EXPERIENCES OF FRONTLINE NURSES ABOUT THE ENAYATAK NURSING MODEL OF CARE IMPLEMENTED IN A PUBLIC HEALTH CARE FACILITY IN THE EMIRATE OF ABU DHABI, UNITED ARAB EMIRATES

by

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third-party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2020

ABSTRACT

In the United Arab Emirates (UAE), the healthcare system is challenged by a workforce and population diverse in culture, background and education. In 2016 a public-sector healthcare organization in the UAE, implemented the Enayatak Nursing Model of Care across its hospitals to generate a unified approach to nursing delivery. Since the implementation of the Enayatak Nursing Model of Care, their has been no research about this model. The aim of this research study was to explore and describe the experiences of frontline nurses about the Enayatak Nursing Model of Care.

The researcher utilized an exploratory-descriptive qualitative study design. The study setting was a public sector hospital of Abu Dhabi in the UAE and the study population was frontline registered nurses. Purposeful sampling was utilized to identify study participants to take part in semi-structured interviews to collect data. The study met all ethical principles of research. The trustworthiness of the study was addressed by member checking, the use of a fieldworker, reflexivity, bracketing and providing elaborate detail of the steps and emergent details of the study.

The themes that emerged from the study were: drivers of implementation, strategies, perceived benefits, leadership support, challenges and sustainability. It was evident from participant responses that the mandated strategies of the model need flexibility depending on the practice environment. There were variances in reports from participants around leadership support and integration, and sustainment of the model in the staff's daily practice. There was an overall agreement from the participants that the implementation of the Enayatak Model of Care was a large-scale project that was transformational with regard to patient care and staff experiences and directed and unified their nursing practice.

Change management, total quality improvement theory, individual and collective leadership support are critical requirements for the implementation of a model of care. This study could benefit and provide guidance for hospital group leaders interested in developing a Nursing Model of Care for their hospitals.

OPSOMMING

In die Verenigde Arabiese Emirate (VAE) is ‘n arbeidsmag en ‘n bevolking met ‘n uiteenlopende kultuur, agtergrond en opvoeding ‘n uitdaging vir die gesondheidstelsel. In 2016 het ‘n staatsektor vir die organisaie van die gesondheidsorg in die VAE, die Enayatak Verpleegsorgmodel dwarsoor sy hospitale geïmplementeer om ‘n verenigde benadering te genereer wat tot voordeel sou wees van verpleegsorg. Sedert die implementering van die Enayatak Verpleegsorgmodel is daar geen navorsing gedoen oor hierdie model nie. Die doel van hierdie navorsingstudie is om die ervaringe van die voorste linie van verpleegsters in verband met die Enayatak Verpleegsorgmodel te ondersoek en beskryf.

Die navorser het ‘n beskrywende, kwalitatiewe ontwerp vir die ondersoek van die studie geïmplementeer. Die plekbepaling vir die studie is ‘n staatshospitaal in Abu Dhabi in die VAE en die studiebevolking is voorste linie geregistreerde verpleegsters. ‘n Doelgerigte steekproefneming is gedoen om die deelnemers vir die studie te identifiseer vir deelname aan semi-gestruktureerde onderhoude vir die insameling van data. Al die etiese beginsels vir navorsing is in die studie toegepas. Die geloofwaardigheid van die studie is aangespreek deur lede-kontrolering, die gebruik van ‘n veldwerker, reflektiwiteit, afbakening en verskaffing van uitgebreide detail van die stappe en voortkomende inligting van die studie.

Die temas wat hieruit voortgespruit het, is: aandrywers van die implementering, strategieë, gepersipieerde voordele, leierskapondersteuning, uitdagings en volhoubaarheid. Dit is merkbaar vanuit deelnemerresponse dat die beopdragte strategieë van die model buigsaamheid benodig, afhangende van die omgewingspraktyk. Daar is meningsverskille in verslae van die deelnemers rondom leierskapondersteuning, integrasie en volhoubaarheid van die model in die personeel se daaglikse praktyk. Daar is ‘n algemene ooreenstemming onder die deelnemers dat die implementering van die Enayatak Verpleegsorgmodel ‘n grootskaalse projek is wat transformasioneel is ten opsigte van pasiëntsorg en personeelervaring, en dat dit rigtinggewend en samebindend vir hul verpleegpraktyk is.

Bestuur van verandering, totale kwaliteit gegrond op verbeteringsteorie, individuele en kollektiewe leierskapondersteuning, is kritieke vereistes vir die implementering van ‘n verpleegsorgmodel. Hierdie studie kan voordelig wees en leiding verskaf aan leiers van hospitaalgroepe wat belangstel in die ontwikkeling van ‘n verpleegsorgmodel vir gesondheidversorging by hospitale.

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ABBREVIATIONS

ADON	Assistant Director of Nursing
ANCC	American Nurses Credentialing Centre
CINAHL	Cumulative Index of Nursing and Allied Health Literature
HAAD	Health Authority of Abu Dhabi
HREC	Health Research Ethics Committee
NHS	National Health Service
NMOC	Nursing Model of Care
NPC	Nursing Practice Committee
NSW	New South Wales
4 P's	Pain, Position, Personal needs, Possessions
PDSA	Plan, Do, Study, Act
PUBMED	Public Medline
SBAR	Situation, Background, Assessment and Recommendation
TQM	Total quality management
UAE	United Arab Emirates

Chapter 1:
Foundation of the study

1.1 Introduction

The Enayatak Nursing Model of Care implemented in the public sector hospitals in Abu Dhabi is an eclectic model incorporating evidence-based strategies based on literature and successful clinical practices. It consists of core foundational elements and principles within a framework that provides structure and strategies for implementation and subsequent evaluation of practice within a multicultural environment. (Nursing Practice Committee, 2016:10).This model was launched in September 2016 across the organization (Zaman, 2016:1).

Swick, Doulaveris, and Christensen (2012:314) state that the most significant decisions a healthcare system chief executive can make, when an organization consists of multiple hospitals, is endorsing a model of care with the aim of providing a framework that would unite various ideas and approaches to service delivery. In 2014, a public-sector healthcare organization in the United Arab Emirates (UAE), consisting of multiple hospitals, received a directive to develop and implement a nursing model of care across its hospitals.

In order to meet this directive a Nursing Practice Committee (NPC) undertook the task of designing a nursing model of care. The model was called Enayatak which translates to “your care in our hands”. It was introduced after an eight-month consultation and research effort, collaborating with many staff members across the organization to ensure the model was based on international standards of practice and contextually appropriate to the Middle East Community (Nursing Practice Committee, 2016:3).

Slateyer, Coventry, Twigg and Davis (2015:141) completed a systematic review, identifying literature on nursing models of care enforced in hospitals. This review identified that the majority of models were developed in the United States of America (USA) with others being from Australia, Canada, Ireland and one model described in the Middle East (Slateyer *et al*., 2015:141). No publications or studies could be found in the literature about the implementation of a model of care in the UAE. Additionally, no qualitative studies are identified in the literature exploring and describing the experiences of the frontline nurses with the implementation of a Nursing model of Care.

Thus, for the purpose of this study, the researcher aimed to explore and describe the experiences of frontline nurses about the Enayatak Nursing Model Care adopted and implemented in public sector hospitals in the emirate of Abu Dhabi.

1.2 Rationale

An increased pressure exists on the organization and management of nursing care attributed to several demands of the healthcare sector, including rising healthcare demands, shortages in nurses, patient safety events and quality care evolution (Dubois, 2012:1). These pressures and challenges force health organizations to investigate alternative models of care, with scanty resources for reference to define and develop what a nursing model of care encompasses (Davidson, 2006:47).

Thus in response to these pressures the NPC (2016:3), developed the Enayatak Nursing Model of Care with the aim to promote positive outcomes, enhance nursing practice as well as to improve patients and families experiences within the different business entities in the public sector. In their document they list the following domains that the model was intended to promote:

- A shared governance framework improving communication, teamwork and vitality.
- Team functioning with positive results.
- Improved patient safety and quality of care.
- Improved patient and staff satisfaction.
- Meeting the patients' care needs in a timely and appropriate manner.
- Continuity of care.
- Effective and efficient patient flow processes throughout the system.
- A positive and supportive workplace with organizational commitment and loyalty.
- A safer and more organized, efficient productive work environment.

Since the roll-out and implementation of a standardized nursing model of care in public hospitals in Abu Dhabi in 2016, there has been no research or evaluation regarding the Enayatak Nursing Model of Care. Dubois *et al*. (2012:14) identified that nursing care organization models are complicated and subjected to several influences and diverse realities.

Therefore, the researcher intended to explore and describe the experiences of nursing staff about the Enayatak Nursing Model of Care implemented in public healthcare facilities in the emirate of Abu Dhabi, in the Middle East.

1.3 Problem statement

As described above there had been no research or evaluation of the experiences of nurses with the Enayatak Nursing Model of Care since the implementation in 2016. The researcher observed that there was a diversity in practice, knowledge, attitude, application and sustainment of the Enayatak Nursing Model of Care among the nurses of the organization. Thus, exploring the experiences of the frontline nurses about the Enayatak Nursing Model of Care implemented in the United Arab Emirates were required to address this diversity and the gap in the knowledge of nurses involved in applying this model.

1.4 Research question

The research question which gave guidance to this study was:

What are the experiences of frontline nurses about the Enayatak Nursing Model of Care since the implementation of the model in a public healthcare facility in the emirate of Abu Dhabi, UAE?

1.5 Research aim

The aim of this research study was to explore and describe the experiences of frontline nurses about the Enayatak Nursing Model of Care since the implementation of the model in a public healthcare facility in the emirate of Abu Dhabi, UAE.

1.6 Research objective

The objective set to direct the study was to:

- Explore and describe the experiences of frontline nurses about the Enayatak Nursing Model of Care implemented in a public healthcare facility in the emirate of Abu Dhabi, UAE.

1.7 Conceptual framework

The Enayatak Nursing Model of Care had a strategic-phased approach, utilizing evidence and strategies from previous quality improvement programmes and cultural models, including the International Healthcare Improvement Transforming Care at the bedside programme of the United States, National Health Service Productive Ward programme of the United Kingdom and the Crescent of Care Model of Saudi Arabia (Lovering, 2012:17; NHS England and NHS Improvement, n.d. and Rutherford, Lee & Greiner, 2004:1).

1.7.1 Core foundations principles of the model

The model was aimed at the promotion of four core foundation principles within a multicultural environment.

1.7.1.1 Safe and reliable care

This foundation principle is reflective of the aim to deliver care to patients and their families in a safe, effective and efficient manner.

1.7.1.2 Patient centered care

The next foundation represents the respect and consideration of patient and family's individual values and choices in care delivery.

1.7.1.3 Teamwork and vitality

A supportive work environment where teamwork is encouraged, and a supportive work environment is a fundamental principle in promoting professional excellence and commitment.

1.7.1.4 Value-added care processes

Value-added care processes are required for efficient work processes. This requires a review of all work processes to identify unnecessary inefficiencies and sub optimal workflow to support optimal and continuity of care throughout the patient's journey.

In figure one a pictogram is displayed representing the four foundation principles discussed (Nursing Practice Committee, 2016:11):

Figure 1.1: Nursing model of care pictogram

(Source: NPC, 2016:11)

1.7.2 Strategies of the Enayatak Nursing Model of Care

Table 1.1 shows a summary of strategies that were implemented to achieve the foundations set. Strategies were grouped in four themes. An overview explanation of each theme and strategy is discussed.

1.7.2.1 Theme: Knowing and understanding the team and service

This theme with the identified strategies as per Table 1.1, links to the foundation of teamwork and vitality.

1.7.2.1.1 Knowing how we are doing display board

A "knowing how we are doing display board" was a strategy adopted from the National Health Service Productive ward programme (NHS, 2008). This strategy focusses on displaying ward performance data. Regular meetings of the frontline nurses are expected around this board to discuss performance and make decisions and action plans to improve performance. Through this strategy measures related to the core principles of the Enayatak Nursing Model of Care are measured, tracked and improved (Nursing Practice Committee, 2016).

1.7.2.1.2 Patient journey at a glance board

Every nursing unit places a board in the unit to display information that can be ready at a glance, in order to reduce interruption of nurses and save time looking for information (National Health Service, 2008).

1.7.2.1.3 Staff team identification boards

A clearly visible team identification board displaying all the members of the multi professional team is displayed in the unit. This is to enhance communication and openness between patients and caregivers (Nursing Practice Committee, 2016).

1.7.2.1.4 Staff identification boards

Contact details of the manager and shift leader are displayed in poster form in the units to open up communication channels to the unit leaders (Nursing Practice Committee, 2016).

1.7.2.1.5 Patient bedside board

The use of bedside visual tools may improve patient-provider communication. The bedside board is utilized to highlight relevant care goals and identification of the healthcare providers (Goyal, Tur, Mann, Townsend, Flanders & Chopra, 2017:930).

1.7.2.2 Theme: Environmental safety and efficiency

This theme with the identified strategies as referred to in Table 1.1 links to the foundation of value-added care processes.

1.7.2.2.1 Well-organized ward

The National Health Service (NHS) developed the well-organized ward initiative, which entails the work area to be assessed and arranged to promote safer and a more organized work environment (National Health Service: 2018). Various tools and methods based on the Lean Healthcare Enterprise were implemented to reach this goal. Lean organizations strive to match medical services to patient needs, exactly as demanded and with no waste in effort or resources (MacInnes & Dean, 2012:125). The 5S (Sort, Set in order, Shine, Standardize and Sustain) approach is a structured methodology which is implemented to organize the work environment in a systematic way (MacInnes & Dean, 2012:126).

1.7.2.2.2 Medical Equipment Library

The establishment of a central Medical Equipment Library is a systematic approach to utilizing, storing and monitoring medical equipment. This strategy was optional for the hospitals due to the limitation of resources (Nursing Practice Committee, 2016:18).

1.7.2.3 Theme: consistent communication with family, patients and staff

This theme with the identified strategies as per Table 1.1 links to the foundation of patient-centred care and teamwork and vitality.

1.7.2.3.1 Clinical handover at the bedside and Situation, Background, Assessment and Recommendation (SBAR)

Handover is essential to enable continuity of nursing care to patients when shifting nurses. In the past it was defined as a process of nurse-to-nurse communication and conducted in a variety of ways. Clinical handover at the bedside is a process that includes the patient in the conversation during the handover process to support patient-centered care (Tan & Amil, 2015:188).

The SBAR is a standardized communication tool that is utilized for handover of any patient information or situation during shift handovers or communication with the multidisciplinary care team. The acronym SBAR

represents “Situation, Background, Assessment and Recommendation”. The SBAR was introduced in nursing in 2002 to facilitate communication of patient care information and has since been proven as an effective intervention for patient safety related to improved communication (Steward & Hand, 2017:297).

1.7.2.3.2 Cultural and spiritual care

The NPC (2016) states that: “A holistic approach to the spiritual, cultural, psychosocial, interpersonal and clinical needs of our patients will be considered and individualized”. In order

to realize this the Crescent of Cultural Care model by Sandy Lovering figure 1.2 was adopted and all nurses trained according to this model. The Crescent of Cultural Care Model is a model that provides guidance in caring for the holistic needs of the Arab Muslim patient, where the patient and the family are the focus of care (Lovering, 2012:171).

Figure 1.2: Crescent of Care Model

(Source: Lovering, 2012:173)

1.7.2.3.3 Intentional Patient Rounding

The intentional patient rounding strategy is about being proactive in patient care. It consists of regularly rounding on patients utilizing an evidence-based tool. The tool implemented was based on 4 Ps i.e. pain, positioning, pan and personal belongings that needed to be addressed during rounds. The nurses end the round by stating when they will return (Nursing Practice Committee, 2016:20).

