Atmosphere in the ward environment: a vulnerable dynamic phenomenon

A phenomenological study guided by
the Vancouver School of Doing Phenomenology

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A dissertation
Submitted in part fulfilment of the degree of Master of Science in Nursing

The Royal College of Nursing Institute, London
December 2002
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This dissertation is submitted to the RCN Institute in part fulfilment of the MSc in Nursing, and has been conducted and presented solely by myself. I have not made use of other people's work (published or otherwise) and presented it here without acknowledging the source of all such work.

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Word count: 21,967
Abstract

It has been pointed out that the atmosphere in the ward environment accounts for certain part of the variation in performance on individual wards. Emphases on economically driven health care have resulted in turmoil among hospital employees with obvious consequences. In the light of these circumstances the attention has been directed towards the infrastructure of hospitals, and the work environment is now under scrutiny as one of the important elements. However, its meaning for nurses has not received much attention. The aim of this study was to increase the understanding of ward environment with special emphasis on ward atmosphere and the meaning of empowering and disempowering atmosphere as nurses on inpatient wards experience it. A phenomenological study, guided by the Vancouver School of Doing Phenomenology, was conducted using individual and group dialogues with nurse managers and staff nurses. The dialogues were all together nineteen, nine with the head nurses and ten with the discussion groups.

According to my understanding the ward atmosphere is a vulnerable dynamic phenomenon, which needs constantly to be attended to. The main theme of the phenomenon is relationships, and spans the range from a self-renewing empowering phenomenon, which is consciously motivated to a stagnated disempowering phenomenon with dead ends and no process.

The essential structure of an empowering atmosphere is constructed of:

- open interaction
- reciprocal care
- holism

The essential structure of a disempowering atmosphere is constructed of:

- lack of caring
- obstacles in the ward environment
- a breach with the ward environment
- baebiting

The findings indicate that the ward atmosphere crystallises in the well-being, strength and confidence/lack of confidence of the individual/team. Moreover, that empowering ward atmosphere is the foundation for personal and professional development.

Through deeper understanding of ward atmosphere, nurses and even people in other disciplines, may be able to relate to that understanding, to create an empowering atmosphere in their own work environment. Additionally, this understanding may help nurses and others to master some of the challenges they are confronted with in their everyday practice.

Nurses possess the knowledge and experience to create an empowering atmosphere; but these factors must be brought to light and utilised. This process would cost health institutions little or nothing in financial terms but could yield a considerable return in terms of performance.
Acknowledgements:

I wish to express my sincere gratitude to all the co-researchers (participants) in the study, who have taken of their time and had the courage to share with us their experience of ward environment. Without them and their sincerity this study could not have been conducted.

I also want to express my sincere gratitude to my tutor counsellor professor Sigriður Haldórsson, for putting me on the track, for always being there for me, for her excellent guidance, endless patience, invaluable encouragement, and for believing in me.

I wish to thank the British Embassy in Iceland for a grant for my student fees. The Icelandic Nurses’ Association and the National University Hospital Research Fund (Visindasjóður Landspítala húskólaasjúkrahúss) helped me to finance this study, for which I am much grateful.

I thank my colleagues and friends at the Intensive Care Unit of the National University Hospital at Hringbraut, Reykjavik, for their encouragement – especially Sigrún Snorradóttir, Marianne Hölm and Lovisa Baldursdóttir.

I express my thanks to the staff of the National University Hospital library for their invaluable assistance and patience.

Hrud Sch. Thorsteinsson and the staff of the National University Hospital Nursing Education Department (Fræðasvís húskólaasjúkrahúss) for excellent assistance they provided.

Christer Magnusson who has asked me challenging questions, and discussed phenomenology with me, receives my warmest thanks.

I thank all those people, whom I consulted, and who made time to discuss the work environment with me, for their help.

I thank Anne Yates for her enormous work in translating and editing the manuscript.

I wish also to express my warm thanks to my dear friend Hildur Magnúsdóttir, who has been selflessly supportive of me throughout my studies.

I thank my mother, mother-in-law and siblings for their encouragement.

Last but not least, I dedicate this dissertation to my beloved family. Thank you, dearest Áslaug, Bergsvønn og Milla for all your help, patience and consideration. Dearest Felix, thank you for always standing by me, reading my manuscripts, household cares, and maintaining a sense of humour in the home.

To all those I am deeply grateful.
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1. The introduction

1.0 Introduction

The focus of this study is the meaning of ward environment for nurses, with special emphasis on ward atmosphere. Furthermore, what meaning does the empowering and disempowering structure of the ward atmosphere have, as experienced by staff nurses and nurse managers on inpatient wards?

Personnel often discuss different hospital wards with reference to whether they have a good or bad workplace atmosphere. Whilst easy to sense, the meaning of the workplace atmosphere, which affects how personnel experience and feel in their workplace, is more difficult to identify (Goleman, 2000). Goleman (2000) refers to the six drivers of climate that have an influence on an organisation’s working environment, which are: flexibility, responsibility, standards, rewards, clarity and commitment. Shortell et al. (1991) found in a study that a certain organisational culture and leadership style provides effective communication, coordination, and problem-solving approaches, which is likely to result in a higher quality of patient care.
Even though nurses represent the largest proportion of professional health-care workers, organisational support for nurses' work remains low (Laschinger, 1996). The main emphasis in organisations tends to be on cost-driven changes (Parker and Gadbois, 2000). Nevertheless, it has been pointed out that the atmosphere in the ward environment accounts for up to 30% of the variance in performance on a particular ward (McClelland, 1984, cited in Snow, 2002). Some authors maintain that by creating an attractive workplace, the turnover rate will drop (Neuhauser, 2002) nurses' feelings towards their workplace become more positive and patient outcomes will improve (Adams and Bond, 2000).

In my experience, the atmosphere in the work environment is discussed among all disciplines. However, not many people bother to explain their understanding of the phenomenon, or reflect on its meaning. The reason is probably that everyone believes they know what the other is indicating. For me as a nurse manager the dimension and meaning of the phenomenon is too blurred for one to be able to use its empowering structures and diminish its disempowering structures in practice. Hewison (1996) states a similar problem when questioning the current widespread route to the concept of organisational culture as a way of explaining all soft organisational issues. Vestal (1997) discusses confusion and a lack of consensus concerning exactly what organisational culture means.

Through deeper understanding of ward atmosphere, nurses in administration as well as staff nurses, and even people in other disciplines, may be able to relate to that understanding, to create an empowering atmosphere in their own work environment. Additionally, this understanding may help nurse managers and others to master some of the challenges they are confronted with in their everyday practice.
1.1 The problem of labelling the phenomenon

Despite the number of writings and studies on the work environment in recent years, and interest from the viewpoint of different disciplines such as nursing, management, and business, the work atmosphere is frequently overlooked and misunderstood (Vestal, 1997; Snow, 2002). Another factor inhibiting its progress is the many labels attached to it, which overlap each other.

Because of this confusion it became a concern of mine to decide which label I should attach to the phenomenon I was going to study. After consideration I decided to label the phenomenon 'atmosphere' in the ward environment. Rosenstein, (2002) discusses the atmosphere of nurse-physician relationships, so the expression is known as such, although it is not much used in the literature.

1.2 Definition of the problem

From the beginning of my career as a nurse manager it has been my philosophy that if nurses are satisfied with their ward environment they are more likely to provide good nursing care. Covey (1990) maintains that the production capability is to always take care of your employees exactly as you want them to take care of your best customers. Snow (2002) states that organizational climate is how it feels to work in a particular work environment, and therefore it differentiates levels of performance on a particular ward. This aspect is also discussed in the business world. Bunz and Maes (1998) discuss the issue when they give a case study about an airline's approach to satisfying its customers. It is a similar philosophy to that used by the airlines when they tell you that if you are travelling with a child you should first put the oxygen mask on yourself before putting it on the child. The philosophy is: take care of yourself first, if you want to be able to take care of someone else.
I consider, as a nurse manager, whether by creation of an empowering atmosphere in the ward environment, gradually the ward will earn the reputation of having a good ward atmosphere. The gain might be less absenteeism, less problems with recruitment, less turnover, nurses with more years in practice, more nursing knowledge, and not least better patient care. By that gain the nurse managers and staff nurses could turn their resources to more productive issues for nursing and the patients' benefit, besides the economic profit. Covey (1990) maintains that it is possible to create an atmosphere where people can seize opportunities and solve problems in a progressively more self-reliant way. Because of these speculations, my interest in the ward atmosphere surfaced. The goal is not to solve problems but to gain a more profound understanding of the meaning of ward atmosphere and its empowering and disempowering structures as experienced by nurses on inpatient wards. Moreover, the understanding could lead to more thoughtful and tactful actions in certain situations.

Nursing students often refer to the atmosphere in the wards where they have been working. When deciding where to work after graduation, they often look for wards where they have experienced a good ward atmosphere. By understanding their experience, it could be possible to generate a ward atmosphere that would attract newly-graduated nurses' attention.

1.3 The methodology

In my speculations I realised that in order to accomplish a change in the ward atmosphere it is necessary in the beginning to be aware of and analyse the prevailing feature of the ward atmosphere. Moreover, to gain an understanding of how nurses are motivated for their work. I have always believed that nurses themselves should give the answers to those questions.
Hewison (1996) calls for more empirical research on the issue, rather than debating options. Koch, (1992) however, asks for different approaches in nursing, to improve the balance between scientific knowledge and understanding. I agree with Koch, as I find it more important at this stage to understand the nurses' and nurse managers' experience of the atmosphere in the ward by way of qualitative research. I want to understand the phenomenon in more depth, to question what seems obvious to most people. Perhaps that understanding might give suggestions for a more empowering atmosphere and a decrease in disempowering atmosphere. In my literature review I have not seen much about the phenomenon of ward atmosphere or a quest for approaching the issue from a phenomenological viewpoint. However, it is my world-view that guides the research approach in this study. That world-view asks for a deeper understanding because one of my passions is to understand human phenomena in all their breadth and depth.

I found an appropriate methodology to approach my research interest, having learned about the methodology of the Vancouver school of doing phenomenology (Halldórsdóttir, 2000). The Vancouver school of doing phenomenology is an interpretivist/constructivist school of doing phenomenology, and adopts a world-view that is made up of meanings. Those meanings affect how people experience and live their lives. Phenomenology as a methodology is concerned with investigating phenomena and understanding the meaning of human phenomena. Research conducted using the Vancouver school studies the world from the point of view of the interacting individual, whom I will call my co-researchers (Halldórsdóttir, 2000).
1.4 Research question

In my study the aim was to gain a holistic picture of the phenomenon *atmosphere in the ward environment* within the limits of the time and space of this study. Therefore the research question is:

'*What is the experience of staff nurses and nurse managers of empowering and disempowering atmosphere in the ward environment on inpatient wards***?'

It is also of importance to understand what meaning *ward atmosphere* has for the patients (Björnsdóttir, 2002). Because of time and space limits I was unable to explore this question at this time. Furthermore, the perception of ward atmosphere by practical nurses, physicians, nursing students and other employees is not studied here, for the same reason.

1.5 Summary

Because of the importance of ward environment for nurses I will in this phenomenological study seek an increased understanding of ward environment, with special emphasis on ward atmosphere as it is experienced by nurses on inpatient wards. I will outline my research process by beginning with reviewing mainly nursing literature. After going through the research design I will explain my data collection and analysis. In chapter five I will present my findings and then discuss them in chapter six, in addition to analysing their implications for practice. Finally, I will discuss the limitation of the study and make suggestions for further studies in this important area of research.
2. The literature review

2.0 Introduction

In the introductory chapter I emphasised that the purpose of my study was to understand the meaning of the phenomenon ward atmosphere from a phenomenological viewpoint using dialogues with co-researchers. To that end I wish to add the discussion of the cost of health care in the western world, which has risen dramatically during the past decade. This discussion has led to new emphasis on how healthcare institutes are run (Gilmartin, 2001). Those new emphases are economically driven interventions that have resulted in turmoil among hospital employees, and the consequences are apparent. In nursing there is an ongoing discussion regarding shortage of nurses, increase in workload, diminished quality of patient care (Laschinger et al. 1999; Gilmartin, 2001). In light of these situations the attention of directors, managers and researchers in nursing has been directed towards the infrastructure of hospitals, and the work environment is now under scrutiny as one of the important elements. (Keuter et al., 2000; Disch, 2001a).
The following literature review relies mostly on recent (from the last five years) literature dealing with nurses' work environment. My aim is to point out authors' different emphasis regarding influencing factors in the work environment that extend from organisations' structural issues, to individuals' personal development and competency and team behaviour.

I will begin the literature review by presenting Kanter's theory from 1977, which paid attention to workplace conditions of women, and which is popular in nursing research to use as a framework to examine the relationship between perceptions of power and opportunity in the nursing work environment. Secondly, I will draw attention to a study from 1983 called the 'Magnet hospital', which identified factors used by these hospitals to attract and retain registered nurses. In spite of findings that identified long-term solutions, the research was then ignored until 1990 (Robinson, 2001). Thirdly, I will introduce an ideology that is a possible answer to economically driven managerial interventions in health care, which I call 'humanism and caring in health care management'. Fourthly, I shall discuss 'self-organisation', which is the new emphasis in management conducted through qualitative studies, and is intended to give organisations an 'eternal fuel' which comes from within the organisation and the individual. I will discuss the concept of empowerment to gain some coherence and clarify its meaning in the context of this study. Finally, I will give an account of ward atmosphere and summarize the chapter.

2.1 Kanter's structural theory of organisational behaviour

Kanter's (1977) theory of power, presented in her book Men and Women of the Corporation, emerged from her qualitative study of work environments in a large corporation in America. In the late sixties and early seventies when Kanter conducted her study, women were still in their 'early' days of fighting
against inequities and discrimination against women in work organisations and professional life. The efforts made by women were not working, according to Kanter (1977), because of individual model-thinking, 'women are different' (p.261), which led women to believe that the problem lay in their own psychology and gave organisations excuses for slow changes. In contrast Kanter's theory was to present an alternative model, one that demonstrated that responses to work are a function of basic structural issues. The whole force of Kanter's book was to draw attention to the idea that these issues would require organisations, not people, to change. However, in afterwards to the 1993 edition of her book Kanter points out that people increasingly understand that the reasons for their own success lie more and more outside the organisation, in the person's own professional base and experience.

Kanter's theory has been used in nursing to provide a framework to examine factors in nursing work environments that influence the ways they respond to work experiences. According to Laschinger (1996), Kanter's theory is particularly appropriate for examining nursing work, given Kanter's attention to the workplace conditions of women. Furthermore, she states that it adds to nursing knowledge of work structures that empower nurses, and provide conditions that promote meaningful engagement of nurses in organisational life.

Laschinger has conducted over fifteen studies based on Kanter's theory. In all of these studies, nurses' empowerment scores have been moderate. Laschinger (1996) maintains that these studies deserve serious attention, as nursing struggles to retain its professional edge in current health-care settings. I want to emphasise that Kanter's theory was in its time revolutionary, for employers and for women. Moreover, Kanter (1977) points out obstacles to change in organisations, which to my mind are still present in nursing to some extent, no less than at the time when Kanter presented her theory.
I will now draw attention to a study that identified *structures* in hospitals to attract and retain registered nurses.

### 2.2 Magnet hospitals

The research 'Magnet hospitals, attraction and retention of professional nurses', was a study conducted in the United States of America in the 1980s at a time of severe nursing shortages (Buchan, 1999). The study identified a national sample of magnet hospitals. 'Magnet hospitals' are hospitals that attract and retain registered nurses, and the research identified the factors that seemed to be associated with their success in doing so (McClure et al., 1983). The organisation of nursing in those hospitals has empirically presented positive patient and staff outcomes (Havens and Aiken, 1999), and better than average measures of nursing staff job satisfaction (Buchan, 1999).

The research presented in 'Magnet hospitals' had a marked effect. However, the patterns identified in the study were not in themselves new or novel. What the study did was to emphasise the need to plan for and integrate these patterns within a strategic framework. It also served to give some evidence-based confirmation that identified characteristics relating to organisational success in recruiting and retaining nursing staff. More recent research projects on magnet hospitals in the USA have focused on examining the organisational characteristics of hospitals and quality of care (Buchan, 1999). However, many authors’ attention is increasingly directed at the *individual employee* rather than structural issues.
2.3 Humanism and caring in health care management

Business literature directs more and more attention to the individual, and emotional intelligence is one popular issue (Goleman, 1996). Möller, a founder and chairman of Time Manager International A/S, states in an interview with Emerald Now that a major concern in organisations is inadequate use of people's competencies, and lack of recognition for work well done (Powell, 2001). Furthermore, hierarchy and hierarchical working methods are seen to dominate, he maintains. Möller further states that motivation comes from within the individual; someone else may be able to inspire you, but he/she cannot motivate you. He maintains that many managers lack the skills to inspire their workforce.

The effects of economically driven managerial interventions in hospitals have been disappointing both financially and for health-care professionals. The counter to this dominant profit management is the emerging discourse of health-care delivery environments where the human condition is distinguished, exemplary service is developed and human caring becomes a mission of value (Gilmartin, 2001). This new ideology is viewed as a way to rebuild the business enterprise as a humanistic endeavour where ethics and business are seen as inextricably linked. Furthermore, it fosters intraprofessional collegial and collaborative working relationships as a necessary component of quality patient care (Gilmartin, 2001). It seems to me that this ideology, called the ‘stakeholder theory’ of management, is in line with Möller's ideas presented previously, where everyone is involved and everyone's competencies are used, independent of level in the hierarchy.

