, and ignored, and clinical safety.

Most recently, Tsogbadrakh et al. (2020) performed a qualitative descriptive study with 21 nurses and 18 patients to determine nurse and patient perceptions of QNC. They reported that the following seven categories emerged: symptom management, activities of daily living, encouragement, emotional support, nurturing relationship, respect for religious beliefs, and concern for cultural differences.

### **Measurements of Quality**

The lack of consensus in defining the quality of nursing care complicates evaluation and measurement (Stolt et al., 2019). Despite this historical dilemma, and since nurses make up the largest segment of health care workers providing direct patient care, efforts have been made to measure what was felt to be representative of QNC. The social contracts that nurses have with the public place through licensure dictate that nurses “engage in self-regulation to assure quality performance” (Jones, 2016, para. 3). Furthermore, having measures of process may provide a mechanism for causal relationships to be assessed between nursing care and patient outcome;

“researchers cannot establish specific causal chains without capturing the effects of nurse structures on nurse processes and/or the effects of nurse processes on patient outcomes” (para. 29). Thus, Jones asserted that the components of nursing care must first be recognized and then quantified.

Despite the dilemma in defining QNC, efforts have been made to measure it. It has been found that the quality of nursing care in acute care hospitals is typically quantified by measures such as nurse job satisfaction, nurse engagement, patient satisfaction with the overall experience, and hospital-acquired conditions (Grimley, 2017). To capture components of structure, process, and outcome, nurse-sensitive indicators (NSIs) were brought into use to evaluate the quality of nursing care (Stalpers et al., 2016). “Nurse-sensitive indicators are a metric for the degree to which acute care hospitals provide quality, patient safety, and promote a safe and professional work environment” (Phillips et al., 2021, Safety and Quality Rating System section). Established in 1998, the National Database of Nursing Quality Indicators (NDNQI) was founded by the American Nursing Association (ANA) for nursing care units to collect, analyze, and benchmark components of NSIs. The database, now managed by Press Ganey, collects hundreds of NSI data points related to structure, process, and outcome. While this instrument is a cornerstone mechanism for the assessment of quality, there are limitations. Oner et al. (2021) performed a 20-year literature review on NSIs and determined that there was inconsistency in the sensitivity of certain nursing care indicators that were related to nurse staffing variables. This robust review further highlighted inconsistent and contradictory associations, suggesting a need for standardization of the language used.

While instruments for measuring QNC continue to evolve, existing methods of measures of quality, particularly quantitative measures, may lack the specificity to evaluate quality of care

in all settings. Specifically, this study aims to understand how quality is described by BCCNs in a critical care setting in which a plethora of factors determine a patient's outcome. Thus, evaluating QNC purely on outcomes may not provide for accurate assessment. Danelis et al. (2021) performed a review to summarize the literature regarding nursing factors that influence patient outcomes in the ICU. After reviewing 93 studies from over 20 years, the authors extracted 21 nursing factors that were mostly process-related. Despite this existing work on the topic and due to the continuously evolving field of health care, there is a continued need to understand quality further, as its measurement is essential in improving the health care system (Burstin et al., 2016).

### **Recognition of Quality Nursing Care**

Measurement of QNC allows for tracking following interventions as well as benchmarking within and across institutions. Furthermore, some aspects of QNC previously discussed have been incorporated into measurement instruments that lead to certifications meant to distinguish institutions as being of "excellence." The American Academy of Nursing (AAN) authorized a study to identify hospitals that attracted and retained registered nurses in their employment and the elements that were associated with their attainment (McClure & Hinshaw, 2002). These hospitals became known as Magnet hospitals, and the original study, "Magnet Hospitals: Attraction and Retention of Professional Nurses," began in 1981 (McClure & Hinshaw, 2002). As a result of this work, an additional study was performed in 2001, titled "Staff Nurses Identify Essentials of Magnetism," to identify 10 items from a 37-item list that were important for nurses to deliver quality patient care (McClure & Hinshaw, 2002). Eight of the 10 items selected were considered the essentials of magnetism (McClure & Hinshaw, 2002):

- working with other nurses who are clinically competent

- good nurse-physician relationships and communication
- nurse autonomy and accountability
- supportive nurse manager-supervisor
- control over nursing practice and practice environment
- support for education (inservice, continuing education, etc.)
- adequate nurse staffing
- concern for the patient is paramount. (p. 29)

Currently, the Magnet Recognition Program® developed by the American Nurses Credentialing Center (ANCC) is an organizational innovation that redesigns the work environment (Lasater et al., 2019). A Magnet-designated hospital demonstrates a culture that supports professional nursing care environments advocating high-quality patient care and nursing excellence. Hospitals may apply for Magnet status once they complete the journey to Magnet designation and demonstrate excellence in patient and nursing care as well as a sustained culture of excellence.

Magnet status sets the standard for nursing excellence and is a prestigious designation. In the Magnet hospital environment, nurses have the opportunity, ability, and support to provide quality care and professionally develop themselves. This results in high job satisfaction (ANCC, n.d.), lower nurse dissatisfaction (ANCC, n.d.; Kelly et al., 2011), lower nurse burnout (ANCC, n.d.; Kelly et al., 2011), and higher nurse rating of quality of care (ANCC, n.d.; Djukic et al., 2013).

### **Experiential Context**

Several individual experiences have led to my interest in studying QNC. As a teenager, I received what I perceived to be poor care from nurses during my hospitalization. The nurses

lacked compassion and empathy. I was not assisted as I expected to be, and there was a lack of communication as to my care plan. I would often wait for my family to help me because I was uncomfortable asking for assistance from the nurses caring for me. I remember feeling frustrated and saddened with the care I received, so much so that I asked if I could sign myself out. This experience was instrumental in my decision to pursue nursing with a desire to positively impact patient care.

I, unfortunately, have required a few hospitalizations since. All these experiences touched me as a person and as a nurse. Following the delivery of my son, I had many complications. With symptoms of shortness of breath, fatigue, and a fever, I felt I had a pulmonary embolism and infection, but unfortunately, my symptoms and concerns were not assessed for two days. Finally, a nurse advocated for me and reported that I had a fever, and I was treated with intravenous antibiotics and insisted I be evaluated; however, it was only when my situation became acute, requiring my transfer to a critical care unit, that I was diagnosed with a pulmonary embolism.

During this hospitalization, I had other complications, including a hemorrhage requiring a blood transfusion and the inability to care for myself. I questioned the medical and nursing care I received during and after my hospitalization. Why did I receive what I perceived to be such poor care? Is this the care the nurses felt represented quality of care? Were there barriers to them providing it? Did they care?

As a former bedside critical care nurse (BCCN), I have observed both excellent as well as substandard nursing care. The QNC delivered became especially apparent to me when I assumed care of a patient. After a shift change, I would question the care provided to the patient prior to my arrival. I witnessed nurses delivering care based on the rationale, "That is how we have

always done it here.” I have observed the ramifications of poor staffing, time management, and resources. I have witnessed nurses who took pride in the care they delivered and others who simply performed the bare minimum. Specific nurses in the unit were known for their QNC, while others were known for poor care. I was curious if the nurses providing what was seen to be poor care were aware of what was thought of them, or if they felt they were providing quality care. Was QNC defined, measured, and evaluated by the nursing staff in the same way to arrive at these conclusions?

Later in my career as a critical care nurse educator, I witnessed the number of resources invested in orienting and educating BCCNs. Much time and money were invested in providing nurses with the opportunity to learn their new roles and become successful. In addition, the nursing education department provided in-services, education, and competencies for nursing interventions to support clinical nurses with their development. Here I also witnessed the variations in the nursing care provided. I questioned myself as to why those I was training were offering care with such variation. Was there too much focus on outcome-driven care and not on creating an environment to provide care the nurses felt represented quality?

In the role of an NM of a critical care unit (CCU), I was responsible for the staff’s safe delivery of quality nursing care 24 hours a day, 7 days a week, for the most acutely ill patients in the hospital. It was expected of me to respond to patients, their families, and other disciplines for concerns related to quality. My other responsibilities included the appraisal of BCCNs based on their performance and delivery of care, monitoring the CCU performance, and benchmarking against other CCUs in the hospital using Hospital Consumer Assessment of Healthcare Providers (HCAHPS) scores to assess the patient experience with the hospital and quality metrics from NDNQI®. Lastly, I was accountable for nurse satisfaction, retention, and turnover. From my

experience as an NM, I observed that QNC delivered by the nurse varied. In exploring this further, it became more evident that many times this variation in care was based on the nurses' own perceptions of QNC.

It is through my experiences that I have decided to study QNC through the experiences of those providing the care. It is my hope that this research study will reveal the meaning of QNC among BCCNs, allowing for a better health care experience for those delivering and receiving care. Through this qualitative work, I hope to formally study my experiences and report the results to positively influence the profession as a nurse leader.

### **Summary**

This chapter touched upon the concept of quality as a general term and subsequently in more detail discussed literature related to quality as it relates to nursing care. The measurements of QNC used presently were reviewed as well as the limitations of such measures that are heavily outcome based. Further discussion was put forth regarding components of the nursing profession that have impacted nurses' perception of being able to perform their duties in a manner they consider to be satisfactory. The chapter concluded with my own experience related to QNC having worked in various roles including as a BCCN to provide personal context in relation to the study. In the next chapter, I introduce phenomenological methods of research and discuss the basic principles and background, as well as the reasons I selected phenomenology as the method for this research study.

## Chapter 3: Method

This chapter discusses the phenomenological method, its basic principles, the background for its use, and the general procedures of phenomenology. Additionally, I discuss the rationale for selecting phenomenology as the philosophy and methodology of this inquiry to examine the lived experience of quality nursing care (QNC) among bedside critical care nurses (BCCNs). Lastly, this chapter introduces some of the historical phenomenologists and their approaches and philosophical perspectives of phenomenology.

### Introduction to the Phenomenological Method

The term *phenomenology* refers to a methodology, a philosophy, or an approach to study or research (Dowling, 2004; Sloan & Bowe, 2014). It is derived from two Greek words. The first Greek word *phainomenon* means “appearance” (De Chesnay, 2015; Vivilaki & Johnson, 2008), and the second Greek word *logos* means “order, word, and reason” (*New World Encyclopedia*, n.d., para. 3). Phenomenology is the study of phenomena, the study of the appearances of things as opposed to reality. Essentially, phenomenology is the description of the phenomena from the perspective of the person experiencing them (Tuohy et al., 2013). Phenomenology seeks to describe phenomena through the lens of the lived experience (Streubert & Carpenter, 2011), aiming to gain a deeper understanding of the meaning of experiences in everyday life (Beck, 2021).

Eighteenth century philosophers Immanuel Kant, Ernest Mach, and Wilhelm Friedreich Hegel laid the groundwork for an historical understanding of phenomenology. The movement gained ground as a philosophical tradition with German theorists in the 20th century (Earle,

2010). However, phenomenology as a philosophy arose in Germany before World War I (Dowling, 2007). Edmund Husserl is often regarded as the founder of phenomenology (Cypress, 2022; Earle, 2010), as he introduced phenomenology as a means of “doing philosophy” in the 20th century (Tuohy, 2013).

According to Cypress (2015), the objective of phenomenology is to illuminate themes and express the meaning of lived experiences. In doing so, its goal is to articulate the essence of human experience. Polit and Beck (2017) suggested that phenomenologists assume there exists an unchanging structure, which is the essence that can be comprehended. Accordingly, “Phenomenologic researchers ask, ‘What is the *essence* of this phenomenon and what does it *mean?*’” (p. 470). Hence, the aim of phenomenology is to reduce individual experiences of phenomena to a description of their essence (Creswell & Poth, 2018).

While traditionally, there have been two approaches to phenomenology—descriptive and interpretive (Beck, 2021; Sloan & Bowe, 2014)—descriptive-hermeneutic and hermeneutic-reflective life world research have been proposed (Cypress, 2022). An introduction to the approaches and some of the historical phenomenologists’ philosophical perspectives are discussed next.

### **Descriptive Phenomenology**

Descriptive phenomenology originated from Edmund Husserl, a German philosopher (Polit & Beck 2017; Sloan & Bowe, 2014; Sundler et al., 2019; Tuohy et al., 2013). The aim of descriptive phenomenology is to describe a particular phenomenon (Streubert & Carpenter, 2011). According to Polit and Beck (2017), descriptive phenomenology is “a description of ‘things’ as people experience them” (p. 471). The objective is to determine the essence of a phenomenon, that is, to describe the general characteristics of a phenomenon rather than to

describe the individual's experience (Tuohy et al., 2013). Thus, an objective of descriptive phenomenology is to provide an in-depth description of a phenomenon, aiming for maximum clarity of understanding without relying on unexamined premises (Streubert & Carpenter, 2011).

### ***The Phenomenology of Husserl***

Edmund Husserl (1859-1938) was a German philosopher who studied mathematics, physics, astronomy, and philosophy (Zahavi, 2003). Husserl conceived of phenomenological inquiry as an attempt to arrive at a deeper understanding of human consciousness and experience (Converse, 2012; Cypress, 2022; Dowling, 2007). This was done through rigorous and unbiased study of things as they appear (Converse, 2012; Cypress, 2022; Dowling, 2007). The importance of phenomenological inquiry was not to explain or interpret a phenomenon but rather to describe it (Cypress, 2022). For Husserl (1931/2017), extensive descriptions of the phenomenon should focus on essences rather than on concepts or facts; the aim should be to establish knowledge of essences. Husserl asserted that intentionality is an important characteristic of a phenomenon because the focus is on the interaction between the phenomenon and consciousness.

Husserl defined phenomenology as the systematic study of the essence of our experiences from an epistemological and transcendental or pure perspective (Cypress, 2022). Given this definition, phenomenology is a descriptive philosophy of the essence of pure experiences (Beck, 2021). Husserl claimed that "experience is the fundamental source of knowledge" (Cypress, 2022, p. 18). In his pure or transcendental phenomenology, Husserl (1931/2017) proposed a science of essential being, an eidetic science, not a science of facts. In his belief, one could dive deeply into consciousness employing the transcendental reduction process and discover the phenomenon's underlying structures (Cypress, 2022). He maintained that some important characteristics of experiences are subjective in nature. Husserl asserted that a researcher should

set aside any prior thoughts, presuppositions, or preconceptions about the phenomenon through reduction. This allows the researcher to keep the essence of the phenomenon as the focus of the study and ensure a reliable description of the phenomenon. This key element of descriptive phenomenology is called phenomenological reduction. Husserl developed the method of epoché, also known as bracketing, as a means to achieve reduction (Cypress, 2022). As a result of bracketing, the researcher's beliefs, presumptions, and viewpoints are minimized (De Chesnay, 2015). This is to ensure that they do not influence the researcher's account of the phenomenon under investigation. The researcher takes a phenomenological stance by setting their prior thoughts or preconceptions aside and attempts to remain objective with the use of bracketing. This allows the researcher to experience the pure essence of the phenomenon (Converse, 2012).

### **Interpretive Phenomenology**

The aim of interpretive phenomenological research is to understand another's world, including its practical wisdom, understandings, and possibilities (Polit & Beck, 2017). Additionally, interpretive phenomenology aims to describe, understand, and interpret a participant's experiences (Tuohy et al., 2013). Interpretation plays a crucial role in interpretive phenomenology (Beck, 2021). Instead of focusing on the phenomenon, the focus is on exploring the lived experience of the individual (Flood, 2010). The question behind hermeneutic phenomenology is: What is the lived experience of the phenomenon of interest? The purpose of interpretive phenomenology is to study and describe a phenomenon as an experience in life that illustrates the meaning of the experience (Flood, 2010). Through interpretation, interpretive phenomenology facilitates an appreciation of the phenomenon.

### *The Phenomenology of Heidegger*

The philosopher Martin Heidegger (1889-1976) was Husserl's student and then his assistant (Horrigan-Kelly et al., 2016). He developed interpretive (hermeneutic) phenomenology (Horrigan-Kelly et al., 2016). Similar to Husserl's phenomenology, his phenomenology is concerned with human experience as it is lived (Dowling, 2007). However, in contrast with Husserl, Heidegger did not believe that phenomenology should be used to focus on experiential epistemology (Converse, 2012). To him, the phenomenon should not be described but rather understood as a process of interpretation (Dowling, 2007). Heidegger emphasized interpretation rather than description as Husserl did. According to Heidegger, it was vital to interpret and comprehend the human experience instead of merely describing it (Polit & Beck, 2017). Essentially, he believed the meaning of the "being" of the phenomenon to be critical (Converse, 2012; Cypress, 2022; Dowling, 2007; Polit & Beck, 2017) rather than the essence of the phenomenon. The "being," on the other hand, refers to its meaning or the nature of that phenomenon (Cypress, 2022; Dowling, 2007; van Manen, 1990). Furthermore, "Heidegger also uses the phrase 'Being-in-the-world' to refer to the way human beings exist, act, or are involved in the world" (Dowling, 2007, p. 133).

Consequently, Heidegger's philosophy of phenomenology had an ontological focus, that the lived experience is an interpretive process (Cypress, 2022; Dowling, 2007). Heidegger's interpretation of phenomenology was that experiences are interpreted or assigned meanings (De Chesnay, 2015). Unlike Husserl, Heidegger believed one cannot set aside one's own beliefs or presuppositions (Cypress, 2022). He rejected the concepts of phenomenological reduction and bracketing (Earle, 2010).

Heidegger asserted that the researcher must be immersed in a phenomenon to gain an understanding of the experience of that phenomenon (Cypress, 2022). He reintroduced the notion of the hermeneutic circle to understand lived experience (Dowling, 2007; Earle, 2010). To explore and discover the meaning of the experience, the researcher applies the hermeneutic circle (Tuohy et al., 2013), using a circular process involving continuous reexamination. Relevant questions are asked and then followed by back-and-forth questioning to discover the meaning of being (Tuohy et al., 2013).

### ***The Phenomenology of Merleau-Ponty***

Maurice Merleau-Ponty (1908-1961) was a French philosopher (Earle, 2010) who drew on the writings of both Husserl and Heidegger (Cypress, 2022; Dowling, 2007) and focused on existential phenomenology (Earle, 2010). In his view, phenomenology is the rigorous science of seeking out essences (Sadala & Adorno, 2002). Phenomenology is, for Merleau-Ponty, the search for the essence of consciousness or perception that aims to describe the lived experience in the perceived world (Cypress, 2022). Merleau-Ponty sought to provide a direct description of the experience (Cypress, 2022; Thomas, 2005). It involved describing rather than analyzing or explaining the phenomenon (Merleau-Ponty, 1945/2012). Merleau-Ponty utilized phenomenological reduction to hold beliefs in abeyance, as Husserl did (Racher & Robinson, 2002).

For Merleau-Ponty, the lived body is the person's point of view of the world, the perceiving subject (Cypress, 2022). He believed that a person's perception plays an important role in the experiences of reality. Moreover, the phenomenological philosophy of Merleau-Ponty views people in a world that already exists before any reflection (Cypress, 2022; Sadala &

Adorno, 2002). Therefore, to understand the meaning of an experience, it is essential to describe it from the perspective of the person experiencing it.

### **Descriptive-Hermeneutic Phenomenology**

This type of phenomenology combines both descriptive and hermeneutic phenomenology and draws on the work of the philosopher van Manen and others (Dowling & Cooney, 2012).

#### ***The Phenomenology of van Manen***

Max van Manen is a Dutch-born Canadian scholar (Cypress, 2022). His type of phenomenology combines interpretive as well as descriptive phenomenology (Dowling, 2007) and is aligned with the Dutch school, also known as the School of Utrecht, phenomenological approach (Errasti-Ibarrondo et al., 2017).

As the study of phenomena evolved and progressed from pure or abstract philosophy to become a qualitative research method, the scholarship appropriated historical ideas and revised how it is understood. Van Manen drew upon Husserl's focus on indisputable knowledge and Heidegger's ontology to develop a scientific research method to reveal prereflective meaning in lived experience as an object of research. Van Manen's focus is not unlike that of earlier scholars, just with more practical aim.

According to van Manen (1997), phenomenology aims to gain a deeper understanding of our everyday experiences. Moreover, "phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience" (p. 10). For van Manen (1990), hermeneutic phenomenology is a human science, a research approach that "is interested in the human world *as we find it* in all variegated aspects" (p. 18).

In his book *Researching the Lived Experience*, van Manen (1997) introduced hermeneutic phenomenological human science and stated that hermeneutic research is (a) the

study of lived experience; (b) the explication of phenomena as they present themselves to consciousness; (c) the study of essences; (d) the description of experiential meanings we live as we live them; (e) the human scientific study of phenomena; (f) the attentive practice of thoughtfulness; (g) a search for what it means to be human; and (h) a poetizing activity (pp. 8-13).

Van Manen (1997) asserted that a human science researcher is a scholar, and the research method of hermeneutic phenomenology is scholarship. Van Manen, similar to Heidegger, does not support the concept of isolating or ignoring bias. “If we simply try to forget or ignore what we already “know,” we might find that the presuppositions persistently creep back into our reflections” (van Manen, 1990, p. 47). According to van Manen (1997), even though there is no established method of phenomenology, there are a tradition and body of knowledge that may serve as a methodological ground for human research practices. Thus, van Manen (1997) suggested that phenomenological scholarship can be used as a guide and recommendations for inquiry.

Van Manen (1997) proposed six activities to perform human science research. The research method used in this study are based on van Manen’s methodical research activities that guide human science research. His research activities are listed as follows:

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon; and
6. balancing the research context by considering parts and whole. (pp. 30-31)

Van Manen’s methodological structure of human science inquiry is operationalized in the next chapter.

## **Rationale for Method Selection**

The aim of this study is to explore, uncover, and illuminate the meaning of QNC as it is experienced by BCCNs in the critical care unit (CCU). Therefore, a hermeneutic phenomenological approach as described by van Manen was used in this study to understand the participants' lived experience with QNC. The rationale for choosing this phenomenological methodology is discussed below.

According to Polit and Beck (2017), "The goal of phenomenological inquiry is to understand lived experience and the perceptions to which it gives rise" (p. 471). Generally, phenomenological questions seek to understand the essence and importance of certain phenomena (Polit & Beck, 2017). Since the goal of this study is to understand the meaning of QNC as it is experienced by the nurses themselves, I chose a hermeneutic phenomenological approach.