1.7.2.3.4 Start and communicate with Heart

This strategy refers to a communication model to enhance professional and caring communication. Each nurse attends a four-hour training session called “Communicate with Heart”, a programme developed by the Cleveland Clinic, to acquire and improve skills focused on expected service behaviours (NPC, 2016:19).

The acronym START guides the first contact with a patient and represents:

- **S**mile
- **T**ell your name role and what to expect
- **A**ctive listening and assisting
- **R**apport and relationship building
- **T**hank the person

The acronym HEART guides the response of nurses to patients and represents:

- **H**ear
- **E**mpathise
- **A**pologise
- **R**espond
- **T**hank

1.7.2.3.5 The ten guiding principles of the model

Figure 1.3: Ten guiding principles of the model

(Source: NPC, 2016:12)

Figure 1.3 describes the concept of the guiding principles endorsed by the model to promote the four foundation principles and to create a positive working environment. The figure consist of key words in English and Arabic representing the guiding principles. The expectation is that all nursing staff follow the principles in their everyday practice and are being held accountable to these principles:

- Treat patients as you would treat your family
- Embrace cultural diversity
- Be trustworthy, ethical and honest
- Work as a team
- Continually improve in everything you do
- Strive for a happy work environment with respect and mutual trust
- Be careful and efficient in the use of resources
- Commit to professional development, innovation and learning
- Leaders acknowledge and value your people
- Actively engage and value the community

1.7.2.4 Theme: Leadership

1.7.2.4.1 Intentional Leadership Rounding

This strategy requires the nurse leaders to visit the staff and patients in the units at regular intervals. These rounds enable the nurse leader to address patient satisfaction and nursing care, as well as recognizing the staff that performs exceptionally (NPC, 2016:22). Evidence suggests that rounds have a positive impact on patient experience, quality care indicators and employee satisfaction (Reimer & Herbener, 2014:654).

1.7.2.4.2 Workplace culture

Creating a positive workplace culture in the working environment may contribute to increased employee satisfaction and in turn patient satisfaction. This included various strategies already discussed, e.g. intentional leadership rounding and guiding principles. The “above and below the line behavior” methodology was introduced as the first suggestions to encourage a positive workplace culture. This requires staff members to participate in identifying behaviours that are acceptable and those that are not. These lists are then agreed upon and displayed on the unit board for reference (Nursing Practice Committee, 2016:24).

Additionally, staff were asked to rate their shift on the unit display board before going off duty. An example is provided in figure 1.4. When the staff meets around the unit “knowing how we are going display board” results are discussed and action plans made to address any patient needs which have been identified. This makes staff satisfaction visible on a daily basis to the

leaders of the organization to enable workplace culture awareness (Nursing Practice Committee, 2016:24).

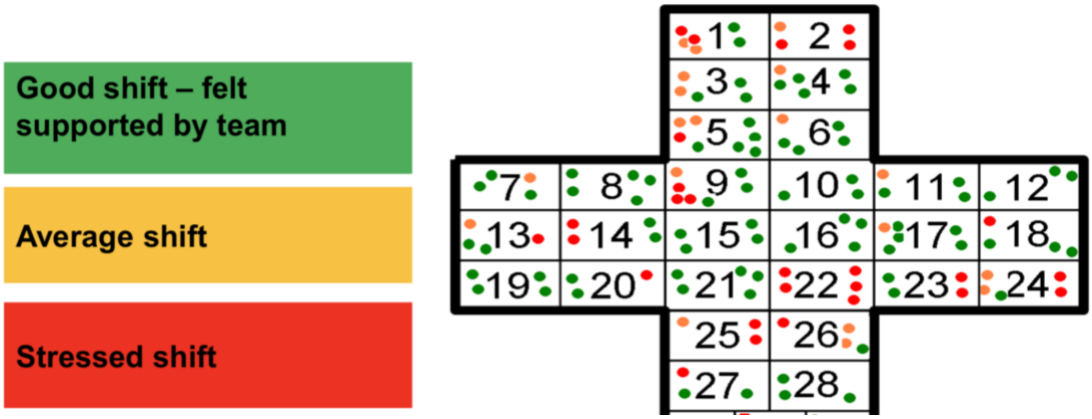

Figure 1.4: Rate your shift example

(National Health Service: 2008)

Table 1.1: Strategies of the Enayatak Nursing Model of Care

No.	Strategy Description	Theme
1	Knowing how we are doing display board	Knowing and understanding the team and service
2	Patient bedside board	
3	Patient journey at a glance board	
4	Staff Identification signs	
5	Staff team identification board	
6	Medical equipment libraries	Environmental safety and efficiency
7	Well Organised Ward (WOW)	
8	Clinical handover at the bedside & SBAR	Consistent communication with patient, family, and staff
9	Cultural and spiritual care	
10	Intentional patient rounding	
11	Start and communicate with HEART	
12	SEHA Ten Guiding Principles	
13	Intentional leadership rounding	Leadership
14	Workplace culture	

(Source: Nursing Practice Committee, 2016:29)

1.8 Research methodology

The following section is a brief description of the research methodology applied in this study as a more detailed discussion is provided in chapter 3.

1.8.1 Research design

The researcher applied an exploratory-descriptive design with a qualitative approach in this study. The researcher was focused on exploring the experiences of nurses about the Enayatak Nursing Model of Care implemented in public healthcare facilities in Abu Dhabi.

1.8.2 Study setting

This healthcare system currently consists of 12 hospitals across the Abu Dhabi emirate. The study setting was a public sector hospital in the emirate of Abu Dhabi in the UAE, located in the Middle East. This hospital is a multidisciplinary acute care and emergency hospital with a total of 409 beds, with more than 20,000 inpatients, and 320,000 patients in the outpatient clinics on an annual basis.

1.8.3 Population and sampling

The public healthcare system in Abu-Dhabi, UAE has a collective nursing workforce of approximately 7000. The population of this study consisted of registered nurses employed in a public sector hospital in Abu-Dhabi, UAE with a nursing workforce of approximately 800.

The researcher applied purposeful sampling to identify a public sector hospital as research site. Permission was granted by the hospital and participants were identified using purposeful sampling. A total sample of nine participants were reached at the point of data saturation.

1.8.3.1 Inclusion criteria for the study

Participants had to meet the following criteria in order to be included in the sample:

1.9.3 Justice

- The principle of justice requires fair treatment of participants during the study (LoBiondo-Wood & Haber, 2013:237). In this study the participants who agreed to an interview, were given the opportunity to choose a convenient time for conducting the interview. The Frontline registered nurses providing direct patient care.
- Frontline registered nurses employed since September 2015 or earlier in a public sector hospital in Abu Dhabi.
- Frontline registered nurses needed to have been employed for at least one year in the same hospital prior to implementation of the Enayatak Nursing Model of Care.
- Frontline registered nurses working in an in-patient unit of the hospital

1.8.4 Data collection tool

A semi-structured interview guide was formulated based on the purpose and objective of the study informed by a literature review and conceptual framework on the topic.

1.8.5 Pilot interview

The fieldworker conducted a pilot interview with a frontline registered nurse who met the study criteria, utilising the interview guide and was successful in collecting information about the experiences of the nurse. Therefore the pilot interview was included in the data set of the study.

1.8.6 Trustworthiness

The four criteria for trustworthiness of a qualitative study as introduced by Guba and Lincoln (1982:246) were applied: credibility, transferability, dependability and conformability.

1.8.7 Data collection

A fieldworker conducted nine individual interviews over a period of three days until data saturation was reached.

1.8.8 Data analysis

The steps of Terre Blanche, Durheim and Painter (2006:322) were applied for the process of qualitative data analysis.

1.9 Ethical considerations

The researcher obtained approval from the Health Research Ethics Committee (HREC, Reference # S19/01/026) of the Stellenbosch University (SU) (Annexure 1). In addition ethics approval had to be obtained for this study according to the governing policy regarding research in the emirate of Abu Dhabi, UAE. The Policy PHP/PHR/R03 of research on human subjects (Health Authority of Abu Dhabi, 2012) sets out the ethical framework governing Human Subjects Research in the emirate of Abu Dhabi in the UAE. It requires that all research be approved by an institutional research ethics committee that is registered with the Health Authority of Abu Dhabi (HAAD) research ethics committee. The researcher applied to two hospitals for institutional research ethics committee approval and obtained approval from only one hospital (Annexure 2).

The researcher adhered to the HAAD research policy and the policy of HREC of SU which requires conformity to international ethical principles and conduct as described in the Nuremburg Code, World Medical Association Declaration of Helsinki and the Belmont report. These principles include, respect for persons, beneficence and justice.

1.9.1 Respect for persons

The researcher maintained respect for the participants' human rights during the study. These rights included, self-determination, privacy, confidentiality, fair treatment, selection and protection from harm (Grove *et al.,* 2015:100). The study participants were treated as autonomist subjects. They were given information about the study and a choice to participate or not. They were also given the opportunity to withdraw from the study at any time without any consequences. In addition to obtaining signed informed consent from the participants prior to each interview, permission to voice record the interviews was obtained. The voice recordings were kept confidential and stored by the researcher in a locked cupboard at the researcher's home. Electronic records remain stored and password protected, allowing access to records only to the supervisor and researcher of the study. Finally, anonymity of participants was ensured by allocating a number to each participant and the corresponding transcript.

1.9.2 Beneficence

This principle refers to the protection from any discomfort or harm in a study (Grove et al., 2015:108). The participants of this study were protected from any harm or discomfort, by ensuring that they were interviewed in a comfortable environment. They were informed that there was no foreseeable risk or benefit from their participation. This study was of low risk and arrangements for support for any counselling were not required.

The fieldworker was on time for data collection appointments and there were no changes to the agreed participation as outlined in the research information leaflet and consent form. The participants of the study were provided with the opportunity to review the data of the interview transcriptions in order to make any clarifications or suggestions. At the end of the interview, participants were provided with a gift card to compensate and thank them for their time.

1.10 Conceptual definitions

A conceptual definition is a comprehensive description of a term, including meaning that the word may have in the particular study, to allow consistency in meaning and understanding of the reader (Grove, Gray & Burns, 2015:192). The following conceptual definitions of this study are identified and described:

Nurse: A person registered with the Health Authority of Abu Dhabi in order to practice nursing or midwifery within the HAAD Scope of practice (United Arab Emirates: 2012).

Frontline Nurse: Frontline is an adjective used to describe an employee who deals directly with customers (Cambridge dictionary: 2020). In this study the frontline nurse includes the registered nurse who deals directly with patients and provides nursing care.

Experience: Knowledge obtained through participation of an event, situation or circumstance (Grove *et al*., 2015:508).

Nursing care: Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people (International Council of Nurses, n.d.).

Model of Care: The way in which best practice health services are delivered, with the goal to ensure people get the right care, at the right time, by the right team and in the right place (The NSW Agency of Clinical Innovation, 2013:3).

1.11 Duration of the study

After receiving ethics approval from SU and the hospital ethics review committee, the data collection commenced in August 2019 and was completed in September 2019. Thereafter, data analysis and documentation of the findings commenced. The study was completed with the writing of the research thesis in December 2019.

1.12 Chapter outline

The chapters included in the thesis are as follows:

- Chapter 1: Foundation for the study
  In chapter one the rational, problem statement, and a brief overview of the research methodology were described.
- Chapter 2: Literature review
  In chapter two the process of searching for literature were discussed and findings of the literature search on the topic were summarized.
- Chapter 3: Research methodology
  In this chapter, the research methodology was discussed including sampling, data collection methods and data analysis that were applied in the study.
- Chapter 4: Findings
  The fourth chapter was dedicated to present the interview findings.
- Chapter 5: Discussion, recommendations and conclusion
  In this final chapter, a discussion of the findings, recommendations, limitations and significance of the study were presented.

1.13 Summary

In this chapter the researcher provided an overview of the rational, problem statement and a brief of the conceptual framework and research methodology that guided the study. The ethical considerations of this study were described, ending the chapter with the duration of this study and a chapter outline of the thesis. In the second chapter the review and discussion of the literature are undertaken, based on the objectives of the study.

1.14 Conclusion

The background of this study described a healthcare climate filled with pressures and challenges of delivering quality nursing care which demands a re-evaluation of nursing care in an organization. Implementing a nursing model of care may be the answer towards transforming and standardising a nursing approach towards quality patient care and positive staff experiences.

Chapter 2:
Literature review

2.1 Introduction

A critical first step of a research study is the systematic and broad exploration and evaluation of the literature to develop a knowledge base about a concept, subject or problem (LoBiondo-Wood & Haber, 2018:47). This literature review guided the researcher to determine the current state of theory about nursing models of care. It led the researcher to identify a gap in knowledge that generated the research question for this study and the significance in studying it.

2.2 Selecting and reviewing the literature

Searches of electronic databases, including Public Medline (PubMed) & Cumulative Index of Nursing and Allied Health Literature (CINAHL) were conducted. The keywords, "nursing model", and "professional practice model", were utilized to conduct the searches for the time period between 2008 and 2019. Additionally, the internet was searched, utilizing the same keywords for grey literature and researcher education. The reference lists of relevant studies and conference proceedings were also scrutinized and relevant textbooks consulted to explore the topic and research methodology.

2.3 Findings of the literature review

The findings of the literature review are discussed under the following headings:

- Defining the concept of a nursing model of care
- The purpose of and need for a nursing model of care
- International perspective of nursing models
- Model of care genesis
- Factors influencing the implementation and development of a nursing model of care
- Theoretical influences
- The relevance and importance of evaluating conceptual models
- The impact of a nursing model of care

2.3.1 Defining the concept of a nursing model of care

According to Davidson, (2006:3) an ambiguity exists in the literature with the description of a nursing model of care with the use of terminology that describes similar concepts e.g. philosophy, framework or paradigm. Early literature defines a nursing model as "a picture or representation of what nursing actually is" (*Pearson,* Vaughan & FitzGerald, 1996). Dubois, D'Amour, Tchouaket, Rivard, Clarke and Blais (2012:2) point out that the majority of the

literature defining nursing delivery models, focus mainly on different allocation or staff assignment systems. This does not represent the full picture of nursing and its context in an organization. The NSW Agency of Clinical Innovation (2013:3) defines this concept more broadly as the way in which best practice health services are delivered and with the goal to ensure that people get the right care, at the right time, by the right team and in the right place.

2.3.2 The purpose of and need for a nursing model of care

Conceptual models are vital instruments towards developing service delivery systems and describing how processes, resources and system components relate to the achievement of objectives in a given context (Dubois *et al*., 2012:2). Swick *et al*. (2012:314) re-iterate the importance of a model of nursing care by stating that the endorsement of a model is one of the most significant decisions a health system chief nursing executive can make, when an organization consists of multiple hospitals. Concurrently, Bigby (2015:9) highlights the need for a comprehensive model, due to the diversity of a nurse's education and practice experience. They cite Ondrejka and Bernard, 2011 who conclude that: "nurses may provide relevant care, but have many different approaches and attitudes, causing patients to experience inconsistencies in care and clinical outcome".

Khan, Van der Morris, Shepherd, Begun, Lanham, Uhl-Bien, and Berta (2018:1) wrote a paper after a seminar series in Toronto that focused on complexity and thinking applied in healthcare. They identify, that we need to embrace "complexity thinking" in order to control the "messiness" of healthcare. This involves encouraging and adopting innovative solutions spread across a system and involving the social system to generate ideas. Moreover, complexity thinking enables meaningful engagement in healthcare transformation (Khan, et.al., 2018:1).

