A Lonely Endeavour: Clinical Nurse Leadership and the Older Unpopular Patient in Community Settings.

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A thesis submitted in partial fulfilment of the requirements for the award of Professional Doctorate in Nursing of the University of Portsmouth

2014
Declaration.

Whilst registered as a candidate for this degree, I have not been registered for any other award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

Jacqueline Metcalfe
2014.

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Abstract

*Rationale for the Study:* High quality care is high on the national agenda together with the centrality of clinical nurse leadership to achieve this. The issue of the unpopular patient in nursing, as someone nurses do not enjoy caring for, is important, because when it occurs, the prejudice negatively impacts the quality of nursing care. Yet the concept of the unpopular patient has been rarely studied, and the specific experience of clinical nurse leaders, who are said to set the climate and tone of the care setting, has not previously been explored.

*Aim of the study:* To explore the lived experience of clinical nurse leaders leading a team caring for an older patient perceived as unpopular in community nursing settings.

*Methodology/Methods:* A Heideggerian hermeneutic approach was taken. Data was gathered using in-depth semi-structured audio recorded interviews with eleven female clinical nurse leaders.

*Findings:* Five themes which contributed to the whole interpretation; “Knowing the Unpopular Patient”, "Being Faithful”, "Betwixt and Between”, "Joined at the Hip" and "Growing into Leadership". The visible meanings of the experience included moral distress and moral courage, and the hidden meaning was the loneliness the clinical nurse leaders seemed to experience when trying to prevent, or address, the development of the older unpopular patient.

*Implications for practice and research:* NHS organisations need to be aware that clinical nurse leaders may feel distressed and lonely as a result of trying to create a culture of quality care and dignity in difficult circumstances.

*Original contribution to knowledge:* The unpopular patient also exists in community nursing settings, and importantly, clinical nurse leaders can experience
moral distress and loneliness in response to the attitudes and behaviours of their staff team as the 'wounds of clinical nurse leadership'.
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1.0 CHAPTER ONE- INTRODUCTION TO THE THESIS.

1.1 Background.

In 1972, Stockwell's study suggested the presence of the unpopular patient in nursing in *The Unpopular Patient* (Stockwell, 1984, p.1). Stockwell defined the unpopular patient as 'patients whom the nursing team enjoy caring for less than others' (Stockwell, 1972, p.11), and the term the 'unpopular patient' is now synonymous with the term the 'difficult patient' used by other authors (Conway, 2000, p.1). Stockwell's study revealed the existence of prejudice in nursing (Woodward, 1999, p.391), and a reduction in care quality for patients who were unpopular with nurses (Allen, 2003, p.14). Frequently unpopularity was related to individual patient personality, and at times, personality alone determined unpopularity (Stockwell, 1984, p.27). However, nurses were reluctant to acknowledge that they treated unpopular patients any differently, despite observed discriminatory behaviour such as ignoring them, forgetting requests, enforcing rules, and being sarcastic. This means that unpopular patients are likely to experience isolation at a time when they are most vulnerable (Lowbridge & Hayes, 2013, p.448).

Most of the literature in relation to the unpopular patient is either anecdotal, or originates from North America. The concept of the unpopular patient has not been widely addressed (Juliana, Orehowsky, Smith-Regajo, Sikora, Smith et al, 1997, p.5; Conway, 2000, p.2), and although it remains relevant to nursing today, and continues to be discussed in the popular literature (Price, 2013, p.27), there is limited research on the subject (Lowbridge & Hayes, 2013, p.448), and limited evidence on how widespread the problem is. Nurses are expected to provide compassionate, respectful and dignified care, treating each person as an individual, and yet the presence of the unpopular patient indicates that this does not always happen. The available literature is very limited in relation to the older unpopular patient, and available studies did not explore the experience of the clinical nurse leader when their teams are caring for an unpopular older patient.
The structure of this thesis commences with a review of the literature in relation to the contemporary drivers for high care quality, clinical nurse leadership as central to care quality including the influence of organisational culture, my involvement in the area of the unpopular patient which prompted the inquiry, followed by a review of the literature on the unpopular patient and the justification for the research question. This is followed by the qualitative methodology and approach taken to the study. The unique findings are then presented as the themes and sub-themes, as the visible and hidden meaning of the interpretation. The discussion which follows sets the findings in the context of the contemporary literature, highlighting the implications of the findings and recommendations. The final chapter provides the researcher's reflection on this doctoral programme of study.

1.2 Introduction to the literature review.

To inform this thesis, Chapter 2 explores the current contemporary drivers in the NHS for high quality care for older people, which aim to put patients at the heart of the NHS (DH, 2010c, p.3), supported by a public and professional drive to review the value of compassionate care (Turkel & Ray, 2004, p.249). The literature review then introduces general leadership theory and explores the importance of leadership in the NHS for high quality care proposed by the Department of Health & National Health Service Commissioning Board (2012, p.11). This is followed by the literature related to clinical nurse leadership, as clinical nurse leaders are suggested to be core and central to the high quality care (DH, 2000,p. 86; Shirey, 2005, p.61; DH, 2008, p.65 ; Murphy, 2009, p.28; Barwell & McDonald, 2012, p.S3; Willcocks, 2012, p.1). The review reveals how clinical nurse leadership is said to be poorly defined (Stanley, 2004, p.39), and how its uniqueness as a leadership role has also been unrecognised (Stanley & Sherratt, 2010, p.116), but aims to present the broad components of the role suggested in the literature for good clinical nurse leadership. Components of poor clinical nurse leadership, the outcomes of good clinical nurse leadership, and the support needed for good clinical leadership by the organisation are then presented.
The chapter then goes on to explore how, as a researcher, it was important to reveal how I have been involved with the area of interest suggested by Drew (1989, p.431), and my experiences of the unpopular patient are made explicit. This is followed by a review of the literature focused on the unpopular patient in general nursing settings and specifically the interpersonal, or relational problems, between the nurse and the patient. Such factors have been found to negatively impact on care quality, and as the clinical nurse leader is considered central to care quality, the exploration of their experience was important. The literature review also includes those factors which contribute to the situation within society and within nursing, and the consequences for both nurses and patients. The literature review highlighted gaps in what is known, specifically in relation to the older unpopular patient, studies undertaken in community settings, and the experience of the clinical nurse leader when leading a team caring for an unpopular patient. This study aimed to address this by exploring the experiences of clinical nurse leaders when their teams were caring for an older unpopular patient in a community nursing setting. The chapter concludes with the justification for this study, which was to reveal greater insight into a largely invisible concern (Rubin & Rubin, 1995, p.52), in a previously under-researched area of nursing (Weaver & Olson, 2006, p.466). The study is unique as it explores the unpopular patient from the perspective of the clinical nurse leader. In addition it is unique because it focuses on previously rarely explored areas in relation the unpopular patient, which are, firstly the older unpopular patient, and secondly, community nursing settings. Further discussion about the justification for the study can be found in Section 2.16.

1.3 Introduction to the methodology and methods.

Chapter 3 presents the formal ethical approval and research and development approval for the study, and the methodology and methods. The researcher’s ontological and epistemological beliefs are explored. The rationale for taking an interpretive qualitative approach employing Heideggerian phenomenology is discussed. This is followed by the approach taken to answer the research question in
accordance with the chosen philosophy, using one to one in-depth interviews to explore the lived experience of clinical nurse leaders in community settings leading teams caring for an older unpopular patient. The data analysis was approached iteratively using hermeneutic approaches as suggested by Crist & Tanner (2003, p.202), to include the uncovering of hidden meaning within the data advocated by Dowling (2004, p.32), supported by the methods suggested by Cohen, Kahn & Steeves (2000).

1.4 Introduction to the findings of the study.

Chapter 4 presents the findings of the study which employed a Heideggerian Phenomenological approach. This approach upholds that the meaning of something must be understood as a whole, which may have inseparable parts (Overenget, 2001, p.99). Therefore the findings are presented as the themes of the interpretation which contributed to the visible meaning and interpretation. These themes are Knowing the Unpopular Patient, Being Faithful, Betwixt and Between, Joined at the Hip and Growing into Leadership. Following this, the whole and hidden meaning of the interpretation, the experience of loneliness for the clinical nurse leaders, is presented.

1.5 Introduction to the Discussion Chapter.

Chapter 5 firstly presents a discussion of the most novel findings in relation to the contemporary literature. The findings are placed in the context of what is already known about the unpopular patient and what this study adds, including the seemingly ironic finding that the clinical nurse leader who addresses poor attitudes and behaviours can become the unpopular nurse. The chapter then presents the experiences of the clinical nurse leader in relation to the older unpopular patient, including moral distress which is under-researched in nursing, and moral courage, about which there are also relatively few studies. The chapter includes the implications of the findings, and what the study adds to the current body of knowledge. This is followed by a discussion of the whole meaning of the
interpretation, which was illuminated from between the lines of the data, and this is the loneliness which the clinical nurse leaders seemed to experience. The experience of loneliness for clinical nurse leaders has previously not been well reported and is therefore another important finding. The chapter continues with the approach taken to maintain the rigour of the research, followed by the strengths and weaknesses of the study.

1.6 Introduction to the researcher’s reflection.

Chapter 6 presents my reflections on the experience of undertaking the professional doctorate and a primary piece of research. The chapter includes why I chose to undertake the Professional Doctorate and my reasons for my interest in the topic of the research. The chapter also includes my reflection on my personal journey during this undertaking.
2.0 CHAPTER TWO-LITERATURE REVIEW

2.1 Introduction.

This chapter commences with national concerns about care quality for older people and the drive for high quality care in the NHS, which includes compassionate and dignified care. The importance of leadership in the NHS, including nursing leadership and clinical nurse leadership, as major contributors to high quality care, are then discussed.

This is followed by a discussion in relation to the lack of clarity around the requirements for clinical nurse leadership and the confusion this causes, the qualities nurses value in clinical nurse leaders, and the suggested requirements for nursing values and ethics within the clinical nurse leadership role. The components of poor clinical nurse leadership, the outcomes of good clinical nurse leadership, the importance of the organisation for effective clinical nurse leadership, the link between clinical leadership and patient outcomes, and the challenges of clinical nurse leadership are then discussed.

The chapter then continues with an introduction to the importance of clinical nurse leadership in the arena of the unpopular patient and my personal interest in the field. This is followed by a review of the literature focused on the unpopular patient in nursing in order to understand what is already known about the subject, and to identify any gaps in the literature.

2.1.1 Nursing and the ageing population.

The number of people in this country over 80 years of age will triple by 2050 (Office of National Statistics, 2010; Joseph Rowntree Foundation, 2012, p.6), and within an ageing population nurses spend most of their time caring for older vulnerable people (Pope, 2012, p.32), as two thirds of hospital beds are occupied by older people
Older people also constitute the largest patient group in care homes (Taylor, 2011, p.5). Chronic illness and disability can render older people more vulnerable, and various reports have expressed concern over how older people’s dignity is diminished in care settings (Baillie, Ford, Gallagher & Wainright, 2009, p.22).

2.2 The drive for high quality care in the NHS.

Recent NHS reforms have put care quality in the NHS higher up the agenda (DH, 1998a, DH, 1998b, DH, 2000, DH, 2001b, DH, 2001c), underpinned by the drive to ensure that patients are treated as individuals (Williams, 2007, p.59). Central drivers support safe and effective high quality care which is compassionate, dignified, respectful, and personalised (DH, 2008, p.10). More recently, the focus of putting patients at the heart of the NHS was re-asserted, centred on personalised care (DH, 2010c, p.3), and ensuring no trade off between efficiency and patient safety (DH, 2010d). In addition, the NHS Outcomes Framework 2013/14 (DH, 2012b) intends to drive up quality by encouraging a change in culture and behaviour in NHS organisations. Another driver, The NHS Patient Experience Framework (DH, 2011), highlighted the importance of care providers having patient centred values, respecting preferences and expressed needs, the provision of emotional support, and welcoming the involvement of patients and their family and friends. Therefore policy drivers have continued to recognise that quality of care not only depends on the treatment given, but also the way in which it is delivered (DH, 2001a).

2.2.1 The NHS Constitution.

The NHS Constitution (DH, 2012a) reinforces that a principle of the NHS is to provide safe, high quality care focused on positive patient experience, and that NHS values include respect, dignity and compassion (DH, 2012a, p.14). The later handbook (DH, 2013c) highlighted the responsibilities of staff to uphold the highest standards of professionalism, treating patients and relatives with sensitivity and kindness (DH,
The principles are therefore set, yet to achieve this, staff need to be supported and feel valued in order to provide care which is respectful and compassionate (DH, 2013, p.13), and it is suggested that if the NHS Constitution is to guide behaviour in the NHS, it needs to be given a very high profile (Nuffield Trust, 2013, p.5).

2.2.2 Restoring compassionate care.

Nursing has been said to be defined by its inherent values such as treating others with respect (Snellman & Gedda, 2012, p.714), and staff attitudes can have a significant impact on care quality (Taylor, 2011, p.11). Recently there has been a public and professional call to review the value of compassionate caring (Turkel & Ray, 2004, p.249), and compassion is cited as a core value of the NHS (DH, 2012a, p.6). Truly compassionate care is said to be skilled, competent, value based care that respects individual dignity, and requires the highest levels of professionalism (DH, 2010c, p.3). It includes working in a positive way with older people, including valuing and respecting them, to enhance their sense of compassionate care (Taylor, 2011, p.13).

In response to concerns that nursing has lost compassion, Compassion in Practice (DH and NHCB, 2012), acknowledged both the poor care which happens at times, the implications of an ageing population and their increasingly complex needs, and specifically states that the nursing profession needs to work together to ensure dignified and respectful care (DH & NHSCB, 2012, p.5). The strategy focuses on components that support this shared purpose, including the need for effective leadership and the right organisational culture (DH & NHSCB, 2012, p.9). Embedding compassion as a core value through leadership is therefore said to be a key consideration, and the clinical leader's role is considered pivotal (Straughair, 2012, p.242). It has been suggested that the focus on compassion by the Department of Health mirrors that which was being considered when it funded Stockwell's (1972) study of The Unpopular Patient (Waters, 2008, p.23).
2.2.3 Restoring Dignified Care.

Dignity is defined as 'being worthy of respect' (DH, 2001a), and every encounter in health care settings is an opportunity to either enhance or violate their dignity, as unequal relationships exist between health care providers and their patients (Tadd, Hillman, Calnan, Calnan, Bayer & Read, 2011, p.170). Undignified care is that which depersonalises and objectifies people, is narrowly focused, and can be abusive or humiliating (Tadd et al, 2011, p.7).

Recent national interest has therefore focused specifically on the provision of dignified and respectful care (DH, 2001a, DH, 2001b; DH, 2001c; SCIE, 2007; DH, 2008; DH, 2010a), especially in relation to older and vulnerable people (Gallager, Li, Wainwright, Rees Jones & Lee, 2008, p.1). Many nurses do provide dignified care but this is not universal, and a lack of dignity and respect for older people is not new (Dennis & Morgan, 2008, p.14). Moreover the provision of dignified care for older people does not depend on nurses alone. It also depends on the wider organisational climate of care (Cornwell, 2012, p.1), and the clinical environment of care (Baillie, Ford, Gallagher & Wainwright, 2009, p.29). Indeed, studies have shown that patients were more likely to be treated with respect and dignity by staff who were treated in the same way by the organisation (Lupton & Croft-White, 2013, p.9).

A review of dignified care for older people highlighted that some staff were condescending or dismissive towards patients (Care Quality Commission, 2011, p.7). However, in some places poor care was isolated on one ward rather than across the hospital (Care Quality Commission, 2011, p.6), indicating the importance of the climate of care in each clinical area. Acute settings are often the focus of attention on poor quality care, but the report of the Parliamentary and Health Service Ombudsman (Parliamentary and Health Service Ombudsman, 2011) also highlighted the poor treatment of older people across a range of settings including acute, community and primary care. Such inquiries have recognised the role of clinicians in ensuring care quality (Swage, 2003, p.4). A hermeneutic study (n=12), although not specifically
focused on older people and focused in one small location, indicated concern, and concluded that care in professional nursing must be focused on protecting patients' dignity (Heijkenskjold, Ekstedt & Lindwall, 2010, p. 321).

A qualitative case study in an acute hospital has explored the nature of patient dignity and what threatens it, from a case study approach (Baillie, 2007, p.8). The patients associated dignity with feeling comfortable, feeling in control and valued, being physically well presented (including being dressed appropriately and not being exposed), and being treated with respect (Baillie, 2007, p.125). Threats to dignity included the environment (being unclean and in poor repair), staff behaviour (interactions which do not make people feel comfortable or in control) and patient factors (such as being able to develop relationships with staff). However, few staff could identify that nursing interactions which made patients feel valued promoted patient dignity (Baillie, 2007, p.225). Although only conducted on one hospital ward the findings illuminate the patient perspective on dignified care.

This study suggests that threats to dignity are varied and include the climate in which nurses practice, and another study has highlighted the importance of the climate of care. A substantial ethnographic study included interviews of patients, their families, staff and managers in four acute NHS Trusts (Tadd et al, 2011, p.61). The study identified how the fear of making mistakes produced defensive nursing practice which compromised patient dignity through actions such as limiting mobility through fear of the patient falling. This further impacted on patients and their families, who, when they raised concerns, were met with hostility (Tadd et al, 2011, p.243).

In a qualitative study using interviews older people in hospital reported that poor and inappropriate communication detracted from being treated with dignity (Webster & Bryan, 2009, p.1788), whilst nurses communicating with empathy was considered by patients to protect their dignity (Webster & Bryan, 2009, p.1790). However, nurses can be challenged to provide dignified care. The Royal College of Nursing’s largest reported survey of nurses’ experiences of promoting dignified care found nurses often
reported a lack of time as a barrier to providing dignified care, and the physical environment could also inhibit the provision of dignified care. The organisational ethos, leadership and staffing were also considered to inhibit the provision of dignified care (Baillie, 2009, p.25). Following this study Gallagher, Wainwright, Baillie and Ford (2009, p.15) commented how promoting dignified care is complex and requires amongst other things, tenacity, courage and humility, and this has implications for clinical nurse leaders.

In addition, a consultation which involved managers, professionals and other staff in acute hospitals considered how dignity is compromised (including physical and emotional care). It identified systemic root causes which undermined dignified care for older, vulnerable people (Goodrich, 2011, p.4). These causes included increased patient throughput, the increasing size of organisations, the ageing population (who have co-morbidities and more complex needs), and the increasing specialisation within medicine and nursing which fragments the care of people with complex needs (Goodrich, 2011, p.5). The stress experienced by staff, and the failure to address it, was considered to negatively impact relationships with patients as the compassionate response was negatively affected in staff who were stressed. Another systemic issue was the delegation of fundamental care to the least qualified staff, and nurses feeling guilty for spending time with patients (Goodrich, 2011, p.6). These systemic issues impact dignified care because dignified care includes the transactional and relational aspects, that is, what is delivered, and how it is delivered (Goodrich, 2011, p.3), highlighting the importance of the quantitative and qualitative aspects of nursing care. Hence, although care (dignified or otherwise) is delivered by nurses and others, the evidence suggests that the ability of staff to deliver dignified care is complex and dependent on wider factors such as organisational climate.
2.3 The theoretical basis of studies on leadership.

A review of the general leadership literature revealed that early theories (up to and including those from the 1960's) tended to focus on the characteristics and behaviours of successful leaders, but later theories moved to consider the role of followers and the context in which leaders operate (Bolden, Gosling, Marturano & Dennison, 2003, p.6). Table 2.1 highlights how leadership theory has developed from 'Great Man' theories in the nineteenth century, to 'Transformational' leadership theories in the nineteen seventies (Bolden, Gosling, Marturano & Dennison, 2003, p.6).

Table 2.1 From Great Man Theories to Transformational Leadership

| Great Man Theories (19th Century) | • Leaders are exceptional people with innate qualities and destined to lead.  
|                                 | • The use 'man' was intentional until the late twentieth century as the concept was primarily male, western and military. |
| Trait Theories (early 20th Century) | • Lists of traits or qualities existed and continue to be produced.  
|                                 | • Describe positive human attributes necessary for successful leadership. |
| Behaviourist Theories (1960's) | • Focused on what leaders do rather than their qualities.  
|                                 | • Different patterns of behaviours are grouped as styles of leadership. |
| Situational Leadership (1960's) | • Leadership which is specific to situations. Some situations may require autocratic approaches and some more participative.  
|                                 | • There may be differences in the styles required at different levels of the organisation. |
| Contingency Theory (1960's) | • Builds on situational leadership and identifies the variables which best predict the most effective leadership style in particular circumstances. |
| Transactional Theory (1970's) | • Focuses on the contract between the leader and the followers and mutual benefits such as recognition and reward for loyalty. |
| Transformational Theory (1970's) | • Central concept is change and the role of leadership in envisioning and implementing organisational change. |

However, each of the theories above has been considered to hold an individualistic perspective of the leader, and more recent schools of thought focus on 'dispersed leadership', that is, the emphasis moves from individual leaders to 'leaderful'
organisations who have a collective responsibility for leadership (Bolden, Gosling, Marturano & Dennison, 2003, p.6). Therefore the need for the leader to be accepted by their followers, and the understanding that no one person is the ideal leader in all situations, has brought a new school of leadership thought referred to as 'emergent' or 'dispersed' leadership. This approach holds that individuals at all levels of the organisation can exert leadership influence over their colleagues and the overall leadership of the organisation, and the key is the distinction between 'leader' and 'leadership'. Leadership is the process of sense-making and giving direction within a group, whilst the leader can only be identified due to their relationship in the group because others follow them (Bolden, Gosling, Marturano & Dennison, 2003, p.17).

2.4. Leadership in the NHS.

In recognition of the impact of wider organisational factors on the delivery of dignified care, in recent years there has been increasing emphasis on the need for high quality leadership in the NHS to ensure the provision of high quality care (Hewison & Griffiths, 2004, p.464). Despite this, there has been recent national concern about care quality and inquiries have highlighted a lack of leadership as a contributory factor.

In particular, the Mid-Staffordshire inquiry (at the Mid-Staffordshire NHS Foundation Trust) led by Robert Francis QC also identified systemic failings. Subsequent to the findings of the public inquiry, the Kings Fund suggested that nowhere is leadership more crucial to improving care quality than on the front line in the NHS (Kings Fund, 2013, p.13). Many of the reports of unacceptable care affected vulnerable older people. The Kings Fund highlighted that wards where the worst patient failures occurred were where strong, principled and caring leadership was lacking (Kings Fund, 2013, p.15). The clinical nurse leader was universally recognised as absolutely critical to care quality, but it was equally recognised that they faced the challenges of nurse recruitment and high turnover of older people with complex needs, making good nurse-patient relationships difficult (Kings Fund, 2013, p.15). It was argued that
the critical role of clinical nurse leaders must be recognised, and support given to clinical nurse leaders to fulfil their role (Kings Fund, 2013, p.16), and recently there has been a call to review and strengthen the role of the Ward Sister (Fenton & Phillips, 2013, p.13).

In response to national scandals, the government included a commitment to putting patients first, upholding the consistency of care quality including fundamental nursing care (DH, 2013b). This includes a commitment to positive patient experience every time, and compassion in terms of responding to patients with humanity and kindness (DH, 2013d, p.5). The need to care for the most vulnerable, including the very old, most carefully, was highlighted (DH, 2013d, p.6), and the need for compassionate care for older people, as fundamental in all settings, was accepted, with older people being valued and listened to (DH, 2013e, p.89). The government also accepted the need to ensure that a culture of compassion is developed through leadership at all levels of the NHS (DH, 2013e, p.88).

Following this inquiry The Berwick Report (DH, 2013a) called for all leaders, including clinical leaders in the NHS, to put care quality and patient safety as the top priority (DH, 2013a, p.4), suggesting systemic change was needed to reassert the primacy of working with patients and families (DH, 2013a, p.15). The need for leadership in the NHS to be visible, and to learn from those for whom they are responsible was advocated, together with the need to address the poor practice of teams and individuals (DH, 2013a, p.16). This has placed renewed emphasis on the role of leadership in the NHS as the key method to ensure the delivery of high quality care.

2.5. Nursing Leadership in the NHS.

Even prior to the Mid Staffordshire NHS Foundation Trust inquiry, the importance of good leadership within the NHS for high quality care has been recognised in commentary in the nursing literature (Firth-Cozens & Mowbray, 2001, p. ii3; Taylor, 2011, p.12), and good leadership has been said to be important for organisational
culture and effective clinical governance (Hiscock & Schudlam, 2008, p.900). Therefore leadership has been acknowledged as being central to recent NHS modernisation policy (Millward & Bryan, 2005, p.13), and has been a key consideration in the NHS due to the necessary radical changes (Clarke, 2008, p.30). Policy makers in the UK have acknowledged the important leadership role of nurses (Willcocks, 2012, p.8), including their role in managing the increasing demands on the NHS (Cummings, MacGregor, Davey, Lee, Wong, Lo, Muise & Stafford, 2009, p.2), and there have been calls to strengthen nurse leadership roles from ward to board level (Dean, 2010, p.5).

The culture of an organisation has been held as important for high quality care, and within the NHS the values and behaviours of staff, and the organisation, are also suggested to be of central importance (Bassett, 2012, p.24), and leadership is considered to have the responsibility for creating caring cultures (DH & NHSCB, 2012, p.11). However, a recent survey highlighted how Board Members were consistently more positive about the work environment than clinical staff (Kings Fund, 2014, p1). Where there have been significant organisational failings inadequate leadership has been highlighted as a common theme (Sawbridge & Hewison, 2011, p.5), and the Care Quality Commission and others have highlighted the critical relationship between leadership and the quality of patient care (Hiscock & Shuldham, 2008, p.900; Barwell & MacDonald, 2012, p.S3).

In addition, the health care leadership literature is broad and lacks consensus on the exact nature of leadership in nursing (Willcocks, 2012, p.11). In the literature, the terms nursing management and nursing leadership have been used interchangeably (Cook, 1999, p.307; Stanley & Sherratt, 2010, p.116), meaning that these concepts have been confused, but they are very different. Management is about planning, controlling and organising, whilst leadership relates to a process of influence (Millward & Bryan, 2005, p.15).
Leadership in nursing generally is under-researched and much of the literature is based on approaches within private enterprise (Davidson, Elliott & Daly, 2006, p.182). Nursing leadership in the literature can also relate to functions which may be removed from direct patient care delivery (Stanley & Sherratt, 2010, p.116). The longstanding distinction between Board level leadership and clinical nurse leadership has also been suggested (Firth-Cozens & Mowbray, 2001, p. ii3). Within nursing there are many leadership roles and these may be termed general nursing leadership roles. However, clinical nurse leadership is a role which is distinct because it is the leadership role of team which is undertaken alongside, and includes, direct patient care.

2.5.1 Clinical Nursing Leadership in the NHS.

The Department of Health and other commentators have therefore proposed that if the NHS is to achieve care quality at its heart, clinical nurse leaders are core and central to achieving this (DH, 2000,p. 86; Shirey, 2005, p.61; DH, 2008, p.65; Murphy, 2009, p.28; Barwell & McDonald, 2012, p.S3; Willcocks, 2012, p.1), and clinical nurse leadership has become central to health policy reforms across the world (Cunningham & Kitson, 2000, p.34). Initiatives which recognise the need for local leadership in clinical services also recognise that leadership should be locally meaningful and clinically responsive (Millward & Bryan, 2005, p.24), yet most importantly, the danger of casting the clinical nurse leader as the necessary change agent without a supportive infrastructure has also been highlighted (Millward & Bryan, 2005, p.21).

2.5.2 The poorly defined role of the clinical nurse leader.

A review of the literature from both the United States of America and the United Kingdom (Cameron-Buccheri & Ogier,1994, p.208) highlighted the power of the ward sister as the key person to affect patient care. However, none of the government documents which cite the necessity for strong clinical leadership define what effective
clinical nurse leadership is, and the Performance and Innovation Unit (2001) revealed that there was little understanding of the qualities required for effective leadership in the public sector generally (Cook & Leathard, 2004, p.436). Much of the nursing literature relates to more general leadership or management in the NHS, rather than clinical nurse leadership (Stanley, 2006a, p.21; Hutchinson & Jackson, 2013, p. 14), and the literature which supports nursing management has been transferred when trying to understand clinical leadership, leaving the uniqueness of clinical leadership unrecognised (Stanley & Sherratt, 2010, p.116), and poorly clarified (Stanley, 2004, p.39). Additionally, it has been assumed within the NHS that leadership qualities can be nurtured through a focus on personal competencies, but the question remains about which qualities best suit the clinical nurse leadership context (Willcocks, 2012, p.12).

Davidson, Elliot & Daly (2006, p.182) propose that implicit within the enactment of clinical nurse leadership is mentorship, supervision, clinical excellence, supporting colleagues, a positive outlook and inspiring others. However, despite the espoused central importance of clinical nurse leadership for high care quality, it is argued that limited attention has been afforded to it (Stanley, 2004, p.39; Stanley, 2006a, p.21). In addition, clinical nurse leadership has rarely been studied (Stanley, 2012, p.3; Bondas, 2009, p.352), and when it has, it has been presented in different ways in the literature including the evaluation of leadership development programmes, the role of managers who work in the clinical setting, and clinicians who practice as clinical experts, all adding to the confusion (Stanley, 2006b, p.108). It has been highlighted how, in the past, the clinical nurse leadership literature in the UK and the USA has been primarily anecdotal in nature (Cook, 2001c, p.39), with recent studies being focused on more senior posts in organisations (Stanley & Sherratt, 2010, p.116). Unfortunately, there is a lack of research in relation to who the clinical nurse leaders are, that is, who in practice are the clinical nurse leaders, and what clinical nurse leadership means to nurses and the profession (Stanley, 2006c, p.474; Stanley, 2012, p.3).
2.5.3 The broad range of components of clinical nurse leadership.

Clinical nurse leadership is said to have its prime focus on the patient or service (Edmonstone, 2009, p.292). Although there is a lack of research relating to clinical nurse leadership, the available literature (both academic and popular) presents a broad range of components and attributes which are desirable for the role. However, there is confusion and a lack of consensus, with various commentators highlighting different aspects of the role requirements as important. Despite this, the requirement for clinical expertise is cited most frequently (Cook, 1999, p.306; Gould, Kelly, Goldstone & Maidwell, 2001, p.3; Stanley, 2006b, p.110; Sawbridge & Hewison, 2011, p.7; Fenton & Phillips, 2013, p.13), and actually delivering nursing care to patients (Cook, 1999, p.306). The role is also considered to combine both management and leadership functions (Sawbridge & Hewison, 2011, p.7; Willcocks, 2012, p. 10; Fenton & Phillips, 2013, p.13), together with other functions such as the educator of nurses, professionals, patients and carers (Gould, Kelly, Goldstone & Maidwell, 2001, p.8; Sawbridge & Hewison, 2011, p.7), mentorship and supervision, supporting colleagues, and a positive approach to inspire others (Cook, 1999, p.306). In addition it is has been said to include questioning practice, problem solving, supporting change and supporting staff (West, Lyon & Gass, 2004, p.33), forging ahead to improve practice based on their values and beliefs, being open and approachable, being visible, role modelling, and being empowered decision makers (Stanley, 2006b, p.110; Stanley & Sherratt, 2010, p. 121). Highlighting new ways of doing things by engaging in practice has also been found from a small qualitative study, and respecting the feelings of others, being empathetic, influencing and enabling others, having creativity for new ways of working, tolerating chaos in change, and creating harmony in the setting (Cook, 2001a, p.35). Creativity and change management has also been highlighted within a small ethnographic study, and respecting signals from individuals and the organisation for an appropriate response (Cook & Leathard, 2004,p.439). The clinical nurse leader is also said to be both a member and a leader of the team, and is obliged to act as an advocate for the patient and nursing (Fealy, McNamara, Casey, Geraghty, Butler, Halligan, Treacy &
Johnson, 2011, p.2024), and these perspectives are said to reinforce the difference between nurse leaders in other positions, and clinical nurse leaders, who may well have different drivers, values, aims and objectives (Stanley & Sherratt, 2010, p.117).

2.5.4 Qualities associated with clinical nurse leadership by team members.

A small pilot study using questionnaires explored which qualities nurses most associated with clinical nurse leadership in a paediatric unit in England. The most common responses included clinical nurse leaders having integrity, being supportive, valuing relationships, flexibility, guiding and motivating others, inspiring confidence, critical thinking, taking responsibility, being a change agent and being compassionate (Stanley, 2004, p.41). Although the sample size was very small, the findings are similar to those of later studies.

The qualities nurses associated with clinical nurse leadership have also been found to be important in relation to why more junior nurses follow them. A study employed questionnaires for nurses and two interviews of clinical nurse leaders in one NHS Trust to identify who clinical nurse leaders were (Stanley, 2006b, p.109). Although the study identified some of the attributes above, importantly, nurses did not identify the clinical nurse leaders’ vision as the reason they followed them, but instead identified the demonstration of values and beliefs as the reason they admired and followed them (Stanley, 2006b, p.110). In addition, a study in an NHS Trust using questionnaires (n=188/22.6%) and interviews (n=42) explored the views of nurses about the qualities and characteristics of clinical nurse leaders. This study added being approachable, supportive, flexible and visible and having integrity. Other important areas included working with the team delivering care, being caring and being patient- centred. The least associated characteristics reported were being controlling, being routinised and conservative, utilising reward/punishment, showing favouritism to some staff and lacking a sense of humour (Stanley, 2006c, p. 476). Being controlling has been reported previously as being a negative aspect of clinical nurse leadership (Stanley, 2004, p.41). When asked to describe the differences
between managers and leaders, the consensus was that managers depended on their position for authority, but clinical nurse leaders depended on their ability to motivate others whilst relying on their knowledge and experience (Stanley, 2006c, p. 478). The limitations of the study included only seeking the views of Registered Nurses, and the setting being one NHS Trust.

However, a larger study using questionnaires in two different countries, undertaken six years apart, of two different groups (nurses and paramedics with different gender ratios), aimed to describe the attributes of clinical nurse leaders. The study also suggested that people relate to clinical nurse leaders when they identify with the leader's values, and when these are reflected in their actions (Stanley, 2012, p.1). Although the characteristics of clinical nurse leaders were found to be approachability, clinical competence, being supportive, mentoring or role modelling, being visible in practice, directing and helping others, giving confidence, effective communication and demonstrating integrity (Stanley, 2012, p.8), of interest is that clinical nurse leaders were respected because they had a belief in themselves and stood up for high standards of care. Being a clinical nurse leader did not depend on hierarchical position, but depended on the values and beliefs the clinical nurse leader held about care and nursing (Stanley, 2012, p.9).

In summary, clinical nurse leadership is a complex phenomenon which is multifaceted (Willcocks, 2012, p.17), and the central role of the clinical nurse leader is to translate the meaning of caring into the nursing culture (Bondas, 2003, p.251). Essentially, clinical nurse leadership can be summarised as the effective delivery of health care at the front line (Millward & Bryan, 2005, p.20), or patient care level (Willcocks, 2012, p.10), and transforming the service to meet patient need (Willcocks, 2008, p.158). It is considered unique as a leadership role as it includes the responsibility for the care and safety of patients, and monitoring individual and service outcomes (Davidson, Elliott & Daly, 2006, p.182), and studies have revealed some consistency in the reported desirable attributes of clinical nurse leaders. However, although many attributes have been suggested, as discussed, nurses have reported that having
integrity (Stanley, 2004, p.41), holding appropriate values and beliefs (Stanley, 2006b, p.110: Stanley, 2012, p.9), and standing up for high standards of care (Stanley, 2012, p.9) are the attributes they admire and respect in clinical nurse leaders.

2.5.5 Values and ethics.

Clinical nurse leadership has also been described as being defined by the values and beliefs the leader holds about care, nursing and respect for others (Johansson, Sandahl & Andershed, 2011, p.144), and having values and beliefs about care on show (Stanley & Sherratt, 2010, p.121). The skills and attributes of clinical leaders are considered to dramatically impact upon patient care quality (Stanley, 2012, p.1), and when facing challenges it has been suggested that clinical nurse leaders are recognisable because they display their principles about the quality of care (Stanley, 2008, p.521). In addition, the translation of the leader's values and beliefs into the actions and functions of clinical nurse leadership is said by nurses to be why they are admired and followed (Stanley, 2006b, p.110), and excellence in care delivery has been considered to come from within the clinical nurse leader (Grossman & Valiga, 2000, p.77).

A qualitative study using narratives and grounded theory in Finland (n=65) aimed to explore how clinical nurse leaders developed nursing care. The findings included creating a caring atmosphere based on human dignity (Bondas, 2009, p.356). However, the limitation of the study was that it was self-reported rather than observation of practice, and whilst the clinical nurse leaders reported that their aim was to create a caring atmosphere, it is unclear to what extent they were able to do this.

Ethics are a set of principles that guide conduct and morals are what people do, but having ethical principles does not mean a person will act morally (Storr, 2004, p. 417). In light of major scandals in health care, and the rapid changes and challenges the
NHS faces, it has been argued that ethical leadership which is informed by values and moral codes is needed to underpin leadership behaviour (Willcocks, 2011, p.97), and clinical nurse leaders need to set an ethical climate of nursing practice (Shirey, 2005, p.63). It has also been argued that clinical nurse leaders need to live their ethical values in their leadership actions (Willcocks, 2011, p. 97), having an awareness of guiding principles, and guiding and shaping the behaviour of others in an appropriate manner (Storr, 2004, p. 417). Although the importance of values and ethics within clinical nurse leadership is gaining prominence, Cook (2001c, p.45) suggested that constantly seeking to define the necessary range of skills, traits and attitudes for clinical nurse leadership will not provide the solution to the issue of what a clinical nurse leader is. Instead, Cook argues that opportunities to articulate values and views in a supportive environment are more important, and this reasserts the importance of the climate in which clinical nurse leaders work. In relation to this, it has recently been suggested that good care can only be achieved when the whole organisation has the core values of dignity, respect and equality as overriding values, and if compassionate care is to be achieved, staff must be treated in the same way (West, Steward, Eckbert & Passmore, 2014, p.10).

2.5.6 Poor clinical nurse leadership.

In a large qualitative study, poor clinical nurse leaders have been identified by nurses as those who are gossipping, moody, not listening or lazy. In addition they were dictatorial, lacked humour, were bullies, were not aware of what was going on, were unapproachable, disinterested, disorganised, favoured individuals, were poor communicators and did not engage in clinical care delivery (Stanley, 2012, p.29). Therefore, it has been suggested that clinical nurse leadership is not just about the competency of the person. Instead, it depends on the readiness and motivation to assume a clinical nurse leadership role (Willcocks, 2012, p.16).
2.5.7 Outcomes of clinical nurse leadership.

The Healthcare Commission (2008, p.39) highlighted nursing leadership as one of the most important factors for providing good, safe and dignified care, yet little is said to be known about the relationship between this and patient outcomes (Wong & Cummings, 2007, p.509). A systematic review of English studies exploring the link between nurse leadership and patient outcomes concluded that the mechanisms by which leadership was related to patient outcomes were indirect, being related to changing the work context, influencing nurse behaviour which facilitated improved patient care and outcomes, and the possibility that effective leadership is related to improved patient outcomes through increased nurse job satisfaction. Patient satisfaction was also significantly associated with positive leadership behaviours, but a wide span of control reduced the effect of positive leadership behaviours on patient satisfaction (Wong & Cummings, 2007, p.518). It was concluded that if nurse leadership has an indirect relationship with patient outcomes through staff, there is a need to better understand how leaders are either able, or unable to influence staff performance (Wong & Cummings, 2007, p.519), and this is of particular relevance to the concept of the unpopular patient because its presence implies sub-standard care, and clinical nurse leaders are said to set the tone of the care setting.

Although leadership to build quality work environments is considered important, how such leadership is enacted is rarely indicated. A systematic review examining the relationship between leadership style and outcomes for the nursing workforce supported that people focused leadership, (supportive and considerate, rather than task focused practices such as pacesetting and commanding), led to better outcomes for the workforce, the working environment, and productivity and effectiveness (Cummings, MacGregor, Davey, Lee, Wong, Lo, Muise, Stafford, 2009, p.16). This has implications for clinical nurse leaders working to negate the development of the unpopular patient by supporting their staff to have a patient centred approach and the creation of a caring climate.
2.5.8 The importance of the organisation for effective clinical nurse leadership.

