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Hidden Dimensions Revealed: Progressive Grounded Theory Study of Quality Care in the Hospital

Vera F. Irurita

The delivery of quality care, although acknowledged as being vital to health care systems, is a complex, poorly understood phenomenon. This article describes an attempt to respond to the challenge of studying the meaning of quality nursing care in an acute-care hospital setting. Grounded theory method was used to progressively develop theory incorporating both patients' and nurses' perspectives. Separate studies were undertaken concurrently in the same setting, and the ongoing development of theory is continuing. The patient's perspective is presented as the central focus, with findings and data from the nurse study being used for further comparative analysis. The different levels of analysis and progressive stages of theory development are highlighted.

The quality of patient care has come under increasing attention in recent times, especially in a climate of economic uncertainty. One of the issues addressed in the literature on quality patient care was the incongruence between the perceptions held by various groups, par-

Author's Note: The research project reported in this article was supported, in part, by the Nursing Division and Nursing Research Department at Sir Charles Gairdner Hospital, Perth, Western Australia. Study participants and their experiences were drawn from a range of hospitals; hence these findings are in no way confined to the above hospital as the primary study site.

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ticularly by nurses and patients (Larson, 1987; Mayer, 1986, 1987; Pettit & White, 1991). Quality of care is probably best defined and measured by the perceptions of the patient/client (Stewart-Amidei, 1989; Strasen, 1988). Yet the quality of care is frequently measured against professional standards and expectations only, overlooking consumer perceptions of, or satisfaction with, care (Vuori, 1991). This observation prompted the undertaking of a study to explore the phenomenon of quality nursing care in an acute-care hospital setting. The study was planned to incorporate and compare both patients' and nurses' perspectives of quality care.

A decision was made to use the grounded theory method (Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990) to discover the important underlying dimensions and patterns of relationships, as well as the social processes involved in the complex phenomenon of the delivery of quality nursing care in an acute-care hospital setting. At the outset, it was clear that there were two distinct phenomena, one of receiving care and the other of giving care. I decided then to separate the project into two independent studies to be undertaken concurrently by myself and a colleague. The plan was to observe and interview (separately) patients and nurses in the same clinical setting. This meant that although the groups were not deliberately matched, the nurse participants were likely to have cared for the patient participants. Each set of data was to be analyzed separately, then compared with secondary data sets obtained from interviews with both patients and nurses from an array of different hospitals. The constant comparative method of analysis, incorporating relevant literature, was intended to reveal the major categories and core processes from the two different perspectives, prior to comparing the findings and further studying these phenomena. Subsequently, similarities and differences found in the two studies were to be explored, using additional data, different contexts, and focusing on the interaction of both nurses and patients in the delivery of care. A synthesis of these findings and those of others (in the literature) would be attempted.

The decision to use this approach was based on the complexity of the phenomena under study and the desire to capture the perspectives of both patients and nurses. There appeared to be a risk of losing some of the depth of understanding and individual focus by merging these two aspects in one project. Furthermore, I expected that the basic social psychological problems and processes inherent in the two groups involved in nursing care in the hospital would be different. Development of a grounded theory of quality nursing care might be

limited by an attempt to include both perspectives initially. The separate, in-depth exploration of each perspective was intended to enhance the eventual development of a midrange theory encompassing the interaction of both parties involved and including both perspectives of quality care. Using this approach, it was hoped to reveal dimensions of care that otherwise may have remained hidden.

THE STUDIES

On the basis of the above rationale, two grounded theory studies were undertaken in the same setting over the same period. One explored quality care from the hospitalized patient's perspective (Irurita, 1993, in press) and the other focused on the nurse's perspective (Williams, 1994). The same methodological steps were taken for both studies, which were approved by the hospital's ethics committee. The major sources of data, obtained through theoretical sampling, were recorded, transcribed, semistructured interviews with 10 patients 1 to 2 weeks following discharge from the hospital for the patient study, and with 10 nurses from the same hospital wards for the nurse study. Thirteen additional interview transcripts from patients discharged up to 3 months from a wide array of hospitals (making a total of 23 patients) and 12 additional interview transcripts from nurses working in a range of different hospitals (making a total of 22 nurses) were used in conjunction with the primary sample.