Phenomenology is used to learn how a phenomenon is experienced and what it means; it is discovery-oriented (van Manen, 1997). It searches for universal meaning and a description of experiences (van Manen, 1997). Furthermore, phenomenology attempts to describe and interpret lived meanings, as people live them in their everyday life (van Manen, 1997). Since the aim of this study is to discover and explore the experience of BCCNs' delivery of QNC through their lived experience, this approach was appropriate to attempt to achieve the study's goals.

Hermeneutic phenomenology is both descriptive and interpretive. This approach offers the ability to learn about the phenomenon from the perspective of BCCNs, which would not be possible using other research approaches. Additionally, this approach offers insights into the participants' experiences and essences with the phenomenon of QNC.

The objective of this approach is to provide the essence of the lived experience in the form of a text that is expressive. The emphasis of phenomenological research is on the meaning of lived experience, and the point is to allow people to share their experiences and reflections to formulate an understanding of the meaning of human experience (van Manen, 1997). Since I intended to interview BCCNs about their experience with QNC to obtain a deeper understanding of the meaning of QNC, I selected this approach.

Lastly, phenomenological approaches are particularly useful in cases when a phenomenon is not well defined or conceptualized (Polit & Beck, 2017). A hermeneutic qualitative research study on the lived experience of QNC among BCCNs in the CCU is unique and may give understanding to the meaning of QNC.

### **General Procedures for the Method**

In qualitative research, interviews are a critical piece of data collection (Cohen et al., 2000) and a preferred method for the qualitative researcher (Cypress, 2022). Interviews are used to elicit information based on the types of questions asked to the interviewee. The interview data collected are transcribed, sorted, and examined. Then, the data are classified, categorized, and interpreted. The researcher must code the data from the transcripts, and this process of coding includes developing themes, building detailed descriptions, and providing interpretations (Cypress, 2022). The researcher then writes up the results by creating phenomenological text. Through the act of reading and writing, knowledge is produced from the texts that offers insight into the phenomena (Cypress, 2022). For van Manen (1997), the act of doing phenomenology includes responsive-reflective writing. The researcher needs to be engaged in the reflective writing activity.

## **Summary**

This chapter presented the phenomenological method and its approach to research. Its basic principles, background for its use, and general procedures were reviewed. The phenomenological approaches of Husserl, Heidegger, Merleau-Ponty, and van Manen were introduced. The rationale for selecting the hermeneutic phenomenological methodology for this study was posed. The next chapter describes van Manen's phenomenological method as applied to this study.

## **Chapter 4: Method Applied**

This chapter explains the application of van Manen's hermeneutic phenomenological method of scholarship for this study. Each of the six research activities proposed by van Manen (1997) to carry out human science research is discussed. Also, the procedures used to carry out this study will be described, including this study's aim, sample, setting, gaining access, data collection procedures, trustworthiness, data storage, data analysis plan, and protection of human subjects.

### **Van Manen's Method of Phenomenology Applied**

Van Manen's (1997) hermeneutic phenomenological research method was utilized in this study to uncover, describe, and express the lived experience of quality nursing care (QNC) among bedside nurses in the critical care unit (CCU). Six research activities were used as the methodological structure for human science research to guide this study. Van Manen's research activities can be completed in sequence or simultaneously.

The first research activity involves orienting oneself to a phenomenon (van Manen, 1997). Based on van Manen's approach, this first activity involves turning to the phenomenon, one that is of specific interest to me, one to which I am committed, and one that requires me to approach it with curiosity. I am extremely interested in describing the phenomenon of QNC among bedside critical care nurses (BCCNs) in the CCU. QNC in relation to bedside critical care nursing has been a major part of much of my career to date as a nurse myself providing bedside care as well as in positions of education and management of BCCNs. I have also had personal experiences as a patient that make this an important topic to me. The question proposed by me is:

What is the meaning of QNC through the lived experience of the bedside critical care nurse?

Based on the literature review, there is a paucity of research on QNC among BCCNs. This research aims to illuminate the lived meaning of QNC among BCCNs in the CCU. As part of the first research activity, I approached the phenomenon of QNC among BCCNs in the CCU with a spirit of inquiry and open-mindedness.

The second research activity recommended by van Manen (1997) is “investigating experience as we live it rather than as we conceptualize it” (p. 30). According to van Manen, the objective of phenomenological research is to reestablish contact with the primary experience. This research activity involves looking at an experience with a fresh outlook. The researcher must become entirely involved with the lived experience. The researcher begins by using personal experience with the phenomenon (van Manen, 1997). To investigate the phenomenon as we live it, we must be present and question the meaning of the phenomenon.

The lived experience serves both as the subject and source in phenomenological research. To investigate the lived experience, the researcher must use the lifeworld of the participants in the study as a source. Some of the approaches to investigate the experience as we live it include obtaining experiential descriptions from others, such as protocol writing, interviewing, and observing (van Manen, 1997, pp. 62-69). Another approach is through experiential descriptions in the literature, such as a biography, diary, journal, log, art, or consulting phenomenological literature (pp. 70-74). To implement the second research activity, I addressed my experience with the phenomenon as well as reflected on and shared my biases. For data, I conducted interviews to enable BCCNs to recall a time when they provided QNC to their patients. I allowed participants to share their stories and experiences. I was present and attentive. I wrote in a journal to

acknowledge my opinions, thoughts, beliefs to remain focused on the participants' lived meaning.

The third research activity recommended by van Manen (1997) is “reflecting on essential themes that describe the phenomenon” (p. 30). Van Manen suggested that to reflect on essential themes, the researcher should thoughtfully and deliberately highlight the experience's unique significance. According to van Manen, we can ask ourselves what it is that makes up the essence of this lived experience.

The third research activity is meant to assist the researcher to understand the essence of the phenomenon. Van Manen (1997) stated that “the purpose of phenomenological reflection is to try to grasp the essential meaning of something” (p. 77). To do this, the researcher must gain insight into the essence of the phenomenon being questioned, and this involves a process that includes “reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience” (p. 77). Completing the third research activity is necessary because the essence or meaning of a phenomenon is complex. Therefore, the researcher needs to engage in reflexive activity and in the “crafting of a text” (p. 78). According to van Manen, the researcher should think of the phenomenon described in text in terms of themes, structures of meaning, or meaning units to help understand the structure of the meaning of the text.

Additionally, the third research activity involves performing a thematic analysis to uncover and isolate what themes are the experiential structures that make up the specific experience (van Manen, 1997). According to van Manen, thematic analysis can be accomplished using three approaches: “(1) the wholistic or sententious approach; (2) the selective or highlighting approach; or (3) the detailed or line-by-line approach” (pp. 92-93). All three approaches were utilized for this study. My goal was to discern the fundamental meaning of the

text by reading it as a whole. I reread the transcripts a few times, listened to and watched video recordings of the interview to evaluate which participant statements were essential to the phenomenon being explored. I conducted a thematic analysis by reading the transcript as a whole, highlighting relevant phrase(s) and reviewing my notes related to responses.

Follow up interviews with each participant allowed them the opportunity to elaborate or clarify their experience, permitting for a hermeneutic conversation and completing a member check. The goal was “to be silenced by the stillness of reflection” (p. 99), representing the fulfillment of the text. The final step was to determine which themes were essential.

The fourth research activity recommended by van Manen (1997) involves the art of writing and rewriting—the application of *logos*. Therefore, to perform phenomenology is to apply *logos*, which is the application of language and thoughtfulness to a lived experience, the phenomenon (van Manen, 1997). Consequently, “responsive-reflective writing is the very act of doing phenomenology” (p. 132). Therefore, it is through this process of writing and rewriting that the meaning of conversation is retained, “letting that which is talked about be seen” (p. 33). Accordingly, “it is in and through the word that the shining through (the invisible) becomes visible” (p. 130). The writing process is basically inseparable from the research process. In this manner, to implement the fourth research activity, I listened repeatedly to the audiovisual recordings of the participants’ interviews to orient myself with the experience, to rethink and reflect and listen to what was spoken. My goal was to develop a reflective cognitive stance by rereading the transcripts and rewriting as I went back and forth repeatedly.

The fifth research activity recommended by van Manen (1997) involves “maintaining a strong and oriented pedagogical relation to the phenomenon” (p. 31). Hence, this requires the researcher to stay committed to, focused on, and excited about the question or phenomenon

(van Manen, 1997). Consequently, to do research and theorize, the “texts need to be oriented, strong, rich and deep” (p. 151). To implement the fifth research activity, I focused on the phenomenon of the study and avoided getting sidetracked. Throughout the writing process, I was thorough, with the goal of writing robust text. The purpose of the study remained my focus. I remained excited and curious about the phenomenon of study; a topic very important to me.

The sixth research activity recommended by van Manen (1997) is “balancing the research context by considering parts and whole” (p. 33). Van Manen acknowledged that the researcher may get caught up in the “whatness” of a phenomenon, get stuck in the process, or only view the bigger picture, and thus becomes unable to notice what the text is revealing about the phenomenon. Thus, van Manen advocated that the researcher ponder carefully, look at the study, and see how the parts impact the whole to avoid getting stuck throughout the research process. Moreover, van Manen encouraged the researcher to determine if the study’s design remains suitable for the parts to add to the overall text. Lastly, van Manen suggested organizing the research and writing approach to search for the wholeness of the text.

I implemented the sixth research activity by keeping my phenomenon of interest—namely, QNC, or the lived meaning among BCCNs in the CCU—at the forefront of my mind. To construct wholeness in a text, I applied an analytical approach to my research and writing and implemented the six research activities discussed. Therefore, I examined the transcripts of the interview to discover any descriptions that illuminated QNC themes.

### **The Procedural Description of the Method**

#### **Aim**

The aim of this study was to discover the meaning and understanding of the lived experience of QNC among BCCNs in the CCU. I also aimed to uncover and reveal the essences

or themes shared that characterize the phenomenon of QNC to transform the lived experience of QNC into a written description by applying van Manen's six research activities. Additionally, in studying the lived experience of the BCCNs, the essence of QNC may be better understood.

### **Sample Selection**

To begin this research study, I used convenience sampling to recruit volunteer study participants by contacting colleagues and peers for recommendations. Additionally, study participants were supplemented through the snowball method. As the study evolved, I applied purposive (purposeful) sampling as the method of sample selection. Purposive sampling is a strategy that allows the researcher to select cases that will benefit the study (Polit & Beck, 2017). Thus, study participants in qualitative research are selected for the aim of describing an experience, the phenomenon under study (Streubert & Carpenter, 2011). Also, an important aspect of qualitative studies is to extract the greatest amount of information possible from the sample (Polit & Beck, 2017).

The sampling method for this study included BCCNs working in CCUs who experienced the phenomenon of interest, QNC. The population for this research study consisted of bedside critical care registered professional nurses employed in a hospital and working in a CCU. Inclusion criteria for study participants included registered nurses with a minimum degree of a Bachelor of Science in Nursing (BSN), and who had been employed in a hospital CCU as a bedside critical care registered nurse for a minimum of one year. One year of experience had to be in a CCU with an equivalent to a full-time status of 1950 clinical hours of experience. A CCU was defined as any type of intensive care unit in the hospital.

According to Polit and Beck (2017), "there are no fixed rules for sample size in qualitative research" (p. 497). A guiding principle is that the size of the sample should be

determined by the informational needs of the study (Polit & Beck, 2017). Streubert and Carpenter (2011) conveyed that data collection will cease when saturation occurs; thus, there is no way to predetermine the number of participants required for a study. Van Manen, however, felt that “one cannot catch all the meaning or meaningfulness of a human phenomenon” (Cypress, 2022, p. 41), and therefore using data saturation to determine sample size is inappropriate. As the methodology of this research aimed to follow van Manen’s methodology, the sample size would be determined once enough data were collected to illuminate the themes; thus, there was no “typical” sample size. A goal of 10 participants was created as a starting point.

### **Setting**

I conducted individual online interviews with study participants for this research study. I selected a quiet and secure place in my home that allowed for privacy during the interview to minimize disruptions. Virtual technology (i.e., Zoom) was used as a cloud-based video conference communications platform to allow me to meet virtually with the study participants. This service was chosen due to the ability to record the interviews. In addition, this allowed me to review each recording as many times as needed for clarification, with the ability to observe body language and listen for changes in tone of voice. This served as both an auditory and a video record of the study participants’ interviews. I obtained written permission to record the Zoom interviews in the form of consent. Also, the study participants were notified of the recording via a message notification on their computer screens from Zoom, displaying a recording consent disclaimer. The study participants needed to consent to the Zoom notification to stay or leave the virtual meeting. The Zoom consent disclaimer could not be disabled. All participant interviews were recorded on the Zoom virtual technology communications platform on my private password-protected computer.

## **Gaining Access**

BCCNs were recruited through voluntary participation. Convenience sampling was used to contact peers and colleagues to suggest volunteers who might serve as study participants. I also implemented the snowball method to recruit participants for this research study. To gain access, I supplied a flyer along with a business card with my name, email, phone number, and protocol number. These flyers read: “In search of Critical Care Nurses to participate in a research study. Participate in an interview, I would like to hear about your experience with quality in nursing care.” Flyers were shared with each participant. An advertisement on LinkedIn was used that contained the information on the flyer and my contact information. After I received a phone call or email, I spoke with each participant to discuss the research study.

## **Data Collection Procedures**

Data collection began when the participant agreed to participate in the research study. Each participant was asked to complete the demographic questionnaire form prior to the interview process. Demographic data (Appendix A) included the following: gender identity, age, ethnicity/race, nursing degree, year of graduation from an undergraduate nursing program, year of graduation from a master’s degree program (if applicable), current place of employment, current nursing position, type of intensive care unit currently working in, full-time or part-time status, number of years as a registered nurse, and number of years as a BCCN.

The method of data collection was a minimum of one in-depth semi-structured interview with each participant. I selected this method to allow for a conversational and interactive experience, allowing the participants to share their stories more comfortably. This method also allowed me to listen to and process the participants’ narratives. Each interview began with an ice-breaking statement: “Becoming a critical care nurse is a significant accomplishment, thank

you for your service;” designed to initiate small talk and build rapport. The first interview question was a broad general open-ended question: “Talk about the type of care you deliver to your patients in the intensive care unit.” Open-ended follow-up questions were asked based on the response to the broad question to support participants to share their stories.

The location of the interview was in a private, quiet location in my home to allow for minimal interruption. I asked interviewees to also pick a private location that would be conducive to quiet and confidential recording. Face-to-face interviews were conducted remotely using video conferencing. I avoided note taking during the interview as it could have been distracting. The videoconference were recorded and transcribed for review. I wrote my notes immediately after each interview with a reference date correlating with the interview data. I also used a reflexive journal to write my thoughts, feelings, and personal reflections stirred up during the interview. Interviews were conducted through virtual technology, namely Zoom, and transcriptions of interviews were completed by Otter.ai using imported Zoom recordings. I reviewed every transcription from Otter.ai and compared each transcription to the Zoom recording to ensure accuracy.

### **Trustworthiness, Dependability, Subjectivity, and Reflexivity**

According to Cypress (2022), reliability and validity, which are measures used for quantitative studies, are exchanged with the notion of rigor and trustworthiness in qualitative research. Rigor is defined by the strength of the research design and appropriateness of the methodology used to conduct the study (Cypress 2022). Trustworthiness, which is determined after the research has been conducted, deals with methods used to make certain the research process was carried out without error (Cypress 2022). Accordingly, Polit and Beck (2017) recommended the frameworks of quality criteria that were proposed by Lincoln and Guba (1985)

and Whitemore et al. (2001) to create a qualitative study that is as well-founded, intuitive, trustworthy, and as thorough as possible. Trustworthiness was the goal of this qualitative study. Therefore, I applied the framework developed by Lincoln and Guba (1985) and Whitemore et al. (2001) to this study to attain trustworthiness.

Lincoln and Guba (1985) proposed four criteria to develop trustworthiness for a qualitative study: credibility, dependability, confirmability, and transferability (also see Cypress, 2022, Polit & Beck, 2017). The methods used to achieve each criterion are discussed as follows.

“Credibility refers to confidence in the truth of the data and interpretations of them” (Polit & Beck, 2017, p. 559). It is equivalent to internal validity (Cypress, 2022; Lincoln & Guba, 1985). Participants’ lived experience must be accurately and truthfully represented for credibility to be established. To apply this criterion to the study, I took steps to ensure reliability with interview transcripts. Member checking with each participant was performed to discuss interpretation and allow for elaboration. Additionally, the participants were asked about their experiences to allow for a hermeneutic conversation. According to van Manen (1997), the researcher can go back and have hermeneutic conversation to allow participants to reflect on their experiences.

Dependability refers to the reliability of the data (Cypress, 2022; Lincoln & Guba, 1985; Polit & Beck, 2017). The methods used to achieve dependability include the same methods used for credibility (Cypress, 2022).

Confirmability pertains to the objectivity of the data (Cypress, 2022; Lincoln & Guba, 1985; Polit & Beck, 2017). Confirmability refers to ensuring that data are reflective of participant responses. A researcher’s interpretations of data must be consistent with the information participants provided. The participants’ voice, not the researcher’s biases, must be

reflected in the findings to achieve this criterion (Polit & Beck, 2022). In this study, the methods used to achieve confirmability included keeping a reflexive journal and performing an audit trail. A reflexive journal allowed me to be aware of my own biases, assumptions, and beliefs through writing and bracketing. An audit trail was performed to assess the steps taken to collect, analyze, and interpret the data. I reviewed the notes taken after each interview, as well as the steps performed for thematic analysis.

Transferability relates to the ability to apply research results across various groups or settings. I intended to achieve transferability by providing a thorough description, conducting a robust data collection, and using a purposive sampling method. Data were videorecorded through the Zoom communications platform and transcribed by a professional transcription service, Otter.ai. Data analysis was methodological and systematic, categorizing information obtained to illuminate themes and descriptions. I used purposive sampling to recruit participants who could provide details on their experience with the phenomenon of study.

Whittemore et al. (2001) developed primary and secondary criteria for developing validity in qualitative research. Four primary criteria must be met to achieve validity in qualitative research: credibility, authenticity, criticality, and integrity. Secondary criteria, while not required, include explicitness, vividness, creativity, thoroughness, congruence, and sensitivity (Whittemore et al., 2001). Validity was developed based on the four primary criteria described below.

First, establishing credibility requires an accurate interpretation of the experience. As discussed in previous paragraphs, credibility was established by member checking. Second, authenticity refers to portraying the research in a manner that reveals the perspectives and experiences of participants, both as perceived and as lived (Sandelowski, 1986; Whittemore

et al., 2001), and reveals many realities. Authenticity was ascertained by giving voice to the participants' experiences. Third, criticality refers to demonstrating evidence that the research process had a critical appraisal. Criticality was validated by appraising the research design, sampling methodology, data collection, and data analysis. I applied member checking, performed checks of interpreted data, and discussed data analysis decisions. Fourth, integrity refers to maintaining an honest approach during the research process. Integrity was demonstrated by continuously performing checks of interpretations through member checks and providing the evidence to validate interpretations.

The secondary criteria of validity developed by Whittmore et al. (2001) that were applied to this study include vividness, creativity, and thoroughness. The presentation of the data includes thick descriptions and detail for interpretation to maintain vibrancy. Data have been organized, documented as text, and analyzed in a creative manner using the scientific process to demonstrate creativity (Whittmore et al., 2001). An association among themes, an in-depth research approach, and data analysis were performed to demonstrate thoroughness (Whittmore et al., 2001).

### **Data Storage**

To conduct this study, the following data points were collected: transcribed interviews, written notes, informed consent, demographic information, and a reflexive journal. Written documents were secured in a locked safe within a locked closet at my home. Electronic documents, video recordings of participant interviews, and electronic transcriptions of interviews were stored in a password-protected Teachers College Google Drive accessible through a password-protected computer in my home. The computer was encrypted using a password-protected screensaver and screen lock. Additionally, each participant was given a pseudonym

that was included in all written documentation and digital information after informed consent was completed. All hardcopy files will be destroyed by shredding, and electronic data will be deleted three years after completion of the dissertation.

### **Data Analysis**

Data analysis usually begins during data collection in qualitative research (Polit & Beck, 2017). The collected data were organized and stored in files for analysis. Van Manen's (1997) third research activity was applied to "reflect on the essential themes which characterize the phenomenon" (p. 30) for isolation of thematic statements. Van Manen (1997) recommended three approaches to bring themes to light and isolate aspects of the experience: "(1) the wholistic or sententious approach; (2) the selective or highlighting approach; (3) the detailed or line-by-line approach" (pp. 92-93).

I applied the first approach by reading the transcript of the interviews as a whole and articulating their meaning in one sentence. I applied the second approach and reread the transcripts a few times, identifying statement(s) or phrase(s) that illuminated the experience or the phenomenon and highlighting or underlining those statement(s) or phrase(s). The third approach involves analyzing every sentence of the transcribed interview and searching for any relevance to the experience or phenomenon.

Data analysis included watching and listening to video recordings and reading the transcripts to compare and check for accuracy. Once I confirmed that the transcripts matched the interview recording, I watched the video recordings repeatedly and read over the transcripts multiple times until I became familiar with the data, thus allowing me time to dwell with the data. I reread the interviews in their entirety several times and scrutinized every sentence to isolate and identify themes. While reading the transcripts, I took notes and wrote them in the

margins. Statement(s) or phrase(s) that illuminated the experience were highlighted using different color highlighters for related ideas. When reflecting on what I read and what I observed, I wrote comments and summarized any notes. Comments that I wrote were labeled “O.C.” for observer comments and “A.M.” for analytic memos. I added observer comments to the text that were not in the actual interview. Observer comments included incidental points I noticed, comments I found interesting or maybe meaningful, or anything else I felt necessary to state in the text after I viewed the video-recorded interview. Analytic memos were also added to the text. I added an analytic memo when I noticed a thread, categories, or themes in the data. Also, I referred to my journal notes when I watched the videos and read the transcripts to assess if body language and nonverbal cues supported the emergence of themes. I continued to scrutinize the data until I became close-knit with them.