The purpose of nursing models of care is to unify and align nurses towards a common vision, values and professional practice (Bigby, 2015:2; Slateyer, Twigg, & Coventry, 2016:140). Additionally, Slateyer *et al*. (2016:140) identify that a nursing model is unique to organizational culture, lays the foundation for safe, high quality, patient-centered nursing practice and care.

2.3.3 International perspective of nursing models

Internationally, there is a focus on developing models of care that are being endorsed and supported country wide by different Government Agencies and credentialing centers, mostly in Western countries. The American Nurses Credentialing Centre (ANCC) initiated a Magnet Recognition programme in 1990 with the focus of credentialing organizations internationally and nurses who advance nursing. One of the requirements to achieve magnet status is an established professional practice model for staff (ANCC, 2018). Additionally, in 2013 the

Canadian nursing Association published a report “Nursing Care delivery models: Canadian Consensus on guiding principles” and the NSW Agency for clinical innovation published a document to serve as a practical guide for hospitals across New South Wales in Australia to develop a “Model of Care”.

Slateyer *et al*. (2015:141) completed a systematic review identifying literature about “models of care” up to August 2014 and professional models were chronicled since 1990, but on a single unit scale. The review revealed 51 studies with 38 models identified and the majority of professional practice models were developed in the USA, with others being from Australia, Canada, Ireland and one model described in the Middle East.

A bibliographical analysis of the literature conducted by Han (2017:117), appears to be with a broader approach, identifying hot topics and developmental trends of research on nursing models. His study focused only on the PubMed database between 2005 and 2014 which included 1 472 articles pertaining to nursing models other than China, with the US leading with 59.42% publications, the UK with 20.87%, followed by Australia which published 4.06%.

2.3.4 Model of Care genesis

The complexity and multidimensional nature of nursing in organizations mandates a planned and specific approach to the development of a nursing model. A “one size fits all” approach will not suffice as the development of models need to be consistent with the mission, vision and values of the organization (Stallings-Welding and Shirey (2015:199).

2.3.4.1 Guiding principles

The Canadian Nurses Association (2012:1) embarked on a research project, utilizing a Delphi survey distributed to nurses across Canada. As a result of this study guiding principles were identified for the development of Nursing Care Delivery Models. These principles included: integration of the health-care needs of patient, families and communities, reflecting evidence based practice, use of technology and staff competence, demonstrating shared decision-making, enhancing cost-effective, safe and quality care, effective communication and complete organizational leadership support. Additional, guiding principles were identified in the NSW Agency for Clinical Innovation (2013:3) published framework for developing a model of care: flexibility of implementation, supporting integrated care, patient centeredness, efficiency, measurable outcomes and most importantly encouraging innovative and alternative strategies for organizing and delivering nursing care.

Consequently, the Genesis of a Model of Care requires certain foundational pillars identified by Booker, Turbett and Fox (2014:136) as - “integrated care models, team functioning and

communication, leadership, change management and efficient work processes.". These pillars are reflected in the principles identified in the preceding text.

2.3.4.2 Key elements

Slateyer *et al*. (2016:145) presented their work at the 27th International Nursing Research Congress, and through thematic analysis of the 38 nursing models, identified three themes:

1. An underpinning theoretical foundation
2. Six essential professional practice components
3. Nurses' articulation; a simple, translatable model.

The six professional practice components that were universally included were: "leadership, independent practice, collaborative practice, development and recognition, environment and research/innovation".

Another key characteristic of professional models of care is the focus on patient integrated care. Swick *et al*. (2012:315) describe in the journey of Model of Care transformation in the Inova Health System, that there is a move from the traditional view of the patient as a "recipient of care" to the patient as a "full partner" in the care delivery process, demonstrated by strategies like involving the patient during shift-to shift handovers and multidisciplinary bedside rounds.

2.3.5 Factors influencing the implementation of a professional practice model

Implementation of a professional practice model or framework to guide practice in an organization is complex and need a rigorous approach to ensure roll out and sustainability as described in the seminal work done by Kotter (1995), "Leading Change: Why Transformational efforts fail". He highlights that a key reason for failure is that managers think that change is an event and not a step-by-step process. Bigby (2015:44) concluded from her study on building a framework for professional practice, that it is critical for nurse leaders and managers to understand their own professional practice, in order to achieve spreading to the frontline nurses. Additionally, Cordo, and Hill-Rodriquez (2017:325) report that leadership support, empowerment and shared decision making were instrumental in developing and implementing a model successfully. This contributed to the journey of their hospital towards implementing professional practice.

Furthermore, communicating the model of care is an essential step. Twinkham (2014:314) concluded from their experience in developing a professional practice model, that finding a customized framework and visual concept representation are important for staff engagement and essential for the success of the model. Additionally, education, the use of champions, the train-the-trainer approach, shared decision-making committees, and reward and recognition are necessary for roll out of a professional practice model (Slateyer *et al*., 2015:147; Cordo *et al*., 2017:326).

2.3.6 Theories influencing the implementation of a model of care

Theory provides the foundation for science, describing ideas and knowledge (Grove, Gray & Burns, 2015:190). With the ever-changing healthcare climate and increasing demands on healthcare staff, it becomes a matter of professional urgency to build on existing knowledge and ideas through research (Maleis, 2011:67). Maleis describes this urgency, claiming that in order to shape a future for quality healthcare, the historical theories and its influences on the present and future healthcare needs must be uncovered and understood.

Davidson (2006:51) provides the conceptual and practical elements of a model of care namely, identifying a quality improvement theory and change management theory influencing the implementation of a novel model of care.

Kurt Lewin is famous for his theories of applied behavioural science, action research and planned change which originated during World War II and subsequently triggered research interest in the dynamics of groups and implementation of change programmes (Burns, 2004:99).

However, Edward Deming is acknowledged as the leader in the field of quality, with his work focused on a philosophy, “Total Quality Management”, conceptualizing quality and continuous improvement (Taylor, McNicholas, Nicolay, Darzi, Bell and Read, 2014:291).

2.3.6.1 Lewin’s theory on change management

Lewin believed that through facilitating learning one could change the perceptions of the individuals about their surrounding environment (Burns 2004:986). A belief that stemmed from his view that the individual’s feelings, actions and perceptions are shaped by the group or organization that the individual belongs to and therefore, the focus of change and learning should be at a group level (Burns 2004:986).

Lewin developed a 3-step model (figure 2.1), to describe an approach to facilitate change in an organization. A discussion on the application of these steps in a model of care implementation follows.

Figure 2.1: Change as three steps

(Source : Burns 2004:986)

2.3.6.1.1 Unfreeze

The challenge in a healthcare system is that the workforce and community that it serves is diverse in various domains and each patient, staff member and chief executive officer in a

hospital has an idea of what good care is and how it should be delivered. The first stage of Lewin's model is "Unfreezing", which involves preparing for change. This requires a change agent for example, a nurse leader to recognize the need for change and mobilizing others to identify this need (Shirey, 2013:69).

Swick, Doulaveris and Christensen (2012:314) state that the most significant decisions a health system chief executive can make, when an organization consists of multiple hospitals is endorsing a Model of Care with the aim of providing a framework that would unite various ideas and approaches to nursing service delivery. Based on Lewin's theory this would call for the acknowledgement of the need for a nursing care model as well as the collaboration and participation of all concerned in the different hospitals for the development and implementation of such a model.

2.3.6.1.2 Change

The second stage of Lewin's 3-step model demands an attitude and approach to change as a process, rather than an event, in order to facilitate an action plan and engagement of people to try out the proposed change (Shirey, 2013:69). The physical, cognitive, psychosocial and professional dimensions of the work environment need to be addressed as a dimension in the implementation of a model of care, as it influences and support staff and nursing practice (Dubois, 2012:4). Systems and processes, needs to be examined to remove redundant steps and barriers to efficient workflow changes (Swick, et al. 2012:315).

2.3.6.1.3 Freeze

Burns (2004:986) states that during this phase of change management, refreezing seeks to establish and sustain new behaviours leading to positive outcomes. All the more why Lewin saw change as a group activity, in order to ensure the transformation of group norms and routines towards sustaining new organizational culture, norms, practices and policies (Burns, 2004:986). The researcher identified guiding principles described in section 2.3.3.1, supporting the implementation and sustainment of a nursing model of care (American Nursing Credentialing Center, 2018; Canadian Nurses Association, 2012 & New South Wales Agency for Clinical Innovation, 2013). Principles essential for sustainment of change include innovation, team functioning, communication, education, leadership, recognition and empowerment.

Lewin's planned approach to organizational change has been criticized for its simplicity, even though Lewin saw change as a slow complex process of working with groups to facilitate behavioural and cultural change (Burns, 2004:995). Nevertheless, Burns illustrates through a re-appraisal of Lewin's theory, that at face value Lewin's three-step model seems simple, but

it is this simplicity that becomes an advantage, enabling the communication and implementation of a conceptual nursing model of care in an organization.

2.3.6.2 Deming's theory of total quality management (TQM)

Deming's philosophy and theory of "Total Quality Management" included the concept of continuous improvement of processes, which led to the development of the four stages of Plan, Do, Study and Act (PDSA), (Taylor, McNicholas, Nicolay, Darzi, Bell & Read, 2014:291). Figure 2.2 represents the cyclic four stages of this quality improvement model:

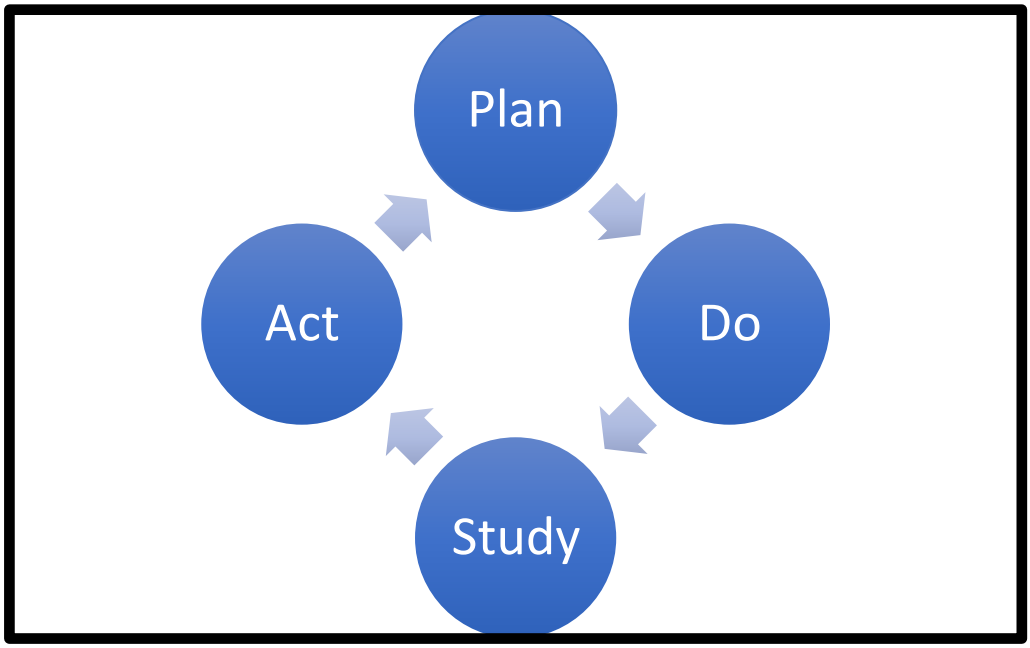

Figure 2.2: Deming's Wheel

(Source: Taylor, McNicholas, Nicolay, Darzi, Bell & Read, 2014:291)

The "plan" stage entails identification of an improvement area requiring change, the "do" stage reflects the testing of the change towards the improvement, the "study" stage evaluates the success of the change and the "act" stage identifies adaptations to apply in the new cycle (Taylor, *et al*., 2014: 292). As a supportive mechanism of TQM, the PDSA cycle offers a scientific basis for testing improvements in complex healthcare systems, therefore it's application on the components and strategies of a nursing model of care may contribute to the effective and successful implementation of a nursing model of care. (Tailor *et al*., 2014:295).

Rajah and Wey (2014:1028) conducted a systematic review of recent research about TQM practices and stated that empirical studies from different industries have shown a positive relationship of TQM and organization performance, but others have also found a negative relationship. In the end, the authors conclude that the majority of TQM practices do have

positive outcomes, although only in organizations where the cultural, financial resources and business environment were well constructed.

2.3.7 The relevance and importance of evaluating conceptual models

The nursing profession has a rich heritage of theoretical works dating back to Florence Nightingale's era including philosophies, conceptual models and theories (George, 2014:13). Fawcett and Desanto-Madya (2013:1) suggest that metaparadigms, philosophies, conceptual models and theories carry a degree of uncertainty which necessitates continual revision and systematic enquiry. The latter continues to be relevant for contemporary nursing practice and may provide frameworks guiding nursing practice.

The use of an explicit conceptual model for example, can contribute to achieve consistency in contemporary nursing practice through, facilitating communication among nurses, reducing conflicting goals for practice and providing a systematic approach to nursing practice. (Alligood & Tomey, 2010:14). However, it is important to tailor models of nursing care delivery to meet the needs of the healthcare environment, patient and families based on systematic enquiry and evaluation of the model (Davidson & Everett, 2015: 126).

2.3.8 The impact of a Nursing Model of care

It may be reasonable to assume that the impact of professional models of care would be positive on patient outcomes, nursing practice and staff engagement after understanding the elements, recommended principles and success factors for implementation discussed. However, Dubois *et al*. (2012:14) recognize a limitation in their study eluding to the fact that nursing care organization models are complicated and subjected to several influences and diverse realities. This diversity makes it challenging towards quantifying standard measures for research.

Additionally, studies done in exploring the effect of implementing a model of care on staff satisfaction and patient outcomes, are reported as part of a quality improvement approach and/or a single site study that does not confirm a causal relationship between models and positive outcomes which can be generalizable (Can & Gardner, 2012: 111; Murphy *et al*., 2017:10).

Slateyer *et al*. (2015:147) report that only 26 of 38 of the models identified in this systematic review had been partially evaluated. A trend of anecdotal reporting was seen in early versions and later evaluations included pre and post implementation data on patient and staff outcomes. In analysing data, a link was established between positive practice environments and quality patient outcomes.

Stallings-Welding and Shirey (2015:199) investigated this phenomenon with a different approach by researching the predictability of a Professional Practice Model (PPM) to affect nurse and patient outcomes, collecting secondary data from 2 395 nurses across 15 hospitals. This study yielded positive correlations between the initiation of a PPM and the nurse's perception of quality of care, nurse interactions, decision making, autonomy, job enjoyment, and patient satisfaction.

In contrast, Griffith (2012:356) in his research found a significant negative correlation between overall work satisfaction and satisfaction with the professional practice environment, after implementation of a professional practice model. It is notable that this study was conducted in only one hospital with a 55% response rate. His interpretation of the results being that nurses may have become more aware of the components of a professional practice environment, thus realizing the gaps or shortcomings in this area.

2.4 Summary

The review of literature provided information regarding the defining concepts and purpose of a nursing model of care. The universal latitude of nursing models was discussed and explored. Evidence was explored regarding influencing factors to consider during development and implementation of such models. Finally, this is the footprint that nursing models made in transforming healthcare in organizations.

2.5 Conclusion

Although this topic seems to have matured in literature in Western countries, it is still an emerging topic and concept in the Middle East, with only one article identified in Saudi Arabia related to a model of care implementation. No studies could be found of implementing a Nursing Model of Care in the United Arab Emirates, neither about the experiences of nurses with the implementation of a Nursing Model of Care.