Primary data for both studies were collected, over the same 12-month period, from the same clinical area of a large, acute-care hospital in Perth, Western Australia. Patients who had been in the hospital for a minimum of 5 days and were willing and able to share their experiences were approached while still in the hospital to arrange a postdischarge interview (in their homes). Theoretical sampling resulted in a mix of 4 male and 6 female patients representing a range of ages (18-73 years), experience (first hospital admission to many hospitalizations), emergency and booked admissions, surgical and nonsurgical cases, and lengths of stay in current hospitalization (6 to 63 days). First interviews ranged from 35 to 120 minutes; four patients were reinterviewed, one twice. The nurse participants (9 females and 1 male) ranged from 21 to 45 years of age and had a variety of educational backgrounds (hospital certificates, bachelor's degrees, specialty certificates). Their nursing experience ranged from 11 months to 22 years, and the length of their employment in the study

hospital was from 9 months to 11 years. Their interviews were conducted in a quiet room in the hospital, either before or after a shift, and lasted 30 to 60 minutes; three nurses were reinterviewed.

The secondary interview data were obtained, during the same period, from a convenience sample. Postgraduate research students under my guidance and using the same objectives and interview guide collected these. The samples of 13 patients and 12 nurses had similar profiles to those of the primary samples. Only one interview was conducted with each of these participants; each interview lasted from 30 to 60 minutes. Although theoretical sampling was not used for this group of interviews, the data made available in this way proved to be extremely useful in facilitating the constant comparative method of analysis and for ensuring theoretical saturation of the major categories. Further questions raised during analysis were addressed using the primary study participants, several of whom were reinterviewed.

Additional data were obtained from participant observation of nursing practice at the study site (for several weeks during the study period), inpatient surveys administered to patients on discharge as part of the hospital quality assurance program, hospital documents, and literature. Data were managed by the Ethnograph computer software (Seidel, 1988) and were analyzed by the constant comparative method (Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990). During and on completion of the studies, coding and interpretations of the findings were reviewed for credibility by other researchers at qualitative analysis seminars, several of the study participants, and other secondary informants who had experienced either being a patient or a nurse.

INITIAL FINDINGS

Similarities were apparent in the perceptions held by both patients and nurses of some of the elements of quality care. However, as was expected, the core problem and process was different for each group. Furthermore, major categories related to aspects of care that were not evident in those of the nurses were identified in the patient data. Patients were found to share the problem of vulnerability, the level of which varied depending on factors related to the perceived risks to their integrity and the degree of control that they could retain (Irurita,

1993, in press). A process of preserving integrity was identified as reducing patient vulnerability. Initially, this was labeled *integrity preserving* and was interpreted in terms of levels of care and the perceived obligations of patients. The problem identified in the nurse data was their inability to consistently provide high quality care, dealt with by a process of prioritizing nursing care (Williams, 1994).

The Patient's Perspective: Vulnerability

The basic social-psychological problem shared by the patient participants was identified as *vulnerability*. The transition from person to patient was found to threaten a person's integrity, making that person vulnerable, that is, susceptible to physical and/or emotional hurt, harm, or injury; defenseless or weak with respect to defense or self-protection, open to assault (Irurita, 1993, in press). In the context of this study, integrity meant having control over one's life (situation); being able to protect oneself; maintaining dignity as a human being; being an individual; remaining whole, intact, undiminished (physically and emotionally or psychosocially); and being in as good a condition or as sound or unimpaired a state as possible. Many incidents of vulnerability were expressed or inferred in the data, such as, "you just feel so *vulnerable*, you just have to *wait for people to come*"; "*you might fall off the edge* and disappear"; and "The day I could help myself to the toilet was a big jump, when *you feel* like *you've got a bit of control over your life*."