Also of importance in terms of clinical nurse leadership effectiveness is the context in which the clinical nurse leader works. Yet there is evidence that nurses are ill prepared for clinical nurse leadership roles (Cartier, 1995, p.276; Douglas, 2008, p.767), and that clinical nurse leaders struggle to appreciate the difference between bedside nursing and clinical nurse leadership (Bondas, 2009, p.353). Studies have highlighted that clinical nurse leaders received little support from the organisation as they move from the role of nurse to clinical nurse leader (Cunningham & Kitson, 2000, p.34; Paliadelis, Cruickshank & Sheridan, 2007, p.830), and opportunities to learn to lead are inadequate (Willmott, 1998, p.424; Gould, Kelly, Goldstone & Maidwell, 2001, p.7; Cook & Leathard, 2004, p.440; Paliadelis, Cruickshank & Sheridan, 2007, p.832; Lawrence & Richardson, 2012, p.7). In addition, a qualitative study in the United Kingdom reported that fifty-nine per cent of clinical nurse leaders have received no formal leadership preparation (Sutherland & Dodd, 2008, p.577), and in another study, sixty-six per cent (Fealy, McNamara, Casey, Geraghty, Butler, Halligan, Treacy & Johnson, 2011, p.2029). Yet scepticism in relation to formal education meeting their needs as clinical nurse leaders has been found to be held by them (Lawrence & Richardson, 2012, p.7), possibly because it is felt that formal leadership programmes fail to deal with the unique challenges of clinical nurse leadership (Cook & Leathard, 2004, p.440).

The demands of the role mean that newly appointed clinical nurse leaders have reported achieving a balance between the clinical demands, organisational demands, and patients and their families to be challenging (Waters, Clarke, Ingall & Dean-Jones, 2003, p.517). Clinical nurse leaders have reported often learning by trial and error in organisations, which they feel, do not value their role or support them (Paliadelis, Cruickshank & Sheridan, 2007, p.831). Yet it is suggested that whilst clinical nurse leadership preparation can be considered important, again the more powerful influence is a culture where clinical nurse leadership is fostered and rewarded (Cook, 2001b, p.28), as cultural barriers can inhibit clinical nurse leadership
where there is inadequate support (Millward & Bryan, 2005, p.xxi). Newly appointed clinical nurse leaders may therefore benefit from mentorship, and newly appointed clinical nurse leaders in one study reported needing to feel supported and valued, being able to contribute to the organisation's decisions, and receiving feedback as important factors within mentorship (Waters et al, 2003, p.524). However, although mentorship may be helpful, the wider climate remains important so that clinical nurse leaders can enact their values.

2.5.9 The challenges of clinical nurse leadership.

Various challenges have been cited for clinical nurse leaders including balancing the demands of their roles, challenging poor practice and staffing levels.

2.5.9.1 The challenge of balancing demands.

Poor preparation for the role of clinical nurse leader has been discussed in section 2.5.8, and the current pressure to increase quality whilst achieving cost efficiency has been highlighted (Wikstrom & Dellve, 2009, p.411). This can further challenge clinical nurse leaders as they strive to maintain a caring environment (Hardt, 2001, p.37). It has also been suggested that there can be tensions when the role is viewed as primarily related to staff and ward resources, rather than to ensure high care quality and a positive patient experience, and that these tensions can affect the environment of care (Sawbridge & Hewison, 2011, p.7). An additional challenge suggested is that the clinical nurse leader's team will have their own beliefs, attitudes and expectations, and these influence the individual's responses to the leader, the organisation and their desire to accept change (Oliver, 2006, p.44). In view of this it has been proposed that the development of followership, or the capacity of individuals to follow the leader, needs as much attention as clinical nurse leadership (Ham, 2003, p.9373), and this too is important in relation to the concept of the unpopular patient.
The demands on the clinical nurse leadership role have been reported to have increased in multiple ways in recent years including patient complexity, efficiency demands, and managing the budget and staff, which it has been argued, can make the job almost impossible (Fenton & Phillips, 2013, p.13). The role conflict between the managerial and leadership components of the role have also been highlighted by various studies (Willmott, 1998, p.424; Stanley, 2006b, p.108; Delmar & Pedersen, 2011, p.424; Stanley, 2012, p.32; Gaskin, Ockerby, Smith, Russell & O'Connell, 2012, p.625). In an ethnographic study in Denmark, nurses reported their roles were taken up with administration which sometimes took priority over clinical work (Sorensen, Delmar & Pedersen, 2011, p.425), and this has been reported elsewhere (Lawrence & Richardson, 2012, p.5). Another study employing an occupational stress questionnaire described how half the clinical nurse leaders reported emotional exhaustion and feelings of frustration on a daily basis, with the other half reporting this on a weekly basis. Feelings of accomplishment were also reported as low (West, Lyon & Gass, 2004, p.38). Such demands on the role mean that distance from direct patient care has implications for being able to closely observe the practices and culture of the nursing team.

2.5.9.2 Challenging poor practice.

Another facet of clinical nurse leadership is said to be to change routines and behaviours which are no longer acceptable, but that opposition and confrontation may be experienced (Porter-O'Grady, 2003, p.173). This is an aspect of the role of clinical nurse leaders which has become particularly important in light of the discussions following the inquiry into the Mid-Staffordshire NHS Trust. When attempting to change unacceptable practices it has been highlighted how clinical nurse leaders can experience resistance to change (Sutherland & Dodd, 2008, p.576). Interestingly, an undertone emerged in one study in relation to clinical nurse leaders not wanting to 'harm' others (staff), and there was a desire to develop skills in conflict management and assertiveness. Within clinical nurse leadership, a lack of conflict management skills has been identified (Sutherland & Dodd, 2008, p.576), and it has been
suggested that there is a need to develop the confidence and ability to challenge poor practice (Kings Fund, 2011, p ix). Yet, although this is important, caution has been suggested in seeing clinical nurse leadership as the panacea for success, unless the NHS creates the conditions which support and enhance this approach (Hewison & Griffiths, 2004, p.472).

2.5.9.3 Staffing levels.

Staffing levels can also provide another challenge for the clinical nurse leader. Greater awareness of the link between nursing staffing levels and patient outcomes is developing (Duffield, Roche, O'Brien-Pallas & Catling-Paull, 2009, p.103). In the United Kingdom a survey of nurses on acute medical and surgical wards (401 wards) reported that as the number of patients per Registered Nurse increased, so does the frequency of missed care for patients (Ball, Murrells, Rafferty, Morrow & Griffiths, 2013, p.5). Missed care most frequently related to comforting and talking to patients. However, on wards where nurses rated the practice environment as more positive, they were less likely to miss any care (Ball, Murrells, Rafferty et al, 2013, p.5). The limitations were that missed care was a nurse reported measure and therefore open to subjective interpretation, and the skill mix of staffing numbers was not known. However, the strong relationship between nurse staffing and missed care has significant implications for clinical nurse leaders in terms of their responsibility for care quality.

2.6 Clinical nurse leadership, the organisation and older people.

Nursing older people is considered a specialist and complex area of nursing (Dwyer, 2011, p.388). Yet a review of qualitative evidence exploring the experiences of clinical nurse leaders in settings for older people (Dwyer, 2011, p.388) highlighted consistency in findings across several countries. The clinical nurse leaders in this setting had a strong motivation to work with older people, but reported receiving little, if any, professional support (Dwyer, 2011, p.398). The key findings presented a
generally negative view of the experience of clinical nurse leaders in older people’s settings, including feeling devalued in this field of practice, and organisational barriers, including staff retention, which hindered the clinical nurse leader (Dwyer, 2011, p.399). These findings are important in relation to the potential impact on the nursing culture and care quality.

Another study which included direct observation of the care given by Registered Nurses in an acute care setting (Milton-Wildey & O'Brien, 2011, p. 8), highlighted how the care of older people was not to the standard known to be acceptable by the nursing team. Here the organisational barrier was seen to be valuing efficiency over a holistic approach to care, but the nurses rationalised their action by blaming the system and others. Yet, although time for patients was limited, nurses found time to socialise for long periods with each other. In this study clinical nurse leadership was highlighted as missing from the hospital, with clinical nurse leaders being invisible, ineffective and not aware of the problems on the ward (Milton-Wildey & O'Brien, 2011, p.13). Again, administrative tasks which took the clinical nurse leader away from the bedside removed the connection with patient care, and the clinical nurse leadership role of managing caring practices. In the absence of clinical nurse leadership, other types of leadership developed which were counter to high care quality care, with good nursing care being marginalised as a disruption to efficiency (Milton-Wildey & O'Brien, 2011, p.14). The study highlights the importance of the organisation establishing effective clinical nurse leadership which remains close to care delivery and sets the tone of the area.

More recently in a discussion article aiming to raise nurses’ awareness of why patients are labelled as difficult and become unpopular, Price (2013, p.27) suggested that older patients might be deemed unpopular because their needs, such as frailty and dementia, poorly fit the organisation’s services available, and that this combined with increasing acuity, frailty and shorter hospital stays can increase communication difficulties which may produce a recipe for unpopularity.
2.7 Accountability and ethical responsibility of the nurse.

All nurses, including clinical nurse leaders, in the United Kingdom share a set of values which are expressed in the Nursing and Midwifery Council Code for Nurses (NMC, 2008, p.8). These values include every nurse treating every patient as an individual and respecting their dignity, and not discriminating in any way against a patient (NMC, 2008, p.3). The aim of the NMC Code is to safeguard the public and to regulate the nursing profession (Cooper & Scammell, 2013, p.95). These values are of central importance when considering the issue of patients being difficult, or unpopular, as nurses are considered to be moral agents who enhance the welfare of human beings through ethical practice (Maupin, 1995, p.13).

Regardless of the nurse’s personal values, the nurse’s commitment to the patient should go beyond what they feel personally, and contribute to the quality of nursing care (Huynh, Alderson & Thompson, 2008, p.196). In addition, there is consensus that positive concern for the patient is reflective of good and ethical nursing care (Olsen, 1997, p.515). Yet despite these responsibilities it is known that some patients are unpopular with nurses (Erlen & Jones, 1999, p.76), and the quality of care for patients who are unpopular, or considered difficult, is reduced (Allen, 2003, p.14). Importantly, whilst poor nursing practice can be down to an individual, evidence suggests that there needs to be active or passive co-operation from many people (Cooper & Scammell, 2013, p.96). In addition, despite the espoused significance of clinical nurse leadership, it is often said to be ignored, or un-addressed, by senior managers, and therefore it has been suggested that clinical leadership is the elephant in the room (Edmonstone, 2009, p.301), despite its potential to protect an ethical culture of nursing care (Bondas, 2009, p.360). Clinical nurse leadership can be said to hold great potential to positively impact the climate of care, but to be effective it has been said to require a range of attributes. Yet even when these are in place, clinical nurse leaders may well face many challenges and constraints in creating an environment where compassion, dignity and respect are of paramount importance within the climate of care. The literature in relation to the unpopular patient now
follows which reveals an aspect of nursing which does not support ethical practice, and undermines dignified and respectful care.

2.8 Introduction to the Unpopular Patient.

Interactions between a patient and a nurse may have been acknowledged to experience difficulties at times just as in any other relationship (Podrasky & Sexton, 1988, p.16), and nurses deal with the full spectrum of human behaviour whilst trying to provide high quality care (Santamaria, 1993, p.1). However, the difficult or unpopular patient is a situation encountered by many nurses (Carveth Trexler, 1996, p.131), and in daily practice nurses continue to regularly describe patients as difficult (MacDonald, 2005, p.1).

The issue was first highlighted in the seminal study by Stockwell (1972), *The Unpopular Patient* sought to determine whether there was a difference in the nursing care given to patients who were popular or unpopular with nurses using both quantitative and qualitative approaches (Stockwell, 1984, p.10). This introduced the method of triangulation (McFarlane, 1984, p.4 in Stockwell, 1984). Methods used included a forced ranking scale to assess whether patients were popular or unpopular, content analysis of nurses' statements about popular and unpopular patients, a card sort method to define the nurses' views of the patient role, non-participant observation and semi-structured interviews with nurses.

Nurses generally agreed about patients they enjoyed caring for more often than those who were out of favour (Stockwell, 1984, p.15). Factors which contributed to popularity or unpopularity were personality factors (cheerfulness, pleasant, selfish), communication factors (grateful, amusing, unco-operative or grumbling), attitude factors (understanding, optimistic, non-concordance or reluctance for discharge) and nursing factors (interesting to nurse, does not need to be in hospital or not well known). The interviews supported the assumption that, frequently and interestingly, unpopularity is related to personality, and at times, personality alone determines unpopularity (Stockwell, 1984, p.27).
Patients the nurses most enjoyed caring for included those who communicated readily, knew the nurses' names, laughed and joked with the nurses, and those who wanted to recover. Responses to popular patients included willingness to give them more time, a more personalised interaction, willingness to accept gifts and favours, and allowing lapses in keeping the patient rules. However, those whom nurses least enjoyed caring for were grumbling and complaining, voiced unhappiness at being in hospital, reported greater suffering more than was believed, those the nurses believed should be on another ward, and whose personalities did not outweigh this judgement by the nurses. Frustration and impatience were expressed in relation to patients who grumbled, moaned or demanded attention. However, nurses were reluctant to acknowledge that they treated patients any differently, despite discriminatory behaviour resulting in sanctions such as being ignored, forgetting requests, refusing gifts and favours, enforcing rules, and using sarcasm (Stockwell, 1984, p.53).

Of interest was that few of the reasons given for popularity related to the nursing needs of patients (Stockwell, 1984, p.54). One of the key factors that distinguished popular patients was that their ability to attract the nurse's attention easily, and teasing and banter was used very differently for both popular and unpopular patients (Stockwell, 1984, p.58).

Although Stockwell did not focus specifically on the Ward Sister, she noted a range of observations about those involved. One was observed to be respected by the nursing team (Stockwell, 1984, p.38), another expressed concern that staff did not attempt to find out about patients (Stockwell, 1984, p.40), one shared limited information about patients with student nurses (Stockwell, 1984, p.42), and one was a strict disciplinarian (Stockwell, 1984, p. 42).

The study did reveal the existence of prejudice in nursing (Woodward, 1999, p.391) and a reduction in care quality for unpopular patients (Allen, 2003, p.14). When Stockwell's study was published it was poorly received within the nursing profession, because it contradicted the conventional wisdom that nurses treated all patients
equitably. Ironically, in response, Stockwell was professionally ostracised, many rejected her thesis, and she herself became unpopular (Waters, 2008, p.23). Although there have been limited studies since, much anecdotal literature exists highlighting the continued presence of the problem in nursing practice.

2.8.1 The prevalence of anecdotal literature.

It has been suggested that nurses do not care for all patients with the same depth of concern (Baer & Lowery, 1987, p.298), but most of the literature is either anecdotal, or originates from North America where the context of care is different. The issue of the unpopular patient has not been widely addressed (Juliana, Orehowsky, Smith-Regojo, Sikora, Smith et al., 1997, p.5; Conway, 2000, p.2), and following Stockwell's study, there are only limited studies available, and only two studies could be found from the United Kingdom (Johnson & Webb, 1995a, p.466; Conway, 2000, p.1). This limited number of studies could be deemed to suggest that the issue is of little significance, yet the continued prevalence of the anecdotal literature suggests the opposite. Moreover, I have many times witnessed the unpopular patient in nursing practice, and it is from this which my personal interest in the field has arisen.

2.9 Personal Interest in the Field.

As a researcher it is important to reveal one's involvement in the area of interest (Drew, 1989, p.431). My first experience of an unpopular patient took place on a female cardiac ward as a newly qualified nurse. At the time, I did not understand what I was experiencing. Lucy was a middle aged woman who had suffered a heart attack. She was overweight. She was recovering well and her sisters and her children visited, bringing her chocolates to enjoy. As such they were gifts of affection from her children to cheer her up, and to show they cared about her. The chocolates and her weight became the focus of conversation at nursing handover, and I witnessed many disparaging comments about her, including negative comments about her having a poor attitude to her health, and jokes predicting that she would choose the comforting
puddings on the menu. On this ward healthy living was central to the philosophy, and this patient was judged to be non-concordant with this. The nurses did not form any close relationship with her, yet their intimacy with other patients made the rejection of her obvious to me, and probably to her. Of interest was that despite the chocolates being there, she ate very few.

At this time, the nursing skill mix on wards contained a much higher registered nurse to patient ratio than today. The ward was staffed by Registered Nurses and only one care assistant, and as such, I felt my position as a newly Registered Nurse, was one above the care assistant. I was allocated to Lucy's care each morning. I felt I needed to compensate for the negativity and developed a warm relationship with her. The negativity about her continued and was passed on to her consultant using disparaging language, which the Consultant did not challenge. I was present when this happened and I felt uncomfortable. As a newly registered nurse, the situation seemed to conflict with how I felt a nurse should care for a patient, but the dominant and powerful nursing culture meant at that time, I felt unable to challenge due to my junior position. This is why this situation remained with me, and I continued to carry guilt about not speaking up.

In the 1990s I chose to work with older people and my experiences of the unpopular patient continued in a community hospital setting. I had previously experienced older people as unpopular in the acute hospital system. As a new ward manager for an older persons rehabilitation ward the development of unpopularity challenged me repeatedly. My first experience of an unpopular patient was when the staff on a neighbouring ward were very keen to transfer Jim to my team. Jim was only in his early sixties, but had suffered a serious stroke, leaving him immobile. His speech was affected and he struggled to communicate. His transfer from another ward included information about his physical nursing needs and his dependency level, but revealed nothing about his psychological needs and the difficulty the team had caring for him. Jim created a great deal of noise and threw his faeces at team members. He thrashed and kicked out, and showed his despair and frustration. Caring for him in the
early days was challenging. He resisted care and seemed to hate everybody. Care needed to be delivered in short episodes, using each episode as a chance to gain his trust.

Jim had lived on a boat on the river, and his partner held strong beliefs about healthy foods, and she brought his meals to him. She also believed in herbal remedies and I ensured these were prescribed for him. Both issues contributed to a negative attitude towards Jim and his partner within the team as they were 'different.' Negative remarks were made about his food and her 'fussing over him'. His partner's concern and worry for his future was profound, but was wrapped in self-control, and she held her focus, directing her concern and actions towards meeting his needs. She was remarkable in her composure, wanting to discuss her role and how to help him, and I held great respect for her.

As the clinical leader my challenge was primarily in relation to the attitudes of the care assistants in my team, and my sense of responsibility came to the fore. I was acutely aware that the care assistants were not inclined to develop a compassionate relationship with him, care delivery by them was at best a task, and even when he settled, there was a lack of warmth and compassion. My memories are of their avoidance of him, disparaging comments and their disgust, and making jokes about finding a nursing home by the sea, so he 'felt better', which was sarcastic and demeaning. I found it excruciating. My overriding feeling was one of frustration with my team, and sadness. At times I felt powerless against the negative forces bringing feelings of stress. As the clinical leader I needed to constantly ensure he was receiving the attention he needed. When his partner came on to the ward, she was avoided, and I overheard disparaging comments about his meal, despite it being his favourite foods. I challenged these comments with individuals, and reinforced his need for support. I felt I had to compensate for their avoidance, spending as much time with her as I could. Jim was a bright man and I was acutely aware that he probably sensed the attitudes of individuals, which added to my own guilt and frustration.
I could ensure his physical needs were met. I could ask for them to answer his bell, and they would go, but with a look, and a silence. I could not however force caring, he had been rejected by the care assistants and they withheld compassion and empathy. Conversations with individuals to challenge their attitudes made little difference in terms of prompting caring and concern. My frustration was further heightened when there seemed to be no guilt or remorse. Challenging negativity in nursing handover eventually created a silence in relation to Jim, and 'knowing looks' amongst individuals, so I continued the dialogue with the Registered Nurses, requesting that they role model and lead the care assistants towards compassionate caring.

It was a time requiring steely determination, but I had the privilege of working with Registered Nurses who did not engage in this behaviour, and one in particular who became very fond of Jim and his partner, working tirelessly to ensure he trusted her. Greatest times of worry were those when I left the ward, but I was eternally grateful to my ward sister who continued to lead the team in my absence, and to oversee Jim’s care. This experience, and others, remain with me, as troubled times as a clinical nurse leader, wrapped in guilt about Jim’s care. I came to understand that the unpopular patient can be created by any person, or people, in a nursing team. One person could influence the others in their judgement of the patient. Such experiences taught me to remain astute. These experiences, with others, focused my interest on the importance of a caring culture, and the importance of focusing on nursing values within a team. I began to understand that the presence of the unpopular patient was an indicator of problems with the culture and care quality. My interest in the unpopular patient has continued as part of this.

The next part of the literature review therefore sought to understand what is already known about how nurses, including clinical leaders, experience the unpopular patient.
2.10 A review of the literature on the unpopular patient.

Qualitative researchers do not generally begin with an extensive literature review (Streubert & Carpenter, 2011, p.25). Instead, the approach taken to the literature is to situate what is already known about the area of inquiry (Streubert & Carpenter, 2011, p.92), which is said to focus the study (Streubert & Carpenter, 2011, p.25). The researcher was interested in the care of older people in general nursing settings, where the specific focus of the primary study was the nurse's experience of the ‘unpopular’, ‘difficult’, or ‘good’ and ‘bad’ patient, after Stockwell’s (1972) seminal study. Studies which were undertaken in nursing specialities such as mental health, maternity and children's nursing were therefore not reviewed, and neither was the medical literature.

The first literature review was conducted during June, 2008. A thorough review of the literature was undertaken, and the database sources searched were Blackwell Synergy, Ovid (later replaced by Ovid Online), ISI Web of Knowledge and Proquest (later replaced by Proquest New Platform) to find reports of primary studies. Potentially Related Terms for unpopular patient were identified by the researcher. In order to find primary studies of high relevance the search sought the search terms within the title, the abstract and keywords/subject terms. The search terms used and databases can be found in Table 2.2. All studies regardless of design were chosen to maximise retrieval. Secondary references from the primary studies were followed up and relevant papers obtained for review. Databases which were continued to be reviewed during the study were Ovid Online, Proquest New Platform, Ebscohost, Sage Journals and Wiley Online and Cinahl. The final search was undertaken during October, 2014 and yielded only one study previously not identified. The internet provided access to online theses which were also reviewed. In total, fifteen primary studies which were reported after 1972, and were focused on adult general nursing settings were included.
Table 2.2 Search Strategy.

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<td>Patient</td>
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<td>Nurse + Interpersonal relations</td>
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<td>Sage Journals</td>
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<td>Wiley Online</td>
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<td>Cinahl</td>
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The literature continued to be reviewed periodically. Table 2.3 summarises the fifteen studies identified from the literature between 1972 to October, 2014.
Table 2.3 Summary of the studies identified.

<table>
<thead>
<tr>
<th>Title</th>
<th>Date &amp; Country of Origin</th>
<th>Setting and Methodological approach/ Methods</th>
<th>Main Findings</th>
</tr>
</thead>
</table>
| 1. Lorber, J. Good Patients and Problem Patients; Conformity and Deviance in General Hospital. | 1975 North America | Setting: Large Hospital. Medical/Surgical wards. Methods: Administered Questionnaires. | • Definition of a problem patient was one who interrupted the work of the ward.  
• Doctors and nurses did not necessarily agree which patients were a problem. |
• Patient is essentially adaptive to their situation but nurses consider it maladaptive. |
| 3. Podrasky, D.L. and Sexton, D.L. Nurses reactions to difficult patients. | 1988 North America | North America Setting: Hospital setting. Medical/ Surgical wards. Methods: Administered Questionnaire and a Reaction Inventory. | • Frustration and anger were the two most common response to difficult patients together with a fight or flight response.  
• The emotional tone of the unit was important in determining the nurse's reaction. |
| 4. Carveth, J.A. An investigation of perceived deviance and avoidance by nurses. | 1991 North America | Setting: Hospital setting. Medical/Surgical Unit. Methods: Observation using Slater Rating Scale. | • In the majority of cases nurses were in agreement about who was unpopular.  
• Quantitative measures of care were not affected but the qualitative aspects were affected. |
| 5. Santamaria, N. The difficult patient: an important educational need of Registered Nurses. | 1993 Australia | Setting: Hospital settings. Medical/Surgical wards. Methods; Self-completion of scales and interviews. | • Nurses are inadequately prepared for handling difficulty and experienced high levels of anger and frustration.  
• Nurses could not identify the goals of the patient's behaviour and proposed responses were likely to escalate the behaviour. |
| 7. Little, D.J. Temporary is avoidance, forever is lobotomy. | 1996 North America | Setting: Hospital Methodological approach: Descriptive phenomenology. | • Nurse's silence in relation to the unpopular patient.  
• Experiences with unpopular patients were out of the ordinary but left nurses feeling guilty or professionally inadequate. |
<p>| 8. Olsen, D.P. | 1997 | Setting: Nurses on | • Caring concern is influenced by |</p>
<table>
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<tr>
<th>Reference</th>
<th>Title</th>
<th>Year</th>
<th>Country</th>
<th>Setting</th>
<th>Methods</th>
<th>Findings</th>
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<tr>
<td>When the patient causes the problem: the effect of patient responsibility on the nurse-patient relationship.</td>
<td>North America</td>
<td>degree programmes. Methods: Secondary data analysis/ interviews.</td>
<td>the degree to which the patient is considered responsible for their situation. - Distancing occurred when they felt the patient was responsible for their situation.</td>
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<td>11. Santamaria, N. The relationship between nurse’s personality and stress levels reported when caring for an interpersonally difficult patient.</td>
<td>2001 Australia</td>
<td>Setting: Acute Hospital. Methods: Self-report measure and interviews.</td>
<td>• Stress in relation to a difficult patient is independent of age, education, experience and qualifications. • Stress is better understood in terms of personality. • Low stress personalities are more solution focused.</td>
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<td>12. Roos, J.H. Nurse’s perceptions of difficult patients.</td>
<td>2005 South Africa</td>
<td>Setting: University students. Methodological approach: Qualitative descriptive/narratives.</td>
<td>• The patient’s physical, psychological, attitudinal, social factors can contribute to difficulty. • Nursing factors which can contribute include skill/experience, training and attitude.</td>
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<td>13. MacDonald, M. Reconciling temporalities: A substantive explanation of the origins of difficulty in the nurse-patient relationship.</td>
<td>2005 Canada</td>
<td>Setting: Acute hospital. Methods: Participant observation and interviews.</td>
<td>• Factors which contribute to a lack of time to meet patient need such as team work. • The longer the time taken to address difficulty, the more time is required to restore the nurse-patient relationship. • Temporal incongruence and reconciling temporality.</td>
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<td>14. Robinson-Wolf, Z and Robinson-Wolf, G. Strategies used by Clinical Nurse</td>
<td>2007 North America</td>
<td>Setting; not stated Methods; Postal survey.</td>
<td>• Respect for the patient was the most frequent and highest priority strategy used by clinical nurse specialists.</td>
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2.10.1 *Terms in use- clarifying the use of 'difficult'.*

The review of the literature highlighted how the term 'difficult' is used within nursing practice in different situations. The term 'difficult to nurse' sometimes referred to technical complexity, rather than being related to the aspect of relational or interpersonal difficulty (Juliana et al, 1997, p.1), serving to highlight differences in the use of the term. However the literature also revealed that most nurses are familiar with the different uses of terms in practice (Conway, 2000, p.4; Roos, 2005, p.54). This literature review focused on difficulty as interpersonal or relational.

2.10.2 *Terms used for the unpopular patient in daily practice.*

Stockwell introduced the term the 'unpopular patient' to this country. However, the wider literature produces a range of terms in use including good and bad patients (Kelly & May,1982, p.147), unpopular patients (Little, 1996, p.1), difficult patients (Podrasky & Sexton, 1988, p.16; English & Morse, 1988, p.23; Santamaria,1993, p.1; Juliana et al, 1997, p.1; Conway, 2000, p.1; Santamaria, 2001, p.20 ; Roos, 2005, p.52; MacDonald, 2005, p.1; Robinson Wolf & Robinson-Smith, 2007, p.74: Michaelsen, 2012, p.90), deviant patients (Carveth, 1995, p.173) and problem patients (Lorber, 1975, p.213). However, in essence, it is suggested that patient behaviours and characteristics which result in negative labels from nurses can be grouped under the umbrella of the unpopular patient (Corley & Goren, 1998, p.100).

The frequent use of such terms in practice have been said to imply that they refer to a well known and well-distinguished group of patients. However, this is said not to be
the case, as they are hard to describe and characterise (Koekkoek, Van Miejel & Hutschemaekers, 2006, p. 795), having variable complex behaviours (English & Morse, 1988, p.35) and there is no unequivocal definition of a difficult patient (Michaelsen, 2012, p.90).

2.11 Why patients are deemed difficult or are unpopular.

Using an exploratory survey design, nurses (n=73), highlighted how difficult patients were those who were demanding, complaining, frustrating, time-consuming, made frequent requests, called frequently, were manipulative, female, impolite, unreasonable and unco-operative (Podrasky & Sexton, 1988, p.19). The limitation of the study however, is that the reactions explored were in relation to hypothetical situations. However, the scenarios were constructed from conversations with nurses in relation to patient characteristics they found difficult, and therefore may represent the way in which nurses might react. Other reported causes have been trivial requests, not trying to recover, knowing the hospital system, nasty, abusive, and non-conforming (Conway, 2000, p.4). In addition, the type of illness such as socially stigmatised illnesses (Carveth Trexler, 1996, p.132), intense nursing needs, fear and withdrawal, nagging, dirtiness and untidiness, reporting the nurse, and social status have also been cited by nurses (Roos, 2005, p.57).

When nurses (n=52) were asked to rank patients as 'difficult', 'ideal' or 'neutral' in response to descriptive statements, 18.84 % of patients were classified as difficult (Carveth, 1991, p.60). Although asked not to consider diagnosis, drug and alcohol abuse, altered consciousness, AIDS/HIV, cancer and brain haemorrhage accounted were cited as difficult (Carveth, 1995, p.178), and primary diagnosis as a source of difficulty and labelling has also been highlighted by other studies (Podrasky & Sexton, 1988, p.19; Roos, 2005, p.55). Patients were judged more frequently as difficult where they were judged as unattractive, and in Carveth's (1995, p.176) study, agreement about classifications of ideal, difficult or neutral was found.
These are only a few of the reasons cited in the literature. In essence, the literature revealed an extensive list of causes of unpopularity. However, there is a lack of definition of such concepts, and an assumption of a common discourse and agreement in relation to these, whereas it has been proposed that the cause of difficulty may vary between class and culture (Kelly & May, 1982, p.151). Yet MacDonald's (2003, p.305) concept analysis (from the literature) highlighted three key attributes. The first was the presence of certain behavioural characteristics which nurses perceived as objectionable, such as insulting remarks and violating rules. The second was the presence of certain personal characteristics that conflicted with the values and beliefs of the nurse, such as alcoholism and prostitution, and thirdly the nurse being challenged by who is in control of the situation (MacDonald, 2003, p.306).

All labels, such as 'difficult' are negatively toned (Carveth, 1995, p.173), but there is nothing intrinsic in any patient to create popularity, or unpopularity, and instead, it develops due to the occurrence of external evaluation by others (Kus, 1990, p.62). Often there is broad agreement amongst nurses as to who constitutes an unpopular patient (Carveth, 1991, p.1; Santamaria, 1993, p.2) and yet at other times, it is specific to an individual nurse (Kus, 1990, p.62; Michælsen, 2012, p.90). In addition, sometimes what is considered negative behaviour on one ward may not be considered so on another (Juliana et al, 1997, p.8).

2.10.1 The difficulty lying with the patient.

Most research focuses on describing the characteristics of the difficult patient which locates the problem with the patient, but there is a virtual absence of patients as participants from studies which focus on the difficult patient (MacDonald, 2003, p.308), and the source of difficulty may not solely be attributable to the patient (MacDonald, 2003, p.309). However, it has been suggested that patients sometimes believe they are entitled to a nursing service regardless of their own behaviour (Little, 1996, p.81), suggesting that occasionally the patient's behaviour is unacceptable.
2.12 Influences on the development of the unpopular patient.

Citing the cause of the problem as being with the patient alone is suggested to fail to consider the context of care, and absolves society and organisations of responsibility to change the construction of difficulty (MacDonald, 2005, p.1). The literature revealed a range of influences on the creation of the unpopular patient which include wider social influences, the influence of the organisation, social norms, deviance and patient rules within nursing, and stigmatised illnesses and behaviours.

2.12.1 Societal Influences.

Humans receive significant informal influences in deciding other's value from family, friends, social institutions, educators and role models (Little, 1996, p.25), and those who do not meet these identity norms are often stigmatised (MacDonald, 2003, p.307). Possibly, as a consequence of society, it has been suggested that some nurses consider some people as having lower social or moral worth than others (Kus, 1990, p.62), such as those engaging in prostitution, having unchosen stigmata such as race, 'own fault diagnoses' such as alcoholism, and negative behaviours such as violence (Kus, 1990, p.63). In addition, where primary diagnosis has been a source of difficulty, it has often been related to socially undesirable conditions such as drug abuse and AIDS (Carveth, 1991, p.vi).

Until the 1950's individual acts which breached the accepted norms of society were considered due to personality, but the concept of deviance was later understood to be due to the interaction between two people, with one judging the other. However, acts defined as deviant may be dependent on the situation, meaning the concept is modified by society (MacDonald, 2005, p.18). Not all people who engage in deviant acts are labelled, but those from socially oppressed or stereotyped groups, such as older people, are more likely to be judged than those from more powerful groups. Also, those who are judged as deviant can take on a deviant identity, and the response to their judgement is that it becomes self-fulfilling (Carveth Trexler, 1996, p.132). In addition, organisations can also contribute to judgement of deviance.
2.12.2 The organisational influence.

Within nursing, negative thoughts about patients do not necessarily affect behaviour towards them, and the patient's characteristics and behaviours do not predict the nurse's response. It has also been suggested that the behaviour of nurses does not continue without tacit, or even overt peer group support, or support from the organisation, and therefore the behaviour needs to be considered in this context (Corley & Goren, 1998, p.103).

Importantly, the context of care has been found to have a significant impact on whether difficulty in a nurse-patient relationship develops (MacDonald, 2005, p.1). MacDonald's ethnographic study employed grounded theory in an acute hospital setting to move beyond the focus of the patient as difficult, and to explore the context in which difficulty arose (MacDonald, 2005, p.5). The availability of nursing time was been found to be a significant factor in the creation of difficulty (MacDonald, 2005, p.110), and when nurses lacked the necessary time for patients this caused difficulty. In particular nurses knew that patients needed care in a timely and compassionate manner, but in this study, when this could not be given, temporal incongruence, or difficulty in the relationship due to time constraints, resulted (MacDonald, 2005, p.113). Time needed to be reinvested with the patient to restore the relationship, and the greater the difference between the time needed by the patient, and the time offered by the nurse, the greater was the need for reconciliation between the two. Contextual factors contributing to temporal incongruence were families needing time, lack of supplies and equipment, team members knowing each other, working together, increasing dependency of patients, shorter stays, inappropriate environments for patient need, and reduction in nursing skill mix (MacDonald, 2005, p.79). This study did include the views of patients (n=12), and patient satisfaction was based upon the time they perceived the nursing staff had. They considered that nurses were overworked, but felt they were still entitled to timely compassionate care (MacDonald, 2005, p.111).
Another study which used focus groups of Registered Nurses (n=58) to explore the links between effective nursing interventions with difficult patients and behavioural outcomes supported this lack of time (Juliana et al, 1997, p.5). Fifteen participants reviewed the results and confirmed the description. Within the findings nurses reported the lack of time they had for patients negatively impacted the qualitative aspects of nursing care (Juliana et al, 1997, p.8) and how competing demands on nurses meant patient need remained unmet which created difficulty (Juliana, et al, 1997, p.13).

Difficult relatives have also been raised as an issue in nursing practice (Conway, 2000, p.11), and this has been reported elsewhere (MacDonald, 2005, p.84). In response to a lack of time, nurses have cited controlling their situation and managing families as ways to manage their work (MacDonald, 2005, p.88), citing caring for patients over their families as their priority (MacDonald, 2007, p.77). This however, may negatively affect the relationship with the family, and patients have also been labelled as difficult because their family's behaviour is considered challenging (Juliana et al, 1997, p.11). This means that patient care quality may therefore be reduced as a consequence of challenges with their family.

2.12.3 The judgement of social deviance.

Nurses do not practise in isolation from society, their profession and their institution, which all influence the caring relationship (Gastmans, 1998, p.236). When the phrase ‘difficult’ is used to describe a patient, it takes on a range of negative connotations, and stigmatises patients who may already be stigmatised by wider society (MacDonald, 2003, p.305). The label ‘difficult’ can also be consistent with the social phenomenon of deviance, and applies to actions considered either illegal or immoral (Carveth Trexler, 1996, p.131; Robinson Wolf & Robinson-Smith, 2007, p.75).

In a South African study using nurse's narratives (n=81) to explore how nurses perceived difficult patients, the social status of patients as the foundation of
stigmatisation by nurses has been found including occupation, religion and culture, communication skills, and antisocial behaviour (Roos, 2005, p.57), with perceptions of lower social worth also prompting negative judgements by nurses (Roos, 2005, p.56). The sample was unrepresentative of the wider nursing population and the findings may reflect the societal culture of the area, but stigmatisation in response to antisocial behaviour has also been found in the United Kingdom. Conway (2000, p.1) explored the personal characteristics which nursing staff (n=18) considered contributed to difficulty using focus groups. Conway (2000, p.10) discussed the preliminary data categories with the participants to aid trustworthiness, and identified patients who abused alcohol, sniffed glue, beat their wives and abused children as difficult patients (Conway, 2000, p.5).

Following a review of the difficult patient literature, Kelly and May (1982, p.153) suggested the concept should be investigated using an interactionist perspective and ethnographic approaches. In response, a study which set out to explore how nurses face moral problems on one acute ward using participant observation and grounded theory identified the frequent labelling of patients during the early fieldwork (Johnson & Webb, 1995a, p.467). Evaluations of the social worth of patients were widespread on the ward regardless of whether the patients were good or bad, popular or unpopular (Johnson & Webb, 1995a, p.476). The study highlighted that the expression of social evaluation is not tied to traits or variables, but is constructed within powerful social influences, and is flexible and dependent on the social context. The study refuted the claims of Stockwell (1972) as having identified a means of identifying the unpopular patient as a fixed judgement, and the situation of the difficult patient as a relative position, rather than a constant quality, has been reported elsewhere (Conway, 2000, p.1).

Johnson & Webb's (1995a, p.474) study resulted in the development of the term 'social judgement', a key property of which was its universality, as all were aware of it, and qualitatively nurses interacted differently with patients depending on their view of them as people. Social judgement was used by nurses to maintain a position of
power over patients (Johnson & Webb, 1995b, p.87). The study also added how patients could be judged on a range of levels, possibly being unpopular due to the demands of their physical care, but popular on an interpersonal level because they were humorous. Labels could also change in response to knowing more about the person (Johnson & Webb, 1995a, p.472), and some stereotypes associated with difficulty were refuted (Johnson & Webb, 1995b, p.84). When difficulty in the relationship developed, a process of negotiation took place as the patients tried to gain social worth with the nurse. When this failed, the struggle began between the patient and the nurse. Yet if the patient acquiesced, it paved the way for compliance with nursing goals and the difficulties reduced. Interestingly, patients realised the importance of their social reputation with the nurse as exceeding their own views of their care (Johnson & Webb, 1995b, p.86).

2.12.4 The patient role.

How a person reacts to illness is defined socially, culturally and individually (Podrasky & Sexton, 1988, p.16), and for many people, the illness experience generates anxiety (Carveth, 1995, p.173). This can exaggerate personality traits, contributing to difficulties between the nurse and the patient (Nield-Anderson, Minarik, Dilworth, Jones, Nash, O’Donnell & Steinmiller, 1999, p.2). Nurses can also judge a patient based on their past experience of other patients. One study added how nurses will be convinced and predict that certain patients will be difficult, such as those with long term illness, and those with an unfriendly personality (Juliana et al, 1997, p.9). As nurses observe and interact with patients and families frequently they are often the primary judges of deviance, and the literature supports how group consensus can exist to justify responses which punish the patient (Carveth Trexler, 1996, p.133).