Current research literature seems weakly conclusive with regard to the influence of a nursing model on staff, nursing practice and patient outcomes, due to the complexity of designing a rigorous evaluation approach. However, it is identified throughout the literature as a valuable tool to generate a unified approach to nursing delivery in an organization with diverse and complex dimensions.

As the topic further emerges in professional literature and spreads internationally, this complex and innovative phenomenon can be further unpacked to prove its relation in supporting and enhancing nursing quality and professional practice, towards transforming "good" healthcare.

Chapter 3:
Research methodology

3.1 Introduction

Research is a systematic, rigorous and scientific investigation into a phenomenon. (LoBiondo-Wood & Haber, 2018:6). This process creates knowledge that enables the nurse to answer questions about nursing phenomena. A knowledge gap was identified in the literature regarding nurses' experiences about the implementation of the Enayatak nursing model of care. Consequently, the research question which guided this study resulted from this gap in knowledge: What are the experiences of frontline nurses about the Enayatak Nursing Model of Care in public healthcare facilities of Abu Dhabi, UAE?

In this chapter the researcher provides an in-depth discussion of the qualitative research process that was applied to investigate this phenomenon.

3.2 Aim and objective

The aim of this research study was to explore and describe the experiences of frontline nurses about the Enayatak Nursing Model of Care since the implementation of the model in a public healthcare facility in the emirate of Abu Dhabi, UAE.

The objective set by the researcher to direct the study was to:

- Explore and describe the experiences of frontline nurses about the implementation of the Enayatak Nursing Model of Care since the implementation of the model in a public healthcare facility in the emirate of Abu Dhabi, UAE.

3.3 Study setting

The United Arab Emirates is situated in the Middle East and divided into seven emirates. The broader setting of this study is in the emirate of Abu Dhabi. Of the total Abu Dhabi Emirate population, 551 535 (18.1%) are Emirati citizens with the remainder being expatriates from several countries around the globe. In the Emirate of Abu Dhabi there are 56 hospitals of which 13 are public healthcare facilities. These hospitals are spread out over four regions. The Enayatak Model of Care was implemented in all the public healthcare facilities in Abu Dhabi providing healthcare to a diverse population by multicultural healthcare providers.

The specific setting of this study was a public sector hospital in the Al Ain region of Abu Dhabi. This hospital was a multi-speciality acute care and emergency care hospital with a 402- bed capacity and 800 nursing staff at the time of the study. According to Grove et al. (2018:277), a natural or field setting in a study refers to a real-life situation that is not controlled or

manipulated by the researcher. The researcher in the study conducted the study in the natural setting convenient for the participants.

3.4 Research design

Qualitative research approaches allow the researcher to discover the perspectives of the people involved in a phenomenon where little is known about it. This may provide rich descriptions of experiences from the participants' viewpoint (Bradshaw, Atkinson, and Doody, 2017:3). Although participants' experiences are individual, collective similarities may emerge that would enable a common understanding of the phenomena (Holland and Rees, 2010:70). Additionally, Grove, Gray and Burns (2015:77) explain that the pragmatic researcher is searching for information and solutions that are practical with a focus on what is effective in practice.

Therefore, the researcher utilized an explorative descriptive research design with a qualitative approach in this study, in order to explore the experiences of nurses about the Enayatak Nursing Model of Care implemented in public healthcare facilities in Abu Dhabi. The researcher sought to understand the phenomenon from the views of the frontline nursing staff involved to gain knowledge about the implementation of the model by the nurses who deliver direct care.

3.5 Population

The general population of a study is the group of people or elements that are the center of interest (Grove et al., 2017:250). Researchers conducting qualitative research base the identification of this group of people on the primary characteristic inferred by the research topic and goal (Nestor, Mensah, and Oteng-Abayie, 2017:1611). Therefore, in this study the people of interest are the frontline nurses practising in hospitals in the public health sector in Abu Dhabi. Being a frontline nurse is the primary characteristic of the population for this study.

When identifying the target populations of qualitative studies, a focal point is the participant who can provide inimitable thoughts and experiences addressing the research goal, while eliminating people from the general population who may not be able to discuss their experiences with clarity and depth (Asiamah, *et al*., 2017:1613).

In order to select these participants of a qualitative study, sampling criteria needs to be set to identify the target population of the study (Grove *et al*., 2017:250; Nestor et al., 2017:1613). In this study the target population was determined by the inclusion and exclusion criteria as discussed in paragraph 3.5.1.

3.5.1 Inclusion criteria

The accessible population of a study is reached after eliminating individuals from the target population that the researcher does not have reasonable access to and who will or may not participate (Grove et al., 2017:250; Nestor et al., 2017:1613)

In this study the accessible population targeted frontline nurses in one of the public hospitals available to the researcher at the time of the study.

- Frontline registered nurses providing direct patient care.
- Frontline registered nurses employed since September 2015 or earlier in a public sector hospital in Abu Dhabi.
- Frontline registered nurses needed to have been employed for at least one year in the same hospital prior to implementation of the Enayatak Nursing Model of Care.
- Frontline registered nurses working in an in-patient unit of the hospital.

3.5.2 Exclusion criteria

Nurse managers and higher-level leadership and administration staff were excluded from the study as the goal of the research was to discover the experiences of the frontline nurses providing the bedside care with the implementation of the Enayatak Nursing Model of Care.

3.6 Sampling

Purposeful sampling is a method that qualitative researchers utilize to consciously select “information -rich” participants in order to collect in-depth information for the study (Grove *et al*., 2017:270). In this study the researcher utilized purposeful sampling in order to identify participants that could describe and discuss their experiences with the implementation of the Enayatak Nursing Model of Care.

After ethics approval was obtained, the researcher conducted a meeting with the nurse managers at the hospital to explain the study and objectives. The nurse managers provided a list of potential participants that met the criteria of the study and their contact details. The researcher contacted the participants telephonically to explain the research study and invited them to participate. An interview appointment with the fieldworker was scheduled for each participant who agreed to participate.

In qualitative studies the purpose of the study, together with the aim to obtain deep insight and quality information into the research topic provide the rationale for the sampling size. On the contrary, quantitative studies are driven by the ability to generalize findings and detect relationships and differences (Grove *et al*., 2015:266). Therefore, the sample size of qualitative studies is often smaller and is determined by the point of data saturation. Data saturation is

the point when no new information can be uncovered and additional sampling provides repetitiveness of data (Grove *et al*., 2015:274). The point of data saturation in this study was reached after the ninth interview making the sample size n=9.

3.7 Data collection Tool

Interviews is a commonly utilized method for qualitative research and often a chosen method to collect data in health services research (Dejonchgeery & Vaugn, 2019:1). Semi-structured interviews are interviews based on a specific set of questions that will allow a variety of responses from the participants (Grove *et al*. 2017:83). This method of interviewing creates a dialogue between the researcher and participant that allows the exploration of the participants, thoughts, feelings and perceptions about a topic (Dejonchgeery & Vaugn, 2019:1).

A semi-structured interview guide (Appendix 4) was constructed, based on the purpose and objectives of this study, informed by the literature review and conceptual framework. This guide was utilized as a tool during face-to-face interviews with participants. The interview guide consisted of two sections. In the first section demographic data relevant to the study criteria was obtained with close-ended questions. In the second section open-ended questions were utilized to create a dialogue for example: “Tell me about your experiences with the Enayatak Model of Care?”.

3.8 Pilot interview

A pilot study is conducted to refine and determine the quality of data collection and measurement methods (Grove *et al*., 2013:45). It is important in a qualitative study to pilot test the interview with the proposed guide, in order to make necessary adjustments to questions, familiarize the interviewer with the tool and the pace for the interview (DeJoncdheree, 2019:5).

In this study the researcher thoroughly briefed the fieldworker about the study and the interview guide, after review by the study supervisor and ethics approval of the study. The fieldworker met with the first study participant identified through the purposeful sampling process described for the parent study. The pilot interview was successful in obtaining rich information about the experiences of the nurse with the implementation of the Enayatak Nursing Model of Care in the hospital. The questions set were effective and accepted for use in the subsequent interviews. The interview duration was 32 minutes and was included in the dataset of the study.

3.9 Trustworthiness

Trustworthiness refers to the rigour of the research in a qualitative study and is a means of demonstrating credibility and integrity during the qualitative research process (LoBiondo-

Wood & Haber, 2018 :517,141). The authors, Guba and Lincoln (1982:246) known for their qualitative research experience, lists four criteria that must be evaluated to determine the trustworthiness of a qualitative study: credibility, transferability, dependability and confirmability. The researcher in this study applied the Lincoln and Guba framework to contribute to the integrity of the research.

3.9.1 Credibility

Credibility of the study refers to the extent to which findings represent the truth (LoBiondo-Wood & Haber, 2018:119). The researcher utilized audiotaping and verbatim transcription, as well as triangulation to contribute to the credibility of this study (Guba & Lincoln, 1982: 247).

Triangulation is a strategy utilized to address bias that may develop if research methods are limited, for example to single sites or single types of participants (Pilot & Beck, 2014: 326). In this study person data triangulation was achieved by collecting data from different types of nurses with a range of years of experience in the hospital which included, charge nurses and staff nurses. Space triangulation was achieved by collecting data from five different types of units in the hospital.

Investigator triangulation was achieved in this study by utilizing a fieldworker to conduct the interviews in the data collection phase to prevent bias. The researcher made contributions to the content of three of the strategies of the Enayatak Model of Care from her experience with a hospital wide quality improvement programme. Subsequently, she was part of the teaching of the Enayatak Nursing Model of Care in the hospitals across Abu Dhabi. Thus, the researcher utilized an experienced fieldworker that was not an employee of the hospital group and holding a master's degree in qualitative research. With this approach the researcher intended to enhance neutrality and minimize risk of bias, due to her role in educating and contributing to the strategies of the Enayatak Nursing Model of Care.

The researcher validated the experiences of the participants by returning the transcribed descriptions to them to compare with the experiences they described and to offer any comments or changes to be considered in the final description. This process is referred to as member checking.

3.9.2 Transferability

This construct refers to the degree in which the findings of one study can be applied in other settings (Grove *et al*., 2015:392). The investigator can help the reader to make such a transfer realistic, with a well-described context about the research sites and an in-depth description of the phenomenon being explored (Guba & Lincoln, 1982: 247). Additionally, the use of a

conceptual framework would also promote the transferability of the research (*De Vos*, Strydom, Fouché, & Delport, 2011:420). In this study the researcher ensured the richness of data and contextual detail as described in the data collection and analysis section, as well as describing the conceptual framework of the Enayatak Nursing Model of Care to contribute to transferability.

3.9.3 Dependability

Dependability refers to the meticulous reporting of the research process to enable replication of a study (Grove *et al*., 2018:392). The emergent design of naturalistic inquiry prevents an exact replication of study. Therefore, the naturalistic researcher refers to dependability as the stability of the study after discounting any unpredictable changes, when a similar study is repeated in a different setting (Guba & Lincoln, 1982: 247). Thus, the researcher in this study elaborated and described in detail the steps and emergent details of the study within the thesis.

3.9.4 Confirmability

The investigator's concern to maintain objectivity of the data is referred to as confirmability (Guba & Lincoln, 1982:247). Besides utilizing triangulation during data collection described earlier in this section, the researcher utilized bracketing during data analysis. This concept means that the researcher identified and has set aside any personal opinions or experiences about the phenomenon being studied during the research (LoBiondo-Wood & Haber, 2018:104). To contribute to the confirmability of the data analysis, an audit was conducted. The supervisor of the study reviewed three of the transcripts, proposals and all study material during the course of the research study to validate themes and findings that developed throughout the study.

3.10 Data collection

The researcher utilized semi-structured interviews to collect data for this study. A fieldworker conducted nine one-to-one interviews over a period of three days. The study participants were met at a convenient time at their hospital and interviews were conducted in a quiet office which allowed for uninterrupted time. The interview was conducted in English using an interview guide and was recorded on a recording device with permission from the participant for this purpose. The participants agreed to participate in the study and were willing to attend the interview during their off-duty time, as to not interrupt any patient-care activities.

The study participants were sent an information leaflet about the study prior to the interview, including the interview questions that were going to be asked, to allow the participant to

prepare and organize thoughts, in order to provide in-depth data during the interview. The fieldworker met with the participants at their hospital as arranged by the researcher.

Participants were presented with the informed consent paperwork that was signed prior to commencement of the interview. The fieldworker explained to the participants the anonymity and confidentiality of responses that would be maintained. She put the participants at ease by ensuring them that no harm can come to them from their participation and that they could speak freely. Copies of the ethics approval letter from the Stellenbosch University and a consent letter from the hospital were available to view as confirmation for the participants that the study was permitted and complied with ethical standards.

The fieldworker utilized the interview guide to conduct the interview. Planned and unplanned follow-up questions and prompts were used in order to clarify, explore and elaborate on the participant responses. Examples of prompts that were utilized by the interviewer was a summarisation of the main idea from the participant or repeating their words and expressing interest with verbal questions. At the conclusion of the interview, the interviewer gave the option for the participant to talk about anything they had not shared and felt was relevant. The interview was concluded by thanking the participant and presenting them with a gift card as an appreciative gesture for their time.

3.11 Data analysis

Terre Blanche, Durheim and Painter (2006:322) describe the steps for qualitative data analysis which include, familiarization and immersion with the text, inducing themes, coding, elaboration and finally interpretation and checking.

3.11.1 Familiarization and immersion

All the interviews of the participants was transcribed. The researcher read all the data and listened to the tape recordings of the interviews to obtain a general understanding and comprehension of the scope, context and emerging themes of the transcribed data. Terre Blanche *et al.* (2006:323) recommends that the researcher should take all the material and "immerse" oneself in it. This was achieved by the researcher through reading the text several times and comparing different texts to guide interpretation.

3.11.2 Inducing themes

Terre Blanche *et al.* (2006:234) defines induction as: "inferring general rules or classes from specific instances." As the researcher continued to read and explore the data, she searched for categories or principles that were hidden in the data to determine themes and subthemes, while moving from one transcript to the other.

3.11.3 Coding of the data

The next step that followed was the coding of the data. Coding is a process of labelling a part of the text, in order to compare sections of the text that is coded in the same way (Grove *et al*., 2013:89). The researcher studied the text and made use of color coding to identify, lines, paragraphs or sections of text that pertain to the different themes in the text.

3.11.4 Elaboration

Induction of themes and coding of data allow the researcher to break up the text and study it in depth to determine the finer meanings which one might have missed with the original coding (Terre Blanche *et al*., 2006:326). In this study the researcher identified more themes with the repetitive coding, elaborating and recoding until no new significant insights appeared to emerge.

3.11.5 Final interpretation and checking

Finally, the researcher rechecked and read the text for themes and subthemes. She studied the written account of the phenomenon to rule out any potential bias in interpretation.

3.12 Summary

In this chapter the research methodology of this study was discussed. A qualitative research approach was described, with an in-depth overview of data collection techniques, the sampling process and data analysis. The rigour of trustworthiness as described by Guba and Lincoln (1982:246) was applied in the study and described in this chapter.

3.13 Conclusion

Planning and decisions regarding the research methodology for a study are essential steps towards scientific and ethical execution of the research. In this study an explorative descriptive research design with a qualitative approach allowed the researcher to explore and describe the experiences of nurses about the Enayatak model of care since implementation of this model.

Chapter 4:
Findings

4.1 Introduction

In the previous chapter the detail of the research methodology was discussed. In brief a qualitative approach was adopted, applying semi-structured interviews to explore and describe the purposeful selected participants' experiences about the Enayatak Nursing Model of Care adopted in public care hospitals in the emirate of Abu Dhabi in the Middle East. A Pilot interview was conducted to validate the data collection tool and an audit trial on data collected. Subsequently, the findings of the interviews are presented in this chapter in two sections, outlining the biographical data of participants and the themes that emerged from the data analysis.