Vulnerability was described in terms of the degree and type of risk or threat to the integrity and the degree of control retained by the patient. Depending on the perceived risk (to integrity) and the degree of control that patients could retain, three levels of vulnerability were identified: high vulnerability (high risk, low control), moderate vulnerability (moderate risk, low to moderate control), and low vulnerability (low risk, high control). The vulnerability level varied for any given patient during an episode of hospitalization.

Factors increasing levels of patient vulnerability were the following: (a) the illness, injury or impairment (severity, type, course), and related interventions; (b) dependence, which may be related to the illness, injury or impairment, or to diagnostic or therapeutic interventions; (c) age—the elderly were more vulnerable, ascribable mainly to ageism (negative stereotypical attitudes toward the elderly resulting in impatience, ignoring, and devaluing their input) and physical

frailty or sensory loss; (d) power imbalance between the caregiver and patient, and abuse of power; (e) lack of information or preparation; and (f) loss of identity or individuality.

Preserving Integrity

As described by Irurita (1993, in press), quality nursing care from the patient's perspective was interpreted as involving the basic social-psychological process of *preserving integrity*. This process was used by patients to deal with their sense of vulnerability by increasing control and by protecting, conserving, and restoring their own integrity. Depending on the perceived level of vulnerability, different levels of activity to preserve integrity were needed to achieve positive outcomes from the patient's perspective (considered as quality care).

Preserving integrity involved both a patient role and a nurse role. Patients perceived that they had a role or obligations in the process, such as being a "good patient" (unselfish, uncomplaining, undemanding, and not ringing the bell too often), trying to recover, and enhancing the development of the nurse-patient (patient-nurse) relationship. Examples of these strategies include the following:

> Patients should not be *too demanding*. They have to realize *they're not the only people in hospital.*

> The care you get is *a lot to do with you.* If you *try* and make your stay *as best you can,* and *not expect too much,* you'll come out on top. But if you *expect too much* and *moan and groan* for the least little thing, they're not going to spend time with you. . . . *If you're too demanding, they're going to back off.*

Even though these actions were given as having the intention and the potential to increase and enhance the quality (and amount) of care received, it was apparent in this study that they were mostly unsuccessful as integrity-preserving strategies.

The nurse role was thought to be far more salient in preserving integrity. The words *hands* and *touch* were used frequently in the patients' descriptions: "it was all *in her hands,*" "*in good hands,*" "*hands-on care,*" "*personal touch,*" "*human touch.*" Patients perceived a number of variations in the quality of "hands-on" nursing care and their relationship to the process of preserving integrity. These were identified as *soft-hand care, firm-hand care, hard-hand care,* and *rough-hand care.*

Firm-hand care referred to technically competent, mediocre, or purely clinical care. This was considered the first or minimum level

of nurse action to preserve integrity, adequate for patients who viewed themselves to be at low risk but not sufficient for those with moderate and high levels of vulnerability. It was described as "*perfectly adequate, technically*," but *not* demonstrating "*feeling*," "*sensitivity*," or "*compassion*"; "probably a *very good nurse . . . just totally clinical*," "*putting in the hours*," "*only doing their job*." Aspects of firm-hand care were the following:

- demonstrating technical competence;
- providing adequate, relevant information in a timely manner;
- attempting to equalize the power imbalance by increasing the control retained by patients, involving patients in decision making; and
- facilitating patient independence without forcing this prematurely.

Individualizing care and being flexible were also considered to be aspects of this level of care, but they were more effectively achieved in conjunction with elements of "soft-hand care," discussed later.