Social rules are created by a specific group (Becker, 1991, p.15), and studies of the unpopular patient have revealed how the person is expected to behave in the patient role (Podrasky & Sexton, 1988, p.16), conforming to the behaviours set by nurses (Carveth, 1995, p.173). However, Kelly & May (1982, p.147) criticised previous
studies for employing approaches which did not include direct observation of practice as they measure subjective attitudes, and this can be said to apply to some studies included in this review. The review also added that concepts which are said to contribute to the patient being labelled as bad, such as dirtiness and being unappreciative, are poorly defined and assume people share the same understanding, and this weakness in studies continues. In addition it was highlighted that most of the literature which explores the unpopular patient centres on the opinions of staff (Kelly & May, 1982, p.151).

Although many patients accept their patient role, and are passive, trusting and adapt to routines, some reject this role (Lorber, 1975, p.215). A study (which included patients) predicted that not to act in the patient role would result in judgements of deviance by doctors and nurses (Lorber, 1975, p.215). On the basis of an attitude questionnaire most patients (n=103) felt they should be co-operative, but patients who were considered to have deviant attitudes in relation to the patient role argued with doctors and nurses more frequently. Regardless of the patient's condition the best predictors of deviant or conforming attitudes were age and education. Poorly educated patients were not considered to have deviant attitudes, and those over sixty were considered to be moderately conforming (Lorber, 1975, p.216). However, here, the use of a questionnaire on doctors and nurses who had cared for the patient revealed that the doctors and nurses did not necessarily agree on who was unpopular, or deviant, which supported another study (Johnson & Webb, 1995a, p.470). 'Ease of management' has been highlighted as the criteria for judgement of patients (Lorber, 1975, p.220), with the amount of trouble the patient caused central to the evaluation of the patient, with trouble including the patient arguing about prescribed routines (Lorber, 1975, p.223). The study highlighted the relationship of judgements of deviance in relation to nurses controlling their work, and how deviant behaviour can result in neglect or a stigmatising label (Lorber, 1975, p.275). However, the study assessed attitudes and did not observe attitudes in practice, which may or may not have been evident in practice.
Another study in the United Kingdom on medical and elderly care wards interestingly illuminated the kinds of behaviours nurses considered deviant, such as breaking the rules (Conway, 2000, p.1). Manners and politeness, patients assisting in their own recovery, and conversation being limited to ‘illness business’ were considered important by nurses (Conway, 2000, p.6). Patients who demanded attention and had expectations over and above the unspoken patient role were also considered difficult. The issue of the nurse knows best was also revealed (Conway, 2000, p.9). The issue of non-compliance, or not accepting the patient role, has been found to be related to many categories of difficult behaviour (English & Morse, 1988, p.26), and appears consistent with the concept of deviance. However, if trust and respect between the patient and the nurse develops, it has been found to be a redeeming quality which negated the nurse's judgement of rule breaking (Conway, 2000, p.10). Difficulty by diagnosis has also been found to be linked to rule breaking behaviour, such as being demanding, rather than the diagnosis alone creating the difficulty (Conway, 2000, p.5). Conway (2000, p.13) found agreement between nurses in relation to unpopularity which contradicted the findings of other studies (Lorber, 1975, p.216; Carveth, 1991, p.1; Johnson & Webb, 1995a, p.470).

It has been found that if patients do not conform to the rules, and their behaviour intensifies, the hostilities between the patient and the nurse increase, serving to validate the nurse's original negative judgement (Carveth Trexler, 1996, p.133). Studies have found labels can be given to patients within twenty four hours of admission (Santamaria, 1993, p.2), and communicated through nursing handovers, nursing records and informal channels within teams (Carveth, 1995, p.174). However, if the patient begins to comply with the nursing rules, the improvement in behaviour was also communicated at handover (Juliana et al, 1997, p.12).

The label a patient is given has also been found to travel with the patient to other clinical teams, and has been described how it is easier for the patient to gain the difficult label than to lose it (Juliana et al, 1997, p.12), including the re-assignment of the label when the patient is re-admitted to the hospital (MacDonald 2005, p.77).
Although only cited once in the literature, it has been reported that within a nursing team stronger personalities and formal status give an authority to labelling by that person (Johnson & Webb, 1995a, p.471), and this is of particular interest in relation to the clinical leadership of the area, although the study did not illuminate whether the clinical leader was involved.

These studies suggest that nurses consistently label patients when they do not conform to the patient rules, and that labelling is very common within nursing culture. However, the literature suggests that patients can be forgiven for their rule breaking behaviour. Studies have shown that problem patients are of two types for nurses, those with an ordinary illness, who demand unjustified attention (wilfully deviant), and those who are behaving in the same way, but have an extraordinary medical problem, and so are forgiven by nurses (accidentally deviant) (Lorber,1975, p.222). This is because they are deemed 'innocent' (Olsen, 1997, p.7), having un-modifiable characteristics for which they are not responsible (Conway, 2000, p.8), and which are not their fault (Podrasky & Sexton, 1988, p.19). The existence of behaviours which were judged intentional or non-intentional was also highlighted by English & Morse (1988, p.26), and that nurses consider that patients have a choice about being difficult or not (Conway, 2000, p.8).

The issue of labelling patients is therefore complex, and the multiple characteristics and behaviours of the patient are open to constant judgement by nurses. Interestingly, Stockwell had previously observed how nurses' opinions of how much they enjoyed caring for a patient could change during a care episode possibly highlighting the transience of labelling (Stockwell, 1984, p.45).

2.13 Nursing factors which contribute to difficult nurse-patient relationships.

The literature revealed a range of nursing factors which contributed to difficult nurse-patient relationships including the nurse controlling the patient, nurses using
interventions which do not work, the contribution of the personality type of the nurse and confusion between liking and respecting patients with the nursing profession.

2.13.1 Needing to control the situation.

A reported common response by nurses to patient deviance is social control (Hewison, 1995, p.79; Carveth Trexler, 1996, p.133). The nurse is frequently the frontline practitioner who will be in receipt of the demands from patients (whether or not these can be met), and contextual factors which escalate the need for greater control, such as staffing issues have been cited (MacDonald, 2005, p.88). However, studies have shown repeatedly that both patients and nurses are striving to control their situation, and that this can be the source of difficulty (English & Morse, 1988, p.33; Juliana et al, 1997, p.14; Roos, 2005, p.58).

One of the few studies to include the experience of hospitalised older patients in the study using interviews and observation (n=9) found that patients felt a lack of control over a life threatening situation (English & Morse, 1999, p.37). They experienced a loss of control over independence which went to the nurse, but when this happened nurses did not communicate, were not caring, and did not ask the patient about their treatment (English & Morse, 1988, p.29). English and Morse also employed interviews with nurses to identify types of difficult patients, and content analysis of vignettes in the anecdotal literature to identify whether selected patient characteristics were present and any nursing interventions evident or absent to resolve the problem to triangulate the data. Labelling was suggested to be more commonly applied to an individual's behaviour, or perceived attitude, which conflicted with the way the nurse expected the patient to behave in the patient role (English & Morse, 1988, p.24). Yet the patient's behaviour was essentially adaptive to their vulnerable situation, but nurses considered it maladaptive (English & Morse, 1988, p.37), as both struggled to control their own situation.
The key variable preceding the onset of difficulty was unmet need, and there was evidence that nurses ignored or punished unpopular patients (English & Morse, 1988, p.37). Attempts by the nurse to control the patient, or situation, exacerbated the problem (English & Morse, 1988, p.23) which supports other studies (Johnson & Webb, 1995b, p.86; Juliana et al, 1997, p.14). However, time spent talking to the patient was considered the most appropriate intervention for difficulty (English & Morse, 1988, p.35), which supports the need to get to know the patient expressed by MacDonald (2005, p.129). In English and Morse's study simultaneous triangulation increased reliability and validity, but anecdotal case studies limited the findings (English & Morse, 1988, p.37). However, the inclusion of the patient's perspective is valuable.

Only one study could be identified which was conducted in community nursing settings and this study took place within patient's own homes. The phenomenological study (n=12) used participant observation and interviews to explore nurses' relationships with patients they regarded as difficult (Michaelsen, 2012, p.90). Different strategies were used by nurses when they felt the patient was being difficult. The first strategy used was persuasion, and this included various approaches ranging from giving advice to threatening the patient (Michaelsen, 2012, p.93). The second strategy was distancing and was considered a survival strategy. Distancing included both emotional distancing and physical distancing by handing the case to a colleague. These first and second strategies are similar to the fight or flight reactions of the nurse discussed by Podrasky & Sexton (1988, p.19). The third strategy was compromise, a balance between persuasion and avoidance where the nurse gave up on trying to achieve compliance with nursing goals, but had not reached a situation of avoiding the patient, and continued to try and support them in a positive way. It was suggested that where compromise is enacted, the nurse has discontinued trying to put the patient in the role of a patient, that is, not focusing in compliance, and instead moving to tolerance and greater potential for caring (Michaelsen, 2012, p.95).
Difficulty has also been considered to develop because the nurse lacks the experience and skills to meet patient need, or because the nurse is lazy (Roos, 2005, p.59) and not trying to meet patient need. However, there are other reasons such as nurses being overworked as a cause of unmet need (MacDonald, 2005, p.113) which reinforces the importance of care context as an important factor in the development of the unpopular patient.

2.13.2 Negative reactions.

Nurses have been found to admit they could be difficult through their own prejudice and anxiety. Their own negativity then provokes a negative reaction by the patient (Juliana et al, 1997, p.12). Interventions considered by nurses to minimise the development of difficulty by nurses in their interactions with certain patients were not being angry or defensive in response to patient anger, and not showing negativity, as this created a cycle of difficulty. It has also been reported that nurses consider that avoiding the patient or moving the patient to another ward fails to address the situation (Juliana et al, 1997, p.14). This study concluded that resolution is primarily interactional, with the responsibility to change the situation resting with nurses (Juliana et al, 1997, p.15). However, although the responsibility may reside with the nurse, the wider contextual factors cited previously, such as the context of care, need to be considered.

2.13.3 The personality of the nurse.

A study (n=120) aimed to assess whether nurse's self-reported stress in relation to difficult patients is mediated by age, clinical experience or education, whether the stress is mediated by personality, and whether high or low stress personalities had different experiences of difficult patients (Santamaria, 2001, p.22). The stress the nurses experienced was independent of age, clinical experience and post graduate qualifications, and was better understood in terms of personality (Santamaria, 2001, p.22). The study added to the literature suggesting that low stress personalities
experience less stress and take a problem solving approach to difficult nurse-patient interactions. They then work with the patient through concern for the cause of the difficult behaviour (Santamaria, 2001, p.25). However, the study purposefully omitted male nurses, and it is not known if male nurses would report similar reactions.

2.13.4 Liking or respecting patients.

Respecting the patient has been found to be successful in mitigating difficulty (Juliana et al, 1997, p.13). Nurses are taught to respect each patient as an individual (Erlen & Jones, 1999, p.76), but the concept of respect may be confused with the need to like every patient. Little's study illuminated the theme ‘Nurses Must Like All Patients’ (Little, 1996, p.78) as a prevailing myth in nursing. This resulted in the nurse blaming the patient they disliked in order to avoid the feelings of interpersonal conflict (Little, 1996, p.81). Nurses were also careful in admitting their dislike in order not to appear unprofessional, but engaged in turning other staff against the patient so that they were not alone in their judgement (Little, 1996, p.80). Other studies have raised the discrepancy between the reality of nursing people who were found to be difficult, and the professional ideal of moral practice (Johnson & Webb, 1995a, p.471; Michaelsen, 2012, p.94). Liking all patients was deemed unrealistic (Johnson & Webb, 1995a, p.470), and the ideal of moral practice led to moral dissonance when nurses could not achieve their professional ideals (Johnson & Webb, 1995a, p.471).

Clinical nurse specialists have also ranked respect for difficult patients as a priority strategy in order to transcend difficulty. However, this approach to transcending difficulty was possible because they were not enmeshed in the complex care situation on the ward (Robinson-Wolf & Robinson-Smith, 2007, p.80). This meant that they were not needing to control the multiple demands placed on nurses which can result in unmet need, and hence difficulty, when caring for a group of patients.
2.14 The consequences for patients and nurses.

Unfortunately, the judgement of patients by nurses as difficult or unpopular has consequences for both patients and nurses. It has been found that as nurses and patients strive to control their situation the breakdown in the relationship benefits neither (Juliana et al, 1997, p.14).

2.14.1 The consequences for the patient.

Poor care quality is always concerning, and the consequences for unpopular patients are of particular significance because the effect of nurses stereotyping patients affects both the process of care and the outcomes (Corley & Goren, 1998, p.108). When nurses convey their negative judgements it can impact on the response of the nursing team to that patient (Kelly, 1996, p.8), leaving the patient outside the caring loop with the potential for missed diagnosis and interventions, social isolation, and minimal contact with the nurse (Maupin, 1995, p.11).

The way in which nurses react to difficulty has been found to be fight or flight rather than seeking to understand the situation, or trying therapeutic interventions (Podrasky & Sexton, 1988, p.19; Michaelsen, 2012, p. 93), and labelling has been found to qualitatively, rather than quantitatively, affect nursing care (Carveth, 1995, p.177). If patient deviance is limited, the nurse might respond with an inclusionary reaction of more frequent contacts of longer duration to influence the patient to return to the patient role using persuasion, manipulation and coercion. If this fails, exclusionary actions may follow, with the most frequent form being reported as avoidance (Carveth Trexler, 1996, p.133; Michaelsen, 2012, p.93), or distancing from the patient with decreased care quality (Little, 1996, p.73; Robinson Wolf & Robinson-Smith, 2007, p.75; Michaelsen, 2012, p.93).

When nurses perceive the patient to be responsible for their illness many nurses felt that their sense of caring, and hence their relationship with the patient, was influenced
by the degree of responsibility the patient was considered to have for their situation, and this justified a limited sense of caring and distancing by the nurse (Olsen, 1997, p.7). Nurses punishing the patient has also been suggested (Podrasky & Sexton, 1988, p.19). The large amount of anecdotal literature available identifies helpful nursing interventions when a patient is considered difficult by a nurse, and a descriptive study used focus groups to identify patient outcomes following nursing interventions (Juliana, Orehowsy, Smith-Regojo, Sikora, Smith, Stein, Wagner and Robinson-Wolf, 1997, p.5). The study concluded that interventions were largely interactional and can be embraced within fundamental nursing care. However, at times, nurses abandoned attempts to establish a relationship with the patient (Juliana et al, 1997, p.11).

In a qualitative study employing nurses' narratives (n=81) to explore their perceptions of difficult patients (Roos, 2005, p.54), unpopularity was said to exist even when patient requests were met on time (Roos, 2005, p.57). This reflects the findings of another study which highlighted a reduction in the qualitative aspects of nursing even when the quantitative aspects are met (Carveth, 1995, p.176). However, Roos' (2005) study sample was not representative of nurses in South Africa and it was suggested that participants may have described patients in ways they felt professionally acceptable.

Nurses do not necessarily agree who is unpopular, and one nurse reported that she would engage in the secret, or covert liking of the patient, feeling unable to challenge the dominant conception of the patient within the nursing team (Johnson & Webb, 1995a, p.468). Another study added how some nurses do not accept the label given and suspend judgement, considering that passing the label on is akin to 'looking for trouble' (Juliana et al, 1997, p.12). These findings highlight how individual nurses try to maintain their nursing values in a culture where different values may prevail.
2.14.2 The consequences for nurses.

The development of difficulty also has consequences for nurses. A survey design study using four difficult patient scenarios (n=30) suggested that nurses are ill prepared for difficult situations, and have no effective responses to them (Santamaria, 1993, p.8), causing frustration and anger amongst nurses (Santamaria, 1993, p.1). However, the survey design produced responses to hypothetical situations, which although felt, may not have been conveyed to the patient in the practice setting. The same responses to hypothetically difficult patients have been found elsewhere but added upset, hurt and offence (Podrasky & Sexton, 1988, p.19), and disliking the patient (Juliana et al, 1997, p.11). It is of interest that nurses' emotional responses are similar to those reported as experienced by patients in the study by English & Morse (1988, p.20).

Nurses have also been found to experience frustration when patients reject their care and compassion (Juliana et al, 1997, p.11). In addition, a phenomenological study of the nurse's experience of caring for an unpopular patient (n=5) reported the self reproach that can be experienced by nurses when they cannot establish a therapeutic relationship (Little, 1996, p.90). Therefore, although nurses are aware of their own role in the labelling process, the consequences can be deeply felt (Johnson & Webb, 1995, p.470). These experiences has been said to live with the nurse for a long time. The duration of stress as 'Unfinishedness' has been illuminated, as nurses internalised the residual frustration, guilt, or perception of professional inadequacy which could last for years (Little, 1996, p.96), and feelings of guilt have been reported elsewhere (Johnson & Webb, 1995, p.474).

2.15 A Hidden concept perpetuating harm but difficult to accept.

The alienation of those who suffer has been said to be one of the greatest paradoxes of human existence (Younger, 1995, p.53), but regardless of the risk to patients, and the distress experienced by nurses, the concept of the unpopular patient remains
hidden because it is not widely discussed within nursing, and this means that potentially for the unpopular patient harm is perpetuated, and nurses continue to suffer (Little, 1996, p.111). The whole meaning of Little’s (1996) interpretation presented the silence in relation to the concept of the unpopular patient as temporary avoidance, but that avoiding the silence for ever is ‘akin to lobotomy’ (Little, 1996, p.129). It was proposed that the secrecy within nursing can be resolved when there is some honesty about the issue, and an examination of how to work with it (Little, 1996, p.106).

It has been suggested that problems within nurse-patient interactions will not be solved by simple prescriptions because the cause is endemic within social interaction (Kelly & May, 1982, p.154). In order to influence the discussions about the unpopular patient some honest discussion about the social realities of nursing is required (Johnson & Webb, 1995b, p.88).

The nurse’s attitude towards a patient is considered to be one of the fundamental factors contributing to therapeutic care (Brady, 1976, p.11), and yet the term ‘difficult’ is common parlance amongst nurses (MacDonald, 2003, p.305), and the characterisation of the unpopular patient has developed within the culture of nursing (Robinson Wolf & Robinson-Smith, 2007, p.75). However, nurses have traditionally only learned to care for patients exhibiting difficult behaviours from each other and in an ad hoc way (Santamaria, 1993, p.2), and studies have continued to highlight that nurses develop unfavourable attitudes to some patients (Williams, 2007, p.59). In addition, some time ago, it was suggested that it can be difficult to accept that all nurses are not examples of nursing excellence, perhaps reflecting the lack of studies undertaken (Nicksic, 1981, p.317). Since this suggestion was made, there continues to be a lack of studies, but there is no evidence of how widespread the issue is. The unpresentable in nursing is those things which are absent from a discourse (Cameron, 2004, p.2), such as the unpopular patient, but its presence symbolises poor, incompetent or non-caring practice (Juliana et al, 1997, p.13), although complicating contextual factors may be present. The central characteristic of nursing
as caring remains, and nursing work is in close relationships with patients who are vulnerable, and often dependent on nursing care (Fagermoen, 1997, p.434). Yet nursing is a very complex activity which is intertwined with other professional roles and services, and the wider social milieu (Stockwell, 2002, p.103)

2.16 Summary of the literature.

The findings of studies are contradictory in some places, but the unpopular patient is clearly a consistent occurrence within nursing, and results in labelling and stigmatisation. Patients are labelled for a wide range of reasons and nurses are familiar with the way in which they label patients.

Development of unpopularity means the requirements of being a professional nurse are breached. At times nurses agree who is difficult, and at times they do not, and labelling can be conducted by one nurse, or a group of nurses. However, the culture of the team may mean that challenging the prevailing practices is risky for an individual nurse. Not all situations are serious, but all have implications for the quality of nursing care (Nicksic, 1981, p.318) and patient experience. Labelling also impedes the nurses’ ability to meet their obligation to provide quality care, promote well being and treat patients with dignity, and the duty to prevent harm means not intentionally putting patients at risk by stigmatising them (Erlen & Jones, 1999, p.78).

The influences of wider society and the expectations by nurses of the patient role can contribute to difficulty. That said, the context of care may well mean that nurses are striving to control their work in difficult circumstances. It is of interest that none of the studies revealed the experience of the clinical nurse leader, or cited clinical nurse leadership in any way, particularly in light of the fact that the climate of care, and tone of the setting, are said to be set by the clinical leader.

Reports of poor care quality, including that for older people, may be unwittingly inclusive of the unpopular patient, but the discrimination is subtle and the issue
hidden from wider professional discourse, and therefore it would seem that the issue remains obscured from the agenda. In light of this, current drivers for quality are unlikely to directly address the issue.

2.17 Justification for the study.

Clinical nurse leadership has received much attention centrally and within the nursing profession, and is said to be vital to quality nursing care and upholding patient dignity (Gallagher, Li, Wainwright, Rees Jones & Lee, 2008, p.1; Murphy, 2009, p.26), and yet the presence of the unpopular patient indicates that dignity, among other aspects of care, is not upheld, and the qualitative aspects of care may be negatively impacted. Clinical leaders are said to set the tone of the care environment, and the emotional tone of a unit has a strong influence on the way in which nurses interact with patients (Podrasky & Sexton, 1988, p.20). However, promoting dignified care is considered complex and challenging for the clinical leader who requires knowledge, skills, tenacity, courage and humility to be successful (Gallagher, Wainwright, Baillie & Ford, 2009, p.15). Although the link between leadership and dignified care has rarely been made explicit, it is present (Gallagher et al, 2009, p.14). However, the link between care quality and the unpopular patient has been made and hence is of significant importance.

Some nursing scholars suggest that it is caring which transforms nursing (Turkel & Ray, 2004, p.250), but as Mayeroff (1971, cited by Turkel & Ray, 2004, p.251) proposed, caring is not always easy, and it can be frustrating. Nurse leaders need to be able to articulate what nursing is (Boykin & Schoenhofer (2001, p.5), and create a culture which helps nurses to rediscover their values (Turkel & Ray, 2004, p.252). However, the importance of organisational factors and cultural barriers which can inhibit clinical nurse leadership where there is inadequate support (Millward & Bryan, 2005, p.xxi) are also important.
The literature review has revealed the current national concern in relation to care quality, and the improvement drivers to ensure that care is compassionate, respectful and dignified, with a particular focus on the care of older people. The concept of the unpopular patient signifies care which lacks compassion and dignity. The role of the clinical nurse leader is held as central to high care quality and for setting the tone of the unit, and yet studies of the unpopular patient have not alluded to this key function in relation to care quality. The role of the clinical nurse leader could therefore be considered to be important in relation to the development of patient unpopularity. Previous studies about the unpopular patient have rarely focused specifically on the older patient (except English & Morse, 1988) or community settings (except Michaelsen, 2012). Through exploration of the experiences of the clinical leader in relation to the unpopular patient, the aim was to reveal greater insight into a largely invisible concern (Rubin & Rubin, 1995, p.52), in a previously under-researched area of nursing (Weaver & Olson, 2006, p.466), and in a setting which was previously under-explored.

Firstly, this study contributes to the body of knowledge about the unpopular patient by exploring community settings and older people. This is important because as the population ages, nurses will spend more time caring for this group, a group which may already be vulnerable, and, or stigmatised by wider society. In addition, it is important as most studies have focused on acute care settings. Secondly, it contributes to the existing body of knowledge in relation to the unpopular patient as it is experienced by clinical leaders, which is a different and unique perspective. Thirdly, studies about the unpopular patient within this country are also very limited, and this study contributes to these and the wider literature. As clinical nurse leaders are upheld as fundamental to care quality, it is vital to understand their experience. The focus of the study is therefore to explore the experience of the clinical leader when older patients are considered unpopular within their clinical teams. In order to gain in-depth insight into this experience there needs to be voice given to the subjective experience of clinical nurse leaders to reveal the meanings and practices through which their experiences are found (May, 2003, p.24).
2.18 The research question.

Doctoral researchers should be clear about why they chose their study and why it is timely now (Kamler & Thomson, 2006, p.67), as emotional investment can create the inception of a study (Drew, 1989, p.436). Clinical leaders lie between the many facets of organisational life, being situated between many parts, influences and situations (Latimer 2003, p.238), but are cited as central to the provision of high quality care. In view of this there was the need to focus on the concept of the unpopular patient within its context, buttressed by ‘local groundedness’ so that the context is retained and considered, revealing hidden and underlying issues (Miles & Huberman, 1994, p.10) for the clinical nurse leader. The primary study therefore explored the clinical leader’s experiences when leading a nursing team caring for an older unpopular patient in community nursing settings using this research question;

‘What is the lived experience of clinical nurse leaders leading teams caring for an older patient perceived as unpopular in community hospital and community settings?’
3.0 CHAPTER THREE- FORMAL ETHICAL APPROVAL, METHODOLOGY AND METHODS

3.1 Introduction.

Streubert & Carpenter (2011, p.25) suggest that a review of the literature is undertaken to ensure the need for the study, and to highlight any important gaps within it. It is over forty years since the unpopular patient was highlighted by Stockwell, but the concept still exists today. The literature has revealed how being an unpopular patient can result in a reduction of care quality. Yet it has been suggested that clinical nurse leaders have their focus on the patient (Edmonstone, 2009, p. 292), set the tone of the care environment (Podrasky & Sexton, 1988, p.20), and translate the meaning of caring into the nursing culture (Bondas, 2003, p.251). Therefore the experience of clinical nurse leaders' work in relation to the unpopular patient was of interest. However, the literature did not reveal any studies which specifically explored the experience of the clinical leader in relation to the development of the presence of an unpopular patient.

3.2 Ethical review.

Ethical review from two sources was sought. Firstly, the study gained a favourable opinion from the School of Health Sciences and Social Work at the University of Portsmouth. This provided opportunity to refine the data collection methods. Secondly, the study documentation was submitted through the National Research Ethics System (NRES) and given favourable opinion by the Portsmouth and Isle of Wight Ethics Committee (Appendix One). Advice received from the Portsmouth and Isle of Wight Ethics Committee suggested that, as the study focused on older people, this should be made more explicit in the participant information sheet. The participant information sheet was therefore amended prior to final approval in October, 2009. Finally, prior to the research study commencing Organisational Research and
Development Permissions were gained from the two participating NHS Trusts during February, 2010 (Appendix Two).

3.3 Justification for choosing a qualitative approach.

The aim of the inquiry for this study was to develop deep understanding by interpreting the subjective meaning of the lived experience, or life world (Kvale & Brinkmann, 2009, p.27), for clinical nurse leaders of teams caring for an older unpopular patient in a community setting. A qualitative approach was therefore chosen to answer the research question and the rationale for this is now discussed.

Qualitative research is used as a broad descriptor for a range of distinct approaches underpinned by common foundations (Wilding & Whiteford, 2005, p.98). Qualitative approaches describe people’s experiences, behaviours, interactions and social contexts (Fossey, Harvey, McDermott & Davidson, 2002, p.717). These approaches aim for subjective interpretation and understanding (Porter, 2000, p.141; Seaton, 2005, p.204), and are focused on the personal experiences of participants (Hill Bailey, 1996, p.19; Fossey, Harvey, McDermott & Davidson, 2002, p.723; Streubert & Carpenter, 2011, p.21).

Another important characteristic of qualitative research is that it is conducted in the natural setting (Mulhall, 2001, p.72) and accepts multiple realities (Appleton & King, 1997, p.14; Van Der Zalm & Bergum, 2000, p.3; Streubert & Carpenter, 2011, p.20). Qualitative research has an iterative nature (Morse, Barrett, Mayan, Olson & Spiers, 2002, p.13) and data analysis is inductive, as the depth of the data is more important than the recruitment of large samples (Smith, Bekker & Cheater, 2011, p.41). Also, the researcher is an instrument due to the acceptance of subjective bias (Streubert & Carpenter, 2011, p.22), and the researcher has a commitment to the participant’s viewpoint (Streubert & Carpenter, 2011, p.21). Qualitative research is also context specific, and the aim is not to generalise findings (Fossey, Harvey, McDermott &
Davidson, 2002, p.730), but instead provides understanding and interpretation, which this study aimed for.

Qualitative research is therefore suited to a research question which focused on the subjective experience (Porter, 2000, p.141; Denzin & Lincoln, 2011, p.107). However, people interpret their lived experience differently, and qualitative researchers contend that there are always multiple realities to consider when trying to understand the situation (Appleton and King, 1997, p. 14; Streubert & Carpenter, 2011, p.20). Therefore in this study a qualitative approach aimed to explore the multiple realities of clinical nurse leaders leading teams caring for an older unpopular patient, and aimed to give privilege to their personal experiences (Fossey, Harvey, McDermott & Davidson, 2002, p. 723). The decisions related to the choice of philosophy, methodology and data collection methods to address the research question now follows.

3.3.1 The starting point for the study- personal ontology and epistemology.

It is often argued that researchers are shaped by their own background and experience, and are ‘positioned’ in relation to their own research (Hasselkus, 1997, p.81; Simmons, 1995, p.839). The philosophical assumptions underlying a ‘method’ or approach, and whether these are consistent with the researcher’s own view were the essential starting point because a researcher’s personal philosophy can strongly influence the chosen paradigm, methodology and data collection methods chosen (Koch, 1995, p.827). An exploration of the researcher’s ontology is therefore the first phase of the research process (Koch, 1995, p.827), as knowing our own ontological position drives the epistemology and leads to the chosen research approach (Koch, 1999,p. 22). When the researcher explores their own assumptions they will be in a better position to approach the topic openly (Streubert & Carpenter, 2011, p.26).
Ontology is the nature of the social world and what there is to know about it (Ormstone, Spencer, Barnard & Snape, 2014, p.4). It is concerned with the assumptions, and the nature of reality and its characteristics in which researchers operate to search for knowledge (Denzin & Lincoln, 2011, p.102). One position is that the nature of reality is single reality with cause and effect laws (Koch, 1999, p.23). However, many qualitative researchers reject the view that fixed laws can govern the social world and the alternative position is one where there are multiple, context specific realities (Ormstone, Spencer, Barnard & Snape, 2014, p.4).

My own ontology supports humans as self interpreting beings and that people's experiences are their own constructions of reality. My own ontology therefore concurs with the constructivist paradigm ontologically where there are always multiple realities (Denzin & Lincoln, 2011. p.101), and a person's own reality exists in their mind (Guba, 1990, p.26). Different people experience these multiple realities differently (Grbich, 2007, p.9), and this ontology is relativist in that reality is socially and experientially based (Guba, 1990, p. 27).

Epistemology determines what we consider to be knowledge and how we know the world as we experience it (Munhall & Oiler, 1986, p.28; Koch, 1999, p.21). A key epistemological issue is the relationship between the researcher and the researched. One suggestion holds that the researcher is seen as independent and objective in their approach, being value free. Another suggestion holds that the relationship between the researcher and the social phenomena is interactive, and the researcher cannot produce a value free account (Ormstone, Spencer, Barnard & Snape, 2014, p.5). A further epistemological concern is whether claims are accepted as truth. In the natural sciences it is considered that there is a match between observation and independent reality. For the study of the social world it is proposed that reality can only be gauged by consensus rather than in an absolute way, that is, several reports can confirm the true representation of a social reality (Ormstone, Spencer, Barnard & Snape, 2014, p.5).
The constructivist epistemology supports knowledge is a human and social construction, where knowledge is considered to be subjective (Grbich, 2007, p.9), and that subjectivity is the way to reveal the constructions in people's minds about their situation (Guba, 1990, p.26; Streubert & Carpenter, 2011, p.13).

I also do not contend that a value free account can be developed by the researcher because I come to the research with experience which cannot be set aside. I also believe that in the social world, there is no absolute truth, but instead, I hold that reality is a subjective interpretation supporting a constructivist epistemology. The research process within the constructivist paradigm therefore means that the epistemology is based on the creation of knowledge through interaction between the researcher and the participant, and that the findings of the study are created together (Koch, 1999, p.25; Denzin & Lincoln, 2011, p.100).

Based on my beliefs regarding ontology and epistemology my chosen philosophy was phenomenology. Essentially, phenomenology is concerned with human experience, and the meaning of an event.

3.4. Chosen philosophy-Phenomenology.

Phenomenology is a philosophy, or method of inquiry, based on consciousness of objects and events as they are experienced by humans, making the nature and meaning visible (Tucakovic, 2005, p.96). Phenomenology attempts to describe the phenomenon as it is experienced by people. It is not intended to generate theory, but instead to provide insight into the experience and the meaning given to the phenomena (Corben, 1999, p.56). Phenomenology as a research approach therefore offers a way to collect and analyse data, and to learn about phenomena which are difficult to observe or measure (Wilding & Whiteford, 2005, p.99). It is also an
approach which can bring to light something which has received little attention (Wilding & Whiteford, 2005, p.100).

Phenomenology offers an approach which supports the understanding of unique individuals and their meanings and interactions with others (Lopez & Willis, 2004, p.726). Phenomenologists assume that knowledge is achieved through interactions between researchers and participants (Reiners, 2012, p.1), having the goal of understanding the experience of humans, which is suited to nursing research (Streubert & Carpenter, 2011, p.94). Phenomenology’s primary position is that the human truths can only be accessed through inner subjectivity (Thorne, 1991, p.182), and therefore phenomenology was appropriate to explore the experience and meaning for clinical leaders of leading teams caring for a patient who was unpopular with the team.

However, as assumptions drive methodological decisions, I explored the values and claims of each different phenomenological approach before making a choice (Lopez & Willis, 2004, p.726). It is fairly well recognised that both Edmund Husserl (1859-1938, transcendental or descriptive phenomenology) and Martin Heidegger (1889-1976, interpretive phenomenology) were two of the most influential philosophers of the twentieth century (Giorgi, 2007, p.63). Heidegger challenged the ideas of Husserl (McConnell-Henry, Chapman & Francis, 2009a, p.1), and as a result Husserl and Heidegger's early philosophical focuses were fundamentally different to each other (Rapport & Wainwright, 2006, p.228). The significant difference between the main descriptive (Husserlian) and interpretive (Heideggerian) approaches relate to how the findings are generated (Lopez & Willis, 2004, p.727). Both these philosophical approaches were considered before choosing the most appropriate approach.

3.4.1. Choosing between two philosophies.

Husserl contended that phenomenology was to become a rigorous science (Paley, 1997, p.188) by removing all preconceptions and assumptions about a phenomenon,
making no assertions which were not absolutely guaranteed (Paley, 1997, p.188). This is achieved through the processes of ‘bracketing’ the personal influence of the researcher in order to see the phenomenon as it is for the first time (Rose, Beeby & Parker, 1995, p.1124). The aim is to identify the ‘essences’, or facts which are unchanging and absolute (Walters, 1995, p.792), as Husserl believed that there are features of each lived experience that are shared by all who have that experience, and these represent the true nature of the phenomenon (Lopez & Willis, 2004, p.728).

However, Heidegger rejected Husserl’s standpoint and his pure description of phenomena (Sadala & Adorno, 2002, p.283; Dowling & Cooney, 2012, p.24) and replaced it with interpretation (McConnell-Henry, Chapman & Francis, 2009b, p.8). Heidegger believed that meaning for humans is always in the context of influences such as one’s background, culture or situation (Johnson, 2000, p.135; McConnell-Henry, Chapman & Francis, 2009b, p.9), and Heidegger saw phenomenological reduction (bracketing) as impossible due to our integral relationship with the world (Rapport & Wainwright, 2006, p.229). Heidegger therefore suggested that pure description was not possible without some interpretation (Mackay, 2005, p.181). The two philosophies therefore fundamentally differ because the central task of Husserlian phenomenology is a pure description of the phenomena (Koch, 1995, p.828), whilst Heideggerian phenomenologist’s give meaning to a shared understanding of the phenomena (Rapport & Wainwright, 2006, p.229).

Husserl focused on the epistemological question of the relationship between the knower and the known, whilst Heidegger moved to an ontological focus of the reality of being (Laverty, 2003, p.14). My ontological beliefs informed the choice of philosophy for the study, as I hold that there are multiple truths. I also concur with Koch (1999, p.25) and Laverty (2003, p.8) that we cannot suspend our assumptions about something, or put them aside, because we are bound in our past experiences, and also, there is considerable argument as to whether this is actually possible (Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013, p. 18). I therefore chose Heideggerian Phenomenology to underpin the data collection and analysis.
3.4.2 Chosen philosophy-Heideggerian Phenomenology.

Heideggerian philosophy is focused on the notion of everyday existence, or being-in-the-world (Annells, 1996, p.706; Wrathall, 2005, p.60), and Heidegger considered every human as a meaningful being who can wonder about their existence (Pratt, 2012, p.12), and what it means to be a person (Vandermeuse & Fleming, 2011, p.369). Humans interpret meaning about something as a whole which can have parts, but these parts are not separate and they contribute to the whole meaning (Overenget, 2001, p. 99). The study was focused on what it meant to be a clinical leader in everyday practice leading a team caring for an older unpopular patient. seeking to find the parts and the whole meaning of this experience for the clinical nurse leaders.

3.4.3 Major concepts within the philosophy.

The concept of 'Dasein' was central to the philosophical standpoint of Heidegger, and Dasein is essentially the meaning of being a human (McConnell-Henry, Chapman & Francis, 2009a, p.5). A major term used throughout Heidegger's work was that of 'Being' which refers to the essence of human existence. Being is invisible as it cannot reveal itself outside humans (Watts, 2007, p.17). Heidegger's investigation of Being was carried out by an analysis of human existence, which had a spiral structure, continually reinterpreting facets of human existence at deeper levels to find the meaning of Being (Watts, 2007, p.24). The main tenets included temporality, authenticity and truth, ordinary life and the hermeneutic circle, and these were considered as important in relation to this study.

3.4.3.1 Temporality.

To develop a deeper understanding of Being, it needs to be placed in the appropriate context (Watts, 2007, p.17). Heidegger contended that we are deeply rooted in our past heritage whilst living in the present and anticipating the future (Watts, 2007, p.
17). The concept of time was central to Heidegger, with no distinction between past, present and future, it is indivisible (Watts, 2007, p.18). Instead it is a unification of past, present and future and it is this perspective, or horizon, from which something has meaning. Nothing can be encountered without reference to the person’s background, or historicality, and all understanding therefore entails interpretation based on this (Koch, 1995, p.831).

Heidegger used the term ‘temporality’ for time. Time is always conceived in relation to the future, because for humans, things acquire significance in relation to the choices available to how they live their lives (Johnson, 2000, p.138), and this supports foresight, or the ability to make interpretations based on background understanding, (Vandermeuse & Fleming, 2011, p.369), or historicality. Therefore, meaning and significance is thought to be understood in the context of the unfolding of our life, where we have come from, and where we are going (Watts, 2007, p.18).

Heidegger used the term pre-understanding in relation to our historicality to describe the culture which is already present before we understand, and that as humans, we always come to a situation with pre-understanding which cannot be eliminated (Koch, 1995, p.831). This notion of pre-understanding, or background, determines what counts as ‘real’ for a person, and it cannot always be made completely explicit (Koch, 1995, p.831). The importance of temporality in this study therefore relates to how the clinical nurse leaders understand their situation from their past experiences, the situation they are presently in, and their thinking and actions related to predicting the future in relation to the experience of leading a team caring for an older unpopular patient.

3.4.3.2. Authenticity.

For Heidegger, another key tenet was authenticity. If the individual embraces the beliefs and prejudices of society, individuals can fail to differentiate themselves from the masses, and they can live in an inauthentic way, being disengaged or distant
(Conroy, 2003, p.8). When individuals grasp the fact that each human is an individual, and that they have potential to fulfil, their concern is more authentic, fulfilling their real potential in the world (Hornby, 2010, p.2). Authentic existence allows for a much deeper experience (Watts, 2007, p.57) and involves acting in accordance with what is morally good in the world (Conroy, 2003, p.8). Inauthenticity conceals the meaning of being human and one is not as aware of oneself and one's possibilities (Watts, 2007, p.57). This tenet was therefore important in terms of the clinical nurse leaders' experience of the unpopular patient as someone whom others treat in an inauthentic way.