4.2 Section A: Biographical data

In-depth interviews were conducted with nine participants. Seven of the participants were females and 2 were males, together with ages ranging between 27 and 50. The years of service of the participants in the hospital ranged between 3 years and 19 years with a mean of 8.5 years. Amongst the participants there were five staff nurses and four charge nurses. During the interviews seven of the nine participants indicated that they were champions for the implementation of the model of care.

4.3 Section B: Themes emerging from the interviews

There were 5 guiding questions that were utilized to direct the semi-structured interviews. These questions, listed below gave rise to six main themes and 15 subthemes.

- Tell me about your experiences with the Enayatak Model of Care?
- What has implementing the Enayatak Model of Care been like for you?
- What have you found helpful in your practice with the Enayatak model?
- What has been not so helpful or a challenge to you?
- Can you think of anything that we have not talked about that you would like to share about your experience with the model?

A summary of themes and subthemes identified from the interview data is presented in table 4.1.

Table 4.1: Themes and subthemes

Themes	Subthemes
Drivers of implementation	Champion empowerment
	Belief in the project
	Awareness sessions and baseline audits
Strategies	Usability and value of strategies:
	SBAR and clinical bedside handover
	Well-organized environment
	Knowing how we are going
	Intentional patient rounding
	Positive workplace environment
	Staff identification board
	Patient status at a glance board
	Cultural and Spiritual care
	START with HEART
	Creativity and unit initiatives
Perceived benefits	Influence on practice
	Staff satisfaction
	Customer satisfaction
Leadership support	Communication and follow-up
	Visibility and Recognition
	Resources
Challenges	Timeline
	Resistance
Sustainment	Audits and Action plans
	Ongoing improvement process

4.3.1 Theme 1 : Drivers of implementation

Frontline nursing staff unanimously identified that the implementation of the Enayatak Model of Care was a project of magnitude that required commitment and planning to drive implementation. The following subthemes were identified as contributors to the implementation of the model of care.

4.3.1.1 Subtheme 1.1: Champion empowerment

Participants reported that there were champions elected that were trained regarding the implementation of the Enayatak Model of Care and the expectation was that they spread the

awareness of the model and started implementation with an incremental approach in their hospitals.

> *"Then, we attended so many lectures, so much training before we started to implement and before we started to deliver to our colleagues. We got enough training"* (P2, page 1, line 25).

> *...in the beginning because it was a new thing they are introducing and the staff should get the awareness. So, even initially we got the awareness session first. (P7, page1, line 22)*

The champions that were interviewed, expressed their feelings of empowerment for the implementation of change in the hospital that the model of care would require.

> *"Such a great thing, like empowerment of the chosen staff initially to be part of the change that needs to be done in the hospital"* (P5, page2, line 21).

> *This is our mission from this programme. We will start it, step by step. (P2, page2, line 2)*

4.3.1.2 Subtheme 1.2. Belief in the project

It was argued by the participants that they had to "believe" and develop an "interest" in the model, before they could introduce it to their staff and feedback suggests that this was achieved by the organizational training and awareness plan.

> *"I think for me, it's very important that you believed in the project first, then you can disseminate the right information to others"* (P1, page3, line 6).

> *I have to convince myself first so I can convince my colleagues. (P2, page3, line 31)*

> *"We referred to the literature review, and we were so interested. I was so interested. I can say that"* (P3, page 1, line 33).

4.3.1.3 Subtheme 1.3. Awareness sessions and baseline audits

Staff indicated that the initiation of the project in the units was reliant on familiarisation with the model of care. Awareness sessions was conducted to achieve not only familiarisation with the model, but to introduce the goals and benefits of implementing the model of care. Champions reported that their initial focus was to determine baseline audit data prior to the implementation thereof.

"Awareness sessions for staff in the unit to know what we are going to do, what we are going to implement in the unit. And this will be in the whole hospital" (P6, page 2, line 1).

"...baseline audit. We gathered crucial things that needs to be improved in the unit. We have patient problems that are not being dealt with before because the staff are not encouraged" (P5, page 1, line 35).

4.3.2 Theme 2: Strategies

Conflicting opinions were reported about the usability and value of the different strategies of the Enayatak Model of Care. There was however a trend identified from the feedback of the participants on how strategies were adapted which led to creative initiatives to suit their care environment.

4.3.2.1 Subtheme 2.1: Usability and value of the different strategies

4.3.2.1.1 SBAR and clinical handover at the bedside

The majority of the participants reported that the SBAR and clinical handover at the bedside was the most valuable strategy that was implemented and brought significant change in practice. Prior to the implementation, patient handover was done in a central location discussing patient care in general. The new practice required the ongoing and outgoing nurse to handover the patient at the bedside, utilizing the SBAR communication tool (Situation, Background, Assessment, Recommendation). This was viewed by the participants as a useful tool to help them to discuss and plan for patient care effectively. Feedback from participants suggested that with the implementation of the clinical handover at the bedside, patients were now involved in their plan of care, staff were conducting handover more efficiently and communication with patients increased. Some participants also found that handing over at the bedside gave them the opportunity to introduce themselves to the patient, assess the environment and identify any safety issues, for example checking that the patient identification bands are on and correct, and evaluating patient surroundings.

"So, the first thing we introduced is the clinical bedside handover. This is the most important thing which I really like. Because before our endorsement was not like that. There was no communication with the parents. ...Really the receiving nurse and the handover nurse together going to the patient's side and introducing the name and checking the name band and we are involving the family in the plan of care" (P7, page 1,line 32).

> *"Now everybody is happy to implement these things in the SBAR because they are really recognizing that there is a big difference in what we were doing before. We are doing the handover but in organized way"* (P2, page 6, line 2).

It was however mentioned that the "negative point" of the new handover process was that it resulted in longer handover time. Patients were now involved in the handover and at times wanted to engage in longer conversations and raise questions that required a more detailed explanation.

> *"Every phase which we implement, there is a positive and negative thing. For this one what `I noticed, our endorsement is not finishing within 30 minutes"* (P7,page 2,line 23).

In contrast to the majority of the feedback favouring handover at the bedside, it was not implemented in the psychiatric unit. Participants working in this unit reported that their patient population are prone to being provoked and becoming suspicious and paranoid, and they felt that this strategy of handing over at the bedside would escalate these patient behaviours. They continued to have handover in a separate room and rounding on patients after it was completed.

> *"So, we're doing it as a team handover. It's like a closed room updating all the patients' conditions.... if we will do it bedside, especially for acute setting, the patient is really highly paranoid or suspicious, and then even just talking or mumbling, they will get provoked"* (P9, page1, line 34).

4.3.2.1.2 Well-organized environment

The next strategy that the majority of staff reported on was the well-organized environment that had a positive impact in their units. The staff felt that although this strategy was labour intensive it resulted in a more organized and efficient work environment with an improved appearance. They felt that going through the process of 5Ss (Sorting, Shining, Set, Standardize and Sustain) in their unit resulted in optimizing the use of their time by minimizing searching and movement.

> *"...they are not wasting their time searching...so the staff were really telling that it's really helping us ...and everything was well organized"* (P7, page 3, line 32).

> *"And after the implementing the WOW, even the unit itself. We can see there is improvement in the appearance, and things are arranged properly"* (P3, page 3, line11).

It was not just the training in the methodology that helped staff to implement this strategy, but also competitiveness between different units and team involvement.

> *"...It is not only our ideas...It's all 22 staff working, we have to have an idea about what we are going to do, or they agree on the plan...I went to some other unit. So, they already started working on it...it's wow. So, I came back, I said no, now I can't sit., They already started, so, we are going to start also"* (P6, page 9, line 4).

4.3.2.1.3 Knowing how we are going

The Knowing How We Are Going (KWAG) strategy was acknowledged by participants as valuable, in the sense that staff became more aware of what was happening in the unit with regard to care audits and it helped in reminding staff of the guiding principles of the nursing model and the four foundations of the model. Some participants felt that this was also a good opportunity to communicate any challenges experienced during their shifts and discuss action plans to address it.

> *"...and what we are doing is, we are just taking the staff, just 10 minutes, give a short presentation near to the KWAG board. Like, what are expected from the nurse? What are the challenges we faced last week? ...So, this is a good thing and the staff are getting information, like the fall risk, pressure sore ulcer rate... So, these are the information the staff are getting the awareness"* (P7, page 2,line 31).

4.3.2.1.4 Intentional patient rounding

There were conflicting opinions amongst staff regarding the usefulness of this strategy, where staff had to round on their patients at least every two hours. This strategy was regarded as valuable and having a positive impact in the general medical and surgical units, as well as the psychiatry units. The staff in the general units believed that the implementation of the rounding had reduced the amount of patient activating the call bells, because the patient knew when the nurse would be returning and was expecting the nurse. In contrast, the intentional patient rounding was a cause of frustration and regarded as not helpful in the more specialised units, like the labour and delivery unit and the neonatal intensive care units where the nurse-patient ratio is often one to one.

> *"Every two hours I'm going to visit you. Between that if you need anything, you can call. The first thing that we get, benefit from this one is that reducing of the call bell because the patient knows that I'm going to visit him after two hours"* (P2, page 2, *line 39).*

> *"... I don't think it's appropriate for us because we are staying on the bedside, but again they force it, until such time they withdraw the project"* (P1, page 2, line 10).

4.3.2.1.5 Positive workplace environment

There were two tools introduced in this strategy that participants described: The "above and below the line behaviour" and the "rate your shift".

a) The above and below the line behaviour

Participants replied that staff were involved in making a poster and were eager to identify behaviour that was unacceptable and what was acceptable to display in the unit on a poster, in terms of below the line and above the line behaviour. However, it was claimed that staff were reluctant and found it challenging to remind and call out their colleagues on behaviours that is below the line and that the outcome of this activity was difficult to evaluate. It was reported that this poster was useful in the sense of raising awareness amongst staff about their behaviour, but whether this activity changed the workplace culture was not acknowledged in participant responses.

> *"...now it's there in the unit just a reminder... but actually we cannot audit it consistently...plus of course you have the bias. This is your friend, you cannot say, oh my God, taking too long for endorsement, using the mobile phone. Because it's a personal thing. It will be just a reminder"* (P1, page 7, line 6).

b) Rate your shift

Two participants explained that staff had to rate their shift at the end of each shift as good, normal or a stressed shift. This was subjective and staff had different views on what a stressed shift was. Consequently, a trend that the participants reported was that staff were educated on "what is really the meaning of good, average and stress shift?" Despite this challenge, it was reported that it was helpful and improved staff's stress levels and teamwork, when there was a review of the data and action plans made to address the "red" or "stressed" shifts.

> *"...our team members sit together and discuss, why it is happening, for particular days the staff are always rating as stress shift. Then we came to know that that particular day is a procedure day. So, what our in-charge did, she assigned one staff on eight-hour duty basis for that procedure days, so the workload is reduced. So, that rating the shift, in that way, really is helpful for us"* (P7, page 12, line 11).

> *"We will see this paper with green and red and blue. Red we see sometimes...the patient acuity was very high. So in this cases, we told in that shift...we should stop in*

some point in the middle of the day, to see what's going on and what's going bad, or to help that staff to make things easy for her" (P4, page 3, line 7).

4.3.2.1.6 Staff identification board

Having a staff identification board in the unit displaying pictures and names of the care team, were regarded valuable and the staff reported that it was beneficial for both patient and staff, but it was challenging to manage and keep it updated with movement of staff between units. They reported that patients would look at the board and recognize nurses for taking good care, but at the same time raise complaints against others.

One participant believed that the fact that the pictures of staff and their names were visible in the unit supported the notion of accountability for nursing care.

> *"It's benefits for both patient and staff. Patient can recognize staff, as well as this is like you are accountable for your patient. So, when they see this board, they will ask, where is this nurse now? She was there for my last delivery. So, you feel very great when somebody says, oh, she was very nice"* (P6, page 7, line 14).

4.3.2.1.7 Patient status at a glance board

The patient status at a glance board that was placed in each unit was the least favourable of the strategies. Staff felt that the boards were difficult to keep accurate and updated, and some reported that nobody looked at this board. In certain units this strategy was not implemented at all, as they had electronic dashboards in their units.

Some participants agreed that the board can be helpful and a useful idea, but needs to be implemented in an efficient way. It was reported that the updating of the boards was time consuming, because of all the different elements displayed that required updating. One participant did have an opposite opinion and explained that this board was helpful in their unit to manage patient flow and communication with the multidisciplinary team. Responses suggest that the impact that this strategy had in the units were highly individual experiences, dependant on unit dynamics and approach.

> *"Actually, this is good idea if it is done properly. Now we are updating this board with so many information's. Fourteen elements we are to fill. The staff, team leader, it's really a headache. It is done it takes two hours"* (P3, page 4, line 35).

> *"...the doctors also, what do you call this? Relate to what the board is trying to present in regard to the patient, and who's assigned the procedure to be done. And it is helpful*

also in our unit to monitor the flow of the job or the task in the particular shift" (P5, page 4, line 30).

4.3.2.1.8 Cultural and spiritual care

Participants acknowledged that the workforce represents many nationalities which demands an increased understanding of the cultural and spiritual influence of the Muslim religion and Arab culture in caring for patients. Consequently, the Crescent of Care Model was introduced to support cultural and spiritually directed care for the Muslim patient. The participants verified that the introduction and teachings of this model enhanced the ability of Non-Arab and Non-Muslim staff to tend to the patients' needs and expectations holistically.

> *"It is holistic nursing care. We have to think about their culture, the spiritual needs and the social needs. So, in that actually, because we have non-Muslim, non-Arabic caring for the patient and we don't know their culture and beliefs, they have so many... We presented this Crescent of Care Model, one presentation, how to look after them. If they need someone to pray for them, how we can get help...."* (P6, page 12, line 3).

4.3.2.1.9 START with HEART

Two of the participants commented on the START with HEART strategy. They both felt that the training regarding this communication strategy was helpful and empowered staff in communication skills to build relationships with patients and staff. One participant claimed that this communication model enhanced customer satisfaction and was of the opinion that this programme made a positive difference in how staff communicated with their patients.

> *"From my experience, when I joined 19 years before, it was not happening. Never say, my name is so-and-so, I am the nurse looking after you for this shift. So, it was a very nice topic actually to provide customer satisfaction and to identify. We were more empowered `I think in that subject. Even in the unit they all attended the course and they were happy with that. There were no negatives about the course"* (P6, page 2, line 28).

4.3.2.2 Subtheme 2.2: Creativity and unit initiatives

Participants provided examples of how staff were creative and took initiative to adapt some of the strategies to suit their unit environment. Some staff identified certain limitations that a specific strategy had in the unit and discussed staff initiatives to overcome these limitations. One of the examples was shared by participants working in the psychiatry unit. They reported that rounding is a priority for them and that they needed a tool to reflect important assessments that needed to be checked even hourly. They utilized the acronym DONE (Distress,

Observation, Needs and Environment) to guide their clinical rounding as opposed to the model of care's acronym of the 4 Ps (Pain, Position, Personal needs, Possessions).

> *So, if we apply that DONE in the intentional, we will assess the patient if they are being distressed or any problems or is he in pain. Same with other units. The only thing is, it's more detailed...because as much as possible there was no harm happened to patients. (P9, page 5, line 26)*

In the Neonatal Critical Care unit they identified that there are limitations in the benefit of the Crescent of Care model for the newborn, however they can consider the parents religion and culture.