After rereading and identifying statement(s) or phrase(s) that illuminated the experience of the phenomenon, I described, classified, and interpreted the data. Statement(s) or phrase(s) identified that illuminated the experience or the phenomenon were grouped into meaning units (codes) using different colored highlighters to represent ideas. Meaning units were categorized for patterns among them and synthesized into preliminary themes. Each participant’s transcript underwent the same process.

Preliminary themes were reviewed for accurate representations of the data and developed into essential themes. I included quotes from participants to support the themes identified.

### **Protection of Human Subjects**

Institutional Review Board (IRB) approval was obtained from Teachers College, Columbia University. I adhered to all policies and procedures recommended by the IRB. The protection of participants included the following: obtaining informed consent; voluntary

agreement of participants to take part in the study; the ability to withdraw from the study at any point in time without penalty; providing information to the participant in an understandable way; answering any questions the participants may have to ensure they understand their role; confidentiality of participant information and documents; participant notification of the nature of the study; participant notification of the risks and benefits of the study; assurance that participant notes, transcripts, and my journal would be kept in a locked safe in a locked closet in my home and that audiovisual recordings would be stored within a secured password-protected virtual drive. Pseudonyms for each participant allowed for de-identification. Participants were informed of compensation for completing all tasks in this study on the informed consent form. Participants had a choice of a \$35 USD Amazon or VISA gift card for completing all tasks of this study. No compensation was provided if all the tasks of the study were not completed.

### **Summary**

This chapter discussed the application of van Manen's phenomenological method of scholarship, procedural description, along with the sample selection, setting, and data collection process. The methods used to gain access to participants was described and the topics of trustworthiness, dependability, subjectivity, and reflexivity were discussed. In the next chapter, the findings of the study are presented.

## **Chapter 5: Findings of the Study**

Words mean more than what is set down on paper. It takes the human voice to infuse them with shades of deeper meaning. (Maya Angelou, in Smith, 2021, p. 56)

The purpose of this research study was to discover and explore the lived meaning of quality nursing care (QNC) among bedside critical care nurses (BCCNs) staffing critical care units (CCU) in hospitals in the United States. To uncover and illuminate the meaning of QNC as it is experienced by BCCNs in the CCU, a hermeneutic phenomenological approach, according to Max van Manen, was used to identify themes.

### **Participants' Demographics**

Twenty-two BCCNs were interviewed for this research study. All the participants worked in hospitals in New York; however, two participants had experience working as travel nurses throughout the United States, and seven had experiences as travel or flex nurses working in various hospitals in New York. Fifteen of the participants were female, and seven participants were male. The participants' ages ranged from 24 to 59 years old. Participants' years as a BCCN ranged from 2 to 33 years. Five participants worked part-time, and 17 participants worked full-time. Five participants worked in a cardiothoracic/surgical intensive care unit, four participants worked in a surgical intensive care unit, one participant worked in a coronary care unit, two participants worked in a medical/surgical intensive care unit, three participants worked in a neonatal intensive care unit, one participant worked in both a pediatric intensive care unit and neonatal intensive care unit, one participant worked in a medical intensive care unit, surgical

intensive care unit, cardiothoracic intensive care unit, and neurosurgical intensive care unit, one participant worked in a medical intensive care unit, and four participants worked in a cardiothoracic intensive care unit. Every participant had a BSN, and five participants had a master's degree. See Appendix H for the participants' demographic data.

### **Individual Participants' Experiences**

#### **Allison**

Allison was the first participant I interviewed in this study. She learned about this study from another critical care nurse who also participated. Allison decided to pursue a career in nursing after taking a health course in high school and shadowing a nurse anesthetist. She worked as a certified nursing assistant in nursing homes and was able to experience nursing outside the hospital during her high school course. Allison became interested in critical care nursing after taking a college class that allowed her to shadow a nurse in the intensive care unit. Allison is a BCCN employed in a teaching hospital, currently working in a combined cardiothoracic and surgical intensive care unit (ICU). She has been a registered nurse for four years, with three years of experience in critical care nursing.

Allison had a warm demeanor, was clear and focused on her responses, and described herself as having a type A personality. She was eager to contribute and share her experience with quality nursing care (QNC) as a critical care nurse. Allison felt the desire to participate in this research study to contribute to the nursing profession by providing her experiences, hoping they may make a difference.

#### **Samantha**

Samantha contacted me to participate after I shared my research flier with her. Despite her tight and demanding schedule, she was determined to share her views and knowledge.

Samantha was excited to participate in this research study. She shared information about the study with her colleagues and seemed intent on helping and recruiting other nurses.

Samantha became a nurse because family members who were nurses inspired her to become a nurse. She had a calling to be the voice for people in need and stick up for people who could not express their desires and wants, which ultimately led her to critical care. She enjoys working under pressure and described critical care as: “an exciting place because there are a lot of things happening all the time” (p. 1, lines 20-21). Samantha wanted to help patients that are “super sick” (p. 1, lines 23-24). Samantha was very direct, engaged, and wanted to share her experience with QNC. Currently, Samantha is a BCCN who works in a combined cardiothoracic and surgical ICU, where she has been employed for three and a half years and began her nursing career.

### **Aiden**

Aiden contacted me after learning about the research study from a colleague. He was eager to share his experience. Aiden had a positive and outgoing personality. He said it was important for him to give back to the nursing profession and help in any way. He described getting into nursing as “quite the adventure” (p. 1, line 7). He started his career as a nursing assistant after graduating high school when he was 17 years old. Aiden stated, “I owe my entire career to my boss at the time” (p. 1, lines 15). He shared that his boss took him under her wing and enrolled him in nursing school. Aiden was originally a graduate of a diploma program. He was very proud of being a diploma nurse graduate, stating, “I think they make the best nurses” (p. 1, line 29). Aiden was drawn to critical care to provide nursing care for the most helpless patients while developing a trusting relationship with the patients. He described his proudest moments as “getting people through really, really, really, really, really, terrible times” (p. 2, lines

27-28). He described another proud moment as a nurse: “When I can help make things happen for patients in this hot mess of a healthcare system that we have” (p. 2, lines 43-45). Aiden has been a registered nurse for 12 years and a BCCN for 10 years and is currently a BCCN, working part-time in a combined cardiothoracic and surgical ICU.

### **Emily**

Emily decided to pursue a career in nursing after her father passed away early, and she was interested in health care. Her best friend’s mother was a nurse, and Emily’s family were doctors. However, Emily felt the desire to help people and began in medicine. She pursued medicine for two and one-half years and then decided to learn more, do more, and be more involved with the patients in one-to-one or two-to-one patient care assignments, so she thought critical care nursing was best. Emily has been a registered nurse for 37 years and a BCCN for 34 years. She is a BCCN in a surgical ICU (SICU) in a teaching hospital, where she works part-time.

Emily contacted me after learning about the research study from a colleague. She wanted to share her experience, as she was proud of her team and described her colleagues as her work family. She shared that she “love[s] the team aspect of nursing” (p. 2, line 16). Emily was proud of how the nursing team came together as a group within the last three years. She spoke about COVID and how people would be fearful to enter the profession, and although the nursing team was scared, they were right there working as a team in COVID units.

### **Sally**

Initially, Sally’s interests were in veterinary medicine, and she became a veterinary assistant. Discovering her allergy to animals made Sally reassess her career goals. Knowing she was a caring and giving person and having a close friend who was a nurse, Sally decided to

become a nurse. Sally did well in nursing school and seemed proud to share that experience. She excelled in clinical, which boosted her confidence; however, she said she was very nervous because she started her career in the SICU right out of nursing school. Sally contacted me after learning about the research study from another participant. She was willing to share her experience with quality in the critical care unit (CCU) and add to the literature. Sally was engaged and ready to share her experience.

Despite getting the advice to start her career getting medical-surgical experience, when she applied for a job, she was offered a position in the ICU. Finding herself overwhelmed and working in the ICU was very difficult, she often cried after work because of the responsibility of taking care of critically ill patients. She went as far as typing up a letter of resignation; however, she never handed it in because when she went to work, she had a good night, and then many more good nights followed. Thirty-four years later, Sally is still employed in the SICU at the same hospital. She spoke about how she loves critical care and caring for one patient. In addition, Sally routinely takes the role of charge nurse for the shift and is a preceptor for new BCCNs.

### **Lisette**

Lisette works in a cardiac ICU in a teaching hospital. She is proud that she has continued her education and always seeks opportunities to improve herself. Her goal is to be a good bedside cardiac ICU nurse with a solid foundation for the patients. Lisette has been a registered nurse and BCCN for three years and completed a BSN program.

Lisette contacted me after learning about the research study from a colleague. She was happy to participate. She was clear, direct, and shared her narrative of getting into the nursing profession. She spoke of the influence of her grandmother, who was a labor and delivery nurse

for 50 years. Lisette revealed that she began in emergency medical services (EMS) when she was 18 years old and knew she wanted to be in a profession that helped people. She stated that “EMS kind of let me to meet some nurses in the ER locally, and that’s kind of what led me to nursing” (p. 1, lines 10-12).

### **Khloe**

Khloe did not want to pursue a career as a registered nurse. Her mom was a registered nurse. So, after she graduated high school, she began working in the hospital as a nursing assistant and “was like, wow, like I can actually do this, I was a nursing assistant, and I was like I wanted to make a difference” (p.1, lines 25-26). Khloe began her nursing career in a cardiac monitoring nursing unit and transferred into the cardiothoracic and surgical ICU by accident. She believes that taking care of patients in this ICU is “like my calling” (p. 1, line 42) and is so happy that she is employed in this specific nursing unit, where she has been a BCCN for 7 years and a registered nurse for 10 years.

Khloe contacted me to join after seeing the research flier from a colleague. She was delighted to participate and share her experience. She was positive and enthusiastic and worked hard to fit the interview around her busy schedule.

### **Laura**

Laura was an accountant working in a private equity fund compliance company for a few years and knew she wanted to transition into something different, one where she would see benefits from the work she did. While Laura was deciding what path to take, her dad was diagnosed with cancer. She observed how the nurses treated her father, the connections they made with their patients, and the direct impact the nurse has on the patient, and she decided to

pursue nursing. Initially, Laura wanted to be an oncology nurse; however, she was assigned to a SICU to complete the capstone rotation and was in awe of what she saw. Laura stated:

I didn't think I was ever going to go in the direction of critical care, I wanted to do oncology and kind of follow in the footsteps of those nurses who really had a big impact on my life, and I didn't get the oncology rotation for capstone, I got a SICU rotation. My first day there, it was, as a level one trauma center, I saw what nursing could be, you know, someone came up, there was a code, it was chaos, but it was organized, highly efficient chaos, and that's the unit that I would up working on for 10 years. (p. 1, lines 25-33)

Laura has been a registered nurse and BCCN for 10 years. Her clinical experience is in SICU. Laura contacted me about this research study after hearing about it from a colleague. She was interested in participating in this research study and helping in any way. At our interview, Laura was starting a new position in a SICU at a different hospital.

### **Raquel**

Raquel is a neonatal ICU nurse with 22 years of nursing experience and 17 years of her career working in critical care. She completed a BSN program and a master's degree in nursing (MSN). Her goal is to obtain a Ph.D. in nursing. She became a registered nurse because she always enjoyed taking care of animals when she was a child. Raquel stated:

So, and then as I grew up like you know reaching the age when you decide what you want to pursue, I felt like I would love actually to take care of patients and be a contributor on the journey from sickness to wellness, and so kind of yeah, that's my story. (p. 1, lines 12-16)

Raquel was born prematurely, and even though she was not thinking about working in this area of critical care nursing, it worked out that way. She stated: "So, I was not really looking for that because I was born prematurely, but I felt like something fell into place linked to my birth" (p. 1, lines 20-22).

Raquel contacted me after viewing my research flier on LinkedIn. She was interested in participating in and experiencing the interview process, as she is currently enrolled in a Doctor of

Philosophy (Ph.D.) program with the goal of conducting a qualitative research study to complete the dissertation requirement. She was excited to participate, smiled a lot, and was delighted to help another nurse.

### **Cathy**

Cathy works in a neonatal ICU in a teaching hospital. She fell in love with the atmosphere after shadowing a nurse and seeing the nurse has a role in helping patients navigate through having a baby for the first time, or even if it is not the first time for the patient, having a less than positive experience in the birthing process. She said that nurses have a bridge role in the neonatal ICU: “Getting to see these tiny, small, incredible beings become big 6-7-8-year-old, that’s the best thing in the world” (p.1, line 47, & p. 2, lines 1-2).

Cathy has been a registered nurse and BCCN for 8.5 years. She contacted me after hearing about my study through a colleague. Cathy was eager to participate and wanted to share her experience, contribute to nursing research, and help another nurse complete research, since she completed her master’s degree in nursing education. She was outgoing and engaging. Cathy shared her journey into nursing:

I actually don’t even come from a family of nurses. I know usually its like my aunt was a nurse, I actually kind of fell into it by accident a little bit. My first goal when I was younger was to be a dentist, and I worked in a dental office for a little while that did oral surgery, and I actually ended up kind of falling into like a watered-down version of nursing. We did a lot of pre-op and post-op care and teaching and all of that stuff, and I was talking to a friend about it, and they were like you really should consider going back to nursing school. I was like Yeah that’s a really good idea. So then of course obviously I started clinicals and fell in love with it and that’s kind of the weird, weird way that I found my path into nursing. (p. 1, lines 7-18)

### **Jennie**

Jennie was diagnosed with diabetes when she was 12 years old. This diagnosis took a lot of planning and thinking to treat, involving not only Jennie but her family and friends. Jennie wanted to help others who might be going through what she went through. Originally she

thought about becoming a doctor and searching for a cure, but Jennie felt the need to be helpful and supportive, and her mother was a nurse, her aunt was a nurse, and she grew up in a family of nurses.

Jennie enrolled in a nursing program and saw different nursing units. She enjoyed the ICU during her clinical rotations. Jennie worked for five to six years in adult nursing units, and for approximately two to two and one-half years, she worked in a step-down unit and experienced smaller patient-to-nurse ratios. She wanted to learn more about each patient and felt the ICU was the ideal environment.

Jennie has been a registered nurse for 10 years and a BCCN for 7 years. She works in both a pediatric ICU and neonatal ICU in a teaching hospital. Jennie contacted me after she learned about the research from a colleague. Despite a challenging schedule, Jennie was enthusiastic about participating.

### **Mannie**

After learning about it from a colleague, Mannie contacted me to participate in the research study. Mannie became interested in nursing because his mother is a nurse's aide, and his cousin is a nurse. He knew that the nursing field offered job security. As an immigrant coming to this country, job security is the most important aspect that attracted Mannie to nursing immediately. Additionally, the nursing profession allowed Mannie to get employed anywhere, in any state, wherever he wanted to live, which was also an attraction.

Mannie began his nursing career in a step-down cardiac monitoring unit. He was drawn to critical care after observing a code. His patient in step-down had a seizure, which progressed, and the code team was called. Mannie was in awe at how the code team responded to the patient, worked together synchronously, turned a chaotic experience into a streamlined process, and

controlled the situation. After that experience, he figured out the necessary steps to enter the critical care environment.

Currently, Mannie is employed in a teaching hospital in a CTICU. The nursing unit Mannie is employed in is unique and allows the nurse to work rotations among the step-down and CTICU, letting the nurse participate in the patient's transition of nursing care from pre-op surgery to post-open heart surgery. Mannie has been an RN for four years and a BCCN for three years.

Mannie was serious, direct, and clear, using different tones of voice to emphasize words and his hands when explaining his experiences. He was thankful to participate in the research, give back to the nursing community, and propel nursing forward.

### **Alex**

Alex contacted me after learning about the research study from a colleague. He was excited to share his experience and wanted to give back to the nursing profession. He shared his journey into the nursing profession. Alex said that nursing was not originally in his cards, even though his grandmother and mother were certified nursing assistants, and he grew up around the hospitals. Initially, Alex wanted to be a doctor; however, he took a job as a ward clerk in a labor and delivery unit in a hospital and observed the difference between doctors and nurses. He felt it was important for him to take care of the patient rather than being a doctor and taking care of what the patient needed, so he pursued his nursing degree.

Alex began his nursing career in an emergency room in a level-one trauma hospital. His goal was to get into the ICU; however, he felt it was more important to get nursing experience first. After he obtained experience in the adult emergency department, he transferred to the pediatric emergency department. Alex found his niche and transferred to the adult SICU. Alex is

a BCCN in a SICU at a level one trauma teaching hospital. He has been a registered nurse for 10 years and a BCCN for 5 years.

### **Abigail**

Abigail contacted me after learning about this research study from a colleague. She was very eager to participate and share her experiences. Abigail's initial degree was in English, and she worked in publishing. She felt like everything she did in publishing did not matter. It was not uncommon for a colleague who worked with her often to say, "It's just publishing; we're not saving lives" (p. 1, lines 32-33).

Abigail learned about an accelerated nursing program and returned for a nursing degree to make a difference. Abigail's nursing career has been in the neonatal ICU. She knew she could not work with adult patients and was fortunate to get a preceptorship in the neonatal ICU. She loved it and knew that was the patient population she wanted to care for. She has remained in the neonatal environment since graduating from a nursing program eight years ago. Abigail has a broad spectrum of responsibilities, from attending deliveries with the initial resuscitation team, stabilizing babies, attending surgeries performed in the patient's room and providing post-anesthesia care, and providing end-of-life care.

Abigail was straight to the point, clear and direct, on target, proud, and dedicated. She used different tones of voice to emphasize words and was passionate about her work. She has been a registered nurse and BCCN for eight years.

### **Keith**

After learning about it from a colleague, Keith contacted me about participating in the research study. Initially, Keith was an emergency medical technician (EMT), and he enjoyed interacting with the patients he cared for. However, he always wondered about their outcome

after dropping them off in the emergency room. Keith felt he never got the patient's full story and what was happening to them. Not knowing what happened to the patients he connected with drove him to pursue a nursing career.

Keith enjoys interacting with patients and their family members and educating them on their treatment plans and diagnosis. During nursing school, he became interested in critical care and started his nursing career in a step-down unit. He felt that in a medical-surgical or step-down unit, the nurse is more focused on completing tasks, and most of the time, the nurse does not get to know the patient. Keith said that in critical care nursing, he gets to know his patients, which interested him in critical care.

Currently, Keith works in a medical and surgical ICU. He has worked both day and night shifts. During COVID-19, he experienced working at institutions other than the one in which he is currently employed. Keith was sincere and passionate about participating and giving back to the nursing profession. He was eager to share his experiences with QNC. Keith has been a registered nurse for four and one-half years and a BCCN for three years.

## **Tom**

Tom's initial degree path would be in exercise science, and he wanted to help people in that area specifically. However, during a nutrition course at a university, Tom spoke with a classmate and learned about the possibilities of pursuing nursing as a major. Tom heard about the various opportunities a nurse can pursue, and he went home that day and researched how to become a nurse. As Tom thought about his career choice, he began to think back on all his experiences with medical issues during his childhood. He realized that all the positive experiences he had with medical professionals were with nurses. Tom realized that nursing offers the opportunity to live in many places, serve the underprivileged, and work in world-class

institutions while never getting bored. He felt that nursing was honest work, which attracted him to the profession.

Tom began his nursing career in orthopedics and telemetry. He aimed to get one year of experience before applying to the ICU. Tom was inspired to become a BCCN after observing a code situation where the action was seamless: “everybody was clicking on all cylinders” (p. 2, line 13). Tom believed that the experience in the ICU offered him the opportunity to have a great foundation to understand patients front to back and an in-depth understanding of complicated diseases. Tom is a travel nurse currently working in a cardiothoracic ICU. He has worked in various ICUs throughout the United States. He contacted me to participate in this research study after learning about it from a friend. He was engaged, articulate, and thankful for the chance to share his experiences. Tom has been a registered nurse for nine years and a BCCN for seven and one-half years.

### **Gabriel**

Gabriel’s parents did not want him to pursue a nursing career; rather, they wanted him to focus on technology and computer science. However, Gabriel was driven to become a nurse after his exposure to nursing during his volunteer experiences in high school and college. Gabriel stated, “The ultimate thing that drove me in nursing was the job satisfaction, the feeling you get at the end of the day that you have made a difference in somebody else’s life” (p. 1 lines 14-17).

Gabriel began his nursing career in a medical and surgical unit. He was in awe of BCCNs when they came to his unit in response to a code or rapid response patient situation. He observed how knowledgeable the BCCNs were about medications, and his goal was to learn and grow as a nurse and explore critical care nursing. Currently, Gabriel works in a SICU in a teaching institution. Gabriel contacted me to participate in this research after learning about it from a

colleague. He was excited to participate and share his experiences. Gabriel has been a registered nurse for five years and a BCCN for three years.

### **Betty**

Betty described getting into nursing as a “pretty crazy story” (p. 1, line 11), one that is unfortunate, interesting, and ended with a good outcome. When Betty was 18 years old and a college student, her best friend was hurt. Betty found her after the injury, knew something was wrong, and took her to the hospital. Her friend was in the hospital for a long time and required help to learn how to write and walk again. Betty was inspired by participating in and observing her best friend’s progression back to health. This experience motivated Betty to become a nurse.

Betty has been an RN and BCCN for six years. She began her career in the SICU and became a travel nurse. Currently, Betty works in a teaching hospital where she works between the MICU, SICU, CTICU, and neurosurgical ICU. Betty contacted me after learning about this research project from a colleague. She was eager and enthusiastic to participate and share her experience. Betty has been a registered nurse and BCCN for six years.

### **Nate**

Nate was always interested in the sciences. He enjoyed learning about how things in the body worked and physical fitness. When it became time to decide on a career path, Nate met with his guidance counselor in high school to discuss his interests. The guidance counselor recommended looking into nursing due to his love of sciences and the high demand for male nurses. Nate decided to research nursing and loved what he found. Nate spoke about how he has always been driven to help others. His father always participated in volunteering for charitable work, and Nate believes his desire to help others stems from his father’s example.