Technical aspects of care were assumed to be present and were commented on only when omitted, "*It's not something you think about*, you just *take it for granted*." In other words, although technical competence was a component of firm-hand care, it was not given priority by patients in this study. This is in contrast to previous findings indicating technical or instrumental actions as most important nurse-caring behaviors (Mayer, 1986; Larson, 1987). On a review of related studies, Brown (1986) declared that although patients consistently ranked instrumental activities as most important to care, and nurses ranked expressive activities more highly, both groups agreed that both these components are necessary for the experience of quality care. Firm-hand care encompassed technical competence but was found by the patients to be lacking in expressive components. These latter were deemed necessary for what they perceived to be high-quality nursing care, particularly when the patient is highly vulnerable. Patients considered technical aspects of care as something they should be able to take for granted, and that the nurse activities that made a substantial difference to their hospital experience were those encompassed in soft-hand care, a finding similar to that of Price (1993, p. 39). In other words, it was the "*other things*" that were said to contribute to high-quality care.

Soft-hand care included elements that, when added to firm-hand care, resulted in the patient's sense that the nurse was doing more than the job required. This type of care encompassed the following:

- "the little extras" to ensure physical and emotional comfort ("she went *above and beyond* what she was supposed to do");
- "being there" for patients, being available and dependable, enhancing a sense of security or safety;
- the use of touch; and
- demonstrating empathy and compassion (particularly for those experiencing high levels of vulnerability, including the elderly).

These aspects of care also facilitated nurse flexibility and individualizing patient care. Soft-hand care is reflected in statements such as:

> The nursing staff are very kind, very thoughtful. They're *always there when you need them;* nothing's too much trouble for them. They'd *pop in* to see how I was when *they didn't have to.*

> Just *being there* . . . a hand comes out and just *touches* you . . . it *reassures* you. . . . When you're *really and truly battling the odds to stay alive,* a bit of *compassion* can make the *difference between feeling that you're going to make it* and . . . you're *falling over the side.*

In addition, soft-hand care encompassed the actions on the part of the nurse to be a patient advocate and develop an effective nurse-patient relationship. Advocacy was found to be an important aspect of preserving integrity; however, it was mainly noticeable by its absence. The aspect of building a relationship was identified as central to the phenomenon of high-quality care, and experienced patients emphasized this as being a two-way process. The importance of this mutual relationship building has been described by Morse (1991), who found, as part of this process, patients made overtures toward the nurse so that he or she would "willingly become involved in their care" (p. 461). Soft-hand care was found to be essential by patients who saw themselves to be highly vulnerable, and it was very important to those with moderate vulnerability (Irurita, in press).

Hard-hand care encompassed nursing actions that contributed to vulnerability. It was described as:

- technical incompetence, omission of care or errors;
- being mechanical, doing the minimum;
- being "off-hand," unfeeling;
- rushing, bustling, "overefficient," regimenting care;
- forcing independence prematurely; and

- treating the patient as a patient or a number, not as a person or an individual.

These properties were reflected throughout the data: "They're in *such a hurry*"; "once I knew that *they might not have time to spare for me*"; and:

> And they *never put a press button* within your *reach* and you feel so *embarrassed* when you've got to go to the toilet, or something.

> I hated the thought of being treated as a *room number* and a *patient number*, because I did feel like that at one stage.

Rough-hand care encompassed nursing actions that reflected caregivers' abuse of their position of power, causing or increasing vulnerability. It was described as:

- threatening, bullying;
- rough handling;
- impatience;
- not being dependable (i.e., unreliable);
- ignoring patients, not listening to them; and
- dehumanizing, treating as objects or as "slabs of meat."

Examples included: "I found one of the nurses very *threatening*. . . . *It was all very much in her hands*"; "a couple get a bit *rough* with you . . . and *hurt* me . . . I'm a *human being* not a *piece of meat*"; and

> You were just a *body that's in the bed*. *We're* the medical staff, we'll treat you as *we see fit*. . . . They will *not listen* to a patient. A *patient* is an *object*; they *haven't got a brain*, *don't know* their own body . . . they don't know anything at all. You're *merely there*.

Rough-hand care had led one patient who saw himself as highly vulnerable to describe his situation in this way:

> *I just wanted to get out . . . I felt as though no-one there cared*. It was *bullying* and my wife said that she was bawling [crying] at the way some of the nurses treat you as though you were either *beyond it*, or *too old*, or whatever.