> *If it comes to the newborn, it's less. But when it comes to parents, it's kind of okay. If they want to pray for the baby or giving this water, the Holy Water from Mecca, then we are allowing it to be there. But we are telling them you cannot give it to the baby to drink, we are just incorporating it into their bath. (P1 ,page 6, line 28)*

In one unit where there are many long-term patients the bedside handover strategy and SBAR was customized to utilize time efficiently.

> *The patients who will stay, patient is with us more than three months, that means everybody in the unit knows that patient. So, we suggested that we are not going to endorse every single thing on that patient. (P2, page 7, line 39)*

Another initiative described by one of the participants was Cyber rounding. Instead of only intentional rounding by staff in the units, they initiated a multidisciplinary round involving all the healthcare professionals responsible for care of the patient.

> *The team that is involved with the patient will be available in one particular round. The dietician if needed, physiotherapy will be there. That will make it organized and make the communication for each and every one of the team.... Then they will form the plan of care for the patient in one. (P5, page 5, line 33)*

In the paediatric department staff felt that utilizing the suggested tool to conduct the intentional rounding was not helpful and they got the feeling that parents will get irritated with them. Therefore they continued doing the rounds, but ask different questions.

> *But the thing is, every two hourly I don't like to go and ask Mama, your child is having any pain? You need something and then again after two hours. These questions may be irritating the parents if the child is very stable. So...we are going to the patient's side*

and we asking, how is your child? Do you need something? I just came to see how your baby is doing. This is what I want to change, that they are telling to go ask pain, position, possession and pan. (P7, page 6, line 4)

4.3.3 Theme 3: Perceived benefit's

Participants reported on their perceived benefits as a result of the implementation of the Enayatak nursing model of care. Three subthemes were identified and are discussed.

4.3.3.1 Subtheme 3.1: Influence on nursing practice

Participants reported that the implementation of the model of care did influence their nursing practice. They reported that the model standardized, directed and enhanced efficient and effective care for the patients and their family. Their perception was that the model contributed to the delivery of quality nursing care.

"I can say it's a really good project because it's giving the nurses direction when it comes to patient, to their family to their culture, to environment" (P1, page 1, line 29).

"Actually, the positive things in all the phases...actually we became unified because the patients, ...they will tell us, we are expecting the same because when I was in the other unit, they were doing the same" (P2, page 5, line 30).

"It's like making our task easier. Making our shift...It's like, in a shift we have a goal to do, but with this guideline, with this new model of care, it found out that it was very efficient or effective when it comes to delivering quality care" (P9, page 2, line 7).

4.3.3.2 Subtheme 3.2: Staff satisfaction

Participants claimed that they felt empowered and motivated since the implementation of the Enayatak model of care. They felt that the model of care supported staff recognition, personal and career growth and consequently this augmented their motivation.

"To me, it's enhanced my communication and enhanced my knowledge in a way that I could develop myself more in my career" (P8, page 1, line 25).

"Nurses are more empowered to deliver care, and we think apart from the routine work this is something greater you can do to perform for the patient's safety and patient customer satisfaction" (P6, page2, line 19).

"Actually ... we were doing things before in our hospital, but it was not recognised as a unit project because there was no structure, nothing. So, now, it's clear that there is a structure, as part of the nursing model of care. So, we are getting recognition.... So,

we feel proud that it is motivating us to do the things in a better way" (P7, page 11, line 16).

4.3.3.3 Subtheme 3.3: Customer satisfaction

Patient and family involvement in their care has increased according to the participants. One participant was of the opinion that patient trust and confidence in the nurses increased as well. Overall the participants reported their impression that customer care and patient outcomes have improved with the implementation of the model.

"I have seen so much improvement in the patient outcome. There is declining bedsore, and infection rate is decreased. Staff satisfaction, patient satisfaction improves" (P3, page 2, line 28).

"Actually, there was a much big difference, which I was surprised with. That was patients, themselves, they were confident in dealing with us, and they were trusting us" (P2, page2, line 30).

4.3.4 Theme 4: Leadership support

There were conflicting reports from participants regarding leadership support during the implementation of the model.

4.3.4.1 Subtheme 4.1: Communication and follow-up

Participants agreed that communication from leadership and unit based follow-up from the organizations' leaders about the implementation of the model of care is an expectation, in order to sustain unit achievements and demonstrate staff appreciation. There were conflicting reports about the level of commitment from different leaders of the hospital to follow up on and communicate about the Enayatak Model of Care implementation. Some participants felt that leaders provided continuous feedback, advice and demonstrated support about their work, while others reported disheartenment by the level of support and feedback.

"It's now a two-way communication, that leaders and the members are giving and taking feedback which is helpful in the unit. Communication is more improved and we find it very helpful for us to work with our leaders that are giving and taking communication inputs and feedbacks" (P5, line 2, page 7).

And the good thing, when they are coming they will come to know that what is really happening in our department. Whether they are very busy, whether staff are really running here and there. And sometimes they will select one staff and they will ask, okay, how do you feel about today's work? Whether you want to feel that whether you

want to change something? So, if the staff can tell the proper answer, then I think they will make some changes. And they are appreciating one staff for their work. (P7, page 4, line 33)

4.3.4.2 Subtheme 4.2: Visibility and recognition

Leadership rounding is one of the strategies of the model of care that requires the organizational leaders to round on the units and talk to staff and patients. This allows them to recognise outstanding performance and evaluate the Enayatak Model of Care strategies. The participants reported that these rounds make the leaders visible and recognition that is given as a result of these rounds are highly valued by the staff. Additionally, some participants admired the leaders for their increased involvement and awareness of unit dynamics as a result of increased visibility in the unit.

"You know what that means when your manager will send you an email and tell you thank you so much for being in the ward.... This is what's happening, actually. Leadership round... coming for this purpose. For our ADON, she will come every month. Whoever is available staff, she will talk to him and she will take a tour with him in the ward. He knows about NMOC, he knows what is the board, Well organized ward...everything. That time also she will ask about any problems. This is involvement of the leadership. They know what's going on. They know what problems there are. They will say okay, let's try another thing" (P2, page 7, line 29).

Before we didn't used to see any manager in our ward. Really, they are coming, and they are checking sometimes around the surroundings. What happening, what's going on? (P4, page 6, line 10)

We need support from the managers, from the charge nurse and the team members. Sometimes, we are working hard, and we are not getting recognition. That is also sad thing. Recognition means, if we are asking help for certain things, which we are finding difficult, this should be supported. If they are just ignoring that...that is disappointing" (P3, page 8, line 28).

4.3.4.3 Subtheme 4.3: Resources

The majority of the participants acknowledged that there was a lack of support with regard to financial, material and human resources with the implementation of the model of care. Some participants, especially the champions reported that they often offered up their own time and contributed money during the implementation of the model, due to the pressure and the responsibility they felt to implement the model over and above their regular duties on shift.

> *"For example, if we have meetings, deadlines. So, you really have no choice to come when your off duty, because if we will do that things...during our duty, it could affect the rendering of care"* (P9, page 8, line 29).

> *"Because whatever activities which we are doing actually we are taking the budget from our hand. It's not the hospital paying for that...Anyway, it's not a big amount which we are paying, but still we are taking from our hand for all the activities which we are doing in our department for NMOC"* (P7, page 14, line 9).

There was one unit where the participants' feedback contradicted the notion of staff having to offer up their own time to complete activities. This participant reported that the manager was helpful in looking at how he could avail himself for duty time of these activities and when it was not possible, he would ask all for their help and come in with the staff to help.

> *"He himself, he was coming on Saturdays. He will come for three hours. He will ask who else wants to join us? Then the one from off day will come with us. The one on duty if they are free...they will join us. Then the materials. He was also helping us. He is telling us okay, I will bring the material because they are giving us ideas"* (P2, page9, line 9).

4.3.5 Theme 5: Challenges

The majority of participants experienced the set timeframe and resistance demonstrated by some staff members during the implementation of the nursing model of care as a tangible challenge.

4.3.5.1 Subtheme 5.1: Timeline

Considering the magnitude of the implementation of the model of care, together with current unit responsibilities, some staff felt that the timelines to implement the different strategies were narrow.

> *"So, when NMOC came in, and the higher ups introduced this to us, we are shocked. It's very big. And the timeframe for doing everything is very limited. And, there's too much audit left and right that is going on, while doing the project, which for me, I want to concentrate on this one." (P1, page 2, line 3)*

> *"Timelines. Yes. There are some reasonable, but the most it's like, you need to do this. It's a push". (P9, page 9, line 26)*

In one unit the participant (P4, page 2, line 8) reported that when she questioned staff regarding their cooperation with the implementation of the model in the unit, they reported that they were “too busy to handle this.”

On the contrary, two participants reported that the timeframe set for implementation was acceptable, even though implementing something new poses some difficulties.

> *“We get actually, enough time for each phase but something new to the unit, something new to be applied. It’s difficult”* (P2, page 2, line 14).

> *... the pace is just the right pace, which we we’re given enough time to do the task in our unit, our project (P5, page 2, line 33).*

4.3.5.2 Subtheme 5.2:Resistance

Staff attitude towards change and implementation of a new project was repeatedly stressed as a barrier towards transformation. This resistance was described as animosity and rigidity, often demonstrated by the older staff and staff that has been employed for a long period of time in the hospital. It was emphasised that the implementation of the model of care required a cultural and attitude change.

> *“Especially in our unit, we have different nationalities, different cultures. We have different ages. We have people there who worked more than 20 years, more than my age. Imagine you are telling people no, we are going to change the system. Who are you, telling me, you are just joined how many years before?”* (P2, page 3, line 35).

> *“You are introducing something, everyone will have resistance. It’s very difficult to push through that resistance. Because it’s culture, you are going through the culture and resistance is very difficult to solve immediately. First the staff, they don’t want to do it, it’s very difficult, it’s not appropriate for our unit. You will hear a lot of things”* (P1, page 2, line 41).

4.3.6 Theme 6: Sustainment

Participants reported that the model is not fully sustained or integrated in practice yet and requires support going forward.

> *“Once it’s really integrated, it’s like the air that we are breathing, then that is the time. But since we are just less than two years. I don’t believe that it’s in the system already of the nurses”* (P1,page 9, line 17).

4.3.6.1 Subtheme 6.1: Audits and Action plans

The participants emphasised that going forward, audits, action plans, monitoring and follow-up education were necessary for sustainment of the Model of Care, as they perceived the model not being fully integrated in the staff's day-to-day practice yet.

> *The challenges actually, as I mentioned, how to maintain these things? How to maintain how to sustain? So, we have to keep on educating staff, we have to take initiative. At least our champions have to take initiative to tell the staff that we have to maintain these things. Even we are making an action plan for whatever thing (P7, page 11, line 31).*

> *And once in three months we have a quarterly meeting with the NMOC managers or teams. Then, another thing, we have a staff audit. Like there is a questionnaire and five staffs are audited per month. We learn so many things. We implemented, still we are monitoring (P6,page 15, line 3).*

4.3.6.2 Subtheme 6.2:Ongoing improvement process

Participants insisted that sustainment of the model requires an ongoing improvement process including continuous follow up, resources and encouragement of staff.

> *"We don't have much particular problem, aside from still we are in process of improvement. Although the problem is there, but improvement really continues, and we need to work on it even at this time. We have to work on encouraging staff because staff sometimes forget... We also welcome, because this is an ongoing process, and it is ongoing improvement. We are still open for suggestions that might arise". (P5, page 2, line 36)*

The following metaphor that was expressed by a participant, reaffirms the crucial role of continuous guidance and support towards the maturity of the Nursing Model of Care project in the care environment.

> *"But now it's very young, it's just two years old. So, it's really need a guidance. It's like a baby, you know. It's just barely walking, so it's need a holding hand until that baby is walking alone and running. Once it's running, then let go" (P1, page 9, line 35).*

4.4 Summary

This chapter described the findings of the data collected in the research study. The researcher initially presented the biographical data, followed by a description of the findings detailing the themes and subthemes that emerged from the data analysis process. The six themes that

were deducted from the participants' feedback were, drivers of implementation, strategies, percieved benefits, leadership support, challenges and sustainment. In the next chaptor the interpretation, limitations and significance of the findings are explored.

4.5 Conclusion

The objective of this research study was successfully completed namely to explore and describe the experiences of frontline nurses about the Enayatak Nursing Model of Care since the implementation of the model in public healthcare facilities in the emirate of Abu Dhabi, UAE. The objective was successfully explored with an in-depth investigation and emersion into the qualitative data collected from participants' responses of the phenomenon investigated.

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Chapter 5:
Discussion, recommendations and conclusion

5.1 Introduction

In this chapter a discussion of the findings, limitations and significance of the study are presented. Recommendations are made based on the critical review of the content. Finally the dissemination of the research is outlined, opportunities for future research identified and a conclusion derived.

5.2 Discussion of findings

The objective of this research study was to explore and describe the experiences of frontline nurses about the Enayatak Nursing Model of Care since the implementation of the model in public healthcare facilities in the Emirate of Abu Dhabi, UAE. Six themes emerging from the data analysis process were associated with this objective and are discussed below:

5.2.1 Drivers of implementation

In the current study participants consistently reported that the Enayatak Model of Care implemented in the healthcare facility was a large-scale project requiring commitment. The participants that were champions explained that they were trained in this Model of Care, that resulted in their understanding and belief in the project. This in turn empowered them to be the change agents in the hospital. These findings are consistent with the studies of Cordo and Hill-Rodriquez (2017:325) and Slateyer et al. (2015:147) who reported that empowerment, education, the use of champions and the train-the-trainer approach are drivers of successful implementation of a model of care.

5.2.2 Strategies

The Enayatak Nursing Model of Care is presented as an eclectic model incorporating evidence-based strategies based on the literature and successful clinical practices (see paragraph 1.7). The strategies prescribed in the Enayatak Model of Care are presented in table 1.1. There is a plethora of literature providing an evidence base for the individual strategies presented. In the Enayatak Model of Care. The combination of all of these strategies defines its eclectic nature. The concept of including strategies in a model of care is emphasised by the New South Wales Agency for Clinical Innovation (2013:3) who published guiding principles for a framework towards developing a model of care. They state that a model should be innovative and encourage alternative strategies for organizing and delivering care. The narratives of the participants included feedback regarding the value and usability of the individual strategies of the model that was implemented.

5.2.2.1 SBAR and clinical handover at the bedside

The participants in this study acknowledged several times the value of handover at the bedside with the use of the SBAR communication tool. They reported that as a result of this strategy patients were now involved in their care and felt included in the care process, communication has improved and efficiency of the handover process improved (Paragraph 4.3.2.1.1.). This correlates with an evidence-based literature review compiled by Dorvil (2018:22) consistently showing that handover at the bedside improves overall patient experience.

Nevertheless, this strategy was not useful in all patient settings as reported by the participants working in the psychiatric department and some staff felt that handover is now more time consuming. Dorvil (2018:25) explains that continuous leadership assessment of the bedside report process and process modification to fit the needs of the unit and considering feedback from nurses is needed to sustain this strategy.

5.2.2.2 Well-Organized Environment

The Well-Organized Environment strategy is described in paragraph 1.7.2.2.1, and the aim is to organize the environment to promote a safer and more organized work environment. The participants unanimously agreed that this strategy was very useful and helped them to save time searching for things and improved the appearance of the unit (Paragraph 4.3.2.1.3). These responses correlate with the final aim of this strategy described by the National Health Service (2006) to release time of nurses to care for patients.