Nate always wanted to work in the ICU after he experienced the ICU environment during his clinical rotations in school. He was fortunate to obtain a position in the SICU at a level-one trauma center. Nate was drawn to the ICU for its fast-paced environment, constant moving, and shared: “You’re using [your] brain, you’re thinking a lot as far as like, trying to anticipate which direction the patient’s heading in and how to prevent that” (p. 1, lines 41-44).

Nate contacted me after learning about this research study from a colleague. He was eager to share his experience with QNC as a travel nurse throughout the country’s many ICUs and hospitals. Nate has been a registered nurse for nine years and a BCCN for seven years. He works as a travel nurse in the MICU in a teaching hospital.

### **Whitney**

Whitney wanted to attend college with a plan. She always knew she wanted to work in medicine and loved science. Whitney discovered that the college she wanted to attend had a well-known nursing program. Whitney applied and, fortunately, was accepted to the nursing program.

Whitney began her career in a medical-surgical nursing unit. She was intrigued when she observed the BCCNs come to the rapid responses on her unit. Whitney was in awe at how fast the BCCNS came to the unit and stabilized the patient. Whitney was interested in finding out what happened to the patient after the rapid response; she wondered how the patient would be treated and what the next step would be. This inspired Whitney to become a BCCN.

Whitney started her critical care nursing experience in an MICU, taking care of patients with sepsis, respiratory failure, pneumonia, and a mixture of things. Currently, Whitney works in CTICU, where she takes care of patients’ status post-open heart surgery. Whitney is very proud

to be a CTICU. She smiled a lot and was happy to share that experience. Whitney has been a bedside nurse for five and one-half years and a BCCN for three years.

### **Kelly**

Kelly had family members with medical backgrounds: one was a psychiatric nurse, and the other was a long-term care nurse. Kelly would listen to their stories while growing up and became interested in helping others and learning as much as possible about medicine and healing. Kelly recalled how her one family member who worked in long-term care would serve as a role model to the licensed practical nurses and nursing aides.

Kelly was always fascinated with emergency nursing; before attending nursing school, she was an emergency medical technician (EMT). In nursing school, Kelly had the opportunity to take a critical care course and complete a clinical rotation in an ICU. Kelly shared her experience:

I really developed a passion for the critical thinking, the knowledge that those nurses had, the confidence they had, just what they embodied as to me everything, what it means to be a nurse and a strong capable nurse. (p. 2, lines 9-13)

After this experience, Kelly knew she wanted to work in the ICU. Kelly contacted me after I sent her a message about the research study. She was eager to participate and thankful for the opportunity. She was delighted to participate and share her passion for nursing. Kelly has been a registered nurse for seven years and a BCCN for four years. Currently, Kelly works as a BCCN in a combined SICU/CTICU.

### **Sandy**

Sandy was always interested in health care and medicine. Sandy shared her journey into the nursing profession. Upon graduating high school, Sandy was not sure what path to take. She remembered her mother attending nursing school as an older child. She recalled her mother always being passionate about nursing. That passion for nursing got Sandy thinking about

pursuing this as a major in college. Once Sandy started college, she decided to take some prerequisite nursing courses. She enjoyed the classes, applied for acceptance to the nursing program, and has loved nursing ever since.

Sandy was unsure about what area of nursing she wanted to work in until her senior year of nursing capstone clinical rotation. She was assigned to a medical respiratory ICU with a preceptor who taught her a great deal and let her participate in patient care. Sandy loved that one could know everything about their patients, and that experience made her passionate about pursuing a position in critical care.

Sandy contacted me after learning about this research study from a colleague. She was engaged and enthusiastic about helping. Sandy has been a registered nurse for four years and a BCCN for two years. Currently, she works in a CTICU in a teaching hospital.

### **Thematic Analysis**

Performing thematic analysis includes determining “the experiential structures that make up the experience” (van Manen, 1997, p. 79). This process included rereading the transcripts and rewatching the video recordings for each participant multiple times, writing, and rewriting. Each transcript was analyzed to isolate thematic statements. To perform the steps of thematic analysis for this research study, I devoted time to dwell on each participant’s responses and personal narrative. The thematic analysis process took eight months.

The thematic analysis consisted of three methods for isolating thematic statements. The first method used was the holistic approach (van Manen, 1997); while reading the transcript, I asked myself, “What sententious phrase may capture the fundamental meaning or main significance of the text as a whole?” (van Manen, 1997, p. 93). To perform this method, each participant’s transcript was analyzed for a phrase that captured the main significance. Next, I

formulated a phrase to express the meaning or main significance. I created a table to display the phrase representing the main meaning of the whole transcript for each participant (see Table 1).

**Table 1**

*Thematic Analysis: Formulation of a Phrase to Capture the Significance*

<i>Participant</i>	Formulation of a phrase that captured the meaning as a whole
<i>Allison</i>	Take care of your patients as a whole
<i>Samantha</i>	Importance of resources and recognition
<i>Aiden</i>	Establish a trusting relationship
<i>Emily</i>	Know the patients' diagnosis as well as the families
<i>Sally</i>	Ensure every nurse maintains unwritten protocols for high standards specific to this unit
<i>Lisette</i>	Keep the patient involved and informed of their plan of care
<i>Laura</i>	Use clinical and emotional know-how for what you think is going to benefit the patient
<i>Raquel</i>	Recognize critical cues and escalate
<i>Cathy</i>	Use evidence-based practice, know the whole picture, and see all the pieces of the puzzle
<i>Jennie</i>	The human connection to the patient and family must be incorporated into the delivery of care
<i>Khloe</i>	Make a difference, whether as simple as labeling things or being organized, be organized, and make sure the patient's room is clean, organized, and structured
<i>Mannie</i>	Make sure patients understand their care, use communication that is clear and concise
<i>Alex</i>	Use your personal touch, people won't forget how you made them feel
<i>Abigail</i>	Protect your patients and use your 6 <sup>th</sup> sense
<i>Keith</i>	Comfort your patients, hold their hand, talk to them, and advocate for them
<i>Nate</i>	Able to provide the most up-to-date evidence-based practice in a timely, efficient manner to your patients without many obstacles or interruptions in your way
<i>Tom</i>	Honest work, bedside manner, remember your why, why you got into this profession
<i>Gabriel</i>	Pay attention to what is going on around you and leave your patient the way you received them
<i>Sandy</i>	Knowing what the patient needs to get better and then delivering that and making it happen, even though it seems difficult
<i>Betty</i>	A lot of external factors help us deliver QNC, it is hard to deliver QNC without those external factors being met; it's an equation with a lot of components
<i>Whitney</i>	Empowering patients to be involved in their care and giving them the power to guide their care
<i>Kelly</i>	Dignity, everyone wants to feel clean, hair combed and bathed

The second method applied for thematic analysis was the selective or highlighting approach (van Manen, 1997). I reread the transcripts multiple times and used various colored highlighters to highlight statement(s) or phrase(s) that seemed important or illuminated the participants' experience with QNC. While reading the transcript, I asked myself, "What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?" (van Manen, 1997, p. 93).

The third method was the line-by-line approach (van Manen, 1997). I reread the transcript multiple times, paying close attention to each sentence, and as van Manen suggested, I asked myself, "What does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (p. 93).

After completing the three methods above, I created a list with each participant's phrase that attempted to capture the main significance (see Table 1). Then I developed a spreadsheet for each participant that included phrases, statements, and quotes that were essential or revealing about their experience with QNC. I printed the spreadsheet to review and highlight common ideas with the same color. Phrases, statements, and quotes were examined to determine what they revealed. Common ideas and phrases were grouped together, and possible meaning units were formed. I listed the meaning units I uncovered in the interviews that impacted the data and are in no specific order; however, they are important for purposes of thematic analysis to show and help understand how each creates a theme. The meaning units were given to my advisor for review. The 32 meaning units that evolved were:

1. Take care of the patient: medically, spiritually, emotionally, socially, culturally, religiously, psychosocial, and their ethical needs
2. Provide individualized care
3. Provide patient-centered care
4. Advocate for the patient
5. Nurse requires education and knowledge

6. Cleanliness of the patient and patient's room
7. Basic nursing care
8. Safe nursing care
9. Anticipate the patient's needs
10. Critical care nursing care
11. Standard of care
12. Nursing care in a timely fashion
13. Develop a trusting relationship with the patient
14. Treat the patient like how I would want my loved one taken care of
15. Treat the patient like a human being
16. Use your intuition
17. Protect your patient
18. Go above and beyond
19. Take care of the patient as a whole
20. Family-centered care
21. Know your patient
22. Putting the pieces together
23. Connect with the patient
24. Use evidence-based practice
25. Staffing: nurse-to-patient ratios
26. Resources and equipment
27. Leadership support
28. Appreciation, respected and valued
29. Feel satisfied
30. Burn out and checked out
31. Teamwork
32. Coordinator

After creating the list of meaning units, to keep myself focused on the phenomenon of QNC, I viewed the video recordings again and reread the transcripts. The meaning units that represented relevant phrases were combined and placed in categories based on connections, related ideas, common characteristics, patterns, and thoughts. Boxes were created to display how meaning units formed clusters of similar categories, which led to themes (see Table 2).

**Table 2***Themes and Meaning Units*

Themes	Meaning Units
I: Holistic Awareness	Take care of the patient: medically, spiritually, emotionally, socially, culturally, religiously, psychosocial, and their ethical needs
II. Patient-Centered Care	Provide patient-centered care Provide individualized care Treat the patient like a human being Family Involved
III. Science of Nursing	Nurse requires education and knowledge Basic Nursing Care Critical Care Nursing Care Safe Care Standards of Care Know policies and procedures Timely care Use evidence-based practice
IV. Nurse and Patient Relationship	Develop a trusting relationship Treat the patient like how I would want my loved one taken care of Connect with the patient
V. Role of the Nurse	Advocate for the patient Protect the patient Anticipate the patient's needs Know your patient Putting the pieces together Coordinate Care Use your intuition Go above and beyond Teamwork
VI. Tools and Resources	Staffing Supplies Equipment Nurse-to-patient ratios Leadership
VII. Consequences of QNC	Burn-out Checked out
VIII. Results of QNC	Recognition Appreciation Feeling satisfied

## **Essential Themes**

A phenomenon cannot be clearly explained without identifying essential themes. Incidental themes may be related to the phenomenon through indirect associations or through a cause or effect relationship but are not defining of the concept to be studied. Essential themes are exclusive to the phenomenon or experience (van Manen, 1997). During this process, it became apparent that certain meaning units and their associated themes were circumstantially related to the research question. Only themes that were felt necessary for QNC to exist were classified as essential. As simply put by van Manen, “In determining the universal or essential quality of a theme our concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is” (p. 107).

### ***Essential Theme 1: It is not Just Taking Care of the Illness***

Many participants discussed the meaning of QNC to include care that is not necessarily categorized as medical care focused on the presenting morbidity. This care was described using the word “holistic” as well as the term “treating a patient as a whole.” Betty used the word “whole” when discussing what QNC meant to her when she treats a patient: “Just as a whole just looking at their physical needs, their emotional needs, anything that will help us align better with them” (p. 6, lines 4-5). Alex stated: “Quality nursing care also goes beyond the patient, so you have to take a holistic approach to things” (p. 12, lines 8-10). Sandy made the distinction between focusing on presenting pathology during nursing care and understanding and caring for a patient as a multidimensional being, including cultural and religious components:

I think that it involves taking care of the patient, medically, emotionally, culturally, religiously, anything that is important to that patient, and then also having that medical side, constantly being in communication with your patient and making sure that everything that you’re doing is communicated. (p. 3, lines 31-36)

Along the same lines, others discussed addressing spiritual and ethical needs of a patient being a part of the meaning of QNC. Emily declared, “I’m talking about the whole patient, not just their physical needs, but their emotional needs, their ethical needs, their spiritual needs” (p. 1, lines 16-18). Within the same discussion, Emily gave an example of a patient dealing with a grave medical issue but being concerned about their finances and their home:

It’s a holistic approach to nursing that we’ve always been talking about. It’s just not the physical aspects of it. It’s the emotional, it’s the psychosocial, and just trying to touch on all aspects of what I consider quality care. (p. 2, lines 19-22)

Emily continued to share her experience and explained:

They had a splenectomy and bleeding out. But knowing, you know, they’re worried at home, because they’re not going to make the bills. And so that’s not going to help them heal, because they can’t focus on one thing, they’re worried about their wife, their children, you know, and trying to, like, have them talk through it. Because the healing process is not just the body, you have to have the mind. (p. 2, lines 26-32)

At times nurses would be very specific in describing examples of what holistic care meant through their experience. Kelly stated, “I really try to get into the mind of my patient, like if they’re still working, what their background is, what is their story, if they made poor health decisions” (p. 2, lines 23-25). She further discussed her reflections on the patient’s responses. She gave the example of her attempts to understand why patients may be ill due to noncompliance: “I try to understand why they don’t make the best health decisions” (p. 2, lines 27-28).

Themes derived from responses at times would contain some degree of overlap. Nate discussed looking at his patient from a holistic perspective but used an example of his role as a nurse in developing an emotional connection with his patient as an example of what he felt was holistic care:

You know, make sure I’m holistically looking at my patient (p. 3, line 51, p. 4, line 1)... So, to totally disregard the emotional aspect of being in the hospital, I think it’s something that can affect quality care (p. 4, lines 20-22)

He presented a scenario of what he felt would *not* be representative of QNC: “‘Hi, I’m gonna be your nurse, let me do my assessment,’ and then you leave, and you forget that emotional interaction” (p. 4, lines 24-28). Nate elaborated on the impact he felt a holistic connection made, saying that this understanding of a patient:

can really make a difference in patient’s outcomes that I’ve seen, because if they’re, you know, upset, or they just have a negative outcome, or negative outlook on everything that’s going on it can really affect how you know things go in the hospital for them. (p. 4, lines 24-30)

Samantha also discussed holistic care as being emotionally present for the patient.

Being you know, aware that this patient is here, you know, and let’s take a look at the patient. Let’s not take a look at the monitors at the moment. And let’s kind of just be there emotionally for the patient as well. (p. 5, lines 1-4)

Furthermore, this holistic care extends from the hospital through the discharge period in the eyes of some nurses. Kelly explained:

So, I try to, even if I just have a patient for one shift, I try to learn as much as I can about who they are as a person, what I can do to optimize their care, and what they will need to get through that shift and hopefully, eventually, ultimately out of the ICU and discharged. But I think about what difference I can make even in the short term, in that short shift what are the goals of care and what can I do to help them thrive in that short time that I may have with them. (p. 2, lines 24-36)

A near-complete summary of the meaning units that led to an essential theme of holistic care was found in Allison’s interview. She stated:

To me, it’s being able to take care of your patients as a whole, not only medically taking care of them, but also being compassionate, being a listening ear, just being there for them as a whole person because you know, you can be treating a patient medically, but if they’re mentally also, feeling the effects of being in the ICU, you also have to deal with them as an entire person, you have to make sure you’re taking care of them and all that encompasses. (p. 3, lines 30- 37)

Allison discussed:

So as a whole, I mean, you can manage someone medically and get them healthy. But if they’re not mentally in the right state to you know want to get better, want to get out of the hospital and try and get back to their like normal daily routines, you also have to make sure that you’re taking care of them mentally, and spiritually. (p. 4, lines 10-15)

Nurses included spiritual care as part of holistic care. Allison stated:

You have to make sure that you're taking care of them mentally, spiritually. A lot of what we do is bring in outside providers, we have Reiki. We bring in these different providers that all work with the hospital, schedule an appointment so they can come up and talk to the patients and offer them different services they might not otherwise have to make sure they are comfortable, and can talk and express themselves as well. (p. 4, lines 14-23)

Allison also shared:

I offer them all the different services that we offer at the hospital. One of the things I really like is aromatherapy. We call a code lavender, which is a provider that comes up and uses incense. (p. 5, lines 23-26)

Sandy stated:

I think in a way is holistic, and then also including like the cultural and religious aspects. (p. 4, lines 1-3)

### ***Essential Theme 2: Being There for Another, It's the Little Things***

The theme of patient-centered care is presented following the theme of holistic care, considering the potential for overlap semantically in the literature and, most importantly, within the context of this project. However, considering the specificity of meaning units derived from the interview participants and to account for what they were expressing, "patient-centered care" was derived as an additional essential theme since the term was used without simultaneous use of the word "holistic" or other meaning units categorized under "holistic care."

Patient-centered care as a theme was related to care components not necessarily linked to a deeper understanding of the patient's sphere of existence as in holistic care, but based on care that might make the patient more comfortable on a personal level for a particular instance in time or a focused effort to individualize medical care for a particular clinical condition or situation.

Aiden's meaning of QNC was described using the words patient-centered care. His example of providing QNC is expressed as a patai:

Care for the person you are giving care to  
Needs to feel safe, comfortable  
Set up for success  
Tailor care. (p. 4, lines 38-40)

Nurses expressed the need for medical care to be individualized and specific for the patients being cared for. Alex stated, “You need to give care that is comprehensive and personalized to your patient” (p. 3, lines 40-41). Betty was more detailed in her response to how she provides QNC. She stated:

I’m learning what the patients are used to at their own house or in their own environment. If they like to have their medication at certain times, maybe we can see if we can accommodate them that way. Seeing their diets, what they prefer to eat, and anything that they prefer outside of the hospital, we try and integrate them while they are in the hospital. (p. 5, lines 37-42)

Patient empowerment, while not a recurrent theme, was seen to be a component that defined QNC for Whitney. Whitney discussed that “quality nursing care means empowering patients to be involved in their care while they’re in the hospital and giving them the power to like kind of guide their own care” (p. 2, lines 11-17). Tom even took into consideration the unconscious patient and gave an example of how care could still be focused on the patient despite being in a state of unawareness, a common situation in a critical care setting. He described:

Little touches, like maybe turning the channel on or putting on the music that you know the patient enjoyed, even when they are not conscious, are some of the things that may not be, quote-unquote, be absolutely necessary for them to go on and to flourish when it comes to like physiological processes. (p. 2, lines 41-46)

In the same context, describing personal experiences that conveyed the meaning of QNC through patient-centered care, Khloe proudly recalled how her care was patient-centered:

One time, I had this patient who was with us for a long time, and it was the summertime, and he was on TPN, and he couldn’t leave the hospital. But other than that, he was alert and oriented. He was getting up, he was walking, and we got permission from everybody and got orders placed and made sure it was safe and we were able to take him downstairs with a monitor in a wheelchair for a few minutes, just so he could have

some sun on his face. And we brought him back up. I am really very proud of that. Because I felt like, you know, this poor guy has been in the hospital for a month and we were able to just like do that for him, that's all he wanted to do. (p. 3, lines 8-19)

The entirety of her quote conveys her deep attachment to this experience.

Nurses having an awareness that they were caring for another human being was seen to be congruent and within the sphere of patient-centered care. The importance of this in a critical care setting was expressed by Jennie:

Especially like a critical care nurse, like, there's a lot that you have to focus on. But you also have to look at that person in that bed as a human being (p. 2, lines 24-27)..... Quality nursing care is understanding that that's another human being. That's another human being, that's another family. You know, really, really getting in touch with, with, like, I guess core values. (p. 5, lines 7-17)

Khloe, proud of the care she provided for her patient, was specific in discussing a nurse understanding that they were caring for another person. She explained:

And little things like sometimes I feel like I'm working in intensive care, a lot of people are focused on taking care of the patient and making sure the medications are given. And then, like, that's it, the patient is doing well. But remember, the patient is a person also. (p. 4, lines 50-51)

Khloe pointed to specific actions she felt were patient-focused:

So, what's important to you might not be what's important to them, or they might not realize or understand all the things that you're doing, and they just want something to feel normal. So, it's like I said, the little things, brushing your teeth, brushing your hair, maybe sitting in the chair, and having a hot meal, like if a tray from dietary comes and is not given to you right away, and now your food is cold. It's just little things like that that they can't control but it's like little touches. (p. 4, lines 48-51; p. 5, lines 1-11)

Some nurses discussed a time when they felt they delivered QNC. This allowed nurses to share personal stories, sometimes with deep emotion attached. Sally recalled her experience, saying:

This man, dying  
Wife at bedside  
Intubated, multiple machines  
I washed his hair  
She went to nuzzle him

Smelled his hair clean  
It meant so much to her  
He smelled good  
That little extra thing  
He was still a human being  
He still needed to be clean  
It made a big difference  
It was important to her....  
(p. 4, lines 37-50, p. 5, lines 1-2)

Sally's response did not necessarily indicate that the care for her patient was being provided for the benefit or satisfaction of the family but out of a desire to serve the patient she was caring for. The results of this involved the family in the care and experience of QNC through its effect on the patient's wife. On the other hand, some nurses interviewed identified the purposeful involvement of the family or patient caretakers in discussion and care as a component of QNC. Whitney discussed both the patient and family: "I would say, like, involving the patient in their own care, and like, as well as family members, making sure that you know, we are all on the same page" (p. 3, lines 31-35). Cathy brought forth similar thoughts:

And I think it's really important to remember that just taking care of them and giving them good nursing care is not necessarily the whole picture, like, you know, social-wise, being very cognizant of the family and keeping them kind of, you know, happy for lack of a better word in the process is kind of that other part of it for me. (p. 3, lines 16-22)

Making sure the family was aware of the care being provided was echoed in multiple interviews. Keith, speaking from his experience, identified the anxiety family members may have and felt that QNC meant that addressing this was a vital component of QNC, particularly in a critical care setting. Keith explained:

So, I always try to incorporate the family and let them know what I am doing. I try to incorporate them so that they understand because they do not want a nurse to come in and do stuff and not tell them what they are doing. So, I like to, also, it is a way of comforting the family members, because they are also very anxious as well, on what is going on in the ICU. (p. 2, lines 42-48)

### ***Essential Theme 3: It is Knowing Your Stuff—Bed Bath, and Beyond***

An essential aspect of QNC based on the interviews was the professional facets of nursing care. Through the meaning units, this appeared to be focused on components of nursing care that can be taught and learned in a classroom or clinical setting and differentiated from knowledge through practice and experience. As Jennie put it, “I really think it’s; it’s knowing your stuff” (p. 7, line 31). Gabriel, who takes care of surgical patients, said,

I would say the nurse is key to understanding their patients. So, we make sure our assessments were pretty much, yeah, understanding our patient head to toe, noticing our nursing assessment that we learned in nursing school, and pretty much having a good understanding of the anatomy and surgical site that doctors do want us to look at. (p. 3, lines 2-7)

Emily stated that education was a big component of QNC. She explained, “I think education is a big part of it. Because you have to have the knowledge to provide that nursing care” (p. 5, lines 13-14).