Chaboyer (2001) conducted a study which examined the extent to which hospital nurses view their working environment in a positive sense. Chaboyer reports that the most positively rated item was that nurses on the units worked
well together - characteristics congruent with a team spirit, which places the emphasis on paying attention to the ward atmosphere.

Gage (1998) sets forth a similar ideology emphasising interdependence, and that everyone on the treatment team must have his/her needs met, including the client, if the treatment team is to continue being effective. This philosophy is presented under the heading of ‘synergistic teams’ and is also becoming popular in the business community. It requires that the participants build a foundation on which to base a successful relationship, establish a common vision and nurture the relationship on an ongoing basis like a repeating process (Gage, 1998), which I will discuss now.

2.4 Self-organisation and the nurse manager’s role

Turkel and Ray (2001) question how the future of professional nursing will be altered by these economic changes mentioned previously. Their answer is an organisation where human beings can co-create their future, take full responsibility for their own relationships and productivity, and interact with truth, sincerity, and justice to transform organisations into meaningful places where work facilitates relational ‘self-organisation’ (Turkel and Ray, 2000).

Self-organisation is a pattern in a model that emerged in a grounded theory study conducted by Turkel and Ray (2000). It functions as a feedback loop, where the relationship between the nurse, patient and administrator is both outcome and a process. The future work force redevelopment requires a participative approach of administrators and nurses. Using grounded theory, Ray et al. (2002) asked nurses and administrators to explain their experience of the result of organizations being driven by economic survival. Losing trust was the result, meaning nurses becoming dissatisfied with nursing practice and
experiencing decreased loyalty to the organization. Ray et al. (2002) maintains that it is the ethical choice for nurses and nursing managers to work together to make decisions on transforming nursing. Through that approach, constructive human relationship will co-create and facilitate self-organization in a continuously changing health care work environment.

The effects that the new emphases in health care management have had for the nurse manager are presented in a study by Ingersoll et al (1999). The results described how difficult it was for the ward manager to be the central figure in the eye of the storm. Adams and Bond (2000) also point out nurse managers’ experience of dissatisfaction due to heavier workload and role conflict.

Discussions concerning the leader’s role are complex, but Porter-O'Grady (2000) emphasizes the leader’s role as the one who creates culture and builds an atmosphere that either encourages or discourages others to work toward their futures. He maintains that they empower and encourage staff. In light of this discussion it is timely to define the empowerment concept.

2.5 Empowerment

The definition of health promotion by the World Health Organisation (WHO) in the mid-1980s appears to have evoked interest and attraction for the empowerment concept within a nursing perspective. Empowerment is defined as a process of enabling people to increase control over and to improve their own health (Maglacas, 1988). Furthermore, reforms in the health-care system should affect not only the health of clients but also the health of professionals who work within the organisation. Nurses need also a sense of autonomy and control over their practice. Therefore, both from professional and clinical-practice perspectives empowerment has implications for nursing (Gibson, 1991).
Before people can manage others they must manage themselves. An important point set forth by Gunden and Crissman (1992) is that the feeling of being personally empowered is essential to empowering others. Johns (1996) states that empowerment is to have the courage and commitment to take necessary action to change who you are through the process of reflection.

Gibson (1991) states that part of the difficulty in defining empowerment is that it takes on a different form within different contexts and with different people. I consider whether part of this difficulty has its roots in the different ontology of those who are defining the concept. Therefore the form of, the strategies for, and the results of empowerment will be variable. Further, Gibson (1991) analyses empowerment as a positive concept and the empowerment process as a proactive orientation. In addition, she considers it to involve a process of helping individuals develop a critical awareness of the basis of their problems, and a readiness to act on this awareness.

A study examining the relationship of organisational climate to perceptions of empowerment elucidated positive correlation between organisational climate and psychological empowerment (Mok and Au-Yeung, 2002), which directs the discussion to ward atmosphere.

2.6 Atmosphere in the ward environment

In a phenomenological research project studying the relationship between families and staff in nursing homes and its implication for staff’s care approach, it is argued that each unit manager is the one who sets the tone of the ward. However, each shift makes its own impression on the tone, and this is seen, for instance in the staff’s behaviour and interaction with the residents, and in interaction between staff and the residents’ families (Gústafsdóttir, 1999). In accord with these findings my understanding is that the atmosphere on the ward...
is like a circle or chain, where the chain is no stronger than its weakest link, and the one is dependant on the other. In a preface to the AACN Clinical Issues in August 2001, where the issue is work environment, Disch states as a guest editor that the importance of attending to the culture and tone of the work environment cannot be overstated, as Rosenstein (2002) learned in his study on the nurse-physician relationship.

In his survey, Rosenstein (2002) assessed how nurses and physicians viewed the relationship between these distinct groups. It was reported that, although only a small proportion of physicians were reported to exhibit disruptive behaviour, both physicians and nurses agreed that this influenced attitudes of both nurses and other staff members toward patient care, and inhibited teamwork (Rosenstein, 2002). It may be said that those few persons set the tone of the ward, as this often leads to confrontation and unease among those working closely with these persons, and it can cause widespread frustration among staff members, who question why the service tolerates such behaviour. In this dissertation I want to join them in their question, as I consider what the experience of staff nurses and head nurses is, of empowering and disempowering atmosphere in the ward environment on inpatient wards.

2.7 Summary

After my literature review it seems to me that nurses still need to dedicate much energy to their survival and well-being in organisations. However, there is an optimism in the most recent literature, and it seems as if new ways are emerging which should give nurses ‘self-organisations’, so they can devote more of their energy in the future to their co-workers and patients. In the next chapters I will describe how in the present study I will access nurses’ experience of ward atmosphere and its meaning in their work.
3. Research design: methodology and methods

3.0 Introduction

In order to address my question, of what is the experience of staff nurses and nurse managers of empowering and disempowering atmosphere in the ward environment in inpatient wards, I conducted a phenomenological study using dialogues with co-researchers. In this chapter I will outline my research perspective, the methodology that is based on the Vancouver school of doing phenomenology, methods of data collection, ethical issues and the trustworthiness of the study.

3.1 The research perspective and approach

The issue work environment has been studied mainly from the traditional quantitative-research standpoint, and the attitude or meaning that the experience of work environment has for the employees has received less attention from
researchers. In this study the issue will be examined from the viewpoint of phenomenology, whose aim is a deeper understanding of human phenomena.

Colaizzi (1978) believes that the traditional quantitative method is promoted by a technological lifestyle that seeks to dominate, control, and make more efficient. In the predominant health-care management situation, the emphasis is on making less more efficient, through reducing staffing ratios and other savings. However, Drucker (1992) notes that 'there is nothing less productive than making more efficient that which should not be done at all' (p.198).

Reducing staffing ratios may be an effective approach, measured by quantitative standards. What is the nurses' experience and what meaning does it have for nurses? It may be possible that nurses' experience could, through phenomenological approaches, elucidate understanding that could lead to more effective methods. In sociology, phenomenology has been used to explore the events of human interaction and the meanings that the structure of organisations have for the employees (Omeray, 1983). Therefore, it should be possible for phenomenology to give valuable knowledge of the meaning of ward environment for nurses. Moreover, Omery (1983) states that, as long as an experience has meaning, the potential is there for the phenomenological method to be utilised. Although the phenomenological tradition is a varying one it is a unique philosophy, which provides a methodology for studying the lived experience of human beings (Halldórsson, 2000).

Phenomenology is a philosophical approach, which derives from research into the essential questions of ontology (the nature of being) and epistemology (the nature of knowledge) (Thorne, 1991). Its primary premise is that the most basic human truths are accessible only through inner subjectivity (Burch, 1989). Phenomenology seeks a shared and deep understanding (Lawler, 1998). Phenomenological research approaches neither seek for generalisation nor for universality, but focus upon unique human experience whilst recognising the
possibility that unique human experience might also be shared human experience (Little, 1999). It does not deny that such things as process might be discovered, but phenomenology does not assume that processes exist before they are described (Omery, 1983).

3.2 Methodology: the Vancouver school of doing phenomenology

Lawler (1998) maintains that in phenomenology there is a gap in the transposition of philosophical systems of thought into methodologies for the field of nursing research. However, Halldórsdóttir (2000) has by means of the Vancouver school of doing phenomenology bridged this gap between philosophy and research practice. That is one reason why this study will be guided by the Vancouver school. Moreover, Lawler (1998) points out that to have achieved a working understanding of different and difficult influences and concepts such as ontology, epistemology, and their relations to methodology in interpretive paradigm is a struggle for most students. Halldórsdóttir (2000) has delineated clearly the philosophy and methodology, and built up the research process in twelve basic steps which are:

- Selecting dialogue partners (the sample).
- Preparing for dialogue (first, there is silence).
- Participating in a dialogue (data collection).
- Beginning data analysis (sharpened awareness of words).
- Beginning consideration of essences (coding).
- Constructing the essential structure of the phenomenon for each case (individual case construction).
- Verifying the single case construction with the co-researcher.
- Constructing the essential structure of the phenomenon from all the cases (metasynthesis of all the different case constructions).
- Comparing the essential structure with the data.
- Identifying the over-riding theme, which describes the phenomenon (interpreting the meaning of the phenomenon).
- Verifying the essential structure (the findings) with some research participants.
- Writing up the findings.

(Halldórsdóttir, 2000, p.57)

Halldórsdóttir (2000) emphasises that the seven basic stages in analysis, *silence, reflection, identification, selection, interpretation, construction and verification* are indeed a process, as they are entered into again and again throughout the research process (p.56). Halldórsdóttir (2000) provides accurate instructions on the twelve steps and the basic stages and theoretical underpinnings of data analysis, which were followed in conducting this study. The analyses carried out are outlined in chapters 4.3 and 4.6.

The Vancouver school is not the only way to do phenomenology: it is one route to follow, and it is a route that suited my research question well. This methodology of having a dialogue with co-researchers through bridge-building and the process of verification in the dialogical situation fits my philosophy in gaining deeper understanding of the question of the life world of the nurses and what it means to be a nurse in the ward environment. Moreover, in the analyses the identification of how each concept is related to another, and the case construction for each dialogue partner/group, fitted the present research question. Additionally, in the Vancouver school each dialogue partner is called a *co-researcher* and the researcher’s construction is verified with each one, which emphasises each participant’s voice (Halldórsdóttir, 2000).

The Vancouver school is an interpretation of phenomenological philosophy and is essentially an interpretive/constructivist school. It is primarily influenced by Spiegelberg, Ricoeur, and Schwandt. It stands for moderate realist ontology, a
transactional epistemology, and a hermeneutic, dialectical methodology (Halldórsdóttir, 2000). Lawler (1998) maintains that phenomenology remains fixed in the modern period and does not allow for the influences of multiple subjectivities, multiple realities or the problematic of discourses. However, the Vancouver school of doing phenomenology insists on such flexibility.

Taylor (2002) states that the great challenge of the century is that of understanding the other. Gadamer's model, the fusion of horizons, bridges both knower and known. The horizon is at first the way that each individual has of understanding the human condition. The fusion occurs when one (or both) undergoes a shift; i.e. the horizon extends to make a room for a new object (Taylor, 2002). The Vancouver school emphasises this important point (Halldórsdóttir, 2001a).

3.3 Methods of data collection, sample size and selection of co-researchers

In discussing how health-care culture can be understood, Nordstrom and Allen (1987) recommends that an appropriate instrument for the cultural survey in health care organisations should be designed and tailored to fit the needs of the particular institution. However, in order to be able to conduct a survey, some basic items about the phenomenon must be known in order to design the instrument. Phenomenological study could be an approach to get to know those items. Participant observation is another method to share people's experience. The strategy is inductive and the observations could be used as a starting point to formulate hypotheses (Waddington, 1994).

Participant observation requires reasonable access, that the research problem is observable, and that the research setting is sufficiently limited in size and location for it to be effectively observed. Research settings inevitably vary in

Atmosphere in the ward environment - Chapter 3 – Methodology and methods
the extent to which they are open or closed off, and sometimes they incorporate offstage regions, which are of interest (Waddington, 1994). The intention in the present study was to use nurses' experience as a window to the ward environment, and the Vancouver school of doing phenomenology with its bridge-building between researcher and co-researcher fulfils that goal.

In qualitative studies data collection needs to be efficient because large amounts of data are gathered from small numbers of individuals (Morse and Field, 1996). This entails that those individuals who are involved are those who can best inform the researcher about the phenomenon under investigation, give the broadest range of information and express their experience as they live it in their everyday life (Colaizzi, 1978). Furthermore, enough data have to be gathered from the individuals to provide full and rich description, and the process should ideally continue until no new data emanate from undertaking further interviews. The principles of data sampling in qualitative research are therefore appropriateness and adequacy (Research Methodology Study Guide p. 51). In the present study both individual and group dialogues (focus groups) with co-researchers were used for data collection, which is in accordance with the Vancouver school. The sample size and selection of co-researchers is discussed in more detail in chapters 4.1 and 4.2.

The advantage of using a dialogue group is the use of group interaction to produce data and insights that would be less available without the interaction found in a group (Morgan, 1988). According to Benner (1994) such dialogues should take place between the co-researchers themselves, rather than between co-researchers and the interviewer. However, dialogue groups may be inhibitory (Little, 1999) and so there were also individual dialogues.

Benner (1994) outlines the purpose of the focus group (dialogue group) in interpretive phenomenology in the following way.
• They create a natural communicative context for narratives from everyday work, allowing participants (co-researchers) to talk to one another as they ordinarily talk rather than translating their clinical world for the interviewer.
• They provide a base for active listening when more than one listener is trying to understand the story.
• The meaning of the stories can be illuminated by stories triggered to counter, contrast, or bring out similarities.
• The small group discussions (dialogues) are reminiscent of the work environment

Probes are used to fill in unclear aspects or details of the story, and allow the dialogue partners to stay in the situation and expand their understanding. The aim of the researcher is to empower the speakers to tell their story in their own way (Benner, 1994). The interview with co-researchers departs from focus group interviews insofar as it is conducted between the researcher and a single respondent.

3.4 Ensuring the rigour or trustworthiness of the study

Sandelowski (1993) maintains that it is most important to recognise the complexity of trustworthiness. Moreover, a research product that is easily read, convincing or probable has trustworthiness. To achieve trustworthiness, researchers need to monitor ‘what is going on’ throughout the whole research process using a reflective journal (Koch and Harrington, 1998, p.882). The reflective journal is discussed in more detail in chapter 4.3.

According to the Vancouver school one factor in achieving trustworthiness is to have the researcher’s interpretation verified during the dialogues. Moreover, during the analysis phase the interpretation should continually be questioned...
(Kvale, 1989). Each case construction should be verified with relevant co-researcher. The final analytic framework should also be presented to some chosen co-researchers for identification of their lived experience (Halldórsdóttir, 2000). However, according to Koch and Harrington (1998) it is an argued technique, and Sandelowski (1993) maintains that it may cause as many problems as it solves. Kristinsson (2001) maintains that it is the co-researchers' ethical right to verify their experience and withdraw information.

Additionally, to assure trustworthiness is to have preferably two dialogues with each co-researcher. Moreover, to have the dialogues to take place on a basis of equality, by showing each co-researcher confidence, respect and willingness to listen, and presume that the co-researchers are telling the truth (Halldórsdóttir, 2000). Permission from the co-researchers to audiotape the dialogues needs to be obtained, and the dialogues should be transcribed directly in order to ensure verbal accuracy (Koch and Harrington, 1998). Writing down the research report should be done in such a way that it is true to the experience of the co-researchers (Halldórsdóttir, 2000).

### 3.5 Ethical issues

Respect and protection of co-researchers' and researchers' responsibilities and obligations is the main issue of ethics. The researchers must safeguard the autonomy and confidentiality of the co-researchers and are obliged to protect the co-researchers' interests. The researchers are responsible for obtaining freely given and informed consent from each co-researcher. It is important that the co-researchers are in possession of all the relevant information necessary as their rights to withdraw at any point during the study. Moreover, that they are given the opportunity to ask questions and receive honest answers (Kristinsson, 2001). It is important that the researchers acknowledge that the ways they present their findings involves moral choices (Sandelowski, 1993). The
researcher's challenge is to maintain discretion and confidence and to be cautious in management of information (Kristinsson, 2001). Further ethical considerations concerning the present study will be discussed in more detail in chapter 4.5

3.6 Summary

In this chapter the research perspective, methodology, methods of data collection, trustworthiness and ethical issues have been outlined. In the next chapter I will clarify my data collection and analysis.
4. Data collection and analysis

4.0 Introduction

In the following pages I will explain how I collected and analysed my data. My experience of going through the research process can be compared to a time of change in organisations and management. While the changes are taking place the organisation is disrupted due to the effects of conflicts that ensue from the decisions of change. It is during this disrupted phase that the opportunities for change exist, before the organisation gradually takes on a new form. I experienced a similar process as I carried out this phenomenological study. From the time of participating in the first dialogue until the end of the discussion chapter, I experienced first that the dialogues dissolved during my analysis, and that gradually the phenomenon emerged and solidified. This chapter describes this research process.
4.1 Access to the sites and permission to collect data

The setting for this study included two of the largest hospitals in Iceland. The data collection consisted of dialogues with four nurse managers and four dialogue groups (focus groups), each consisting of three to four staff nurses. In one of the hospitals I contacted the Chief Nursing Executive to approach my co-researchers, and to ask for advice on whom I should contact for permission to conduct the study. At the other hospital I have been an employee more-or-less since my graduation, so I knew whom to contact and simply informed the Chief Nursing Executive about my study.