3.4.3.3 Truth.

For Heidegger, truth can be seen in the disclosure of the intrinsic meaning of ordinary everyday events (Watts, 2007, p.65), and perceptions of truth are only relevant in the time and situation in which they arise (Watts, 2007, p.19). Heidegger's focus on subjectivity also aims to reveal the embedded meanings within language (Higginbottom, 2004, p.12). Heidegger believed that language can create the way we feel and relate within our culture (Leonard, 1994, p.43). Language is an open dialogue which is fluid and dynamic (Vandermeuse & Fleming, 2011, p.369) and this is reflected in ontological research questions which aim to reveal understanding (Koch, 1995, p. 831). In this study therefore, the aim was to uncover what it means to be a clinical leader leading a team caring for an older unpopular patient, and the perceptions of truth, or the intrinsic meaning about the experience.

3.4.3.4 Ordinary life.

Heidegger believed it was fundamental to study ordinary life (Wilding & Whiteford, 2005, p.99), and to reveal ordinarily hidden aspects of an experience (College, 2001, p.563), focusing on understanding and meaning (Draucker, 1999, p.361). The aim of the study to was explore the ordinary life of the clinical nurse leader and its meaning in relation to the presence of an unpopular patient.
3.4.3.5 The hermeneutic circle.

People commonly use hermeneutics in everyday life to make sense of their world (Moustakas, 1994, p.9; Lopez & Willis, 2004, p.728) because they try to understand the nature of an experience (Kvale, 1983, p.185; Moustakas, 1994, p.9; Byrne, 2001, p.968). The philosophy of hermeneutics underpins interpretive methodologies (Crist & Tanner, 2003, p.202), as hermeneutics is concerned with the nature of understanding (Draper, 1996, p. 45). Heidegger’s philosophy makes it clear that human understanding is hermeneutic by nature, as our understanding of the everyday world is actually derived from, not only our everyday experiences, but our interpretation of it (Reiners, 2012, p. 2).

It is Heidegger’s past, present and future unification, as a circular movement, that can be described as the hermeneutic circle (Vandermause & Fleming, 2011, p.369). The Heideggerian assumption is that we all consistently live in a hermeneutic circle of understanding (Plager, 1994, p.71), and meaning has both visible meaning, and hidden meaning (Smith, Flowers & Larkin, 2009, p.24). However, meaning is not always apparent to the person describing the experience, because meaning can also be hidden (Lopez & Willis, 2004, p.728), and is there to be uncovered. The study therefore sought to find the visible and hidden meaning from within the data.

Hermeneutics also seeks commonality and difference in understanding between the subjective experiences (Lopez & Willis, 2004, p.729). The process has no stepped approach (Koch & Harrington, 1998, p.882). The approach stresses how prior understanding and prejudice shape the interpretive process (Denzin & Lincoln, 2011, p.16), and therefore the pre-understanding of the researcher is embraced within the research process which constitutes the forward arc of the hermeneutic circle. The process of the interpretation of the data constitutes the return arc (Packer & Addision, 1989, p.275), and the movement between the two uncovers the circle (Crist & Tanner, 2003, p.203). However, the understanding gained is always temporary (Rapport & Wainwright, 2006, p.233) acknowledging the dynamic nature of human
understanding, or Heidegger’s temporality. The researcher must drive the interpretation and not the chosen framework (Thorne, Reimer Kirkham & O’Flynne-Magee, 2004, p.6), because, as Heidegger argued, it is only possible to interpret something according to one’s own lived experience (Walters, 1995, p.794).

Hermeneutic interpretation of data is infinite process, but pragmatically finishes when a sensible meaning has been found (Kvale, 1983, p.185). New knowledge is not developed from the process, but the world of the participants is revealed (Crist & Tanner, 2003, p.203).

3.5 The Approach to the study.

Heidegger did not prescribe a method to underpin his philosophy, and phenomenology as a philosophy guides the researcher’s approach rather than providing a rigid data collection method for the inquiry (Hallett, 1995, p.55).

3.5.1 An approach to support the philosophy.

The term ‘method’, or the approach to data collection for Heideggerian research is applied incorrectly, and the term ‘approach’ is preferable as the research is dependent on the way the researcher collects the data and analyses it to support the chosen philosophy (Pringle, Hendy & McLafferty, 2011, p.8; Koch, 1999, p.31). The findings of the study should be enriched by the tenets within the philosophy (Koch, 1996, p.175; Draucker, 1999, p.360), and in this study they are included where relevant within the findings. As the role of the researcher was as an instrument (Webb, 1992, p.751) the first person is used when describing data collection and analysis.
In accordance with the chosen philosophy, the researcher's subjectivity was firstly embraced as part of the research process as this reveals the researcher’s contribution to the inquiry.

3.5.2 Researcher subjectivity.

The choice of a phenomenon to study can stem from the researcher's own predisposition and values (Drew, 1989, p.431), because the phenomenon matters to the researcher (Drew, 1989, p.436). The phenomenon mattered to the researcher because it negatively affects the care of older people. My own experiences have previously been made explicit. I have significant nursing experience in community nursing settings in clinical nurse leadership positions, and I believe I also share the nursing language of the participants.

3.5.2.1 The researcher’s beliefs.

Heidegger (1962) believed in the researcher having pre-understanding of themselves, and their world, and the researcher, and the researched, being linked by among other things, language, explanations, social structures and beliefs (Risteen Hasselkus, 1997, p.82). The researcher is the instrument in semi-structured or unstructured qualitative interviews. In light of this, the researcher has the potential to influence the collection of data and the analysis of the data (Pezzala, Pettigrew & Miller-Day, 2012, p.165). Heideggerian philosophy encourages exploration of the researcher’s background as a legitimate component of the research (McConnell-Henry, Chapman & Francis, 2009a, p.3). This is because Heideggerian philosophy holds that nothing can be understood without reference to one’s background, and therefore my own preconceptions needed to be made explicit (De Witt & Ploeg, 2006, p.216). The horizon, or prejudice the researcher brings to the study, is historically and culturally bound, and influences the interpretation (Whitehead, 2004, p.513; Lopez & Willis, 2004, p.795), and therefore openness by the researcher relating to this provides
crucial context for the study (Todres & Wheeler, 2001, p.6). It is an integral part of the research process (Walters, 1995, p.795).

3.5.2.2 Working out my own pre-conceptions.

Developing complete openness may not always be possible as the researcher may not always be conscious of their own biases or be able to tease apart experiences easily (Pringle, Hendry & McLafferty, 2011, p.12). However, researcher pre-understanding should be worked out as far as possible before entering the hermeneutic circle (Geanellos, 1998b, p.241) in order to be open to the data. Identifying pre-understanding means the reader can consider influencing factors on the final product (Tuohy et al, 2013, p.17). Heidegger concurred that expression of pre-understanding includes forehaving, foresight and foreconception (Geanellos 1998b, p.241) and these are examined below.

- Forehaving - background practices from experiences which make interpretation possible.
- Foresight - background practices which carry a viewpoint from which the interpretation can be made
- Foreconception - background practices that create expectations about what might be expected in an interpretation.

Within Heideggerian philosophy analysis begins at the point of data collection, and as my pre-understanding could have influenced this, I firstly examined my own pre-understanding. To do this, I asked a colleague, not involved in the study, to interview me using the interview schedule prepared for the primary study (Appendix Six) and this was audio-recorded. I listened to the audio-recording to reveal explicit and implicit understanding. The benefits of this process were that, firstly, it helped me to anticipate any of my own responses or emotional reactions to a sensitive topic that might be experienced in a similar way by the clinical nurse leaders. Secondly, on reflection, the process highlighted to me how past experiences, which had been partly obscured in my memory, suddenly were re-awakened and came alive again as I
revisited and explored them. With hindsight, it seems that to have sat and reflected on my experiences alone would not have been as beneficial as participating in the interview. I feel uncertain that, without prompting, I would have really explored some of the necessary areas. Therefore, although complete openness and the ability to tease apart previous experiences may not always be possible (Pringle, Hendry & McLafferty, 2011, p.12), the interview process assisted me to explore areas I may not have considered when reflecting alone.

My own forehaving is related to the past experience of leading a team caring for ‘unpopular patients’ in a range of clinical settings which makes interpretation possible. This experience shaped my own interpretive position and a viewpoint from which interpretation could be made. My own foresight relates to my experience of nursing practice which informed my own viewpoint. As suggested by Geanellos (1998b, p.241), by analysing my beliefs and interpreting and re-conceptualising them I brought forward my foreconceptions. Twenty two statements were firstly generated as my most strongly held beliefs, which at first presented superficial, descriptive understanding. I then reflected on these and analysed them to develop my final deeper understanding as my foreconceptions (Geanellos, 1998b, p.241). These are presented in Box 3.1 to indicate their potential influence on the research (Laverty, 2003, p.17).

Box 3.1 My own foreconceptions.

1. I believe that a) nurses caring for older people should value each person as an individual, being unique and worthy of b) respectful nursing practice which protects and promotes their dignity, and c) is understanding and compassionate in its response to the illness experience and suffering, accepting difference, and working to promote and celebrate this. Together, these values, attitudes and behaviours combine to create a climate of nursing care which is warm, protects patients, and fosters nursing growth and development.
2. To achieve high quality care constant and consistent vigilance is needed around climate of care, which can be challenging to sustain, and this can be tiring.
3. The development of unpopularity of a patient is stressful due to the breach of
espoused nursing values, and was experienced as embarrassing as a clinical leader. Poor attitudes by individuals towards patients feel excruciating to me as the leader.

4. Judgements by staff about patients can start immediately and unpopularity can begin before the patient is met by the team as judgements are passed between nurses and teams. For the clinical nurse leader this can be challenging to prevent. Unpopularity of patients can arrest caring behaviours and escalate if unaddressed.

Knowing what had influenced my foreconceptions, and the development of a deeper understanding of these meant I was aware of how I might influence the research. I would also be aware of when there was a fusion of horizons, that is, common understanding between myself and the clinical nurse leaders. The product of the research is then the co-constitution of the researcher and the participants (Koch, 1999, p.24; Wimpenny & Gass, 2000, p.1487).

3.5.3 Setting.

The setting for the study was two NHS Trusts in the South of England. One NHS Trust provided services for a small city, the other provided services for a much wider geographical area which included a small city, several large towns and a large rural population.

3.5.4 Sampling.

Within phenomenological approaches the sampling approaches are not intended to provide generalisation, but instead apply to the population under investigation (Higginbottom, 2004, p.14). Purposive sampling is employed in order to only seek those participants who meet the inclusion criteria (Marshall, 1998, p.523; Crist & Tanner, 2003, p.203; Higginbottom, 2004, p.15). For this study purposive sampling aimed to find clinical nurse leaders who had experience of the unpopular patient
within their leadership roles. I sought multiplicities of experiences (Tuckett, 2004, p.51) and therefore both community hospital and community staff were included.

3.5.5 Recruitment.

All the clinical nurse leaders within both NHS Trusts, were invited to join the study. The Director of Nursing and senior managers sent the information by email out to all clinical nurse leaders by selecting the appropriate clinical teams who cared for older people (approximately sixty). The emails included the letter of invitation which introduced the study (Appendix Three), and the Information Sheet (Appendix Four) which provided full written information explaining the purpose of the study, what taking part involved and the contact details of the researcher. This first contact with potential participants gave them time to think about their experience more deeply (Vandermause & Fleming, 2012, p.370). It also provided them the time to consider whether they wanted to join the study. The email sent to the clinical teams asked that those clinical nurse leaders who wanted to join the study to contact me directly.

3.5.5.1 Inclusion criteria.

The inclusion criteria were, 1) Registered Nurses (RNs) in adult nursing roles, and 2) caring for older people, and 3) who held a formal clinical leadership position (in nursing pay grades where clinical team leadership is explicitly stated as the core component of the role), and 4) either within community hospital settings, or within community nursing teams. This excluded those nurses in these settings who may well have been considered clinical nurse leaders, but who did not hold a formal clinical nurse leadership position in the team. It also excluded nurses who may be in more general nursing leadership roles.
3.5.5.2 How many to sample.

I anticipated that obtaining a representative sample of clinical nurse leaders willing to talk about this sensitive area of practice might prove difficult. The literature review had revealed how the issue of the unpopular patient is not widely discussed outside the clinical nursing environment (Little, 1996, p.129). However, it was estimated that a total sample size of ten, comprising five community clinical nurse leaders, and five hospital ward team clinical nurse leaders, might be sufficient in order to ensure rich data was obtained to adequately explore the phenomena. The actual size of a required sample is difficult to predict at the beginning of the study (Streubert & Carpenter, 2011, p.91), and the number of participants necessary for a qualitative study remains contentious among prominent methodologists (Baker & Edwards, 2012, unpublished). However, some guidance is available. Bryman (2012, p.19) explains that suggestions for sample size from prominent authors conceal that sample size is based on the philosophical underpinnings of the study, adding that interpretive phenomenological analysis requires much smaller samples due to the detailed analysis involved.

3.6. Justification for one to one, in-depth semi-structured interviews.

The in-depth interview is considered the main data collection method in phenomenological research, and in-depth interviews involve reconstructing past experience, describing the details and context of the experience, and reflection on the meaning the participant gives to the experience (Wimpenny & Gass, 2000, p.1487). One to one in-depth interviews were chosen to collect the data. This approach creates a space where experiences can be explored and participants can be gently probed (Wimpenny & Gass, 2000, p.1487). While focus groups were considered as a means to collect the data, it is suggested that they can capitalise on the breadth of the experience within a group, rather than describing an individual's in-depth unique experiences, which is desirable in phenomenological research, (Webb & Kevern,
Therefore focus groups were discounted as a means of collecting the data for this study.

In-depth interviews can be structured or semi-structured, but both aim to provide rich and comprehensive data (Corben, 1999, p.59; Tuckett, 2004, p.49), being dialogical and reflective in phenomenological research between the researcher and the participant (Wimpenny & Gass, 2000, p. 1487). They involve a conversation between two people (Kvale & Brinkmann, 2009, p.123). The interviewer’s questions aim to gain cognitive understanding of the person's experience (Kvale & Brinkmann, 2009, p.25), and the quality achieved is vital for the analysis and reporting of the findings because the meaning of what is said, its interpretation and verification, need to be established within the interview (Kvale & Brinkmann, 2009, p.164). Whilst some people can be harder to interview than others, the aim is to facilitate accounts which obtain rich information (Kvale & Brinkman, 2009, p.165).

The unstructured interview (where questions are limited and the conversation is free flowing) is commonly cited as appropriate to phenomenological research approaches (Balls, 2009, p.31). In unstructured interviews the interviewer does not attempt to influence the range or depth of the conversation. However, semi structured interviews allow the interviewer to focus on topics of importance, and to probe and clarify comments (Rose, 1994, p.24), and therefore this approach was chosen. In order to be able to focus the interview, a semi structured interview schedule sets out the main topics of the interview to provide a loose guide (Playle, 2000, p.3; Chase, 2011, p.423). Prompts were then used to encourage a dialogue. This interview schedule can be found in Appendix Six.

3.6.1 Issues of familiarity with the setting.

Nurse researchers are often familiar with the research setting and the potential participants (insider research). The term insider is used when the researcher is part of the topic under study (Sherry, 2008). For insider researchers there is much debate
about the impact this can have on the data collection during the research. Insider research can help to gain a richness and depth of data which would not be possible by an outsider researcher (those external or unfamiliar with the setting), due to the ease of access and rapport with the participants (Hewitt-Taylor, 2002, p.33, Bonner & Tolhurst, 2005, p.9). Insider researchers can also fully understand the conceptual frameworks described reducing the risk of misinterpretation (Hanson, 1994, p.941), and the benefits of insight into the culture can also be helpful (Bonner & Tolhurst, 2005, p.9).

Conversely, it has been argued that a lack of critical distance may mean the researcher is unable to perceive taken for granted meanings which bind the culture (Hanson, 1994, p.940; Jootun, McGee & Marland, 2009, p.44). However, others temper the need for this outsider approach by suggesting that an intimacy between the researcher and the participants promotes truth telling (Bonner & Tolhurst, 2005, p.9). Regardless of the viewpoints associated with the insider position, as I was already part of the topic under investigation by virtue of my background position, I took an insider researcher position.

This issue of power imbalance was present as I was in a more senior position, although not in a direct management relationship with the clinical nurse leaders. In order to address these issues developing rapport and reciprocity was essential, combined with ensuring a lack of critical distance meant not simply following the story preventing pertinent questions being asked. There was a need for a warm, yet professional, relationship.

3.6.2 Undertaking a pilot interview.

An important part of interview preparation in qualitative research is that of piloting the interview schedule to determine if there are inherent flaws or weaknesses. Preferably this should be conducted with participants who are similar to those included in the
main study. A pilot interview also allows the researcher to refine their questioning and probing techniques (Turner, 2010, p.757).

The pilot interview was undertaken with a nursing colleague who was informed that I needed to undertake a pilot interview. The participant information sheet was provided (Appendix 4) and verbal and written consent were obtained (Appendix 5). A pilot interview using the proposed semi-structured interview schedule was undertaken (Appendix 6). A pilot interview aims to ensure the interview schedule supports appropriate data collection (Van Teijlingen & Hundley, 2002, p.35). It also provides opportunity to check the interview schedule for adequacy, check the clarity of questions and any modifications are required (Vivar, 2007, p.67). The pilot interview took place at the person's workplace at their request.

3.6.2 1. Pilot interview and schedule adequacy.

I recorded and transcribed the pilot semi-structured interview verbatim into an electronic document file. Whyte’s Six Point Directiveness Scale (Britten, 1995) assists researchers to analyse their own interview technique, and this was employed to check for a balanced approach to the directiveness of questioning in relation to the information gathering approach. Whyte’s scale and my own scores can be found in Box 3.2. The aim of this process is to uncover any problems with the interview technique, and to ensure data collection is concentrated around the area of interest (Van Teijlingen & Hundley, 2002, p.35). The scale below was checked against the transcript to assess my approach to questioning.

**Box 3.2 Whyte’s Directiveness Scale for analysing interviewing technique.**

<table>
<thead>
<tr>
<th>Element of interviewing</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making encouraging noises</td>
<td>4</td>
</tr>
<tr>
<td>Reflecting on remarks made by the informant</td>
<td>4</td>
</tr>
<tr>
<td>Probing on the last remark by the informant</td>
<td>4</td>
</tr>
<tr>
<td>Probing on ideas preceding the last remark by the informant</td>
<td>3</td>
</tr>
<tr>
<td>Probing on ideas expressed earlier in the interview</td>
<td>2</td>
</tr>
<tr>
<td>Introducing a new topic</td>
<td>1</td>
</tr>
</tbody>
</table>

1= least directive  6=most directive  Total 18/36
The quality of the data generated depends on the researcher’s skills (Appleton, 1995, p.994), and the pilot interview offered an opportunity to be alert to how the participant may have felt. This means that any potential reactions to questions which may probe into sensitive areas of practice can be better identified and anticipated at future interviews (Tobin & Begley, 2004, p.389; Kvale & Brinkmann, 2009, p.65). On the Whyte’s scale I scored 18/36. As the interview flowed well and the clinical nurse leaders talked freely, we developed areas of interest together, I concluded that the interview technique was well suited to the necessary data collection. According to Whyte (1984, p.100) my directiveness was reasonably balanced. The pilot also served to increase my attention around the need for sensitive questioning when exploring meaning, and being attuned to the potential responses of the participant, both verbal and non-verbal, to ensure it felt safe to probe.

Review of the interview transcript using Whyte’s Directiveness Scale revealed the early phase of the interview as focused on encouraging the participant to talk about their experiences, and I did so by making encouraging noises and demonstrating understanding by using words such as ‘OK’ and ‘Yes’. My aim was to affirm to the clinical nurse leader that I was attuned, and keen to hear their story in their own words, which I wanted them to continue. Four examples of the interview technique can be found in Box 3.3.

**Box 3.3. Four examples of my interview technique**

1. An example of probing on the last remark by the participant, Interviewer: ‘So that trust and communication is what you see as key?’

2. An example of my probing on ideas made in the last remark, Interviewer; ‘As the leader, how do you get that to happen? How do you show them the way?’

3. An example of my probing of ideas expressed earlier in the interview, Interviewer; ‘You used the word ‘earthmoving’ to express how you feel when you see a really good nurse-patient relationship. Tell me a bit more about that as a clinical leader?’

4. An example of introducing a new topic, Interviewer; ‘Absolutely………………OK, that’s brilliant. Can you now tell me about a patient………………’
Following review of the audio-tape and transcript, I concluded that the interview technique was balanced between the levels of directiveness necessary to encourage appropriately detailed narrative, whilst remaining sensitive and supportive to the participant.

3.6.2.2 Inclusion of pilot data.

Written informed consent was obtained for the pilot interview. There can be concerns regarding the inclusion of pilot data where quantitative intervention studies are undertaken, where those included in the pilot respond differently from those who have not. This contamination is of less concern in qualitative research where pilot data is often used as part of the main study (Van Teijlingen & Hundley, 2002, p.35). Pilot interviews can facilitate the collection of complex data and the meaning for the participant (Jootun, McGee & Marland, 2009, p.44). When I listened to this pilot interview audio recording, and read the transcription, it revealed a relevant and in-depth pertinent experience which I felt needed to be included in the main study. As the main interview schedule remained unaltered following the pilot interview, the inclusion of the pilot data was considered appropriate.

3.7. The participants in the study.

Following the pilot study the recruitment of clinical nurse leaders for the main study commenced. On one occasion the clinical nurse leader asked if a colleague could join her in the interview, and the decision made was that if the two clinical nurse leaders preferred this, then the challenge rested with my own interview skills. Therefore eleven participants contributed to ten in-depth interviews. All the clinical nurse leaders were female as no males requested to join the study. These clinical nurse leaders would have been leading teams with a staff complement between approximately ten.
and sixty staff. The recruitment of clinical nurse leaders was pragmatically concluded when no new clinical nurse leaders volunteered for the study and themes were repeating.

3.7.1. Recording the semi-structured interviews for the main study.

The audio recording of interviews ensures the accuracy of the verbatim data (Koch & Harrington, 1998, p.885). Each semi-structured interview was audio-recorded. The potential distraction from using an audio recording device was minimised by using a small inconspicuous digital device (Fernandez & Griffiths, 2007, p.9), and the small device was placed to the side of myself and the participant. I transcribed each audio recording myself verbatim. This supported both the detailed and circular reading of the data suggested by Polkinghorne (2005, p.142), and the immersion in the first phase of the analysis suggested by Skene (2007, p. 60).

3.7.1.1 Creating the semi-structured interview situation.

Preparation for the semi-structured interviews was undertaken. This meant having some time away from busy professional life, to review my diary notes and to be open to the participant’s story. This contributed to being present in the interview situation and remaining responsive to the cues of the participants (Hutchinson & Wilson, 1994, p.307). Heidegger (1962) considered that ‘to live is to listen, interpret and learn from the stories of others’ and listening intensely was required (McConnell-Henry, Chapman & Francis, 2011a, p.33). Following the interview I took time to record my thoughts.

All the semi-structured interviews took place in a venue chosen as suitable by the participant. All the clinical nurse leaders chose an NHS site, although they were given the choice of being interviewed at home. On some occasions the clinical nurse leader offered to book a room for the interview and this assisted rapport building. My aim was to conduct the interview process within a situation of safety and trust, and within
a supportive relationship as suggested by Laverty (2003, p.19). The main focus of interest was the participant's story (Wimpenny & Gass, 2000, p.1487), and as such, the interviews were not conducted, but were participated in (Sorrell & Redmond, 1995, p.1120).

Time was created to prepare the clinical nurse leaders for the semi-structured interview by explaining the process to them, and explaining that the interview may take up to two hours to complete, depending on how much they wanted to share. Time was spent checking with each participant again that they were happy to proceed. The aim was for interviews to be conducted without distractions or interruptions in a quiet, undisturbed area to support the participants to be able to openly describe their unique perspective (Sorrell & Redmond, 1995, p.1120). Interruptions within an interview can destroy continuity (Bell, 1999, p.141), so a 'Please do not Disturb' sign was placed on the door. However, since the clinical imperative takes priority (Mulhall, 2001, p.538) I explained that I would stop the interview if they needed to return to clinical work. Twice a telephone rang during one interview but the clinical priority needed to remain. After interruption continuity and flow were retained by relaying back the last part of their story. In order to be supportive, assurance that the interruption was not a problem was provided.

3.7.1.2 Undertaking the semi-structured interviews.

The semi-structured interviews were similar to that of in-depth conversations. Reflecting on the participant's experiences and holding dialogue between the participant and the researcher is central to this (Wimpenny & Gass, 2000, p.1487) in order to elicit rich contextual stories (Cohen, Kahn & Steeves, 2000, p.60). The purpose of the hermeneutic approach is to hear the stories as their reality, their construction of how they saw the world, and what it was like in their world (Koch, 1999, p.27) which is underpinned by human consciousness being able to make sense of experiences (Cohen, Kahn & Steeves, 2000, p.59). Data collection is designed so that the researcher and the participants work together to create the interpreted story.
To achieve this, understanding of stories should be confirmed (Kvale & Brinkmann, 2009, p.164). I therefore clarified and summarised their stories to ensure we had a shared interpretation.

Sensitivity to the clinical nurse leaders was essential, deciding when to encourage dialogue and when to remain silent. At times it may not be in the participant’s interest to talk about the things the researcher wanted to know (Clarke, 2006b, p.24), for example, if it causes distress. Remaining alert to the body language to observe for any emotional distancing assists decisions on whether further probing is appropriate (Clarke, 2006b, p.24), and I tried to remain attuned to the participant to be aware of discomfort and distress.

3.7.1.3 Developing the shared stories.

The in-depth semi-structured interview can commence with a general question to build rapport with the participants (Clarke, 2006b, p.19). The interview aimed to start with a question which settled the clinical nurse leader into talking about their experiences and I asked them, ‘Can you tell me about a time when the team were caring for somebody they really enjoyed looking after?’ Participants should be provided the time to freely to discuss their experiences without direction (Rose, 1994, p.26) and I allowed them time to share their stories. Follow up questions clarify points and seek further detail (Rubin & Rubin, 1995, p.212), for which I gently probed where I felt appropriate. The development and refining of questioning increases as exposure to experiences increases (Wimpenny & Gass, 2000, p.1489) and as individual interviews progressed I attempted to focus on the meaning held for each participant. Each clinical nurse leaders' interpretation was conveyed differently, but as Melia (1982, p.327) suggested, the importance for them was to be able to ‘tell it as it is’

Open ended questions and conversational style encourage participants to explain their experience in their own words (Morse & Field, 1996, p.66) and I focused on
creating a warm dialogue. The aim is to develop reciprocity and a non-hierarchical relationship (Clarke, 2006b, p.20). It was important to gently check understanding. The summarising of responses assists in seeking clarity, and an empathetic approach encourages honesty (Skene, 2007, p.60).

Systematic effort to hear the story is needed (Rubin & Rubin, 1995, p.17) and this was achieved by intense listening and seeking meaning in the stories. The areas requiring greater probing became more evident as the stories unfolded, particularly in relation to how the experiences left the clinical nurse leaders feeling. Periods of silence should be anticipated (Morse & Field, 1996, p.73) but the reality was quite different. The willingness of the clinical nurse leaders to share their stories meant silence rarely occurred, and as Rubin & Rubin (1995, p.26) suggest, stories can contain points people urgently want to share. However, it was important that I was comfortable with silence, as silence is known to be powerful and may say more than words (Sorrell & Redmond, 1995, p.1121). On the rare occasions when silence did occur, it was important to remain non-verbally engaged through eye contact and to convey understanding using facial expression.

When talking about the ‘unpopular’ patient, the clinical nurse leaders often became emotional. One clinical nurse leader revealed how, as a new clinical leader, she had been unable to cope with an unpopular patient and the team, and how painful this had been. However, with experience, she described how she would handle things very differently, and therefore the interviews achieved the authentic accounts of the participants’ subjective experience as suggested by Crotty (1996, p.22). In this way some of the clinical nurse leaders revealed their own hermeneutic circle of understanding in relation to their experiences at times.

Trust, compassion and empathy should be inherent in all nursing endeavours, including research (Houghton, Casey, Shaw & Murphy, 2010, p. 22), and when participants revealed strong emotions, I ensured a compassionate and empathic response. At these times I checked their willingness to continue due to the risks of
self-exposure and the principles of informed consent. As suggested by Bulpitt & Martin (2010, p.7) the researcher should aim to ease any psychological distress, and this was found though shared humour, as the clinical nurse leaders frequently used humour when sharing their stories. It was also important to convey understanding.

The clinical nurse leaders shared emotions as they began to reveal their experience. This is said to be an indicator of the validity of the semi-structured interview (Morse & Field, 1996, p.74). Although meaning is sought, meaning is never completely revealed (Johnson, 2000, p.142), and this was evident throughout some of the semi-structured interviews. Their stories were vivid, and yet at times, there appeared to be more to be understood, but it was difficult to probe the most private of thoughts. The importance of Kvale’s (1996) ‘hearing between the lines’, Van Manen’s (1997) ‘significance of the absence of speaking’ and the ‘silence of the unspeakable’ (Laverty, 2003, p.19) came to the fore. It seemed that the clinical nurse leaders could not reveal their complete story at times, and intonation and restraint in the dialogue were occasionally evident. Developing reciprocity is promoted (Clarke, 2006b, p.20), and although I felt that this was achieved, the unspeakable may have been 'held in' for many reasons, including professional pride, and my influence as a more senior nurse. In addition the researcher can share the participant’s feelings and can feel exhausted (Clarke, 2006a, p.26) as listening well to sensitive accounts of experiences is necessary (Walker, 2007, p.40). The intensity of the dialogue and its emotive content was tiring at times, and breaks between interviews conducted were scheduled to allow time for reflection and self-understanding.

3.7.1.4 Ending the interviews.

Ending the semi-structured interviews on a positive note was easier than anticipated, especially after sensitive conversations. The clinical nurse leaders seemed relieved by the opportunity to share their experiences, and most shared how interesting and necessary the study was for them, which was encouraging. Thanking them and reminding them of the value of their contribution was important, and ensuring they
were aware of the available support structures if needed, for example, through the Occupational Health Department.

3.7.1.5 Temporality of understanding and single interviews.

Heidegger’s beliefs about the temporality of understanding means that each time an experience is revisited, meaning may have altered (McConnell-Henry, Chapman & Francis, 2011, p.30). We are located in a temporo-spatial experience which influences the meaning of the event at that time. When time and setting differ, the meaning of the experience differs, because everything is context specific (McConnell-Henry, Chapman & Francis, 2011, p.31). In view of this, within a Heideggerian approach, follow-up interviews are invalid (McConnell-Henry, Chapman & Francis, 2011, p.32), because meaning and understanding may have changed. In relation to this point, even within the interview conversations there was evidence that the participants had discovered new aspects which they had not previously thought about as suggested by Kvale (1983, p.177), demonstrating their own temporality of understanding. Examples of the clinical nurse leader’s own temporality of understanding are later shown in the findings.

3.8 The ethical considerations for the study.

The three primary ethical considerations when undertaking this research were firstly, beneficence and non-maleficence, secondly, respect, and thirdly, justice (Cerinus, 2001, p.76; Walker, 2007, p.39).

Firstly, beneficence concerns actions which benefit others. This was upheld by increasing nursing knowledge related to a sensitive area of nursing practice through hearing the clinical nurse leader’s lived experience of their stories, and acknowledging and reassuring each clinical nurse leader that they had made a unique contribution to the area of interest. The hidden issue of the concept of the unpopular patient meant that the study provided the first opportunity for clinical leaders to share their
experiences, aiming to reveal greater insights into their world around this difficult area of practice. Non-maleficence is an ethical duty means not intentionally harming others. This was enacted through several processes including informed consent, maintaining confidentiality and data security. Informed consent is discussed in more detail later. The returning of transcripts provided the opportunity for the clinical nurse leaders to remove data they decided they did not want included following the interview. Together with ongoing informed consent during the interview process, aimed to provide the clinical nurse leaders with control over the disclosure of their information.

The second ethical consideration of respect was particularly important as the study would not have been possible without the contribution of the clinical nurse leaders, and this was consistently uppermost in my mind. In addition to the information sheet provided, and the opportunity to discuss the study prior to agreeing to participate, I discussed the purpose of the study, the interview process and the dissemination strategy with the clinical nurse leaders prior to commencing the interview. As the area of enquiry involved a sensitive topic, I was attuned to the possibility of the clinical nurse leaders becoming upset during the interview process, and only probed where the clinical nurse leader was happy to continue. This is further discussed within the discussion on researcher reflexivity. Blanket anonymisation of the data (changing the names of all people and places), and the use of pseudonyms (alias) supported maintaining confidentiality. In addition, the narrative was reviewed to remove terms which may identify the clinical nurse leader through identification of the function or location of their team. The return of their transcripts to provide control over the data included also contributed to the principle of respect, and the clinical nurse leaders were also made aware of their right to withdraw from the study at any point and to have their data removed. Respect for confidentiality included the safe storage of the interview data and the plan to destroy the data once the study had been published.

Justice, as the third ethical principle, refers to equality. The consideration of justice included the exploration of my own prior understanding of the area of interest in
accordance with the chosen approach. This also facilitated deeper insight into those areas of exploration which may be sensitive for the clinical nurse leaders, ensuring that I was better prepared for the interviews. To ensure accuracy of the data, the interviews were audio-recorded and transcribed. I transcribed each interview myself which ensures verbal accuracy (Koch & Harrington, 1998, p.885). A particularly important part of the principle of justice was to include all issues of relevance and importance within the data analysis, providing an accurate interpretation of the clinical nurse leaders' experiences. The clinical nurse leaders were offered an Executive Summary of the final product once completed within the informed consent process in order to demonstrate openness.

3.8.1 Informed consent, confidentiality and anonymity.

The principles of beneficence and non-maleficence were embraced firstly through written informed consent. This ensures adequate information and free choice (Walker, 2007, p.40). Senior managers in both Trusts agreed to support the study. Information about the study, including the letter of invitation (Appendix Three) and the Information Sheet (Appendix Four) was circulated to the senior managers who then circulated the information to community hospital and community nursing clinical leaders. This circulation asked that clinical leaders who were interested in joining the study contacted me directly, or if more information was required, to contact me by telephone. The information explained that if they agreed to participate in the study, I would meet with them to gain formal written informed consent (Appendix Five). Taking time to gain written informed consent means the potential participant have the opportunity to change their mind about joining the study. Informed consent should also make participants aware if there is an intention to publish the work (Chase, 2011, p.424), and this was included. As participation was voluntary, every participant was given the right to withdraw from the study at any point (Walker, 2007, p.41). This was included in the information sheet and discussed during the informed consent process, and the clinical nurse leaders were asked to contact the researcher by telephone.
The process of informed consent served to remind the clinical nurse leaders that they were engaging in a professional conversation and as such were bound by their professional code (NMC, 2008). The information sheet set out the conditions of confidentiality by stating,

'Due to the nature of the study, absolute confidentiality cannot be guaranteed. However, every effort will be made by the research to protect it. Your name will not be used and you will be given a pseudonym to protect anonymity. Any names of places or details you give will be removed.'

In general, researchers have a common law duty of confidentiality to research participants, but there are certain circumstances which may override this duty (Wiles, 2012, p.1). During the informed consent process I discussed my responsibilities as a researcher with the clinical nurse leaders. Keeping responses confidential is important in qualitative research (Rubin & Rubin, 1995, p.95). However, should they have disclosed that a patient was 'at risk' I would have been bound to abide by my own professional code (NMC, 2008) to report the risk to the appropriate person. Confidentiality generally means that information given to one person will not be repeated to another, and therefore 'absolute' confidentiality is precluded if the situation was considered risky for a patient (Bell & Nutt, 2008, p.73). It was acknowledged that informed consent for this kind of study must be a dynamic process, and the issue of informed consent needed to be considered throughout the study. Whilst written informed consent is obtained prior to the interview, informed consent should be continued throughout the interview process by checking the participant's willingness to explore topics (Rubin & Rubin, 1995, p.97), and I continued to check this with the clinical nurse leaders, especially during sensitive periods of dialogue.

Anonymity is the process of not disclosing the identity of a research participant, and the author of a particular view or opinion (Clarke, 2006a, p.4). Anonymisation is the primary way in which researchers seek to protect the identity of participants. In
order to ensure no harm was cause, data was reported so that no one was able to 
identify the source (Walker, 2007, p.42) and pseudonyms replaced participant’s 
names on transcripts. Disguising the research location can assist anonymisation 
(Clark, 2006a, p.4) and therefore names of places, clinical settings and identifying 
features (blanket anonymisation) mentioned during the interviews were removed, or 
changed on the transcriptions, to remove background and identifying data which may 
have made identification possible (Clark, 2006a, p.5; Wiles, 2012, p.2). However, 
despite making every effort to protect anonymity, it cannot be guaranteed as others 
may recognise things such as incidents and speech patterns.

3.8.1.1 Data storage.

The digital recorder was stored in a locked drawer to maintain confidentiality, and 
recordings were transferred to a home password protected computer as soon as 
possible. Apart from the researcher, no other person had access to the recordings or 
the verbatim transcriptions.

3.9 Temporality of understanding and member checking.

Many approaches to qualitative data analysis propose the use of member checking, 
or returning transcripts and the interpretation to participants, as the final step in 
validating data, and the interpretation of meaning. However, Heideggerian 
phenomenology seeks to gain meaning from the pre-reflective world of people 
(Robertson-Malt, 1999, p.292), recognising the participant's temporality of truth at the 
point in time of the interview. The meanings given to experiences can be tentative 
and changing (Geanellos, 1998a, p. 158), and as time passes after the interview 
there is opportunity for the participant to further reflect on the area of interest (Gelling, 
2010, p.6), and reinterpret experiences (Chang & Horrocks, 2008, p.389). Therefore 
the issue of member checking is not consistent with the chosen philosophy 
(McConnell-Henry, Chapman & Francis, 2011, p.30). and therefore was not 
undertaken. However, although the interpretation was not returned to the clinical
nurse leaders for checking, transcriptions of the interviews were returned so that they had control over any data they wished to delete or adapt. Of the eleven transcriptions only the pilot interview transcription was returned with minimal alterations related to the clarity about the geographical places. No other transcripts were returned. Within Heideggerian approaches the final construction is therefore judged accurate by the researcher (Bradbury-Jones, Irvine & Sambrook, 2010, p.25).

3.10 Reflexivity and promoting the rigour of the research.

Reflexivity can be defined as thoughtful, conscious self awareness, and lies on a continuum with reflection at one end (‘thinking about’), and reflexivity at the other end, (immediate and dynamic self awareness) (Finlay, 2002, p.533). Reflexivity acknowledges that the researcher is involved in the process of qualitative research, including being aware in the moment of the responses of the participants and how the story affects the researcher (Dowling, 2006, p.8). I achieved this in a number of ways, firstly through dynamic self-awareness during the interviews, and secondly by using a reflective diary to record non-verbal gestures and thoughts about each interview, areas to consider again, and the developing story.

3.10.1 Reflexivity during the interviews.

I remained attuned to the clinical nurse leaders and which questions should follow, as well as my own responses to the stories. As suggested by Vandermause & Fleming (2011, p.374), where digressions had occurred it was necessary to bring the participant gently back to the story to keep the story moving forwards. Reflection in action (Schön, 1996, p.49), or ‘thinking on my feet’, required responding to the verbal and non-verbal responses of the clinical nurse leaders. This reflexivity supports consideration of further probing and clarification of points made (Dearnley, 2005, p.21). Each participant's use of language helped me to decide whether to probe or remain silent. On one occasion a participant was torn between tears and laughter as
she shared her pain, and the tone was of sorrow despite the laughter. At this point I chose to remain silent.