Nursing curriculums include pharmacology, which Tom stressed the importance of as an example of QNC, along with stressing the need for proficiency. Tom stated,

And that it’s extremely important to be proficient and knowing, you know, the drugs that you’re implementing, and their mechanisms of action, but also knowing what that looks like when it comes to not just, you know, the mechanism of action, but how is it going to present with the patient. (p. 11, lines 37-42)

The fundamentals of nursing care that are repeatedly reviewed through all nursing education programs are also seen to be a cornerstone and priority in the meaning of QNC. Aiden said,

The fundamental basics of nursing care need to be met before we do anything else. I mean, maybe that’s just my diploma nursing training shining out before anything, but like until my patient is comfortable and clean and in order, like nothing else matters. (p. 7, lines 29-33)

Sandy related providing QNC through basic nursing care for the prevention of nosocomial infections to a positive patient outcome. She also felt that staying up to date on nursing practice was imperative to delivering good care: Sandy shared,

Delivering your basic nursing care without error, always maintaining correct hygiene, preventing patients from getting any hospital-acquired infections, which I think is basic in the sense of nursing care, but I think it's delivering all of that, and then also staying updated on current practices and being able to deliver care. So that your patient, you know, maintains a positive hospital course and hopefully gets better. (p. 2, lines 45-50, p. 3, lines 1-2)

Emily highlighted the importance of providing basic nursing care to have QNC, even in a setting where highly specialized care is essential. She explained, "And it's just everyday things like turning and positioning every two hours" (p. 4, lines 3-4). And she added:

I think, you know, there's certain criteria in nursing, you know, you have to make sure that you check on your patients, at least every hour, you know, you do the vital signs in critical care a little bit more, but there's certain quality of care that's just basic, you have to make sure that they're safe, that they have the call bell, those kinds of things that you know, you turn and position them every two hours, that you assess pain issues, I think those are the basics. (p. 3, lines 5-12)

Patient safety and safe care were discussed by several nurses interviewed. When discussing the importance of safe care in relation to QNC, one of the nurses described a scenario when she was responsible for an error that may have had significant clinical implications. The error was noted before any harm could occur. However, this event of not providing what the nurse felt to be quality of care and recognizing the implications had a lasting impact.

It was a real eye-opener, and I, like, I cried, like you know, like you know, forget it, like they took my puppy or something, because the thought of hurting somebody just, you know, was so upsetting that that could have caused somebody to have been hurt in my hands. And I could never have that. So even to this day, if I'm in charge, I'm taking care of very sick patients, but I still pull over another nurse to double-check things. (p. 7, lines 29-35)

Cathy, along with other nurses, spoke about the intensity surrounding the efforts to provide safe care and provided a glimpse into what is involved through her experience as a neonatal ICU nurse taking care of the smallest of patients. Cathy shared,

So, delivering quality nursing care in the ICU is sometimes exhausting, especially in the ICU; there are a lot of things that pop up that you're maybe seeing for the first time. So quality care, for me, means that I take that extra 5-10 minutes to look up the policy, look up the procedure, and make sure that I'm doing things the correct way and the safe way. (p. 3, lines 35-40)

Safe care, as the meaning of QNC, was seen by nurses to be important from admission through discharge. Betty said,

For me, I think safety is number one for patients, I think we need to always ensure their safety, whether that be explaining and educating patients on discharges, medications, what the expectation is for us to get them to go home, decreasing the length of stay. (p. 3, lines 38-41)

QNC through safe care was seen as competency, as Khloe explained: "Well, it means I want to deliver safe, competent care" (p. 2, line 33).

Performing tasks in a timely manner falls under the theme of patient-centered care as well as the science of nursing. Tasks are generally time-sensitive and, in a critical care setting, may be "ordered" to be performed in a specific sequence or at a specific time. Two of the nurses interviewed said that the meaning of QNC had to do with timeliness. Emily shared,

Making sure that you do everything in a timely manner... I think quality nursing care for me also is when that bell rings, you answer it, you know, you have to think about the person on the other side of the bed. They're in pain. And you and you're saying, oh, well, let me just finish charting. (p. 4, lines 11, 36-43)

In discussing the meaning of QNC, Samantha provided a glimpse into the care of patients in the surgical and cardiothoracic ICU where she works and how timeliness is of utmost importance. Samantha shared,

So sometimes, yes, it's easy, but for the most part, it's very difficult to get my patients their treatments on time. So, for example, like, if they need to get chest PT, that's a treatment that we do, or if they need to get a certain medication, or they need to go

down for a certain test, all of that, that's total care, that's on me. So also address for pain, antibiotics, those need to be done in a timely matter, lab work, that's one of the things that we do that needs to be done in a timely manner, especially for titrating drips based on the lab work. (p. 2, lines 15-21)

One of the components of training as a bedside nurse is learning the process of transitioning care to colleagues. The seamless transition between nurses providing high-quality care was seen to be an experience nurses felt was the meaning of QNC. Kelly expressed,

When I think of quality nursing care, any nurse should be able to take over from you and understand, of course, the report is important, but they should be able to walk into your room and understand what medications that patient has, if they have something like an EVD or an ICP, if something's being monitored like any nurse should be able to walk into your room and have an understanding without report, obviously should have report, but they should have an understanding of what's going on with your patient that any nurse within the same specialty can have an idea of what's going on with your patient. (p. 5, lines 33-42)

Patient care units within hospitals have operating policies and procedures. These have components that are institution-specific and usually meant to provide roadmaps and maintain consistency and quality. Nurses performing their duties based on these guidelines was what many nurses felt was a component of the meaning of QNC. Sandy, who works in a cardiothoracic intensive care unit, added in her discussion of QNC that to her, it meant "meeting the standards that are set by our hospital, and also by yourself, like the hospital expects that certain protocols are maintained to deliver quality care" (p.10, lines 43-45). Nate, having worked in multiple institutions and critical care units as a travel nurse, explained that facilities have unique processes in place, and knowing what they were wherever he worked was an example of him providing QNC.

I tried to make sure that I'm aware of, like, what the policies and procedures are for certain aspects that change from site to site. Certain sites have different policies regarding things like how long an IV can stay in, can you run pressors through a peripheral IV, things like that. So, I try to stay up to date with the website on that, because I want to be able to ensure that the patients get the best care at that site with whatever that site has regarded as the best care. (p. 10, lines 35-42)

Cathy summed up her reflections on this same component of QNC as “doing things the way that they’re supposed to be done” (p. 3, lines 26).

Nurses participating in this study felt that QNC, through their experience in intensive care units, meant that care being provided reflected advanced training, critical care knowledge, certifications, the use of evidence-based practices, and being updated as to changes in standard practices. To demonstrate this, I created a pastiche from my participants’ shared experiences (Table 3, see p. 91).

#### ***Essential Theme 4: It is Roles, Not Just Responsibilities***

Many aspects of nursing care are learned through experience, and some fall under the traits or personality of a nurse. The dictionary definition of “role” is “a socially expected behavior pattern usually determined by an individual’s status in a particular society” (Merriam-Webster, 2023, para. 1). The “Role of a Nurse” essential theme brings to light the aspects of nursing care felt to be a component of the meaning of QNC that are usually developed with experience.

In an ICU setting, the ability of a nurse to advocate for a patient regarding clinical findings may take some degree of experience and confidence. Being able to understand, either through experiential knowledge or intuition, the clinical state of a patient and requesting additional support has been represented as a meaning of QNC. Emily gave an example of advocacy through her experience:

And you keep bringing up to the doctor and you go, something’s just not right here, can you just go check again, can we just go again, and you could be annoying as can be. But you know that you’re the only advocate for that patient. That patient cannot say anything because, most of the time, they’re intubated. And so if you don’t speak up, it might be 12 hours, 24 hours, 36 hours that this is taken care of. And sometimes, when you can nip it in the bud, the outcome is better. (p. 3, lines 38-45)

**Table 3**

*Knowledge and Education*

***Kelly: Certifications***

I'm proud of obtaining nursing certification just because it helped enhance my knowledge base and enhance my competence to deliver the care that's expected as a critical care nurse. And although if you're certified, you don't know everything, it's still cements that you have like a baseline knowledge of what you would be expected as a critical care nurse (p. 6, lines 9-16).

***Allison: Critical Care Knowledge***

Because that's part of the medical management of taking care of a patient, you know, if I am taking care of, say, an open heart, and all of a sudden, my chest tubes were really pouring out, I kept telling the providers notifying them of the increased drainage, and all of a sudden, it stops and you see all your pressure start to equalize on the monitor, being able to talk to a provider, escalate it right away. You know, that's a big example of something. You know, that's pretty common, actually. But I think it's important that you're able to recognize those situations, let the provider know, and then come up with an action plan and make sure that the provider hears your concerns as a nurse (p. 13, lines 23-35).

***Whitney: Evidence-Based Practice***

When I deliver quality nursing care, I kind of feel like I'm doing like the best and delivering the best care for the patient, like I'm doing all that I can, like, I'm kind of going off like evidence-based practice, to do what's best for the patient (p. 2, lines 37-41).

***Keith: Critical Care Knowledge***

I tried to deliver quality nursing care almost every shift, I mean, every shift, I try to deliver quality care. And that quality care to me means, you know, turning my patients every two hours and giving them medication on time. And I guess, you know, coming off my sedation and pressors and trying to progress to a state where the patient is stable (p. 7, lines 22-27).

***Cathy: Evidence-Based Practice***

So quality nursing care, to me, kind of has two sides to it. On the one hand, following, you know, evidence-based practice and keeping up to date (p. 3, lines 3-5). So quality care, to me, means that you are flexible in those new things, those new evidence-based practices that are coming out, and that you're able to adapt and give your patients the best care in that fashion (p. 3, lines 10-13)

***Betty: Practice Changes***

I think it's really important for nurses to be in the loop on what's really what's happening currently. And if practices change, it's probably for the betterment of the patient if it is changing. I think that I've worked with a lot of nurses who are older, and they're still stuck in their ways. And sometimes it's not time effective, patient effective, things are changing (p.6, lines 24-31).

Advocacy has been expressed by several nurses in the context of caring for a critically ill patient who, in such a circumstance, is often unable to speak or communicate. Lissette explained, “Being their advocate, so if they don’t have the physical ability to see or speak or hear something as well as the medical knowledge to understand what’s going on” (p. 2, lines 16-18).

In a pediatric critical care unit, even if the patient is alert, if no caretakers are present, there is an inability for the patient to express themselves other than noises. Cathy, who works in a neonatal intensive care unit, was detailed in her expressions:

I think that’s like it’s something kind of unique to caring for patients like in the early stages of life is that they are I mean sick sick patients too, but, you know, they literally have no voice of their own, they have no, they didn’t make their own health care directives, they don’t, they can’t say like, oh, I don’t get that medication or Ow, that hurts. And I’m sure it’s the same with adult patients who are sedated and paralyzed. But it’s just a different aspect of care for an infant, knowing those, you know, paying that extra attention, because there really is nobody else to advocate for those things for them. If the parents aren’t at the bedside, they’re all by they’re all by their lonesome. (p. 7, lines 48-51, p. 8, lines 1-7)

The issue of advocacy is important when dealing with issues of continuing life support and resuscitation, and respecting and supporting a patient’s wishes were seen to be representative of QNC. Gabriel expressed this when he said,

Just being always an advocate for our patients, if you can say, quality nursing can also be respecting the patient’s wishes. That plays a big part in our ICU, getting their DNR, DNI status as well, some patients (sic) because sometimes families come in and they have different views. (p. 3, lines 23-27)

A more seemingly beneficent aspect of QNC was the need for a nurse to protect their patient. While similar to advocacy, the words used to describe examples of protection had more emotion attached. Abigail stated,

I am very, like protective of my patients. And I feel that that’s one of the things that comes along with it. Like, I know that I’m giving good care when I’m being like, aggressive, not aggressive, but like very assertive, and I’m not afraid to speak up to the doctors or surgeons or management about what these patients need. And it just gives you a good feeling of doing the right thing for them. (p. 2, lines 39-45)

One nurse went as far as naming all the disciplines she might have to protect her patient from. Lisette declared,

I'm 100% behind them that I have their best interests at heart, whether it comes to any kind of discipline that touches them in the hospital, whether it's food and nutrition, or spiritual services. But then, of course, the go to one says, cardiac ICU, intensivists. And fellows, I have their backs between all those disciplines. (p. 2, lines 31-37)

A continuous eye on the patient in a manner one may expect a mother to watch over a child.

Sally stated:

If somebody is in my room, or whatever, going to do something with my patient, I am always there. Because I want to see what they're doing, what's your plan? What are you doing? (p. 8, lines 39-42)

Being able to anticipate changes in a fast-paced setting such as a critical care unit requires experience. Using intuition and judgment based on experience was seen to be a repeated description of the meaning of QNC in this setting. In describing his lived experience of what QNC means, Nate said,

I feel like in critical care, you're constantly moving. And you know, you're using your brain, you're thinking a lot as far as like, you know, trying to anticipate which direction the patient's heading in how to prevent that. (p. 1, lines 42-46)

The development and use of foresight in caring for patients is something that is expected of a nurse. Allison describes this in her work setting in the cardiac surgery ICU:

I think it's, you know, identifying it, like, foreseeing possible issues, handling those issues, like if you have you know, that you're getting like a valve patient, fresh out of surgery, like these patients have, you know, the tendency to have arrhythmia. So making sure that everything's connected, the wires to the pacing box, make sure that the settings are you know, what the provider wants, just confirming with them, and then watching their heart rate on the monitor, you know, little things like that, you know, that are huge within our nursing scope of practice. (p. 16, lines 6-14)

Laura explained,

So if there was something in either in the order set, or if there was something that a nurse could foresee happening, that she would take or he would take the opportunity to escalate it and to try to you know, set in a plan of care to manage a potential issue (p. 5, lines 33-37)

Foresight was not just important in the immediate care Tom provided for his patients. He gave an example showing that QNC for him meant that his experience in caring for patients helps him put the pieces together to consider long-term goals for patients.

How does it play a part in to the patient's long term, you know, we're trying to achieve this blood pressure goal so that we get this, so that, you know, in three days out, they get to walk out of here, but kind of putting it into the bigger picture, I think is an important thing as you get experience, too. (p. 11, lines 42-46)

Sally compared care in a critical care setting to a puzzle and described the role of a nurse developed through experience.

So I mean, the short of it. In that experience, I feel like part of that quality nursing care is making sure you see all the pieces of the puzzle, and making sure that all of the things that you have available to you and your nursing care are utilized to the fullest. (p. 3, line 51, p. 4, lines 1-21)

Teamwork was felt to be a critical component of what was expected of nurses in an ICU setting and felt to be a condition without which QNC could not exist. In a setting where multiple emergent events can happen simultaneously, the ability and expectation of a nurse to function with others seems to be a recurring theme. This concept was important to Mannie, who said,

Usually, when we think of quality care, we only think about how we do it at the bedside. But also, I think it, personally, it starts as, as a team, whether it's outside before we start our assignments at the huddle, that's a collectively as a team working with providers, the APRNs, or the physicians, as well, that's a team. So, and the patient care associates as well, that's another team. So collectively, as a whole, I think yes, it starts as a team because without input, in order to implement care, it needs to be done. It's done by a team, that we're all teams in a hospital trying to work on the sole member, you know, the patient-centered model, so the patient's always in the center. So, we're all different, we're all playing different team roles, basically, we're trying to impact better the quality of care to the patient, in order to give care, it needs to be done by a team member. (p. 1a, lines 36-47)

Sally made an analogy between nursing in a critical care unit to a NASCAR pit crew, saying,

So that's part of our delivery and quality is to work together because, when you work together, you deliver a higher quality than if you try and do everything by yourself and things take longer. (p. 4a, lines 44-51)

Abigail similarly felt that quality of care would not exist if it were not for her colleagues. She explained,

I think teamwork is essential in quality nursing care, too, because it would be impossible to deliver care like that without colleagues like mine, like you need them to help you. (p. 7, lines 41-44)

Nurses interviewed discussed their experience of QNC using analogies much like Sally did. Where Sally discussed QNC as teamwork, Allison spoke of her lived experience with QNC describing the nurse functioning as the conductor of a train.

You're kind of the conductor on the train for the patient. Between, you know, giving medications, dealing with emergency situations, taking care of any equipment that they have, whether it be a balloon pump and ECMO device, a ventilator, titrating drips, your kind of coordinating all of that. And then also coordinating with providers as well. (p. 2, lines 32-44, p. 3, lines 1-3)

Aiden used the analogy of the conductor of a symphony, and Cathy described QNC as the nurse putting the pieces of the puzzle together for patients and their families:

Think of it like a conductor of a symphony orchestra where every like you have to bring all these moving parts together to make something like to make something work. (p.3, lines 31-33)

It's also making sure that you know, my patients and their families are comfortable with what's going on that they're fully updated and kind of keeping you know, all of the specialties and the pieces of the puzzle transparent to them. Because you're also, you know, the messenger for a lot of other people. So, I find myself, you know, kind of being a care coordinator to making sure everybody's on the same page. (p. 3, lines 30-33, 40-47)

### ***Essential Theme 5: It Means Having Resources***

Nurses participating in this study felt that QNC, through their experience in intensive care units, meant that providing QNC required certain tools and resources. To demonstrate this, I created a pastiche from my participants' shared experiences (see Table 4).

**Table 4**

*Tools and Resources*

**Tools and Resources**

***Tom***

Factors when it comes to giving quality nursing care is having enough resources in order to complete the things that are required to give that quality care. I think that when nurses are stretched too thin by having too high of a ratio or too little resources, that comes at a cost to the quality of care that you're able to deliver. Whether that's having to skimp out on time with a patient so as to build that personal bond and connection or being able to give an in-depth answer to that family member who may want to know more about the disease process, or where you may not have the time to put that personal touch and, you know, maybe, you know, put some pictures up over the course of a few minutes in a patient's room that just can oftentimes brighten their day. I think the quality oftentimes can become limited. And I think that there's a direct correlation with resources (p. 5 lines,16-45)

***Keith***

When staffing isn't adequate, you know, if we don't have any ancillary staff that is there to pick up the phone, or we have PCAs that are being floated to other units, and we're left with just us nurses caring for the patient. So, it gets very stressful when there are a lot of tasks for us to do. We can get a PCA to take a finger stick for us, just follow up on a finger stick for us, or help clean a patient who's having multiple bowel movements throughout the day. So that's additional tasks that affect how we take care of our patients (p. 1a, lines 19-32)

***Betty***

I wanted them to have a walker in the unit. We don't have any walkers in the units. Only physical therapy brings them and takes them. So, they'll help us get patients out of bed and then we have no walker to get patients back in bed or on the weekends when they're not there. I can't get patients out of bed and it's kind of unfortunate. So, I said we need to have more tools and resources here (p. 2, lines 26-32)

***Samantha***

I remember, as a new grad nurse, I had two ECMO patients and one intubated patient, I was tripled; they're all on titrated drips. And I'm like, what's going on? You know, we do what we have to do. But there are a lot of things that fall on the nurse. And because it is our responsibility, I feel like we would be able to do, you know, a better job, if we had resources, if we had people to go to (p. 5, lines 34-40)

***Jennie***

I think I could talk more about what I feel is not quality nursing care. One of the big things that I mean, I know this is like, forever, is the importance of a safe patient-to-nurse ratio. When I worked on the floors, my ratio was one to nine or one to ten. You're not going into that room to talk to the patient, have a conversation with them. The hospital pushes so much about documentation and getting medications right and giving the medications at a specific time and using these things and charting this and scanning this that you lose the art that there's a human being in that bed

### **Interpretive Statement**

The interview process through which the themes of this study were uncovered provided a portal into the thoughts of BCCNs related to the meaning of QNC. The synthesis of the five essential themes illuminated in the shared lived experiences of these highly specialized nurses led to the creation of an interpretive statement: *The meaning of quality nursing care is that patients are treated as multidimensional human beings and not only as an illness, with care and focus on their needs by educated nurses who fulfill their responsibilities as well as their roles using the tools and resources they need to provide such care.*

### **Establishing Rigor**

Establishing rigor is an essential element of human science research. It means that the data collected were appraised or explained (Cohen et al., 2000). Additionally, it means that the researcher validates the accuracy of the themes through peer account, member checking, or triangulating sources (Creswell & Poth, 2018). According to Cypress (2022), trustworthiness is now utilized to evaluate rigor in qualitative research. Credibility, dependability, confirmability, and transferability are four criteria used to develop trustworthiness for a qualitative study (Cypress, 2022; Lincoln & Guba, 1985; Polit & Beck, 2017). To ensure rigor, these strategies were carried out throughout the research process.

To develop trustworthiness using credibility, I accurately and truthfully represented the data and interpretations of the data. I had the interview transcripts transcribed by a professional company, compared the transcripts for accuracy while watching the interview, and completed member checking with each participant. Additionally, I reviewed the essential themes with my advisor, who is a doctoral-prepared nurse and an expert in qualitative research. To develop dependability, I had my advisor review the meaning units, themes, and essential themes and the

transcribed quotes to validate and describe each essential theme. To develop conformability, I ensured the participants' voices were reflected in the essential themes. I wrote down my assumptions and biases at the beginning of this research study and would self-reflect in an attempt to control my biases. I completed journaling after each participant's interview to allow me to write down my assumptions and beliefs. I completed member checking with each participant to ensure that I interpreted the participants' experiences accurately. To develop transferability, I used purposive sampling and had robust data collection through rich descriptions.

To ensure robust data collection and rich descriptions, I used van Manen's (1997) research activities; the fifth step requires "maintaining a strong and oriented pedagogical relation to the phenomenon" (p. 31). The researcher must remain focused on the research question and phenomenon (van Manen, 1997). The phenomenological text must be oriented, strong, rich, and deep (van Manen, 1997). According to van Manen, those four conditions are required for human science texts, thus giving the power and validity of the text. Also, these four conditions are used as evaluative criteria for phenomenological human science research texts.