4.2 Choosing the sample

My main rationale for selection of co-researchers (dialogue partners) was the following:
As I wanted to attain a deeper understanding of the phenomenon ward atmosphere, and to avoid homogeneity, I decided to include nurses from different types of wards and to have dialogues with both nurse managers and staff nurses. I matched the wards in both the hospitals in deciding which wards to select. Furthermore, the nurse managers with whom I had dialogues had to have at least two years’ experience as nurse managers. Every co-researcher had to have experienced empowering and disempowering atmosphere in a ward where she was or had been working, and be willing to have a dialogue with me about her experience (Halldórsdóttir, 2000).

I contacted the nurse managers by telephone and requested their participation. Then I sent them an introductory letter (appendix 3) and an informed consent form (appendix 4) and contacted them again, and we decided on a time and place to meet. The same procedure was followed with the dialogue groups. I contacted the nurse managers on the dialogue groups' wards, and they pointed
out a staff nurse in their ward with whom I could make contact. That nurse in turn selected the other nurses to be included in the dialogue group. After this selection I contacted every nurse in the dialogue group by telephone, after which I sent an introductory letter (appendix 5) and informed consent form (appendix 6). All the co-researchers were women, and their experience ranged from one year as a nurse to being close to pensionable age.

4.3 Before entering a dialogue and the pilot study

The first step in the process of doing a study according to the Vancouver school is silence, which is re-entered again and again (Halldórsdóttir, 2000). In this silence I reflected on my own preconceptions about the phenomenon, and wrote them down in my reflective journal. Gadamer states that ‘we inherit particular parameters of interpretation, or a particular background, through the history of the society and culture we belong to’ (Arnswald, 2002 p.35). As I am a nurse manager and the issue under study is closely related to me, I found it important to understand my history or knowledge of the past in order to be able to undertake the encounter with the others and reach further understanding, knowledge and a common ground. The reflective journal, which is a kind of a diary, was one way of doing so. I recorded a variety of information about my own reflections, discussions with colleagues and friends, and lectures that I had attended relating to the phenomenon. In my reflective journal I also noted down comments about the literature I was reading, and on doing phenomenology. I drove to the north of Iceland to reach my co-researchers, about five hours’ drive; I used the time to dictate my thoughts about my experience of the phenomenon and the procedure of the study. I also used that time to listen to the dialogues, and that drive was like entering another world; the landscape was beautiful, quiet and inspiring.
The first interview was meant to be a pilot study. However, my co-researcher and I easily achieved the bridge-building that Halldórsdóttir (2000) explains in her methodology, and my co-researcher opened up her 'world' and made it accessible to me. During the process of living with her data and transcribing it, and during its analysis, I realised that it was a dialogue that gave deep understanding of the phenomenon. I therefore decided to use that dialogue as part of my study. That dialogue taught me a lot about conducting the subsequent dialogues.

4.4 Data collection and concerns

All of the dialogues took place at the hospitals in a quiet room, with the exception of one dialogue that was conducted at a co-researcher's home, and another conducted over the telephone. The use of audio-tapes, and destruction of the tapes following completion of the study was discussed and agreed with each co-researcher. Each dialogue started as a mere chat with coffee, and then gradually the topic was approached. The experience is not regarded as being fixed in time, so I began each dialogue on 'neutral ground' by asking the co-researchers to reflect on their experience of being a nursing student in a ward. Then I asked them if they had experienced ward atmosphere that made them think that this was a ward they wanted to work on, because they experienced an empowering atmosphere, or if it made them think that they did not want to work there because they experienced disempowering atmosphere. From this point the dialogues evolved back and forth in time, around the experience and the meanings attached to the phenomenon, now and at the time of the experience.

I approached the dialogue groups in the same way as I had the nurse managers, with the exception that I asked the staff nurses to discuss the phenomenon as if they were sitting in their coffee room talking. Sometimes I felt as if they had
forgotten my presence, but occasionally they wanted me to join in their discussions; this, however, was the exception.

All together there were nineteen dialogues, nine with nurse managers and ten with dialogue groups. The second dialogue with the nurses from the dialogue groups was conducted with one or more nurses from each group, because of their time constraints. During the second meeting we continued to have a dialogue about the phenomenon. Furthermore, I brought my notes with me and we discussed unclear points from previous dialogues. The dialogues took from twenty minutes to three-and-a-half hours.

One of my concerns is that when I had the dialogues with the dialogue groups the staff nurses could have been influenced by each other, which might have hindered them in expressing their experience as freely. Little (1999) points out that focus groups may be inhibitory when seeking to encourage personal disclosure. With three of the four groups I had the feeling that my co-researchers wanted to give a positive image of the atmosphere in their ward, but that there was more to be said. Sandelowski (1993) points out that people may strive to be accepted as respectable people. My feelings were confirmed when I had a second dialogue with a staff nurse from one of those groups. She mentioned that in the previous dialogue in the group she found it difficult to mention a particular experience when the other nurses were listening. A nurse in another group expressed a negative viewpoint in the second dialogue - when she was alone with me – which had not emerged in the dialogue group. A nurse in the third group said that the nurses in that group had still had the 'sweet taste in their mouth' from the dialogues when they came back to the ward (they wish to present themselves favourably). However, my experience was that the groups made their world gradually more accessible to me during the dialogues.
4.5 Ethical considerations

My first step in the research process was to gain permission from the research ethics committees of the hospitals involved (appendices 7 and 8). Moreover, I sent a notice to the Data Protection Authority (appendix 9), which granted permission, and an enquiry to the National Bioethics Committee, which replied that I did not need its ethical clearance to perform the study (appendix 10). Each dialogue started by each co-researcher and myself signing a consent form, after I had informed them about their rights and my obligations, explained important issues of the study to them and answered their questions.

As Iceland has a small population, the possibility of tracing the co-researchers' identity was always in my mind. Therefore I found it very important to carry out the dialogues in more than one hospital. I tried not to be seen at the wards, or to mention to anyone which wards I had selected. I gave each nurse a pseudonym, which I use in presenting the findings, and I will destroy the key to the names when the dissertation process is over as emphasised by Kristinsson (2001). I typed up all the dialogues myself, so nobody else had access to them.

In the research process I needed to take several more considerations into account regarding ethical points. I needed to ask myself where I, as a researcher, draw the line regarding how deep I am allowed to probe, and when I may be 'encouraging emotional pain' (Smith, 1992). Moreover, I considered what I should do with information about legal discrimination. I had also considered the question of what I should do in case of verification where the co-researcher wished to retract or alter information previously provided. No such case occurred, however, in carrying out this study.
4.6 Data analysis

In my data analysis, which ran concurrently with the data collection, I tried to be true to the basic steps of the Vancouver school of doing phenomenology (Halldórsdóttir, 2000). I was very concerned about living with the data during analysis, typed all the interviews, read the transcripts over and over again and listened to the tapes several times. It is part of involving the hermeneutic circle of grasping the meaning of a phenomenon by understanding the parts and the whole (Halldórsdóttir, 2000). I have been trying in my studies to understand what it means to apply the hermeneutic circle. The building of the Relationship model, which is part of my findings and which I present to facilitate the understanding of the ward atmosphere, explicated for me exactly what it means to involve the hermeneutic circle of grasping the meanings of a phenomenon by understanding the parts and the whole.

I analysed the transcripts from the dialogue groups in the same way as the other transcripts. Krueger (1998) emphasises the importance of analysing focus groups systematically, and I found that the basic steps in the Vancouver School fulfilled that need. In writing the transcripts I used bold type and underlining to capture the mood of the discussions. I did not encounter any particular difficulties, apart from the fact that the transcripts were long and very rich in content, and took me much longer time to analyse than I could ever have imagined, although this had been predicted in the literature (Krueger, 1998). Some themes were more complicated to interpret than others. I took those themes and explored them through using the Vancouver school basic stages. It could be a long detour, for instance regarding the subject of irritation, chapter 5.4.1.a. Some themes I lived with for weeks before I reached an understanding. In that process it was important to extend the horizons (Taylor, 2002) and be ready to hear something new (Halldórsdóttir, 2000).
In the coding phase of the research process I wrote themes in the margins of the transcript of each dialogue. Then I took sheets of paper and wrote down the themes, and from those themes emerged key statements or main themes. Then I grouped the main themes and related them to each other, and constructed the essential structure of the phenomenon. This construction became a picture or a model. I verified the single case construction with each nurse manager in the second dialogue and some of the staff nurses in the discussions groups. It took a long time to construct the metasynthesis. One of the case constructions crystallised the phenomenon, and I used that case construction or model as a framework. However, the hermeneutic circle has not yet come to a complete stop in my mind.

The overriding theme emerged, although the research process continued. I wrote the findings chapter initially in English, and had a meeting with two co-researchers for its verification. They said they were satisfied with the results. Then I rewrote the findings chapter in Icelandic, as I felt I reached a deeper understanding by writing it in Icelandic. Then I mailed out the draft summary along with a stamped envelope to every co-researcher - a total of nineteen - for verification, and to give them access to what has been made of their experiences, and invited them to comment by phone or in writing. The accompanying letter is presented in appendix 11. I received two envelopes back with comments, and those co-researchers said they were satisfied. I find that I am not finished with this phenomenon, and there is a lot more to understand.

4.7 Summary

In this chapter I have delineated my research journey; by explaining access to the site, my choice of the sample, the first steps of the study process, data collection, ethical issues and lastly data analysis. Now it is time to present the findings.
5. Presentation of findings

5.0 Introduction

The aim of this study was, by the approach of qualitative methodology, to gain a deeper understanding of what constitutes the ward environment, with special emphasis on the ward atmosphere and its empowering and disempowering structures.

The findings indicate that the ward atmosphere is multi-faceted, and cover many issues that have emerged generally within nursing and management theories and writings. However, it can be said that they are presented here from a different viewpoint, as this is a phenomenological study and, I believe, present a new understanding of the phenomenon.

In the presentation of the findings, firstly the ward environment as it is revealed in the study, comprising ward atmosphere and ward structures, will be explained. Secondly, an idea will be given of how some of my co-researchers experience the ward atmosphere. Thirdly, the ward structures in the ward environment will be mentioned briefly. Fourthly, the emergent main theme of
the phenomenon ward atmosphere, relationships, will be depicted using a model called ‘the Relationship Model’. The model is part of my findings and I constructed it from the data in order to enhance the understanding of this complicated phenomenon and its meaning. Fifthly, the essential structure of empowering (see fig. 2-A appendix 1) and disempowering relationships (see fig. 2-B appendix 2) will be discussed, briefly due to constraints of time and space. Finally, a summary of the findings will be presented.

In my presentation of the findings, those people with whom I had dialogues are termed co-researchers, in keeping with the methodology I apply. This entails that all the information is derived from the co-researchers, while it is my role as researcher to interpret that information and present it in accessible form.

All references to the co-researchers are in the feminine (‘she’), as all are women. The co-researchers have been allotted pseudonyms derived from the famous people.com website. A team is a group within the ward which I perceived as working as an energetic group of people who are committed to attaining common objectives, who work well together and enjoy doing so. A discussion group comprises three to four staff nurses with whom I had dialogues, and formed a discussion group from the same ward. A nurse manager is the head of the ward.

The co-researchers state in the dialogues that there is a good ward atmosphere on the wards where they now work. In my view, they are thereby expressing a sense of responsibility for the ward atmosphere. A case in point is nurse manager Kate (see below), and the same applies in the discussion groups, when they speak of motivating themselves, working with themselves and improving their manner and communication, due to tension relating to their work.

Findings indicate that the ward atmosphere is a ‘vulnerable dynamic phenomenon’, i.e. that the ward atmosphere is constantly fluctuating within the.
Relationship Model, between an empowering and disempowering ward atmosphere. Also those small fluctuations can entail major changes in the ward atmosphere. Co-researcher Kate is conscious of this, and speaks of always having to ‘fill up the cracks in the ward atmosphere,’ which is the crux of the matter. When individuals motivate themselves, they are ‘filling up the cracks’. This contributes to making the empowering atmosphere a self-renewing phenomenon.

5.1 Ward environment on an inpatient ward: ward atmosphere and ward structure

I wish to start by explaining that, according to my interpretation of the dialogues with the co-researchers, the ward environment comprises two factors: on the one hand the phenomenon *ward atmosphere*, which is the main focus of this study, and on the other hand what I call the *ward structure* (the nurse manager, the individual), which is discussed in section 5.1.2 (see fig. 1, p.37). In accord with this interpretation, the true ward atmosphere is the intangible in the ward environment, which is crystallised in the *wellbeing, strength and confidence/lack of confidence* of the individual/team.

To explain further, the ward atmosphere and ward structure may be likened to ice and water. We can count the number of ice cubes, and we can remove them with our hands, but we cannot count the water or remove it in our hands. In this context, I refer to what has sometimes been said: that the ward atmosphere is ‘in the walls of the ward’, and that changes of staff make little difference.

5.1.1 The phenomenon ward atmosphere on an inpatient ward

In this section my co-researchers, who have given much thought to the phenomenon *ward atmosphere*, will explain how they experience the
phenomenon, and describe how strength is tied into the phenomenon ward atmosphere. Nurse manager Kate uses a metaphor:

I feel that the ward atmosphere is like a life-egg (fjöregg) \(^1\) ... if I lose it I feel I will be finished ... And I’m afraid I will miss something that’s happening, so I have ‘deputies’ whom I trust to ‘take the pulse’ ... I must be on the alert... I feel it’s terribly important to nurture the ward atmosphere, no less than the professional side. Of course the professional work is of enormous importance, but I feel I have to protect the ward atmosphere - because my worst nightmare is that the ‘life-egg’ as I call it should be broken. ... And I’m striving to bring it here [the ward was moving to new premises]. And I feel it’s up to me to bring the ward atmosphere with us, to bring this phenomenon that we don’t know what is. ...

In terms of Maslow’s hierarchy of needs, Kate perceives the ward atmosphere as coming before the professional work in the pyramid when she says it would be her worst nightmare if the ‘life-egg’ should be broken. Kate also said that the ward had a long history, a heritage that she wanted to preserve in the ward, as she saw this as one aspect of development.

Nurse manager Monica describes her experience of the ward atmosphere in the following way:

It’s really just a question of timing ... And it’s the same in all relationships, naturally, sometimes I’m more polite and courteous, and sometimes not ... Sometimes it’s appropriate to behave a bit badly, and sometimes it’s appropriate to be more serious, and of course that’s what you learn, and teach yourself, and what has been taught over the years. ... It’s having a sense for what’s appropriate at the time ... And I have tried to keep my ears open; I’ve tried to listen for when it’s appropriate to talk to people or with people, and when it’s appropriate just to stay silent with people ... So a lot of it is a matter of training ... And most of it is a matter of listening - people tell you so many, many things, and you may not notice because you’re not listening well enough.

\(^1\) In Icelandic folklore, the fjöregg (life-egg) is an egg that contains the life-spirit of the creature. If the life-egg breaks, the creature dies (Arnason, 2002).
**Ward environment on an inpatient ward**

ward atmosphere and ward structure

![Diagram showing the relationship between empowring atmosphere, ward atmosphere, and disempowring atmosphere.]

**Ward structure**
- Nursing manager
- The individual (employee)
- The team
- Unexpected events on the ward
- External events
- Gender mix
- Nursing structure
- Patient group
- Patient and/or family
- Disciplines in the team
- Grass-roots/physician dominated environment
- Nursing roles/physician-extender roles
- Type of ward

**Fig. 1.** The ward environment consists of the ward atmosphere and the ward structure. The nurse manager is often mentioned as an important structural factor in the ward atmosphere on an inpatient ward. The ward structure supports the ward atmosphere, allows it to develop, which provides security, strength and wellbeing, among the personnel, to meet their work demands. In some cases the ward structure has a negative effect upon the ward atmosphere. In that case the individual, and even the team, is uncomfortable, lacks confidence and has little strength to deal with her/their tasks.

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Monica is telling us here that the ward atmosphere is in fact a process which many have been working on gradually through their lives, by working with themselves. She points out that we must be aware of our role as individuals in the ward atmosphere. The ward atmosphere does not come out of nowhere, but is contingent upon our willingness to listen, and build up and promote relationships. Our willingness to listen also puts across the message that we care about the person in question. Monica too talked about heritage, but in her case her heritage as an individual, her background and that of the people she had worked with, not the heritage of the ward or the institution, as Kate emphasised. In the Vancouver school it is emphasized precisely that the individual sees the world in light of his/her prior experience and his/her own interpretation of that experience, which in turn shapes how the individual sees the world and lives his/her life.

Sandra, staff nurse, said of her experience of ward atmosphere:

I couldn’t survive if the ward atmosphere were bad ... I’d rather have a heavy workload and a good atmosphere than an easier workload and a bad atmosphere.

Sandra is of the same view as Kate, that the ward atmosphere is a prerequisite for being able to do the job, the energy that gives her impetus in her work.