Observing body language is also important (Clarke, 2006b, p.19) and a particular incident conveyed a great deal. We were talking about the organisation the participant worked within and how information was collated for quality assurance. Although softly spoken, she threw her hands up in exasperation and appeared frustrated. Recording this data assists in the understanding of the meaning of the dialogue (Kvale, 1983, p.175), during analysis. Further probing revealed that the meaning she held in relation to the approach did not support what was important to her about patient care, but she appeared to feel guilty about saying this.

3.10.2 Diary notes and reflexivity.

Reflexivity also relates to the degree of influence that the researcher has, either consciously or unconsciously on the findings of a study (Jootun, McGee & Marland, 2009, p.42), as an instrument in the research (Finlay, 2002, p. 541). I maintained a personal journal to record both reflexive and reflective thoughts about the research process, the interviews, and meaning as it developed.

My use of the reflective notes in my diary were used to develop understanding, and as suggested by Finlay (2002, p.225), this reflexivity promoted rich insight through the examination of personal responses and interpersonal dynamics in the process particularly in relation to the anger, frustration and emotions the clinical nurse leaders expressed. It also provided opportunity to consider my own foreconceptions in relation to the stories. The ethical significance of reflexivity is the issue of honesty, transparency and overall accountability in the research (Doucet & Mauthner, 2002, p.125), and reflexive thoughts should be included within the findings (Gough, 2003, p.22). Therefore, where reflexive thoughts supported the interpretation, these were included.
In my diary I also noted non verbal emotions such as sadness. These should also be analysed with the interview narrative (Crist & Tanner, 2003, p.203), in order to support an accurate representation of the participant’s experiences (Skene, 2007, p.58). I therefore included this with the verbatim data. Heideggerian hermeneutical phenomenology includes seeking hidden meaning, and my diary notes started to record and consider this. When talking about the experience of caring for an unpopular patient, one participant seemed reluctant to pursue the discussion about feeling lonely. Box 3.4 shows the narrative from my own diary about my thoughts at this point.

**Box 3.4 Reluctance to discuss loneliness.**

‘First mention of loneliness. Is this about not being able to reveal their loneliness? Does this mean it is unsafe as a leader to say it feels lonely? Keep in mind for next interview.’

I noted that I felt uncomfortable and how the participant appeared not to want to talk about feeling lonely. Reflection on action (Schon, 1996, p.177) is necessary after each interview to review what had emerged (Dearnley, 2005, p.21,) and I recorded this. The researcher can be affected by the interview process (Dowling, 2006, p.17) in terms of their own horizons (Koch, 2006, p. 98), and the emotions and meanings shared resonated with some of my own past experiences. Within the hermeneutic circle understanding occurs through the fusions of horizons, that is, the understanding between the researcher and each participant (Koch, 1995, p. 835). One such fusion came through the clinical nurse leaders’ use of humour when sharing sensitive stories. Box 3.5 highlights the notations I made in my diary.

**Box 3.5 Reflection on action about the use of humour.**

1. ‘Humour-? Can see the lighter side?-? Protection mechanism?’
2. ‘HUMOUR-why? Is this found in the release of the stress? Is this coping? Is it relief? Does it ease telling the story?’
3. ‘This feels like it comes from feeling heard and releasing the strain to somebody who might understand?’
The reflexive process should also include how the researcher is affected by the process (Dowling, 2006, p.17), and I felt my own sadness in relation to some of the experiences of the clinical nurse leaders. The feelings of the researcher should also be recorded (Koch & Harrington, 1998, p.888; Koch, 2006, p.99) and so I recorded my own feelings in brief notes after the interviews. Following the final interview I felt tired and guilty as I felt my concentration was not optimum, and therefore I may have not been attuned to the nuance of the stories, meaning I may have missed some important points. This is shown in Box 3.6.

**Box 3.6 Reflection about my own feelings.**

'I felt tired today and being present was challenging. I am not sure if I missed some opportunities, I feel guilty.'

With emotive content the researcher needs to ensure their own psychological safety (Skene, 2007, p.60). Throughout the data collection phase I had access to my own professional mentor if required, who was my Director of Nursing at the time. She had a general nursing background and was very interested in the study, and she was someone I felt comfortable talking to if I needed to.

### 3.11 Data Analysis.

The goal of the data analysis was to integrate the emerging themes into an accurate, detailed account (Rubin & Rubin, 1995, p.227), from core ideas, emotive stories, meaning and themes (Rubin & Rubin, 1995, p.231).
3.11.1 The Approach to Data Analysis.

The philosophy of hermeneutics underpins interpretive methodologies (Crist & Tanner, 2003, p.202) and Heidegger's philosophy specifically makes it clear that human understanding is hermeneutic by nature (Reiners, 2012, p. 2). Therefore the orientation to the interpretation was through the hermeneutic analysis of the data to explore the meaning of the lived experience for the clinical nurse leaders. The hermeneutic circle is a metaphor which guides data analysis on several levels (Cohen, Kahn & Steeves, 2000, p.72). The interpretation of meaning in this way is found through the meaning of the separate parts in relation to the meaning of the whole interpretation (Kvale, 1983, p.185) and vice versa (Cohen, Kahn & Steeves, 2000, p.72). The researcher begins with vague and tentative notions of meaning but as understanding develops in relation to the whole interpretation, deeper examination of the data drives the interpretation ahead (Cohen, Kahn & Steeves, 2000, p.72).

Hence, data analysis is iterative when using hermeneutic phenomenological approaches (Crist & Tanner, 2003, p.202) and it includes the uncovering of hidden meaning (Dowling, 2004, p.32). The data collection methods suggested by Cohen, Kahn & Steeves (2000) were embraced because they support the hermeneutic methods of Heidegger, and offer some analytic steps to guide the novice researcher. Although there is no stepped method as such for hermeneutical data analysis, the eleven steps set out in Box 3.7 was useful to guide the process. However, it should be noted that steps nine and eleven outlined below include field notes. I decided to maintain a diary instead.
Box 3.7 Cohen, Kahn & Steeves (2000, p.75-76), approach to data analysis.

1. Analysis commences during the interviews as the researcher listens to meaning.
2. Data is converted to a digital form, being transcribed verbatim.
3. Transcripts are line coded numerically.
4. Careful analysis of the data begins through reading and re-reading of the texts to immerse the researcher in the data, the purpose being to gain initial interpretation to drive the subsequent phase of the analysis.
5. Data transformation follows by reorganising the transcripts to put similar topics together, eliminate digressions that are off topic and remove verbal ticks (such as ‘um’ and ‘er’).
6. Transcripts are then coded with tentative thematic labels without overly reducing the meaning of the whole text.
7. Similar themes are put together and groups of text may be sub-divided.
8. Exemplars are identified which capture essential meaning of the themes.
9. Field notes and reflective diary notes are built into the analysis.
10. Writing and rewriting is then crucial to develop the movement from identification and comparison of themes to a coherent picture of the whole.
11. Field notes are used to contextualise and clarify themes from interview data during the process of writing and rewriting.

I decided against using a qualitative analysis computer package to assist with the data analysis. Firstly, this was primarily due to the considerable amount of time to become proficient, and secondly, it has been argued that once initial categories have been developed using such software there can be reluctance and less incentive to change them (Bergin, 2011, p.60). Even experienced researchers can prefer the manual management of research data rather than using a computer package (Cohen, Kahn & Steeves, 2000, p.75), and for me, I had analysed data manually before and had felt I remained closer to the data.

I did not have access to secretarial support to transcribe the data. However, transcribing the data verbatim myself (stage two) supported my ability to relive the interview experience. Returning to the atmosphere of the interview is the first phase of the analysis (Skene, 2007, p.60), and this can re-awaken the purpose and sensitivities of interview (Kvale & Brinkmann, 2009, p 180). Although immensely time consuming, I concur with Dearnley (2005, p.27) that this brings the opportunity to relive, and become immersed again, in the situation of the interviews with the clinical nurse leaders.
The transcribed texts were read alongside diary notes from beginning to end as the first phase of the analysis (Kvale & Brinkmann, 2009, p. 180). Text was then line coded (Cohen, Kahn & Steeves, 2000, p.77), read, and re-read to gain initial interpretation (Cohen, Kahn & Steeves, 2000. p.79) (as stages three and four).

Stage five commenced with the process of data reduction, which includes removing digressions from the phenomenon of interest (Cohen, Kahn & Steeves, 2000, p.77), such as discussions about issues unrelated to the area of interest. This meant that about one seventh of the data was removed. Similar topics were then put together and then tentative theme labels given to units of data (stage six).

To undertake the data analysis I used the traditional manner of cutting the transcripts up manually and then moving the slips of paper. Similar topics were then grouped together (as stage seven). This movement continued many times, and again each time I returned to the analysis. Dey (1993, p.131) refers to a ‘splitting and splicing’ process using computer software. Splitting refers to the refining of themes by sub-categorising data, and splicing refers to the combining of sub-themes and themes to develop the integrated product. Although data analysis was undertaken manually, Dey’s (1993, p.131) description depicts the process I used succinctly. Firstly, splitting the whole of the data created many sub themes. I then reviewed these sub-themes which resulted in further movement of data between these. Splicing of the sub-themes created tentative, more comprehensive themes, but the theme labels also developed as the analysis continued. One of the benefits of using the manual system was the ease of tracking the movement of pieces of data between themes, and sub-themes, by simply writing the movement on the individual pieces of data, but this was still challenging to remember and record the movement of every piece of data as my thinking developed. Plager (1994, p.77) notes that this is an arduous process. My own experience was one of many months of working with the data. Photographs of the manual process of data analysis and theme development below reflect the complexity of the process in Pictures 3.1a and 3.1b.
An example of the development of themes is illustrated by the following verbatim quote moved from the tentative theme ‘Positive Support’ to ‘Grappling with the Culture’ to 'best fit'. The decision to move this data occurred when it became clearer
that the clinical leaders were not only trying to support their teams, but were grappling with clinical cultures they had inherited.

_T101; You know, we’re talking band six and band seven’s here, so we are not talking about junior staff. A lot of_ T102; them here definitely need to be empowered to do things. I don’t know whether it’s because previously they T103; haven’t had that (…) (Comment {VAC139} T105 Sanctioning Autonomy)

Cohen, Kahn & Steeves (2000, p.76) propose that as immersion in the data continues, analytic decisions become more focused on the whole encounter, and this is achieved through 'dwelling with the data' (Streubert & Carpenter, 2011, p.45). However, the researcher can feel discomfort in relation to analytic decisions (Finlay, 2002, p.541) and many hours were spent deciding where to place pieces of narrative. Time away from the analysis was useful to reflect on the chosen language to support the interpretation. It also helped to spot discrepancies and irregularities within the work (Wolcott, 2009, p.108). Nevertheless, the process of movement within the hermeneutic circle, between the smallest parts of data and the whole text, although time consuming and sometimes tedious, did inform a richer understanding of the lived experience. The interpretation continued until a sensible meaning of the experience had been developed as discussed by Laverty (2003, p.22).

3.11.2 Writing as data analysis.

Although the creation of themes and sub-themes took place, writing is the main focus (Wolcott, 2009, p.94) and is an essential part of the analysis (Corden & Sainsbury, 2006, p.10). I found that writing was the most productive element of the analysis. The process of writing and rewriting to develop the final construction into a coherent whole is not made explicit by Cohen, Kahn & Steeves' (2000, p.81) stepped approach. The thoughts from my reflective diary were incorporated into the analysis and reviewed during the writing process (stages nine and eleven). The process of developing the final construction was one of 'writing into' rather than 'writing up' as understanding deepened during the process which was described by Pelias (2011, p 660), and this
supported the illumination of the hidden meaning within the text. This then comprised the final stage when the coherent picture of the whole interpretation was developed (Cohen, Kahn & Steeves, 2000, p. 77). The iterative and dynamic process of analysis and interpretation was clear.

The goal was thick description to convey the meaning of the lived experience which Denzin (1989) proposed should be in ‘it’s richest and fullest complexity’ (Cohen, Kahn & Steeves, 2000, p.72). The study of everyday life meant that the study should not be pretentious, but portrayed people using their everyday language (Wolcott, 2009, p. 106), so that readers can enter their world (Rubin & Rubin, 1995, p.257). The interpretation of the text should ‘ring true’ with the reader because it honours the experience which has been genuinely shared, and is a meaningful account of the human experience (Vandermause & Fleming, 2011, p.373). These points guided the development of the final construction, ensuring the rich breadth and depth of the experience was shared, to represent the clinical nurse leaders' world accurately and vividly (Rubin & Rubin, 1995, p.261). A representation of how themes and sub-themes moved during the analytic phase prior to show the decision trail as advocated by Koch (1994, p.978) can be found in Appendix Seven.

Exemplars can sometimes be found within the final construction (Crist & Tanner, 2003, p.204). An exemplar is a salient excerpt which characterises common meanings (Crist & Tanner, 2003, p.204; Conroy, 2003, p. 32). Although Cohen, Kahn & Steeves (2000, p. 77) suggest these are identified at Stage eight, I actually identified these during the completion of the final construction. It has been suggested that sufficient verbatim data should be provided to support the credibility of the interpretation (Anderson, 2010, p.141). It also allows readers to make their own judgement of the interpretation (Walters, 1995, p.795). I therefore attempted to provide enough verbatim data to fully illustrate the description and interpretation of the findings of the study.
4.0 CHAPTER FOUR- FINDINGS

4.1 Introduction.

The aim of the study was to explore the lived experience of clinical nurse leaders who were leading teams who had cared for an older unpopular patient in community settings. As discussed in the literature, the concept of the unpopular patient can be hidden and silent within nursing practice, and the aim of the study therefore, was to explore the issue through a dialogue between the researcher and the clinical nurse leaders (Lawler, 1991, p.11). This qualitative study employed the philosophical approach of Heideggerian Phenomenology, to seek an answer to this research question;

‘What is the lived experience of clinical leaders leading teams caring for an older patient perceived as unpopular in community hospital and community settings?’

Eleven female clinical nurse leaders participated in the study. Their professional roles (n=11) and their areas of practice are shown in Table 4.1.

Table 4.1 The clinical nurse leaders in the study.

<table>
<thead>
<tr>
<th>Role</th>
<th>Area of practice</th>
<th>Number of clinical leaders</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modern Matron</td>
<td>Community Hospital</td>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>Modern Matron</td>
<td>Older Person's Mental Health Unit</td>
<td>1</td>
<td>Female</td>
</tr>
<tr>
<td>Ward Manager</td>
<td>Community Hospital</td>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>Team Leaders</td>
<td>Community Nursing Services</td>
<td>3</td>
<td>Female</td>
</tr>
<tr>
<td>Community Matrons</td>
<td>Community Nursing Services</td>
<td>3</td>
<td>Female</td>
</tr>
</tbody>
</table>
Presentation of the findings.

The rationale for the chosen approach for presenting the findings is firstly discussed, followed by the findings themselves. The findings have been set out as the themes and sub-themes which contributed to the whole interpretation.

Generally two main approaches are taken to the presentation of hermeneutic phenomenological research. These are the category and quote approach and the case study approach. Case study can be used when a single case represents all the themes, but this is rare (Cohen, Kahn & Steeves, 2000, p.96), and not suitable for this study, and instead a category and quote approach was taken.

There is no rule to decide the order of the presentation of the findings (Cohen, Kahn & Steeves, 2000, p.96), but for Heidegger, the meaning of something must be understood as a whole, which may have inseparable parts (Overenget, 2001, p. 99). I have, therefore, firstly presented the inseparable parts of the interpretation, as the themes of the interpretation. This provides insight into the visible meaning given to the phenomena (Corben,1999, p.56) by the clinical nurse leaders. However, Heidegger considered meaning to also contain hidden meaning (Smith, Flowers & Larkin, 2009, p. 24). The hidden meaning is presented at the end of the findings as the overarching whole interpretation of the experience.

A theme and quote (of verbatim narrative) approach was taken (Cohen, Kahn & Steeves, 2000, p.96) in the order which best represented the interpretation of the clinical nurse leader's stories. The themes were derived from those areas which repeated in the transcripts and were worthy of further analysis. Their sub-themes are the parts which contribute to the theme. Each theme is introduced to the reader, and each sub-theme is illustrated with the verbatim quotations. These were chosen to best illustrate the interpretation of meaning (Cohen, Kahn & Steeves, 2000, p.96). Pseudonyms are used for the names of the participants across the findings to protect their confidentiality. In addition, the participants work roles are not specifically
mentioned. The findings also present some exemplars, or a salient piece of verbatim which highlighted common meanings for the participants (Crist & Tanner, 2003, p.204; Conroy, 2003, p.32).

The inclusion of verbatim quotations provides thick description, including emotions and meaning (Corden & Sainsbury, 2006, p.19). Which quotes to select is not easy to define, and the explanation of the rationale for the selection of quotations within the findings is rare (Corden & Sainsbury, 2006, p.1). Nevertheless, the critical ethical obligation is to be faithful to the experience of the participants (Walker, 2007, p.42). Therefore verbatim quotes which deepen the reader's understanding of the complexity of the experience should be chosen (Corden & Sainsbury, 2006, p.13), and those which were the most representative of the experience (Anderson, 2010, p.143). The selection of quotations was therefore based on these points.

In order to assist readability the presentation of the verbatim includes some minor amendments. Utterances have been removed (Corden & Sainsbury, 2006, p.18) and missing material is indicated by three dots before and after the verbatim. Single words and short phrases of verbatim are used at times within the text to highlight the meaning being conveyed. There was a great deal of narrative data and verbatim has been woven into the interpretation. This supports the continuity of the story the participants shared (Corden & Sainsbury, 2006, p.14).

4.2 The Parts of the Experience.

The five main themes and their sub-themes emerged from within the data and contributed to the whole experience. These are presented in Table 4.2. Appendix Eight presents the number of clinical nurse leaders who contributed to each theme and sub-theme to provide an audit trail the for reader. This indicates the relative robustness of each (Cohen, Kahn & Steeves, 2000, p.97).
Table 4.2 The main themes and their sub-themes.

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Knowing the Unpopular Patient</th>
<th>Being Faithful</th>
<th>Betwixt and Between</th>
<th>Joined at the Hip</th>
<th>Growing into Leadership.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-themes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Understanding Unpopularity</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Understanding Popularity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Easy Feeling</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

4.3 Theme One-Knowing the Unpopular Patient.

This first main theme, Knowing the unpopular patient, has three sub-themes; 1) Understanding Unpopularity, 2) Understanding Popularity, and 3) Easy Feeling. This main theme revealed meaning for the clinical leaders of the older unpopular patient both in its absence and in its presence.

4.3.1 Sub-theme One-Understanding Unpopularity.

Sub-theme one highlights the meaning held by the all clinical nurse leaders in relation to the unpopular patient within their teams. All the clinical nurse leaders understood the meaning of the unpopular patient, as someone nurses enjoyed caring for less than others. Having an older patient whom nurses did not enjoy caring for seemed to bring significant challenges for the clinical nurse leaders. The apparent simplicity, and multiplicity of issues which caused their team members difficulty resulted in feelings of exasperation and frustration, sometimes being astounded by what caused the difficulty. However, they used humour at times to convey their frustration.
The clinical nurse leaders seemed very familiar with those things that could make an older patient unpopular with their team including dietary choices, discharge planning, non-concordance with care, patients patronising staff, wanting a daily bath or having religious beliefs. The unpopular older patient was known by the clinical nurse leaders to exist both at an individual nurse level, and a team level. They were surprised about how simple the issues were at times, and this seemed to mean that they felt alone with the amount of work they had to do to change the attitudes of individuals towards certain patients. When the patient was considered non-concordant with nursing goals by nurses, negativity towards the patient developed, and the clinical nurse leaders were aware of this. Annabel said,

‘Often they can be perceived as the patient not doing... what they (nurses) think they (patient) should be doing... it becomes a challenge, and you might get some negativity…’

The clinical nurse leaders were also aware of judgements of deviance by nurses, such as sexual innuendo and perceptions of eccentricity, and Zoe laughed through frustration when her team judged a patient,

‘... We had a patient... very set ways of doing things, and she was classed as a problem patient because she had her rituals… (Laughs)’.

However, Zoe confirmed how judgements varied among individuals in their teams a times,

‘... some people find that difficult whilst others think they absolutely understand that need.’

Amanda understood that team members avoided patients they considered to be difficult to ‘...keep out of trouble’, because interaction was challenging and avoidance required no overt conflict. It appeared that such behaviours frustrated them as it breached their nursing values within which they held respect for each individual as central to practice, and experience seemed to have taught the clinical nurse leaders that patient avoidance fuelled the difficult situation further. Veronica highlighted the consequences of the avoidance of difficult patients. She spoke with sadness,
‘You see them (unpopular patients) on their own a bit, and that’s not good...’

The familiarity with difficult families was discussed during the conversation without any prompting. Chloe knew that some patients could be considered to be ‘lovely’ by the staff, but their family considered ‘difficult’. This also resulted in avoidance of the family by staff. She showed controlled infuriation about avoidance and distancing behaviour by the nursing team, and I felt her frustration,

‘...They say, Well I wasn’t here yesterday!'...I mean, just don’t do it! (emphasis)...or, 'She isn’t in my team!' So they think nobody did anything there then! And it does make you feel like that... and it does make you wild!’

Difficult families were said to consume the team's thoughts and conversations. Tina said,

'...when you talk to the nurses they always talk about the family...they tend to forget the patient...'

The clinical nurse leaders then needed to focus on constantly returning the team's attention to the needs of the patient.

A lack of time to care for the patient by the nursing team was not highlighted by the clinical nurse leaders as the cause of difficulty or unpopularity, but instead the attitudes of team members appeared to be the primary issue. The development of unpopularity by the nursing team meant the clinical nurse leaders needed to invest significant time of their own to restore the situation.

The creation of difficulty meant that the clinical nurse leader needed to pay particular attention to the situation. The poor attitudes of some team members challenged the clinical nurse leaders and caused them immense frustration. Veronica’s story about nursing handover highlighted how she had to address communication which labelled patients,
'...and instead of giving the facts, it’s her view of the individual, and it’s so awful! It’s full of judgement, it’s awful!... she labels them a ‘bell ringer’ or ‘demanding’ and I have to tell her to ‘stick to the facts’.

The clinical nurse leaders shared their experiences in relation to labelling patients and older unpopular patients, and the kinds of issues which caused difficulty in the team including expectations of the patient role. Zoe knew that in her team any patient request outside the normal nursing routine, or nurses rules, caused a grudging reaction,

‘…But you see the (demonstrates folded arms and a sour face, laughs) and you think ‘Why would you find that a challenge…? It’s more of a challenge for the patient! (Laughs)...and it’s like ticking boxes... we come to something that is not what you would expect, and you’ve got a problem, and they’re labelled a problem!’

At this point Zoe conveyed her sense of frustration and dejection by raising her hands in despair.

In addition, the clinical nurse leaders were aware that patient labels could transfer between teams overtly and covertly. Overt transfer of unpopularity was evident to Julia when the person referring the patient to her made comments like ‘pain in the arse’, or ‘banging my head on a brick wall.’ These comments heightened her concern about the way in which the patient was spoken about, and she showed her anger and frustration.

Similarly, Sally explained how a patient’s doctor had referred to her a patient who was ‘nicely labelled!’ He said to her,

‘You can have this one! I want her to phone you (emphasis), not me!’ (Emphasis) (Laughs)...Ugh! Take her!’ (Gesturing giving the patient away)… You know! Lock, stock and barrel!’

Sally seemed to feel exploited by another professional, who had found the patient taxing, and her gestures seemed to convey revulsion. There was a sense that she felt
alone because the referrer had the authority to just pass a patient to her because he was tired of the challenge he faced.

4.3.2 Sub-theme Two-Understanding Popularity.

In contrast, popular patients were considered to be those the team members really enjoyed caring for. They meant that they understood how patient popularity resulted from a positive personal connection between the patient and the nurse, but interestingly, the meaning was found in how popularity brought its own challenges for them as clinical nurse leaders in terms of equitable care provision.

The personal connection which created popularity was highlighted by Diana,

‘...it’s not being down to more affluent, it is the interest in the person. I mean they could be living in absolute squalor, but if they are interesting that’s what seems to trigger it.’

However, interestingly, the presence of an older popular patient also brought complications for the clinical leader as they needed to ensure equitable care provision, and to interrupt any favouritism and preferential relationships or treatment showed by team members. Diane was irritated, but found humour when she explained how the team tried to keep patients they liked on the caseload,

‘It’s keeping to the facts, not, ‘Ahhh! That patient is lovely! We have to go back for a couple of visits just to make sure they are ok. ‘Actually, they (the staff) have to move on.’

Chloe understood that when team members showed favouritism to a patient it caused an atmosphere between other patients on the ward,

‘...every time they go into a bay they go to the same person and this creates tension amongst the patients.’

When this happened, Chloe seemed to express feeling uncomfortable and guilty.
Interestingly, Sally revealed a divergence in the meaning of popular patients. She explained how nursing assessment and care could be superficial when patients were popular with staff. She considered that the personality of the patient meant the nursing staff enjoyed the relationship but did not critically assess the patients’ needs. This resulted in a lack of comprehensive assessment and things being taken at face value by the nurse,

‘It’s problem free, stress free, things roll along. But then you can look under that and sometimes things are missed … I don’t want to use the word complacency, but I can’t think of a better word.’

Although life felt easier for the clinical nurse leaders when there was not an unpopular patient on the caseload, the presence of a popular patient was understood to be based on a personal connection which meant the clinical leader needed to be astute around equitable care provision, and the tensions caused amongst other patients. The divergent story raised interesting issues in relation to superficial nursing practice and not meeting needs as this had been associated with unpopular patients. However, it was only raised once.

4.3.3 Sub-theme Three-Easy Feeling.

This sub-theme provides the interpretation of meaning in relation to the clinical nurse leaders feelings when the team enjoyed caring for all their patients. During these periods the clinical nurse leaders felt happier and more assured about care quality when their teams were both cohesive and positive.

In the absence of an unpopular patient Julia expressed life as ‘much easier’ for her. She felt that team members were motivated to care for patients and there was no need for her ‘to chase them’ to see patients. Tina reported ‘less complaints and unhappiness’ which meant less of a challenge for her as the leader. Tina understood staff to be ‘happier’ at these times, and Veronica explained with relief the times when staff enjoyed caring for all the patients,
‘... you don’t have so much sickness, so many complaints, fewer moans and groans! Staff are proud of what they are managing. So it makes my life a lot easier as you can imagine!! (Laughs).’

Amanda confirmed her own assurance in relation to care quality at these times, and her feelings of security about patient care quality,

‘... you can walk around the patients and know they are safe and well looked after...and that’s brilliant, the best feeling ever! (Laughing)...it’s great, it’s what I strive for’ and,’...it makes the patient experience better too’.

Rosie explained how these periods were less stressful because she knew staff were meeting patient's needs,

‘If you know everybody is pulling together with that patient and it’s going well, then your stress levels are massively reduced, you know?’

In summary, my interpretation was that, although the presence of popularity challenged them, the absence of an unpopular patient seemed to bring relief for the clinical nurse leaders. Meaning related to the absence of unpopular patients was found within an energised climate of care which felt enjoyable, unified, relaxed and comprehensive for the clinical nurse leader. These experiences assured them about the provision of good nursing care, and they could be more relaxed as there was an easier feeling within their leadership roles. They seemed to thrive on what felt like a pleasing rhythm and climate of care.

4.3.4 Summary of Theme One.

The multifaceted causes of labelling an older patient as unpopular were clearly understood by the clinical nurse leaders, and some of the trivial causes, such as dietary choices, amazed and frustrated them. The responses of individuals and teams in terms of reactions, avoidance and distancing behaviours towards patients and families considered unpopular were known, and overt and covert labelling of both had
been experienced. These poor attitudes and behaviours towards disliked patients meant a stressful time for the clinical nurse leader as it breached their nursing values.

However, the absence of an older person being labelled as unpopular meant the clinical nurse leaders felt more secure about care quality and they were more relaxed at these times. The presence of popularity was understood to be bound in a personal connection with the patient, but this meant the clinical nurse leaders needed to ensure equitable provision. The divergent story raised an interesting point. Patient popularity was considered to result in superficial nursing assessment and care, because the nurse enjoyed the patient's lively and friendly personality which seemed to obscure any potential nursing concerns.

The attitudes of team members towards patients they disliked caused intense frustration and anger, hurt and distress for the clinical nurse leader, and this is further revealed in theme Two.

4.4 Theme Two-Being Faithful.

This theme comprises how the clinical nurse leaders sought to remain faithful to their nursing values as leaders, holding respectful and compassionate care as central to their leadership mission. However, the breaching of these values by others resulted in experiences of strong emotional experiences and suffering. The duration of their task to change the prevailing nursing culture to prevent labelling patients was appreciated by them. Within main theme two, there are three sub-themes, 1) Clarity of Purpose, 2) Moral distress 3) In for the Duration.

4.4.1. Sub-theme One-Clarity of purpose.

Nearly all the clinical nurse leaders talked frequently about a firm clarity of purpose in their leadership roles bound in leading the team to provide good quality care, delivered with dignity, respect and compassion. Their leadership endeavour seemed
founded on, and enacted through this clarity of purpose and they conveyed their concern and empathy in relation to the older people they cared for. Their sense of purpose was expressed with passion, and they were intolerant of what they considered intentionally sub-standard practice, meaning they challenged such attitudes and behaviours within the team. This challenge was honest, direct, and sometimes frank in its expression. Zoe provided an exemplar which summed up the common meaning related to clarity of purpose vocalised by the clinical nurse leaders,

Exemplar;

Zoe; ‘At the end of the day we are here to meet each individual’s needs.’

Many felt they needed to be clear in their expression of the standards for care, and Julia highlighted this and her own sense of responsibility,

‘Tell them straight...No, I just tell people if they don’t like it, to get out, because they are in the wrong job... everything I do is patient focused, that’s what I am paid for, and if people aren’t going to follow that, then I will say it (Laughs).’

Amanda added to this,

‘You just have to be straight, I think that helps. What you see is what you get. The staff know if I am not happy they will know about it…’

Sally challenged team members when she felt the behaviour of the nurse was creating an unpopular patient. She said that she addressed this by asking the person,

‘What is the problem for you (emphasis) with this patient?’

The clinical nurse leaders seemed absolutely clear that their work was to uphold their nursing values in relation to high quality care for older people founded on respect, compassion and dignity. However, doing this, and challenging poor practice meant
experiencing significant painful emotions and feelings for them, an experience I have interpreted here as one of moral distress.

4.4.2 Sub-theme Two- Moral Distress.

Moral distress is a complex experience which can be felt when someone cannot pursue their morally acceptable choice or action. It can result in distress and suffering for individuals. Although the clinical nurse leaders made their expectations for nursing practice clear, their seeming resoluteness and courage to change a situation unacceptable to them, brought significant emotional consequences when team members stigmatised patients. The clinical nurse leaders' values meant they wanted their teams to respect each patient and treat them accordingly, but seemed unable to prevent their negative actions. When team members behaved in an unacceptable manner, I heard the clinical nurse leaders' experiences of pain and distress, hurt and sadness, an experience that appeared to create 'moral distress'. I heard their exhaustion at times, their frustration and anger. They looked 'wounded' by some of these experiences, and they seemed alone with their feelings and in their mission.

Tina's was clearly saddened when her team were unprofessional in their response to a family,

‘…It can be frustrating at times though, feeling disappointment with the way my colleagues are being towards somebody and that those values are in my team…’

However, the more powerful emotion of anger was shared frequently by the clinical nurse leaders in response to poor attitudes and behaviours in their teams, and they sounded hurt and troubled. They seemed to have experienced significant pain in response to their experiences. Their evident passion for high quality patient care seemed under assault in such situations. Sally shared the anger and distress she felt when colleagues talked about patients in a disparaging way,
'A bit angry sometimes. How would you like it? I can feel it…welling up. Yeah! How would you like it?'

Although such situations were in the past, the emotions experienced during the re-telling of their stories came to the fore again, and at times the clinical nurse leaders' suffering was overt and palpable. At times their stories were expressed in humour, but their nursing leadership wounds were laid bare. There were sometimes tears of sadness, tears of frustration, and anger, and exasperation and frustration came to the fore. Yet they seemed to have contained this suffering alone.

Veronica seemed outraged by those who showed no compassion towards older people, and she expressed needing to control the situation. During this story tears came, I used touch to convey support. Unspoken, her non-verbal communication seemed to convey her feelings of wanting to withdraw from me momentarily. She seemed alone in her story. She then seemed to have to release her feelings in quiet anger, to get it out in the open with somebody who might understand. Her distress was evident, but she blurted out,

‘…You’ve got to be on top of it. In some places there are nasty people, and they shouldn’t be working with patients, they don’t like patients, and those sorts of people are evil (tearful).’

Her words were powerful. We then continued together in the story, and my non-verbal gestures aimed to convey understanding. It then seemed that she wanted to tell me more as she was focusing intensely on me. I probed gently asking her how this made her feel. The following verbatim revealed the turmoil of emotions she felt. Her anger was evident, and when she said 'You’re fired', she gave it a prominence, conveying a seemingly desired authority to address the situation immediately. She then shared how, when her suffering spilled out publicly, she felt her leadership legitimacy had been compromised,
Veronica; ‘Absolutely awful. Really, really angry. So angry that I could just say to them, ‘Right! Just go, and don’t come back’……..You’re fired! It makes me so angry. I mean I have brought people in and asked them about things and I have actually sat in front of them and cried because I was so angry. And then I think they will think I am a wimp.’

Other clinical nurse leaders shared how their anger meant they wanted to immediately repel the staff member, questioning the individual’s right to be in a caring role. The lack of genuine concern for patients also caused the clinical nurse leaders’ distress. Julie and Zoe shared,

‘…And sometimes I feel, angry is not the right word, it’s that sort of…people come into a caring profession, regardless of their role, and actually don’t give a shit about people! And I get angry about that. You know, they’re in the wrong job! Go work at Tesco’s!’

‘… I think, ‘Why don’t you do something else? The whole idea is that we provide a patient centred approach. We’ve taught you what that means and you are not doing it! Why do you stay in nursing? You feel like saying, ‘What does nursing mean to you’ (emphasis).

Zoe added that she experienced,

‘Mixed feelings really. Sometimes you get really frustrated and sometimes you get genuinely upset… And sometimes you just want to go right up to them (staff member) and say,’ Why are you working in this job?’

Veronica shared how being compassionate to older people was a fundamental essential requirement. She shared how sometimes older people asked to see her because someone had been unkind which had devastating effects on her. At this point she conveyed her sense of desperation and the loneliness of her role,

‘The patients do ask to see me, and I ask them what the problem is …I have had patients say to me that somebody has been really horrible to me but they won’t say who. And I do try to coax it from them, and I know it’s really hard for them to say. To me that’s the ultimate. If nurses can’t be nice to patients, they shouldn’t be here. No way! And it’s something that really upsets me (tearful). Oh dear! (Laughs nervously). That is something that gets to me more than anything, so if I have little patients all on their own and somebody has been horrible, that’s a killer (tearful).’
Veronica’s story was moving and arresting. It was at this point that I thought that these are ‘the wounds of clinical nurse leadership’, the painful side effects of upholding an appropriate value base in relation to the unpopular older patient. Yet these wounds seemed enveloped within the role, contained within the individual, silent, covert, and obscured. There seemed to be a need to absorb and contain such emotion within themselves, needing to appear in control of the situation, seeming to add to their experience of loneliness.

Sally and I shared a period of humour when discussing handling anger. The conversation was about a doctor with poor attitudes to a patient, and Sally needed to contain her anger in order to find resolution for her patient. Sally highlighted how her own work to address her concerns extended beyond her direct nursing team,

‘…and I suppose I used that anger then to constructively make a contract with the referrer. I think I can get hold of my anger and shake it (Laughs). I really do. I think I can get my anger out and say, ‘Well, now then Doctor!’ (Laughs).

Sally summed up how she generally handled her emotions when dealing with the immediate situation, but the residual emotions after the event were powerful. The clinical nurse leaders un-wrapped their feelings related to a seemingly single handed leadership affair which appeared to wear them down at times. Amanda discussed a gentleman on her ward who shouted and screamed, and how the team avoided him. She had not been overly expressive about her own emotions, remaining positive about her role until this point, but she conveyed such sadness, and her despondence was palpable. Between the lines she conveyed her loneliness as she said,

‘I suppose it makes me feel a bit desperate at times. I just want them to go and sit with him. It was so sad. Having spoken to him and knowing the things that were bothering him.’

I sensed that this experience had been profound for Amanda and she seemed to convey tiredness. Sally also confirmed that staff tired her at times, ‘…sometimes it makes me kind of wearisome’, and Veronica relayed how it was, ‘…one or two people
that completely wear you out.’ This sense of a tireless endeavour was shared consistently, and seemed to add to the experience of frustration.

When a staff member avoided a difficult patient, Julia revealed her embarrassment as the team leader. The time needed to address the issue brought frustration for her, as it negatively impacted the time she had for her own patients and extended her working hours, revealing a tension between clinical nurse leadership and the managerial elements of her role,

‘...and then it’s embarrassing when the patient tells us they haven’t had a visit… I feel like I spend all my time documenting things because of the performance issue... I want to go out and see my patients… my patients get put on the back burner because I am sorting out members of staff...and I mean, I work stupid hours!’

Interestingly, a lack of time to care for patients as an antecedent to unpopularity was not raised as an issue. However, ironically, the clinical nurse leaders were very familiar with the time they themselves needed to address situations of unpopularity once it had been created. Tina voiced how an unpopular patient meant she ‘got pulled in more’ (to sort things out). Sally confirmed the complication of the time needed to repair and restore patient or family relationships,

‘…in the sense of time and disturbance, she phones about six times a day! Now that’s singularly irritating! (Laughs)’.

Nearly all of the clinical nurse leaders shared the negative emotions they experienced including anger, frustration and hurt, as a moral distress, and these felt like the private wounds of clinical nurse leadership, contained within themselves, which seemed to contribute to their experience of loneliness. They appeared to feel their nursing leadership responsibility intensely, but addressing issues with staff, and repairing damaged patient relationships took time. They seemed to bear a weariness and tiredness at times. They seemed battered and alone within their teams, and yet they appeared to have the courage to continue.
4.4.3 Sub-theme Three-In for the Duration.

In order to change the attitudes and behaviours which created the unpopular patient, the clinical nurse leaders understood that a shift in nursing culture was required, and the duration of the journey ahead to achieve this was appreciated. This sub-theme depicts this, and the seeming strength of purpose and apparent courage the clinical nurse leaders held where there was no quick fix solution to the changes needed.

Despite the intense emotions, the clinical nurse leaders seemed resolute in their endeavour and pressed ahead. Their experience of what appeared to be moral distress did not deter them. They understood that cultural change required absolute persistence and tenacity, and courage seemed evident within their driving forces. Rosie acknowledged the energy and dedication this required with individual patients who had been deemed difficult by others,

‘…to change things, to build a relationship with that difficult patient that nobody gets on with to prove you can do it. You’ve got to have a certain amount of energy to do that…’

Addressing difficulty appeared to require focused determination and dedication. It required additional personal investment, and constancy of purpose to try to understand the patient. Sally felt that strength of character and tenacity were needed, but that some nurses did not have the conviction to unpack and understand the situation,

‘It’s about perseverance to understand the person you are dealing with, and that takes time…So in terms of difficult patients, it’s about untangling what the difficulty is with… needing to be able to stay with that patient…and feel it. I know that lots of people are unable to do this’.

I clarified with her whether this was about ‘being in for the duration’ and she agreed, rejecting light touch, superficial nurse-patient relationships. She felt strongly that she
was not satisfied with ‘...thinking the patient is ok’, but felt a responsibility to ‘know’ *(emphasis).* I probed and asked if she thought the quick fix approach was a convenience thing for others, and she said,

‘Yes, and there’s nothing critical about it…eating, pooing, weeing, that’s fine! *(Laughing)*…It does happen, and I think it is about tolerance of a difficult situation.’