To ensure a rich description of the data, I immersed myself and dwelled with the data for eight months. I re-watched the video interviews and re-read the transcripts, developing a personal connection with the participants' experiences. Thematic analysis, according to van Manen (1997), was performed in an effort to illuminate themes. The four conditions to evaluate a phenomenological text were applied to emerging themes.

### **Writing in the Margins**

During thematic analysis, I took notes in the margins of each participant's transcript when statements appeared to represent a meaning unit or theme. Despite this procedure not being

considered a part of van Manen's methodology, I did not want to forgo this exercise, since performing the additional writing helped me better visualize words or phrases that stood out as possibly representing the experience of QNC. I included in my notes what I saw and perceived as the participant's body language or change in vocal tone through the video recording and related it to the transcript. This allowed me to better illuminate the participant's experience.

### **Summary**

This chapter aimed to fulfill two research activities of van Manen's (1997) method for the descriptive, hermeneutic phenomenological inquiry, which include steps: (3) "reflecting on the essential themes which characterize the phenomenon; and (4) describing the phenomenon through the art of writing and rewriting" (p. 30), into the meaning of QNC through the lived experience of the BCCN. To the extent of this researcher's knowledge and search, there has been no similar inquiry performed and published focused on this subset of specialized nurses and the phenomenon.

This chapter includes the expressions of the BCCNs related to QNC through their practice of nursing and reflective thoughts concerning the phenomenon QNC. Listening and watching the interviews many times, followed by multiple readings of the transcripts of these reflections as well as my own reflective notes regarding their statements, led to essential themes. The nurses' reflections, at times, are conveyed as poetic expression. The themes were discussed with my sponsor, leading to further reflection until finalized. Through these steps, the participants' words took on life, leading to the interpretive statement that drew the pieces of the puzzle together, representing the essence of QNC. The essence of the phenomenon is discussed in the following chapter.

## **Chapter 6: Reflection on the Findings**

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel. (Maya Angelou, in Smith, 2021, p. 1)

### **Synthesis of Data**

Nurses make up the largest human resource component of health care in the United States, with an estimated 3 to 5.2 million registered nurses performing millions of nursing encounters per day (American Association of Colleges of Nursing, 2023b; U.S. Bureau of Labor Statistics, 2023). Thus, understanding quality nursing care (QNC) is important to the discussion of improving health care. Numerous efforts have been made to define, characterize, quantify, and improve QNC. However, it became apparent in the review of the literature that more clarity is needed as to what QNC means. What something “means” or the “meaning of something” should be differentiated from the words “define” and “definition.” QNC based on a definition may result in the care being provided confined to rigid descriptive boundaries to be considered quality. Definitions that are commonly used are usually based on quantitative data points, such as described earlier in Chapter 2. These are related to outcomes or obtained through a process that does not involve an intense investigation, such as phenomenological inquiry with its methods of data collection, reduction, and synthesis.

Many seemingly qualitative descriptions that have been previously reported on in the literature review reported the meaning of quality through a more descriptive scientific process as opposed to trying to capture the essence of a lived meaning in a more philosophical manner. The word “quality” is frequently used throughout health care and admittedly within this research

presentation so much so that it may lead to semantic satiation for those reading without a specific interest in the topic. Through this endeavor my aim was to uncover and clarify for myself as well as the reader what QNC means through the lived experience of bedside critical care nurses (BCCNs) as told by them.

This final chapter will serve to reflect on the essential themes illuminated and their correlation with existing literature on QNC. Furthermore, nursing themes that correlate with findings of this study are discussed to establish commonality of experiences. Limitations of this study as well as reflections of my experience will follow, as well as implications of this work on the nursing profession and recommendations for further research. Lastly, I will share an artistic representation to portray the findings of this process.

Qualitative research is used throughout nursing literature. It is “a form of social inquiry that focuses on the way people make sense of their experiences and the world in which they live” (Holloway & Galvin, 2023, p. 3). Van Manen’s (1997) phenomenological method was used as the basis of this study. Following the guidelines of this combined descriptive and hermeneutic phenomenology, I reflected on my relationship with the topic at hand, identified and acknowledged my biases, and reviewed literature to understand a scientific perspective. Interviews of participants followed, asking open-ended questions using a semi-structured process that created a platform off which a deeper dive into the phenomenon was conducted. This allowed for the identification of various themes surrounding it. The data collected through interviews were reviewed on multiple occasions to understand, organize, analyze, and convey the essential themes. This chapter also highlights existing nursing theories, how they relate to essential themes, and their overlap that represents the meaning of QNC to BCCNs through their lived experience.

The essential themes uncovered through this research were: (a) It is not just taking care of the illness; (b) Being there for another, it's the little things; (c) It is knowing your stuff—bed bath, and beyond; (d) It is roles, not just responsibilities; and (e) It means having resources.

These results represent the interview responses of 22 BCCNs working in the United States who have a minimum of a bachelor's degree and are employed in a critical care unit (CCU) with at least one year's worth of experience defined as 1950 hours. Themes were derived from the interviews after a process of reading, reflecting, and considering the researcher's own lived experience and knowledge to control for bias. Efforts were made to be inclusive. Essential themes were then derived from the themes. Essential themes represented themes without which QNC would not exist as conveyed by the nurses interviewed. When categorizing meaning units into a theme, it became obvious that views expressed did not necessarily fit into single categories alone. Effort was made, however, through reviewing the interview transcripts and mannerisms in expressions in recorded video to categorize them into a theme. It is broadly accepted that qualitative studies such as this result in themes that may intersect. Tesch (1987) stated, "Some themes overlap, and could be sorted into more than one category. For others the borders are fuzzy, and they are not clearly distinguishable from one another" (p. 233). Tesch further quoted van Manen to describe the process of thematic creation as discovering "knots in the web" (p. 233). The description is consistent with the overlap expressed in the discussion that follows.

### **Essential Theme 1: It is Not Just Taking Care of the Illness**

Many of the participants discussed providing QNC outside the realm of disease-focused care and instead in a holistic manner or as a "whole." Their expressions regarding this appeared to be based on efforts they personally make to give such care. Providing holistic care for the participants included incorporating the medical components as well as taking care of the

patient's spiritual, social, emotional, cultural, religious, psychosocial, and ethical needs.

Participants discussed the importance of including psychological and emotional components to deliver QNC. Some of the participants shared stories regarding the impact that providing holistic care made for their patients, how proud it made them feel, and how rewarding it was for them.

Making efforts to understand and incorporate the multiple dimensions of a patient's existence may not be an obvious component of treating a physiologic disease. However, it has been seen to be an important part of care overall, as well as affecting outcomes of illness. The history of taking care of patients in such a manner dates to Florence Nightingale over 150 years ago. Karoliussen and Hov (2020), suggested that Nightingale's chief contribution to contemporary nursing was to focus on the person as a subjective being rather than on the disease.

Spirituality is one component of holistic care that will be focused on in this discussion, as this was mentioned by some of the study participants. Spirituality has been seen to be increasing in healthcare, possibly due to increased interest in spirituality throughout society (Bone et al., 2018). Along these lines, awareness and caring for a patient regarding their spirituality were discussed by nurses interviewed for this study when asked what QNC meant to them. This is supported by literature. Badanta et al. (2022) conducted a 10-year review of literature and found that spiritual and religious strategies have been shown to be used by patients and families to deal with stressful situations in intensive care unit (ICU) settings. Respecting these beliefs was seen to be an essential part of critical care nursing.

Bone et al. (2018) sought to determine how Canadian critical care nurses understood the role of spiritual care in their practice. Their qualitative descriptive study determined that "nurses report that attending to the spiritual care of their patients was a part of their scope of practice and rooted in holistic care" (p. 213). They also felt spiritual care was essential in caring for the

critically ill patient in a holistic manner. This was also found in Badanta et al.'s (2022) review of literature that showed taking into account spiritual and religious needs and “providing spiritual care is an important part of a holistic care for critically ill patients and should be considered by nurses” (p. 349).

The CCU is a place where critically ill patients are being managed in a setting that may not be conducive to holistic care. The focus may be on pathophysiology of disease and sophisticated tools to manage these components of a patient's condition. Tian (as cited in Ahmed et al., 2021) suggested that:

the ICU use of advanced technology has tended to tremendously limit chances to improve caring communication, involvement, and provision in a safe, effective, and time-saving manner, fundamentally undermining holistic and person-centered nursing care due to a skewed preoccupation in practice with technological (in addition to biomedical) aspects of care. (p. 2)

While this may be the case, reflecting on the interviews of QNC with the participants in this study showed that a holistic approach was important enough to them without which QNC would not exist.

### **Essential Theme 2: Being There for Another, It's the Little Things**

Recognizing a patient as a fellow human being and caring for the patient to ease their discomfort were themes repeatedly expressed in this study. This appears to be related to the phrase “patient-centered care,” at least in meaning. “Humanistic care” is a term also used in a similar context. In the literature reviewed, “patient-centered care” and “holistic care” apply to a distinction between holistic care are to be used interchangeably or to define one another. However, interpretation of the interviews led to a distinction between holistic care and patient-centered care in which patient-centered care appeared to be components not necessarily linked to a deeper understanding of the patient's sphere of existence as in holistic care, but based on care that might make the patient more comfortable on a human and personal level. Interestingly,

reviewing the literature following the illumination of this theme called attention to a report of a roundtable discussion concerning improving the ICU experience in which members of the European Society of Intensive Care Medicine suggested that “measuring and understanding recalled patient discomfort has the potential to provide a global measure of patient ICU experience” (Latour et al., 2022, pp. 1-2). The nurses interviewed identified their commitment to ease the discomfort of a patient as an important aspect of QNC.

Care based on beneficence was also a frequently expressed thought among participants. The primary objective of nursing care is to benefit the patient. Beneficence is a fundamental component of the nursing code or the moral core of the nursing profession (Cheraghi et al., 2023). Furthermore, included within the interpretive statements of the American Nurses Association (2015) regarding the nursing code of ethics are provisions related to beneficence that align with meaning units derived from interviews. Of eight total provisions, the corresponding provisions relevant to the results of this study are:

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of each person

Provision 2: The nurse’s primary commitment is to the patient, whether an individual, family, group, community or population

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions, and takes action consistent with the obligation to promote health and to provide optimal care

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities. (American Nurses Association, 2015, pp. 13-14)

Provisions 6 and 7 were not seen to be related to the findings of this study.

At times nurses were passionate about the protection they felt and showed toward their patients, especially the patients who were not in a condition that would allow them to express themselves. Nurses felt they needed to protect patients from environmental harm and, interestingly so, from other health care providers.

Many of the BCCN participants discussed their awareness of providing care to a human being and did not consider them to be just a patient or just a pathology. The human being cared for was felt to have needs; to be advocated for, protected, and treated with dignity. Nurses from a setting where patients may be unconscious, with no indication of their existence other than their body and the beeps of machines, discussed brushing a patient's hair, making sure they smelled nice for loved ones, even holding a patient's hands as representing the meaning of caring as part of QNC. One nurse felt that care should be personal, and this care would not be forgotten. These expressions are included within the realm of what can be considered humanistic care. Humanistic care enhances the "professional status of nursing, promoting organizational environment, and improving health for the patients, their families, and nurses in the CCU" (Asl et al., 2022, p. 609). Patients suffer from being treated as if they are less than human, which has several negative effects on them, including loss of self-worth, loneliness, losing the meaning of life, objectification, loss of personal journey, and a disregard for their personal integrity (Todres et al., 2009).

### **Essential Theme 3: It is Knowing Your Stuff—Bed Bath, and Beyond**

Providing care for critically ill patients requires a solid educational foundation, specialty training, as well as a keen understanding of policies and procedures that each institution may have in place. Understanding basics as well as advanced nursing is a cornerstone that, if

removed, will result in no nursing care, let alone QNC. According to Keogh and Weaver (2022), critical care nurses require knowledge beyond the basic level of nursing education and additional nursing skillsets. Critical care nurses need to understand the pathophysiology of the patient's illness, the pharmacology behind the multiple medications they administer, as well as have the technical knowhow to perform basic troubleshooting if not fully understand ventilators and other complex medical equipment.

Many of the nurses who participated in the interviews pointed to these fundamental aspects of nursing education and advanced training through which patients are provided care that was seen to mean QNC. The words and phrases expressed to convey the meaning of QNC included: "requiring education and knowledge," "basic nursing care," "critical care nursing knowledge," "safe care," "knowing policies and procedures," "evidence-based practice," "certification," and "awareness of practice changes."

The American Association of Colleges of Nursing (2023a) stated, "Education has a significant impact on the knowledge and competencies of the nurse clinician" (para. 1). Furthermore, the organization claims that nurses with a Bachelor of Science in Nursing (BSN) are valued for critical thinking skills, leadership, case management, health promotion abilities, as well as versatility in their ability to practice in different clinical settings (AACN, 2023a). Upon completion of undergraduate nursing education, including basic sciences and the fundamentals of nursing, there is an expectation that nurses will seamlessly transition into a clinical setting. However, knowledge gaps do exist. Gassas (2021) identified three main themes through an integrative literature review to address the source of knowledge gaps in nurse training. These themes were personal factors including internal motivation, learning style and attitude,

educational structure, and organizational characteristics. These gaps need to be addressed through education.

Audet et al. (2018) performed a literature review to summarize the relationship between nurse education, experience, and patient outcomes related to mortality and outcomes of adverse events. After reviewing 27 papers, the authors concluded that there was strong evidence to suggest that the greater the percentage of baccalaureate degree nurses in acute care hospitals, the lower the rates of mortality and failure to rescue. The relationship of the percentage was more significant for failure to rescue possibly related to the multifactorial causes of mortality.

Dierkes et al. (2021) described advanced certification as “a form of individual credentialing above and beyond entry-level education and licensing” (p. 249). The authors further stated that a nurse pursuing such certification shows a commitment to professional advancement, lifelong learning through need for recertification, leading to the establishment of specialized competencies. “Hospitals, nurses, and patients benefit from nurse specialty certification” (p. 255). Consistent with the literature, critical care knowledge and certification were highlighted as a component of QNC within a CCU setting in the interview responses.

As nurses enter clinical practice, they are introduced to and expected to follow policies and procedures, which are a set of rules, algorithms, and advisories based on unique characteristics and experience of the institution meant to optimize care and result in the best outcomes. Kelly et al. (2021) performed a study to determine the extent to which nurses use nursing policies and protocols to identify barriers and facilitators affecting the frequency of their use. The study was conducted at a large Veterans’ hospital in the United States through a survey provided to 235 nurses. The researchers found that “almost half the nurses who responded to the

survey referred to policies or protocols within the previous 6 months, and 44% did so every 1 to 3 weeks” (p. 221).

The importance of understanding the policies and procedures and the integral relationship to QNC was a belief frequently acknowledged in this study. The BCCNs who were part of this study conveyed the importance of understanding the policies and procedures and their integral relationship to QNC.

Evidence-based practice helps guide nursing care (Vega & Hayes, 2019). The effect on improved patient outcomes is well documented in the literature (Vega & Hayes, 2019). The term is used throughout nurses’ training and practice to represent care that is based on the most current scientific evidence. In the CCU setting where patients present with complicated conditions, “evidence-based practices help ICNs [intensive care nurses] to provide patient care based on research rather than traditions, myths, or advice of colleagues” (Abuejheisheh et al., 2020, p. 6).

Interestingly, a comparison of nurses with bachelors degrees and nurses with both bachelors and masters degrees in nursing showed no difference in level of “knowledge of or perceived value in evidence-based practices” (Gigili et al., 2020, p. e7). However, the same authors in their cross-sectional study looking at factors associated with nurses’ knowledge and perceived value of evidence-based practices concluded that nurses with specialty certification had a greater professional identity. Higher perceptions of knowledge of and value in evidence-based practices used in the ICU were also present in this subset of nurses. This study demonstrated a similar finding regarding the value seen in evidence-based practice in relation to providing QNC, especially by nurses with specialty certification.

#### **Essential Theme 4: It is Roles, Not Just Responsibilities**

The analogies used by nurses interviewed, such as a CCU team working like a NASCAR pit crew, each member with specific duties, or the nurse acting as a conductor in an orchestra, were colorful and painted a picture of QNC working like a well-oiled machine. The word “roles” as previously defined is “a socially expected behavior pattern usually determined by an individual’s status in a particular society” (Merriam-Webster, 2023, para. 1). This should be differentiated from “responsibilities.” Synonyms of the word “responsible” include “liable,” “answerable,” “obligated,” and “accountable” (Merriam-Webster, 2023). Society, as well as institutions, has expectations of nurses. Nurses have expectations of their peers. There are many factors that can impact a nurse’s ability to fulfill these roles. We all have different personalities, and these personalities become evident in our professional lives. There are individuals who are innately caring or develop caring personalities through experience and those that will not be caring whether it be in their personal lives or professional spheres.

Along the same lines, teamwork, collaborating care, and being closely involved with a patient’s wellbeing are all examples that are not necessarily learned but developed through practice with the right ingredients of personality. Advocacy, care collaboration, priority setting, teamwork, and intuition were concepts discussed frequently by the participating group of nurses. The applicability of these themes to nursing and to QNC is reflected and supported by the literature.

Nurses interviewed saw themselves as the central figure of care in the CCU setting. They reported receiving, transmitting, and coordinating plans of care as well as providing the care ordered. The coordination extends into interprofessional collaboration also. CCU nurses serve as a central care hub; the care they provide is continuous and involves interprofessional

communication (Kendall-Gallagher et al., 2017). Deliberate interprofessional interactions coupled with experience will allow nurses to move from coordinator to collaborator in patient management (Kendall-Gallagher et al., 2017).

Advocacy was a repeated theme among BCCNs. They used the words “protect the patients” in their interview responses. It is particularly important for a critical care nurse to act as a patient advocate because they care for patients who are incapable of speaking for themselves (Parsons & Walters, 2019). An example from the interviews that can be imagined is a pediatric nurse taking care of a baby without caregivers and being the child’s voice if they are too young to speak.

Advocating and collaborating care go hand in hand. To assist families in making informed decisions, the nurse acts as a connection between the patient and the health system (Parsons & Walters, 2019). This theme of roles overlaps with the essential themes related to holistic care in that “educating the patient, explaining procedures, and practicing sound communication skills represents higher levels of psychological care” (Parsons & Walters, 2019, p. 544).

The intersection of the first theme discussed related to holistic care and its psychosocial effects and the fourth theme related to roles was discussed by Parsons and Walters (2019) when they spoke of strategies including those related to advocacy to improve psychosocial outcomes in the CCU. Some of the strategies suggested included:

- Ask the patient if they need a question answered or a procedure explained,
- Make rounds with the medical team to hear what is being said to the patient, and
- Act as a liaison between the patient or family and the medical team. Go into the room after to see if the patient understood what was said by the medical team. Reinforce

that all questions that the patient and/or family have are important and that nothing is too basic to ask (p. 539).

The complexities of CCU nursing can be exacerbated by shortages of nurses as well as ancillary staff. Being able to prioritize care within an ethical and professional framework is essential. However, this is something that comes with experience. In addition to managing their workload, nurses are held professionally accountable for their behavior and the caliber of the nursing care they provide (Suhonen et al., 2018). “Nurses may face difficulties in fulfilling their professional and ethical roles in an appropriate manner” (p. 27). For instance, nurses could restrict care implicitly by delaying or skipping specific interventions or giving less priority to some patients (Suhonen et al., 2018). Nurses’ implicit rationing may lower the standards provided, raising the possibility of poor patient outcomes, endangering patient safety, and flouting ethical principles (Suhonen et al., 2018).

Prioritizing provides a segue into a discussion of teamwork, as complex care with limited or restricted resources necessitates a strong team to provide QNC. It is the belief of the nurses interviewed that these hindrances necessitate teamwork to provide QNC. On initial review of the interview transcripts, teamwork seemed not to be essential and was considered a tool to provide QNC as opposed to the meaning of QNC. However, on further reflection of the interview transcripts, it became obvious that nurses felt that without teamwork between nurses and within the larger team of CCU care providers, QNC would not exist. This is also reflected in the literature. Teamwork is necessary for effective and high-quality patient care (Lubbe & Roets, 2014): “Interprofessional teamwork between the various categories of nurses is essential to quality nursing care” (p. 59). Dietz et al. (2014) performed a systematic review of teamwork in the intensive care unit and concluded that “teamwork is essential for ensuring the quality and

safety of health care delivery in the intensive care unit (ICU)” (p. 908). Scholtz et al. (2016) reported the findings of a qualitative study of nurses to explore the culture of critical care nurses; the researchers conducted open-ended interviews, and five themes emerged. One theme related to teamwork, namely, “patterns of sibling-like teamwork.”

The significance of teamwork in this study was unexpected. The interconnectedness of each independent nurse appeared to be crucial to the efficient operation of the CCU setting. The critical care nurses appeared to be aware of each other’s weaknesses and strengths. “In an emergency, it was considered vital to know your colleagues and to apply their knowledge and skills in a way that gives the patient the best chance of survival” (Scholtz et al., 2016, p. 7). It was believed that the most crucial component of critical care nursing work was teamwork.

Intuition is reviewed last here, as this sixth sense is one that develops as the critical care nurse becomes more experienced. It is the intuition I saw and envied in those more experienced than me in my earlier days. Miller and Hill (2018) conducted a descriptive, correlational, cross-sectional, prospective research study to investigate the connections and variations in the application of intuition among three groups of practicing nurses from different clinical units at a Midwestern Medical Center using the Rew Intuitive Judgment Scale. The authors stated that “research has shown a positive relationship between ‘expert’ nurses with more clinical practice experience and greater use of intuitive thinking in their clinical decision-making process” (p. 319).