Sally discussed the strengths of the ward atmosphere on her ward, which had experienced extensive changes in a short period:

I think we’ve sailed through those stormy seas, and few fell overboard ... A positive workplace - nothing’s ever hard there, however much there is to do - no day is ever insurmountable. A co-researcher in another discussion group was of the same view: Here we are still, although various things have happened to us, and I think it simply shows what a good, strong unit we are, having each other (Brinley).
Anyone who has sailed on stormy seas is familiar with the sensation of being overwhelmed with nausea, even the feeling of wishing to vanish into the sea. Struggling to keep the ship on an even keel, as I interpret Sally's experience, makes great demands on the individual and the team, if all are to be brought home safely. Here it is the ward atmosphere which provides security, strength and wellbeing to meet those demands.

5.1.2 Ward structure on an inpatient ward

The ward structure (see fig. 1, p.37) has an influence upon the ward atmosphere at any time; it supports the ward atmosphere, allows it to develop, or in some cases has a negative effect upon the ward atmosphere. I shall here briefly discuss the principal structural factors mentioned by the co-researchers:

1) The nurse manager is often mentioned as an important structural factor in the ward atmosphere on an inpatient ward. For examples:

   *it all comes down to the nurse manager (Laura)... she has such charisma (Sally) ... When the nurse manager came in like a storm cloud I felt paralysed, I felt she was in a bad mood ... if she smiled the atmosphere improved ... at weekends when she wasn't there, the atmosphere was better (Betty).*

Sally's nurse manager is charismatic - like the sun. Betty's nurse manager brings a storm which makes Betty incapable of doing her job, paralysed with fear and insecurity due to the impending storm. Betty also mentions that the nurse manager has only to smile for the sun to start shining; the weather is also fine when the nurse manager is not present. Betty's remarks highlight the vulnerability of the ward atmosphere - a smile can change the ward atmosphere of the day. Anne mentioned that the nurse manager needed to have 'warmth,' indicating again the nature of the environment. If the environment is warm, the staff will be comfortable. Anne spoke of the nurse manager’s understanding giving warmth, and Betty mentioned warmth and a pat on the back.
2) Empowering or disempowering individuals within the group, e.g. leaders who strengthen the group, or team destroyers, perhaps with symptoms of burn-out or a poor self-image, whose negativity infects the group:

... I worked with one icicle; she had a lot of difficulty with human relationships ... everybody freezes a bit ... they're always grumbling. (Anne).

The environment of an ‘icicle’ is like a freezer. The cold makes the staff uncomfortable, and they find it hard to move. All the energy of the individual/team is devoted to staying warm while the icicle is nearby, and so it is difficult for them to do their work.

3) Gender mix in the team. The co-researchers felt that having a man on the team had a positive effect. They felt that men seemed to break up patterns that might have formed in the team, for instance with regard to backbiting.

4) Occupational groups in the team. Are there only staff nurses on the ward, or also practical nurses, unskilled staff and physicians? Where there are many occupational groups, there is a tendency towards tension and hierarchy, and negative effects upon the ward atmosphere (see below).

5) Patient group and type of ward: psychiatric patients, children, elderly people, casualty ward, etc.

... it is more difficult to maintain a good ward atmosphere on geriatric wards, where the same patients stay for years - it's more of a strain ... a lot of people prefer dealing with illnesses rather than old age (Laura).

6) Physician-extender roles, nursing roles: is the ward a physician-dominated environment, or does it operate on grass-roots philosophy? In the physician-dominated environment, the physician is the focus: staff wait for the physician to arrive in order to give instructions, physicians bear more
responsibility, lay down rules. The environment is more hierarchical. A different vocabulary is used from that of the grass-root, and there is a tendency towards passive-aggressive conduct in the team. In the grass-root structure, all are equals: staff, patients, their relatives; all are supposed to take part in teamwork and decision-making, and the team shares responsibility.

7) **Unexpected events on the ward**, such as the sudden death of a patient, can be disruptive to the individual and the team. Britney recalled one such event:

> I remember how our confidence - I remember how terribly poor it was in many of us at that difficult time ...

8) **External events** such as a strike by practical nurses, or merger of hospitals. When unavoidable outside pressure is experienced, there is a risk that the work of the ward will be undermined and become disorganised. This is a test of the ward atmosphere. Ingalill said that it was due to the positive attitude of all the staff that she did not resign when the practical nurses were on strike.

9) **Nursing structure.** Co-researchers said this could be restricting. They mentioned that group nursing prevented holistic nursing, as mentioned by Susanne:

> Going from room to room making beds is awfully wearing [with reference to group nursing in practice] ... It's a pity, sometimes you don't get a chance to use your training (Sandra).

Structural factors can strengthen or undermine the ward atmosphere, and are thus discussed in the context of ward atmosphere. In the next section the overall view of the theme of ward atmosphere will be discussed with reference to the Relationship Model which I have constructed, revealing further how structural factors strengthen or undermine the ward atmosphere.
5.2 A holistic view of the phenomenon: the Relationship Model

The phenomenon *ward atmosphere* emerged from the main theme *relationship*. From this main theme my analysis yielded a holistic view of the phenomenon, which I call a *Relationship Model*. With the Relationship Model I constructed a framework and context for this complex and multi-faceted phenomenon. After considerable thought, I decided to link my principal conclusions to the Relationship Model.

The model is one whole, but consists of two diagrams which are meant to represent the two opposite poles of the phenomenon. Both poles of the phenomenon are based upon the main theme *relationships*; with the essential structure comprising *empowering relationships* on the one hand and *dismantling* on the other. The meaning of the relationships for the individual/team emerges in the wellbeing, strength and confidence of the staff in their work. Figs. 2-A and 2-B (appendices 1 and 2) explain the model.

5.2.1 The ward atmosphere; a vulnerable dynamic phenomenon

The findings indicate that the ward atmosphere is a vulnerable dynamic phenomenon, in which the dynamics are an indicator of the personnel’s wellbeing, and their sense of security and strength as a team in dealing with their appointed tasks. The ‘vulnerability’ of the ward atmosphere signifies that little change is required within the Relationship Model in order to cause considerable change in the ward atmosphere. This vulnerability also reflects the importance of each individual within the whole. The phenomenon may be likened to a mobile: if we touch any part of the mobile, the whole mobile goes into motion.

To say that the ward atmosphere is ‘dynamic’ signifies that it is in constant motion between the opposite poles of the phenomenon, i.e. empowering and
disempowering. By examining movements within the model (between A and B), it may be possible to assess the wellbeing of the team, its confidence in its work, and its strength in dealing with its tasks. The structure (individual/team/nurse manager) influences these movements, as stated above and the individual’s/team’s motivation.

‘It’s the last straw that breaks the camel’s back’. Betty describes fluctuations between poles A and B as she gives an account of her relations with her nurse manager deteriorating (fig. 2-B), as she perceived the nurse manager as ‘tactless bitch’ who would snap at her for no reason. Their relationship changed, however, becoming more cyclic or self-renewing (red arrows in fig. 2-A), and coming closer to pole A, when the nurse manager showed courage and began working with herself and recognised faults in her own character. The nurse manager’s changed behaviour led to an improved relationship, which had a chain effect. After the nurse manager began changing her behaviour Betty started to put herself in the nurse manager’s place, and gained more understanding of their relationship. Betty stopped taking the nurse manager’s moods and conduct personally, gained more confidence, and started to feel much better at work. This example demonstrates that the nurse manager, like all the other members of the team, must be in the self-renewing part of the Relationship Model. Everyone must make a contribution, and relationship is a two-way street.

5.2.2 A self-renewing phenomenon generates an empowering ward atmosphere

Diagram 2-A is a concept of a cyclic or self-renewing relationship, evolutionary and sustainable, and not least generating an empowering creative relationship. This means that the team/individual is comfortable and has strength and confidence at work, because the relationships entail open interaction, care and
an overall view, and are based on a *reflective approach*. Monica describes the crux of the matter:

*Life is in constant motion, and if you want to take part in life, you're in motion.*

Monica is also making the point here that we must make a *conscious decision* as to whether we want to be in motion. To be in motion means to be a participant in life on the ward, to share responsibility for 'filling in the cracks' that form in the ward atmosphere, and to ensure that the self-renewing cycle continues.

An empowering ward atmosphere means the following for the individual/team:

- self-confidence/self-knowledge
- team work
- individual responsibility
- shared responsibility
- positive attitude/enjoyment/interest
- stamina

- high standards
- pride
- tolerance
- grassroots feeling
- patients' safety

The relationships in the cycle are kept self-renewing by the individual/team consciously working to motivate and improve relationships, being sensitive to relationships and conscious of them, and having the will to develop relationships and work to build them up. Building up relationships entails that the individual/team is motivated to *listen, think* (reflect), *learn, gain experience* and team members experience and provide *support/friendship*, which gives them the possibility of reflection.

Nurse manager Monica describes how she builds up relationships and keeps the self-renewing cycle going:

... *sometimes I'll predict something that happens later...* On the occasions I've been able to predict something like that, it's been the
times I've been lucky enough simply to listen to what people said to me. I often don't listen at work, because there are so many people talking to me at the same time, there's so much going on. But I usually listen really well on the way home, and on the way to work in the morning. ... On the way home I'll think about what people were saying to me - I don't necessarily grasp what they mean until I think about it afterwards, and then it's 'Wow, so that's what she meant.' And on my way to work in the morning I'm preparing for the day. ... My colleague and I, we often talk about things, and she's got some problem, or I have, we talk, and consider the situation, and even act out the situation.

The motivation means that the individual can have control of her relations, that she has understanding and is autonomous in relationships. She is proactive in preparing the way for ongoing relationships; her relationships evolve and are self-renewing.

5.2.3 A stagnated phenomenon with dead ends and no process generates a disempowering ward atmosphere

Fig. 2-B depicts stagnated relationships with dead ends and no process. The individual, and even the team, is uncomfortable with these relationships, lacks confidence and has little strength to deal with her/their tasks. This may lead to resignation by members of staff, and in the worst case to the ward closing down.

A disempowering ward atmosphere means the following for the individual/team:

- lack of confidence
- anxiety
- tension
- anger
- fatigue
- negativity
- conflict
- breakdown
- isolation
- irritation
- hurt feelings
- sadness
- lack of concentration
A disempowering ward atmosphere is not self-renewing but stagnated; the individual/team is reactive, which means she is not working consciously to improve and promote relationships. The individual/team is insensitive to relationships. The motivation discussed above, to keep relationships going, is lacking. Relationships have a tendency to leave loose ends, even to be closed off, and come to an end.

In the following I shall discuss the essential structure of the phenomenon with reference to the dialogues, in order to increase understanding of my interpretation. Due to lack of space, only a few examples will be taken.

5.3 The essential structure of an empowering atmosphere

In this section, empowering relationships on an inpatient ward - pole A in the Relationship Model - will be explained. The main themes comprising empowering atmosphere are interaction, reciprocal care and an overview.

5.3.1 Interaction is a key aspect of relationships

5.3.1a Open interaction, frankness and trust, with a touch of humour

Interaction includes such factors as open, frank debate taking place when some problem arises in the team, when someone is discontented, and no less when someone is content. Interaction crystallises to some degree in the word we or the word collaboration, instead of using you and us. In a team where interaction is empowering, there is mutual understanding, even to the degree that members of the group do not need to ask for help or explain the situation; action is taken to do what is necessary and resolve the situation:
When the workload is heavy the staff nurse who is with me comes in and takes over the tasks she can see I cannot cope with. She knows I'm not having a coffee break or on the phone, but that I have very demanding patients, and it's no problem. You don't have to ask, there's simply an understanding (Hillary). Alice adds: the ward is at its best under pressure.

The co-researchers’ interaction with physicians and practical nurses sometimes reflects a 'you/us' attitude. Objectives, practice and responsibility are unclear, and this can lead to tension. The team has to accustom itself to the special needs of some physicians, and sometimes they do not know what to expect in their interaction with physicians. Practical nurses may be working in a world of their own, without taking part in collaboration with staff nurses. This leads to stress and insecurity, and the team's energy is dissipated in difficult interaction, instead of caring for the patients. The co-researchers said that the nurse manager played an important role in prompting open interaction, and no less in setting an example of open interaction.

The co-researchers felt that using humour made a contribution to the job, that it was a means of dealing with problems, creating job satisfaction, and some said that humour enabled them to deal with the new day. Individuals do not take themselves too seriously, and try to see the funny side of things which may be tedious and exhausting.

On the other hand the co-researchers’ experience was that too much cheerfulness and laughter could be offensive when overheard by patients and their families, and that humour could meet with a cool reception when inappropriate.
5.3.1b  Respect, tolerance and equality

When a new member arrives on the ward – a student or inexperienced nurse – respect is shown if the person is accepted with her own level of experience and knowledge, and with understanding of her situation as the ‘new girl’. The co-researchers mentioned cases of practical nurses they remembered for showing them respect and tolerance, in spite of their lack of knowledge and experience. The co-researchers said that they showed respect for themselves, for instance, by daring to emphasise what they did well.

When staff are examining the work schedule to see who someone is working with that weekend or the next evening, or who is working with whom, not everybody is equal. When the nurse manager and an ‘inner circle’, as discussed below, discriminate between individuals, creating inequality or privileged status for some, this encourages insecurity and undermines the self-confidence of those who are not among the chosen few.

5.3.1c  The information system keeps the team in touch, on the inside and the outside

Information and instruction are a part of respect, acknowledging the importance of the team. An information system improves collaboration, promotes an overview and sense of context, and improves nursing and the connection with the work of the ward and the institution as a whole.

Monica mentioned an occasion on which neither she as nurse manager, nor other members of staff, had known of important decisions until several days after they had been implemented. Her experience was:

I'm insecure, I don't know what's going to happen .... Ashly described a similar experience ... we were just thrown into it - we hadn't been given any training, and we became insecure, feeling we couldn't take care of the patients.

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Monica says that she does not know what is going to happen. The context of events is not clear to her. If the information route, or the need for information, is unclear, this leads to insecurity and isolation, the feeling of not being a participant in the work or part of the whole.

5.3.2 The importance of reciprocal care

This theme was important to the co-researchers, and hence I will devote more space to this than to other themes.

5.3.2a Never being alone - Solidarity in the team

The sense of never standing alone is important, one of the most important factors in an empowering ward atmosphere; the team always has the sense of comprising individuals who are there for each other. The co-researchers often seek help from each other, there is a remarkable helpfulness (Alice), and within the team there is a will for everyone to do her best, and for each individual to have the opportunity to thrive.

We're rushed off our feet, but everyone's prepared to give a bit of time to help - it's great, that's what I like. We're not off each doing our own thing (Alice).

There is an atmosphere of mutual care; the members of the team have a sense for the wellbeing of the others, both with regard to work and their private lives, although they leave their problems behind in the dressing room. The members of the team are considerate of each other, show thoughtfulness by giving each other time. If someone makes a mistake she is helped through the experience, not penalised. For such a team, work is enjoyable.

One of the discussion groups mentioned that the nurse manager sometimes interacted negatively with the staff. In spite of this, the discussion group said that the ward atmosphere was good; they said that this was thanks to their being
supportive of each other, and also due to the encouragement of the patients and their families.

I don’t think it’s necessarily management or the boss who has a positive effect on the atmosphere, but my equals—they are always giving you a pat on the back, which I’ve never experienced before, so you just feel comfortable at work—you’re always being asked how it’s going—by your equals or colleagues—and then you feel good (Michele).

Nurse manager Kate gave priority to the staff being able to take coffee- and meal-breaks together—even if only for five minutes—as otherwise the group does not achieve a sense of solidarity. She mentioned this as one of the ward’s objectives, and a condition for a good ward atmosphere. To take a break together is as important as working together. It keeps the team going:

If it doesn’t work [taking coffee/meal breaks together] that’s a black mark for me... we managed it today, and everyone mentioned it. That’s one good day... it gives us nourishment (Kate).

The team experiences the feeling that ‘we’ have achieved something, which creates solidarity in the team.

Solidarity also entails understanding and empathy, knowledge of each other’s strengths and weaknesses; the members of the team are responsible for each other and support each other.

If we’re called in for an extra shift, you don’t just think ‘no, I can’t be bothered to work,’ you think I wouldn’t like to be on the other side of the table, if nobody is prepared to take an extra shift, and I think I can manage that, and I go and do the shift. (Courtney).

On all the wards, there was great emphasis on meeting outside work. This is one aspect of encouraging solidarity. One co-researcher said that she had not been accepted by the team until they went out together.
5.3.2b  Reward, praise and feedback

Reward, praise and feedback are among the energy sources in an empowering ward atmosphere. To receive neither good nor bad marks is like being invisible; it causes disappointment and reduces the will to achieve, reduces motivation. In the above-mentioned case, Kate received a ‘good mark’, the approval of the staff, which is her reward. The staff mentioned it, and this was her feedback. This reassures her that she is doing the right thing and doing it well; she receives praise from the team, and the energy and motivation to continue.

Reward is one aspect of motivation, and also contributes to promoting self-confidence. Sandra here describes the opposite, when promised reward for an unreasonable workload and disruption of shifts, is not forthcoming:

They [the management] trample on you, and promise and promise.

Encouragement and praise are also used by the co-researchers as a buffer, if one of the team is upset or distraught. Unhappiness and fatigue are catching if a little ‘buffer’ is not poured over them.