Rosie felt that some staff lacked the inclination to invest in the situation, but that her own experience had taught her that tenacity and patience was needed,

‘…Whether you are strong enough to deal with the situation. Yeah, some people just really can’t be bothered to put the energy in…’

Sally also shared the confidence and courage needed to influence a doctor about a patient he found difficult in order to address the situation in the patient's best interests saying, ‘… It took a lot of negotiation with the GP...’ When we talked further about this patient Sally shared how her tenacity, and working with the patient had rewarded her. This conversation also revealed Sally’s temporality of understanding,

Researcher; ‘So you have inherited someone who was clearly unpopular, and now you express a real fondness for her because you understand her. How does that make you feel?’

Sally; ‘I hadn’t thought about that! (Laughs). I suppose that......that kind of warmth has developed knowing her, and perhaps having the insight to find out what exactly life has been like for her.’

Researcher; ‘Yes’.

Sally; ‘Can I use the word ‘crap’?’ *(Whispers and laughs).*

Researcher; ‘Yes!’ *(Laughs).*

Sally; ‘Well it has been crap actually! And it still is! (Laughs). And so I can understand her cry for help…because of the dynamics in the house, and bless her, she wants some attention!’

Researcher; ‘It’s her turn?’
Sally; ‘Yes, that’s it. I mean she’s been on my books for a year and I can honestly say she sometimes drives me to distraction! (Laughs). You know eight o’clock in the morning, ‘Hello Doris! Another inhaler?!’ (Laughs). Or a different one or whatever! (Laughs). But on a professional level I have sorted out the issue with the GP because it was risky.’

Annabel seemed pensive and appeared sad when she reflected on how she needed to control negativity about a patient within her team, and revealed her temporality of understanding. She highlighted how her own behaviours needed to be exemplary, standing up, and often alone, leading her team to prevent escalation of negativity,

‘...if you let it happen with one patient, you are letting it happen with another, and it can foster a lot of negativity...and I suppose it’s been quite surprising to think of it in this capacity...if you confirm the patient is awkward...it’s a chink in the armour, and this can be quite detrimental. So it’s about exploring it and turning things round.’

She added that if she allowed the negativity to continue an escalating spiral of difficulty could develop,

‘...other issues in the team can deteriorate, if the standards drop, the patient is unpleasant, then the team member is unpleasant, it could become a time bomb...yes! (Smiles).’

By the end my conversation with Zoe she seemed deflated by the endless battle and the continuation of the long journey ahead,

‘It’s frustrating that in today’s world we still have these issues...to me it is sad, that’s the best word, sad that we have such a long way to go to get it right for patients’.

4.4.4 Summary of Theme Two.

Despite the seeming moral distress they suffered, the clinical nurse leaders appeared courageous in their endeavour. However, they seemed to feel alone in this endeavour. The theme reveals Heidegger’s ‘authenticity’ as the clinical nurse leaders treated each older person as an individual, with their concern being authentic and in
accordance with their values. Their work in relation to the older unpopular patient seemed to be lonely.

The clinical nurse leaders were aware of the long term challenge to change the climate of care in their areas as they struggled with their teams. Although their work within their teams seemed to bring moral distress, they also struggled with the response of the organisation at times, and seemed caught between the two as they tried to address their concerns. This is found in theme three, Betwixt and Between.

4.5 **Theme three-Betwixt and Between.**

The central meaning of this theme conveys the way in which some of the clinical nurse leaders seemed to feel caught between their team and the organisation, and how their mission to address their concerns left them feeling between a rock and a hard place. The theme has two sub-themes, 1) Grappling with the Team and 2) Grappling with the Organisation.

4.5.1 **Sub-theme One- Grappling with the Team.**

Although dealing with individual staff members was reported as challenging, the clinical nurse leaders began to sense and feel the problematic nursing culture of their areas. They seemed alone with the values they held about patient care, and this seemed compounded when they realised the prevailing nursing culture was a powerful force against them. They discussed their intense efforts to develop positive nursing cultures and the consequent frustration they experienced. They watched over their environment for attitudinal and behavioural problems towards their patients and Zoe highlighted this,

‘… you can sense it, how people approach patients, speak to patients, how they make visitors welcome, or whether they walk away…!’
Sally discussed the battle for control which sometimes happened between a nurse and a patient, and that sometimes there was ‘quite a tussle’ (between a patient and a staff member) which annoyed her. Julia appreciated that her entire patient group were unpopular with many people due to their diagnosis alone, and she reported battling for fair access to other services for them. However, despite seeming exasperated by the feeling of being a ‘lone ranger’, as one who battled on her own, she found humour in her story, and together we shared the lighter side of her situation.

‘… they’ve got that mindset of just putting them in a mental bed, even though I don’t know what a mental bed looks like because I can’t find them in the catalogues! (Laughing) …..No the catalogues don’t do them so I don’t know where they are getting them from!! (Laughs)’.

The clinical nurse leaders worked to embed compassion and Zoe’s story touched me deeply. The situation was not completely unfamiliar to me, but in the cold light of day, the dispassionate response of the staff member, and dissociation from the patient’s distress filled the air, and I was taken aback. In the moment I travelled with her and tried to appear unaffected, but the story remained with me for some months. The need to have to instil compassion further seemed to greatly heighten her awareness of the work she needed to do,

‘…Sometimes nurses come across as uncaring and you don’t see them touch patients very much…you might even talk to them about a patient who is really upset and they say,’ Well, that’s life isn’t it!’...Yeah!’(Laughs).

Annabel discussed a gentleman who was sexually disinhibited due to his condition, and having to manage the team’s response to this. There was sadness, and what appeared to be, an intrinsic loneliness in her story as she revealed her struggle with the team,

‘…but I know the comments by the team are about his wife being annoying …or…, the husband touched my breasts, and it’s just reminding them that he is not doing it because he chooses to…and it’s around things like them saying they won’t go in there again, and that sort of thing …’
Some of the clinical nurse leaders shared how a lack of nursing time was often offered by nursing teams as a reason for not persisting with unravelling difficulty. However, the clinical nurse leaders did not perceive a lack of time as the problem, but instead the judgement of, and attitude to, the patient. Annabel would not accept time as an excuse without further exploration, needing to know the problems the patient had and ways of working them through,

'...they didn’t have time, or they’ve tried it before, the old adages that come back … it’s trying to find out what their (patients) foremost problem is.’

Battling to remove task centred nursing practices was a cause cited by many of the clinical nurse leaders as a precursor to difficulty, and this was a source of great frustration for them, as it seemed akin to the simple processing of patients. The clinical nurse leaders appeared to labour to embed a focus on the unique individual and their needs. However, this required considerable effort and constant tending to prevent slippage back to old team attitudes. Annabel knew,

'...the team revert back to ‘get them better and get them off the caseload!’

The frustration of the superficiality of task focused care was conveyed as breaching everything Julia worked towards,

‘...they just want everything task orientated, and that’s historical as well, they want to wash people, feed them, sit them in a chair, take them to the toilet, feed them again…they don’t want to do anything that isn’t controlled.’

The power of some nursing cultures were so entrenched that new recruits were quickly negatively influenced by it. Zoe shared how energy and intensified effort were required by her to oversee the new recruit to try to prevent any contamination with some team member’s poor attitudes. She was exasperated when she explained,

‘...it’s a vicious circle really. And it can be very frustrating…you recruit those with no nursing experience but with really good people skills, and you think, ‘Yes!’… But if they are working with the wrong person…you hear the classics, ‘We never do it that way, we’ve never done it like that, and we always do this.’
The clinical nurse leaders appeared to understand the culture of their teams and how these contributed to the creation of difficulty, through poor attitudes, labelling, avoidance and task focused care. They seemed alone as they battled to address the negative aspects of their cultures, battling with the excuse of time, uncaring approaches, and the prevailing climate of care and the rejection of patients. Their frustration was clearly evident. The prevailing nursing culture therefore presented them with a broader challenge than the individuals alone, and they felt the organisation challenged them further at times in their work in relation to the older unpopular patient. This is expressed in Grappling with the Organisation.

4.5.2 Sub-theme Two-Grappling with the Organisation.

Some clinical nurse leaders discussed the barriers they had faced from the organisation in relation to preventing the unpopular patient, such as their staffing levels and team stability, and the ability to deal with poor staff behaviours due to the lack of appropriate policies. They seemed to feel that the organisation did not appreciate the problems they faced. Some of the clinical nurse leaders felt that the organisation did not share their concerns in relation to the older unpopular patient. The organisational factors seemed to create further frustration and disappointment, and seemed to add to their sense of loneliness.

The benefits of a stable team were held important by the clinical nurse leaders to support cultural change. However, Veronica voiced how team stability was difficult to achieve. Her frustration and disbelief was evident when, having achieved team stability and high care quality, she felt that the organisation interpreted this as meaning it would be appropriate to increase patient numbers and decrease staffing levels. Her past experience, and her experience of the present meant she could predict the consequences of this future (as her temporality), and she said sadly,

‘We get no complaints, and that’s hard to get, and then I hear the patient numbers are going up and the staffing is going down, and people leave you to run on agency
nurses and I think,’ Oh my God!. That’s so sad, it really is…because…it has a detrimental effect on patients, and it really does.’

Inadequate, or absent operational policies to address concerns halted Zoe’s progress despite her having challenged poor practice. Although the behaviours which created the unpopular patient were serious to her, she seemed to feel let down by the organisation whom she felt did not share her concern. She spoke with irritation and sadness as she felt an opportunity had been missed to address the situation, and the story felt as though it reinforced the loneliness of her endeavour,

‘… and not having policies to deal with underperformance like this (poor attitudes and behaviours),… you have a nurse in post who is prepared to stand up and say, ‘No, I saw this and I said that’ (poor treatment of an unpopular patient) and then it’s a case of ‘What happened about it?’ You know! People don’t take it on board as a serious issue… We need managers who support leaders.’

Zoe then captured how she felt caught between addressing concerns in the team and the response of the organisation,

‘… I can take it to the next level and everybody will listen,…but it takes so much time to address concerns…you have patients on the ward who are not getting the care they deserve… And I don’t mean to be disrespectful to the NHS, but it just seems to take far too long to address concerns.’

Julia had arranged training to start to address the stigmatisation of her patient group due to their diagnosis, aiming to minimise their broad unpopularity. She seemed stunned by the response from the organisation and shared her sense of exasperation and futility,

‘We used to do training on study days but the managers stopped it! … It concerns me that somebody at that level is so narrow minded… ‘It’s shocking!’
Zoe conveyed shock and dismay in response to the organisation’s attitude to an older person who raised concerns about their care. She seemed flabbergasted and distressed by the response she received,

‘... I am told they can use the complaints system’... when actually they are too frightened in case they have to come back.’

Veronica shared how the collaboration expected in the clinical environment was not her experience of more senior levels, noting a disconnect between clinical and managerial functions, and this seemed to add to her experience of loneliness,

‘...being very careful about the po...liticial (laughs), because the interpersonal relationships up there shouldn’t impact on patient care, I mean, never! (Emphasis). ...They want nursing teams to work together (for patients), and it should be the same up there! (Laughing)’.

Julia seemed disheartened and frustrated by the culture of a meeting which made her feel set apart from others. She was striving to deliver comprehensive approaches to meet patient need, but felt she was surrounded by an organisational culture of task focused care,

‘I think people do an awful lot of moaning and groaning...I mean there is a senior team meeting in our service and I don’t go any more,... there’s a bunch of people moaning...it’s so task focused. Go and do this bit only! …’

An apparent disconnection between the organisational understanding of indicators of quality, and the clinical leader’s understanding of indicators of quality, was highlighted by Zoe. This story further highlighted the sense of being alone in the leadership endeavour,

‘...I mean when you think of the dashboards (and I’ll get shot for this!)... it doesn’t get down to the patient experience, …that worries me…that there is actually a patient in a bed who has been told to be quiet and stop being a nuisance, that’s what worries me!’
Interestingly, Tina added how nurses were abandoned to deal with difficult issues by others, who might be able to help,

‘The Consultant needs to take responsibility too! Don’t just leave it all to the nurses!’

Tina held that other professionals, ‘walked away from difficulty’. There was a sense that as nurses had the main contact with patients, others abdicated, which seemed to reinforce their sense of loneliness.

4.5.3 Summary of Theme Three.

There seemed to be significant frustration in relation to the culture within the clinical nurse leaders’ teams including the attitudes to disliked patients and the task focused approach to care delivery, which they understood could contribute to the creation of the unpopular patient. They grappled with these issues, including a lack of compassion, and time restrictions as an excuse for the avoidance of patients. The clinical nurse leaders seemed unsupported in their endeavour within their teams, and seemed to feel disconnected from the organisation when they addressed the problem of the unpopular patient, again seeming to add to their experience of loneliness. They understood that individuals, teams and systemic issues created or sustained the unpopular patient.

However, to continue to address their concerns, the clinical nurse leaders had developed their leadership approach to identify, and try to address and mitigate the development of the older unpopular patient by staying close to their teams, and this captured in Theme Four- Joined at the Hip.
4.6 Theme Four-Joined at the hip.

This theme highlights the way in which the clinical nurse leaders' sense of responsibility for their clinical areas, and the need to ensure that patients did not become labelled and unpopular, meant they had developed their leadership approach to remain close to patients and staff, both in terms of proximity and engagement, in order that they could address attitudes and behaviours which created and reinforced unpopularity. This theme has three sub-themes, 1) Being Present, 2) Follow Me and 3) Winning Them Over.

4.6.1 Sub-theme One- Being Present.

The clinical nurse leaders remained close to patients and staff to identify actual and potential difficulties promptly. They seemed to be anxious about the development of the unpopular patient and in response, intensified their proximity to a situation when they felt concerned. Amanda stayed close and encouraged her ward team to ‘spend time with patients’ particularly where difficulty was anticipated, or present, in order to get to know the person. The clinical nurse leaders made sure they spoke with patients frequently, and for Amanda this meant patients would share concerns with her, which reassured her,

‘… they will tell me anything…, if there’s anything wrong they will tell me, rather than have a face they see once a month…’

Being close also meant ‘listening to the team’, scrutinising attitudes, and ‘picking up issues’ when the team were together.

Veronica knew that her investment in a situation where difficulty was developing meant that she could positively influence it,

‘… They’ll (relatives) come to me because everything is wrong…nothing is right. And then it’s good to get in quickly and make a list of things that aren’t right…and you can promise to sort it out and phone them later. They can come and see me any time,'
the door is always open. In a couple of days they settle down, and it’s the best place they’ve ever been! (Laughing).

For the clinical nurse leaders being present meant being available to patients and families, watching over nurse-patient interactions for trouble, and early intervention when difficulty arose. In addition, in order to demonstrate the expected standards of conduct and behaviour, the clinical nurse leaders held important role modelling their expectations for care standards. This is found in the next sub-theme, Follow Me.

4.6.2 Sub-theme Two- Follow Me.

Follow Me was titled to reflect the importance placed on role modelling by the clinical nurse leaders. They seemed determined to set the example of how to care for patients with dignity and respect. When we discussed how they led teams to work with difficulty, the immediate response was 'role modelling'. It was held as vitally important and essential within their leadership role, especially in relation to patient conflict and aggression, holistic assessment, care founded on the patients' beliefs and values, appropriate language and behaviours, and acts of compassionate caring. Role modelling good and compassionate nursing practice seemed to be considered by the clinical nurse leaders to demonstrate the acceptable way to be with patients.

Annabel held role modelling as central to mitigating the unpopular patient, but she revealed how she was alone at times, in front of her team, striving to establish appropriate attitudes. Annabel's exemplar,

‘ … If you are finding you’ve got a bit of work to do on those issues (attitudes to patients), going back to the role modelling is good. It’s …remaining professional and focused, and that’s important… bring up people’s values’.
However, Zoe seemed clearly frustrated and irritated by the need to have to role model caring and compassion, which she seemed to consider should be a very natural response. She had been working with a care assistant but needed to tell her,

‘We are here to support people and to help them face their situation, and if it means putting your arms round them and letting them have a good old cry, then that’s part of caring.’

Leading by example was considered vital to supporting the development of appropriate ways of being, Some incidents appeared to highlight how the clinical nurse leaders were alone in their mission. Many of the clinical nurse leaders also reported the use of their influencing skills within their leadership behaviours to encourage appropriate values and behaviours. This is found in Winning them Over.

4.6.3 Sub-theme Three- Winning them Over.

Influencing skills were frequently employed by the clinical nurse leaders to refocus the team on finding a patient centred solution when difficulty arose. There was also a need to support others to develop the confidence to work with patients labelled as difficult or unpopular, and the need to develop practice cultures as safe environments for constructive critique. The clinical nurse leaders invested significant time to try and positively influence their teams.

Nursing handover was considered an important time to discuss difficulty, but it was a time when the clinical leader often seemed to stand alone when trying to positively influence attitudes. Veronica explained,

‘… It’s the talking, the talking at nursing handover…they say, ‘they are this, this and this,’ and I say, ‘Now come on, if you want to support this patient going home, you need to work hard with them. Meanwhile, they are here and they need you. You need to do your best.’
If there were particular or ongoing difficulties, having additional meetings seemed to be considered useful by some of the clinical nurse leaders. Tina explained the need for her to lead staff to unpack the difficulty,

‘… And so we’ve sat down, and I suppose it is when they think it is a patient who is a ‘problem’ (emphasis), or a concern, it is often about sitting down and talking to them, what we are doing with the patient, or if it is the family…’

Nicky and Diana were acutely aware that staff did need to talk about situations of difficulty to ‘offload’ about patients they found difficult, and they discussed using these times to positively influence attitudes.

The patients remained at the centre of their work as they strived to lead their teams towards positive attitudes to the patient, and Chloe upheld the centrality of the patient in the situation,

‘… but absolutely it has to be patient centred … it’s not about the staff, you have to look after the staff, but it is about the patient, and they have to remember the patient is a person …’

However, Annabel highlighted her lonely ongoing challenge to create a nursing culture where people could be honest about difficulty and challenge each other,

‘… Just getting the team to practice in a safe environment and getting them used to doing that …it shouldn’t be uncomfortable. As the leader I am more than happy to be challenged…I would like to think that’s how it is in a team, that it is safe to challenge the way of doing things… so it’s challenging different ways of looking at things without becoming entrenched in your personal views …’.

4.6.4 Summary of Theme Four.

The clinical nurse leaders appeared anxious and upset about the way in which their teams created unpopular patients and handled difficulty. Their response to this was to role model good practice in relation to attitudes and behaviours which supported
individualised, dignified care. They frequently employed influencing skills to try and positively change attitudes to unpopular patients, but it seemed that they were often the lone voice in this situation.

This took time and energy, but they remained patient focused. However, the way in which the clinical nurse leaders had developed their role to address the unpopular patient seemed to have taken time and experience. The final theme, Growing into Leadership, highlights the journey the clinical nurse leaders felt they had been on in relation to the older unpopular patient.

4.7 Theme Five- Growing into Leadership.

Learning to lead through experience when the team created an unpopular patient seemed to have taken time. The early days of addressing their concerns presented as particularly lonely and challenging for the clinical nurse leaders. They shared their stories about how the early days were painful and distressing for them. However, with greater experience, their confidence and resilience seemed to develop, and although their role in relation to the unpopular older patient seemed to continue to be lonely, they better learned to live with the consequences of addressing poor staff attitudes. The clinical nurse leaders also felt they had developed a heightened awareness and could identify the potential for an unpopular patient to develop much more quickly. This theme has two sub-themes, 1) Learning the Ropes and 2) Leadership Gaze.

4.7.1 Sub-theme One- Learning the Ropes.

In relation to the unpopular patient, some of the clinical nurse leaders seemed to have found the entry to their leadership role particularly challenging, and it seemed the most lonely time for them. It appeared to be a time of feeling separated from others as they tried to implement their desired nursing standards. They seemed to learn experientially, and this meant it contributed to some painful experiences. At times some were openly rejected by their teams for addressing their concerns, which they
had not anticipated, and which seemed to heighten the experience of loneliness. However, they acknowledged their learning, and how with greater experience they had learned to accept being rejected by a team, because patients were always their first concern.

Zoe had learned quickly that she was no longer part of her former group within the nursing team, and how, ironically, when addressing attitudes and behaviours in relation to the unpopular patient, she became the unpopular nurse within the team. She said with humour and irritation,

‘… When you take on this role, suddenly you are not one of the gang… (Laughs)... No! This is how it is going to be…and then you become the unpopular nurse! You do become unpopular! (Laughs)’.

The early days were reported frequently as stressful and challenging, and Tina highlighted her need to have to ‘think differently’ in relation to the responsibility the post held. The early days meant feeling overwhelmed by the challenge of the team creating an unpopular patient. Veronica shared how difficult the early days were for her,

‘… if you haven’t done it before it is the hardest thing… you just don’t realise! (laughs). You believe what people are really saying…‘Of course we do that!’…and you don’t want to change everything at once, but things do need to change, and you don’t know what to do first! (laughs/tearful) …It’s overwhelming, just totally overwhelming!’

Veronica then expressed that she found the development of an unpopular patient difficult to cope with as a new clinical nurse leader. Her memories appeared to be painful and tears came, but she shared how, with greater experience, she had learned to handle things very differently as her confidence to address concerns developed.

Julia’s early experiences seemed bound in frustration with the attitudes she witnessed, but she had learned new skills and could laugh about her journey so far,
‘... I used to get really frustrated, but now I’ve learned some phenomenal management techniques! (laughs)... ‘Yeah! Whilst I welcome your suggestion the ultimate decision is mine!’ That comes from Meg! And it’s the hand as well! (laughs, gesturing raising her hand). So yeah! I’ve had to learn to manage that!’

Julia then summed up the journey of being unpopular as a leader which others had discussed. Shoulders appeared to broaden and the need to be popular with the team seemed to become less important, because she was clear that the patient held centrality for them,

Exemplar;

Julia; ‘I’ve got used to it now, and I think if I am unpopular at times, I am doing my job! (laughs). My job is to challenge, to improve standards and to support patients, and to advocate for them. So that’s fine, I don’t mind being unpopular.’

Undertaking the performance management of individuals with poor attitudes to patients was reported as the most challenging and stressful part of the role in the early days, but the clinical nurse leaders expressed how their experience and confidence had developed. Zoe reflected on how, once undertaken, performance management meant she sorted out the issues, and she became more accustomed to doing this,

‘... it was the part I used to dread, but I don’t dread it now because at the end of the day, you do get the results you need.’

The leadership journey seemed studded with learning through experience in relation to the development of unpopular patients by the team. The trial and error approach also seemed common, and the stress of learning in this way appeared to contribute to feeling alone. Amanda admitted that,

‘You make some mistakes along the way.’
However, when attitudes changed and pockets of nursing practice began to improve, the rewards felt as though they were experienced as highlights of the clinical nurse leadership role. Zoe voiced that the rewards were,

‘…enlightening and heart warming when you see a nurse develop that rapport with a (difficult) patient’ and that it was ‘…earthmoving in a sense.’

I asked her to tell me about the word ‘earthmoving’ and she expressed the sense of achievement when the team developed a trusting relationship with someone who they had perceived as difficult in the first instance,

‘I suppose for me it means that I have succeeded because I’d like to think I have influenced them…I get quite excited! (laughs)…totally inspiring…because the patients we care for are so vulnerable and desperately ill.’

The profound emotions experienced in relation to poor attitudes, and the joy of feeling rewarded when they had positively influenced staff, seemed to comprise a suite of emotions in response to an unpopular patient on the caseload. Julia explained how she, ‘…loves it when people get it’ in terms of patient focused care, and Diana and Nicky referred to a loved poem when we shared a story about interpersonal connections which resolve difficulty. Diana saw this as a celebration,

‘Yeah! And it’s rather wonderful really….that is surely what the patient wants. They don’t want any judgements…you know, it’s the Crabbit Old Woman (poem) isn’t it?’

At times, the leadership journey appeared cyclical in nature, and was reflected in feeling the highs and lows of their endeavour with the unpopular patient. The role seemed to remain lonely in relation to the unpopular patient, but the clinical nurse leaders appeared to better cope with this as their experience and confidence developed. Shifting the team culture seemed to require constant tending, and some days brought frustration, disappointment and sadness, and occasionally joy. Although generally they felt they were achieving some small but important positive changes,
there was also a sense of tiredness, and the seeming need for endurance and tenacity evident again in Amanda's story,

‘Some days are better than others when I think I’ve achieved something. On others I just think I’ve gone backwards.’

Organisational changes and staff changes were voiced as negatively impacting team stability which they considered to inhibit their work in relation to the unpopular patient. Veronica reflected how her sense of purpose carried her forwards, but echoed tiredness from the circular journey these changes brought,

‘…And then I have to team build again, and I think, well luckily my heart is in it, because it really is…but you know! (laughs).’

Learning the ropes as a novice clinical nurse leader meant a particularly challenging time and seemed particularly lonely. Passion for patient care seemed to underpin their drive to address concerns, but they seemed not to have anticipated how this would make them unpopular with their own team. Managing the performance of individuals in the early days was reported as especially stressful, but with experience they appeared to learn to better handle this.

When they positively influenced attitudes it brought rewards, but the cyclical nature of changes within the organisation inhibited their work and added to their tiredness. Yet, as their experience of the unpopular patient and its development accumulated, some clinical nurse leaders revealed how they viewed their world differently, and this is captured in Leadership Gaze.

4.7.2 Sub-theme Two- Leadership Gaze.

The sub-theme ‘Leadership Gaze’ reflects how the clinical nurse leaders seemed to learn to better scan and assess their worlds. Their intuition appeared to develop in terms of sensing the potential antecedents to popularity and unpopularity, and this
helped them in their work. They also seemed to develop a more tacit understanding in relation to their clinical cultures. This sub-theme again reveals Heidegger’s temporality, having learned from the past, they addressed concerns in the present, because they anticipated the consequences of inauthenticity for older unpopular patients, and their nursing values underpinned their way of being.

The clinical nurse leaders appeared to have developed ways of scanning and assessing their areas which was broader in its focus, ensuring any potential antecedent to unpopularity was noted. Zoe explained,

‘… from the nurses point of view, the patient’s point of view, the visitors point of view and the wider team’s point of view, so that you have a wide insight into the needs of the area’,

Annabel shared her heightened sense of awareness, and although seemingly bound in anxiety due to her sense of responsibility, she had become more greatly attuned to the development of difficulty, and knew constant attention to this was required,

‘…aware of everything, you are keeping an eye, there’s that constant keeping an eye. If everything looks like it is flowing I can step back… I just keep my ears open …’

The development of this broader gaze meant they sensed problems quickly in their areas. Veronica highlighted the importance of knowing her team's level of functioning and the mood of the area, so that she could assess whether difficulty was developing from one particular team member. For Veronica this team member was her sense check. She understood that this team member was usually incredibly warm, and was rarely known to have interpersonal difficulties with patients. I asked if she was the ‘thermometer’.

‘She is indeed the thermometer! Bless her, she says what she feels! She’ll say, ‘I just can’t bear to go in there anymore. If I go in there I am going to scream!’ And then I know something is wrong …’
Zoe also shared how with experience she had learned to sense check her area and pick up problems. She was more comfortable in her role,

‘…if you had asked me a few years ago, maybe I’d have been in a bit of another world! (laughs). But now I can walk onto a ward and I can sense it, the unhappiness. I can sense the bad vibes just walking down the corridor, and I can pick it up.’

4.7.3 Summary of Theme Five.

The clinical nurse leaders seemed to experience leading in the presence of an unpopular patient as a particularly stressful in the early days of their leadership roles and these times seemed particularly lonely for them. Their move from being embedded within a team as a nurse, to being in charge of the team seemed especially challenging. They appeared not to have anticipated the rejection by their own nursing team, and their own unpopularity when they addressed their concerns. However, their seeming commitment to the care of older people appeared to sustain their leadership drive to improve practice, and they seemed to learn to tolerate the painful experiences of their roles. However, hearing between the lines of their stories revealed a loud silence in relation to support for their roles, as very little was mentioned in relation to support mechanisms. This may also have contributed to their sense of loneliness.

The clinical nurse leaders stories seemed to be one of survival, but their learning seemed to have taken them to a new vista, in which they were able to sense and scan their clinical worlds for concerns, becoming more expert in anticipating the unpopular older patient. They targeted their gaze towards developing problems. Over time, the clinical nurse leaders expressed becoming more comfortable with their roles, and the need to address their concerns as integral to establishing appropriate attitudes to older patients. It seemed that their courage also developed with time and they felt more comfortable within their leadership skin.
4.8 The whole interpretation of the hidden experience- A Lonely Endeavour.

The five themes which illuminated the experience of the clinical nurse leader leading a team caring for an unpopular patient have been presented. During early readings interpretation across the interviews and theme development, the underlying meaning of loneliness was occasionally implied between lines of the data, but revealed itself more clearly during rewriting and the final analysis. The parts (themes and sub-themes) contributed to the whole meaning of the final construction. The central meaning of the experience for clinical nurse leaders leading a team caring for an unpopular patient seemed to be one of loneliness as they worked to prevent, or address, the attitudes and behaviours which created an unpopular older patient.

The clinical nurse leaders seemed alone in their teams, rejected at times by the team, and ironically becoming the unpopular nurse, as they worked to prevent the development of the unpopular older patient. They also felt caught between trying to address the issues in their teams, but felt that the organisation did not appreciate the issue of the unpopular patient, which they reported hampered their progress.

The leadership experience in relation to the unpopular older patient meant a journey of experiential learning and coping with challenging situations. Loneliness appeared to be felt acutely in the early leadership days when the clinical leaders felt challenged by the situation of the unpopular patient. Zoe had acknowledged being rejected by the team for her values, ‘...you are not one of the gang… (Laughs)... and then you become the unpopular nurse!’ and Veronica highlighted the early days as, ‘... just totally overwhelming!’ Addressing the problem held an ironic twist. In their efforts to prevent the rejection of patients whom the team did not like, the clinical nurse leaders themselves became unpopular. The negative attitudes of an individual or the team towards patients brought pain, anger and frustration for the clinical nurse leaders as what seemed to be moral distress.
Veronica was sharing her story about dealing with the team creating an older unpopular patient in the early days of her role, how she battled alone, and her suffering,

‘It was so awful, it was such a bad experience, it's almost gone out of my head because it was so awful...I think I couldn't cope with it then....(Laughs/Tearful).

Zoe shared how she was rejected by her team. She described how upholding her nursing values during direct clinical care meant her team rejected her. She described how she tried to role model care quality, taking time with patients, listening to their concerns, and enjoying being together, sharing the uniqueness of each patient. However, this made her presence unpopular,

‘...sometimes I go there and I say, 'Well! I am here for the day, I've come to help, what do you want me to do?' And they draw straws I am sure! Who's going to work with her? (Emphasis/Laughing).'

Zoe felt that patients were quickly categorised by staff to fit the system and the routine of the clinical team,

‘...you've (the patient) got to fit boxes, fit criteria, and if somebody comes up with slightly different values or a slightly different culture..., they (the nursing team) think, 'Oh! Flippin’ Heck!'

Zoe explained the exhaustion of constantly trying to lead the team to see the patient as an individual. She seemed alone in her endeavour, which she expressed as endless. Sally also understood the duration of her own endeavour, and how she stood alone with her viewpoint and could not influence her team members. The clinical nurse leaders had moved on from the early days of leadership, but the challenge of the unpopular older patient continued to mean that they seemed to face the challenge alone.
'I've delivered a mattress...but he (the patient) slipped off...he rolled off in the night. He's used to a bigger bed! (Laughs)...I reiterated the risk of skin breakdown and we talked it through. But does that make him a difficult? He's labelled a difficult patient (by the team)'

The clinical nurse leaders appeared to work tirelessly to try to create the appropriate climate of care and set the expected tone. The experience of loneliness appeared compounded by needing to stand alone to address difficulty. However, they persisted, and stood firm, as they tried to lead the team to unravel the issues around the difficulties, and to work positively with the patient. Annabel said,

'...I explore the difficulty with them, whether I looked at hard data in terms of numbers of visits, or challenged what they were doing, or their attitudes.'

Veronica shared her desperation when tried to lead the team to address the situation,

'...So I say to them, please don't give me a complaint, let's deal with it now before it gets right out of hand...'

Knowing the vulnerability of unpopular older patients meant the clinical nurse leaders needed to uphold positive nursing values when the team's values fell below those they expected. However, when the tide of the prevailing team culture was against them, their experience of loneliness seemed at it most intense, and Annabel revealed how when she worked in partnership with a patient who had become unpopular due to non-concordance with nursing advice, she felt undermined by her team and lost credibility with them,

'...So I went to the lady and she didn't want them (compression hosiery). And she was getting a bit like, cornered (by the team). I think the expectation of me was that this lady would (emphasis) wear her bandages! (Laughs)...I had the conversation
about how the bandages would help, but it was her choice, and I almost felt like I failed because the expectation of the team was that I was the boss so I would get her to wear her bandages!...but she is not at the point where she wants to wear them...but I felt my colleagues felt I hadn't done my job properly...that I lost some value with my colleagues, that I let her get away with it.'

I asked her how this had left her feeling,

'...feeling that they may perceive me as not having the strength...but that's never going to work. It shouldn't be a battle between the nurse and the patient on the journey...'

Annabel seemed pensive, saddened and dejected when she shared this. The clinical nurse leaders were clear about basing their leadership role on their nursing values, but this meant they experienced profound emotions and distress when their nursing values were breached by teams and colleagues. Time with the clinical nurse leaders was, at times, a shared experience of sadness, because their evident passion for older people, and the value and respect that should be afforded to them was revealed as significantly compromised.

At times they seemed to have a heavy heart and at times there were tears of frustration. Yet in their practice they seemed to contain their pain and distress alone, as they did not mention sharing their feelings with others. They shared how the behaviours and attitudes of others so angered them. Veronica expressed feeling ‘awful’ in relation to the attitudes of some staff, Julia felt really ‘frustrated’, and Tina experienced significant ‘disappointment’ with her team when they labelled and rejected people. The actions of some staff made Chloe feel ‘wild’ and Sally reported how her anger ‘welled up’. Julia added that ‘some people don’t give a shit about people!’ and how she ‘gets angry about that.’
Added to the feelings of anger were the experiences of hurt and distress, and this constituted their hidden wounds of clinical nurse leadership. Zoe shared how sometimes she became ‘genuinely upset’ when people created unpopularity. Veronica added that when she was aware that a team member had been 'horrible to a patient', that it was 'a killer' for her, becoming tearful when she expressed this. Amanda expressed with sadness how she felt 'desperate' at times when she struggled to lead the team to invest in understanding the patient's behaviours and needs. Although they strived to live Heidegger's authentic way of being, upholding and living their nursing values as clinical nurse leaders, the witnessing of poor conduct in their teams meant they suffered alone. The loneliness they seemed to experience remained, but they seemed to better learn to accept this as they more greatly believed in themselves and their the necessity to prevent patients becoming unpopular. Julia summed up this adjustment,

'... My job is to challenge, to improve standards and to support patients, and to advocate for them. So that’s fine, I don’t mind being unpopular.'

The clinical nurse leaders' experiences of the organisation meant they felt unsupported as they tried to address their concerns, feeling that the organisation did not appreciate their situation or understand their concerns, and seeming to increase their sense of loneliness. Zoe’s experience was that the issue of poor attitudes to a disliked patient was not considered important when she raised her concerns,

'... People don’t take it on board as a serious issue… We need managers who support leaders.’

The clinical nurse leaders wanted support to address their concerns, but felt let down at times. Zoe highlighted, ‘...not having the policies and procedures to deal with underperformance‘ as having hampered her progress in addressing her concerns about the behaviour of a staff member. Team stability was understood as important to develop an appropriate climate of care. However, constant staff changes meant that
this was challenging, and the achievement of a stable team challenging to achieve. These challenges appeared to increase their sense of the lonely endeavour to prevent or address the development of the older unpopular patient. Veronica shared her frustration in relation to achieving team stability,

'...I mean it's hopeless. Why decide to recruit nurses now when everybody knew a year ago that things were changing and we needed staff! Everybody knows it takes ages to recruit! (Laughing). And then it takes so long the candidate pulls out! (laughs) ...it's a nightmare... and then I have to team build again, and I think, well luckily my heart is in it, because it really is...but you know (laughs)!'

In addition, the clinical nurse leaders had voiced concern that those things which mattered to themselves and patients, the details in care and the attitudes and behaviours of staff, were not upheld as significant by the organisation. This seemed to contribute further to them feeling alone. Organisational performance measures appeared not to support their work, as Zoe explained how '...the dashboards (and I'll get shot for this!)... it doesn't get down to the patient experience, ...that there is actually a patient in a bed who has been told to be quiet and stop being a nuisance, that's what worries me!'

The central meaning of loneliness was hidden within the data. Of particular interest is that this finding of this experience existed in response to an issue already hidden within nursing practice, the concept of the unpopular patient. Also of interest, is the irony that whilst trying to prevent the development of the older unpopular patient the clinical nurse leaders became unpopular themselves. The core and central experience of loneliness, the tenacity required to hold their nursing values, and the duration of the their journey therefore created the title of this study.
4.8.1 *Pictorial Representation of the Interpretation.*

The interpretation in the form of a pictorial representation of the whole interpretation is found below in Picture 4.1.

**Picture 4.1 Pictorial Representation of the whole interpretation.**

The arrows represent the relationship between the themes representing the experience. Each theme contributed to the experience, but the whole and hidden meaning of the experience was of the loneliness for clinical nurse leaders leading teams caring for an older unpopular patient. Knowing Unpopularity revealed how the clinical leaders were very familiar with the development of unpopular older patients in their clinical teams.
Being Faithful revealed how the clarity of purpose the clinical nurse leaders held in relation to the care of older people, and their resoluteness to uphold caring and compassionate care as moral courage, resulted in them experiencing moral distress when their values were not upheld by others. They seemed battered and alone in their mission to prevent the older unpopular patient, suffering the wounds of clinical nurse leadership when addressing their concerns.

Betwixt and Between revealed how the clinical nurse leaders felt caught between, on the one hand, needing to address their concerns and prevent or address patient unpopularity, whilst on the other feeling the organisation did not share their values or support them, which seemed to reinforce their sense of loneliness.

Joined at the Hip highlighted how the clinical nurse leaders had developed their approach to try to mitigate and address the development of unpopularity using role modelling and influencing skills. However, the theme revealed how they stood alone in the team when challenging poor attitudes.

Growing into Leadership revealed the early days of the clinical nurse leadership role as especially challenging and lonely when striving to address their concerns about the development of an older unpopular patient. and due to the unpopularity they experienced in response to their efforts from the team. However, as they became more experienced, the clinical nurse leaders expressed feeling more confident in upholding their values and practice standards, more able to tolerate rejection by the team, and to cope with the experience of loneliness.

Each theme contributed to the final interpretation of the whole meaning of the experience of loneliness, which is pictured as the experience which comprised the meaning of the whole interpretation.
4.9 Rigour and researcher prejudice.

Within Heideggerian phenomenology the researcher is considered inseparable from the assumptions and preconceptions about the phenomenon under study, and these are built into the findings of the study (De Witt & Ploeg, 2006, p.216). My own previous experiences will have influenced the interpretation. Inclusions of my own fore-conceptions and excerpts from my diary have aimed to make my prejudice clear.

The study has meant that I have grasped the meaning of the unpopular patient in a much more comprehensive way. My own experience certainly included frustration with the way in which team members treated those they disliked. The process of research can mean the researcher is open to self-change as a result of the participation in the study (Koch, 2006, p. 98). I now more fully appreciate the struggle clinical nurse leaders face as they strive to address the labelling and the development of an unpopular patient, although I did not conceptualise the experience of loneliness during my own experiences. On reflection, I realise how I contributed to the hiddeness of the problem in nursing practice as I worked to address it on my own. The loneliness and the suffering of the clinical leaders revealed within the study has brought me to a position of understanding their experiences more deeply, and the barriers they struggle against as they strive to ensure dignified and respectful care for older people. The study has left me considering the urgent importance of opening up the discourse in nursing about the concept of the unpopular patient, and the need to explore in much greater depth the lived experience of clinical leadership and its everyday reality.
5.0 CHAPTER FIVE- DISCUSSION

5.1 Introduction.

Heidegger suggested that pure description was not possible without some interpretation (Mackay, 2005, p.181). Phenomenological studies include description of the phenomena, whilst also gaining insight into the experience and the meaning given to the phenomena (Corben, 1999, p.56). This chapter commences, importantly, by setting the context for the study. The discussion then includes a description of the experience given by the clinical nurse leaders. The chapter continues with a discussion about the interpretation of the meaning of the older unpopular patient for them, including both the visible meaning and then the hidden meaning, in support of Heideggerian assumption (Smith, Flowers & Larkin, 2009, p.24). The most novel findings of the study as moral distress, moral courage and loneliness are discussed in relation to the contemporary literature. The implications arising from the study are highlighted. The discussion then continues with the rigour of the research, the contribution of the study to existing knowledge, the strengths and limitations of the study, and a summary of the implications for the reader.