### **Essential Theme 5: It Means Having Resources**

Nurses pointed to certain tools needed to provide QNC. Initially this was not felt to answer the question of the meaning of QNC; instead it was felt to represent what was needed to deliver QNC. Again, the hermeneutic process led to the inclusion of tools needed to provide

QNC as an essential theme. The meaning units derived from the interviews were: staffing, nurse to patient ratios, resources, equipment, and leadership support. The BCCNs interviewed felt that QNC can only exist with the availability of tools such as adequate staffing, ancillary support, and the physical resources, such as chairs for patients to sit in. This begs the question: Is it not possible to provide QNC in an inner-city hospital with limited resources? This self-questioning further clarified to me that the nurses in such a setting may have a different meaning of QNC through their lived experience. Furthermore, they may have workarounds to ensure they are providing QNC within their own meaning, doing the best they can with what is available to them.

Within the cohort of nurses interviewed for this study, the issue of staffing and the availability of ancillary support was a critical component of their lived meaning of QNC. Nurse staffing constraints have been associated with burnout and perpetuate a cycle exacerbating nursing shortages. A thorough discussion of this would require volumes of writing and is outside of the realm of discussing the results of this work. However, it is important to shed light on these matters. The environment a nurse works in includes access to tools and resources to provide care. According to research, a professional and positive work atmosphere can influence QNC and enhance staff and patient outcomes (Aiken et al., 2012; Amaliyah & Tukimin, 2021). Cho and Han (2018) reported that “the nursing work environment has been considered an important factor influencing the quality of nursing care” (p. 404). To achieve high-quality care, the nursing environment’s components must be optimized (Aiken et al., 2008). The American Association of Critical Care Nurses (AACN, 2016) set “six standards for establishing and sustaining healthy work environments” (p. 9), namely, (a) skilled communication; (b) true collaboration;

(c) effective decision making; (d) appropriate staffing; (e) meaningful recognition; and (f) authentic leadership.

There is evidence that nurses working in positive working environments perceive the quality of care to be better (Al Sabei et al., 2020). In addition, research has suggested that nurses who work in favorable work environments have a lower intention to leave their jobs and experience less burnout (Al Sabei et al., 2020). Lynn et al. (2007) reported adequate supplies and workspace in addition to a clinical assignment that can be carried out as necessary elements for the provision of QNC. Aiken et al. (2011) concluded from a study of 98,116 nurses in nine countries between 1999 and 2009 that inadequate hospital work environments are linked to undesirable outcomes for quality of care. Hinno et al. (2011) asserted that nurses' perceptions of the work environment were positively associated to their evaluations of the quality of care.

Kieft et al. (2014) summarized the works of numerous researchers who demonstrated a positive correlation between nurses' satisfaction with their work environment and patient perception of quality of care using various methods. The study conducted by Kieft et al. was performed to examine what nurses felt they needed to provide the quality of care that would lead to positive patient experiences. Many of the themes in their results mirror the themes uncovered in the work being presented here, namely, clinically competent nurses, collaborative working relationships, autonomous nursing practice, adequate staffing, control over nursing practice, managerial support, and patient-centered care.

Establishing a supportive work environment is a fundamental element in providing QNC. In a review of the literature, Amiliyah and Tukimin (2021) reported a strong association between the work environment and the quality of nursing care. Furthermore, Amiliyah and Tukimin conveyed results suggesting that adequate staffing and resources as well as supportive

management influence quality of care. According to Laschinger (2008), a supportive work environment is critical to nurses' satisfaction with the quality of care provided. Furthermore, nurses' perceptions of the quality of care that they can provide are significantly associated with the unit and the working conditions (Laschinger, 2008). When nurses have access to conditions that empower them to provide the care according to their standards, the quality of care should be improved (Laschinger, 2008). Support from nursing management, administration, and education are significant for the provision of QNC, as each one has an impact on the resources, staffing metrics, empowerment, competencies, and skillsets of clinical nurses.

Themes related to areas of QNC such as staffing have been identified in this research and reflected in the literature as well. Brooks et al. (2019) studied the relationship of nurse staffing levels and level of engagement in hospital affairs with indicators of patient safety or outcome. They found that better nurse-to-patient staffing ratios correlated with a better patient safety rating. The finding of missed care as a patient safety issue has also been associated with staffing by Griffeths et al. (2018), who performed a review of studies regarding omission of nursing care.

Nurses interviewed for this study stressed the relevance of the many aspects of leadership to their meaning of QNC through their lived experience. Effective leadership is a critical component for the development of QNC (Boamah et al., 2018; Labrague et al., 2020). The leadership practices of nursing managers (NMs) can influence outcomes for organizations, providers, and patients (Cummings et al., 2008; Labrague et al., 2020; Lavoie-Tremblay et al., 2016). Mendes and de Jesus José Gil Fradique (2014) suggested "that leadership effectively influences nursing quality" (p. 446). Thus, it is the nurses' management style that impacts the nurses who directly influence service quality (Mendes & de Jesus José Gil Fradique, 2014). Furthermore, the researchers' "findings show that the following are important for nursing

quality: recognition shown by the leader; nurses' development; communication; and the way leaders inspires and encourages (sic) service innovation" (p. 446).

Nurse staffing is one essential element to deliver QNC. Aiken et al. (2002) conducted a study of 10,319 nurses working in hospitals on medical and surgical units in the United States, Scotland, England, and Canada. The results of this landmark study showed that a higher nurse-assessed quality of care was found to have a correlation with improved staffing. Accordingly, the provision of adequate nurse staffing and organizational and managerial support to nursing plays a vital role in improving the quality of patient care, while also reducing nurse job dissatisfaction and burnout (Aiken et al., 2002). Liu et al. (2016) concluded from a multisite survey in China "that the conditions of work environments and nurse staffing positively affect the quality of care in ICUs [intensive care units]" (p. E7). Cho and Han (2018) concluded from a cross-sectional study conducted in South Korea with 432 nurses in 57 units at five hospitals that adequate staffing is significant to ensure high-quality nursing care.

Another essential element of providing QNC according to the nurses in this study is the amount of time clinical nurses spend with their patients. This again is mirrored in the literature regarding QNC. Lucero et al. (2009) acknowledged "that it has been documented for over 50 years that the time RNs spend on nursing care activities may affect the quality of care" (p. 2300).

The nurse who provided the example of not having enough walkers to get patients out of bed provided a concrete example that makes it easy to understand how having the right equipment is essential to providing quality care. It is understood that there is a disparity in resources across the globe, and efforts are made by nurses to work within the limitations they are faced with to provide the best care they can.

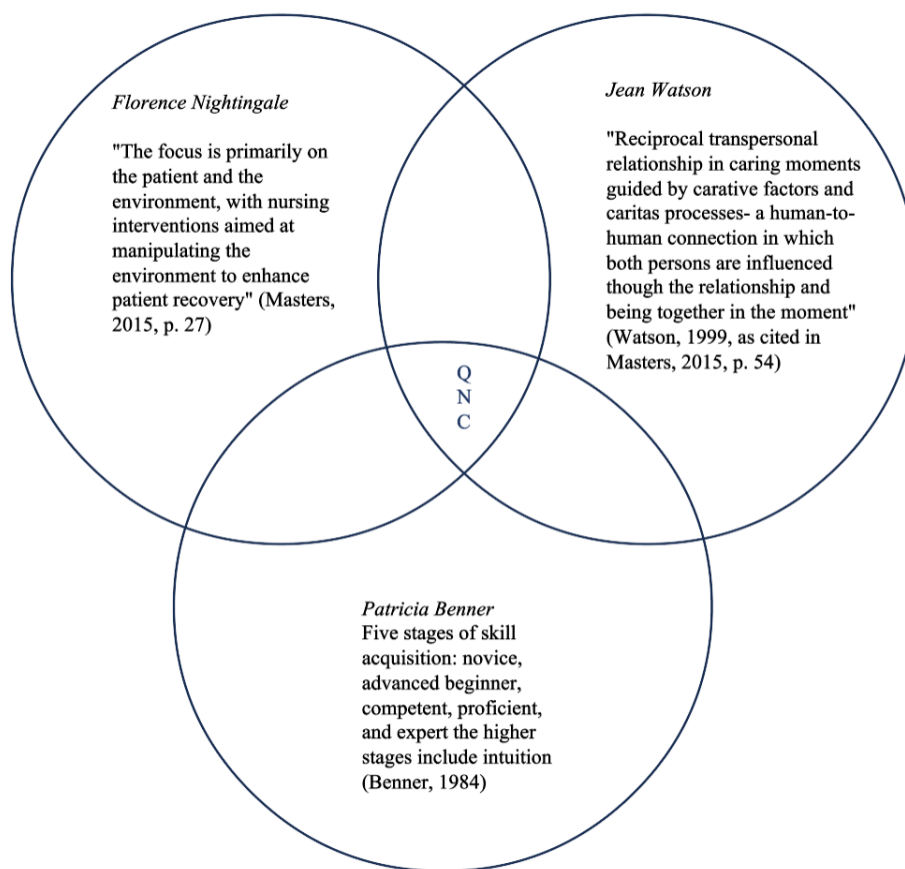
## Thematic Statement Reflecting Using a Theoretical Model

*The meaning of quality nursing care is that patients are treated as multidimensional human beings and not only as an illness, with care and focus on their needs by educated nurses who fulfill their responsibilities as well as their roles using the tools and resources they need to provide such care.*

This thematic statement was arrived at through a process of reflection and meant to be inclusive of the nurses participating, without whom there would be no data. To capture the essence of QNC and the relationship of the uncovered themes to existing theories in nursing, a Venn Diagram was created (Figure 1).

**Figure 1**

*Nursing Theories as Related to Uncovered Themes*



## **Limitations of the Study**

Qualitative phenomenological studies have unique limitations, which will be discussed here. The results of qualitative studies are relevant to the population studied. In healthcare, nurses fulfill various roles. Therefore, the results of this study apply to a small percentage of all nurses and are further narrowed based on the selection criteria of the researcher. Also, the study participants may have valued and or focused on quality in the care they provided, contributing to their decision to participate in the study.

Qualitative studies involve reviewing and interpreting study participants' communications, be they verbal, written, or expressed in other ways. Through this, data points are collected, analyzed, and interpreted. In phenomenological works, the researcher is reliant on the participants communicating in a clear manner. However, all types of communication may result in misunderstanding on the researcher's part or miscommunication on the participants' part. An attempt was made to minimize this by performing member checking with each participant to allow for further elaboration and clarification of experiences.

Furthermore, phenomenological research is not focused on collecting facts but collecting a conveyed experience and interpretation of such. This limitation leads to a justifiable uncertainty regarding qualitative work such that those in healthcare may look at qualitative research "with skepticism and accuses it for the subjective nature and absence of facts" (Khankeh et al., 2015, p. 636). This matter of rigor, while discussed earlier and accounted for, is still of concern "where procedures are interpretive and implicit, rather than explicit and open to replication" (May, 1996, p. 190).

As the researcher and primary instrument for data collection and analysis, my inexperience as a phenomenological researcher may be seen as a limitation. Additionally, being a

novice with interviewing for a phenomenological research study and using hermeneutic conversations may be seen as a limitation. I have experience as a BCCN, nurse educator and nurse manager. Therefore, some data interpretation may be biased, even though assumptions and biases were identified, a reflexive journal was maintained, and member checking was performed. Since this was a hermeneutic phenomenological study using interpretation, my analysis of the findings may lead to different conclusions from those of another person.

The study participants consisted of 7 male and 15 female BCCNs. All of the study participants worked in a CCU within a small geographic area. As a result of these factors, the study findings can truly be applied to a small subset of nurses.

### **Implications**

Understanding what QNC means through the lived experience of BCCNs has far-reaching implications. It provides a description of the phenomenon through the experience of those providing the care. One of the most powerful matters of significance to the researcher was the interpretation that nurses felt that QNC was more about the specifics of the care being provided as opposed to a focus on outcomes. Only three nurses mentioned outcomes in the conversation of QNC. These statements were made in relation to QNC resulting in better outcomes as opposed to the inverse statement that outcomes reflect QNC. The latter concept tends to reflect current measures of QNC. Alex declared:

Quality care for me is doing what we do as nurses as a baseline, but adding your personal touch as what you would deliver as your own person and making sure that this patient can have the best outcome possible. (p. 3, lines 49-50, p. 4, lines 1-2)

Tom stated:

Also, outcomes, I think that it should be driven by I think numbers do play a role, you know, what are the things that can be done in which we're going to decrease the likelihood of this person being readmitted or increase the likelihood of them sticking to a positive treatment plan that is going to decrease their risk of, of having complications? (p. 4, lines 43-49)

Whitney explained:

And me as a nurse, I would be the one to put the patient first and do what's best for them. And how that eventually promotes positive outcomes for the patient. (p. 2, lines 16-19)

In CCU settings, patient outcome is dependent on several factors of which nursing care is just one component. Despite receiving QNC, patients may have a negative outcome. An oversimplified example would be a patient admitted to a trauma CCU after a motor vehicle collision with brain death awaiting family presence to withdraw care. If quality of care in this situation is measured by an outcome of mortality, nursing quality will appear to have been poor. Through the results of this study and provision of QNC, it can be imagined that this scenario would evolve into one where nursing care becomes focused on the sphere of the patient's existence as opposed to directed on the patient. The patient's loved ones and family would become the center of focus.

This study can add value in understanding how to better measure and make efforts to improve quality. It creates a framework for replication to determine if the findings of this subset of nurses are applicable to other areas of nursing and if the uniform quantitative approaches to measure QNC are valid. Having a "meaning" allows for more flexibility regarding the understanding of QNC and measuring it. Furthermore, it is felt that understanding what QNC means to nurses who have experience in CCU settings can influence education from undergraduate training to critical care certification and within practice.

Understanding what QNC means can also lead to steps aimed at improving professional satisfaction among nurses. If measures are taken to improve job satisfaction, the result in turn may lead to improved QNC. It has been reported that low job satisfaction of nurses has contributed to decreased quality of patient care (Lu et al., 2019). Furthermore, according to Laschinger and Fida (2015), nurses' satisfaction with their job has been correlated to the

provision of high-quality care. Additionally, Stalpers et al. (2017) conveyed that “nurses’ abilities to deliver high quality of care to patients has been linked (sic) to workplace satisfaction” (p. 1486). The level of job satisfaction among nurses plays an instrumental role in attracting and retaining nurses as well as maintaining the quality of patient care. Thus, to maintain quality of care, nurse job satisfaction is essential.

The issue of professional exhaustion or burnout is the topic of dissertations and books. The scope of this discussion is only to bring light to the issue as it relates to the consequences of nurses not being able to provide QNC. The topic is revisited from Chapter 1 in “justification for the study.” Quality of care is directly impacted by factors affecting nurses’ job satisfaction, since nurses perform the primary and most significant role in the delivery of health care services (Heidari et al., 2022). “Burnout causes a deterioration in quality of care, increasing the risk of mortality in patients due to poor performance and errors in the healthcare environment” (Ramirez-Elvira et al., 2021, p. 1). Burnout has detrimental effects on outcomes at the individual, organizational, and unit levels (Browning, 2019). The degree to which nurses are satisfied with their jobs and whether they are burned out have a significant impact on the quality of nursing care (Heidari et al., 2022). Support, job satisfaction, and an increase in an employee’s self-esteem can all be protective factors, since the work environment has a significant impact on lowering the prevalence of burnout (Ramirez-Elvira et al., 2021). Furthermore, as previously mentioned but reiterated here for impact, the average cost of turnover for a bedside RN is \$52,350 per year (NSI Nursing Solutions, 2023).

Chapter 2 contains a review of measures of nursing quality, including National Database of Nursing Quality Indicators® (NDNQI®) and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which is a 32-item survey sent to random patients

to measure their perceptions of their hospital experience. This measure, which is used as a surrogate at times as a measure for nursing quality, is a component of value-based quality measures. Up to 2% of a hospital's reimbursement through Centers of Medicare and Medicaid Services (CMS) is linked to reporting, and hospitals are incentivized to improve performance based on these measures (Chen et al., 2023). With QNC tied to reimbursement, the value of understanding the meaning of quality nursing care to those providing it becomes relevant. Understanding the meaning should be followed by implementing changes to support nurses and follow-up studies performed to evaluate impact.

### **Recommendations for Nursing Education and Leadership**

Reflecting on the findings of this study has allowed me to arrive at several recommendations for the various stages of a nurse's training through practice. As a nurse manager (NM) in the ICU, I spent time with nurses performing evaluations and getting feedback. This was done with a goal in mind that quality had to improve within the framework of the institution's expectations. The interviews conducted as part of this project allowed me to spend time listening to the BCCNs with an open mind. Instead of listening and advising what quality meant, I was listening and learning what quality meant to the nurse participants.

The interviews reinforced for me the enormity of the tasks needed to be performed by nurses to provide the care they felt represented quality. During the recruitment process for baccalaureate nursing programs, a more detailed analysis of applicants for nursing may be considered, allowing for a more longitudinal evaluation. Following these students into practice, insight may be gained regarding what types of candidates will excel and uphold the values of nursing. Personality and commitment to providing QNC are essential and may affect outcomes.

Understanding an applicant's motivations and goals and assessing their personalities to determine their ability to care and nurture can be considered important.

During the undergraduate period of training, coursework should reflect the theories reviewed earlier and highlight the importance of interpersonal relationships between nurses, patients, and their families or caretakers. The importance of interprofessional collaboration should be highlighted as well. Simulation should be used to assess a student's inclination toward providing QNC and their ability to formulate interventions. Furthermore, simulation can be used to teach and assess the ability of students to function within a team and collaborate with other professionals if such scenarios are created.

Within this same period, students should begin to understand what quality is defined as, what it means to nurses in practice, how to achieve it, and how to advocate for themselves if they recognize their inability to provide QNC due to factors within their work environment. Additionally, the consequences of not being able to provide QNC should be discussed, as well as ways in which to gain professional satisfaction.

Nurse educators (NEs) can use this research study to make efforts to understand what QNC means to the cohort of nurses they are responsible for and incorporate findings into their curriculum. Critical care educators specifically can integrate the results of this study and consider ensuring discussions of teamwork, communication skills, patient advocacy, importance of basic nursing care, roles of the nurse, value of policies and procedure,s and providing care that includes a holistic perspective, including considering the spiritual, emotional, social, cultural, religious, psychosocial, and ethical needs of the patient.

Once nurses are at the bedside, open-ended assessments performed by managers and leaders may be beneficial to gain insight as to what nurses in their institutions are facing in their

lived experience. Discussions regarding the BCCN's ability to provide QNC in relation to work environment should be had with open communication. Furthermore, audit and feedback regarding the aspects of providing QNC can be assessed. An example of this would be assessing a nurse's ability to function within a team using existing tools and resources available through multi-directional discourse. Through such a mechanism, management can identify needs and intervene.

NMs are responsible for ensuring quality patient care is delivered by the staff in the nursing unit. The results of this study should reinforce the need to create a work environment that supports the bedside nurses' meaning of QNC. NMs can meet periodically with bedside nurses on the unit to understand their meaning of QNC and implement interventions to provide bedside nurses the tools and resources to provide QNC. An example of this would be a NM starting a question for the bedside nurse, "What do you need to ensure QNC for your patient today?" At the end of the shift, the NM can ask, "Were you able to provide care you felt represented QNC; if so, what helped you and what prevented you?"

NMs need to differentiate between what QNC is, the tools to provide QNC, and distinguish professional outcomes from patient outcomes. Showing an understanding of QNC and regularly assessing nurses' ability to provide QNC should be required, as well as advocating for nurses to have the tools and resources to provide QNC. NMs need to have training to assess the consequences of nurses not being able to provide QNC.

The findings of this study present a view of QNC through the experiences of those providing care. The view may not be consistent with an institutional definition of QNC and therefore provides an opportunity for NMs and NEs to work together to understand and influence QNC within their institutions. This may lead to improved environments for nurses and have

potential implications on outcomes and quality metrics. Working together, the NM and NE can assess the bedside nurses' meaning of QNC, evaluating if the bedside nurses' meaning aligns with that of the unit and supporting efforts to change practice expectations, behaviors, and environment if necessary to ensure the bedside nurse can deliver what he/she values as QNC.

Administration and leadership within institutions need to acknowledge the difference between the meaning and definition of QNC. In doing so, employee engagement, environment, and satisfaction may improve. As a result, patient outcomes may be positively impacted. To prevent falling short on improving the professional lives of the nurses, identifying the specifics of what is needed for nurse professional satisfaction is necessary instead of making general assumptions based on what makes all employees happy.

### **Recommendation for Further Study**

It becomes evident to the reader that there is a plethora of studies and reviews regarding QNC. Through the discussion, the relevance of the topic regarding the profession of nursing, patient satisfaction, patient outcomes, and financial success of healthcare intuitions cannot be denied. However, this study uncovered the meaning of QNC for a limited subset of nurses. Illumination should only lead to further study. When we shine light to find something, what we do with that something then becomes the question. Studies can be performed through replication using the framework provided here including studying various subsets of nurses independently, such as medical-surgical unit nurses, recovery room and preoperative nurses, and emergency room nurses, to name a few. Most healthcare professionals can already imagine what the findings might reveal. Building upon the findings of this qualitative work, quantitative methods can be employed to perform a study to determine reliability through statistical analysis.

## **Reflections of Researcher's Experience**

My reflections are based on a 30-year career in nursing. My career started as an LPN in 1993, which is considered the ground-level position providing basic nursing care under the supervision of an RN or physician. I subsequently went on to complete a diploma program in nursing in 1997. From 1997 to 2006, I worked at the bedside. To open doors and to advance in my career, as well as stay ahead of what was felt to be pending legislation mandating that nurses have a bachelor's degree, I completed a BSN in nursing in 2006. When I developed the pulmonary embolus I described in my narrative, the lack of knowledge among the nurses who were taking care of me motivated me to pursue a master's degree in nursing to become an educator. My goal was to improve nursing care as well as patient outcomes. My career advanced from education to management as the nurse manager of a multispecialty critical care unit at a tertiary hospital. With the desire to further influence the field of nursing and a passion for education, I enrolled in the Teachers College Doctor of Nursing Education and Leadership program for which this study was performed to fulfill requirements for the degree.