5.2.2.3 Knowing how we are going

This strategy was favoured by the participants and their feedback indicated that this facilitated awareness of the staff on key performance indicators (KPI) in the unit and collaboration on action plans to improve the KPI's . This strategy is based on the NHS Quality improvement programme: Productive ward as described in paragraph 1.7.2. A recent independent study investigated the status of the program implemented in the hospitals after 10 years had gone by and still found evidence of the display board sustained (Sarre, Maben, Griffitths & Chable, 2019:1). This finding correlates with the feedback of the participants evaluating this strategy.

5.2.2.4 Intentional patient rounding

The participants disagreed regarding the usefulness of intentionally rounding on patient every one to two hours according to a set protocol. While some participants reported a decrease in call-bell usage of patients, others claimed it is frustrating and not always applicable in their type of units. A recent systematic review about the relevance of intentional rounding in clinical practice, confirmed the ambiguity of evidence around the sustainable positive effect on patient

care, suggesting the robust evaluation of the protocol and implementation of this initiative (Christiansen, Coverty, Graham, Jacob, Twigg & Whitehead, 2018:1759).

5.2.2.5 Positive workplace environment

A large-scale study titled “Association between organisational and workplace cultures, and patient outcomes: systematic review” confirmed a consistently positive association between workplace culture and outcomes supporting the implementation of activities that promote positive cultures (Braithwaite, Herkes, Ludlow, Testa & Lamprell, 2017:1). Similarly, the participants of this study reported on the benefits of the two activities related to workplace culture: the above and below the line behaviour identification and rate your shift (see paragraph 4.3.2.1.5).

5.2.2.6 Staff identification boards

The narratives of the participants confirmed that the availability of a staff identification picture board in the unit encouraged patient feedback and increased the nurses’ feeling of accountability. This finding is consistent with one study identified in the literature of a hospital who displayed a picture of the nurse on the patient’s room door (Shimp & Simms, 2016:309). The study findings suggested that this initiative created an environment that allowed for ease of communication.

5.2.2.7 Patient status at a glance board

The general consensus amongst the participants was that this strategy was least favourable. They admitted the potential of the strategy, but felt it was not implemented efficiently to produce any benefits. Additionally, it was reasonable to say that the availability of electronic boards will replace the need for such a board (see paragraph 4.3.2.1.7). A study on the utilization of privacy-friendly digital white boards, provided qualitative evidence that presenting updated information on patient care in an identified format may support care coordination in the unit (Gjaeri & Lillebo, 2014:27).

5.2.2.8 Cultural and spiritual care

Participants reported that the Crescent Care Model was adopted in the hospital to support cultural and spiritual directed care for the Muslim patient. The teachings of this model were especially useful in the multicultural workforce environment of the hospital (Paragraph 4.3 2.8). Participants’ responses support the goals described by the author of the Crescent Care nursing model which was to provide guidance for meeting the holistic needs of Arab Muslim patients (Lovering, 2012:171).

5.2.2.9 START with HEART

The positive effect of a small investment in training time for healthcare providers in communication skills on patient satisfaction has been proven (Allenbaugh, Corbelli, Rack, Rubio & Spagnoletti, 2019:1167). In this study qualitative data suggests that the communication programme START with HEART (see paragraph 1.7.2.3.4.) has improved patient-nurse relationships.

5.2.2.10 Leadership rounding

As described in paragraph 4.3.2.2. the participants communicated their value of the leaders regularly rounding on the units, in the sense that it resulted in visibility of the leaders, recognition of staff and awareness of unit dynamics. Evidence suggests that rounds have a positive impact on patient experience, quality care indicators and employee satisfaction (Reimer & Herbener, 2014:654).

5.2.2.11 Patient bedside boards, medical equipment library & the 10 Guiding principles

These three strategies are mandated as part of the Enayatak Nursing Model of Care as discussed in paragraph 1.7. However, there were no participant responses regarding these strategies identified during the thematic analysis. The medical equipment library was an optional strategy and not implemented at this research site.

5.2.3 Perceived benefits

In the interviews the data revealed an overall impression of participants that the implementation of the Enayatak Nursing Model of Care had a positive influence on their practice. This influence was explained as the model having standardised, directed and enhanced efficient quality care for patients and their families. Alligood and Tomey (2010:14) predicted the contribution of an explicit conceptual model towards consistency in nursing practice through enhancing unified goals for practice and a systematic approach to nursing delivery.

Additionally, the participants in this study confirmed that staff satisfaction and patient outcomes were influenced positively by the implementation of the Enayatak Model of Care. They reported that they felt empowered, “happier” and motivated since the model implementation, because it supported staff recognition and personal career growth. An increase in customer satisfaction was also anecdotally reported on by the participants. The participants claimed that both customer care and patient outcomes improved as a result of the implementation of the Enayatak Nursing Model of Care. These experiences correlate with findings of studies done by both Slateyer *et al*. (2015:141) and Stallings-Welding and Shirey

(2015:199) which established a link between positive patient and staff outcomes and the implementation of a model of care. Stallings-Welding and Shirey, in their study further elaborated on a positive correlation of nurses' perceptions of quality of care, nurse interactions, decision making, autonomy, job enjoyment and patient satisfaction in hospitals where a Professional Practice Model was implemented.

5.2.4 Leadership support

Literature regarding the genesis of a model of care discussed in paragraph 2.3.4. indicates that one of the guiding principles and foundations of the genesis and implementation of a nursing model is complete organizational and leadership support. The feedback from participants in this study indicated a significant variance in the level of leadership support and commitment from unit to unit. Participants that did report leadership support, identified regular communication, follow up, visibility and recognition of efforts as motivating factors in successful implementation of the model. However, the majority of participants repeatedly mentioned a lack of financial and human resources support for the implementation of the model. Participants felt the pressure of implementation over and above their regular duties and multiple organizational priorities (paragraph 4.3.4.3).

A concept analysis of "Leading change" completed by Nelson-Brantly and Ford (2017:834) indicated that operational support, individual and collective leadership are defining aspects of leading change, as indicated by some of the participant narratives in this study. Nurse managers and directors have the responsibility to provide operational support in the form of strategic staffing plans, activation of resources, navigating issues and monitoring progress, when transformation of nursing practice is required (Nelson-Bradly & Ford 2017:839). Another study conducted by Rajah and Wey (2014:1028) on quality improvement practices confirms that a positive outcome is dependent on a well-constructed business environment that supports the culture of change and provides the necessary resources.

5.2.5 Challenges

All the participants reported that there was resistance towards the implementation of the Enayatak Nursing Model of Care, demonstrated through animosity and attitude contention by the "older" staff in the organization. Lewin's theory on change management described as three steps in paragraph 2.3.6.1, suggests that the recognition of the need for change is a starting point and that perceptions of individuals about their surrounding environment and practice can be changed through facilitating learning.

Going forward an understanding that change is a process rather than an event is required, in order to engage people to try out the change. However, in this study participants often

described the time frame for the implementation of the Enayatak Model of Care as insufficient, indicating a perception of this model as possibly being seen as an event rather than a process. In paragraph 2.3.5. the seminal work of Kotter describes this perception of change as “an event” common amongst nurse managers, leading to transformational failure.

5.2.6 Sustainment

The participants in this study reported that sustainment strategies in the form of audits, action plans and follow-up education were required to sustain the Enayatak Nursing Model of Care in the organization. Participants were of the opinion that the model was not fully integrated in the staff’s day-to-day practice yet and that continuous follow up, provision of resources and education of staff is an ongoing improvement process. This feedback is consistent with Edward Deming’s “Total Quality Management” philosophy that requires a culture of continuous improvement (Taylor *et al*., 2014:291).

5.2.7 Conclusion

The exploration of the nurse’s experience about the implementation of the Enayatak Nursing Model of Care revealed the extent of this large-scale project. It fundamentally requires leadership support and a change management process to overcome challenges and fully integrate and sustain the model in the staff’s daily practice. Leadership support from all levels in the organization is key to imprint a professional practice model across all areas of nursing practice and requires commitment to a multiyear journey (Mensik, Martin, Johnson, Clark, & Trifanoff, 2017:425). The utilisation of theory of change and theory of quality can provide navigation for the implementation of such large projects (Fawcett & Desanto-Madya, 2013:336).

It was evident that some of the strategies mandated for implementation, were not viewed as significant and required flexibility depending on the unit it was applied in. Davidson and Everett (2015:126) indicate that it is important to tailor models of nursing care to meet the needs of the healthcare environment, patient and families.

Based on the findings discussed in this section it can be concluded that the implementation of the Enayatak Nursing Model of Care was experienced by the frontline nurses as transformational with regard to patient care and staff experiences in the hospital.

5.3 Limitations of the study

This study population was limited to one public sector hospital in the Emirate of Abu-Dhabi where the Enayatak Nursing Model of Care was implemented. Frontline nurses in other hospitals may have different views about the experiences with the Enayatak Nursing Model of

Care implemented in their hospitals. The study participants met the inclusion criteria, however the majority of participants identified themselves as champions tasked with the implementation of the model in their units during the interviews. The inclusion of more non-champion frontline nurses may contribute additional data on the experiences of the frontline nurse.

5.4 Recommendations

The thematic data analysis of this study about the experiences of frontline nurses with the Enayatak Nursing Model of Care contributed to the schematic structure figure 5.1. This schematic structure incorporates the recommendations from this study which may guide the implementation of a Nursing Model of Care in a healthcare organization.

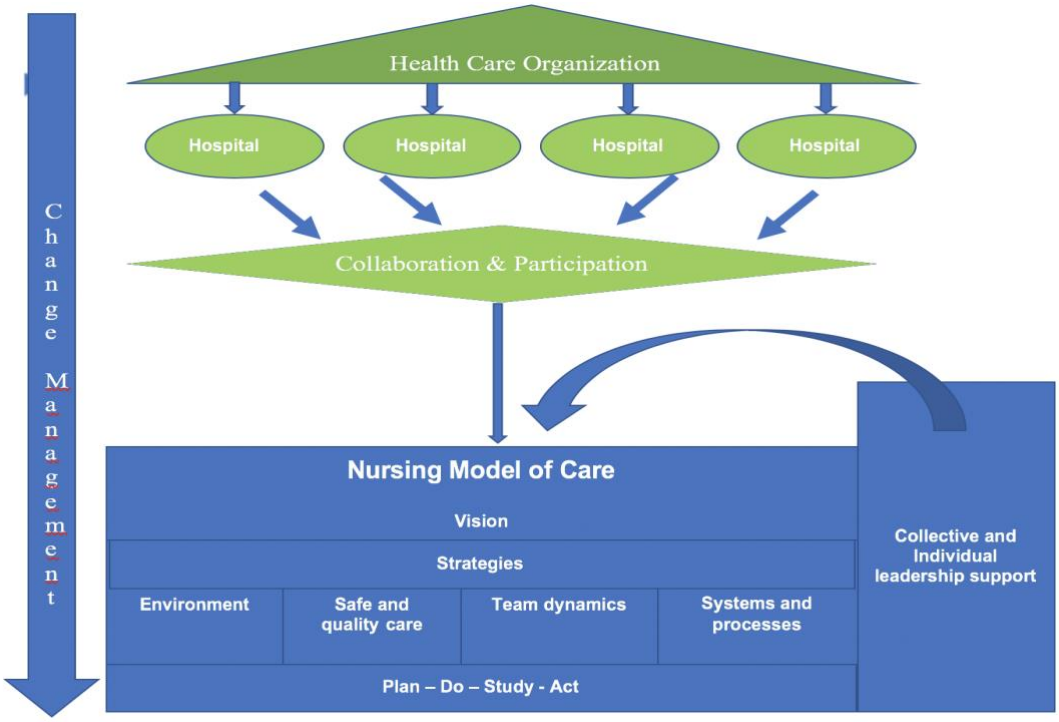

Figure 5.1: Schematic presentation of a Nursing Model of Care implementation

5.4.1 Implementation of a Nursing Model of Care across a Healthcare system

The schematic illustration of a healthcare system as shown in figure 5.1 involves multiple hospitals, going through a process of change to implement and establish a standardized nursing model of care. Swick, Doulaveris, and Christensen (2012:314) state that the most significant decisions a health system chief executive can make, when an organization consists of multiple hospitals is endorsing a model of care with the aim of providing a framework that would unite various ideas and approaches to service delivery. Based on the perception from the participants about the Enayatak Nursing Model of Care in this study, this model provided a suggested framework that standardized, directed and enhanced efficient quality care for patients and their families.

5.4.2 Communicate and imbed a vision for the nursing model of care

The participants in this study did not verbalize or comment on the vision or the guiding principles of the Enayatak Model of Care . A nursing model needs to describe a common vision and values for professional practice (Bigby, 2015:2; Slateyer, Twigg, & Coventry, 2016:140). This concept is represented by the roof of the hospital structure in the schematic presentation, symbolizing its importance in accommodating several strategies towards optimizing nursing care delivery.

5.4.3 Utilize change management theory to support the roll out of the model across the system

The participants of this study emphasised the challenges with implementation of the changes related to the model, especially resistance from “older” staff towards the model. Utilization of a framework for planned change may assist in eliminating potential barriers to change (Mitchell, 2013:37). The change management framework of Lewin is discussed in paragraph 2.3.6.1. as an example, however there are several change management frameworks and it is up to the organization to identify the most appropriate one fitting their specific circumstances (Michell, 2013:37). The potential for failure to change could be mitigated by the proactive considerations of the process for change and to assist those impacted by the change to be more accepting of it (Michell, 2013:37).

5.4.4 Apply Total Quality Management theory to explain and address challenges and sustainment of the strategies

The researcher uncovered conflicting opinions of the participants regarding the usability and value of the different strategies of the Enayatak Model of Care, and they reported that the strategies needed to be adapted to suit the care environment. The PDSA Cycle (Plan-Do-Study-Act) described in paragraph 2.3.6.2 is a step-by-step process for gaining valuable knowledge and experience for the continual improvement of a product, process, or service (Deming Institute, 2018). This concept forms the foundation of the hospital structure depicted in figure 5.1. The frontline nurses need to apply a cyclical PDSA process on the strategies to be implemented in order to adapt, sustain and constantly re-evaluate the strategy. The frontline nurses therefore need to be trained in quality management theory and tools, as well as being empowered towards innovation of the strategies to their care environment.

5.4.5 Establish foundational components of the Model of care

Slateyer *et al*. (2016:140) identify that a model should describe safe, high quality patient-centered care and the relationship between an organization and the nurses. Team dynamics and quality patient care are represented in the schematic presentation as building blocks for a nursing model of care. The environment and system and processes are represented as two

additional building blocks. Business processes, need to be examined to remove redundant steps and barriers to efficient workflow (Swick, *et al*., 2012:315).

5.4.6 Establish and agree on requirements of leadership support prior to the implementation of a model of care

The researcher identified guiding principles described in the literature supporting the implementation and sustainment of a nursing model of care (American Nursing Credentialing center, 2018, Canadian Nurses Association, 2012 & New South Wales Agency for Clinical Innovation, 2013). These guiding principles include innovation, team functioning, communication, education, leadership, change management, recognition and empowerment. In this study the participants' narratives described in chapter four eludes to the application of some of these principles in the implementation of the Enayatak Nursing model of Care, however there was an explicit focus on leadership support and at times the lack of it. In figure 5.1 leadership is the interconnecting building block of the hospital structure, conveying its crucial role.

According to Nelson-Bradley and Ford (2016:835) one of the defining attributes of establishing change is both individual and collective leadership. They explain that often a need for change or project is suggested or shared by an administrative leader e.g. a director of nursing, but subsequently it is the collective leadership of change champions at different levels that is required to support change. Support can be tangible by creating time and opportunity for dialogue and reflection about the implementation and sustainment of a model (Fryers *et al*., 2012: 23). Additionally, providing operational support is the responsibility of nurse managers and directors and requires mobilizing resources, managing roadblocks and developing strategic plans to enable implementation of a model of care (Nelson-Brantly & Ford, 2012:839).