5.1.1 The stereotyping of older people.

Age is a social division and a dimension of the social structure which can be highly significant and the basis on which power, privileges and opportunity can be allocated (Thompson, 2012, p.103). In other European countries ageing is celebrated as an asset to society, but in this country it is often stereotyped negatively in the media and at a policy level (Joseph Rowntree Foundation, 2004, p.3). This stereotyping can influence the judgement of older people within healthcare (Devine, 1980, p.26; Corley & Goren, 1998, p.103). This judgement can then result in discrimination, or the way in which the difference of being old means people are treated, and includes small actions which denigrate or sub-ordinate the individual (Ryden & Willetts, 2013, p.29). This may include ageism at a personal and institutional level, that is, common assumptions about older people which reflect their low status and a lack of respect (Thompson, 2012, p.105). Common assumptions which reinforce ageism are those
which assume for example, older people as a burden, older people as childlike, and older people as unintelligent (Thompson, 2012, p. 106). Attitudes which denigrate the individual based on such assumptions may be subtle, but they can damage someone’s emotional and psychological well-being (Ryden & Willetts, 2013, p.29).

5.1.2 Dignified care, negative judgement and the unpopular patient.

A lack of dignified and respectful care for older people is not new (Dennis & Morgan, 2008, p.14). Recently there has been a drive for more compassionate care (DH & NHSCB, 2012, p.8), and compassionate care is said to be value based care that respects individual dignity (DH, 2010c, p.3). The literature on the unpopular patient did not include studies which identify older people as particularly unpopular with nurses, but the negative stereotyping by society, and the potential consequences of negative judgements in healthcare systems, may mean that older people may be more at risk of being unpopular patients, and therefore may receive less than dignified care. The literature on the unpopular patient in general nursing revealed that nurses can lack caring and compassion when they dislike a patient. Although the concept of the unpopular patient is hidden from the wider nursing discourse (Little, 1996, p106), and has not been well studied in this country, the presence of the unpopular patient symbolises non-caring practice (Juliana et al, 1997, p.13).

Yet effective nurse leadership is positioned as central to optimum patient outcomes (Hutchinson & Jackson, 2013, p.11). Nationally there has been a call for improved nursing leadership in the NHS and clinical nurse leaders are said to be core and central to this (DH, 2000, p. 86; Shirey, 2005, p.61; DH, 2008, p.65; Murphy, 2009, p.28; Barwell & McDonald, 2012, p.S3; Willcocks, 2012, p.1). However, clinical nurse leadership is ill-defined and under-researched (Stanley & Sherratt, 2010, p.115), leaving the uniqueness of clinical nurse leadership unrecognised (Stanley & Sherratt, 2010, p.116), and poorly clarified (Stanley, 2004, p.39).
Clinical nurse leadership is a complex and multifaceted role (Willcocks, 2012, p.17), but essentially it is said to be centred on the clinical nurse leader creating a caring environment (Bondas, 2003, p.251), ensuring the effective delivery of health care at the front line (Millward & Bryan, 2005, p.15), and providing the best possible care to patients (Bondas, 2009, p.359). A further aim of clinical nurse leadership is also said to transform the service to meet patient need (Willcocks, 2008, p.158), based on the clinical nurse leader’s values, and their views of fundamental care and nursing (Stanley, 2005, p.135). Despite national concern about the care of older people, and the focus on clinical nurse leadership to improve care quality, previous studies about the unpopular patient have not focused on the experience of the clinical nurse leader, had rarely focused specifically on the older person (except English & Morse, 1988), or community nursing settings (except Michealsen, 2012). Therefore this study adds to the body of knowledge in relation to the unpopular patient, but more specifically the older unpopular patient, and for the first time, the experience of the clinical nurse leader. This is particularly important as current policy drivers seek to provide services outside the acute care sector wherever possible (DH, 2009, p.8).

5.2 Previous studies on the unpopular patient.

As long ago as 1972 Stockwell highlighted the presence of the unpopular patient in nursing, thus revealing the existence of prejudice in nursing. Of concern is that the unpopular patient may receive qualitatively poorer nursing care. However, the issue is hidden from wider discourse within nursing and has not been widely studied, although it is frequently presented in the anecdotal literature. Of the small number of studies which have explored the issue of the unpopular patient, most were undertaken in the USA. The role of the clinical nurse leader in the USA is fundamentally different in that it requires significant specific academic preparation usually at Masters level, which results in a formal qualification. In this country the label of clinical nurse leader is applied commonly to nurses in clinical leadership positions who may well not have received such formal preparation, and the role usually includes direct care delivery. In essence, the clinical nurse leadership role in this country appears to involve greater
engagement in the delivery of nursing care, and does not require the same formal preparation. Only two studies about the unpopular patient have been conducted within the United Kingdom in NHS acute care settings, and the issue of clinical nurse leadership was absent from the studies. As mentioned previously, only one previous study has focused on older people (English & Morse, 1988) and only one on community nursing settings (Michaelsen, 2012).

5.3 The aim of the study, the approach taken and the summary of the findings.

The aim of the study was therefore to explore the lived experience of clinical leaders when leading their teams caring for older unpopular patients using in-depth semi-structured interviews. The setting was community nursing settings, including community hospitals and nursing in people’s own homes.

The approach to this research was qualitative and interpretive, employing Heideggerian hermeneutic phenomenology. Heideggerian phenomenology seeks to understand everyday existence (Annells, 1996, p.706; Wrathall, 2005, p.60), and the meaning of being human (McConnell-Henry, Chapman & Francis, 2009a, p.5). The study aimed to understand the meaning of the experience (Van der Zalm & Bergum, 2000, p.212) for clinical nurse leaders, revealing the complexity of human reality in relation to the area of interest (Wolcott, 2009, p.70), the concept of the unpopular patient. The research question was,

‘What is the lived experience of clinical leaders leading teams caring for an older patient perceived as unpopular in community hospital and community settings?’

As Heidegger considered meaning as being composed of visible meaning and hidden meaning (Smith, Flowers & Larkin, 2009, p.24), hidden meaning was sought from within the narrative to enrich the understanding of everyday experiences (Van der Zalm & Bergum, 2000, p.213) of the clinical nurse leaders. Ten in-depth interviews (eleven clinical nurse leaders) were undertaken with clinical nurse leaders in
community hospitals and community nursing clinical leadership roles. The application of Heideggerian hermeneutic phenomenology focused on the experience of the individual, and co-constitution brought together the context, the clinical nurse leaders’ experience and the researcher’s understanding.

This study illuminated the lived experience of clinical nurse leadership when striving to lead teams to care appropriately for an older unpopular patient. They described the challenges they faced both within their teams and within the organisation. This included a novel finding which meant them feeling they became the unpopular nurse within the team when they addressed poor attitudes and behaviours of team members. This is also a novel finding and important finding, and once which seems ironic when the clinical nurse leaders were working to protect patients. The visible meaning the experience held for the clinical nurse leaders was found in upholding their nursing values as they worked to mitigate the presence, or development of, the older unpopular patient. However, living their beliefs and values resulted in two interesting and novel findings, the visible meanings of the moral distress they seemed to experience when older people were treated by team members in ways they considered unacceptable, and how they seemed to retain the moral courage to continue in their mission. In addition, the hidden meaning of the whole experience was found in their loneliness, feeling unsupported and rejected by their team at times, and not feeling understood by the organisation in relation to their concerns about the older unpopular patient. The visible meanings of moral courage and moral distress, and the hidden meaning of loneliness are all under-researched areas of clinical nurse leadership and are therefore important findings.

5.4 The description of the concept by the clinical nurse leaders.

The clinical leaders in this study described the concept of the older unpopular patient as it appeared to them, including knowing that it existed within their teams and knowing nurses labelled and avoided patients. The presence of unpopularity meant they needed to uphold their nursing values and strive to lead the team towards
caring culture. The clinical nurse leaders also described how they grew into their leadership roles in relation to dealing with the development of the unpopular patient.

Nurses have been said to know about the concept of the unpopular patient (Conway, 2000, p.5; MacDonald, 2003, p.305; Johnson & Webb, 1995, p.467), and the concept of the unpopular patient was known to the clinical nurse leaders. However, this study has highlighted that the unpopular patient is also specifically created in older people’s settings. The findings of this study therefore imply that the presence of the unpopular patient may be more widespread in nursing than previously alluded to in the literature, and this has important implications for the quality of care for older people. This study importantly adds to previous studies of the unpopular patient undertaken in the United Kingdom, as previously only two studies could be found (Johnson & Webb, 1995a, p.466; Conway, 2000, p.1).

The common practice of labelling patients as difficult, or unpopular, has been identified previously (Erlen & Jones, 1999, p.76), and the clinical nurse leaders in this study also reported this. This study did not seek to establish why patients were labelled as difficult or unpopular, but the clinical leaders described many of the reasons already cited in the literature in other clinical settings. These reasons included making frequent requests (which has been previously identified by Podrasky & Sexton (1998, p.19), having difficult relatives (previously identified by MacDonald (2003, p.306), having religious beliefs (previously identified by by Roos (2005, p.57), non-concordance with nursing care (also identified by cited by Conway (2000, p.4) and Stockwell (1984, p.27), being demanding (also identified by Stockwell (1984, p.27), societal norms in relation to eccentricity (as reported by MacDonald (2003, p.307) and antisocial behaviour (as described by Conway (2000, p.1). The clinical nurse leaders also described how nurses in their teams avoided difficult patients, something else reported in previous studies (Podrasky & Sexton, 1988, p.19; Lorber, 1995, p.177; Michaelsen, 2012, p.90), and physically separating themselves from unpopular patients (a finding also reported by Carveth (1995, p.174). The finding that older people specifically can also be unpopular patients, and can experience
nurses avoiding them, with the risk of some of the consequences for poorer quality care cited in the literature, raises implications in particular for older people’s care quality. It also adds to Michaelson’s (2012, p. 90) findings that the older patient can be unpopular in community nursing settings, contributing to the previous literature. Yet this is particularly concerning and has implications as older people may already be vulnerable. However, of interest, is that many of the reasons cited for patients being unpopular with nurses by the clinical nurses leaders, have been cited in studies not centred on the older person, and it therefore seems that ageism was not the cause of unpopularity in this study.

5.4.1 Upholding nursing values in the clinical nurse leadership role.

When team members labelled patients as unpopular the clinical nurse leaders described how they needed to uphold their nursing values within their roles. An American qualitative study reported that nurses hold a strong connection between being a good nurse and doing the right thing (Smith & Godfrey, 2002, p.308), although the research question was acknowledged as being biased towards positive response. The clinical nurse leaders in this study described their own clarity of purpose in relation to high quality care, and clear expectations are often cited as central to good clinical nurse leadership (Girvin, 1998, p.97; Shirey, 2005, p.63; Gaskin et al, 2012, p.637). However, in this study the clinical nurse leaders described how challenging this could be, and they described how sometimes, this meant that they themselves, ironically, became unpopular with the nursing team. This is a novel and important finding, which contributes to current knowledge and has important implications for how successful clinical nurse leaders can be when trying to change the culture whilst feeling rejected by their own team, including the potential negative impact of patient unpopularity on care quality.

The clinical nurse leaders described how, if they adhered to their values and beliefs, and role modelled good nursing care, this demonstrated to their team the way to be with patients. Studies have clearly identified that clinical leaders are chosen for such
reasons, and in addition, displaying these principles about the quality of care (Stanley, 2008, p.521; Lawrence & Richardson, 2012, p.6). A small qualitative study of intensive care nurses’ perceptions of leadership reported leading by example and ensuring their ethical standards were visible to others as important (Linton & Farrell, 2009, p.66), and staying close to care delivery has been reported elsewhere (Sorensen, Delmar & Pedersen, 2011, p.424; Gaskin et al, 2012, p.636). However, although the clinical nurse leaders in this study described having their values on display, and transforming these into their actions, they felt they were frequently unable to positively influence an individual or team’s attitude towards somebody who was unpopular. This perhaps reflects how embedded the concept of the unpopular patient is within nursing culture, as the clinical nurse leaders worked tirelessly to address negative attitudes and behaviours. This has implications for clinical nurse leaders’ ability to influence such attitudes without the wider support of the organisation, particularly if they become the unpopular nurse.

Frustration was described when the clinical nurse leaders’ needed to encourage staff to tend to the person who was unpopular, and the experience of frustration in such circumstances has been reported elsewhere (Bondas, 2009, p.358). Interestingly, dealing with difficult patients and visitors has been said to be one of the challenges of the clinical nurse leadership role (Gaskin, Ockerby, Smith, Russell & O’Connell, 2012, p.630), but instead in this study, dealing with the attitudes and behaviours of their team appeared to present the greater challenge to the clinical nurse leaders. This is a novel finding which contributes to current knowledge as it highlights how staff can present a greater challenge to clinical nurse leaders than their patients and visitors. This has implications for the preparation of clinical nurse leaders and the skills and tools available to manage situations where staff members do not treat patients with dignity and respect.
5.4.2 Striving to lead the team towards a caring culture.

In a meta-analysis of qualitative evidence nurses reported that a heavy workload hampers good interpersonal relationship with patients (Rittenmeyer & Huffman, 2009, p.1242), but the clinical nurse leaders in this study did not report that the workload was the cause of poor interpersonal relationships between staff and patients. Instead, they felt the cause was the attitudes and behaviours of team members which they struggled to positively influence. The clinical nurse leaders described their sense of responsibility for ensuring their clinical areas were caring environments, and a qualitative study in the peri-operative setting in Sweden also reported this finding (Rudolfsson, von Post & Eriksson, 2007, p.318). However, the struggle to create a caring environment has been reported by clinical nurse leaders as one of sometimes battling alone (Rudolfsson, von Post & Eriksson, 2007, p. 320). Although the context of care was different, the findings are interesting. The duration of the struggle to create a caring culture, that is, one in which the unpopular patient did not occur, was also described by the clinical nurse leaders in this study, and creating a caring culture has been as a long term aim of clinical nurse leaders, and one to which they consistently returned was also reported by Rudolfsson, von Post & Eriksson (2007, p.321). Clearly this has implications for patient care quality in the period of time in which the clinical nurse leader works to change the nursing culture. It is unlikely that clinical nurse leaders will be able to effect an immediate change in the team's attitude to patients they dislike, and the time the change may take means the presence of unpopularity and its potential consequences may continue.

The clinical nurse leaders in this study felt that their concerns about the older unpopular patient were not understood by the organisation in which they worked. In a qualitative study in Australia clinical nurse leaders also expressed that they felt that their values were not well understood by the organisation, and their voices not heard (Paliadelis, Cruickshank & Sheridan, 2007, p. 835). Although the findings are not generalisable, they were reported as consistent with the broader literature (Paliadelis, Cruickshank & Sheridan, 2007, p. 836). The clinical nurse leaders in this study
described how the organisational constraints caused frustration and anger, and it has been proposed that when the espoused values of the organisation are at odds with its lived values strong reactions can be experienced by individuals (Graber & Osborne Kilpatrick, 2008, p.190). There are therefore wider implications for organisations, insofar as there needs to be shared values which translate into proactively supporting clinical nurse leaders to address the issue of the unpopular patient, as this indicates undignified and disrespectful care.

5.4.3 Growing into Leadership.

The clinical nurse leaders in this study recalled the early days of the role as particularly challenging in relation to the unpopular patient. The early days were reported as especially distressing for them. However, with greater experience and growing confidence, they felt that they better identified and dealt with the issue of the older unpopular patient.

Many of the clinical nurse leaders described their experience of the older unpopular patient as a leadership challenge, and the early days were described as especially difficult for them, which has previously been cited (Bondas, 2009, p.357). A qualitative study in an acute hospital of female Ward Managers in Sweden reported nurses feeling lonely when 'leaving' the bedside nursing role, needing time and support to transition to a leadership role, yet support systems were particularly inadequate (Persson & Thylefors, 1999, p.78). Some of the clinical leaders in this study felt they were 'no longer one of the gang', being excluded from previous relationships and feeling alone, and this has also been previously reported in a qualitative study in the Swedish peri-operative setting (Rudolfsson & Flensner, 2012, p.282). Although the context is very different from community nursing settings the findings are similar to those in this study. There was also a silence in relation to support mechanisms in the early days, and several other studies have highlighted how clinical nurse leaders receive little support from the organisation, and a lack of processes to assist them to transition to the position of clinical nurse leader.
In addition to these challenges, previous research has found that, with regard to the development of an unpopular patient, nurses who do not follow the practices of a group can find themselves ostracised (Podrasky & Sexton, 1988, p.20). As the first study to examine the experiences of clinical nurse leaders this study found that, in relation to the unpopular patient, such experiences are not limited to nurses who challenge such practices, and clinical nurse leaders can be similarly affected. It is not known whether the clinical leaders in this study were the first of those in the role to challenge the presence of unpopularity, but another study has reported that an incoming clinical nurse leader having differing priorities to the previous clinical nurse leader contributes to the challenges (Gaskin et al, 2012, p.632). This could be further compounded if neighbouring clinical teams are not being challenged in the same way, having implications for even greater isolation of one clinical nurse leader.

The clinical nurse leaders described how the responses of staff members significantly challenged them, and another study employing nurses' narratives about their practice identified that clinical leaders felt unprepared for the negative responses of staff (Cathcart, Greenspan & Quin, 2010, p. 444). This study therefore adds to previous literature in relation to the transition to a clinical nurse leadership role and has important implications in terms of the necessary support mechanisms, such as mentorship, which acknowledges and works through the emotions of clinical nurse leadership in order to support professional growth, particularly in the early days. It also raises important implications in relation to developing junior staff to uphold the desired values, which requires organisational support. This can be considered essential, as where the appropriate attitudes and values are not embedded in the team, the clinical nurse leader may have to continue to battle alone.
The clinical nurse leaders also described how they learned on the job, making some mistakes, and although not directly related to the unpopular patient, two other studies found that clinical leaders learn by trial and error in the early days of their roles (Paliadelis, Cruickshank & Sheridan, 2007, p. 833; Gaskin et al, 2012, p. 633). This clearly has implications for care quality whilst the clinical nurse leaders learn, as learning on the job conflicts with the expectation that clinical nurse leadership should be effective as soon as the person commences their role (Cook & Leathard, 2004, p.440). New clinical leaders have also reported substantial staff resistance and needing to pass the 'staff test' to gain credibility (Cathcart, Greenspan & Quin, 2010, p.445). In this study, the clinical leader's work to mitigate the unpopular patient but appeared not to pass the 'staff test', and instead, they were sometimes rejected. However, they described how they needed to hold staff to account, sometimes using performance management, and how this was a difficult aspect of their role, which has also been supported by another study (Gaskin et al, 2012, p.630). Again this has significant implications for the support of new clinical nurse leaders, both emotionally and practically, to address such concerns, and to negate the need to learn by trial and error. This could take the form of more intense supervision, mentorship or coaching in the early days.

Finding the balance within a leadership role has previously been cited by nurse leaders as challenging, as within leadership roles clear demarcation of position can reduce closeness and create loneliness (Paliadelis, Cruickshank & Sheridan, 2007, p. 834). The findings of this study appear to reflect this, as the clinical nurse leaders tried to adapt to not being embedded in the team, while being close enough to care delivery to detect problems and deal with them. Finding this balance has implications for clinical nurse leadership preparation and ongoing support, perhaps during supervision and mentorship. It also has implications for future research employing approaches such as participant observation to explore how clinical nurse leaders are helped, or hindered in their work, when trying to develop caring cultures.
However, the clinical nurse leaders in this study went on to discuss how, with greater experience, they adapted, and were better able to address their concerns about the unpopular patient. It has been suggested that there may be a transition towards psychological hardiness which brings a sense of increased comfort and confidence in the clinical nurse leadership role (Cathart, Greenspan & Quin, 2010, p.446). This study appears to support this, as the clinical nurse leaders seemed to gain confidence in addressing poor staff attitudes, and felt more comfortable with rejection, as they developed their leadership confidence in relation to their sense of responsibility for patient care quality. Interestingly however, Cathart, Greenspan & Quin (2010, p. 446) suggested that investment in nursing staff by clinical nurse leaders meant the nursing staff became more committed to authentic nursing practice, but this appears to conflict with this study. The clinical nurse leaders in this study worked consistently to role model and influence the attitudes of the team in relation to the unpopular patient. However, this ongoing investment seemed ineffectual because the clinical nurse leaders felt that they had been unable to substantially influence the attitudes of their teams.

5.4.4 The clinical nurse leadership gaze.

With greater experience the clinical nurse leaders felt they had learned to sense and detect issues pertinent to the development of the unpopular patient more quickly. This may have been what has been termed 'nursing conscience'. 'Nursing conscience' as a warning signal, and an increasing sensitivity to patients' needs, can help to recognise inadequacies in care and poor relationships between staff and patients, and their families (Jensen & Lidell, 2009, p.36). It can also inform the intuition developed throughout the nursing career (Jensen & Lidell, 2009, p.38). This study appears to support these findings as the clinical nurse leaders described how they had learned through experience to sense issues related to care quality being delivered by their team. Clinical nurse leaders in another qualitative study identified the advanced skill, or ability, to be a sensor of the temperature of the unit, picking up early signs of potential problems (Shirey, Ebright, McDaniel, 2008, p.127), and in this
study, this was interpreted as the 'clinical nurse leadership gaze'. This may imply that clinical leaders develop their sensing of concerns about care quality with experience, and this is worthy of much greater exploration, having implications for further exploration of expertise within clinical nurse leadership. There are also wider implications for risk management within organisations as it has been suggested that by leaving the patient outside the caring loop there is potential for missed diagnosis and interventions (Maupin, 1995, p.11). This means the development of the clinical nurse leadership gaze may be important to support patient safety and may be of particular importance for older patients, who may already be vulnerable.

5.5 The visible meaning of the concept for the clinical nurse leaders.

The visible meaning, (as that which was found and interpreted from verbatim data, non-verbal communication and diary notes), of the experience of the older unpopular patient for the clinical nurse leaders in this study appeared to have core and central meanings. Firstly and importantly, meaning for them was found through upholding their nursing values as central to their clinical leadership roles. However, as a consequence of this, secondly, two novel findings were found as moral distress and moral courage. The first important novel finding, moral distress, interestingly, was visible in response to their values being breached by their team members rather than in response to major ethical dilemmas. The second important novel finding was the moral courage they seemed to maintain to stand up for that they believed to be right, to address poor attitudes in relation to patients staff did not like, aiming to prevent unpopularity. This perpetuated despite, at times, feeling they were the unpopular nurse. In essence, the meaning for them in relation to their leadership responsibilities seemed to sustain their courage in difficult circumstances.

The clinical nurse leaders in this study worked to be true to their nursing values. A qualitative study in Canada highlighted nurses' deep commitment to their nursing values, how these values sustained them despite challenges, but how difficulty enacting their values took an emotional toll (Beagan & Ells, 2007, p.41). Upholding
nursing values was considered by the clinical nurse leaders in this study as central to
the meaning of clinical nurse leadership. In addition to nursing values, within
leadership, it has been proposed that the emotions of the leader are central to
practice, whether or not they are displayed or acknowledged at the time (Beatty,
1999, p.12). Although much has been written about leadership styles, it has been
suggested that leaders are open to the values and the emotions which sustain them
(Beatty, 1999, p.8). Heidegger contended that authentic existence allows for a far
deeper experience (Watts, 2007, p.57), and involves acting in accordance with what
is morally good in the world (Conroy, 2003, p.8). Yet for the clinical nurse leaders,
living authentically and acting in accordance with their nursing values brought painful
consequences in the form of moral distress.

5.6 Moral Distress.

The clinical nurse leaders in this study were verbose in their expression of their
feelings towards poor staff attitudes, providing the emotional truth about their
experience (Sandelands & Boudens, 2000, p.47). The meaning the concept of the
older unpopular patient for the clinical nurse leaders was feelings of anger, frustration,
hurt and distress which manifested as moral distress.

The label of moral distress involves anguish or suffering (Hannah, 2004, p.73), and
their moral distress constituted the experience being interpreted as the 'wounds of
clinical leadership' in relation to the older unpopular patient. Moral distress often
refers to the stress associated with the ethical concerns in practice (Pauly, Varcoe,
that moral distress 'arises when someone knows the right thing to do, but institutional
constraints make it nearly impossible to follow the right course of action', or 'when 'the
morally acceptable choice is thwarted by other constraints' (Bargagliotti, 2011,
p.1423). The majority of research on moral distress concerns nurses, although it is
not unique to nurses (Austin, Lemermeyer, Bergum & Johnson, 2005, p.33) and
although moral distress within nursing practice has been explored, it remains under-
researched (Gallagher, 2010, p.2). However, at the heart of moral distress are the values and beliefs of the nurse (Coverston & Lassetter, 2010, p.4).

A meta-synthesis of the qualitative evidence on nurses’ experience of moral distress in hospital settings indicated that nurses respond with a myriad of reactions including anger, loneliness, depression, guilt, anxiety, emotional withdrawal and feelings of powerlessness, and all could lead to physical symptoms (Rittenmeyer & Huffman, 2009, p.1239). Anger and frustration as responses have been reported elsewhere (Porter, 2010, p.64; Manning, 2010, p.36). In a Canadian study using large amounts of narrative data from nurses (Varcoe, Pauly, Storch, Newton & Mackeroff, 2012, p.490), anger and frustration were experienced in relation to workload, but feelings including shock, anxiety and being emotionally drained were reported. In essence, moral distress is an umbrella concept capturing a range of experiences when individuals are morally constrained either due to a personal failing such as fear, or through situational constraints such as resources (McCarthy & Deady, 2008, p.254).

Anger, frustration and loneliness are particularly pertinent to the findings of this study as this appeared to be a consistent response by the clinical nurse leaders. In addition, and of relevance again, is that a qualitative study reported that the anger experienced by student nurses was more intense if harm or neglect has been intentional (Gunther, 2011, p.244). The anger expressed by the clinical nurse leaders in this study in response to the negative attitudes and behaviours of staff, could be considered intentional by staff, and may have therefore heightened the clinical nurse leaders’ experience of anger, thus heightening their emotional response. This is an important finding which contributes to the literature in relation to the experience of moral distress in response to intentional harm and neglect.

Situational constraints in organisations are commonly reported by nurses in the moral distress literature. A Canadian qualitative descriptive study explored what ethical nursing practice constituted for hospital and community nurses. The researchers found that in nearly all the transcripts the organisational climate was problematic,
including issues with policies and resources (Storch, Rodney, Pauly, Brown & Starzomski, 2002, p.9). Resources and high workload have been reported as a cause of moral distress elsewhere (Varcoe, Pauly, Storch, Newton & Mackaroff, 2012, p.493), and the reason why nurses feel they cannot practice ethically (Storch, Rodney, Pauly, Brown & Starzomski, 2002, p.9). However, the inclusion of two survey instruments which drew attention to the potential obstacles in the organisation may have influenced responses (Varcoe, Pauly, Storch, Newton & Mackaroff, 2012, p.494).

In addition, Ward Managers have also reported a lack of time and resources as the dominant dissatisfying factor in their roles (Persson & Thylefors, 1999, p.72). In this study the constraints of the organisation were discussed by the clinical nurse leaders without prompting and were part of their wider story. Although staffing was considered to negatively impact the clinical nurse leader’s ability to develop a positive nursing culture, staffing was not considered to be the cause of difficulty with individual patients, but instead the attitudes and behaviours of their team members towards patients. This is an important finding and has implications for the current national debate on staffing levels, and raises the importance of not only staffing levels, but nursing culture, and the organisational support for positive nursing cultures for care quality.

Moral distress in response to an apparent disconnection with management has also been reported by nurses in a qualitative study in Canada (Beagan & Ells, 2007, p.48), and some of the Ward Managers in a Swedish qualitative study reported a poor relationship with managers as their key source of dissatisfaction (Persson & Thylefors, 1999, p.72). Rittenmeyer & Huffman’s (2009, p.1241) synthesis highlighted that nurses reported consistently that there is an institutional culpability in the causes of moral distress regardless of the geographical or cultural context, and moral distress is felt most intensely when advocating for a patient in the face of organisational constraints. In addition, where nurses have been unable to uphold their values on an ongoing basis, consistent disillusionment has been reported by them (Rittenmeyer &
In this study the organisational constraints reported sometimes included staffing. However, the nursing cultures the clinical nurse leaders had inherited were the primary constraint when trying to address the presence of unpopularity, and therefore this study raises the importance of nursing culture per se as a contributory factor for moral distress in clinical nurse leaders. This has implications for organisations to support clinical nurse leaders to proactively address issues in the nursing culture which negatively impact patients, as moral distress in response to organisational constraints has been found to result in nurse attrition (Rittenmeyer & Huffman, 2009, p. 1240).

Of note, in relation to this study, is that the specific patient situations which caused nurses moral distress have been found to include situations when others make negative judgements about patients and their families (Varcoe, Pauly, Storch, Newton & Mackaroff, 2012, p.491). However, this study adds how, although nurses have reported moral distress in such situations, clinical nurse leaders can also experience moral distress, contributing to current knowledge. This has implications for the well-being of clinical nurse leaders and the need for support as they strive to embed dignified and compassionate care.

The clinical nurse leaders very rarely mentioned sharing their moral distress with others, and also felt they needed to hold their composure in front of their team. From a literature review nurses have been reported to withhold talking about their moral distress, and instead reconcile their feelings alone (Coverston & Lassetter, 2010, p.8). The silence within the clinical nurse leaders' stories in this study in relation to support mechanisms has implications for the emotional well-being of clinical nurse leaders. It has been suggested that the NHS can build resilience by simply providing the opportunity for nurses to discuss the psychological and emotional aspects of their work (Gray, 2012, p.1), including the ability to reflect on difficult issues within leadership roles (Gray, 2012, p.61). Hence, it may be useful to provide clinical nurse leaders the opportunity to discuss aspects of their role causing them distress, including issues related to the unpopular patient.
5.6.1 Moral distress and caring for older people.

Although with an ageing population nurses spend most of their time caring for older vulnerable people (Pope, 2012, p.32) the literature is sparse on both moral distress in nurses caring for older people (Burston & Tackett, 2012, p.2), and in relation to long term care settings (Edwards, McClement & Read, 2013, p.325). Therefore the finding of moral distress is important. Available studies again highlighted the situational constraints which cause moral distress in older people's care settings. An interpretive descriptive study in Canada involving registered nurses in long term care settings again included resource constraints as an issue which caused moral distress. Sometimes they found support within the team. However, at times, some nurses reported their manager as difficult to talk to, which created feelings of isolation, frustration and despair (Edwards, McClement & Read, 2013, p.332). Some felt they had to muster courage to contact their manager (Edwards, McClement & Read, 2013, p.334). The study included nurses from private healthcare settings and it was suggested that the response to moral distress in different settings may differ. Yet as discussed previously, moral distress in response to organisational constraints has been found to be consistent regardless of the geographical or cultural context (Rittenmeyer & Huffman, 2009, p.1239). This study highlights that in care settings for older people moral distress is not only experienced by team members, but also by clinical nurse leaders, in this case in response to managing an individual or team who have labelled a patient, or patients, as unpopular.

5.6.2 Moral distress, the organisation and nursing leadership.

Although studies have been undertaken in relation to the moral distress nurses experience, the experience of moral distress among nurse leaders is practically absent from the nursing literature (Edmonson, 2010, p.1; Porter, 2010, p.3). However, in a review of eight qualitative research papers the high motivation of clinical leaders in residential settings to work with older people was highlighted, but also how organisational barriers de-motivated them (Dwyer, 2011, p.393). In addition, an
Interpretive study of nurse managers in acute hospitals in America revealed how they experienced a mismatch between their own professional values and those of the organisation which caused their moral distress (Porter, 2010, p.107). Moral distress was reported at times when there was a pattern of multiple demands, or a single repeating demand which was in conflict with their moral values and professional ethics. A finding to emerge was that moral distress for the nurse managers emerged over time rather than in response to one event. This did result in some participants planning to leave their roles (Porter, 2010, p.128). The role of the nurse manager appears to be not so directly engaged in care delivery compared to a clinical nurse leader in this country. However, the cumulative effect of moral distress has implications the well-being of clinical nurse leaders and for organisations regarding the retention of clinical nurse leaders.

In addition, in Storch, Rodney, Pauly et al's (2002, p.9) qualitative study, some clinical nurse leaders reported being marginalised by managers when reporting ethical concerns, and some nurses commented that the nursing leadership was as powerless as the nurses when raising ethical concerns (Storch, Rodney, Pauly et al, 2002, p. 11). Nurses have also reported having their concerns being disregarded by managers elsewhere (Varcoe, Pauly, Storch, Newton & Mackeroff, 2012, p.495). This has implications for organisations as it is those on the front line who can identify and report concerns which may harm patients. In order to avoid individual clinical nurse leaders being marginalised in such situations, a first step would be for the profession to acknowledge the concept of the unpopular patient as an ethical and a care quality concern within organisations. There are also implications for the organisation in relation to introducing a 'Leadership Charter' (Bolden, Gosling, Marturano & Dennison, 2003, p.40) which centralises the responsibility of all leaders in the organisation to act ethically when concerns are raised, and to support the clinical nurse leader in their work to address the unpopular patient.

Organisational culture can have a significant impact on the ability of leaders to achieve cultural change (Rycroft-Malone, Kitson, Harvey, McCormack, Seers, Titchen
& Estabrooks, 2002, p.176), and the ethical climate of an organisation can be seen as an important component in the creation of moral distress (Porter, 2010, p.9). Ethical climate and levels of moral distress are positively correlated, which importantly means caution must be offered in framing moral distress as an individual concern (Pauly, Varcoe, Storch & Newton, 2009, p.569). Moral distress is experienced by individuals, but is shaped by their values and beliefs, and the context, including the interpersonal context and the healthcare environment (Varcoe, Pauly, Webster & Storch, 2012, p.96). Importantly, it is not about the inadequacy of the health professional, and when considered as such, the influence of the organisation on the individual's practice is ignored (Varcoe, Pauly, Webster & Storch, 2012, p.97). In relation to the findings of this study, this is of particular significance, as the concept of the unpopular patient may well not be understood by the organisation, and this has implications for the misjudgement of those clinical nurse leaders who experience moral distress in response to this. Instead, the organisational influence on moral distress should be further explored (Pauly, Varcoe, Storch & Newton, 2009, p.569), but as discussed previously, it will also require the concept of the unpopular patient to be acknowledged by the profession and institutions in the first instance.

In relation to the findings of this study, of importance are two points that have previously been made. Firstly, the point made by Ham (2003, p.9373), that the development of followership needs as much attention as clinical nurse leadership, as the clinical nurse leaders faced an uphill struggle with the nursing culture, a culture in which the older unpopular patient developed despite the actions of the clinical nurse leader. Secondly, that there is a need to better understand how leaders are either able, or unable, to influence staff performance (Wong & Cummings, 2007, p.519), including asking whether conditions in the NHS support challenging the status quo (Hewison & Griffiths, 2004, p.472). Both these factors are important for addressing the development of older unpopular patients, and in terms of the associated experience of moral distress for clinical nurses leaders.
5.6.3 The attributes of clinical nurse leadership and moral distress.

Clinical nurse leaders are said to be respected by nurses because they stand up for high standards of care based on their values and beliefs (Stanley, 2012, p.9), and translate the meaning of caring into the nursing culture (Bondas, 2003, p.251). However, this study revealed that despite upholding their values, the clinical nurse leaders did not seem to have the respect of the nursing team when they addressed their concerns in relation to the unpopular patient. The findings of this study are therefore important as standing up for high quality care may not necessarily mean the clinical nurse leader is respected by the team. Nursing is essentially a moral endeavour (Smith & Godfrey, 2002, p.302), and although a moral orientation to practice can be considered positive, if the work situation prevents enactment of underpinning values, it has been suggested that nurses can feel responsible for the care they cannot provide (Lutzen, Cronqvist, Magnusson & Andersson, 2003, p.314). In relation to clinical nurse leadership, the findings of this study are important, as having a moral orientation and standing up to address the care quality afforded to unpopular patients clearly had its own consequences for clinical nurse leaders. Therefore the attributes of clinical nurse leadership cited in the literature, although worthy and undoubtedly positive, need to be reconsidered in the context of the organisational culture. Citing the ideal attributes and values in the absence of discussion of the consequences of less than optimum nursing and organisational climates may leave individuals open to feeling as though they have failed when they are unable to achieve their aspirations for care standards.

5.7 Moral courage in nursing.

Another important and novel finding from this study, and one which contributes to knowledge was the presence of moral courage. The experience of moral distress has been suggested to sometimes strengthen the nurse's sense of patient advocacy when witnessing others devaluing patients and their families, and when patients suffer a lack of treatment (Rittemeyer & Huffman, 2009, p.1240). Due to the different use of
terms it is unclear whether this advocacy constitutes moral courage, but it may do. The clinical nurse leaders in this study appeared to find the moral courage to pursue their aspirations for high care quality despite the challenges they faced. Courage in nursing has been said to include speaking our beliefs even when unpopular (Crigger & Godfrey, 2011, p.E13). However, it has been identified that there are few papers on moral courage in the healthcare literature, and when it is found, it relates to a lack of moral courage (Murray, 2010, p. 2) rather than to its presence, and the impact on those who demonstrate it.

In addition, there is a void in relation to courage within clinical nursing leadership and holding true to one's beliefs in order to ensure the care and protection of patients (Clancy, 2003, p.128). In this study only one participant actually voiced the need for courage, and it has been suggested that successful leaders may well have courage but often do not consider it as this (Clancy, 2003, p.128). It also is not common language (Storch, Rodney, Pauly, Brown & Starzomski, 2002, p.12) and remains a hidden part of nursing practice (Crigger & Godfrey, 2011, p E14). Rudolfsson, von Post and Eriksson's qualitative study (2007, p.317) reported the caring aspect of the clinical nurse leadership role as being to stand up and protect patients, and the clinical nurse leaders in this study described how they challenged poor practice and addressed their concerns. Nurses who take steps to address poor practice are said to display acts of courage (Crigger & Godfrey, 2011, p.E13), and this study has suggested how courage is a hidden part of clinical nurse leadership practice, which is required to address a hidden problem in nursing, the concept of the unpopular patient. Although not overtly expressed by the clinical nurse leaders in this study, moral courage may therefore be more of an important attribute of clinical leadership than has previously been identified in the clinical leadership literature.

5.8 Moral distress and moral courage.

Although systemic barriers to nurses enacting their values have been reported, it has been suggested nurse's values endure despite this (Beagan & Ells, 2007, p.2007,
p.50), and suggested that it can strengthen their commitment to their goals (McCarthy & Deady, 2008, p.257), and increase their sense of patient advocacy (Rittenmeyer & Huffman, 2009, p.1242). Importantly therefore, particularly in relation to this study, it has been suggested that repeated attempts to pursue the right course of action is not about failing, but about an inability to enact professional standards. However, although moral distress may actually refine commitment and strengthen resolve, it may also result in ethical desensitisation (Varcoe, Pauly, Webster & Storch, 2012, p.59) and nurse attrition (Rittenmeyer & Huffman, 2009, p.1240). Additionally, as discussed previously, nurses who have had moral courage have reported being marginalised by managers when reporting their ethical concerns (Storch, Rodney, Pauly, Brown & Starzomski, 2002, p.9). Therefore the suggestion that nurses who experience moral distress must develop moral courage in order to protect patients and themselves (Coverston & Lassetter, 2010, p.11), also requires the commitment of organisations to hear the situation and to act positively to support those with the necessary courage. Of significance therefore, is that although an important attribute of clinical nurse leadership is to display principles about care quality (Stanley, 2008, p.521), the potential consequences for clinical nurse leaders require much greater attention and discussion. Having moral courage can mean standing alone and feeling lonely (Clancy, 2003, p.129), and this reflects the hidden meaning of the experience of the clinical nurse leaders in this study which now follows.