Throughout my career, providing what I considered great care was always important. The many experiences of my career thus far led me to my interest in QNC as a topic. I realized there was a different meaning for QNC in each of the positions I held. When I first embarked on this path, my dissertation was going to be centered around quality and creating a tool for auditing the bedside nurse and providing a quantitative analysis of the impact. For various reasons, this project evolved into an in-depth study of QNC through qualitative research. My impression is that this evolution has opened my eyes to the intricacies and explorative nature of qualitative phenomenological research as it applies to QNC. Previously I thought I was able to understand what people experienced, but I have since become enlightened as to the fact that this

understanding was through my own bias. Learning to reflect on my biases and set them aside through this process has allowed me to understand the concept of perceptions and meanings and how they can differ among people with similar backgrounds. I see myself wondering about the lived experience of other phenomena as they exist around me from within my personal and professional life. My understanding of the words “definition” and “meaning” also evolved to the extent that I am careful not to use them interchangeably.

When I embarked on this investigation, I was concerned about recruiting 10 candidates to interview. The snowball recruitment method resulted in accepting and interviewing 22 nurses. My concerns of participant disinterest in this topic were quickly alleviated as my interviews started. The passion regarding nursing and QNC was evident in almost all the interviews. Many of the participants were emotionally expressive, delving deep into experiences that shaped their meaning of QNC. The stories shared were intimate and detailed. Hearing these memories revived my own recollections of events that were meaningful for me as a BCCN and the QNC I provided.

The open-ended and semi-structured component allowed for the participants to venture outside of the general questions regarding the meaning of QNC, showing that they had a great interest in nursing care as well as what constituted that care. They shared in detail descriptions of their roles through stories of their work. They were proud and aware of their roles as nurses to their patients and society.

When I first identified themes from reviewing meaning units, I was not satisfied that the words I used expressed the emotions and thoughts of the nurses I interviewed. This sense pushed me to reconsider my biases and revisit the interviews in order to describe the themes in a more descriptive manner. My initial themes were holistic care, patient centered care, education,

experience, roles, and tools needed for QNC. Expressed in this way, the themes seemed insipid, without feeling and more along the lines of a scientific and linear definition. Through reflection, my themes evolved to: (1) It is not just taking care of the illness; (2) Being there for another, it's the little things; (3) It is knowing your stuff, bed bath and beyond; (4) It is roles, not just responsibilities; and (5) It means having resources.

Controlling for my biases, I was careful not to interject my experiences into the interview questions. I had to speak with nurses and gather information through the eyes of a researcher and not a supervisor or colleague. However, their awareness of my background possibly allowed for a more forthcoming narrative. The study allowed for an unstated bonding experience regarding life as a CCU nurse.

While many themes were relevant to me when I was in the position of BCCN, there were some which I could not relate to. This may be due to the dynamic nature of the nursing profession through changing times and demonstrates the need for this process to be an active one. As the world evolves, so might the perception of QNC.

Given the data, my understanding on how to assess QNC has changed. In a critical care setting, nurses have a meaning of QNC, the components of which should be assessed and supported. In the CCU setting, the rigidity of numerical metrics may not solely apply to determine QNC, as outcomes for patients are dependent on several factors.

This project allowed me the opportunity to spend time reflecting on my own understanding and meaning of QNC. The topic is near to me through my experiences as a patient as well as my professional connections. The sentiment regarding the importance of providing QNC has been a motivating part of my entire career. It was rewarding to see this same sentiment expressed by the nurses who participated in this study. The experience also further reinforced the

complexity of care being provided by nurses to their critically ill patients and the effort and commitment it takes to do a good job.

### **Artistic Expression**

Objects of art are visual, tactile, auditory, kinetic texts—texts consisting of not a verbal language but a language nevertheless, and a language with its own grammar. “Because artists are involved in giving shape to their lived experience, the products of art are, in a sense, lived experiences transformed into transcended configurations” (van Manen, 1997, p. 74). When imagining how best to describe the essential themes uncovered through art, the imagery of soup being a source of healing and providing comfort was vivid. I commissioned the artwork displayed here. The essence of the lived meaning of QNC is expressed as soup. A google search of quotes related to soup results in meaning units and themes that overlap with the ones uncovered through this research project. The can of soup represents QNC through its ingredients that are the meaning units. These ingredients, while distinct, when combined, result in a product. The product is QNC. The can opener represents the process of phenomenological inquiry. When the can is uncovered, the essential themes are seen and the spoon representing the tools and resources allows the provision of the contents (Figure 2).

**Figure 2**

*Artistic Expression of Uncovered Themes*



### Summary

This chapter closes the loop of inquiry and reporting by relating back to the justification of the study provided at the outset. The synthesized data and blossomed themes were supported by a review of the literature. Theoretical models were then highlighted, demonstrating that relevance of the findings in relation to the observations of Florence Nightingale, Jean Watson, and Patricia Benner. In addition, limitations of the study and the implications of the findings in

relation to the profession of nursing and health care were discussed. Additionally, recommendations for nursing education and future study were shared. The chapter closed with commissioned artwork putting all the pieces together to be visualized and digested.

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## Appendix A: Demographic Questionnaire

The image shows a screenshot of a demographic questionnaire on a desktop computer and a mobile phone. The desktop version is on the left, and the mobile version is on the right. Both versions display the same content, which includes the Teachers College Columbia University logo, the title 'DEMOGRAPHICS', and the following text: 'Protocol Title: What is quality nursing care? The lived meaning of quality nursing care among clinical nurses in the critical care unit.', 'Principal Researcher: Nicole Mascellaro, EdD(c), MSN, RN 516-943-7503, nm3096@tc.columbia.edu', and 'Protocol Number: 23-153'. Below this text are input fields for 'Gender Identity:', 'Age:', and 'Ethnicity/Race:'. The mobile version also shows a time of 12:29 and a 'Share Preview' button.

### Demographic Data Form (Collected on Qualtrics)

Gender identity: \_\_\_\_\_

Age: \_\_\_\_\_

Ethnicity/race: \_\_\_\_\_

Nursing Degree: \_\_\_\_\_

Year of graduation from an undergraduate nursing program: \_\_\_\_\_

Year of graduation from a master's degree program (if applicable): \_\_\_\_\_

Current place of employment: \_\_\_\_\_

Current nursing position: \_\_\_\_\_

Type of intensive care unit currently working in: \_\_\_\_\_

Full-time or Part-time Status: \_\_\_\_\_

Number of years as a Registered Nurse: \_\_\_\_\_

Number of years as a Critical Care Nurse: \_\_\_\_\_

# Appendix B: Informed Consent

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212-678-3000 | www.tc.columbia.edu

## INFORMED CONSENT

**Protocol Title:** What is quality nursing care? The lived meaning of quality nursing care among clinical nurses in the critical care unit.

**Principal Researcher:** Nicole Mascellaro, EdD(c), MSN, RN  
516-943-7503, nm3096@tc.columbia.edu

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### INTRODUCTION

You are invited to participate in this research study. The title is, "What is quality nursing care? The lived meaning of quality nursing care among clinical nurses in the critical care unit."

*You may qualify to take part in this study if you are:*

- A Registered Nurse with a minimum degree of a Bachelor of Science in Nursing
- Are employed in a hospital in any type of intensive care unit as a Registered Nurse
- Have a minimum of one-year experience as a Registered Nurse in an intensive care unit (The experience of one year is equivalent to 1950 hours of clinical work)

*You will not qualify if you have a:*

- Associate degree in nursing
- Diploma degree in nursing

Ten participants will be selected. The study will take two to three and a half hours to complete.

### WHY IS THIS STUDY BEING DONE?

The study is being performed to discover what quality nursing care means from the lived experiences of clinical nurses in the critical care unit. To add to the existing definition of quality specifically related to nursing care.

### WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY?

- Read the informational flyer and talk by phone about the study
- Discuss the informed consent and demographic form over the phone
- Fill out and submit the informed consent form online using Qualtrics

Teachers College, Columbia University Institutional Review Board Protocol Number: 23-153 Consent Form Approved Until: No Expiration Date
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- Fill out and submit the demographic questionnaire online using Qualtrics
- Complete a recorded interview via Zoom that will be transcribed
- Review your transcript for accuracy
- Discuss reflections about the transcript and add comments in a follow-up video recorded interview on Zoom.

Face-to-face interviews will take place on the online program Zoom. The researcher and participant will choose a quiet, private place of their choice. This is to ensure confidentiality during the recorded interview.

Participants will be asked to consent to the recording before the Zoom meeting starts. The participant will leave the name field blank on the Zoom module for privacy.

During the interview, you will be asked about your experience with quality nursing care in the critical care unit.

The interview will be recorded and transcribed. The recording will be deleted after the interview is transcribed. You cannot participate without being recorded.

The interview will take about 45- 60 minutes. Your identity will be kept private by using a pseudonym.

During the follow-up meeting, the researcher and participant will meet face-to-face via the Zoom platform. This will be conducted in the same way as the initial interview.

### **WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART IN THIS STUDY**

This is a minimal-risk study. You should not experience any harm or discomfort that you would not experience taking routine physical or psychological tests or exams in your daily life. You might feel uncomfortable recalling stressful patient care or professional interactions. You do not have to discuss or share anything you do not want to talk about. You can stop participating in the study at any time without penalty. The information you provide will be kept confidential.

In the event you experienced discomfort, every effort will be made to refer you to receive psychological and physical treatment.

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**WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY?** There is no direct benefit for you in taking part in this study. The results of the study may benefit the field of nursing. The study may lead to a better understanding of the meaning of quality as it is experienced by the critical care nurse.

**WILL I BE PAID FOR BEING IN THIS STUDY?**

There are no costs to you for taking part in this study. You will be paid \$35 USD via VISA or Amazon gift card **upon completion of all the processes.**

**Please select one:**

Amazon gift card

VISA gift card

**WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?**

The study will be over when all participant interviews and follow-up meetings are completed. You can leave the study at any time even if you have not finished. If you leave the study early or do not complete all tasks you will not qualify for a gift card.

**PROTECTION OF YOUR CONFIDENTIALITY**

The researcher is taking precautions to keep your identity and interview answers confidential. A pseudonym will be used to organize data instead of your actual name. All electronic information including interview recordings will be kept in an encrypted folder. The folder will be stored on the Teacher's College (TC) Google Drive. There is a password and virtual firewall protecting the computer. There is malware and antivirus software installed on the computer. All physical forms of data will be stored in a locked safe in the researcher's home. The safe will be kept in a locked closet only accessed by the researcher.

Data will be kept for the required duration of three years. After that electronic data will be erased, and physical data will be shredded.

For quality assurance, the study team, and/or members of the Teachers College Institutional Review Board (IRB) may review the data collected from you during the study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.

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**HOW WILL THE RESULTS BE USED?**

This study is being conducted as part of the primary researcher’s dissertation. The results of this study may be published in journals and presented at academic conferences. Your identity will be removed from any data you provide before its use. Your name or any identifying information about you will not be published.

**WHO MAY VIEW MY PARTICIPATION IN THIS STUDY**

Only the primary researcher will know of your participation in this study and view your interview. Transcription will be performed using an internet program and artificial intelligence.

**CONSENT FOR AUDIO AND/OR VIDEO RECORDING**

Audio and video recording are part of this research study. If you decide that you will not consent to be recorded, **you will not be able to participate** in this research study.

\_\_\_\_\_ I give my consent to be recorded \_\_\_\_\_  
Signature

\_\_\_\_\_ I **do not** consent to be recorded \_\_\_\_\_  
Signature

**OPTIONAL CONSENT FOR FUTURE CONTACT**

The researcher may contact me in the future for information relating to this current study:

Yes \_\_\_\_\_ No \_\_\_\_\_  
Initial Initial

**WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?**

**If you have any questions about this research study, you should contact the primary researcher, Nicole Mascellaro at 516-943-7503**

Teachers College, Columbia University  
Institutional Review Board  
Protocol Number: 23-153  
Consent Form Approved Until: No Expiration Date

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If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email [IRB@tc.edu](mailto:IRB@tc.edu). You can also write to the IRB at Teachers College, Columbia University, 525 W. 120<sup>th</sup> Street, New York, NY 10027, Box 151. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.

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### **PARTICIPANT'S RIGHTS**

- I have read the Informed Consent Form and have been offered the opportunity to discuss the form with the researcher.
- I have had ample opportunity to ask questions about the purposes, procedures, risks, and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty.
- The researcher may withdraw me from the research at the researcher's professional discretion. **Conditions: does not want to participate in audio/video recording, does not complete the informed consent form or demographic data form, does not maintain a private location during the interview process, and does not participate in all the study's activities.**
- If, during the course of the study, significant new information becomes available which may impact my willingness to continue my participation, the researcher will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- Identifiers will be removed from the data. Data will not be used in further research studies.
- I should receive a copy of the Informed Consent Form document.

**My signature means that I agree to participate in this study:**

**Print name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

Teachers College, Columbia University Institutional Review Board Protocol Number: 23-153 Consent Form Approved Until: No Expiration Date
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## Appendix C: IRB Approval Letter

**Attachments:**

- Informed-Consent-Nicole mascellaro December 28 2022.pdf
- Exemption Notification - IRB ID: 23-153.pdf



*Teachers College IRB*

*Exempt Study Approval*

To: Nicole Mascellaro  
From: Amanda O'Hara  
Subject: IRB Approval: 23-153 Protocol  
Date: 01/19/2023

Thank you for submitting your study entitled, "*What is Quality Nursing Care: The lived meaning of Quality Nursing Care among clinical nurses in the critical care unit*," the IRB has determined that your study is **Exempt** from committee review (Category 2) on 01/19/2023.

Please keep in mind that the IRB Committee must be contacted if there are any changes to your research protocol. The number assigned to your protocol is **23-153**. Feel free to contact the IRB Office by using the "Messages" option in the electronic Mentor IRB system if you have any questions about this protocol.

**Please note that your Consent form bears an official IRB authorization stamp and is attached to this email. Copies of this form with the IRB stamp must be used for your research work.** Further, all research recruitment materials must include the study's IRB-approved protocol number.

As the PI of record for this protocol, you are required to:

- Use current, up-to-date IRB approved documents
- Ensure all study staff and their CITI certifications are on record with the IRB
- Notify the IRB of any changes or modifications to your study procedures Alert the IRB of any adverse events

You are also required to respond if the IRB communicates with you directly about any aspect of your protocol. Failure to adhere to your responsibilities as a study PI can result in action by the IRB up to and including suspension of your approval and cessation of your research.

You can retrieve a PDF copy of this approval letter from Mentor IRB.

Best wishes for your research work.

Sincerely,  
Amanda O'Hara

amanda.oharaa@gmail.com

## Appendix D: Flyer

### Study Alert: In Search of Critical Care Nurses

Participate in an Interview for a Research Study

Share your experience with Quality Nursing Care

**Study Title: What is Quality Nursing Care: The lived meaning of Quality Nursing Care among clinical nurses in the critical care unit**

**Purpose:** To understand the essence of Quality Nursing Care through the lived experiences of Nurses in critical care. To add to the existing definition of Quality specifically related to Nursing Care.

**Investigator:**

Nicole Mascellaro EdD (c), MSN, RN

Email: [nm3096@TC.Columbia.edu](mailto:nm3096@TC.Columbia.edu)

Call or Text: (516)943-7503

Affiliation: Teacher's College, Columbia University

TC IRB#

**Risks:** Minimal.

**Benefits:** No Direct benefit. Help contribute to the nursing profession by sharing your experience.

**Time Commitment and Tasks:**

- 140 min to 220min spread out over 1 week period
- Phone call to discuss study: 15-30 minutes
- Phone call to discuss informed consent and demographic survey and fill out the consent and demographic forms online: 15-30 minutes
- Download a copy of the informed consent
- Recorded Interview on Zoom: 45-60 minutes
- Review transcript of the interview: 45-60 minutes
- Follow-up recorded Zoom meeting to review the transcript and add additional comments: 15-30 minutes

**Location:**

- Virtual

**Compensation:**

- \$35 USD Amazon or VISA gift card upon completion of all tasks

**Eligibility to participate in this study:**

- Registered nurse with a minimum degree of a Bachelor of Science in Nursing
- Employed in a hospital in a critical care unit (any type of intensive care unit)
- Minimum of one year experience in any type of intensive care unit
- One year of experience is equivalent to 1950 hours of clinical experience

## Appendix E: Business Card

**Researcher**

Nicole Mascellaro  
EdD(c), MSN, RN

Email: [nm3096@tc.columbia.edu](mailto:nm3096@tc.columbia.edu)

Call or Text: (516) 943-7503

IRB Protocol # 23-153

(Front Side of Card)

Title: What is quality nursing care? The lived meaning of quality nursing care among clinical nurses in the critical care unit.

In search of critical care nurses to participate in a voluntary study about quality nursing care.

Contact if interested in participation

(Back Side of Card)

## **Appendix F: Interview Questions**

### Interview Questions:

To build rapport, each interview will begin with an introductory statement of gratitude: “Becoming a critical care nurse is a significant accomplishment, thank you for your service.”

- The first interview question will be a broad open-ended question: Talk about the type of care you deliver to your patients in the intensive care unit
- Speak about the care you provide to critically ill patients
- What does quality nursing care mean to you?
- What are you most proud of as a professional registered nurse in the intensive care unit?
- Do you have any additional thoughts or comments?

Open-ended follow-up questions will be asked based on the response to the question to encourage participants to share their stories.

## Appendix G: LinkedIn Ad

Excited to begin interviews for my dissertation!  
Looking for participants.

Participate in an Interview for a Research Study  
Share your experience with Quality Nursing Care

Study Title: What is Quality Nursing Care: The lived meaning of Quality Nursing Care among clinical nurses in the critical care unit

Purpose: To understand the essence of Quality Nursing Care through the lived experiences of Nurses in critical care. To add to the existing definition of Quality specifically related to Nursing Care.



**Nicole Mascellaro EdD(c)**  
MSN RN NE-BC  
Doctoral Student  
9mo · 🌐

Excited to begin interviews for my dissertation!  
Looking for participants.... see more

### Study Alert: In Search of Critical Care Nurses

Participate in an Interview for a Research Study  
Share your experience with Quality Nursing Care

**Study Title: What is Quality Nursing Care: The lived meaning of Quality Nursing Care among clinical nurses in the critical care unit**

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**Investigator:**  
Nicole Mascellaro EdD (c) MSN, RN  
Email: [nm3096@TC.Columbia.edu](mailto:nm3096@TC.Columbia.edu)  
Call or Text: (516) 943-7503  
Affiliation: Teacher's College, Columbia University  
TC IRB #23-153

**Risks:** Minimal  
**Benefits:** No Direct benefit. I help contribute to the nursing profession by sharing your experience.

**Time Commitment and Tasks:**

- 140 min to 220 min spread out over 1 week period
- Phone call to discuss study: 15-30 minutes
- Phone call to discuss informed consent and demographic survey and fill out the consent and demographic forms online: 15-30 minutes
- Downloaded a copy of the informed consent
- Recorded interview on Zoom: 45-60 minutes
- Review transcript of the interview: 45-60 minutes
- Follow up recorded Zoom meeting to review the transcript and add additional comments: 15-30 minutes

**Location:**

• Virtual

**Compensation:**

• \$35 USD Amazon or VISA gift card upon completion of all tasks

**Eligibility to participate in this study:**

- Registered nurse with a minimum degree of a Bachelor of Science in Nursing
- Employed in a hospital in a critical care unit (any type of intensive care unit)
- Minimum of one year experience in any type of intensive care unit
- One year of experience is equivalent to 1950 hours of clinical experience

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\$35 USD Amazon or VISA gift card upon completion of all tasks

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Investigator:

Nicole Mascellaro EdD (c), MSN, RN  
Email: [nm3096@TC.Columbia.edu](mailto:nm3096@TC.Columbia.edu)  
Call or Text: (516) 943-7503  
Affiliation: Teacher's College, Columbia University  
TC IRB #23-153

Download the flyer for complete information. Please feel free to distribute this flyer to those who may qualify and contact me if you are interested in participating.

Thank you.

#nursing #criticalcarenurse #criticalcare #hospitals  
#nursingeducation #nursingresearch

## Appendix H: Demographic Table

Name	Age	Gender Identity	Ethnicity/ Race	Nursing Degree(s)	Year of Graduation from degree	Hospital Unit	Position status	Years as an RN	Years as a CCN
Allison	24	Female	Caucasian	BSN	2019	CTICU/SICU	Full time	4	3
Samantha	26	Female	Caucasian	BSN	2019	CTICU/SICU	Full time	3.5	3.5
Aiden	35	Male	Caucasian	BSN	2011	CTICU/SICU	Part time	12	10
Emily	57	Female	Asian	BSN MA	1986 1998	SICU	Part time	37	34
Sally	59	Female	Caucasian	BSN	1989	SICU	Full time	33	33
Lisette	30	Female	Caucasian	BSN	2019	CCU	Full time	3	3
Khloe	37	Female	Caucasian	BSN	2012	CTICU/SICU	Part time	10	7
Laura	40	Female	Caucasian	BSN	2012	MICU/SICU	Part time	10	10
Raquel	55	Female	Caucasian	BSN MSN	2012 2020	NICU	Full time	22	17
Cathy	33	Female	Caucasian	BSN MSN	2014 2022	NICU	Full time	8.5	8.5
Jennie	36	Female	Caucasian	BSN MSN	2012 2020	PICU/NICU	Full time	10	7
Mannie	27	Male	Guyanese American	BSN	2018	CTICU	Full time	4	3
Alex	34	Male	Hispanic	BSN	2013	SICU	Full time	10	5
Abigail	36	Female	Caucasian	BSN	2012	NICU	Full time	8	8
Keith	29	Male	Asian	BSN	2018	MICU/SICU	Full time	4.5	3
Tom	32	Male	Caucasian	BSN	2013	CTICU	Full time	9	7.5
Gabriel	33	Male	Asian/Indian	BSN	2018	SICU	Full time	5	3
Betty	28	Female	Caucasian	BSN	2017	MICU/SICU/ CTICU/ NSICU	Full time	6	6
Nate	33	Male	Latino	BSN	2013	MICU	Full time	9	7
Whitney	27	Female	Asian	BSN	2017	CTICU	Full time	5.5	3
Kelly	30	Female	Decline	MSN	2018 2022	CTICU/SICU	Full time	7	4
Sandy	25	Female	Caucasian	BSN	2019	CTICU	Full time	4	2