5.5 Future research

The following areas for future research are recommended:

- The experiences of organizational nursing leaders with the implementation of a model of care
- The effect of implementation of a model of care on fiscal organizational outcomes
- Quantitative studies measuring staff satisfaction and patient outcomes related to the implementation of a model of care.

5.6 Dissemination

The thesis will be published through the University of Stellenbosch on their database in the university's electronic library. A copy of the thesis will be provided to the hospital that was

identified as the research site. The researcher plans to present the research findings to executive leaders of public healthcare systems of other emirates in the United Arab Emirates, as well as relevant academic conferences. Additionally, the researcher plans to publish an article in a journal to share this information with the academic community.

5.7 Significance of the study

Adopting a nursing model of care is identified throughout the literature as a valuable tool to generate a unified approach to nursing delivery in a diverse and complex organization. Still current research about the frontline nurses' experiences with a nursing model of care is limited. Therefore, this research about the experiences of nurses' about the Enayatak Nursing Model of Care implemented in the Emirates of Abu-Dhabi contributed to existing literature describing this phenomenon. Moreover, reading this study could benefit and provide guidance for hospital group leaders interested in developing a Nursing Model of Care for their hospitals.

5.8 Conclusion

Since the birth of the nursing profession, there have been many iconic authors explaining what nursing is with the development of theories, paradigms and conceptual models (George, 2014:13). In the academic environment nurses study these theories and paradigms to provide application and establish correlations in clinical practice. Yet, when the nurse enters the clinical environment the concept of a standardized nursing model or conceptual framework guiding care in hospitals, is often undefined and remains abstract theory. This necessitates guidelines and the development of evidence based literature to support the implementation of Nursing Models of Care in hospitals.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch university

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

03/05/2019

Project ID :9057

HREC Reference # S19/01/026

Approval Notice New Application

Title: Experiences of frontline nurses about the Enayatak Nursing Model of Care implemented in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates.

Dear Mrs Margaretha Hayton,

You responses to modifications requested on your **New Application** received on 23/04/2019 08:07 **Ethics Committee** via **expedited** review procedures on 03/05/2019 and **approved**.

Please note the following information about your approved research protocol:

Approval Date: 03 May 2019 Expiry Date: 02 May 2020

were reviewed by members of **Health Research**

Please remember to use your project ID (9057)on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC

website https://applyethics.sun.ac.za/ProjectView/Index/9057
If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely, Mrs. Melody Shana , HREC Coordinator,

National Health Research Ethics Council (NHREC) Registration Number:

Appendix 2: Permission obtained from institutions

[redacted]

The Health and Research Ethics committee
Stellenbosch University
South Africa

To whom it may concern

I herewith agree that Margaretha E. Hayton will be supported to conduct her research study titled: Experiences of frontline nurses about the Enaytak nursing model of care in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates, at this hospital. This authorization is valid once institutional ethics approval is granted.

Kind Regards

Mariella Hooper
Chief Nursing Officer
Al Ain Hospital

20/12/2018

Chief of Nursing
Al Ain Hospital

[redacted]

مستشفى العين
AL AIN HOSPITAL

AAH Research Ethics Governance Committee

TO: Margaretha Elizabeth Hayton; mhayton@seha.ae
Clinical Resource Nurse
Tawam Hospital

CC: AAH Research Ethics Governance Committee

Date: 04th August 2019

RE: **Proposed Research Study:** *Experiences of frontline nurses about a nursing model of care in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates.*

Ref: *AAHEC-08-19-027*

Dear Ms. Margaretha,

On behalf of the Al Ain Hospital Research and Ethics Governance Committee, I am pleased to confirm a favorable ethical opinion for the above research on the basis described in the application form and supporting documentation.

The favorable opinion is given provided that you comply as per the context set out in your research study.

You are hereby advised to commence your research study at Al Ain Hospital. In keeping with our policy, the AAH Research and Ethics Governance Committee is kindly requesting you to report any ethical concerns/considerations that may arise during the course of your research, in a timely manner.

Annual Reports plus terminal reports are necessary and the Committee would appreciate receiving copies of abstracts and publications should they arise.

The REC approval is only valid for two years (24 months from the date of the approval letter issued) however it should be renewed yearly for the continuation of the approval. Two (2) months before expiry of the validity period, the Continuing Review Form should be submitted to REC. Late submissions may not be processed in time, and you are not allowed to continue the study without approval.

The Committee is wishing you a success for this project.

Respectfully yours,

Dr. Ghanem Ali Al Hassani
Acting Deputy Chief Medical Officer (A)
Al Ain Hospital

Dr. Ghanem Ali Al Hassani
Chairman, AAH Research Ethics Committee
Acting Deputy Chief Medical Officer
Al Ain Hospital

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Abu Dhabi Health Services Co. PJSC

Appendix 3: Participant information leaflet and declaration of consent by participant and investigator

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF RESEARCH PROJECT:	
Experiences of frontline nurses about the Enayatak Nursing Model of Care implemented in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates.	
DETAILS OF PRINCIPAL INVESTIGATOR (PI):	
Mrs Margaretha Hayton	**Ethics reference number:**
PO Box 15258, Tawam Hospital, Al Ain, UAE	+971526926175

We would like to invite you to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. In other words, you may choose to take part, or you may choose not to take part. Nothing bad will come of it if you say no: it will not affect you negatively in any way whatsoever. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled to. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University.** The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice (2006), the Medical Research Council (MRC)

Ethical Guidelines for Research (2002), and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

What is this research study all about?

- In 2016 the public-sector healthcare organization in the United Arab Emirates (UAE), implemented the Enayatak Nursing Model of Care across its hospitals. Based on a literature review, limited studies describe the experiences of the frontline nurses with a nursing model, although a nursing model of care is identified throughout the literature as a valuable tool to generate a unified approach to nursing delivery in an organization. Moreover since the implementation of the Enayatak Nursing Model of Care in public hospitals, their has been no research or investigation about this model. The researcher would like to do a exploratory descriptive qualitative study to investigate the experiences of frontline nurses about the Enaytak Nursing Model of Care.

- This study will be conducted in Al Ain Hospital and in Tawam Hospital located in the Emirate of Abu Dhabi. The total number of participants that are aimed for is approximately 20 with 8-10 participants from each hospital.

- Participants will be purposefully selected in order to obtain rich data regarding experiences with the model of care, based on the inclusion criteria listed below.
    - Registered nurses providing direct patient care.
    - Registered nurses employed since September 2015 or earlier.
    - Registered nurses working in an inpatient unit of the hospital.

- Once you give informed consent the researcher will arrange an interview date with the research fieldworker. The interview will take approximately 1 hour, at a time and place of your choice that will be most convenient. The interview will be recorded and recordings will be kept confidential and protected

Why do we invite you to participate?

You meet the inclusion criteria and so assumed to have experienced the implemented Enayatak Nursing Model of Care in your unit.

What will your responsibilities be?

Read this leaflet. Complete and sign this consent form in duplicate. Keep one form for yourself and give the other to the researcher. Think about, reflect and respond honestly to questions on your experiences about the Enayatak Nursing Model of Care

Will you benefit from taking part in this research?

There will be no direct benefits to participants, however the information from the study will create awareness on the experiences of frontline nurses about the Enayatak Nursing Model of Care.

Are there any risks involved in your taking part in this research?

There will be no direct risks involved. Declining to participate will not affect you negatively in any way. All information will be treated with confidentiality, anonymity and privacy.

If you do not agree to take part, what alternatives do you have?

No alternatives will be offered as your participation is totally voluntary. You may withdraw your consent at any time and discontinue participation without consequence.

Who will have access to your participant records?

All information collected during interviews will be treated as confidential. The identity of the participant will remain anonymous at all times, including in any publication or thesis resulting from the study. All data will be locked up in a safe for a period of five years and will only be made available to the supervisor, and research ethics committee upon request.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid to take part in the study as there will be no costs involved for you. A gift card will be presented to participants to compensate for their time.

Is there anything else that you should know or do?

- You can contact the Human Research Ethics Committee of the Faculty of Medicine and Health Sciences at Stellenbosch university 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the interviewer.
- You will receive a copy of this information and consent form for your own records.
- The study supervisor is Professor E Stellenberg at Stellenbosch university and can be contacted at +27 21 938 9036 or via email at elstel@sun.ac.za
- You will receive a copy of this information and consent form for you to keep safe.

Declaration by participant

By signing below, I ……..…… agree to take part in a research study entitled

Experiences of frontline nurses about the Enayatak Nursing Model of Care in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates.

I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is **voluntary,** and I have not been pressurised to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan that we have agreed on.

Signed at (*place*) .....…..…….. on (*date*) ……...…… 2019

…… ……

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document in a simple and clear manner to

  ……..

- I encouraged him/her to ask questions and took enough time to answer them.
- I am satisfied that he/she completely understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.)*

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2019.

…… ……

Signature of investigator **Signature of witness**

Appendix 4: Semi-structured interview guide

Title: Experiences of frontline nurses about the Enayatak nursing model of care implemented in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates.

Part 1: Demographic data

1.1 Age

1.2 Gender

1.3 Nurse category or rank (e.g. unit manager, staff nurse)

1.4 Employment date in the current hospital

Part 2: Open ended Questions

- Tell me about your experiences with the Enayatak model of care?
- What has implementing the Enayatak model of care been like for you?
- What have you found helpful in your practice with the Enayatak model?
- What has been not so helpful or a challenge to you?
- Can you think of anything that we have not talked about that you would like to share about your experience with the model?

Appendix 6: Extracts of transcribed interview

Participant 3 (P3)

Speaker Key:

IV Interviewer [redacted]

IE Interviewee [redacted]

00:00:00

IE I have read the consent. Good morning ma'am. I have read the consent, and it's all ready. I'm very happy to participate in this survey, and I am ready to give the feedback, as I am the champion of the MOC. I don't have any objection to participate in this survey.

IV Okay. Let me confirm that although I'll use your name during our interview thank you for coming, when the final transcript is written, your name will not be in there. It'll all be de-identified, and this is a confidential interview. What we're looking for is, especially because you were a champion… Your feedback about the implementation and the value of the Model of Care is incredibly important. I just want you to be honest about your experience.

Let me ask you… I'm going to ask you four questions. Let me go through those one at a time and give me as much feedback as you feel comfortable giving. The first question is specific to… With the Enayatak Model of Care… Specific to the implementation, the roll-out. You started, and there were several phases of the roll-out, and you were charged with making it happen in your unit as a champion. Tell me about that. What went well? What didn't go well? That kind of thing.

00:01:29

IE All the strategies in NMOC . I'm very happy. I feel it made much improvement in our practice. Initially they gave a training for us. The champions and the group members.

IV Tell me about that. What was the training like?

IE Training was really very good, informative. We were also interested to know. This is the new project, and we were so interested to know more about that. Then we were assigned to train our staff also. It was a group discussion with all of the ADON's managers. Everybody was present during our presentation. We were prepared well, and we were so excited to have that presentation. We know more than what they taught us. We referred the literature review, and we were so interested. I was so interested. I can say that.

Then for the implementation phase, we trained all the staff. Then we having… Knowing how we are going forward… Initially, it was in the first phase, and the identification board of the staff also was made during the first phase.

Appendix 7: Declarations by language and technical editors

Lona's Language Services

English/Afrikaans
Afrikaans/English

3 Beroma Crescent Beroma Bellville
Tel 0219514257
Cell 0782648484
Email illona@toptutoring.co.za

* Translations * Editing * Proofreading
* Transcription of Historical Docs
* Transcription of Qualitative Research
* Preparation of Website Articles

TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has edited and proofread the **thesis of Marga Hayton** for language correctness and translated the Abstract.

TITLE:
EXPERIENCES OF FRONTLINE NURSES ABOUT THE ENAYATAK NURSING MODEL OF CARE IMPLEMENTED IN PUBLIC HEALTH CARE FACILITIES IN THE EMIRATE OF ABU DHABI, UNITED ARAB EMIRATES

Signed

Ms IA Meyer

04 December 2019

Lize.net
COMMUNICATION (Pty) Ltd
Company registration: 2019/050723/07

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Margaretha Elizabeth Hayton's thesis entitled:

Experiences of frontline nurses about the Enayatak Nursing Model of Care implemented in public health care facilities in the Emirate of Abu Dhabi, United Arab Emirates

Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General or where relevant, the requirements of the department.

Yours sincerely

Lize Vorster
Language Practitioner

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221

Appendix 8: Declaration by fieldworker

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

HEALTH RESEARCH ETHICS COMMITTEE 1 AND 2

INVESTIGATOR'S DECLARATION

(INFORMATION SHOULD BE TYPED)

The principal investigator, supervisor, as well as all sub- & co-investigators must each sign a separate declaration.

SECTION 1: INVESTIGATOR DETAILS and ROLE IN THIS RESEARCH							
Title, First name, Surname: Dawn Kuzemski		**SU number:** N/A				***PROJECT ID NUMBER*** *(HREC office use only)*	
Professional Status: Assistant director of Nursing (Oasis Hospital)							
University DIVISION and DEPARTMENT: N/A (Fieldworker for data collection)							
Telephone No: +971526926008		**E-mail address:** dawn.kuzemski@gmail.com					
Role *(mark with x)*	**Principal investigator**	☐	**Co-investigator**	☐	**Sub-investigator**	☐	**Supervisor** ☐

SECTION 2: PROJECT TITLE *(maximum 250 characters for database purposes)*

Experiences of frontline nurses about the Enaytak nursing model of care implemented in public health care facilities in the emirate of Abu Dhabi, United Arab Emirates.

SECTION 3: CONFLICT OF INTEREST DECLARATION (OBLIGATORY)

I, *(Title, Full name)* Dawn Kuzemski declare that:

☒ I have **no financial or non-financial interests**, which may inappropriately influence me in the conduct of this research study; **OR**

☐ I **do have the following financial or other competing interests** with respect to this project, which may present a potential conflict of interest: (Please attach a separate detailed statement)

Signature: D. Kuzemski **Date:** Jan 6, 2019

SECTION 4: DECLARATION (OBLIGATORY)

I, *(Title, Full name)* Dawn Kuzemski declare that:

- **I have read through the submitted version of the research protocol and all supporting documents and am satisfied with their contents**
- I am **suitably qualified and experienced** to perform and/or supervise the above research study.
- I agree to conduct or supervise the described study **personally** in accordance with the relevant, current protocol and will only change the protocol after approval by the **HREC**, except when urgently necessary to protect the safety, rights, or welfare of subjects. In such a case, I am aware that I should notify the HREC without delay.
- I agree to timeously report to the HREC **serious adverse events** that may occur in the course of the investigation.
- I agree to maintain **adequate and accurate records** and to make those records available for inspection by the appropriate authorised agents when and if necessary.
- I agree to comply with all other requirements regarding the obligations of clinical investigators and all other pertinent requirements in the Declaration of Helsinki (2013), as well as South African and ICH GCP Guidelines and the Ethical Guidelines of the Department of Health as well as applicable regulations pertaining to health research.
- I agree to comply with all regulatory and monitoring requirements of the HREC.
- I agree that I am conversant with the above **guidelines**.
- I will ensure that every patient (or other involved persons, such as relatives), shall at all times be **treated in a dignified manner and with respect**.
- I will submit all required reports within the stipulated **time frames**.

Signature: D. Kuzemski **Date:** Jan 6, 2019.

HREC Declaration Form V4.2 February 2015
Stellenbosch University, Faculty of Medicine and Health Sciences