5.3.2c  A positive attitude leads to a chain reaction

The conduct of the staff affects the team’s wellbeing, and their ability to do their work. Interactions at shift changeover (report), the way the ward has been left, and the behaviour of those giving the report illustrates empowering or disempowering relationships:

Whether the ward welcomes you to work ... Not leaving the medications cabinet in a mess, emptying the rubbish before you go (Hillary) ... the mood of the people who are giving you the report - when the night shift are in a bad mood, and start by taking it out on you ... that's bad (Sally). Then you have a bad feeling right through the shift. You feel as if you've been kicked ... (Hillary)

Courtney said it was quite a balancing act, requiring a lot of practice, to gain the strength and courage to see one’s own faults; and it requires a great and
constant effort to change one's behaviour building, up positive attitudes, or as I state it in the model, to build up a self-renewing relationship. It is the same rule as applies to 'filling in the cracks'.

Kate spoke of serenity, recognising one's powerlessness and doing so with dignity, being oneself. To have serenity is to be strong, having self-confidence, courage and self-respect. One of the discussion groups said:

\[\text{... We know our own limits, and we dare to admit it, and that means}\]
\[\text{that co-workers and patients can trust what we say.}\]

The chain-reaction is seen for instance in tolerance, which makes a positive impact on the atmosphere. The co-researchers said that when they were new to the ward, or students, they had been especially attuned to tolerance.

A discussion group said that the assistant nurse managers on the ward had learned patience from the nurse manager, and nurtured it. Like master, like man, said Alice, who agrees with the idea of chain-reaction. Hillary agreed:

\[\text{The nurse manager supports us, and we automatically support others}\]
\[\text{as we have been supported ... It's great that we look so much to each}\]
\[\text{other for help ... And everybody's so positive when asked.}\]

The reward is job satisfaction, which is obvious here.

5.3.3 An overview is the prerequisite for progress

5.3.3a A vision of the future, objectives and context

Setting objectives, both short- and long-term, following through and seeing results, is development:

\[\text{...we're building up such a strong team, and doing so much for the}\]
\[\text{ward, that I'm sure people will be lining up to work with us. Yes, the}\]
\[\text{ward's objective is to be a sought-after ward to work on} \text{(Sally).}\]
This team is working for open interaction, a positive attitude, giving new members a good reception, learning to give praise, to ‘do unto others as you would have them do to you’ and build up the individual in the team, to name but a few aspects.

The individual gains an overview in various ways; one nurse manager said that the team sometimes thought she was clairvoyant, because she could sometime foresee things. She herself felt that she had simply developed the ability to listen, and pointed out that there is something behind the silence, so one must listen to the silence also (Monica). To listen to oneself is to use oneself as a barometer said Kate.

An unhappy team cannot see itself in the future.

It’s sad not to see any future ... We need to help staff to see themselves in the future (Monica).

A nurse manager explained how interaction with her superiors had cut her off from the future, making her insecure, so that she could not see herself as part of the team in the future.

On some wards work is devoted to planning and a vision of the future and objectives, subject to constant revision and criticism. On other wards little attention is paid to this, and co-researchers talk of promises being broken – of there being no time to look up or look around, being stuck in the same rut, and of lack of development. The co-researchers are of the view that there is a good ward atmosphere if the team is developing, and in motion. In section 5.4 the opposite situation will be discussed, stagnation, when relationships are subject to a disempowering ward atmosphere.
5.3.3b Filling in the cracks

In section 5.2.1 the ward atmosphere was discussed as a vulnerable dynamic phenomenon, which means that by its nature the ward atmosphere is subject to constant erosion, and must constantly be renewing itself. It is a never-ending development task to deal with the work of filling in the cracks (Kate), strengthening the ward atmosphere. Nurse manager Kate has consciously found various ways of ‘filling in the cracks,’ i.e. monitoring and managing organisation and the wellbeing of the individual/team on the ward. She delegates responsibility for this work by using ‘deputies’ who help her take the pulse. For this purpose the deputies use the empowering aspects of the Relationship Model, i.e. listening, thinking, learning, support/friendship and their experience and sensitivity, and to be aware of their environment.

The ‘deputies’ inform the nurse manager, who applies appropriate measures to ‘fill in the cracks.’ This involves such measures as discussing the issue at a staff meeting, and sharing responsibility. In section 5.3.2. an example of a ‘crack’ was discussed: staff could not take coffee- and meal-breaks together. Before long the team had attained its objective and received the benefit, which was a source of energy for the self-renewing system.

With the approval of the entire ward, one of the ‘deputies’ was made an official leader on the ward. This means that she is trusted by most of them, threatens no-one, has the role of supporting the nurse manager and the team, and has more responsibility for the wellbeing of the staff. In order to fulfil this task she was given authority to ‘fill in the cracks’, by resolving problems on the spot, taking them to the nurse manager or following them up at staff meetings.

Kate described her feelings when she made one of the ‘deputies’ a formal leader on the ward, which in practice is a recognition of the fact that the nurse manager cannot always be responsible for everything:

It was a certain relief, because sometimes you feel you’re suffocating, feeling that you have to be everywhere at once.
When I looked for leaders, and informal leaders, on other wards, it transpired that they are found on most wards. They were sometimes described as people with a comfortable presence and self-confidence - as people who do not take part in making problems, but in solving them. They are not, however, generally recognised by the nurse manager and the team as leaders, and hence good use is not made of them, i.e. in collaboration and support for the nurse manager and the team. It is worth considering whether the informal leaders are not a factor that should be brought out, in order to strengthen the ward atmosphere. Such unrecognised informal leaders were from various different groups within the ward: a practical nurse, a medical secretary or a staff nurse.

5.3.3c Letting off steam and reflection

The co-researchers discussed the need to let off steam, in order to work through and rid themselves of events that trouble and disturb them, in order to receive support and take stock and promote solidarity. For this they tend to use the report, although this is not a recognised forum for this.

Purging your mind before you go home (Hillary). And you spend time talking - we have to have that - it promotes solidarity and makes us a team (Alice).

The team, individuals within the team, or the nurse manager, may be used as a safety-valve; the individual meets trust and understanding, and feelings of discontent do not spread in the group or to the patients:

It's just this group [the team] that understands (Ashly) ... You often need to let off steam, but the next day you don't want a fuss made about what was discussed. It's just a matter of letting off steam, and then the issue cools off ... just being able to clear it out ... just someone to listen, and a bit of feedback (Sally).

Section 5.2.2 dealt with the importance of listening to oneself and to what others have said, which is one aspect of reflection. Difficult interaction can upset the individual for the rest of the day, making her frowning and unhappy.
She can unconsciously spread her unhappiness to others unless she stops, listens to how she is feeling, and thinks it's OK to smile (Sally), and accepts help to do so.

Kate spoke of being:

busy doing nothing and you have to re-set the head-piece when you find you're getting slow ... I'm afraid we get stuck in our ruts ... under supervision we learn to stop and think, but then you take the risk of being overwhelmed by something bad ... In supervision you get an hour to take stock - it's hard work. But if you just go on and on, then you don’t have to keep stopping and taking stock. You can just go on until you burst like a balloon.

Kate describes here what happens if the team/individual does not stop to tie up loose ends, to consider what is being done, where the individual/team is heading, and where she/it wants to go. If this is not done, there is a risk of staff becoming unproductive, and dull and desensitised to the environment.

The co-researchers felt that it was important not to be making all one’s feelings public and that it was necessary to have a confidante, who would respect confidentiality, to talk to and reflect with.

5.4 The essential structure of disempowering atmosphere

Disempowering relationships on a inpatient ward -- pole B in the Relationship Model - will be discussed here. Due to lack of space, I shall seek to emphasise those disempowering relationships which have not been discussed as contrasts in the section on empowering relationships. The main themes in disempowering atmosphere are lack of caring, obstacles, a breach with the environment and backbiting.
5.4.1 Lack of caring deters relationships

5.4.1a Destructive responses generate stagnated relationships

Uncaring, tension, lack of consideration and misunderstandings between individuals in a team and between occupational groups can lead to destructive responses, deter solidarity in the team and even prevent interaction. This emerges, among other things in irritation, annoyance, nagging and nasty remarks (Jennifer). Irritation is due to something provocative and uncomfortable, perhaps totally unrelated to the ward environment. But the target is the team, which suffers for it. In sports, if a team is being attacked, it employs a defensive strategy. The co-researchers describe the same response. If they are attacked or ambushed, there is a risk that the relationships will be in the form of defensive responses and tension. This deters further communications, relations are cut off, the issue is never properly discussed and leaves loose ends to get in the way of the individual/team, which may trip over them or even fall.

Sandra’s relationship with a physician illustrates destructive responses such as tension and defensiveness instead of interaction. A misunderstanding occurs, and the interaction produces destructive feelings – anger, hurt feelings, misery.

... I paged the doctor and he said ‘I’ll come when I’ve eaten’, and that was about six. Then he arrived at nine and I hadn’t changed anything. He went berserk in front of the patient, went crazy, he said ‘what the hell is this supposed to mean? and everything was crazy, and you know you just go tachycardic and go red ... and I was so frustrated I went into the nurses' station and swore and cursed him ... someone had seen what happened ... ‘Susanne, dear, you mustn’t take it personally, it’s happened to lots of us before ’ ... and it’s so helpful that there’s so much solidarity in the team.

This is a typical example of interaction where both parties are on the defensive, and finish up with bad feelings, not discussing what happened, or what could
have been done better. In addition, a third party, who is reliant upon these 'colleagues,' is a witness to their rather irresponsible interaction. Nobody learns from the interaction, and everyone is unhappy. Susanne is grateful to have her team as back-up in order to be able to cope with the rest of the shift.

Sally had the experience of someone setting her petrol tank on fire, as she put it so well when describing how she reacted with anger in inconsiderate interaction. She decided to make use of this error, and said:

**We must know our own reactions**

She determined to learn by the experience, learn to know her own reactions so that she could control them, so that she would not have to repeat the experience of having someone 'set her petrol tank on fire'. She started working her way towards pole A of the Relationship Model, and building up herself and her relationships. The ward atmosphere can be explosive, sensitive, and some small thing may spark off a conflagration that requires great energy in a short time.

**5.4.2 Obstacles deter relationships**

**5.4.2a Loose ends in a ward organisation**

Where obstacles prevent interaction, this leads to *loose ends*; unwritten rules are not discussed, division of work and responsibilities between occupational groups is unclear, and there is a lack of professionalism and development. These loose ends around the ward delay and hinder the staff in their work and development. They lead to *insecurity, apathy, distrust, tension and anxiety*. In general, staff nurses do not speak of physicians as part of the team, and practical nurses often go their own way.

Unclear division of duties is sometimes a reason for tension between staff nurses and practical nurses, and between practical nurses and unskilled staff. It is also unclear between these occupational groups who is in charge of the nursing, and whether responsibility is vertical or horizontal. Staff nurses see
practical nurses as perceiving nursing management as horizontal, but responsibility as vertical, i.e. they do not feel that the staff nurses are in charge of the nursing, but that they are responsible for it. This leads to insecurity in the relationship between these occupational groups. The practical nurses form their own team on the ward, which does its work, with little consistency or collaboration with the work of the staff nurses. The co-researchers mentioned cases where unclear division of tasks affected the patients, in an apathetic attitude, which tends to occur when responsibilities are unclear.

An excessive workload and undermanning, which may be one aspect of reactive response and lack of organisation, has a disempowering effect, and is passed on to those who arrive for the next shift, and even those who are not at work at the time. Reactive response is when decisions are made ad hoc as situations arise; problems are constantly being solved on a temporary basis. This prevents professional development of the team. There is a lack of vision of the future, and this leads to unnecessary stress, anxiety and insecurity. The team’s energy is dissipated, instead of being used for nursing and professional development, as Sandra said:

I feel as if we are always finding temporary solutions ... sorting something out ... just emergency measures ... you're always in a hurry ... it's a chronic problem in the institution (Michele) ... every weekend you can expect a call asking you to work (Sandra).

Lack of management leads to discontent:

I sometimes feel I'm not doing anything properly (Sandra). ... all the uncertainty breaks you down, all of us said Monica.

Loose ends do not necessarily mean that the ward is falling apart. It is interesting that, even if members of the team say that there is a good ward atmosphere, a new arrival may receive the opposite impression. She may feel
uncomfortable, not be welcomed into the team, and be ignored. When the co-
researchers recall what it was like to be new, insecurity and loneliness resound:

I was simply left to cope, a third-year student (Monica) .... It was like
a cut to the heart - I was all alone on the first day: 'hey, am I
supposed to be alone on a full ward'? (Michele)

5.4.3 A breach with the environment deters
relationships

5.4.3a Isolation, loneliness and an ordeal by fire
The experience of being isolated on one's work arises, among other things,
from lack of time during the working day to sit down and bond with other
members of the team - and one nurse manager placed emphasis on the team
being able to take meal- and coffee-breaks together. It may also be unpopular
for the report to be prolonged in 'informal chat' as report is not acknowledged
for 'letting off steam'. In addition to this, staff are bound by confidentiality, and
hence cannot discuss the events of the day with family or friends and do not
have the opportunity for reflection.

The sense of being of no importance to the ward, or the institution, being
invisible in the crowd, gives rise to a sense of loneliness. Sandra describes a
strong sense of this:

I think it's an incredibly closed world, I sometimes feel I've got to get
out, get free of it ... sometime I don't look out of the window all day, I
see only people who are ill, people in white coats ... it's as if you never
have time to think of anything other than work ... you're such a tiny cog in
the wheel.

On the contrary nurse manager Kate said that she had learned to use the view
from the window, which had helped her, by being a window to the outside from
her isolation.

Atmosphere in the ward environment - Chapter 5 - Findings
The co-researchers likened entering certain teams with an ‘ordeal by fire’ in which the individual has to prove herself as a person. Sally spoke of a time when a new person joined the ward, and she herself committed the fault of not liking the new arrival much:

I looked at her [the new arrival] askance, without knowing her at all

This could be characterised as prejudice. After this, Sally said she had got talking to the new arrival on night shift, and seen her in a different light, and formed a good opinion of her; Sally is here moving into self-renewing relationships as shown in the Relationship Model. Sally thought afterwards:

You always, always fall into the same trap. We all agree we should give new arrivals a good reception, but we always look at them askance and don’t give them a chance.

5.4.4 Backbiting spreads like wildfire

5.4.4a Everyone falls into the same trap

The co-researchers recalled their experience as students or new members of staff on a ward, and their sensitivity to the ward atmosphere. Jennifer took the example of a ward she had been looking forward to working on as a student. She said:

... I was so distressed ... I was so glad when I had finished working there - not that I felt people were unpleasant to me personally, but there was so much backbiting - it was incredible - both about visitors, patients and colleagues. It was very uncomfortable to be there - you felt that, the minute you walked out, they would be talking about you, as about others ... So everyone gets very insecure and defensive .... I would never have wanted to work there, because of that.

Jennifer said that two staff nurses on the ward, who were familiar with everyone and everything, had encouraged backbiting; when one was working,
or both, everybody fell into the same trap. I asked her what the nurse manager did about this conduct. It transpired that the nurse manager was not highly visible on the ward, and this supports the co-researchers' view that the nurse manager is an important structural factor. It also illustrates the role of the nurse manager in setting a framework, and ensuring that it is respected.

When negative remarks are made about a patient at report, such as she's been ringing her bell all evening (Alice), there is a risk that this will lead to ongoing negative behaviour and talk by the team. Alice said:

It's also a bad habit, picking on patients.

As mentioned above, backbiting is often initiated by two parties. In this context the co-researchers spoke of informal groupings within the team; they call one of these groups the inner circle; this is the group which decides which members of the team are the elite. To me this has the same meaning as a clique, a small, closed group – and hence it exemplifies the opposite of open interaction and team solidarity. Alice commented:

It's not necessarily a good thing if some group likes you. I regard it as a certain mark of distinction for myself, not to be accepted by them.

One may ask why people feel the need to backbite and have an inner circle, and why this is tolerated on a ward which believes itself to have a good ward atmosphere. Is this a matter of poor self-image, a symptom of burn-out, or is the nurse manager failing to tie up loose ends?

Sally and Hillary said they did not have the courage to counteract backbiting, fearing that this would rebound upon them:

Somehow I didn't feel able to say, 'Let's stop talking about her behind her back'. I stood up and turned sideways to them, because I'm so
fond of the person they were gossiping about - but I didn’t have the
guts to say it ... and I suddenly had a feeling of suffocation, and goose
pimples (Hillary) .... It’s the participation in bad behaviour on wards,
you join in talking about someone, to please someone else (Sally).

Backbiting gradually leads to disunity on the whole ward and solidarity ceases
to exist. Michele spoke of a ward where backbiting had led to discord on the
ward, as well as causing additional stress. It had caused difficulties which led to
loss of trust:

Because you didn’t know if you could trust people, you dared not bond
with them.

It should not be forgotten, however, that disunity can also be a result of another
structural factor than the team, such as a patient or family member. This makes
demands upon the understanding and strength of the team. Kate says:

We all know cases of the old lady who’s always ringing her bell, and
says ‘you’re so nice to me, but that one’s nasty’ and you think ‘Why
can’t she take care of her, and what happened yesterday’? And
nothing happened yesterday in fact. You started to mistrust your
colleagues, you observe them to see if they really aren’t taking care
of the old lady, and the old lady heaps praise on you, and you feel
[falsely] good about yourself ...

Co-researchers on one ward said that backbiting received no response, and so it
did not spread. People were allowed to let off steam for two minutes, after
which someone would put them on the back and say you’re having a bad day -
you’ll feel better soon (Sally). Here again we see the importance of a colleague
being prepared to listen, which in this case prevents bad feelings spreading.
5.5 Summary

The findings indicate firstly that the ward environment may be seen on the one hand as structure of the ward, and on the other hand as the ward atmosphere. Structure of the ward environment comprises the individual/team, the nurse manager, and other temporary factors. The team may be the cross-disciplinary group which works on each ward, but is more often only the staff nurses, or sometimes the practical nurses, on the ward. Physicians are not usually perceived as being part of the team.

Secondly the findings indicate that the ward atmosphere may be defined by the theme ‘relationships’ and is a vulnerable dynamic phenomenon, which needs constant attention. This means that it is in constant motion between two poles, of empowering and disempowering relationships. The ward structure influences this motion; the individual makes a difference to the whole.

The findings also indicate that empowering relationships are self-renewing, as the individual/team involved in empowering relationships is constantly developing her/its relationships. This gives the potential for control of relationships, which are proactive, are developing and are autonomous. The individual is sensitive and aware of relationships. This emerges in the confidence of the individual/team, in well-being and the strength to do one’s work. The essential structure of empowering relationships consists of open interaction, reciprocal care and overview.

In the fourth place the findings indicate that disempowering relationships are moving in the direction of stagnation, and no process, as the individual/team is not building up relationships. She/it is not in control of the relationships, and does not have an understanding of them, and relationships are reactive. The individual/team is not sensitive to relationships, not aware of them, and relationships are in danger of coming to an end. This is revealed in the
insecurity of the individual/team, unhappiness and lack of strength to undertake one's work. The essential structure of disempowering relationships is lack of care, obstacles at work, a breach with the environment, and backbiting.

Lastly, according to my interpretations an empowering ward atmosphere is the prerequisite for professional work: the wellbeing of staff, their sense of security and their strength to perform their work.
6. Discussion, implications for practice, limitations and further research

6.0 Introduction

This phenomenological study was conducted in order to gain a deeper understanding of what constitutes the ward environment from the nurses' perspective, with special emphasis on the ward atmosphere on inpatient wards in two the biggest hospitals in Iceland. The purpose was to understand the dimensions of this phenomenon and its empowering and disempowering structures. The results should be interpreted within the limits of the timeframe of the dialogues and the experience of the nurses, and are therefore not meant to give generalised knowledge.

Based on the analysis of the dialogues the ward environment is constructed of ward atmosphere and ward structures (see fig. 1, p.37). The interpretation of the dialogues with the co-researchers indicates that the ward atmosphere is a vulnerable, dynamic phenomenon, which needs constant attention. The main theme of the phenomenon is relationships, and it extends from a self-renewing empowering phenomenon to a stagnated disempowering phenomenon with dead ends and no process. To facilitate understanding of these results, they are
presented in a model called the Relationship Model (see figs. 2-A and 2-B appendices 1 and 2). *The essential structure* of an empowering atmosphere according to my interpretation is constructed of:

- open interaction
- reciprocal care
- opportunities and holism

The essential structure of a disempowering atmosphere is constructed of:

- lack of caring
- obstacles in the ward environment
- a breach with the ward environment
- backbiting

In this chapter I will discuss my understanding, interpretation and construction of the nurses' experience of what constitutes the ward atmosphere on an inpatient ward. Time and space constraints of this study allow only main themes to be elucidated.

### 6.1 Ward environment on an inpatient ward: ward atmosphere and ward structure

In the present study the ward environment is constructed of two factors, *ward atmosphere* and *ward structure* (see fig. 1, p.37). The main focus of this study is the *ward atmosphere*, which is the intangible part of the ward environment. The nurses elucidated their experience of ward atmosphere by stressing that it was the most important aspect of the ward environment - its life (*fjöregg – life-egg*\(^2\)), which they needed to safeguard. Some even maintained that they would rather have a heavy workload and a good atmosphere than an easier workload and a bad atmosphere.

\(^2\) See p. 36.
This interesting finding also emerged from a study of work excitement among nurses in Iceland. Regardless of difficult work environment, it was negative attitudes among staff which nurses found most wearing. The researcher concluded that this indicated that people are more tolerant of a heavy workload on wards if the work atmosphere is good (Jónsdóttir, 2001).

According to the co-researchers the ward atmosphere crystallises in the well-being, strength and confidence/lack of confidence of the individual/team. Their experience was that in a positive workplace, where the team spirit is strong, nothing is insurmountable. The findings of a study of workload and job satisfaction among Icelandic nurses indicated similar results, that it was important to nurses to feel confident at work (Biering and Sveinsdóttir, 2001b). This emphasis on confidence also emerged in research on the effects of unit morale on conflict on an inpatient ward. The findings explicated that nurses were less satisfied on wards with high uncertainty, instability, and variability (Cox, 2001).

The structural factors can strengthen or undermine the ward atmosphere, which means that they enable or hinder the work to be accomplished. Many co-researchers expressed the view that the nurse manager, one of the structural factors, was a major, or even the major, factor in work atmosphere. This is consistent with many other studies and with various writings on management (Laschinger et al., 1999; Chiok Foong Loke, 2000; Koivula et al., 2000; Cook, 2001). But not all the co-researchers were of the same view. In cases where the nurse manager did not have an empowering effect, or was even likened to a storm cloud, or a charismatic leader who misused her power as discussed by Sankowsky (1995), the team’s solidarity and reciprocal care meant that nurses nonetheless felt happy in their work.

The division of the ward environment into ward atmosphere and ward structure is exemplified in the statement that ward atmosphere adheres to ‘the walls of
the ward', and changes of staff (ward structure) make little changes in the ward atmosphere. In their explication of complexity science\(^3\) for health care, Zimmerman et al. (1998) talk about division in the environment of organisations, which is comparable to the division in the ward environment in the present study.

6.1.1 A holistic view of the phenomenon: the Relationship Model

To facilitate understanding of this complicated phenomenon, ward atmosphere, I constructed a model, the Relationship Model. The model is one whole but consists of two diagrams which are meant to represent the two opposite poles of the phenomenon. Both poles of the phenomenon are based upon the main theme relationships with the essential structure comprising empowering relationships on the one hand and disempowering on the other. Hence one may perhaps maintain that relationships are in a sense the core of the work environment; several writers have highlighted the importance of relationships in the workplace (Adams and Bond 2000; Abramowitz, 2001; Farrell, 2002).

The components presented in the Relationship Model are not new in themselves. However, what is new, I believe, is the linkages between and among the components and the overall flow or dynamic of the process through the image (presented with red arrows in fig. 2-A). The culmination of the model is the essential structure that either empowers or disempowers the nurses in their practice.

To consider relationships as a main theme more closely: Ray et al. (2002), in their research employing grounded theory, studied the result of organisations

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\(^3\) Complexity science is the contrast to that when phenomenon follow determined process. Complexity science predicts about phenomenon viability and their possibility of renewal (Walsh, 2000).
being driven by economic survival. Their findings revealed that the core
category was of losing trust. However, they emphasised that constructive
human relationships can be rebuilt, which I interpret to mean that trust is the
foundation of relationships. Drucker (1999) points out the importance of trust
and maintains that organisations are built on trust and taking responsibility for
relationships is an absolute necessity. According to these authors, one may infer
that relationships based on trust are the core of the work environment.

6.1.2 The ward atmosphere; a vulnerable dynamic
phenomenon

According to my understanding of the dialogues the ward atmosphere is a
vulnerable dynamic phenomenon. The vulnerability of the ward atmosphere
means that even a small change in relationships can cause considerable change
in the ward atmosphere. With small changes the ward atmosphere fluctuates
between the two poles of empowering and disempowering atmosphere. This
vulnerability emphasises how the structural factors can strengthen or undermine
the ward atmosphere and enable the work to be accomplished, or hinder it.

Rosenstein (2002) reached the same conclusion in his study of interaction
between physicians and nurses. The conclusion is that disruptive behaviour of a
small percentage of physicians suffices to affect their colleagues’ attitudes
towards patient care and inhibits teamwork, affecting the efficiency, accuracy,
safety, and outcomes of care. The present study, however, indicates that
negative attitudes are not only caused by interaction with physicians, but that all
the occupational groups on the ward appear to play a part. Moreover, the
vulnerability also reflects the importance of each individual within the whole;
some authors have pointed out the importance of the individual in the team
(Neubauer, 1995; Taborda, 2000). The dynamic factor signifies the movement or fluctuation between the
empowering and disempowering poles in the Relationship Model. In discussion
of this dynamic system and vulnerability it has become popular in the literature to express it as the ‘butterfly effect’. The meaning is that if a butterfly flaps its wings today, the tiny changes in air pressure will eventually lead to a hurricane at some future point (Walsh, 2000; Haigh, 2001). The difference between the butterfly effect and the vulnerable dynamic of the ward atmosphere is probably that in the ward the hurricane comes sooner rather than later. This emphasises that the structural factors that undermine or strengthen the ward atmosphere are not just the employees, as in many organisations, but also the patients and their families (Aroian et al., 1996).

6.1.3 A self-renewing phenomenon sustains an empowering ward atmosphere

Diagram 2-A depicts the nurses’ experience of an empowering ward atmosphere, which emerges as self-renewing relationships, i.e. evolutionary and sustainable, based on motivation and reflection. Moreover, through the self-renewing relationship the nurses develop personally and professionally.

Neubauer (1995) maintains that practising reflection is one method to change adult behaviour. Moreover, it prepares people to act on problems and issues facing them and gives the opportunity to learn about them, which is also an issue in empowering relationships. Gage (1998) calls the sustainable relationships ‘team spirit’, which she maintains is a result of passion rather than delegation. She talks about nurturing the relationships as a repetition process, and I call these self-renewing relationships, and maintain that as the relationships develop the foundation becomes firmer.

In present study some nurses pointed out that everyone must make a conscious decision as to whether they want to take part in life, be in the self-renewing cycle and help maintain an empowering atmosphere. Ray et al. (2002) emphasise this point by claiming that to take part in life is an ethical choice for
nurses. This is also recognised by Goleman (1996), who maintains that one point of view may well be inborn, but that positive viewpoints can also be learned. That means that every individual is responsible for what he/she learns concerning relationships and behaviour.

The nurses' experience is that in the self-renewing phenomenon they can have control of their relations, they are autonomous and proactive in preparing the way for ongoing relationships, their relationships develop and the self-renewing cycle continues. I want to point out this important element of being proactive. In an article about nurses' dissatisfaction, Kjartansdóttir (1999) maintains that nursing administration is solving the problem of nursing shortage by reactive projects, which is the opposite of being proactive. She maintains that such reactive projects not only misuse nurses but are also unsuccessful emergency measures. The co-researchers mentioned these unsuccessful emergency measures as part of disempowering atmosphere.

Kjartansdóttir (1999) maintains that the reason for reactive behaviour among nurses is that nurses are co-dependent, and there are some authors who agree with this (Thorsteinsdóttir, 1998). I interpret this disempowering behaviour as lack of management, when the nurse manager and the employees feel overwhelmed by their workload and cannot keep on top of their work. Covey (1990) points out that our behaviour is a function of our decisions, not our conditions. Proactive culture can be created within the organisation, he maintains, and in the present study I call it a self-renewing phenomenon.

The nurses characterised the ward atmosphere on an inpatient ward as vulnerable, because there are many structures in the work environment which put a strain on it. The work atmosphere is thus in a constant process of 'natural' breakdown. One of the nurse managers is conscious of this 'natural' breakdown, and strives to maintain the ward atmosphere, which she calls
'filling in the cracks'. Zimmerman et al. (1998) talk about this 'crumble phase' as a creative destruction phase, and maintain that it indicates potential for a period of high innovation, new insights and opportunities. Porter-O'Grady (1990) calls it life-giving energy. This effort is also one aspect of development: one nurse manager speaks of pausing to take stock. Pausing to take stock may be likened to the 7th habit of Covey (1990) (from the book The 7 Habits of Highly Effective People), which he calls 'taking time to sharpen the saw', and which he asserts makes all the other habits possible i.e. that it is the groundwork in the ward.

6.1.4 A Stagnated Phenomenon with Dead Ends and No Process Generates a Disempowering Ward Atmosphere

The opposite pole to empowering atmosphere is a disempowering atmosphere; a stagnated phenomenon with dead ends and no process (see fig. 2-B). This ward atmosphere is quite uncomfortable according to the nurses; the individual/team lacks confidence and has little strength to deal with her/their tasks.

A newly-qualified staff nurse expressed her feelings of isolation, hurt and disappointment. I interpreted this to mean that she was on the edge of the disempowering pole. Because she felt unhappy in the work atmosphere she met on the ward, her energy was utilized for her own survival, and hence there is little or no energy left for her colleagues or patients.

Halldórsdóttir (2001b) considers power as a kind of energy, which can be used for good or ill. Where does that energy come from? The new nursing graduate's account indicates in my interpretation that she has been 'stripped' of all her energy. She is disempowered because somebody else has been in need of her energy. She is a young, vulnerable, immature nurse whose source of energy is
easy to approach. What that nurse needed, when she began at the ward, was to be empowered, to be given energy. Instead her energy resources were emptied. The people who drained her of her energy did not do it consciously. That is what the disempowering pole of the Relationship Model emphasises. The people in the disempowering atmosphere are not aware of the meaning of their behaviour. They are probably insensitive to relationships. Their relationships are stagnated, and they disempower others who either allow themselves to be disempowered – it is rare for them do anything about it - or move on to another ward. This young nurse said that she could not survive in a bad atmosphere, and I feel that this indicates that she is inclined to leave her job.

6.2 The essential structure of an empowering atmosphere

As mentioned previously, ward atmosphere is based upon the main theme of relationships and either empowering or disempowering essential structure. Kanter maintains that power comes from structural conditions as formal and informal power (Laschinger, 1996). In the present study the self-renewing empowering phenomenon emerges from personal characteristics; which means that the individual’s motivation or power comes from her/his will to listen, think, learn, experience, provide and have support/friendship - and be aware. This is the crux of the matter according to the present findings. People who are motivated and optimistic keep on going in the face of tough times. They see failure as being due to something that can be put right, improved and changed (Goleman, 1996). It is known that each small adversity mounts up and leads to deterioration in the atmosphere. This is why it is so important to nurses to establish internal harmony and ‘fill in the cracks’ which form in the ward atmosphere. In my understanding structural conditions in the organisation are not enough, as Kanter (1977) presents power to promote an empowering atmosphere; the individual’s own motivation and reflection must also play a
Neubauer (1995) also points out that it is the individual who has to change how he perceives others and works with them.

### 6.2.1 Open interaction is a key aspect of relationships

Open interaction and mutual understanding is one of the foundations for effective teamwork according to the co-researchers and in line with Taborda, (2000) and Horak et al. (1991) discussions. My understanding is that the objective is to 'fly in formation'. An encouraging finding in the present study is that the potential for generating such empowering creative relationships exists in the atmosphere of many wards. These qualities emerged when nurses spoke of their wards being able to withstand stress. Everybody pulls together so that work progresses well and is enjoyable; security, tolerance, equality and solidarity are the watchwords.

Although a good ward atmosphere exists among staff nurses, it appears to be necessary to improve collaboration with other occupational groups; it has been demonstrated that this is important to patient-care outcomes and for staff wellbeing (Shortell et al., 1991; Horak et al.; 1991, Disch, 2001b). The reception given to new nurses and students on wards is often far from good, even if a good ward atmosphere prevails within the team. Some nurses said that they were aware of their negative behaviour, and its impact upon the newcomer. Pollak (1994) maintains, in the same way, that at any time each individual does as well as he/she can at that time. Perhaps nurses require support to take the final step, and behave in the way that they know will yield the best results.

### 6.2.2 The importance of caring for each other and ourselves

In an empowering atmosphere, according to the co-researchers, there is a motivation for everyone to do their best, and for individuals to have the
opportunity to thrive. Reward, praise and feedback are among available energy resources as experienced by the co-researchers and this is supported by Taborda (2000). According to the research findings of Bakker et al. (2000) there is a risk of burnout when there is an imbalance between extrinsic reward and job demands and in the present study the co-researchers mentioned this as being invisible in the crowd. Ray et al. (2002) point out the importance of caring relationships of the nurse and administrator. My understanding is that employees caring for each other contributes to a firmer foundation of the ward atmosphere. This finding could be used to encourage nurse managers and staff nurses to make more use of reward, praise and feedback.

According to the findings, the reaction to mistakes made by a member of the team highlights the nature of the atmosphere on the ward. Support for the person who made the mistake, and help to learn from her mistake, indicate a caring attitude, while the opposite disempowers the person, and breaks down her confidence.

Experiencing that ‘we’ have achieved something, and never being alone, creates solidarity in the team according to the co-researchers. In a study conducted in Iceland, over ninety percent of nurses consider that they get a fair amount of support, or considerable support, from their colleagues, which could support this finding (Biering and Sveinsdóttir, 2001a). Gage (1998) identifies this experience as creating synergistic healthcare teams. One nurse manager pointed out that it is a lot of work for the employees to gain the experience of being a team, and this is supported by Horak et al. (1991).

According to the nurses, solidarity is conducive to interactions that lead to a positive chain reaction. McGraw (1999) maintains that it is easy - you get what you give - and he calls this reciprocity. Positive chain reaction could be a new way to deal with conflicts according to Johns (1992). Humour was one thing
that the nurses mentioned that could trigger a positive chain reaction, and some co-researchers said humour even enabled them to deal with a new day.

6.2.3 The importance of holistic view

Having a holistic view and support is an important premise for the existence and strength of the team. It seems to me that for the nurses, the idea of holism extends to both the patient and the staff team. This highlights perhaps that this is the framework within which the ward atmosphere exists. But it is also the framework of loyalty and pride. It emerged that it led only to disappointment to examine the world outside that framework, while not participating in that world led to isolation.

Achieving a holistic view is not easy. The nurse managers discussed the suffocating feeling of having to be everywhere at once, and being responsible for everything. One nurse manager said she used deputies to help her to ‘take the pulse’, improve the ward atmosphere and put positive chain reactions into effect. This may be a factor that nurses and nursing administrators should bring out in order to strengthen the ward atmosphere. The deputies or leaders use motivation, the empowering aspects of the Relationship Model, i.e. listening, thinking, learning, experience, support/friendship, and being aware of their environment. Pollak (1994) asserts that listening is the most effective way of changing the environment, and according to my interpretation this is a tool for understanding context and gaining a holistic view.

The staff nurses said that they dealt with their suffocating feelings, promoted solidarity and maintained an empowering atmosphere by using what they call letting off steam. For this they tend to use the report at shift changeover, although this is not a recognised forum for this. The report is also a forum to learn from each other and discuss how to deal with difficult tasks and to revise judgements. It is worth considering whether nurses need to have a recognised...
forum just to let off steam and develop personally as well as professionally and to listen to each other.

6.3 The essential structure of a disempowering atmosphere

6.3.1 Obstacles in relationships

The nurses indicate obstacles that need to be overcome in order to empower the ward atmosphere. These obstacles prevent interaction. The nurses said for example that collaboration with physicians could be in the form of defensive responses and tension. The roots of this problem are, among other things, according to Horak et al. (1991) 1) lack of coordination, communication, and understanding of others’ roles, and 2) poor understanding of the organisation and how to get things done, particularly with respect to a mechanism for resolving problems (p.31). One may also consider whether physician-nurse collaboration is still based to some degree on what was called the ‘doctor-nurse game’ in 1967 (Stein et al., 1990). This appears to be a common problem, and entail such major consequences, that it would be worth devoting resources to resolving the problem.

The nurses discussed also a lack of collaboration with practical nurses, and said that they often ‘go their own way’. The findings of a survey carried out by the Icelandic Association of Practical Nurses indicate one contributory factor in this problem of collaboration (IMG-Stjórnunafirðaöslu, 2002). Practical nurses were asked for their views on the image of practical nurses: half of them expressed the view that registered nurses had the most negative view of practical nurses, and 70% of practical nurses’ union shop stewards are of this view. These results indicate that there is some tension between these occupational groups, which may hinder their teamwork and disempower the
ward atmosphere, in addition to the same problems that were discussed above with regard to the physician-nurse relationship.

Gage (1998) discusses the issue, and highlights the need to adopt a new mindset, from independence to interdependence. According to my understanding that mindset crystallises in the word *we*, or *collaboration*, instead of using *us* and *them*. That mindset needs to span more than just the nursing team, it needs to be interdisciplin ary, to provide integrated care (Gage, 1998). There is a growing recognition that interdependent care promotes the best outcomes and that every member of the treatment team must have his/her needs met if the team is to continue being effective (Rosenstein, 2002; Gage, 1998).

The co-researchers often spoke of backbiting, which always has a negative chain reaction. Listening to backbiting, according to Pollak (1994), is the same as being under attack, because everybody feels uncomfortable about taking part in backbiting. The staff nurses, however, said that they did not have the courage to counteract backbiting, and that they feared that they themselves would come under attack. It should be the nurse manager's role to support nurses in counteracting backbiting, as backbiting saps their energy.

### 6.4 The need for vision

Last but not least I want to conclude by discussing the extremely important topic of the need for *vision*. Corporations that have survived for the past 50 years have understood that to be successful they must have a vision and a core ideology (Robinson, 2001), and vision gives meaning to work (Aroian, 1996). The co-researchers spoke of the need to see themselves in the future, to be participants in the future, as this was a factor in empowering atmosphere. This means that nurses do not only want to pay lip-service to vision, but also to work for it.
Through the research journey I have understood that the *empowering atmosphere* is a driving force. The nurses' motivation is to achieve their vision, to reach their future; otherwise they end up with a stagnated disempowered phenomenon with dead ends and no process.

### 6.5 Summary

At the end of this research journey my understanding is that the answer to my question:

> 'What is the experience of staff nurses and nurse managers of empowering and disempowering atmosphere in the ward environment on inpatient wards?'

...is that the ward atmosphere is a vulnerable dynamic phenomenon, which needs constant attention.

The employees, who are to accomplish the vision, all need a common driving force, the empowering atmosphere. I understand this to mean feeling good, being secure and having the strength to be able to accomplish one's job. This phenomenon is created through motivation and reflection, and the essential structure of empowering ward atmosphere, and is destroyed or hindered through the structure of a disempowering ward atmosphere. This is the phenomenon I was trying to understand; however, its validity is a matter of judgement.
6.6 Implications for practice

The Relationship Model could be used:

- To analyse current ward atmosphere in a given ward, to evaluate its empowering and disempowering structures.
- To support staff nurses and nurse managers in dealing with aspects of daily life on the ward relating to ward atmosphere.
- To make the ward atmosphere a visible force on wards, by improving understanding of its importance - and in consequence to work systematically towards a good ward atmosphere.
- In teaching on leadership courses.
- As a basis for a questionnaire concerning ward atmosphere.
- Other disciplines in health care could apply the Relationship Model as a framework to evaluate empowering and disempowering structures in their workplace atmosphere.

6.7 Limitations

It is possible that the sample size of nurse managers and staff nurses may be too small adequately to address the analytical importance of each group. It could also be said that the whole subject was too large for the deep analysis that qualitative projects require (see e.g. Sandelowski, 1995). As I am a nurse manager at one of the hospitals where I carried out the study (though on leave during the study), it is probable that this had some effect upon the dialogues and the findings. Finally, study of how the nurses’ patients and colleagues experience ward atmosphere is required, in order to gain a full picture of the phenomenon ward atmosphere on an inpatient ward.
6.8 Further research

Clearly the essential structure and linkages underlying the model of ward atmosphere require much additional research and validation. In addition, the following subjects might be studied:

- The experience of nurse students, practical nurses, physicians and patients of ward atmosphere and its meaning.

Also there are many themes that need to be explored, some more deeply for further understanding.

- What significance does ward atmosphere have for a nurse’s personal and professional development?

- What is the significance of collaboration between professions for staff and patients?

- Ward atmosphere on non-inpatient wards, such as anaesthesiology or intensive care, should also be explored.

- Design a questionnaire based on the findings of this study, in order to survey inpatient wards with the objective of achieving a better ward atmosphere.

Epilogue

Nurses possess the knowledge and experience to create an empowering atmosphere; but these factors must be brought to light and utilised. This process would cost health institutions little or nothing in financial terms, but could yield a considerable return in terms of performance.
Fig 2 - A
Empowering Pole

The individual/group actively seeks to promote and build relationships

- Listen
- Thought
- Learning
- Experience
- Support/Friendship

Sensitivity
Awareness
Motivation

- Control
- Understanding
- Proactive
- Development
- Self-reliance/Independence

Open interaction
- Open interaction, frankness and trust with a touch of humour
- Respect, tolerance and equality
- The information system keeps the team in touch, on the inside and the outside

The importance of reciprocal care
- Never being alone – solidarity in the team
- Reward, praise and feedback
- A positive attitude leads to a chain reaction

An overview is the prerequisite for progress
- A vision of the future, objectives and context
- Filling in the cracks
- Letting off steam

Empowering relationships

Empowering atmosphere

Strength – Wellbeing
Confidence

Flow in an empowering atmosphere
$1 + 2 + 3 + 4 + 5 \Rightarrow 6 + 7$
Nafn
Deildarstjóri

Reykjavík 20. janúar 2002

Efni: Rannsókn: Upplifun hjúkrunarfræðinga og deildarstjóra á eflandi og letjandi anda á legudeild.

Kæra

Ég undirrituð er í meistararanámi í hjúkrun við Royal College of Nursing í Bretlandi, sem er í samvinnu við Háskólaun á Akureyri. Ég er að vinna að rannsókn, sem er hluti af lokaverkefni í mínu námi.

Rannsóknin:
Tilgangur rannsóknarinnar er að öðlast skilning og þekkingu á upplifun hjúkrunarfræðinga og deildarstjóra á því hvað skapar eflandi og letjandi anda á legudeild. Einnig, hvaða áhrif andinn hefur á líðan hjúkrunarfræðinga og deildarstjóra, faglega próun þeirra og þá hjúkrun sem þeir veita. Rannsóknaraðferðin sem ég nota er fyrirbæðafræðileg, sem meðal annars felur í sér samtöl við þátttakendur í rannsókninni.

Samtölin:
Ég mun hafa samtal við deildarstjóra, sem hafa reyndslu af eflandi og letjandi anda á legudeild, þar sem þeir hafa unnið og/eða vinna núna. Samtalið mun taka einn til tvö klukkutíma. Jafnframt, til að öðlast dýpri skilning á þeim efnisþáttum sem koma fram og staðfestingu á að sameiginlegur skilningur þátttakanda og rannsakanda hafi náðst, er æskilegt að hafa annað samtal síðar.

Þátttakendur þurfa ekki að svara spurningum, sem þeir ekki vilja svara, eða tjá sig um. Hvorki nafn þátttakenda né vinnustaður mun koma fram. Ekki verður hægt að rekja það, sem kemur fram í samtölunum, í niðurstöðum rannsóknarinnar.

Pátttaka:
Pátttaka í rannsókninni er sjálfvílug. Með pátttöku í rannsókninni fylgja engar kvaðir eða skyldur. Pátttakendur geta hátt í rannsókninni hvænær sem er, og það mun ekki valda þeim neinum vandræðum. Öllum upplýsingum mun þá verða eytt.

Mér þætti vænt um ef þú sæir þér færð að taka þátt í rannsókninni með mér. Með því getum við stuðlað að auknum skilningi og þekkingu á því hvað er andi á deild og hvaða þýgingu hann hefur í hjúkruninni.

Pað er nauðsynlegt fyrir mig að sjá málið út frá upplifun þinni og annarra deildarstjóra með dænum frá starfinu. Nauðsynlegt er að sjá sem flestar hliðar fyrirbærisins (andann á deild) til þess að geta öðlast skilning og þekkingu á efninu. Ég er hins vegar ekki að leita eftir skoðunum þínnum á anda á deild.

Ég mun gefa viðtölunum þann tíma sem þú þarft hverju sinni og ert tilbúin að gefa mér. Allar hugsanir, vangaveltur, þættir og athugasemdir varðandi andann á deild er þess virði að þær komi fram.


Með fyrirfram hjartans þakklæti.

Ragnheiður Alfreðsdóttir,  
Hjúkrunarfræðingur  
Kópavogsbraut 103,  
sími heima: 564-5206  
farsími: 694-6710  
netfang: ragnalf@landspitali.is
Reykjavík 20. janúar 2002

Upplýst samþykki deildastjóra.

Heiti rannsóknar: Upplifun hjúkrunarfæðinga og deildastjóra af eflandi og letjandi anda á legudeild.

Rannsakandi: Ragnheiður Alfredsdóttir,
Hjúkrunarfæðingur og nemi í mastersnámi við Háskólan á Akureyri.
Heima: Kópavogsbraut 103,
sími heima: 564-5206
sími vinnu: 525-1229
færð: 694-6710
netfang: ragnalf@landspitali.is

Leiðbeinandi: Professor Sigriður Halldórsdóttir
Háskólinn á Akureyri
Postbóð 224, 602 AKUREYRI
sími vinnu: 463-0911 (beinn sími)/463-0900 (skiptiborð)
sími breið: 463-0999
netfang: sigridur@unak.is
heimasöfn H.A:http://www.unak.is/
Heima: Steinahlíð 8a, 603 AKUREYRI
sími heima: 462-7676

Tilgangur þessarar rannsóknar er að auka skilning og þekkingu á upplifun hjúkrunarfæðinga og deildastjóra af eflandi og letjandi anda á legudeild. Þá þekkingu, væri hægt að nýta til að vekja umræðu um þyðingu þess anda sem ríkri á legudeild fyrri líðan hjúkrunarfæðinga og deildastjóra, samskipi, fáglega þróun á deildinni, og þá hjúkrun sem veitt er.

Páttaka í rannsókninni felur í sér að vera viðmælandi rannsakanda í eimu og jafnvel fleiri samtölu. Hvert samtal mun taka um það bil einn til tvö klukktutíma. Í þessum samtölum mun verða fjallað um upplifun og tilfinningar varðandi eflandi og letjandi anda á deild, hvað skapar andann, hvaða áhrif hefur andinn á líðan hjúkrunarfæðinga og deildastjóra, fáglega þróun og þá hjúkrun sem veitt er. Seinn samtalía/samtölin er til að rannsakandinn geti ólæst dýpri skilning á efniþáttum og staðfestingu á að sameiginlegur skilningur þáttakanda og rannsakanda um efnið hafi náðst. Samtölin munu fara fram í rölegu umhverfi á stað sem viðmælandi óskar eftir.

Viðtölin munu verða hljóðrituð og mun enginn komast í þær hljóðritanir nema rannsakandinn. Óll nófin, sem koma fram í samtölu, munu verða aðmáð, og ekki verður hægt að rekja niðurstöður rannsóknarinnar til viðmælanda. Ef í viðtölu, koma fram þættir, sem brjóta í bága við síóferði hjúkrunar, er mér heimilt að taka þá upp samkvæmt hefð. Niðurstöður rannsóknarinnar munu verða kynntar á fundi Fræðasviðs hjúkrunar og liggja frammi á bókasafni Landspísla háskólasjúkrahúss og Háskólans á Akureyri.
Greiðsla eða umbun er ekki fyrir þátttöku viðmælanda í rannsókninni. Persónulegur ávinningur rannsakanda er að nýta það þekkingu sem mögulega kemur fram í niðurstöðum rannsóknarinnar.

Ég undirrituð/undirritaður

lýsi hér með yfir að ég er reiðubúinn/in að taka sjálfviljugar/sjálfviljug þátt í þeirri rannsókn sem að ofan er lýst.

Mér er ljóst að það fylgja því engar kvaðir frá minni hendi að taka þátt í rannsókninni. Einnig að ég get hætt í rannsókninni hvætir sem ég öska eftir því. Mér er ljóst að ég get neitað að svara einstökum spurningum, og að ég þarf ekki að taka fram annað en það sem ég vil að komi fram.


Mér hefur verið geflið tækifæri til að spurja um allt sem ég vil vita varðandi rannsóknina og öllum mínunum spurningum hefur verið svarað af heiðarleika og einlægni og af bestu vitund

Dagsetning

Pátttakandi

Rannsakandi

Gert í tvíriti
Eintak pátttakanda
Hjúkrunarfræðingur
Deild

Reykjavík 20. janúar 2002

Efni: Upplifun hjúkrunarfræðinga og deildarstjóra á eflandi og letjandi anda á legudeild.

Kæri hjúkrunarfræðingur

Ég undirrituð er í meistaránámi í hjúkrun við Royal College of Nursing í Bretlandi, sem er í samvinnu við Háskólann á Akureyri. Ég er að vinna að rannsókn, sem er hluti af lokaverkefni í mínu námi.

Rannsóknin:
Tilgangur rannsóknarinnar er að öðlast skilning og þekkingu á upplifun hjúkrunarfræðinga og deildarstjóra á því hvað skapar eflandi og letjandi anda á legudeild. Einnig, hvaða áhrif andinn hefur á líðan hjúkrunarfræðinga og deildarstjóra, faglega próun þeirra og þá hjúkrun sem þeir veita. Rannsóknaraðferðin sem ég nota er fyrirbærafræðileg, sem médal annars felur í sér samtöl við þátttakendur í rannsókninni.

Samtölin:
Ég mun hafa höpsamtal við fjóra hjúkrunarfræðinga sem hafa reynslu af eflandi og letjandi anda á legudeild, þar sem þeir hafa unnið og/eða vinna núna. Samtalið mun taka einn til tvá klukkanúta. Jafnfram, til að öðlast dýpri skilning á þeim efnisbáttum sem koma fram og staðfestingu að sameiginlegur skilningar minn og þátttakanda hafi náðst, er öskilegt að þeir hjúkrunarfræðingar í hópnum, sem geta og hafa áhuga, eigi við mig annað samtal síðar.

Þátttakendur þurfa ekki að svara spurningum, sem þeir ekki vilja svara, eða tjá sig um. Hvorki nafn þátttakenda né vinnustaður mun koma fram. Ekki verður hægt að rekja það, sem kemur fram í viðöluðum, í niðurstöðum rannsóknarinnar.

Pátttaka:
Pátttaka í rannsókninni er sjálaviljug. Með pátttöku í rannsókninni fylgja engar kvaðir eða skyldur. Pátttakendur geta hætt í rannsókninni hvenær sem þeir óska eftir því og það mun ekki valda þeim neinum vandráðum.

Mér þætti vænt um ef þú sæir þér fært að taka þátt í rannsókninni með mér og með því stuðla að því að hjúkrunarfræðingar öðlist skilning og þekkingu á því hvað er andi á deild og hvaða þýðingu hann hefur í hjúkruninni, í þeirri von að ef til vill geta stuðlað að efandi anda, góðri líðan hjúkrunarfræðinga og deildarstjóra og góðri hjúkrun.

Pað er nauðsynlegt fyrir mig að sjá málið út frá upplifun hjúkrunarfræðinga með dænum úr starfinu. Nauðsynlegt er að sjá sem flestar hlíðar fyrirbærisins (andinn á deild) til þess að geta öðlast skilning og þekkingu á efnum. Ég er hins vegar ekki að leita eftir því hvaða skoðun viðkomandi hefur varðandi efnið.

Ég mun gefa viðtölunum þann tíma, sem hópurinn þarf, til að tjá sig um málið. Allar hugsanir, vangaveltur, þættir og athugasemdir, varðandi anda á deild, er þess virði að þær komi fram.


Með fyrirfram hjartans þakklæti.

Ragnheiður Alfреðsdóttir,
Hjúkrunarfræðingur
Kópavogsbraut 103;
sími heima: 564-5206
farsími: 694-6710
netfang: ragnalf@landspitali.is

Upplýst samþykki hjúkrunarfræðinga.

Heiti rannsóknar: Upplifun hjúkrunarfræðinga og deildarstjóra af eflandi og letjandi anda á legudeild.

Rannsakandi: Ragheioður Alfredsdóttir, Hjúkrunarfræðingur og nëmi í mastersnámi við Háskólan á Akureyri. Kopavogsbraut 103, sími heima: 564-5206 sími vinnu: 525-1229 farsími: 694-6710 netfang: ragnalf@landspitali.is

Leiðbeinandi: Professor Sigridur Halldórsdóttir Háskólinn á Akureyri Pósthólf 224, 602 AKUREYRI sími vinnu: 463-0911 (beinn sími)/463-0900 (skiptiborð) símbréf: 463-0999 netfang: sigridur@unak.is heimasíða H.A: http://www.unak.is/ heima: Steinahlið 8a, 603 AKUREYRI sími heima: 462-7676

Tilgangur þessarar rannsóknar er að auka skilning og þekkingu á upplifun hjúkrunarfræðinga og deildarstjóra af eflandi og letjandi anda á legudeild. Þá þekkingu, væri hægt að nýta til að veikja umræðu um þyðingu þess anda sem ríkir á legudeild fyrir liðan hjúkrunarfræðinga og deildarstjóra, samskipti, faglega þróun á deildinni, og þá hjúkrun sem veitt er.

Þátttaka í rannsókninni felur í sér að vera viðmælandi rannsakanda í einu höpsamtali ásamt þremur dörum hjúkrunarfræðingum.Samtalið mun taka um það bil einn til tvo klukkutíma eftir því sem þátttakandur kjösa og mettun hefur náðst um efnið. Í þessu samtali mun verða fjallað um upplifun og tilfinningar varðandi eflandi og letjandi anda á legudeild, hvað skapar andann, hvaða áhrif andinn hefur á liðið hjúkrunarfræðinga og deildarstjóra, faglega þróun og þá hjúkrun sem veitt er. Jafnframt mun ég (rannsakandi) bjóða þeim í höpnum, sem hafa áhuga og geta, að hafa við mig annað samtal til að ég geti ólast dýpri skilning á efnið þátttum og staðfestingu að að sameiginlegur skilningur þátttakaða og rannsakanda um efnið, hafi náðst.

Viðölín munu verða hljóðrituð og mun enginn kemast í þær hljóðritanir nema rannsakandinn. Þótt nöfn, sem koma fram í samtölunum, munu verða alþað, og ekki verður hægt að rekja niðurstöður rannsóknarinnar til viðmælenda. Ef viðútölu koma fram þátttir, sem brjóta í bága við sístferði hjúkrunar, er rannsakanda heimilt að taka þá upp samkvæmt hefð. Niðurstöður rannsóknarinnar munu verða kynntar og ræddar á fundi Fræðasvæðs hjúkrunar Landspitala háskólasjúkrabúss (LSH) og liggja frammi á bókasafni LSH og Háskólas á Akureyri.
Greiðsla eða umbun er ekki fyrr hættöku viðmælenda í rannsókninni. Persónulegar ávinningar rannsakanda er að nýta þá þekkingu sem morgulega kemur fram í níðurstöðum rannsóknarinnar.

Ég undirrituð/undirritaður

lýsi hér með yfir að ég er reiðubúinn ín að taka sjálfvíljugur/sjálfvíljug þátt í þeirri rannsókn sem að ofan er lýst.

Mér er ljóst að það fylgja því engar kvaðir frá minni hendi að taka þátt í rannsókninni. Einnig að ég get hætt í rannsókninni hvenær sem ég óska eftir. Mér er ljóst að ég get neitað að svara einstökum spurningum, og að ég þarf ekki að taka fram annað en það sem ég vil að komi fram.


Mér hefur verið gefið þækið til að spyrja um allt sem ég vil vita varðandi rannsóknina og öllum mínunum spurningum hefur verið svarað af heiðarleika og einlægni og af bestu vitund

Dagsetning

Páttakandi

Rannsakandi

Gert í tvíriti
Eintak páttakanda
Til: Ragnheiður Alfreðsdóttir
ragn@dlandspital.is
Köpavogsbrait 103
200 Köpavogi

Frá: Rannsóknanefnd hjúkrunarráðs Landspítala - háskólasjúkrahúss
þróunarskrifstofu hjúkrunarforstjóra
Eiriksgötu 19
101 Reykjavík

Efni: Svar við umsókn um leyfi til rannsóknar á upplifun hjúkrunarfræðinga og
deildarstjóra á eflandi og letjandi anda á legudeild, dags. 30.11.2001,
viðbótagögn fengin 7. janúar 2002

Dags: 16. janúar 2002

Ágæta Ragnheiður,

Að þessum umbeðnum gögnum heimilir Rannsóknanefnd hjúkrunarráðs LSH að ofannefnd
rannsökn geti farið fram.

Nefndarmenn fagna að þessi áhugaverða rannsókn fari fram og óska þér góðs gengis.

Virðingarfyllst,

f.h. Rannsóknanefndar hjúkrunarráðs LSH,

Anna Guðlaugsdóttir, formaður
annag@landspital.is

cc: Oddný Gunnarsdóttir deildarstjóri Visinda- og kennislúpíóñustudeildar LSH
FJÓRDUNGSSJÚKRAHÚSÍÐ Á AKUREYRI

Nefedarmenn:
Elisabet Hjörleifsdóttir
hjúkrunarfræðingur, formáður
Fannar Hárardóttir
rémgentaeðnik
Kristján Kristjánsson
professor
Sigmundur Sigfússon
yfirlæknir (í leyfi)
varamáður:
Sigurður E. Sigurðsson
yfirlæknir.

Ragnheiður Álfreðsdóttir
hjúkrunarfræðingur BSc
Kópavogsbraut 103
200-Kópavogi

Akureyri 31. janúar 2002

23. mál: Umsókn um leyfi til að framkvæma rannsókn á upplifun og reynslu hjúkrunarfræðinga og deildarstjóra af eflandi og letjandi anda á legudeild.

Siðanefnd FSA visar til breiðs dags. 20. janúar 2002 þar sem óskað er heimildar Siðanefndar FSA til að framkvæma rannsókn á upplifun og reynslu hjúkrunarfræðinga og deildarstjóra á því hvað skapar eflandi og letjandi anda í persónulegum og faglegum samskiptum á legudeild. Rannsóknin er hluti af lokaverkefni í meistaránámi við Royal College of Nursing við Manchester Háskóla í tengslum við Háskólan í Akureyri. Þáttakendur verða valdir af legudeildum á höfuðborgarsvæðinu og af Norðurlandi.

Siðanefnd þakkar þér breiðið. Siðanefnd FSA telur fyrirhugða rannsókn ekki heyra undir ábyrgðarsvöð sitt og árettar að erindim verði vísæ til Viðindasiðanefndar Heilbrigðis- og Tryggingamálaráðuneytisins og Persónuverndar.

Siðanefnd FSA óska þér gðós gengið við rannsóknina.

Víðingarfyllst,
E. h. Siðanefndar FSA
Elisabet Hjörleifsdóttir, formáður

Afrit: Viðindasiðanefnd
heilbrigðis-og tryggingamálaráðherra
Laugavegi 103, 105-Reykjavik
Ragnheiður Alfredsdóttir, hjúkrunarfræðingur
Kópavogsbraut 103,
200 Kópavogi

Efni: Svar við umsókn um leyfi til að framkvæma rannsókn á Fjördungssjúkrahúsinu á Akureyri (FSA)

Sæl Ragnheiður!

Ég þakka þína um að framkvæma rannsókn á FSA á upplifun hjúkrunarfræðinga og deildarstjóra hvað varðar eflandi anda á legudeild. Ég hef kynnt mér rannsóknarafættunina, tilgang rannsóknarinnar og rannsóknaraðferð. Ég heimila þér framkvæmd rannsóknarinnar á FSA að fengnum tilskyldum leyfum.

Ósk um gott gengi!

Kveðjur

[Signature]

Ólínna Torlindóttir, framkvæmdastjóri hjúkrunar
37 (23), mál: Umsókn um leyfi til að framkvæma rannsókn á upplifun og reynslu hjúkrunarfræðinga og deildarstjóra af eflandi og letjandi anda á legudeild.


Síðanefnd þakkar þér bréfið. Síðanefnd FSA samþykkr að veita leyfi til þessarar rannsóknar í trausti þess að öll medferð upplýsinga hliti lögum og reglugerð um vernd einstaklinga í rannsóknun.

Síðanefnd FSA óskar þér góðs gengis við rannsóknina.

Virðingarfyllst,

f. h. Síðanefndar FSA

Elisabet Hjörleifsdóttir, formáður

Allar tilkynningar sem berast Persónuvernd birtast sjálfskrafa á heimasíðu stofnunarnar. Tekið skal fram að með mótöku og birtingu tilkynninga hefur engin alstada verið tekið af hálfu Persónuverndar um efní þeirra.

Virdingarfyllst,

Erla Björgvinsdóttir
ritari
Hjál.
- Tilkynning nr. S700/2002 um vinnslu persónuupplýsinga.

Tilkynning um vinnslu persónuupplýsinga
Tilkynning móttekin: 28.03.2002 12:24:46
Númer S700

● Ný tilkynning
○ Tilkynning um breytingu

Elda tilkynninganúmer sé um tilkynningu um breytingu vinnslu að ræða:
Konneitala ábyrgðaraðila: 0101555929

Naðin tengiðs ef ábyrgðaraðili er
fyrirtæki / stofnun:
Naðin
Heimilistang
Postnúmer:
Staður:
Ragnheiður Alfreðsdóttir
Kópavogsbraut 103
200
Kópavogur

Símanúmer tengiðis / ábyrgðaraðila: 5645206/6946710
Hver er tilgangur vinnslunnar?
Rannsókn í meistaranaði í hjúkrun við Royal College of Nursing, en hann tengist Manchester University, og er með nármindst 3ði við Háskóllann á Akureyri.

Hvaða upplýsingar verða fengnar/unnið með?

Hvert verða upplýsingarnar sötta?
Upplýsingarnar verða fengnar með viðöllum við hjúkrunarfræðinga á Landspítala háskólasjúkrahúsi og Fjórdungarþjóðs. Akureyri

- Samþykki hins skráda sbr. 1. tl.
- nauðsyn vegna sannings sbr. 2. tl.
- nauðsyn til að fullnægja lagaskýldu sbr. 3. tl.
- nauðsyn til að vernda hagsmuni hins skráda sbr. 4. tl.
- nauðsyn vegna almennahagsmun sbr. 5. tl.
- nauðsyn við beitingu opinbers vaidis sbr. 6. tl.
- nauðsyn til að gæta annara hagsmuna sbr. 7. tl.
- nauðsyn rafræna vöktun sbr. 2. mgr.

Verður unnið með viðkvæmar persónuupplýsingar, sbr. 8. tl. 2. gr. laganna?
Nei

Viðbótarskilyrði um vinnslu viðkvæmra persónuupplýsinga, sbr. 9. gr. laganna:
Frekari skýringar á þeim heimildum sem merkt er við hér að ofan (t.d. ef byggt er á sambykki hins skráða skal hér greint frá efni sambykkissylfrýsingar)

Verða upplýsingarnar afhentur öðrum. Hverjum?

Verða upplýsingarnar fluttar úr landi?
Verða upplýsingarnar birtar á Netinu / Vefnum?

Hvaða öryggisráðstafanir verða viðhafsar við skráninguna?

Nafn þess sem ber ábyrgð á tilgreindum öryggisráðstöfunum ef ábyrgðaraðili er fyrirtæki / stofnun, ef annar en tengiliður:
Verður upplýsingunum/aðkennunum eytt og þá hvenær?
Verður öðrum aðila (vinnumaðila) með skriflegum samningi fælin vinnsla upplýsinganna?

Kennitala vinnsluaðila
Nafn vinnsluaðila
Heimilisfang vinnsluaðila
Póstnúmer:
Staður:

Niðurstöður rannsóknarinnar munu verða sendar til Royal College of Nursing í Bretlandi þar sem ég stunda mitt nám til yfirlestrar og einnunagjafar. Einnig munu þær liggja framm á bökasafni Landspítala hásíðaskjóðhúss og Fjördungssjúkrahúss Akureyrar. Í Viðölin verða ekki send sem sílku heldur aðeins lókar ítgerðin í heild sinni þegar unníi verði úr upplýsingum.

Já
Nei

Aðgangsorð
Dulkóðun
Afmáun persónuaðkenna
Annað
Ef annað, þá hvað?
Viðölinum mun verða eytt þegar viðurkenning hefur fengist frá skólannum um að rannsóknin hafi verði viðurkennd. Samtölin munu ekki verða merkt með stofnun, deild eða nafni heldur verða viðmælendur númerafir.

Samtölinum mun verða eytt þegar rannsókin hefur fengið viðurkenningu frá skólannum sem fullgild sem verður í lok árs 2002.

Nei
Hverjar eru skyldur vinnslaðila
samkvæmt þessum samningi?

Aðrar athugasemdir tilkynnanda: Rannsóknin er hluti af lokartröð til meistaranáms í hjúkrun í Royal College of Nursing í Bretlandi sem tengist Manchester University og er með námsmiðstöð við Háskólan í Akureyri. Viðtölin verða ekki send úr landi heldur lokartröðin sem slikt eftir að unnir hefur við úr viðtölnum. Adeins niðurstöður.
Kær Ragnheiður og Sigriður,

Bestu þakkir fyrir fyrirspurn ykkar um leyfisskyldu rannsóknarinnar "Upplifun hjúkrunarfremöinga og deildarstjóra á eflandi og letjandi starfsanda á legudeild" (tilvísun: FS-02-025). Vísaindasíðanefnd hefur fjallað um málið og er niðurstaða nefndarinnar sú að rannsóknin sé EKÍ leyfisskyld af hennar hálfu, enda varði hun ekki heilsu þátttakanda né skjólstæðinga þeirra, heldur þátti sem varða reynslu og viðhorg fagaðila til þess starfs sem þeir annast.

Gangi ykkur vel með rannsóknina.

Kveðja, Þorvarður

Þorvarður Árnason, framkvæmdastjóri
Vísaindasíðanefnd, Laugavegi 103, 105 RVK
s. 551-7100/ fax: 551-1444

Thorvardur Arnason, managing director
National Bioethics Committee
Laugavegur 103, IS-105 Reykjavik
Iceland
Kópavogur 30. Ágúst 2002.

Varðandi niðurstöður á rannsókn um:

"Hver er upplifun hjúkrunarfræðinga af eflandi og letjandi starfsanda á deild"

Kærnu meðrannsakendur.

Ég vil byrja á því að þakka fyrrir ykkar greiðvirkni og aðstoð við að gera þessa rannsókn mögulega. Ég er búin að skoða samtölín í bak og fyrrir og velta fyrrir mér "hvað eru þær að segja mér" og hef reynt að tūlka ykkar frásagnir og orð.

Í rannsókninni tóku fjórir deildarstjórar þátt sem ég hafði einstaklingsviðtal við og fjórir hoppur hjúkrunarfræðinga með 3-4 hjúkrunarfærðingum í hverjum hopi. Viðtölín foru fram á skurðeild, barnadeild, öldrunardeild, lyflæknisdeild og geðeild á Akureyri og í Reykjavík. Samtölín urðu alls 19 og er ég ykkur afar þakklát fyrrir að hafa veitt mér allan þennan tíma ykkar.

Það væri mikilvægt fyrrir gildi niðurstaðna rannsóknarinnar ef þió séjuð ykkur fiert að skoða niðurstöðurnar og gefa mér svörun við því hvort niðurstöðurnar komi heim og saman við það sem þió voruð að segja mér í samtölum. Ég hef fullan skilning á því að það eru ekki allir sem hafa tekifæri til að sinna þessu eða gefa því mikinn tíma en það væri mér ömetanlegt ef þió getuð gefið mér einhverja svörun. Skrifið gjarnan inn á meðfylgjandi blöð sem ég sendi ykkur og sendið þau aftur til baka til mín. Ég lað fylgja með frímerkt umslag.

Með fyrrirfram hjartans þakklæti og von um að ég eigi eftir að fá að hitta ykkur aftur.
Gangi ykkur allt í haginn. Ef ég get orðið ykkur að liði þá endilega látið mig vita.

Ragnheiður Alfredsdóttir,

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