Other effects included despair, frustration, anger, and fear, all adding to vulnerability. Parallel descriptions of both hard-hand and rough-hand care have been reported in other research on noncaring behaviors (Riemen, 1986).

The Nurse's Perspective: Inability to Consistently Provide High-Quality Nursing Care

The basic social-psychological problem shared by the nurses in this project was their inability to consistently provide what they considered to be high-quality care because of limited time being available (Williams, 1994). This was found to cause constant dissatisfaction, frustration, and guilt feelings, which could lead to stress: "*It's very frustrating*"; "you *feel guilty* because you're *not giving them the care* that you would like"; and "you *don't have time* to talk to the patients to see what's wrong." This affected some nurses' subsequent attitudes and behavior toward patients, as nurses reported that co-workers *put themselves first before the patients* because they *feel themselves getting stressed, more and more stressed.*

The amount of time available for nursing care was found to influence the type and amount of care given. Nurses described time for clinical care to be

- quiet—abundant time for care;
- steady—sufficient time for care;
- busy—minimal time for necessary care; and
- frantic—insufficient time available for necessary care.

Various reasons were given for the lack of time, mainly relating to staffing (number and level in relation to number and type of patient), patient acuity, and availability of physical resources. This finding is consistent with another report suggesting that constraints on nursing time inhibit the development of a caring feeling toward the patient (Morse, Solberg, Neander, Bottorff, & Johnson, 1990).

Prioritizing Nursing Care

In the context of limited time, nurses prioritized care in an attempt to meet the needs of each patient within the parameters of safety (Williams, 1994). Prioritizing involved nurses assessing the physical and psychological needs of individual patients and placing these in the context of the needs of other patients in their care. An ascending order of priority of physical care (especially comfort/pain relief), psychological care, and then extra care was used. Extra nursing care incorporated aspects of both physical and psychological care; it was "*over and beyond* normal expectations" and was said to be related to a

particular attitude of the nurse in that "*nothing was too much trouble*" (Williams, 1994). This included "taking the time" and "doing the *little things*" and showed similarities to the notion of "the personal touch," an aspect of soft-hand care as described by patients. These "*personal touches*" were seen as enhancing nurses' relationships with their patients. On the basis of this process of prioritization, the level of nursing care that time allowed was delivered either immediately, delayed, left to be handed over to the next shift, or in some cases care was omitted. The quality of care provided was considered by the nurses in terms of the consequences of patient safety; patient, family, and nurse satisfaction; and patient progress.

The levels of care occurring as a result of the prioritization process were categorized as:

- low-quality care reflecting the delivery of minimal physical care, with some omissions of care;
- basic care focusing on providing adequate physical care;
- high-quality care described as incorporating both physical and psychological elements of nursing care; and
- exemplary care, called the highest level of care, which was said to consist of high-quality care with the additional dimensions of "extra care" (Williams, 1994).

These levels were found to correspond partially with the levels of care identified from the patient's perspective. Further study of these similarities and differences was indicated.

Hidden Dimensions

The above sections represent the findings of the initial analysis in each aspect (patient and nurse) of the larger project. Next, in an effort to build more complete and explanatory middle-range theory related to quality nursing care, a process of integrating and synthesizing these findings was undertaken. One aspect of that integration/synthesis was an examination of dimensions in each perspective that were "hidden" from the other.

Although the notion of vulnerability as reflected in the patient data was not evident in the nurse data, the essence of high-quality nursing care was described by the nurses as "being there" when the patient had minimal or no control over the body and "providing a protective responsibility for patients" (Williams, 1994) that acknowledged their

vulnerability. Nurses also described hospitalization as being "threatening" and "frightening" to patients.

The inability to consistently provide high-quality care as reported by the nurses was also partly supported in the patient data. Lack of time, perceived as being due to high patient turnover; shortages of staff; and lack of consistency in assigned nurses featured prominently in their data. Patients acknowledged that competing demands on the nurses' time compromised the level of care they received. However, the patient data did not reveal any awareness of the guilt, frustration, and dissatisfaction felt by nurses as a result of this problem.

Considerable consistency was evident between other findings of both studies in that similar levels of care and descriptions of high-quality care actions and interactions were identified in both data sets. Nevertheless, several aspects strongly evident in the patients' data were missing in the nurses' data. The most noticeable differences (i.e., elements repeated in the patient data but not present in the nurse data) included references to ageism, rough-hand care (threatening, bullying, rough handling, and treating patients as objects or "slabs of meat"), some aspects of hard-hand care (treating as a number or "just a patient"), and the notion of "being a good patient." Some elements were present in both data sets, such as ignoring and not listening to patients, being impatient and unreliable, and these overlapped with the nurses' description of low-quality care. Descriptions of low-quality care were more consistent with hard-hand care, basic care was similar to firm-hand care, and high-quality and exemplary care matched aspects described by patients as soft-hand care.

The basis for prioritizing nursing care was given as the assessment of the patients' physical needs primarily, with psychological needs being given secondary consideration. On the basis of the findings of the patient study, prioritizing nursing care in contexts of limited time would be more effective for preserving patient integrity if this included an assessment of the patients' sense of their own vulnerability on an ongoing basis.

ONGOING ANALYSIS

After comparing the patient and nurse data sets for dimensions "hidden" in each perspective, and for elements that were parallel or complementary, the investigators' attention was then directed to advancing analysis of each data set to allow clarification of the basic

processes. Further analysis of the nurse data set is now under way (A. M. Williams, personal communication, 1995). The following section outlines the ongoing development of the process called *preserving integrity*, from the patient's perspective.

Initial analysis of the patient data suggested a continuum of levels of care involved in the process of preserving integrity, as well as the patient's perceived role in this process (Irurita, 1993, in press). Ongoing analysis of the data has revealed phases in the process of preserving integrity. These phases subsume both the identified levels of care and the patient's perceived role and have been identified as *knowing what to expect, contributing to care, eliciting a nursing presence.*

Knowing What to Expect

This initial phase of preserving integrity involved, first, the patients knowing what to expect and what was expected of them—being well informed or prepared in relation to all aspects of hospitalization and their care. Ideally, this process began prior to admission, depending on the nature of their condition, and extended to preparation for discharge from hospital. Second, knowing the nurse (and the nurse knowing the patient) contributed to the establishment of an effective nurse-patient relationship. This depended on the availability of time, actions of the patient, and the attitude of the nurse. Third, knowing they were in good hands encompassed perceived technical competence and the nurse appearing self-confident. The phase of knowing what to expect was particularly effective in increasing patient control but also reduced threats to integrity: "*knowing what to expect* helps"; "I had *no way of knowing*, it's *awful not knowing*"; "you want *more truth*"; "The most important thing is *knowledge*."

Contributing to Care

This phase included the aspects of preserving integrity in which patients were able to contribute to their care and depended on the caregiver listening or attending to them; facilitating, without forcing, independence; including patients in decision making; and acknowledging that patients "know their own bodies" and have a role in their care. The importance of having an effective patient advocate was emphasized in cases where the patient was not able or not allowed to participate actively. Patients' efforts to contribute to their care included trying to recover and contributing to the establishment of the

nurse-patient relationship: "*try to do as much as I can*"; "*You've got to listen . . . learn*"; "*I'm quite capable of making decisions*"; "You *know your own body* better than nursing staff on many degrees . . . they should *listen*"; and:

> If a nursing system is going to work for you, *you've got to work with the nurse* . . . to be a *team*. The patient and nurse have to *work together* . . . to make it a success. *You're both there to get you better.*

Eliciting a Nursing Presence

This phase included patient actions designed to elicit and sustain nursing interaction, thus increasing the likelihood of quality care. The category of being a good patient was included in this phase as was being seen to be trying to recover: "I *tried* pretty hard . . . they knew *I was not a quitter*." These aspects were intended to attract the favor of nurses, ensuring a quicker response to the call bell and a lack of impatience shown by the nurses: "They probably thought *I was not trying . . . they were sick of seeing my face*." Strategies described as contributing to the development of an effective nurse-patient relationship also aimed at attracting more attention in that nurses would stay at the bedside longer to talk, not rushing away, or they would return more often: "There is a *play between the nurse and the patient*"; "it means they come back—you'll get more attention"; and

> when they *come back* to do your treatment, because you've got a *common interest, they are not in such a hurry to race off.*

> If you start *demanding* . . . they're going to get sick of you. You've got to give and take a little.

Attracting and sustaining nursing presence, especially for very vulnerable patients, was a crucial aspect of preserving integrity and encompassed the categories of being there, the personal touch, empathy and compassion, and the use of touch, all aspects of soft-hand care. Although patients themselves were unable to bring about these actions, they reported positive effects in terms of preserving integrity. Conversely, very negative outcomes were evident when this phase was omitted. Evidence of these elements was interspersed throughout the data: "*Human contact is absolutely essential*"; "they come and *put their hand on your hand*, just so that you *know you're not alone*"; "*they took the time . . . a few minutes to sit down and talk*"; "*they come back of their own accord*"; and:

Nurses would *come in* on a fairly *frequent* basis, the sort of *presence . . . the support* they gave, they were *sensitive to your position.*

If you saw someone was really *pulling with you* . . . you couldn't believe what that meant . . . *the bond that came from that person when they touch your hand* as if to say, *I'm with you, I'm helping you, I'm attending you.*

SUMMARY

Clearly, the patients' input to preserving integrity was limited: They were unable to control many of the factors involved in the interactions and the setting; the process, from the patients' perspective, depended to a large extent on the nurses' availability, willingness, or ability to facilitate or engage in the actions or interactions described by the patients. Hence it is necessary to critique this analysis in conjunction with the analysis of data from the nurses' perspective.

In addition to comparing the analysis of the patient and the nurse data sets, the pertinent literature was used as a source of data (Irurita, in press). Many of the aspects identified in vulnerability and the process of preserving integrity were supported in findings of other studies (Bottorff & Morse, 1994; Brown, 1986; Gardner & Wheeler, 1987; Jenny & Logan, 1992; Lawler, 1991; Levine, 1973; Morse, 1991, 1992; Price, 1993; Riemen, 1986; Swanson, 1991). These reports, and others, were used to further the process of constant comparative analysis, seeking similarities and differences to the categories and processes identified in this project.

For example, the phases of preserving integrity identified in this study show some similarities to those identified by Price (1993) in her study of the process of receiving quality nursing care in which she focused on the perspective of parents of hospitalized children. Price's phase of "maneuvering" involved "parent helping" (as in contributing to care), "being nice" (as in being a good patient), and "nurse attracting" (as in eliciting a nursing presence). "Nurse technical" and "nurse repelling" were described by Price as nurse behaviors that did not promote effective maneuvering and gave support to the limitations of patient strategies found in this study.

The "process of knowing" was described by Price (1993, p. 38) as getting to know or not getting to know the nurse (as in knowing what to expect). This was said to follow "maneuvering" and involved the concept of time, similar to aspects of knowing described here. It was represented by the nurse understanding the individuality of the

patient. "Positive relationship" was given as a necessary foundation for receiving the ultimate goal described by Price as "quality nursing care" (p. 39). Activities labeled by Price as "personable care," given as part or positive relationship, reflect aspects of soft-hand care and the notion of eliciting a nursing presence. Quality care was described by Price (p. 40) in terms of patients' needs being met and involved positive reciprocal interactions between nurses and the child and parent (patient), similar to the nurse-patient relationship of this study.

Thus the extant literature provided some support to the findings of this project. Further study of this theory of preserving integrity, through aggregating the data sets and provisional analysis from both studies (Irurita, 1993, in press; Williams, 1994), should enable the development of a broader, more generally applicable theory (Estabrooks & Field, 1994).

The Progressive Nature of Grounded Theory Development

This article highlights the progressive nature of theory development, using grounded theory method, as seen in

- the initial separation for study of the perspectives of different groups involved in a complex interaction in the same setting, prior to focusing on the total situation and interaction in the one context, or expanding to other settings/contexts;
- aggregation of data from separate studies to further theory development; and
- theory building as an ongoing process involving progressive levels of analysis and/or synthesis.

The study reported here is ongoing and has progressed in stages. A fresh look at the data (and further theoretical sampling) at different points in time, after periods of time and reflection, has enabled a gradual clarification and building of theory to proceed. This article demonstrates that it is possible to pause at strategic points along the way to substantive or formal theory development in order to report the findings at different levels, while remaining faithful to the principles of grounded theory method.

Studies may be reported at the descriptive level of analysis, or findings may be in the form of a conceptual model showing the major categories and the hypothesized relationships between these. Reporting of descriptive or provisional findings may be necessary as a

consequence of external factors, such as the constraints of funding agencies, which may dictate a lower level of analysis. However, when reporting the findings, one should be clear about how the grounded theory method was used and what level of analysis was achieved. Furthermore, the concepts should be well developed (i.e., categories are saturated), even though they may not be elevated to a high level of abstraction or the linkages between concepts may not be completely developed. In this way, the findings should make a useful contribution to knowledge and eventual theory development.

As described by Morse (1994, p. 25), data analysis in qualitative methods involves the cognitive processes of comprehending, synthesizing, theorizing, and recontextualizing. A descriptive level of findings may be achieved as a result of employing the processes of comprehending, the collection and analysis of "enough data to be able to write a complete, detailed, coherent, and rich description" (p. 27), and synthesizing, "the merging of several stories, experiences, or cases to describe a typical composite pattern of behavior or response" (p. 30). This level of analysis was attained by Williams (1994) in the description of factors affecting prioritization of nursing care. The cognitive process of theorizing gives qualitative data structure and qualitative findings application (Morse, 1994, p. 32). It is "the constant development and manipulation of malleable theoretical schemes until the 'best' theoretical scheme is developed" (p. 32). This level of analysis may result in the development of typologies, models, or theory and was the level reached prior to the initial report of the patient study (Irurita, 1993) describing types of care received and the factors influencing patients' perception of their own vulnerability.

Recontextualizing, as described by Morse (1994) as the "real power of qualitative research" means "the development of the emerging theory so that it is applicable to other settings and to other populations to whom the research may be applied" (p. 34). At this cognitive level of analysis, the work of other researchers and established theory is seen as playing a critical role, and in grounded theory method, the result of this level is given by Morse as the development of substantive or formal theory. Recontextualizing was undertaken in the ongoing development of phases in the process of preserving integrity (Irurita, in press) and is an ongoing process as this theory is further developed.

Glaser (1978, p. 144) described substantive theory as one developed for a substantive or empirical area of inquiry, and formal theory for a formal or conceptual area of inquiry. Or, as described by Morse

(1994), "Substantive theory is context bound" and "formal theory is more abstract and may be applicable to many settings or other experiences" (p. 40). Whereas the ultimate aim of grounded theory method is the latter, this should not deter its use for smaller studies or for segments of larger studies, the data and findings of which may be used progressively to develop theory to a higher level of abstraction. It is only through appreciating the ongoing nature of theory development that the potential of grounded theory method will be fully realized for research in complex areas of health care delivery.

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Vera F. Irurita is an associate professor, and former Head, in the School of Nursing at Curtin University of Technology, Perth. She has extensive experience in various areas of nursing, rural and urban. She gained her master's degree at the University of Washington, Seattle, under a WK Kellogg Foundation Fellowship, and her Ph.D. at the University of Western Australia, in the area of nursing leadership. Her current reseach interests are in theory development in nursing and caring and focus on incorporating the patient/client's perspective using qualitative research methods. She conducts grounded theory seminars for postgraduate students.