5.9 The hidden meaning of the experience. A Lonely Endeavour.

Both the description of the concept and the visible meaning for the clinical nurse leaders has been presented, but hidden meaning was also found between the lines of the data which constituted the whole meaning of the interpretation. The whole meaning of the interpretation, and again a novel finding, was one of the loneliness they experienced within their roles as they endeavoured to lead their teams to have appropriate attitudes and behaviours towards the older unpopular patient. This is another important finding in relation to clinical nurse leadership which contributes to current knowledge.
5.9.1 Loneliness.

Leadership in general is often viewed as a lonely endeavour (Pittinsky & Welle, 2005, p.2; Wedderburn Tate, 1999, p.51; George, 2003, p.9; Hamman, 2013, p.54), and although the concept of loneliness is well known, it is little understood (Wright, 2005, p.19), and there is no consensus on the definition (Bekhet, Zauszniewski & Nakhla, 2008, p.208). However, loneliness has been said to consist of how people feel about the quality of their relationships in certain situations, and it can be experienced when individuals are rejected by others, and involve feelings of estrangement from others (Ozcelik & Barsade, 2007, p.2). It is suggested that it is generally agreed that it is a distressing and unwelcome experience (Casey & Holmes, 1995, p.172).

The clinical nurse leaders in this study spoke of being rejected by their teams at times, as the unpopular nurse, and feeling disconnected from the organisation in relation to their concerns about the older unpopular patient. They seemed to feel alone in their endeavour to address the presence of the older unpopular patient, and a defining attribute of loneliness has been said to be the perception of being socially unwanted or abandoned (Bekhet, Zauszniewski & Nakhla, 2008, p.209), and a feeling of being by oneself, where the person has no choice in the situation, and has not chosen to be in that place (Bekhet, Zauszniewski & Nakhla, 2008, p.210).

It has been suggested that the societal influence of self-reliance causes lonely people to feel they should deal with their own situation (Ozcelik & Barsade, 2007, p.2), and this, coupled with clinical nurse leaders feeling they need to appear proficient and perfect in their roles (Bondas, 2009, p.360), may have contributed to the clinical nurse leaders’ experience of loneliness. As the experience of loneliness was hidden between the lines of the data it is also of interest that emotions and private feelings are not necessarily the same, and neither are they always known to the individual (Fineman, 2000, p.13). It therefore may have been that the clinical nurse leaders did not conceptualise the experience as lonely, or if they did, they did not want to talk about it. Theorists have also suggested that when asked to talk about periods of
loneliness individuals can be reluctant to recall their feelings (Wright, 2005, p.9), and suggested that staff may also avoid talking about loneliness due to the associated stigma, and hide or mask their emotions (Ozcelik & Barsade, 2007, p.2).

Such influences may have also contributed to a lack of studies and the clinical nurse leaders' experience of loneliness has not been well reported (Rudolfsson & Flensner, 2012, p.278), and within nursing, the emotional demands are rarely acknowledged or studied (Gray, 2012, p.1). However, interestingly, loneliness has been reported to be experienced as part of moral distress for nurses (Rittenmeyer & Huffman, 2009, p.1239) and for health care managers (Mitton, Peacock, Storch et al, 2010, p.105).

5.9.2 Loneliness within clinical nurse leadership.

A qualitative study in the peri-operative setting in Sweden provided an interpretation of the suffering of clinical nurse leaders as both learning and non-learning (Rudolfsson & Flensner, 2012, p.278). Suffering as non-learning included feeling alone, no longer being one of the gang, and feeling as though nobody understood their work (Rudolfsson & Flensner, 2012, p.278). This was considered 'evil' when the struggle did not involve forward movement in the caring mission and brought feelings of sadness, loneliness, guilt and shame (Rudolfsson & Flensner, 2012, p.283). Sadness and loneliness reflect the findings of the experience of the clinical nurse leaders in this study, and although not clear, perhaps guilt and shame were reflected in the silence on the experience of loneliness. Although the contexts are very different, this study appears to support these findings as it illuminated the suffering experienced, as moral distress and loneliness, when the clinical nurse leaders witnessed non-caring practices which they struggled to prevent. The clinical nurse leaders' experience of loneliness has implications for the preparation of clinical nurse leaders and the realities of leadership, but more importantly has implications for how organisations support those who feel alone in their moral endeavour.
5.10 Rigour of the Research.

The rigour of an interpretive phenomenological study has direct implications for the legitimacy of the knowledge which informs nursing practice (DeWitt & Ploeg, 2005, p.214). The rigour of the research also constitutes an ethical consideration by ensuring that the participants will be part of research which is sound, and that participants do not consider it to have been harmful to have been involved in a sub-standard inquiry, thus adhering to the ethical principle of non-maleficence (Cerinus, 2005, p.76). To be judged valid a phenomenological study must embrace rigorous and appropriate procedures and reveal the lived experience (Pereira, 2012, p.19), and present faithful descriptions which researchers and readers recognise (Koch, 2006, p. 91).

De Witt & Ploeg (2006, p.221) critiqued Sandelowski’s (1996) framework for rigour in qualitative studies and proposed a framework intended to be concordant with the unique features of interpretive phenomenology. Hence the criteria for rigour within this study was de Witt & Ploeg’s (2006, p.223) expressions for interpretive qualitative studies. Table 5.1 presents de Witt and Ploeg’s criteria for rigour and how this was achieved within this study.

Table 5.1 Ensuring rigour embracing de Witt and Ploeg’s 2006 criteria.

<table>
<thead>
<tr>
<th>Expression of Rigour</th>
<th>How this was achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balanced Integration (Expression related to process); Articulation of chosen philosophy and its fit with the researcher and the research topic.</td>
<td>Rationale given for the chosen philosophy and its fit with the researcher’s beliefs and the research topic.</td>
</tr>
<tr>
<td>Including philosophical concepts within the study methods and findings.</td>
<td>The concepts relevant to the study were included in the methods and where relevant within the findings.</td>
</tr>
<tr>
<td>Balance between the voice of the participant and the interpretation.</td>
<td>Inclusion of the verbatim quotes. Verbatim quotes chosen to deepen the understanding of the meaning of the experience of the participants and</td>
</tr>
<tr>
<td><strong>Openness (Expression related to Process)</strong>;</td>
<td>to support the interpretation. Balance within the findings between the voice of the participants and the interpretation.</td>
</tr>
<tr>
<td>Explicit accounting for the multiple decisions in the research process.</td>
<td></td>
</tr>
<tr>
<td><strong>Concreteness (Expression related to Outcome)</strong>.</td>
<td>Decisions about the approach to the study are recorded. Decisions related to inclusion criteria, cessation of data collection and making the interview guide available. The movement of data and the development of themes and sub-themes which created the final interpretation are made explicit. Inclusions from the researcher's journal are provided.</td>
</tr>
<tr>
<td>Readers recognise the findings because they are written in a way which situates them in the context and links with their own experiences.</td>
<td>The findings have been written in a way to remain faithful to the participants’ experience. The implications of the findings for nursing practice have been discussed.</td>
</tr>
<tr>
<td><strong>Resonance (Expression related to Outcome).</strong></td>
<td></td>
</tr>
<tr>
<td>The felt effect of reading the study upon the reader when understanding the meaning is juxtaposed with self-understanding.</td>
<td>The findings of the study have been presented to colleagues and it was reported that the finding of loneliness resonated with their experience.</td>
</tr>
<tr>
<td><strong>Actualisation (Expression related to Outcome)</strong></td>
<td></td>
</tr>
<tr>
<td>The future realisation of the resonance of the findings by readers.</td>
<td>This expression remains to be tested.</td>
</tr>
</tbody>
</table>

However, the framework was acknowledged as having weaknesses and the tensions within openness, between the audit trail and the thinking process during analysis have been highlighted in Section 3.11.1. The second tension discussed with balanced integration is the need to fit the findings to the philosophical concepts versus the privileged voice of the participant (de Witt & Ploeg, 2005, p.226). As this tension was felt, the researcher decided to highlight the fit with philosophical concepts when this was particularly evident in order to preserve the clinical nurse leaders’ voice.

### 5.11 Strengths and Limitations.

The strengths and limitations of the study are now discussed.
5.11.1 Strengths.

The study is the first study which has specifically explored the experience of clinical nurse leaders in relation to the unpopular patient, and this brings a unique contribution to the body of knowledge. As the role of the clinical nurse leader is upheld as important within national drivers to improve care quality, and the existence of the unpopular patient can be said to constitute undignified care, it was important to further explore the experience of the clinical nurse leader. The setting for the study, community nursing services, covering multiple settings, also adds a new dimension to what is already known, as previous studies of the unpopular patient focused on acute care environments.

The choice of hermeneutic phenomenology brought a significant strength to the study which descriptive phenomenology would not have achieved. This is because in the process of hermeneutic interpretation the researcher also aims to uncover what is not expressed, that is, the sub-text of the experience, in order that a new understanding of the whole experience is revealed. The meaning of the experience for the clinical leaders had both expressed meaning, and hidden meaning. The process of revealing hidden meaning was achieved by intense listening to what was not said by the clinical nurse leaders and consideration, and reconsideration of the language and meaning conveyed by them within the narrative. Being able to listen to the audio-recordings many times assisted with revisiting intonation and this enabled me to ‘be with’ the clinical leaders again, feeling the experience we shared. The need to read and ‘feel’ between the lines as part of hermeneutic interpretive analysis has assisted developing the interpretation.

The study has meant that an important aspect of older people's care quality has been explored from a different perspective. The illumination of the clinical nurse leaders' experience uncovered the daily reality of their work as they worked to uphold their values, and the uphill struggle they faced in daily practice. Within their teams, the problem of the unpopular patient remained embedded within nursing practice and
presented a particular challenge within their clinical nurse leadership roles. Within their organisations, they felt that neither their values, nor their struggle with the unpopular patient was fully appreciated. The study has served to revisit the issue of the unpopular patient as a clinical nurse leadership concern, and one which has significant consequences for clinical nurse leadership in terms of the moral distress and loneliness experienced in response to the unpopular older patient in practice. The study has also served to highlight the moral courage clinical nurse leaders require when powerful nursing cultures resist those attributes of clinical nurse leadership which are cited as important for care quality.

5.11.2 Limitations.

The study had some limitations. The sample was all female as no males came forward, but male nurses are underrepresented in these older people’s settings in nursing. It is not known whether the inclusion of males would report a different experience to females and as this is not known, this has implications for the findings of the study in terms of whether male clinical nurse leaders will recognise the experience as one they are familiar with.

Eleven clinical nurse leaders were a reasonable sample size for this methodology, and it was not possible to know whether new data would have emerged if greater numbers had come forwards. However, obtaining high quality data was the optimum consideration, and the number of participants less important (McConnell-Henry, Chapman & Francis, 2011, p.34).

The study explored the experiences of one set of clinical nurse leaders in one county in community nursing settings, and whilst the aim was to seek depth of understanding it would be useful to explore whether clinical nurse leaders in other nursing settings in this country have a similar experience in relation to the unpopular patient.
Although the clinical nurse leaders shared their experiences in detail, including their emotions, the presence of the researcher as a more senior nurse may have limited further discussion about the experience of loneliness for reasons discussed in Section 5.8.2, such as needing to feel proficient in their roles. It is also not known whether clinical nurse leaders would discuss any experiences of loneliness with a researcher from a non-nursing background for the same reasons cited in Section 5.8.2.

5.11.3 This interpretation.

These findings are acknowledged as one interpretation of the whole experience which can be challenged by another interpretation, meaning that full explanation of the is never achieved. The final interpretation presented is one possible account of the perceptions, understandings and meanings (Koch, 1999, p.33) of the concept of the unpopular patient for clinical nurse leaders in community settings for older people.

The findings of this study, when read by other clinical leaders, will confirm whether this interpretation is something they have experienced. The experience of loneliness and whether it resonates with readers is important, as it has intuitive meaning for most people (Wright, 2005, p.13). If the findings resonate with the reader now or in the future, or that this may occur in the future (de Witt & Ploeg, 2006, p.226), then ‘actualisation’ or the ‘phenomenological nod’ (Van Der Zalm & Bergum, 2000, p.212) would be achieved, but the intent has been to remain faithful to the experience of the clinical nurse leaders.

5.12 Summary of Implications.

From the analysis of the findings and the evidence, key implications for professional practice, education for professional practice, organisations and research have been discussed. Table 5.2 summarises these.
Table 5.2 Summary of Implications.

**Professional Practice.**

- The issue of the creation of the unpopular patient urgently requires open discussion within the nursing profession. Without acknowledgement that this exists within nursing, the causes cannot be considered, and strategies to address it not developed.
- The presence of the unpopular patient is also developed by nurses in settings for older people, as in other settings, and older people may be more vulnerable than other patient groups. There needs to be a heightened awareness of the issue of avoidance of older unpopular patients and the potential risk of harm.
- Further consideration should be given to the attitudes and behaviours which create unpopularity and attention given to their greater articulation and understanding, in order that they can be addressed.
- The confusion about the need to like all patients should be openly discussed in clinical teams and a respectful culture developed.
- Greater recognition of the challenges of the transition into clinical nurse leadership are needed, and mechanisms put in place to support this transition, in particular to be able to adjust to moving into the leadership role, and support to avoid where possible, learning by trial and error.
- Greater recognition that where clinical nurse leaders base their actions on their values and beliefs, that negative emotions may be experienced by them when these are breached by team members.
- Consideration should be given to how best to support clinical nurse leaders, acknowledging that a range of strategies may be needed. This should include time to reflect on leadership learning and the consequent professional growth which can be gained.
- Consideration needs to be given to the language used to make explicit the attribute of moral courage within clinical nurse leadership.
- Consideration needs to be given by organisations to understand their nursing cultures, and to consider the presence of an unpopular patient as a potential indicator of concern for patient care quality.
- The expertise which clinical nurse leaders develop in relation to scanning their worlds
for indicators of problems should be further considered and articulated so that this expertise can be shared.

**Education for Professional Practice.**

- As the concept remains hidden in nursing practice, undergraduate and post graduate education programmes can assist in raising awareness about the issue. Consideration can be given to including the concept in clinical nursing, clinical leadership and management programmes.
- Education programmes could include a focus on addressing nursing ideals, that is, challenging the ideal that nurses like all patients, and instead promoting respectful, compassionate and dignified care.
- Clinical nurse leadership programmes could focus on the transition into a leadership role, making explicit the experiences which may follow and how best to work with these.
- Education programmes can assist nurses to explore how to work positively with patients they dislike, including strategies for identifying the meaning of the patient's behaviours when interpersonal conflict develops.
- Clinical leadership development programmes for nurses making the transition to clinical nurse leader should consider including issues such as the moral courage needed to live values, its possible consequences, strategies to manage moral distress, and leading teams which require cultural change in relation to the development of the unpopular patient.

**Organisations.**

- For clinical nurse leaders to be supported to address the issue of the unpopular patient, its existence in nursing practice needs to be acknowledged within the organisation, and its implications for poor care quality and avoidable harm understood, as part of the wider care quality agenda.
- Organisations can take steps to understand the nursing cultures in their clinical areas and ways in which assurance can be gained in relation to these. The development of the unpopular patient can be considered as a potential indicator of aspects of the culture which need to be addressed.
- Organisations can consider establishing robust mechanisms to support clinical nurse leaders in relation to the reality of everyday leadership practice, particularly at the point of transition into a clinical nurse leadership role.
• Organisations can ensure that regular clinical supervision and robust mentorship is in place for clinical nurse leaders at the point of transition into the role and on an ongoing basis.
• Organisations can review their policies and procedures to ensure that, when needed, they can address the attitudes and behaviours which create the unpopular patient, including actions such as avoidance and labelling.
• Organisations need to be aware of the potential rejection of clinical nurse leaders who strive to address poor attitudes and behaviours, and ensure robust support is in place during the work to ensure cultural change.
• Organisations should consider how to develop followership in clinical teams.
• Organisations could provide structures to genuinely support clinical nurse leaders who experience moral distress.
• Organisations must acknowledge the discriminatory nature of the creation of the unpopular patient, and the breach this constitutes in relation to espoused ethical standards and organisational values, professional codes of practice and conduct, and relevant policies.

Research.
• The study should be repeated in different clinical settings to understand if other clinical nurse leaders share similar experiences in relation to the unpopular patient.
• Greater understanding of the clinical nurse leader's role in relation to the unpopular patient can be further informed by approaches such as participant observation in order to observe how the clinical nurse leader addresses concerns about the unpopular patient.
• Further research is needed in relation to how the clinical nurse leader develops a caring and compassionate nursing culture, and factors which assist or inhibit this, with a particular focus on followership and organisational climate.
• The experiences of moral distress, moral courage and loneliness within the clinical nurse leadership role are worthy of further research.
• The concept of nursing conscience within clinical nurse leadership and clinical nurse leadership expertise is worthy of further research.
5.13 Conclusion.

The findings provide some insights into the complex landscape in which the clinical nurse leader works in relation to the older unpopular patient as an ethical concern. Upholding one’s nursing values is pronounced within the nursing literature as positive within clinical nurse leadership roles, but the consequences for the individual, of living authentically as a clinical nurse leader, should not be underestimated.

The clinical nurse leaders in this study were working to fix a hidden problem in nursing, the unpopular patient. Upholding their nursing values resulted in the experience of moral distress, an area which also remains under-researched (Gallagher, 2010, p.2), and as an experience is practically absent from the nursing literature in relation to nursing leadership (Edmondson, 2010, p.1; Porter, 2010, p.3). To do this, they showed moral courage, but there is also a void in relation to courage within clinical nursing leadership (Clancy, 2003, p.128). In addition, the hidden meaning of the experience, loneliness within clinical nurse leadership, has not been well reported either (Rudolfsson & Flensner, 2012, p.278). This study focused on the older unpopular patient. However, the findings in relation to their struggle to address their concerns, and reporting feeling unsupported by their organisation, has important implications for research into the lived reality of the clinical nurse leadership role. This is especially in today's health care climate where clinical nurse leaders are held as central to care quality improvement, and therefore the factors which help or inhibit clinical nurse leaders in achieving this are worthy of further exploration.

5.14 Original contribution to knowledge.

This study makes a unique contribution to the body of knowledge on the unpopular patient firstly by exploring the issue of the unpopular patient in community nursing settings, and most importantly as the first study to take a unique perspective and explore the experience of the clinical nurse leader in relation to the unpopular patient. The concept of the unpopular patient is hidden within nursing but its presence is
known to negatively affect care quality. As the role of the clinical nurse leader is central to improving care quality, the experience of the clinical nurse leader in relation to the unpopular patient was important to study. This study adds to the body of literature in relation to the existence of the older unpopular patient, and also adds that the older unpopular patient exists in community nursing settings as well as acute nursing environments.

In addition, this study has illuminated the experience of the clinical nurse leader when trying to mitigate the development of the unpopular patient. The novel findings related to the experiences of moral distress and moral courage within clinical nurse leadership contribute to the body of knowledge particularly in relation to clinical nurse leadership. The whole meaning of the interpretation as the experience of loneliness is another important and novel finding and contributes to the literature on the experience of loneliness within clinical nurse leadership. The clinical nurse leaders felt separated from their team, and felt that their work was not understood by the organisation, and yet they were working to embed the espoused values of dignity, respect and compassion within their teams. With the national emphasis on the importance of clinical nurse leadership for high quality care, there are implications for a greater unification of not only espoused values, but enacted values within organisations, including the support for clinical nurse leaders who work to address sub-optimum attitudes and behaviours.
6.0 CHAPTER SIX- THE RESEARCHER’S REFLECTIONS

6.1 Introduction.

This final chapter records my personal reflection on undertaking the Professional Doctorate Programme.

6.2 Choosing the appropriate programme of doctoral study.

I wanted a doctoral programme which was clinically focused and supported my professional development, and Professional Doctorates are rooted equally in the context of academe, the profession and the practice context of the student (Rolfe & Davies, 2009, p. 1268). It has been said that the traditional PhD prepares 'professional scholars' of nursing whilst the professional doctorate prepares 'scholarly professionals' (Carr & Galvin, 2005, p. 604). For me, the latter is well suited to my personal career plan. However, consistent changes in structures and roles within healthcare mean that the necessary continuity for doctoral work is challenging (Fulton, Kuit & Sanders, 2012, p. 132), and continual changes to my professional role has meant tenacity was required in order to complete the programme.

A previous study has shown that the reason nurses joined the Professional Doctorate programme (and not the traditional PhD), was that their primary interest was excellence in clinical practice (Loomis, Willard & Cohen, 2006, p. 6; Cleary, Hunt & Jackson, 2011, p. 275). I too wanted to further develop professional practice in the real world context. This includes the difficulties and complexities of the world of nursing for which the Professional Doctorate is advocated (Fulton, Kuit & Sanders, 2012, p. 131), and the link to doctoral education with practice based questions (Smith, 2009, p. 8).
6.3 Reflections on the chosen study.

At the outset of the programme my interest in the subject area of the unpopular patient was motivated by a range of experiences within my professional practice. I wanted to pursue this topic in more depth in contemporary nursing practice. I have now had the opportunity to explore an issue which challenges nurses and negatively impacts on the care standards for older people. Having a Consultant Nurse role during this programme which involves working with vulnerable groups, and working in partnership with clinical nurse leaders, has meant that the study has been of interest to colleagues during its progression. My experience to date has meant that I have worked with care providers to explore their nursing cultures when care quality has been found to be compromised, and this has been found to be particularly beneficial in seeking some of the root causes of the problem. The five core functions of Consultant Nurses are considered to be expert practice, professional leadership, consultancy, education and development, and practice and service development linked to research and evaluation (McEvoy & Johnson, 2005, p. 101). This programme has supported me to work across the five core functions, taking my learning and working to support services to improve care quality.

Many students on Professional Doctorate programmes choose to explore practice issues within Schön's (1987) 'swampy lowlands' of professional practice, or what Ritter and Webber (1973) referred to as 'wicked problems' (Fulton, Kuit & Sanders, 2012, p. 132). In addition, the distinguishing characteristic of doctoral study is the ability to develop original knowledge, and in the case of the Professional Doctorate, knowledge for a professional discipline (Smith, 2009, p. 13). The opportunity to be a practitioner researcher and to employ a phenomenological approach to explore the lived experience of what could be deemed a wicked problem, in order to develop new knowledge for nursing, has been particular motivating. As Einstein said,

"Not everything that can be counted counts, and not everything that counts can be counted."

(Albert Einstein)
I feel I have gained insight into the experience of clinical nurse leaders, and their stories provided a novel perspective. An implicit component of the professional doctorate is personal transformation, that is, viewing the practice world with fresh eyes, being unconstrained by the norms of many years of practice (Fulton, Kuit & Sanders, 2012, p. 132). Being in a senior clinical function means being in a position where I can ask the difficult questions about unpopularity with fresh eyes. I can also influence the issues which should receive greater attention, and issues related to support for clinical nurse leaders. I can consider whether the unpopular patient is a symptom of a nursing culture which may require attention, and this is now firmly within the consciousness of my own leadership endeavour, and daily work. It has been suggested that the preparation of doctoral nurses can provide a different voice about practice (Smith, Glasgow & Zoucha, 2011, p. 218). It has also been highlighted how professional growth occurs during a Professional Doctorate programme (Ingleton, Ramcharan, Ellis & Schofield, 2001, p. 1471). The findings of my study have now influenced many aspects of my role including leading others to consider the context of care, the organisational culture, and a depth of awareness in relation to unpopularity and its potential consequences, particularly for older people.

6.4 The personal journey.

During Part One of the programme, students came together for lectures and seminars. Working within a cohort brought advantages in the early days of the programme. The traditional PhD and the professional doctorate differ insofar as the latter progresses as a cohort rather than the individual study journey for the PhD (Smith, 2009, p. 11). The shared journey with peers from a range of professional backgrounds was helpful in the early days. However, undertaking the programme alongside busy professional life is challenging, and the journey had its highs and lows. Yet,

‘Seeing much, suffering much, and studying much, are the three pillars of learning’.
In many ways the doctoral journey includes those details not expressed in the literature, but of no less significance, because the personal journey holds memories too. My two dogs have devotedly sat at my side every time I have sat down to think, and I suggest that at a minimum they deserve an ‘honorary dogtorate’ for their devotion to the cause.

‘It's funny how dogs and cats know the inside of folks better than other folks do, isn’t it?’

Finally, the learning gained from the programme has been multi-faceted, including academic learning and professional development. Not least it has taught me more about myself and my ability to be tenacious when professional and academic demands coincide!

6.5 Dissemination.

On reflection, one of the most simple dissemination techniques has been to discuss the study with other practitioners. This has helped to develop a local intrigue about the concept which can only be positive as it has attuned colleagues to the concept of interest. However, clinical scholarship also includes wider dissemination in order to result in a new understanding of nursing phenomena, and to influence care outcomes (Gonzales & Esperat, 2011, p. 200). My plan for dissemination is therefore listed below.

1. Presentation given to local NHS Trust-Autumn, 2012- completed
2. Presentation to local NHS Clinical Commissioning Groups Clinical Governance Committees- Spring, 2015.
3. Providing participants with a copy of the Executive Summary - Spring, 2014.
4. Providing Directors of Nursing within the sponsoring organisations with a copy of the study- Spring, 2014.
5. Presenting the study to under graduate and post graduate students of nursing at the University of Southampton- October, 2013-completed (Appendix Eight).
6. Acceptance for publication in an international peer reviewed journal- Spring, 2015.
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Appendix One

Permission from the Portsmouth and Isle of Wight Research Ethics Committee
16 October 2009

Mrs Jacqueline Metcalfe
Consultant Nurse for Older People and Complex Care

ISLE OF WIGHT, PORTSMOUTH & SOUTH EAST HAMPSHIRE
RESEARCH ETHICS COMMITTEE
1st Floor, Regents Park Surgery
Park Street, Shirley
Southampton
Hampshire
SO16 4RJ
Tel: 023 8036 2863
Fax: 023 8036 4110
Email: sc:sia.SEHREC@nhs.net

Study Title: A Heideggerian Hermeneutic exploration of the meaning of leading a clinical nurse leaders of hospital and community nursing teams caring for an older 'unpopular patient'.

REC reference number: 09/H0501/58
Protocol number: 1

Thank you for your letter of 28 September 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.cfforum.nhs.uk](http://www.cfforum.nhs.uk). Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.
It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
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<td>Letter from Dr R Stores</td>
<td></td>
<td>04 June 2009</td>
</tr>
<tr>
<td>Letter from Faculty Research Degree Committee</td>
<td></td>
<td>04 June 2009</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>1</td>
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<td>Participant Information Sheet</td>
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<td>Letter of invitation to participant</td>
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<td>Protocol</td>
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<td>Interview Schedules/Topic Guides</td>
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Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0501/58 Please quote this number on all correspondence

Yours sincerely

Mr David Carpenter
Chair

Email: scsa.SEHREC@nhs.net

Enclosures: “After ethical review – guidance for researchers” SL- AR2 for other studies

Copy to:
Appendix 2

Organisational Research and Development Permissions from NHS Trusts
12/02/2010

Mrs Jacqueline Metcalfe

Dear Mrs Jacqueline Metcalfe

Study: A Heideggerian hermeneutic exploration of the meaning of leading a clinical nurse leaders of hospital and community nursing teams caring for an older ‘unpopular patient’.
Research Ref: MWP/1079/09

I am pleased to tell you that the above project has been approved by

Trust.

R&D approval is separate from ethics approval and is also essential for the conduct of research within NHS trusts. It is subject to the following requirements.

1) It is a condition of the approval that the project is carried out according to Good Clinical Practice and within the guidelines of the NHS Research Governance Framework. You have responsibility for ensuring that you and any co-workers adhere to the protocol agreed by the ethics committee.

2) If there are any alterations to the protocol after the study has commenced, you must inform the Research Ethics Committee and the Trust Research Management & Governance (RM&G) Office.

3) It is my duty to remind you that as Chief Investigator you may be required to provide us with project monitoring and outcome information.

In the event that you have applied to have this study adopted onto the UKCRN Clinical Research Portfolio, we take this opportunity to remind you of your responsibility for uploading accurate data for our organisation should adoption subsequently be confirmed and we become a participating site. (http://www.ukcrn.org.uk/index-clinical/portfolio_newP_accrual.html)

Please do not hesitate to contact us should you require any additional information or support.

Yours sincerely

Research Governance Officer

On behalf of DI R&D Lead
18 February 2010

Mrs. Jacqueline Metcalfe

Heideggerian hermeneutic exploration of the unpopular patient
Research Ref: MWP/079/09

I am pleased to tell you that the above project has been approved by the
R&D committee to recruit patients under the care of the Trust.

R&D approval is separate from ethics approval and is also essential for the conduct of research within NHS trusts. It is subject to the following requirements.

1) It is a condition of the approval that the project is carried out according to Good Clinical Practice and within the guidelines of the NHS Research Governance Framework. You have responsibility for ensuring that all participants give informed consent and that you and any co-workers adhere to the protocol agreed by the ethics committee.

2) If there are any alterations to the protocol after the study has commenced, you must inform the Research Ethics Committee and the Research Management & Governance (RM&G) Office.

3) It is our duty to remind you that as Principal Investigator you will be required to provide us, at least annually, with project monitoring and outcome information.
Audit of adherence to research procedures is undertaken and you will be required to make yourself available for this when required. Investigators who fail to provide timely information on Projects may compromise their ability to obtain Trust approval in the future.

Yours sincerely

[Signature]

Director of Clinical Excellence and
Director of Infection Prevention and Control
Appendix 3

Letter of Invitation to Join the Study
LETTER OF INVITATION

Dear

I am inviting you to participate in the following study titled;

A Heideggerian Hermeneutic exploration of leading hospital and community clinical nursing teams caring for an older 'unpopular' patient.

The research is in part fulfilment for my Professional Doctorate in Nursing. The reason you have been invited to join the study is that you are the clinical nurse leader for a hospital or community nursing team. I attach an information sheet for you to read to provide you with greater detail about the study and how it will be undertaken so that you can decide whether you would like to participate.

If you do decide to participate in the study, please contact me directly. I will then meet with you to obtain informed verbal and written consent. Should you wish to discuss the study in more detail please contact me on 07900 325732.

I look forward to hearing from you.

Yours Sincerely,

Jacqueline Metcalfe
Consultant Nurse for Older People and Complex Care.
Appendix 4

Participant Information Sheet
INFORMATION SHEET

1. Study title

A Heideggerian Hermeneutic exploration of leading hospital and community clinical nursing teams caring for an ‘unpopular patient’.

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

3. What is the purpose of the study?

The researcher has reviewed the literature which is available on the ‘unpopular patient’. The purpose of this study is to further understand the relationship between the clinical leader and the unpopular patient in nursing teams in community hospitals and community teams.

This study is in part fulfilment of the Professional Doctorate in Nursing at the University of Portsmouth.

4. Why have I been chosen?

You have been chosen to participate in this study because your professional role involves leading a clinical nursing team in a community hospital or a community nursing team. The researcher anticipates that about ten people will be invited to participate in the study. However, if the required data is not obtained, the researcher will invite more people to participate in the study. If many people are willing to participate, it may not be possible to include everybody. However, if you are willing but unable to participate, you can request a copy of the Executive Summary once the study is completed.

5. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

If you decide to take part in the study, you be invited to an interview. The researcher will ask you about your experience of leading a team caring for an unpopular patient. The interview will last between one
and two hours and will be audio-recorded using a very small digital device. The research is likely to take about three months to have time to interview all the people who agree to take part.

1. **What do I have to do?**

The researcher will record the interview and then transcribe the information provided. No other person will have access to the information you provide. The researcher will return your transcript to you so that you are able to check the accuracy of the information you provided. You will also be able to remove any information you decide you do not want included in the study.

8. **What are the other possible disadvantages and risks of taking part?**

The researcher will contact you to arrange a mutually convenient time to meet for the interview. The researcher will locate a room where the interview can take place undisturbed. The potential disadvantage is that this type of interview can reveal quite sensitive topics, however, you retain control over the information you choose to disclose to the researcher. Should you become upset, the researcher will not pursue the topic unless you wish to do so.

9. **What are the possible benefits of taking part?**

The benefits of taking part in this study are the ability to share information from nursing practice which will illuminate aspects of practice which have not formerly been researched. This will assist current and future practitioners to further understand the area of practice being explored.

10. **What if there is a problem?**

You can contact the researcher any time to discuss the study on 07900 325732.

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The contact number for complaints is;

.........................., R and D Co-ordinator on 02380 241070

11. **Will my taking part in the study be kept confidential?**

Due to the nature of this study, absolute confidentiality cannot be guaranteed. However, every effort will be made by the researcher to protect it. Your data will be transcribed through a personal computer which is password protected. Your name will not be used and you will be given a pseudonym to provide anonymity. Any names or places, or any details you give which may identify you will be removed. Hard copies of transcriptions will be held in a locked filing cabinet. The audio-recordings will be deleted from the digital device and the transcriptions will be shredded on completion of the study. The researcher’s programme of study is completed by the end of 2010 and therefore data will not be held for any longer than this. It will not be used for any future research.

12. **What will happen to the results of the research study?**

The results of the study will be presented at presentation and viva for the part fulfillment of the Professional Doctorate in Nursing at Portsmouth University. The Executive Summary will be available to you should you wish to see it. The researcher intends to publish the results of the study in a peer reviewed academic nursing journal. The anonymity given in the report will be preserved in any publication. You will be asked to consent to this.
13. **Who is organising and funding the research?**

The researcher works for ........................................ is supporting the research. The University of Portsmouth Ethics Committee and the Wessex Regional ethics Committee have reviewed the research.

14. **Contact Details:**

The researcher is Jacqueline Metcalfe, Consultant Nurse for Older People and Complex Care, ........................................ You can contact her on 07900 327532 if you have any questions about the research. Alternatively, you can contact ........................................

The researcher would like to thank you for taking the time to consider participation in this study.
Appendix 5

Informed Consent
CONSENT FORM

Title of Project: A Heideggerian Hermeneutic exploration of leading hospital and community clinical nursing teams caring for an older ‘unpopular patient’.

Name of Researcher: Jacqueline Metcalfe

Please initial box

I confirm that I have read and understand the information sheet dated 9th July, 2009 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

I agree to audio recording of interviews

I agree to take part in the above study.

I agree that the researcher can publish the study.

I would like a copy of the Executive Summary

_________________________________________  ______________________  ______________________
Name of Participant Date Signature

_________________________________________  ______________________  ______________________
Name of Person taking consent (if different from researcher) Date Signature

_________________________________________  ______________________  ______________________
Researcher Date Signature
Appendix 6

Interview Schedule
Interview Schedule

Title: A Heideggerian Hermeneutic exploration of leading hospital and community clinical nursing teams caring for an older 'unpopular' patient.

Researcher: Jacqueline Metcalfe. Student Number 52522.

Section One-Opening the dialogue;

This section aims to develop dialogue with the participant, focusing on popular patients which will illuminate contrary cases to the phenomenon.

Can you tell me about a time when the team were caring for somebody they really enjoyed looking after?
What was this time like for you as the clinical leader?
What was it that made this such a positive experience for the team?

Continuing the dialogue;

This section aims to get description about the role of the clinical leader and what this means to them.

Can you tell me about a time when the team were caring for somebody they did not enjoy caring for?
Tell me about the patient?
What was it like for you as the clinical leader of this team?
Were you able to influence the situation?
How did it progress?
What was that like for you?

Additional Topics to be covered;
Appendix 7

The development and movement of themes and sub-themes.
### Outline of theme development and movement to form the final construction

#### Phase One
- Leadership gaze/radar
- Reactions to challenge
- Honesty
- Emotional reactions/being authentic
- Positive support
- Setting the tone/Leadership virtues
- Creativity
- Lack of support
- Details in care
- Nearby Leadership

#### Phase Two
- Positive support/creativity → Nearby Leadership
- Setting the Tone developed into
- Reaction to Challenge → New theme-Climate of Care
- Lack of Support → Organisational Culture
- Honesty
- Emotional Reactions
- Leadership Gaze/Journey
- New theme-Knowing Difficulty
- separated from Climate of Care
- Nearby Leadership

#### Phase Three
- Organisational culture → Climate of Care
- Honesty
- Emotional reactions
- Leadership Gaze/Journey
- Nearby Leadership
- Knowing Difficulty
- Nearby Leadership

#### Phase Four
- Nearby Leadership → Climate of Care
- Honesty
- Emotional Reactions
- Knowing Difficulty
- Leadership Gaze
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<td>Leadership Gaze</td>
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Appendix 8

The Robustness of the themes and sub-themes
The robustness of themes and sub-themes

Theme One - Knowing the Unpopular Patient.

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<th>Sub-theme- Understanding Popularity</th>
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Theme Two - Being Faithful.

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### Theme Four- Joined at the Hip.

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### Theme 5- Growing into Leadership.

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Appendix 8

Invitation to teach undergraduate nurses
September 20th 2012

Re: Presenting research project “The lived experience of clinical nurse leaders and the unpopular patient” at the University of Southampton.

Dear Jaki

Thank you for discussing your research with me, it sounds very exciting.

I am taking up the leadership of our year 3 undergraduate module entitled ‘Leadership and Management’ and I would very much like you to share your research with our students. I am particularly keen that they gain an understanding for how the leadership and management skills of qualified nurses are crucial in maintaining quality, and I believe that your research can help them to explore this.

My module is running alongside the Research module (in preparation for their dissertation which will be focussed on leadership and management), and it would also be useful if you could tell them a little bit about your chosen methodology. They have quite an unsophisticated view of research at this stage so it would need to be a basic and pragmatic view of your work.

There will be approximately 350 students from three fields of nursing (child, mental health and adult) and the session is 45 minutes long. The module starts on September 30th 2013 and runs until October 25th 2013. The precise dates for the sessions are not yet set, and if you are able to speak we can organise your session for when suits you within these timeframes (subject to lecture theatre booking).

Thank you again for offering to share your research with our students.

Regards

[Signature]

Kim Bezzant, lecturer in the Faculty of Health Sciences
# FORM UPR16
## Research Ethics Review Checklist

Please complete and return the form to Research Section, Quality Management Division, Academic Registry, University House, with your thesis, prior to examination.

<table>
<thead>
<tr>
<th>Postgraduate Research Student (PGRS) Information</th>
<th>Student ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidate Name: Jacqueline Metcalfe</td>
<td>52522</td>
</tr>
<tr>
<td>Department: Health Sciences and Social Work</td>
<td>First Supervisor: Dr Ann Dewey</td>
</tr>
</tbody>
</table>

**Start Date:**
- 2007
- (or progression date for Prof Doc students)

<table>
<thead>
<tr>
<th>Study Mode and Route</th>
<th>Part-time</th>
<th>Full-time</th>
<th>MPhil</th>
<th>MD</th>
<th>PhD</th>
<th>Integrated Doctorate (NewRoute)</th>
<th>Prof Doc (PD)</th>
</tr>
</thead>
</table>

**Title of Thesis:**
A Lonely Endeavour: Clinical Nurse Leadership and the Older Unpopular Patient in Community Settings.

**Thesis Word Count:**
48,571 (excluding ancillary data)

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If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study.

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

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**UKRIKO Finished Research Checklist:**
(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: [http://www.ukrio.org/what-we-do/code-of-practice-for-research/](http://www.ukrio.org/what-we-do/code-of-practice-for-research/))

|   | YES |
---|-----|
(a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame? | YES |
(b) Have all contributions to knowledge been acknowledged? | YES |
(c) Have you complied with all agreements relating to intellectual property, publication and authorship? | YES |
(d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration? | YES |
(e) Does your research comply with all legal, ethical, and contractual requirements? | YES |

*Delete as appropriate*
Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

<table>
<thead>
<tr>
<th>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</th>
<th>15057</th>
</tr>
</thead>
</table>

Signed:  
(Student)  

Date: 5th December 2014

If you have not submitted your work for ethical review, and/or you have answered 'No' to one or more of questions a) to e), please explain why this is so:

Signed:  
(Student)  

Date: