Research Dissertation Level 3

DOES ORTHOPAEDIC PRE-ASSESSMENT CLINIC PREPARE THE PATIENT FOR ADMISSION TO HOSPITAL?

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ABSTRACT

This dissertation proposes a research study that will seek to explore whether orthopaedic pre-assessment clinics (PAC's) prepare the patient for admission to hospital. A review of the available literature addressing PAC's overwhelmingly indicates their necessity and indicates their benefit for both patients and staff (Fellows et al 1998). However there does appear to be gaps in the body of knowledge in this area with very little patient experience and perception being taken into account.

In response to this a qualitative research proposal is presented which will be guided by the principles of phenomenology. A purposeful sample will be taken from orthopaedic PAC's. Data collection will be under taken through the use of semi structured interviews and Colaizzi's (1978) phenomenological steps will guide data analysis.

The aim of this study is not to generalise but rather to explore whether patients feel ready for admission to hospital. The results of the literature review and the proposal will be presented to other health care professionals especially those involved with PAC's in the hope that patients feelings may be acknowledged and considered in preparing them for admission and that funding may be found to continue and complete the research.

Further research may be prompted by this study which could assist in highlighting the importance of patients feelings in medical and nursing interventions.

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CHAPTER 1 - INTRODUCTION

1.0 Introduction to dissertation

The aim of this study is to highlight the need for research into whether orthopaedic pre-assessment clinics (PAC's) prepare patients for admission to hospital and to suggest a way that this research can be conducted. In order to do this a selective literature review has been undertaken and a small-scale qualitative study proposed.

PAC's involve the assessment of patients who are on the waiting list for elective surgical procedures and are usually carried out 1-3 weeks prior to admission for surgery (Lucas 1998). In orthopaedics PAC's were first developed in the United States of America (USA) in 1974 and were medically focused being conceived to assist the medics with their workload. It was to stop the routine clerking of patients and therefore as Bulstrode et al (1972) commented helped to achieve the 'new deal' which governs junior doctors working hours.

In the United Kingdom (UK) research has been conducted as far back as the 1970's recommending PAC's for elective surgery (Crosby 1972). In 1981 the Duthie report (DHSS) reiterated this by recommending PAC's for orthopaedics as there was an increasing demand for orthopaedic surgery and consequent rises in the waiting lists. This specialty has been at the forefront of PAC development ever since.

PAC's have developed rapidly over the last two decades mainly due to the increasing demand on health care provision combined with the relative contraction in resources (Livingstone et al 1993). This is more apparent in orthopaedics where patients requiring surgery are increasingly elderly, often have co-existing diseases and often require major surgery (Davies 1998).

Traditionally patients were admitted to hospital on at least the day before surgery for clerking, investigations and anaesthetic assessment. This had many pit falls as patients could not be replaced if they were found to be unfit for theatre or did not attend and was a waste of a bed space and patient time for healthy patients not requiring specific pre-operative care. It also under utilised theatre time and the results of investigations were often not available due to lack of time for the tests to be processed. Pre-assessment allows for a more efficient and effective service. It identifies patients who are unfit, do not attend or no longer require the surgery in plenty of time for theatre lists to be re-organised and suitable replacements found. It utilizes beds to there full potential as patients are admitted on the day of surgery, this decreases their length of stay and ensures results are available so the patient can be ready for theatre as planned.

As well as advantages to the trusts there are also perceived advantages for the patient. Historical evidence suggests that anxiety among hospital patients is a significant problem requiring positive measures to relieve it (Franklin 1974). This is supported by Wilson-Barnett (1979) and Boore (1978) who advocate that pre-operative information can reduce post-operative stress. Hayward (1975) agrees in her work on pain showing that given the appropriate information pre-operatively pain is better controlled post - operatively. More recent work has concentrated on information giving to patients (Newton 1996) and patient satisfaction (Clinch 1997). All these studies indicate that patient's think that PAC's are helpful and that the information they receive is useful in informing them about their operation. However there are no studies exploring patient's feelings and perceptions of PAC's and their preparation for admission. In order to address this lack of information a qualitative research study is proposed with phenomenology as its guiding concept aimed at investigating orthopaedic pre-assessment clinic and whether it prepares the patient for admission to hospital.

CHAPTER 2 - LITERATURE REVIEW

2.0 Introduction

The aim of this study is to address the perceptions of orthopaedic patients and whether they feel ready for admission following their attendance at orthopaedic PAC. In order to achieve this a literature review was undertaken. This involves being able to interpret and evaluate the research literature, as Parahoo (1997) maintains scanning and critically reading selected literature to find out its usefulness in current research. A skill the United Kingdom Central Council (UKCC 1992) believes all nurses should learn to ensure accountability of their practice.

The literature review was under taken utilising several resources and approaches. The CD-ROM was used to access two electronic databases, Cumulative Index of Nursing and Allied Health Literature (CINAHL) and medline. However, Sindu and Dickson (1997) maintain that these databases are not guaranteed to include all the research on a particular topic. Therefore several other databases were used including the English National Board (ENB) library database, the Royal College of Nursing (RCN) and the Cochrane library database. Many Internet sites were accessed and relevant articles were obtained through manual searches at John Rylands, Gateway and Stepping Hill libraries as well as via the inter library loan scheme. Pollit and Hunglar (1999) suggest that using all these methods ensure that a literature search is a comprehensive selective search.

The search was originally limited to post 1990 to ensure that the evidence was current and relevant. However, one of the themes emerging from the literature is supported by some classic studies i.e. Hayward 1975, Boore 1978, and Wilson-Barnet 1979, which could not be ignored. It was also intended to limit the search to the UK but as PAC's

were initiated in the USA and there is an evident lack of pertinent UK material an international perspective was embraced.

There is a plethora of written text on PAC's however there is little related specifically to the orthopaedic area so a wider context of surgery has had to be used to add depth to the literature review. Areas such as medicine were not utilised as it was felt that this would make the review too large and unmanageable. On review it also transpires there is very little empirical research of any kind with most of the work being anecdotal and descriptive. Despite this four distinct themes do emerge from the literature;

- Information giving to patients
- Processes that occur in PAC's
- Patient satisfaction and
- Efficiency of patient management

However the search did not find any research on whether orthopaedic patients felt prepared for admission following PAC attendance. This current paucity of research in this area assisted in the focusing of the proposal to address this shortfall.

The following sections will briefly examine each of the distinct themes. A methodological critique of the available literature will be under taken incorporating the identified key empirical studies. Assessment of validity and reliability of the research will be made throughout the review and used to guide the consequent research proposal.

2.1 Themes

2.1.1 Theme One - Information giving to patients

Despite extensive discussion in the nursing literature surrounding information giving to patients (Barron 1987, Bysshe 1988, Newton 1996) there has been little systematic research in this field (Roy 1988). It is however an area of nursing that for a long time has provoked great interest with some classic work based on the concept (Hayward 1975, Boore 1978, Wilson-Barnett 1979). In the pre assessment setting for orthopaedics information giving to patients is a crucial area of the pre assessment process and has been mainly linked to the key area of patient outcomes (Hathaway 1986, Munro 1992, Gammon and Mulholland 1996). Leino - Kiepi et al (1993) maintains that:

> "This work has had a distinct practical orientation, the underlying assumption being that psychoeducational information serves to promote the patients physical recovery and their psychological coping with surgical operations'".
>
> (Page 333).

Hathaway's (1986) meta analysis indicated those patients receiving pre operative teaching had postoperative outcomes that pre-operative teaching accounts for a 20% improvement in post-operative outcomes.

Information giving is important for a number of reasons. A Strategy of Nursing (1989) states that:

> "Whatever changes in nursing practice that come about, the most important people will continue to be the consumers, who need knowledge about their condition and the possible courses of action, who's active cooperation is enlisted in all treatment and procedures and who must be encouraged to make key decisions".
>
> (Page 17).

As nurses we increasingly emphasis self care and the patient's rights to self - determination. Patients who understand their condition from experience tend to show

closer compliance to their treatment and will work to advance the ultimate goals of nursing care (Farhenfort 1987), which does appear to have a positive effect on self-care itself (Dodd 1984, Stockdale Woodley 1984 and Niewig et al 1987). As well as this, the general public is much more knowledgeable than they ever were and information giving ensures patient autonomy, dignity and self-respect. Patients want to know and have the right to know what is happening to them (Ley 1972, Dennis 1990). In making patients aware it helps dispel the sense of uncertainty and insecurity that goes along with the operation or illness (McIntosh 1974) and informed consent can only be achieved if the public are fully informed (Kaufmann 1983).

Researchers do appear to agree that as far as patients are concerned there is a positive value to information giving. Hospitalisation regardless of disease makes patients anxious and more so for those patients undergoing surgery (Cochran 1984). Therefore, information giving appears to help patients cope with stress (Lazarus and Folkman 1984, Lepczyk et al 1990, Haines and Viellon 1990) although Vernon and Bigelow (1974) and Zeimmer (1983) would argue that this is not always the case. They assert that depending on what information is given patients anxiety could increase. Information giving also appears to help patients recover from surgical problems (Cohen 1981, Devine and Cook 1983). It can help lessen the symptoms of illness (Hartfield and Carson 1981, Wilson-Barnett 1981) and assist patients to deal with pain post operatively (Hayward 1975, Tan 1982, Devine and Cook 1986). Although again there does seem to be some disparity as to whether information giving with regards to pain is helpful or harmful (Scott 1984, Scott and Clum 1984).

The timing of information giving has also been studied (Levesque et al 1984, Schoelssler 1989) with no clear conclusions being drawn and indicating that it may make no difference at all when information is given (Lepczyk et al 1990). Although

Fellows et al (1998) would argue that choosing the right time to give information is crucial.

From a nursing economic perspective the giving of information can result in saving money through earlier discharge, the reduced use of post operative medication, decreasing treatment required for complications and the more efficient use of beds (Sutherland 1980, Devine and Cook 1986, Newton 1986). However as Leino Kiepi et al (1993) maintain there are very few studies where the measurable benefits of patient education are converted into cost effectiveness (Sinnock 1984, Nieweg et al 1987).

Giving patient information and patient satisfaction has also been studied in the context of reviewing the quality of nursing care with the results indicating that patients tend to be increasingly satisfied the more information that they are given (Devine and Cook 1986, Leino Kiepi and Vuorenheimo 1992, Clinch 1997).

From experience it appears that no matter how much information is given to some patients they are still not ready for admission to hospital. Unfortunately this is an area that has no research attached to it. This then adds weight to the intended proposal for research.

2.1.2 Theme Two – Processes that occur in Pre assessment Clinics (PAC's)

On review of the literature the processes that occur tends to be anecdotal and descriptive (Haines and Veillion 1990, Persaud and Dawes 1992, Bond and Barton 1994). The information relayed through the studies is about how the clinics are run or

how they were first established (Newton 1996, Pring 1997, Fellows et al 1998). Evidence does suggest that PAC's are beneficial to patients and staff (Lewis 1996), although again there is little formal research and the descriptive accounts are clearly aimed towards sharing the experiences of organising a PAC.

An interesting area to be highlighted in the research however and which warrants further investigation is the amount of nurse involvement in the clinics. Again historical work describing nurses with minor roles (Pring et al 1987) or the traditional 'handmaiden' role (Lucas 1998). More recent work describes nursing roles, which encompass tasks, which were traditionally seen as medically focused (Collins 1995). This has developed from the changes in medical staffing as a result in the reduction of junior doctors hours (NHSME 1991) and the scope of professional practice (UKCC 1992) which have both put pressure and opportunity to take on roles traditionally performed by medical staff. Koay and Marks (1996) believe that a nurse given sufficient guidance and support can fulfill most of the duties in a PAC. However, their reasoning is to allow the senior house officers (SHO's) to have more training in outpatients and theatre under the supervision of a consultant. There does not however seem to be any empirical evidence that these roles will benefit the patient or nursing staff. It also raises the issues of professional and legal implications. Under the UKCC (1992) code of conduct as nurses we are personally accountable for our own practice and in exercising our own professional accountability. In taking on these roles we need to be sure that we are acknowledging our limitations in knowledge and competence. Legally we need to ensure that we are covered by are employers for taking on the extra responsibility otherwise we could find ourselves involved in litigation. It is still very unclear where the accountability for the scope of these new roles and the standards of practice, which apply to them lie (Dowling 1996). Again there is no research available that addresses these issues. However some would say

that nurse led clinics provide a more holistic approach to patient care (Nio Ong 1997).

There is however, no research available which explores whether the differing roles nurses undertake have any effect on the patients' experiences of the pre-assessment process and their preparation for admission.

2.1.3 Theme Three - Patient Satisfaction.

A number of researchers have addressed the area of patient satisfaction in PAC (Pulliam 1991, Dixon 1994, Clinch 1997). Pulliam (1991) believes that this is important and that:

> "To survive and thrive in today's competitive health care markets, health care providers must evaluate the outcomes of their services including client satisfaction, then use this information to set standards".

(Page 97).

Several authors surveyed patients to see how they felt about the experience of PAC and all concluded that patients were satisfied with their experiences (Pulliam 1991, Muldawney 1993, Dixon 1994,Clinch 1997). Findings indicated that there was definite stress reduction (Muldawney 1993) and positive quality outcomes (Hathaway 1986). It is difficult however to compare PAC in this situation to other methods of admission as most of the patients studied were attending for elective surgical admission and had not experienced any other form of admission.

Lucas (1998) in his qualitative study does try to ascertain how patients feel about PAC. He found that their perceptions are primarily concerned with:

> "The convenience of the clinic, the reasons why the clinic was being held, descriptions of the clinic and perceptions of information given during the clinic".
>
> (Page 205).

However, what is highlighted in this study is that patients had low expectations of PAC, seeing them as similar to outpatient appointments and being for the benefit of the hospital, and not themselves. It is difficult however to apply these findings to other settings as the sample size is small (n = 8) and the study was only conducted in two very similar orthopaedic settings. However, Lucas (1998) states that this is not his intention.

Clinch (1997) maintains that the measurement of patient satisfaction is difficult, as patients are often reluctant to criticise carers in case their care is affected. Pulliam (1991) used focus groups to give patients an opportunity to evaluate nurse-managed PAC. In this study findings indicated high levels of patient satisfaction. Nio Ong (1997) supported these results in his small-scale qualitative study on patients views of nurse

led clinics, when he commented that preoperative assessment conducted by nurses was acceptable to patients. Although he does admit that further research is required, especially a cost effectiveness study on substituting nurses for junior doctors.

Patients on the whole appear satisfied the PAC but again there is no empirical research on whether they feel it prepares them for admission. This again lends itself to my research proposal.

2.1.4 Theme Four - Efficiency of Patient Management.

Traditionally patients requiring surgery were admitted to hospital at least one or two days prior to surgery. This ensured that all assessments, tests and investigations could be carried out for the patient prior to theatre. However as already stated some patients were found to be unfit for surgery, no longer requiring the surgery or in some instances did not even attend (Livingstone et al 1993). This then led to an under utilisation of theatre and its facilities, a waste of already limited hospital resources and trauma for the cancelled patient. This is particularly pertinent for orthopaedic patients who are often elderly, often have co-existing disease and require major surgery (Davies 1998).

The Bevan report (1989) recommended that PAC be set up to utilise theatres to there full extent and to make more effective use of beds so that the waiting list could be kept down. The Royal College of Surgeons (1991) supported this when they stated PAC's could improve the management of surgical waiting lists. Thus avoiding penalty payments to Health Authorities for patients who were on the waiting list longer than the prescribed time. This, along with the need to ensure services are both efficient and effective assisted with PAC's continued development.

Research into this area of PAC and its effectiveness tend to be concentrated on the screening out of surgically unfit patient (Ross and Watson 1988, MacDonald et al 1992, Pring 1997). The number of patients found to be unfit for surgery varies from 14% (Ross and Watson 1988) to 33% (MacDonald1992), although these figures are debatable due to differing criteria's for defining fitness. Studies by Thompson (1991) and Livingstone et al (1993) indicate that PAC screening reduces the number of patients who fail to attend or are unfit for surgery. They studied waiting lists retrospectively in the light of interventions made at the PAC. They concluded that PAC's improved admission rates and resolved problems that may have delayed surgery. Qualitative work does also

exist on the optimum usage of other services at PAC, e.g phlebotomist, electrocardiogram (ECG) technician, radiography ensuring an efficient and effective service (Koay and Marks 1996). As well as these practical issues money can also be saved as patients are admitted on the day of surgery, thus reducing the length of stay by 1-2 days and causing less disruption to the patients life (Bond and Barton 1994). Spalding (1995) supports this as he believes that patients who attended PAC are discharged earlier due to efficient patient preparation and the fact that discharge planning can begin prior to admission. However there is no objective evidence to support this.

Some qualitative studies have also been carried out reviewing the cost effectiveness of PAC and improving the quality of care (Rost 1992, Newton 1996). However, the results appear inconclusive due to the small sample sizes used which do not achieve 'information redundancy' (Lincoln and Guba 1985) or 'theoretical saturation' (Strauss and Corbin 1999). Therefore, as Sandelowski (1995) maintains undermining the credibility of the research findings. However, Morse (1991) argues that this can never be achieved and that saturation is a myth.

Efficient patient management has to be our ultimate goal and the evidence does appear to indicate that PAC can help us to achieve this. However, further research is required in the area of effectiveness of the service both for the purchasers and the patients themselves.

2.2 Methodological Critique

2.2.1 Research Approach

The empirical studies available on PAC's have adopted both qualitative (Nio Ong 1997,

and Lucas 1998), and quantitative approaches (Mavrais et al 1990, Lepczyk et al 1990, Cupples 1991, Maskell and Wright 1993, Lewis 1996, Newton 1996, Mitchell 1997). With two studies claiming to use combined qualitative and quantitative approaches (Gammon and Mulholland 1996, Clinch 1997). On reviewing the literature it was sometimes difficult to ascertain what methodology the researchers were using. A number of the researchers do not state any methodology but follow distinct qualitative (Lucas 1998) or quantitative (Cupples 1991) approaches, this makes it difficult to critique the reports and assess the validity and reliability of their findings. Those that do state an approach appear reluctant to state conclusively their methodology of choice i.e Gammon and Mulholland (1996) in there abstract state they are using ethnography as their clinical context and then analyse the data with statistics. Although this makes it difficult for the reviewer, it may be an indication that the researcher is trying to achieve 'true' information by the use of methodological triangulation. The purpose of using triangulation is to provide a basis for convergence on the truth. As Carr (1994) maintains drawing on the strengths of qualitative and quantitative approaches and counteracting the limitations posed by both. If this is the case then this can only add strength to their work. However on further review the study is in fact quantitative.

In reviewing the strengths of the studies validity and reliability are seen as key areas in assessing quantitative and qualitative findings (Field and Morse 1985, Brink 1991). In all the quantitative studies there is no direct reference to validity and reliability. This may be due to the researchers assuming inherent knowledge of the reader. However, in the studies claiming to combine the two methodologies, the researchers seem keen to ensure the reader is aware of their reliability and validity. For example Clinch (1997) ensures that we are aware that their questionnaires were deemed as content valid as a project group wrote them. Parahoo (1997) maintains that this is important as this form of

validity assesses the degree to which questions adequately represent the phenomenon being studied. In contrast Lincoln and Guba (1995) supported by Sandelowski (1996) advocate a different criteria for qualitative studies. They believe ‘credibility’ or ‘truth value', ‘fittingness’ or ‘applicability’ ‘audibility’ or ‘consistency’ and ‘conformability’ are more fitting to this approach. In all the qualitative studies all but one of the researchers refer back to the participants to determine credibility and conformability by seeking recognition of findings (Lucas 1998). A process, which Hallet (1995) believes, recognises the researchers 'neutrality' in their interpretation of the data. However Cavanagh (1997) would argue that this amounts to face validity and is undermined by inherent weaknesses. The researchers also believe that audibility has also been achieved by having other researcher’s examining their decision trails. Guba and Lincoln (1985) support this stating researchers who provide a research trail ensure their study is explicit and open to public scrutiny.

Generalisability of findings is another area that can add strength to a study. The aim within qualitative research is to understand and clarify and experience of phenomena in participants, rather than as Reed and Proctor (1996) maintain quantifying the distribution of characteristics in a given population. Therefore, methods employed in quantitative research to improve the generalisability of results do not apply in qualitative research (Morse 1994). Mixed method research undertaken by Clinch (1997) uses the technique of ethnography combined with survey methods. It looks at patient satisfaction within PAC as well as what care nurses deliver in PAC’s. Ethnography studies the phenomenon from the viewpoint of the participants (Cresswell 1998). Field and Morse (1985) have described it as a generalised approach to developing concepts to understand behaviors from an emic (‘the insiders view’) perspective. Data is structured from the participant’s experience and the researchers interpretation of that experience.

Clinch's (1997) aim was to understand what nurses did in PAC so this could then be considered an appropriate choice of approach. Combining this approach with a survey method to determine patient satisfaction would be seen by some as a diverse approach to research and is often described as triangulation (Carr 1994). Huck et al (1974) agrees stating that it provides increased flexibility to study dynamic phenomenon and data relevant to different questions. However, Mason (1993) argues that the use of multiple methodologies gives fragmented, disjointed, situational insights that appear more disjointed than if a single methodology is used. On consideration each case should be judged on its own merit. This is supported by Goodwin and Goodwin (1984) who state that the research question should determine the approach selected and that qualitative and quantitative approaches can be used in one study rather than being opposing paradigms.

Mulholland and Gammon (1996) in their mixed methods approach claim to use a quasi-experimental design within an ethnographic clinical context. As the research was carried out within a hospital setting and aimed to find out how well patients coped psychologically following total hip replacement when given differing amounts of preparatory information, this could be said to be true. The research explores how patients feel they cope, with the researchers using statistics to quantify the results. This study is really quantitative with only the researcher and settings giving it an ethnographic slant. It does however add strength to the research as it allows the researcher to approach the participants and perhaps gain more information from them than they would have by just using a quasi-experimental approach. I.e. because the researchers ask the questions they could get the participants to expand their answers. This gains more information than if the patients were just given questionnaires and asked to give a written answer.

The qualitative studies that study PAC (Nio Ong 1997, Lucas 1998) are descriptions of their research studies. Methodologies in the studies are not stated but they do explore how patients feel about PAC's. Lucas (1998) study although not clear does have a phenomenological influence as it is aimed at investigating the experiences of attending PAC from the subjective perceptions of those living the experience. Lucas (1998) uses 'bracketing' within his work as he acknowledges his own experiences, perspectives and believes as a researcher in an area that he knows very well and where he is known very well. He also recognises his possible effect on the data as a researcher who had problems not participating in the research when patients wanted to ask him questions. It is also a comprehensive study where the research process was provided in the full research report so allowing the work to be audited and transcripts and field notes were made available to check the credibility of analysis. Lucas (1998) however did not manage to get his data checked by his participants due to restricted time although this is not always necessary it does add credibility to a study. The other qualitative work followed a similar pathway but is not as detailed as Lucas (1998).

In contrast the quantitative studies (Mavrais et al 1990, Lepzcsk et al 1990, Cupples 1991, Maskell and Wright 1995, Mitchell 1997) used questionnaires, surveys, experimental and quasi-experimental designs with clear statistical results. Carr (1994) believes quantitative methodologies such as survey test theories deductively from existing knowledge. Qualitative researchers would argue however that questionnaires and surveys produce superficial levels of enquiry, which may not address a subject in enough depth and is seen as limited because it neglects the participant perspectives within the context of an experience. Positivists would argue against this and state that the use of objective, systematic approaches to quantify phenomenon clearly strengthens their arguments (Burns and Grove 1995) although Clarke (1995) believes that involving

scientific equations may demean human relationships.

Again none of the studies reviewed stated clearly the methodology they were using. However, all the studies used structured procedures and methods to collect the information under controlled conditions and emphasize objectivity through statistical analysis (Polit and Hunglar 1995). One of the studies (Cupples 1991) states a clear hypothesis and analysis the effects of pre-admission information on patients under going coronary artery bypass graft surgery (CABG). All the other studies except for one (Newton 1996) use experiments and although clear hypotheses are not stated they do examine cause and effect relationships. Patients have been allocated randomly and control groups are used as well as pre and post testing except for Cupples (1991). This makes the research very strong (Roe 1994) as this sort of testing counteracts threats to internal validity. Cupples (1991) uses posttest only design this weakens the research, as there is no pre-test. However, it could be argued that withholding information could be detrimental to the Patient so therefore is not ethical, so the method used is appropriate. Gammon and Mulholland (1996) used quasi-experimental design. Roe (1994) believes this is the weakest sort of design, as they do not use a control group or random allocation of subjects. Certainly Cupples (1991) does not state how she allocates her patients although she does make an attempt to enhance the study by having a control group. However, there could be bias between the groups as the dependant variables may have been different to start with. Newton's (1996) work is a patient satisfaction survey, which looks at patient's attitudes, and opinions of a nurse led PAC. This work is attempting to describe a situation so is not concerned with relationships so hypothesis testing is not a feature. The studies reviewed are justified in their choice of methodology as they are examining cause and effect relationships. A further study reviewed is a meta-analysis (Hathaway 1986) which reviews studies on

pre-operative information giving and its effect on post-operative outcomes. This form of study uses statistics from a number of studies, in Hathaway's case 68 to establish a numerical estimate of the overall effect of what has been studied. Roe (1994) believes this has great benefits as it ensures systematic reviews of populations, methods and outcomes of the research undertaken in a number of studies. However, in order to achieve this and avoid bias, Curlette and Cannella (1985) believe all published and unpublished work should be included. Chalmers (1990) maintains that this is not possible as studies, which have 'disappointing' results, are not always published and that this borders on scientific misconduct. However, meta-analysis does improve the rigour of the reviewed literature as opposed to more descriptive approaches.

As Cuff and Payne (1985) maintain no one approach can provide the ultimate truth. However, Carr (1994) also believes that neither paradigm is valuable means of discovering the truth about nursing.

2.2.2 Sampling

Sampling as LoBiondo Wood and Haber (1998) states is:

> "The process of selecting representative samples of a population for study in a research investigation".
>
> (Page 248).

In qualitative and quantitative research it is critical that an appropriate and adequate sample is selected as this could have an effect on the ultimate quality of the study (Morse and Field 1996). Whatever method is used to collect data, decisions will always have to be made about who and where to collect it from and as Reed and Proctor (1996) state these decisions have a fundamental effect on the quality and usefulness of the findings. Therefore, criteria for selecting samples should be stated clearly within the published text.

From reviewing the literature this is not all ways the case. A number of the studies failed to explain how they achieved their samples (Mavrais et al 1990, Cupples 1991, Maskell and Wright 1995). This may be an over sight of the researchers however, it does have implications for the validity, reliability and the rigour of the research. How can we be sure that the sample achieved is representative of the population if we do not know how the sample was achieved. The major purpose of sampling is to increase the efficiency of the research study (LoBiondo Wood and Haber 1998). So not identifying where the sample was derived from has implications for analysis and interpretation of the data as well as conclusions derived from the findings.

A number of the studies used convenience sampling (Lepczyk et al 1990, Mulholland and Gammon 1996, Whitley et al 1997, Mitchell 1997, Clinch 1997, Lucas 1998). Frankfort-Nachmais and Nachmais (1996) would suggest that in these studies the

researchers are selecting the most conveniently available subjects. This often due to financial and time constraints and often accounts for the use of more easily obtained opportunistic samples (Crookes and Davies 1998). Lucas (1998) supports this as he admits in his study that due to the limited time available he used patients in the clinics that were available to him. In all the studies the patients are from PAC's and in all but one study (Lewis 1996) there are a small number of patients chosen for inclusion i.e. 8-150. Lewis (1996) however uses the whole of one clinic and all though this still has limited generalisability the data collected is likely to cover a larger cross section of the population. This Crookes and Davies (1998) believe should make us cautious of the results as they maintain that whatever makes the sample convenient may be related to the variables of interest and could introduce bias into the study. All the studies stated that they were not conducting their studies to generalise them but to simply represent the population under study (Blackstop 1996).

Nio Ong (1997) in his study uses random sampling although he does not state how he randomised his sample. Munhall (1994) describes random sampling as occurring when every member of the given population has an equal chance of being included in the study removing the chance of selection bias. However Morse (1991) would argue that potential participants of quantitative research do not have an equal amount of knowledge or experiences. Therefore random sampling can be a problem as:

> "It violates the quantitative principle of sample size and violates the qualitative principle of selecting the most experienced and knowledgeable informants".
>
> (Page 141).

On further review it appears however that non- probability sampling was used, as Nio Ong's (1997) study is a qualitative study which did not lend itself to experimental design

and used patients who had experience of PAC's. LoBiondo Wood and Haber (1998) suggest that this is acceptable as:

> "A well designed, carefully controlled study using a non- probability sampling strategy can yield accurate and meaningful findings that make a significant contribution to nursing's scientific body of knowledge".
>
> (Page 269).

However, Polit and Hunglar (1999) would advocate that we must be cautious about the inferences and conclusions drawn as there could be sampling bias.

Newton (1996) also uses random sampling all though it is not clearly stated in his study. One hundred and twenty postal questionnaires where distributed to patients who had attended PAC with a response rate of 75 (62%). Whilst poor response rates are identified as problem with postal questionnaires (Cormack 1997) 75 (62%) is a comparatively good response. Although not acknowledged within this study, patients who attend PAC are those who are motivated and compliant so may be more likely to respond so the study could be biased towards more motivated patients. There is also the possibility that those who did not respond 45 (38%) may have very different views on PAC's, that could have produced different results.

Most of the studies reviewed had strict eligibility criteria; careful definition of the population helps to increase the internal validity as the difference between groups is due to the provision of information rather than from any extraneous effects. However in some of the studies (Mitchell 1997, Lucas 1998) this excluded patients who may have given a different perspective on PAC's i.e. patients excluded if they lived outside a 3-4 mile radius or those who could not speak english. This adds bias to the studies.

Sample size is all ways a cause for great debate within research (Polit and Hunglar 1999, Hicks 1999). Crookes and Davies (1998) maintain that most nursing studies rely

on relatively small convenience samples. Polit and Hunglar (1999) however would maintain that researchers should use the largest sample size possible as the larger the sample size the most representative of the population it is likely to be. The quantitative studies reviewed all had less than 150 in there samples Sherman and Polit (1990) state that this is too small and has insufficient power to detect real effects. However, Crookes and Davies (1998) would argue that:

> "The claimed association between the two variables in a quantitative study also depends on the data collection methodology, the design of the study and the use of valid and reliable measuring instruments".
>
> (Page 150).

Larger samples however are not all ways better and in qualitative studies if there are too many participants they could distort the issues and as Roberts and Ogden Burke (1989) state over complicate the complex process of analysis. So qualitative studies usually have smaller numbers as represented by the qualitative studies reviewed (Nio Ong 1997, Lucas 1998) with numbers varying from 8-50. Their primary concern is not how representative their sample is of the total population but to seek rich sources of data. Although this is indicated in the studies it is hard to see as they tend to describe their research so the rich data from the patient or very little of it is included.

2.2.3 Data collection and analysis

Behi and Nolan (1995) maintain that precise descriptions of data collection and analysis procedures are essential if findings within a study are to be valid and reliable. All the studies reviewed have varying amounts of data collection and analysis detail within them. Although this may be due to limited manuscript space May (1991) believes that if only brief descriptions are used then they can be a source of confusion and concern with regards to the credibility of the work.

Most of the qualitative studies reviewed use semi structured interviews (Lucas 1998) with data analysis being carried our concurrently. Simultaneous data collection and analysis is not unusual in qualitative research as subsequent information selection is often guided by preliminary findings adding to the thick description of the study (Sorrell and Redmond 1995). Lucas (1998) in his study does not describe in detail his audio taped semi structured interview criteria. He does however indicate the topics used for the interviews and states that his interview planning was derived from areas within his own experiences of PAC's increasing the studies credibility. In doing this he also acknowledges his own subjectivity as he states that this could have encouraged pre-conceptions although evidence of 'bracketing' would have demonstrated this further. Lucas (1998) does fail to say whether he modified the interview structure in any way as a result of his data analysis. This is important as it could effect the consistency of the data collection between those who were interviewed first and those interviewed later. Although this may be seen as omission by Lucas (1998) he does conduct a pilot study where he ascertains that his research instrument requires only minor modification so he includes these patients in his main study. Whilst it is not always necessary to pilot interviews in qualitative research Appleton (1995) argues that it can assist the interviewer in gaining experience.

Lucas (1998) uses non-participant observation in his study to enhance his work. Gribch (1999) believes that this is important in qualitative studies as the researcher needs to get as close as possible to the essence of others' life experiences to collect in depth data, while documenting their own paths. However as Lucas (1998) maintains it can be difficult to remain non-participant when patients ask you questions. Lucas (1998) acknowledges this with his field notes to try to prevent data contamination. Patient observations were also noted although more revelation of this data from his notes may have enhanced his study further and enabled readers to see in more detail the quality of his data collection. Lucas (1998) does describe his analysis in detail with all the tape-recorded information being coded and categorised and then themes developed. Unfortunately time restraints did not allow participants to comment on the transcribed analysis which would have enhanced their credibility.

As with all interviews the data generated is largely dependent on the skills and expertise of the interviewer (Polit and Hunglar 1995) and is acknowledged as an important factor affecting the credibility of studies using this data collection method. Where and when interviews are conducted is also important. Lucas (1998) collects some of his data by interviewing patients while they are still in hospital this can be seen as a procedural reactivity (Crookes and Davies 1998). Patients will perhaps give you the answers they think you want to hear for fear that their care may be compromised or as in the case of Lucas (1998) be unable to answer as the question i.e. whether they felt prepared for their return home, is inappropriate. As Lucas (1998) acknowledges this question would have been better at a later time.

Mixed method studies are unusual as quantitative studies rarely pay attention to qualitative studies and vice versa (Pearson 1997). However they do enable sense to be made of whole data sets although theoretical blending can lead to problems and as

Hanson (1994) maintains:

> "It is naive to presume that a single consistent picture will be obtained by the use of different methods".
>
> (Page 12).

In fact Pearson (1997) debates whether different perceptions of 'fact' can be compared. Clinch (1997) however does try do this to enhance her work using both ethnography and survey methods. Her study uses participant observation to try and clarify what processes occur in PAC's. However she is the only one conducting the observations, Kneale and Santy (1999) would describe this as the researcher being 'reflexive' and almost a research tool themselves. Therefore although inter-observer reliability is reduced there is an increased chance of bias as she may become so immersed in the culture that she is no longer objective. It may have been better to involve another researcher to reduce this bias or to go back to the participants to qualify the results of which there is no evidence that the researcher did this. Field notes Clinch (1997) maintains are transcribed and analysed throughout the work but there is very little transcribed notes used to enhance the text. Survey is used in this instance to try to gather data about the identified population, questionnaires are less costly in terms of finances and resources but limit the responses of the individuals to the questions being asked. Clinch (1997) states that she is using both open and closed questions to gain qualitative and quantitative information but on review of the questionnaire the questions are mainly closed which decreases the chance of rich description that may have enhanced this study further. She did however get a project group to construct the questionnaires from a literature base increasing their validity although a pilot study would have increased this further. The questionnaires had a high response rate 100%, which although not stated indicates that they were given to the patients within the clinical setting thus posing a

question on the reliabilty of the answers. This could as Polit and Hunglar (1999) state give a response bias as they are still in a caring situation and do not want their care compromising. It could also have an effect on the research results.

In contrast to the qualitative studies the quantitative studies under take data collection and analysis as separate elements of the process. Each of these studies collected data through questionnaires of varying types. Some are established questionnaires such as the fear of surgery scale (Johnson et al 1971), the state trait anxiety inventory (Speilberger 1970), the mood checklist (Myers 1966) and the recovery inventory (based on Wolfer and Davis 1970). These are questionnaires that have had their reliability and validity established from previous studies and as Crookes and Davies (1998) maintain this prevents reinvention of the wheel. In the studies that used these scales (Mavrais et al 1990, Lepczyk et al 1990, Cupples 1991 and Maskell and Wright 1993) the scales appear to be used appropriately as they are intended to look at areas of patient feeling such as anxiety levels (Lepczyk et al 1990). Consistency in questioning without researcher involvement is important, as it is likely to produce less opportunity for biasing the study (Behi and Nolan 1995). However some of the researchers developed their own questionnaires (Lepczyk et al 1990, Newton 1996, Lewis1996 and Mitchell 1997) which could negate this. Mitchell (1997) is the only one to show examples of his questions adding strength to his study as it shows evidence of a well designed questionnaire consisting of short, clearly phrased statements (Oppenheim 1992). The total number of questions is five which assists in reducing the chances of respondent fatigue (Cormack 1997). However there is no evidence of how the questionnaire was developed before its application i.e. was there a pilot to establish clarity, readability and completeness (Crookes and Davies 1998). Although Lewis (1996) and Newton (1996) do not publish their questionnaires Lewis (1996) does give detailed descriptions of the statements used

within the text. This is important as it enables the reader to assess the quality of the data and it's relevance to the aim of the study. Lepczyk et al (1990) however is the only one to state that in developing his questions content validity was established by a panel of clinical nurse specialists and a small pilot to establish that it was viable and adding credibility to the study.

Some of the questionnaires were given out at PAC's or when the patients were still in hospital, this has the same effect as interviewing in the same situation, as the patients may give the answers that they think you will want to see. If the questionnaires are anonymous then this may increase the truthfulness of the replies (Cormack 1997). There are however difficulties with postal questionnaires, the greatest of which is low response rate. Parahoo (1997) believes this may be due to 'respondent burden' which is the perceived hardship of being a survey participant. Newton (1996) in fact had a good rate of response 75 (62%). This may be because patients who attend PAC's are more motivated and if as Newton (1996) did you explain the need for their replies in detail they are more likely to fill it in. Maskell and Wright (1993) used telephone questionnaires as part of their study. It is difficult to assess their use, as there is no documentation of the questions and how they are constructed making it difficult to assess the content validity. All the questionnaires applied Likert type scales (Likert 1932 cited in Cormack 1997) or attitude scales to their data. Attitude scales are frequently used as a quantitative tool due to the numerical nature of the data that they generate (Cormack 1997). Scales such as Likert have been criticised as they assume that a numerical score can represent a person's attitude. They also assume each item means the same to each respondent (Cormack 1997) therefore the accuracy and consistency of data may be seen as unreliable. None of the quantitative studies reviewed gave details to how the Likert type scales within the studies are applied creating concern over the

credibility of the findings. It also makes assessing the quality and relevance of the data difficult. However, the consistent manner of questioning without researcher involvement is less likely to bias the study (Behi and Nolan 1995).

All the quantitative studies reviewed in keeping with their approach collected numerical data and used statistical analysis to make their data meaningful. A number of the researchers present their data as respondent percentages (Maskell and Wright 1993, Newton 1996, Lewis 1996 and Mitchell 1997) these gives clearly seen results. Mitchell (1997) and Newton (1996) also use bar graphs and pie charts and although this does not provide any further information it does assist in presenting the data more clearly.

In contrast to these studies Mavrais et al (1990), Lepczyk et al (1990) and Cupples (1991) present their results using percentages, mean scoring and standard deviation. Analysis of variance (ANOVA) was used to determine statistical significance for similarities and differences in replies from different groups. Crookes and Davies (1998) maintain the use of such tools, as ANOVA is helpful in avoiding individual interpretation of results. Hicks (1999) supports this and states that parametric tests are more sensitive tools than non-parametric tests. Polit and Hunglar (1997) also believe that their flexibility and the assumptions that guide them make them more powerful.

2.2.4 Ethical considerations

Reference to ethical considerations within all the studies is variable. All but two of the studies (Lepczyk et al 1990, Lucas 1998) make no reference to ethical approval being obtained within their individual research designs. In all the studies involving patient sand staff ethical approval should be sort from the local research ethics committee's (LREC's) as per the department of health guidelines (DOH 1991) as did Lucas (1998). Although this does not mean that the research is necessarily ethically sound, as LREC's are fallible as can be seen by the degree of variation and subjective appraisal during the approval process. It does reassure the reader that it is an area that they have at least considered and indicates that the process of gaining consent has been scrutinised adding to the rigour of the study. As Polit and Hunglar (1995) stress it is the responsibility of the researcher to ensure that research is under taken in accordance with morally acceptable principles. However just because it is not stated in the study it cannot be assumed that the researcher has not considered this area. As May (1991) maintains that word limitations within published texts can prevent detailed accounts of methodology. Holloway and Wheeler (1996) however believe that complete omission of detail in this can raise uncertainty over the level of respect shown towards the rights and wishes of individual research participants. As most of the studies omit this detail it is difficult to evaluate this area of the research.

2.3 Conclusion of the Literature Review

In conclusion this selective literature review has explored PAC's in a number of areas. Information giving to the patients (Newton 1986, Mavrais et al 1990, Lepczyk et al 1990, Maskell and Wright 1993, Lewis 1996, Gammon and Mulholland 1996, Mitchell 1997), the process that occurs within the clinic (Clinch 1997, Nio Ong 1997), patient satisfaction (Clinch 1997, Nio Ong 1997, Lucas 1998) and the efficiency of patient management (Cupples 1991, Newton 1996). The studies reviewed maintain that PAC's are of positive value to patients and staff. Throughout the review however, it was noted that there was a distinct lack of empirical studies particularly qualitative studies. The poor number of qualitative studies allows for little subjective experience of PAC's and may be seen as a gap in this particular sample of the literature. It is this gap within the literature that I believe warrants further exploration and it is with a view to resolving this issue that this dissertation will continue and perhaps enhance the lack of qualitative work available in this area.

CHAPTER 3 - RESEARCH PROPOSAL

3.0 Introduction

Taking into consideration the literature review and the lack of empirical evidence into how patients actually feel on admission to hospital following orthopaedic pre-assessment, this proposal is justified. The preceding literature review demonstrates the copious amount of evidence-based literature on pre assessment clinics and how they are established and run (Newton 1996, Fellows et al 1998). There is also a large amount of evidence on how information given to patients at these clinics is assimilated (Hayward 1975, Boore 1978, Gammon and Mulholland 1996). These points were corroborated at the 1998 Orthopaedic conference where pre assessment was explored but only in terms of what services the clinics provided (Lucas1998).

The literature shows that pre assessment clinics have developed within practice areas over a relatively short time and have moved on considerable. The author's experience of assisting in the running of this clinic has led to a desire to ensure patients receive the highest quality care tailored to individual need.

Why should we care how our patients feel? As Polit and Hungler (1995) state people are recognising health as a right rather than a privilege and are questioning how the services of health professionals contribute to the total delivery of health care. This increasing interest in examining health care practices has led to nurses evaluating the efficiency, effectiveness and success of practices resulting in modifying or abandoning practices that have no effect on patient health.

The Briggs report (1972) emphasised that nursing should be a research based profession. This coupled with the need for public accountability as dictated by the United

Kingdom Central Council (UKCC) code of conduct (1992) and the recognition that a significant proportion of clinical practice has no scientific justification makes it imperative that nurses justify their practices. Although some would find it difficult to admit nurses often base their choice for many of their clinical interventions not on the basis of empirical information but on intuition, personal preference and familiarity (Walsh and Ford 1995, Hicks 1999). In fact in 1993 the Department of Health stated:

> "Strongly held views based on belief rather than sound information still exert too much influence in health care".
>
> (Preface).

This has led to many central government and professional bodies' directives to increase the research base of clinical practice.

Within the speciality of orthopaedic nursing there are few qualitative studies being undertaken giving the speciality a weak qualitative research base. Kneale and Santy (1999) maintain that in the last decade there has only been one or two specifically qualitative orthopaedic studies such as Detrick et al (1988) study on the process of parenting a one parent child with a disability and Valentines (1996) work on altered body image in adolescents. Salmond (1996) believes this is not enough and asserts that more qualitative and quantitative research is needed to validate orthopaedic nursing practice. This research proposal will add to the current qualitative research base within orthopaedic nursing.

For research to contribute to policies that are beneficial to the health of the nation patients needs must underwrite policy and research and not the perceived needs as identified by health care professionals. It is difficult to determine the needs of the patient if we do not explore them. With this observation in mind and the ever-increasing need to achieve the highest quality patient care this research proposal is justified by seeking to

address the unanswered question does orthopaedic pre assessment clinic prepare the patient for admission to hospital. The results will be illuminating and may provide the catalyst to change practice if that is what is required.

3.1 Aim of the study

The broad aim of this study is to find out weather patients feel ready for admission to hospital following their attendance at orthopaedic pre assessment clinic.

Specifically it will:

- Explore whether orthopaedic PAC prepares the patient for admission?
- Explore what do patients feel they need to know before admission?

And ultimately to:

- Explore whether patients feel they are prepared physically and emotionally for admission to hospital?

The first person will be used throughout. Although some researchers would argue that it would make the study less credible (Spender 1981). Webb (1992) however maintains that it is in keeping with the epistemologies of the proposal and is a personal opinion of how the research will be conducted based on reasonable evidence and therefore is acceptable.

3.2 Research Approach

In order to gain an insight into whether the orthopaedic patient does feel prepared for admission it is necessary to decide on which kind of methodological approach would be the most appropriate. Mason (1993) states that the methodology should complement the research question being asked. Many textbooks support this notion (Morse 1991, Parahoo 1997) and advocate that the method should be sensitive to the needs and features of the respondents or social processes being studied. Morse (1996) advocates it is the responsibility of the researcher to be wise enough to be able to recognise the most appropriate method to be used.

Varying theoretical perspectives of research represents the study of phenomena and the development of knowledge. No single approach can provide the ultimate truth but as Cuff and Payne (1985) maintain will merely illustrate some aspect of the topic that is being studied within the framework of the perspective that is chosen. Morrison (1986) states that specific methodology links both ‘ontology’ - the nature of reality and ‘epistemology’ - the relationship between inquirer and that being studied.

In deciding on the most appropriate methodology for this proposal consideration was given to both quantitative and qualitative methods. I decided that a qualitative study, which draws on phenomenological principles would be the most appropriate. In order to demonstrate why I believe that this is the most appropriate method to use there is a necessity to briefly outline the underlying assumptions of both approaches.

3.2.1 Quantitative versus Qualitative Research

Historically the dominant approach adopted in nursing research was the quantitative approach. Norbeck (1987) believes that it provides the best knowledge base for nursing practice, this is supported Duffy (1986) who maintains that prior to the mid -1980's funding was awarded mainly to quantitative nursing research studies showing how much this method was accepted and respected. This is now disputed as many nurse researchers have realised that quantitative research:

> "Limits the discovery and essential meanings and components of nursing and does not appropriately answer all the questions they seek to address".
>
> (Brink 1991, page. 14).

Lieninger (1985) also argues that quantitative research is inappropriate for the study of individuals as they cannot exist independently of their historical, cultural and social contexts and are not reducible, measurable objects.

As Duffy (1987) maintains the advances made in nursing up to the present day resulting from quantitative research are indisputable. However, research in nursing is needed to generate new and accurate information to direct practice. As Burns and Grove (1995) state the knowledge nurses need is broad and holistic hence a variety of research methods are needed to generate it. This change may be driven as Clarke (1995) states by the desire of nurses to link theory with practice ensuring that patient care is given from an accurate knowledge base and not from ritualistic traditions.

Quantitative and qualitative methodologies come from philosophical views that compete about the nature of knowledge in the social world (Lincoln and Guba 1985). Positivism is the paradigm that underlies quantitative research and as Watson (1989) maintains, proponents of this view support the scientific method. A methodology that Burns and

Grove (1995) believe is a:

> "Formal, objective and systematic process where numerical data is used to obtain information about the world".
>
> (Page. 15).

The aim as Mason (1993) maintains is to find causal relationships between variables and then to use this to predict events. It seeks causes and facts from the world view perspective (Vidich and Lyman 1994). The findings are based on the researchers interpretation of observed events rather than on the subjects views and there is often little or no contact with the people being studied. It primarily tests theory with the researcher working deductively and being outcome orientated. A view that Parlit and Hamilton (1992) believe starves the outcomes of enquiry of their meaning. This research proposal asks for patient's views, it is intended that the researcher will have maximum contact with patients which opposes the quantitative approach in this instance.

There is no doubt that quantitative research has had a powerful impact on nursing research and nursing theory generation (Harper and Hartman 1997) and without its contribution many nursing advances may not have occurred.

Qualitative research in contrast is a naturalistic enquiry. Its underlying paradigms are in interactionism and interpretism. Its origins lie in the disciplines of history, psychology and sociology (Cormack 1991). As this is not a physical scientific domain Bockman and Reiman (1987) have cited this as one of the biggest weaknesses of this form of research and have associated it with the poor initial uptake of the approach within nursing. Qualitative researchers however assert that their work is in fact more scientific as they see it as more scientifically valid and Aamodt (1991) maintains qualitative research is beginning to make its impression on nursing science.

Morse (1996) maintains qualitative research is a process-orientated approach with the goal of developing theory that can guide our knowledge development as nurses. It develops theory inductively consisting of rich description that enables the readers to understand and make sense of clinical reality. The researcher not only collects data but also serves as the ‘instrument’ through which data is collected. However, although it is recognised that the researcher can contribute to data collection it could be argued, that the reliability of qualitative research could be questionable if the researcher is not conscious of their role and their own internal state (Lipson1991). In qualitative research concepts and theories are generated from the respondents and emerge as the study develops and not the other way round (Clifford and Gough 1990). This is supported by Leach (1990) who states that there is no explicit intention to quantify the findings, which are instead described in the language that is used during the research process. This 'soft' language as it is often described, is one of the criticisms of qualitative researchers. They say that this is inadequate for providing answers and generating change and Diamond (1987) believes that it is so crude that it cannot be classed as a science.

It could be argued however that many of these criticisms of qualitative work are unfair as they are levelled by those who are measuring such work against quantitative research and as such, it can be misleading using one paradigm to assess research in another. Duffy (1987) believes that it is an approach that studies the empirical world from the perspective of the subject or in the case of this proposal the patient. It is often used when little is known about the phenomena and it has already been established that there is a lack of research literature available which has guided this intended proposal.

Brink (1991) maintains that qualitative research humanises the research process as it is concerned with the meaning of the phenomena and the lived experience. This would make it particularly suitable for examining the research proposal question as it focuses

on the experiences of people and stresses the uniqueness of individuals. Each patient is a unique individual and has specific attributes of experience and knowledge. Their attendance at orthopaedic pre assessment clinic and how it affects them as an individual will vary tremendously because of these attributes.

However, some authors such as Brockup and Hastings - Tholsma (1995) would argue that qualitative research is concerned with exploring, expanding and describing our knowledge of the world around us. So this does make it difficult to define qualitative research specifically. However, the ultimate aim of qualitative research in what ever context it is used is to analyse and describe experiences, values and attitudes of people in their natural context (Burgess 1984; Hammersley and Atkinson 1995). This means that people are viewed much more holistically and as this is one of the aims of this proposal it seems most appropriate.

I now want to explore the concept of phenomenology and outline why I it is the guiding concept for this proposal.

3.2.2 Phenomenology

Phenomenology has its roots in philosophy and is both a research method and a philosophical theory (Bousfield 1997). It is a way of thinking about what 'life experiences' are like. The emphasis is on how individuals make sense of their own world, how these definitions are shared and how individuals create their own world. The main objective is to explain and describe phenomena as it is experienced which reflects the proposals intent by exploring patient's thoughts and feelings of their experiences. Hallet (1995) maintains that the central element within the phenomenologist approach:

> "Is a rational, intuitive process, a process, which cannot be reduced to a step -by - step method of data analysis relying on mechanistic and empirical processes".
>
> (Page55).

This is particularly suitable for a proposal, which requires the patients to reflect on their experiences of orthopaedic pre assessment, the data lies in the lived experience of these patients. If we tried to quantify these experiences in any way their meaning and understanding would be reduced and may even be totally lost.

Stephenson and Corben (1997) state that there are three main phases of the phenomenological movement and the key figures are Husserl (1859 - 1938), Heidegger (1989 -1976) and Sartre (1905 - 1980). Husserl, a German philosopher conceived the idea at the beginning of the twentieth century. It was seen as a culmination of the Cartesian tradition to examine consciousness as experienced by the subject (Baker et al 1992). Hiedeggar modified Husserl's ideas and took them to a new direction creating hermeneutic analysis. While Husserl focused on a description of the lived world that sees people as detached subjects existing in a world of objects (Dreyfus 1987). Heideggar based his perspective on existentialism, which considers that an understanding of a person cannot occur in isolation from the person's world (Walters

1995). Satre also developed this work further and is often described as an existentialist (Munhall 1994).

The work of all these philosophers has influenced nurse researchers over the last decade and there is no doubt that it has many parallels with nursing (Taylor 1993) and there it is becoming increasingly popular (Benner 1984, Green and Holloway 1996, Bousfield 1997). Ray (1985) believes that the introduction of phenomenology is linked to a new humanism about the nature of nursing. Green and Holloway (1996) agree and state that the:

> "Phenomenological approach has a humanistic ideology that nursing with it's own discrete professional values can identify and feel comfortable with".
>
> (Page. 1015).

These professional values include a humanistic approach towards the individual and their participation that emphasises their own meanings and interpretations. Basically meaning that the researcher works with the participant and the data just like the nurse works with the patient and the nursing process.

As previously stated phenomenology is the investigation of everyday experiences from the perspective of those who live them, in this case the patient. This is because it is considered that those who experience it are the only one's who can understand the meaning. The researcher is directed towards the participant's subjective experiences. The aim is to present these perceptions clearly and through the process of interpretation to understand their basic structure and meaning (Hallett 1995).

Data is collected through unstructured and semi-structured interviews and/or participant or non- participant observation. This raises problems of its own as both the participants in an interview come with their own set of experiences, perspectives and personal

beliefs regarding the phenomenon under investigation. This means that the researcher could influence what the participant discloses or even contaminate data during analysis. This difficulty has been recognised by phenomenologists and the technique known as ‘bracketing’ has been established. Bracketing means the researcher temporarily suspend their own beliefs and assumptions. It is based on the notion of identifying, exploring, acknowledging and laying to one side one’s own lived experiences (Chambers 1998). This is what I intend to do as I have previously run the orthopaedic pre-assessment clinic and attended a clinic as a patient so I will have presuppositions and assumptions of my own. I recognise that it may well be difficult to extract parts of myself and set them aside but I will do this by writing down all my thoughts and feelings, and also discuss it with my supervisor.

This is also and area in which phenomenology has been criticised because it may not be possible to suspend all presuppositions through bracketing (Morris 1991). However, Neilson (1990) argues that this can allow the researcher to study subjective meaning in an objective manner, which follows the subject-object distinction of positivism. Jasper (1994) agrees that the ability to bracket facilitates thorough phenomenological analysis of the data. This occurs because as Chambers (1998) maintains the researcher:

> "Can listen to and hear what the subject is saying and in doing so not merely interpret what the subject is saying but elicit meaning from the data itself".
>
> (Page 431).

In conclusion, phenomenology has been proposed as the theoretical perspective that will guide the approach within a qualitative framework for this proposal as it provides a method for exploring patients perceptions of orthopaedic pre-assessment clinic and whether it prepares them for admission without attempting to limit it into quantifiable units.

3.3 Sampling

Morse (1986) maintains that the sampling method must be both appropriate and adequate. Appropriateness is the degree to which the method of selection and the informants fit the purpose of the study, which can only be determined by the research question. Adequacy refers to the sufficiency and the quality of the data (Morse 1989). In qualitative research the researcher has control over the composition of the sample so as Brink (1991) maintains qualitative researchers:

> "Select their samples according to the needs of their study and according to specific qualities".
>
> (Page 15).

Their primary concern is not how representative their sample is of the total population but to seek the rich sources of data.

It is my intention to use a purposive self -selection convenience sample of patients from orthopaedic pre-assessment clinics. All patients will be given a letter (Appendix A) at the start of their visit explaining the study and asking if they would be prepared to participate. Ensuring that they know the background and purpose to the study so that they can make informed choices regarding their participation. Every patient at the clinic will be asked if they would like to participate regardless of gender and ethnicity. If necessary an interpreter will be available in order to limit bias against ethnic minority populations. The only patients who will not be asked to participate are those who are not mentally capable. Some may feel this compromises the autonomy of the selection, however it is not because they are less capable of making a rational decision but because they may not be able to consent to participate. The letter will indicate that if they were to participate their confidentiality and anonymity in all oral and written reports will be assured. Participants will be informed that the researcher respects their right to

chose what information they divulge in the study and that they can discontinue participation at any time.

Participate in the pre-assessment process is essential so that I can build a rapport with the patients and answer any questions regarding the study. The patients will be informed that they will be interviewed the day of their admission on the ward. This will be the optimum time to gain information on whether the patients felt ready for admission following attendance at orthopaedic pre-assessment. The decision about the optimum time to gain data has changed during the process of writing this proposal. My original thoughts were that data should be collected a week after admission to give the patient a chance to settle in. I now believe that this would be a mistake as patients may well be influenced by their positive/negative experiences of the ward and may well withdraw from the study due to their experiences of surgery and post-operative recovery. Equally patients could still suffer stress following their admission so will require a few hours to settle in.

The patients will be informed that choosing to participate or not, will not affect the care they receive. All participants will complete a consent form (Appendix B) which reiterates their right to withdraw from the study at any time and notifies them that the interviews will be tape recorded to ensure accuracy of the information.

As already proposed the sample will be a purposeful sample (May 1991). This is a non-probability sample in which participants are chosen according to their experience of the phenomenon. This optimises the possibility of gaining the richest and deepest information. By choosing patients who have under gone pre-assessment this fits the criteria. I have chosen this method instead of random sample as a random sampling may preclude key individuals and therefore sources of rich data that could invalidate the

findings. It has been argued that the major criticism of a purposeful sample is that it is ‘biased’ by virtue of the selection process. However, this is the purpose and intent of selecting this method as the bias is used positively to facilitate the research (Streubert and Carpenter 1999).

The size of the sample cannot be determined at this time although because of the in depth nature of the study and analysis of the data required small selective samples are usually used (Parahoo 1997). If large samples were to be used the meaning of individual experiences may be lost, as detailed analysis may be impossible (Sandelowski 1995). Qualitative researchers do not define their sample in advance, as sampling is a process that goes on continuously throughout the data collection and analysis phase making it flexible and evolving as the study goes on (Holloway 1999) reflecting how I intend this study to evolve. I must ensure, however, that I collect enough data and I realise that this may involve collecting more data than an experienced researcher. Although as Stern (1985) maintains we often have all the data we require in the first few pieces although I cannot know this until I have collected more.

3.4 Selection of setting

It is clear from the literature that orthopaedic pre-assessment clinics are increasing (Lucas 1998). Reed and Procter (1996) maintain that the choice of research data collection site should ensure access to the types of data required that will further the aims of the research. An initial consent will be gained in the pre-assessment clinics so setting the locality and obtaining co-operation from the clinic staff are important issues. Initially this will be three local clinics. Three settings will be used as Streubert (1991) sees:

> "The long term challenge for phenomonologists interested in generating theory is to interview several samples from a variety of backgrounds, age ranges and cultures to maximise the likelihood of discovering the essences of phenomena across groups".
>
> (Page 121).

and to eliminate bias introduced by organisational culture. I will take them from differing demographic areas to access the widest variety of patients possible. Appropriate consent and permission from the clinic managers will be obtained.

3.4.1 Access to the setting

Burgess (1984) suggests that negotiating access to a research setting occur throughout the research and that:

> "Access influences the reliability and validity of the data that the researcher then obtains".
>
> (Page. 45).

As this study involves patients who attend orthopaedic pre-assessment clinics and are subsequently admitted to the ward permission to gain access will be sought. Written permission by letter (Appendix C) from the directors of nursing for the hospitals will be followed by direct contact with the directorate managers. This direct contact is a strategy aimed at improving the response from busy managers. Finally I would contact the pre-assessment nurses and the ward sister (Appendix D) to seek permission to enter their specific areas. Acknowledgement has to be made that access may be denied. This is their prerogative and if this occurs the decision has to be accepted and alternate sites considered.

Both verbal and written communication will contain a brief over view of the proposal, including the commitments to confidentiality of the setting and participants. In addition a commitment will be made to present the findings ensuring the research will be valued and will contribute to the overall body of knowledge in an area where so little is known making the proposal more acceptable. Once access has been established and permission gained from the appropriate authorities to undertake the study I will have to obtain permission from each hospitals ethics committee.

3.5 Ethical considerations

Ethical aspects of research are always an issue in research especially in nursing research. Mainly because of our ethical status as human being but also researchers have the practicalities of having research submissions approved and funded by institutional committees. As already identified approval will be required from each of the relevant ethics committees (Usher and Holmes 1997). Often they are reluctant to let their patients be accessed unless they are convinced that you are not out to harm vulnerable and sick people or to harass the already over burdened staff. The primary function of the ethics committees is to protect the interests of the patients who are asked to participate in the study. However, ethical approval from the committees does not automatically guarantee that the study is ethically sound. It has been suggested that the standards by which ethics committees judge proposed work varies greatly and therefore I as the researcher have a responsibility to ensure sound ethical principles are met. Usher and Holmes (1997) believe that this involves three basic principles. Firstly, respect for person's people are autonomous and their right to self -determination should be respected. This study will do this as all the participants will be asked to participate voluntarily and only after being given all the information. This will enable them to decide whether or not to participate. Qualitative researchers have problems with informed consent as qualitative enquiry begins with general rather than specific objectives. Therefore, Ford and Reutter (1990) maintain informed consent in qualitative studies can be described as an ongoing process of informed participation. Secondly, the principle of beneficence, which means the research will be beneficial and do no harm to the participants (Dines 1998). Beauchamp and Childress (1989) agree with this and suggest that part of the professional mandate of beneficence is to do good and serve the patient to the best of one's ability. This research will not physically harm the patients but give us a true indication of whether they actually feel ready for admission, it may provoke some

emotional responses. However well you feel you have informed your participants, they may never be sure what they have consented to, so informed consent is a continuous process. Interviews can highlight concerns that participants may not have anticipated and as Minhull (1988) maintains, qualitative research invades the participant's space and their psyche. Cassell (1980) maintains that participants on the whole in most situations control the setting of the research and influence the context with communication and interactions flowing comparatively freely in both directions. However, when the researcher is a nurse and perceived as authority and/or a caring figure then the perceived powers can shift in favour of the nurse researcher. Often participants forget that research is the investigators main purpose and share more personal and painful experiences with the researcher. I will have to be prepared to offer to stop data collection either totally or at least temporarily as some participants may regain their composure and wish to continue. I will also have counselling facilities available in case they are required or desired. Thirdly, justice which concerns the selection of participants to the study this I have more than covered in the previous section. Ramos (1989) comments that research in nursing must constitute:

> "A delicate balance between the principles of rigorous investigation and a nurturing concern for patient welfare".
>
> (Page. 57).

McHaffie (1996) comments that not only are their obligations for researchers to maintain personal integrity but as nurses we have a professional code of conduct that we are bound to. Ethical commitments are lifelong obligations and they do not end with the signing of a voluntary consent form or clearance from the ethics committee especially in qualitative research.

The areas used will want reassurances that only the researcher will have access to the

data and that there will be no identifying evidence. In this study some verbatim reporting of the data will be used and I recognise this could constitute a breach of confidentiality. However, complete anonymity will be guaranteed in that only I the researcher would have access to the participant's name and place of treatment. Streubert and Carpenter (1999) would argue that the very nature of data collection in qualitative research makes anonymity impossible. Behi and Nolan (1995) also agree and further maintain that if you use one to one interviews it is:

> "Impossible to maintain anonymity at all stages, in other words when using this method becoming cognisant of the source of data is unavoidable".
>
> (Page. 713).

As each of the interviews will be tape-recorded this also represents a challenge to confidentiality. This however I will discuss under the section of tape recording as I feel this is more appropriate.

3.6 Data collection

There are many forms of data collection. The predominant mode of data collection in qualitative research is interviewing which can reveal rich information about the subject being studied. As this is the intention of this proposal then this method is the most appropriate. Popay et al (1998) maintain that the thick description obtained is not a mere statement of facts but the context, experiences, intentions and meanings that arise from the experience. Focus group interviews were considered however due to the nature of the individual feelings one to one interviews were more appropriate (Morse 1991). Straight note taking was also considered as these could be immediately verified. The disadvantage of this method is the difficulty in maintaining eye contact and the problem of incomplete data especially as quotes and narrative are desirable. It is proposed then that I will collect the data via semi structured interviews. I recognise the need to have some control over the interview to ensure that discussions remain relevant to the study so a broad interview guide has been constructed (Appendix E) which still leaves flexibility to explore certain issues in more depth and probe further in order to clarify points (Haggert 1994).

A field journal will be used throughout the data collection and analysis process. This will allow me to describe and interpret the experience of the research process (Koch 1994). It will also assist in establishing credibility, dependability and transferability, as it will provide a recognisable decision trail (Kneale and Santy 1999).

A pilot study will be undertaken, as Kneale and Santy (1999) believe that where the researcher has used a previously untested research tool or is not experienced in data collection a pilot study is advisable. As Robson (1993) maintains this can illuminate some of the problems of the research method that can then be altered or adapted prior to the execution of the main study.

I intend to use my own hospital site and the orthopaedic pre-assessment clinic. Hopefully the experience of putting the plan into action may reveal any problems related to the context of the research. Morse (1997) believes that pilot studies can achieve the opposite of what is intended i.e. to gain the interest of funding agencies. Mainly because pilot data will lack the richness, variability and therefore the potential of a study conducted with adequate and appropriate research. I believe however that the pilot experience for a novice researcher can only enhance what otherwise could be potentially a poorly devised study and enhance the reliability of data collection.

3.6.1 Interviews

The intention as already stated is to use focused semi structured interviews. This is a focused interview technique developed in the social sciences by Merton and Kendal (1948). It is a useful approach that enables the research subject to explore their deeper feelings, attitudes and perceptions towards particular issues (Cohen and Manion 1994). It involves qualities of acceptance and permissiveness with the interviewer respecting the interviewee's own way of describing situations, experiences and perceptions. Interviewing is about building up a rapport this rests on the presumption that the interview situation should be designed to minimise differences in status, knowledge and power (Gribch 1999). This creates a sense of equality that enables the free flow of communication between the interviewer and the interviewee. Ideally to help achieve this I will remove the patient to a quite private room free from interruptions including the phone. The seating will be comfortable and as informal as possible a lay out achieved. A tape recorder will be employed and will be as inconspicuous as possible with a non-recorded period for us both to settle in.

As already stated I will use semi-structured interviews as they focus on the patient who is already aware of the subject of the interview and has been given details of the research (Appendix A). However it essential that the participants and I discuss and clarify they're understanding of the investigation again (Raudonis 1992, Alty and Rodham 1998). As Minhall (1988) states:

> "Continually informing and asking permission establishes the needed trust to go on further in an ethical manner".
>
> (Page 157).

At this time I will also stress the importance of their contribution and clarify their rights as participants to withdraw at any time. Interviews will be conducted face to face as this

allows modification of the participants line of exploration and an atmosphere of mutual trust to develop (Chambers 1998). As respondents explore their feelings interesting responses will be examined more thoroughly by asking additional pertinent questions aimed at drawing out the rich information. Questions and answers are less likely to be misunderstood as clarity of points can be achieved.

I will employ an open and accepting interview style, which will permit the participants to voice their genuine views and feelings without constraint (Hallet 1995). Ensuring that every effort is made not to lead the interviews but to facilitate the participant's responses with open-ended questions. Semi –structured interviews give a more holistic focus and allow the flexibility and the attainment of a deeper, more valid understanding of the participant than would be achieved through a more rigid approach. It allows the participants to raise issues that might not have included in a more structured research design adding quality to the data collected. Mariano (1996) suggests I as the researcher must present the data purely descriptively as opposed to interpretively and listen comprehensively as opposed to selectively. I will be seeking all aspects of the participant's experience, negative, positive and different in order to give the developing breadth depth. It would be an error to exclude an experience because it was uncommon.

As the sample size is anticipated to be small I will conduct the interviews myself thus removing the possibility of different styles of presentation that occur when more than one researcher is used. However difficulties may arise as a result of being the sole researcher, personal values may be transferred that may affect the participant's response. To overcome this the process of 'bracketing' will be used to suspend preconceived ideas that may influence the study's results (Green and Holloway 1997). As I have experience of PAC's this is an important issue. There has been a great deal of

debate among researchers as to whether it is possible to suspend ideas about the world (Jasper 1994, Hallet 1995). I recognise this and believe that it is justifiable to suggest that the ability to achieve this will vary depending on the individual researcher.

Smith (1992) maintains that there are certain factors that threaten the trustworthiness of interviews. These include memory decay, importance of the research topic to the respondent, misinterpretation on the part of both parties and the tendency for the researcher to seek answers to support their pre-conceived ideas. A strategy to reduce the factors that undermine the trustworthiness of the study and to improve the studies overall rigour is to ask all the participants at the end of each interview if they are prepared to ' member validate' or as Lincoln and Guba (1985) call it 'member check' the work produced. This approach ensures participants are asked if the descriptions produced reflect their experiences. This can only add to the trustworthiness of the analysis. However, Robson (1993) would argue that this may not be the case and suggests that participants of a study have an interest in misinterpreting the findings (i.e. if they feel their care may be compromised) creating member bias of which I must be aware.

The interviews will be tape-recorded. Tape recording the interview is controversial and warrants further discussion.

3.6.2 Tape Recorders

Tape recorders allow concentration on the interview without taking notes and provide an accurate account events. This improves data reliability and counteracts that which may be lost if we were required to memorise it. However tape recording can have an inhibiting effect on the participants. To try to minimise this I will use a small powerful Dictaphone. It will be checked prior to the interview to ensure that it is in good working order and it will be positioned to obtain the best clarity of speech. I will introduce it at the beginning of the interview and then hopefully both the participants and myself will quickly forget it about. Holloway and Wheeler (1996) believe that the positioning of equipment is important and that it should not be conspicuous but in a position to obtain a clear recording of what transpires. I will however, place the machine within the participants reach so that they can press the pause button if they desired which ensures that they have some control over the interview.

Tape recording interviews does provide a challenge to confidentiality. Each participant will be assured that they would be allocated a number that would be displayed on the tape with the transcription date and time. Their names will be stored separately to ensure confidentiality. The researcher who plays the biggest role in the collection of information can only achieve all of this.

3.7 Data Analysis

Hammersley and Atkinson (1983) state that in qualitative research, the analysis of the data is not a separate stage of the research but begins at the pre- fieldwork stage and continues into the process of writing up. Streubert and Carpenter (1999) state that:

> "Data analysis requires the researcher to dwell within or become immersed in the data".
>
> (Page 60).

Bauonies (1989) believes that the purpose of data collection is to preserve the uniqueness of each participants lived experience while permitting an understanding of the phenomenon under investigation. In order to achieve this the data needs to be analysed carefully. In order to do this I have chosen to use a structured approach. There are various approaches – Van Kaam 1969, Giorgi 1970, Colaizzi 1978 and Van Manen 1984. I have chosen to use Colaizzi (1978) Structure Interpretation of phenomenology (Appendix F). Hopefully, this will facilitate accuracy in analysis and address the problems of rigour. I have chosen this approach as it contains many of the accepted and standard elements associated with qualitative data analysis and I found it easy to follow and therefore hopefully easy to use. Some proponents of phenomenology oppose the use of a 'method' (Crotty 1996) however the importance of rigour remains an issue. Therefore as this study is only guided by the principles of phenomenology I feel that the use of a framework for analysis is acceptable and will increase the auditability of the research. The purpose of analysis is two fold. Firstly to code the data so that the categories may be recognised, analysed and behaviours noted. Secondly to develop a data filing system that will provide a flexible storage system with procedures for retrieving the data. The computer can be used to do this and a variety of applications are available (Atlas/ti, ethnograph version 4). They are useful because they have

features that would not be available in more traditional storage formats such as hand written files (Streubert 1999). I believe however that you must be proficient in their use to make them work for you, as I am not proficient enough in computer usage a more traditional approach will be used. However it may be better for me to learn as the rewards of using a qualitative data analysis package will outweigh the time spent learning.

I intend to transcribe all the interviews in full as soon as possible after each interview as this will assist me in obtaining a feel for the whole (Colaizzi 1978). Fielding (1993) recommends this especially for small samples. Hutchinson and Wilson (1992) however believe that people are reluctant to do this, as transcribing interviews can be tedious and time consuming. Also the volume of data is likely to present a formidable task. It may be that if the interviews are very close together that I may have to rethink this strategy. Once the tapes have been transcribed I will replay them to check their accuracy. Copies of the transcripts will then be returned to the participants for verification that their personal meanings have been interpreted correctly. Colaizzi (cited in Munhall 1994) supported by Guba and Lincoln (1989) acknowledges this as an important element in achieving credibility. Once this has been completed then I will code and categories the data into emerging themes. These themes are then the basis of the theory and the explanation of the participant's feelings and will be clearly derived from the data (Kneale and Santy 1999). I will then be able to write this data down as meaningful statements that can be reformulated and modified as new data is collected. At each stage data analysis and collection interact (Holloway 1999).

The categories will continually be explored for themes and patterns, as this process is not finished until the writing up stage is complete. As an inexperienced researcher I would approach an experienced researcher to examine the data collected and compare

their results to my own. A process Burns and Grove (1997) refer to interrater reliability and which also increases the auditability of the study. The results can now be integrated and presented to provide accurate and rich descriptions of the participant's perceptions of whether orthopaedic PAC prepares them for admission to hospital.

3.8 Validity and Reliability

Andrews et al (1996) maintain that the research base of any professional activity needs to rigorously evaluated if it is to contribute to the advancement of knowledge and practice. There are dilemmas for qualitative researchers in demonstrating validity and reliability with pressure to conform to the 'scientific' criteria of rigor – objectivity, reliability and validity. However, the work of Lincoln and Guba (1985) supported by Sandelowski (1986) advocates the use of different criteria, which is more suitable for qualitative research. They use the terms 'credibility' or 'truth value', 'fittingness' or 'applicability', auditability or 'consistency' and confirmability.

Credibility will be established through increasing the visibility of my involvement and by the exploration via the interviews of my prolonged engagement with the participants. Also, as previously discussed, by ensuring that participant's 'member check' the data produced so they can verify its accuracy (Baker et al 1992) as well as exploration of the field notes.

Fittingness refers to the probability that the findings have meanings to others in similar situations. This is difficult to determine and as Streubert and Carpenter (1999) maintain rests with the users of the findings and not with the researcher. As Lincoln and Guba (1985) state:

> "It is not our task to provide an index of transferability but it is our responsibility to provide the database that makes transferability judgement possible on the part of potential appliers'".
>
> (Page 316).

The single method of semi-structured interviews and the proposed small size will clearly affect the fittingness of the study and raise concerns over generalisability. However, as Reed and Proctor (1996) maintain the aim of qualitative research is to understand and

clarify meanings and experiences of the phenomenon of peoples lives as opposed quantifying the distribution of characteristics in a given population. The study is will produce data to add to the body of knowledge about PACs on which to build further research and is not intended to be generalised but will be guided by principles of phenomenology in an attempt to demonstrate the uniqueness of individuals (Corben 1999).

Auditability is how the researcher illustrates how they reach their conclusions. Qualitative studies cannot be replicated easily as the data is often the outcome of a unique situation. However, it should be clear what methods the researcher employed providing sufficient information to enable others to follow the 'decision trail' (Avis 1995).

Confirmability is the criterion met once researchers have decided the credibility of the findings. Again it is determined by how well participants recognise their own views. Similar to validity in quantitative research where there is no validity without reliability there can be no confirmability without credibility (Lincoln and Guba 1985).

The proposed study will be guided as opposed to governed by the phenomenological approach. In view of this Colaizzi's structured interpretation has been used for data analysis (Colaizzi 1978). Although some proponents of phenomenology oppose the use of a method for qualitative research (Hallett 1995) it can add to the rigour of the study.

The researcher themselves can also add to the credibility of a study and much of the literature does recognise the contribution of the researcher (Bruni 1995, Rudge 1996). As I will collect the data and interact with the participants I will have first hand experience that will provide meaningful data and field notes. It will also help to build a close relationship so that the data will be of a richer and deeper nature. Some researchers would argue that this is psuedotheraputic complicating the research

process and extending the responsibilities of the researcher (Ramos 1989). Sandelowski (1996) maintains that if the subject and the researcher become enmeshed it could lead to difficulty separate their own experiences resulting in subjectivity. However Oakley (1984) disagrees and believes that it can facilitate a better understanding of the subjects. I also maintain that the process of 'bracketing' will ensure my objectivity and preserve the rigour of the study.

In ensuring that all the above takes place, the reliability and validity will be enhanced. However, in doing this the researcher needs to be sure they do not reduce this technique to a superficial description of others' subjective experience (Grbich 1999).

3.9 Timetable and budget

The proposed time tabling for the study is enclosed (Appendix G). I have tried to be realistic and take into account recent personal issues that may affect the study. I also believe that as a novice researcher the study is going to take me longer than a more experienced researcher. In order to actualise this research, funding will be sought from an external body possible the UKCC or one of the orthopaedic companies who is interested in enhancing the orthopaedic nursing profession. My aim would be to undertake this study on a part time basis (2 days a week) as part of a master's degree Programme.

CHAPTER 4 - CONCLUSION

4.0 Conclusion and summary

In conclusion despite the rapid advent of PAC's little empirical work exists exploring whether orthopaedic PAC's prepare the patient for admission to hospital. The research that does exist is focused on the establishment of PAC's, how they are run and on the information we give to patients. Anecdotal opinion suggests that patients may be prepared to a degree but no matter what information they are given they may never be fully prepared and establishments gain the most from PAC's. Empirical work that does exist is mainly quantitative with little exploration of how patients feel.

The enclosed qualitative research proposal has been presented as a response to this gap in the body of knowledge. The intention is to examine and describe the phenomenon from the lived experiences of the patients using the principles of phenomenology.

The sample size will be small and purposive. The method of data collection will be semi-structured interviews with patients from three different orthopaedic PAC's. Anonymity of the participants and the confidentiality of their replies will be respected to encourage free and open dialogue. Specific inclusion criteria have been identified to try to cut down bias. Throughout the data collection process 'bracketing' will be undertaken in an attempt to acknowledge and suspend my own preconceived ideas of PAC's which may influence the study and it's findings. Data collection and analysis will be undertaken simultaneously with identification of emerging themes enhancing the interview process.

Data analysis will be undertaken using a structured interpretation of Colaizzi's (1978) phenomenological approach. It is hoped that this will preserve the uniqueness of each of the participants lived experience of orthopaedic PAC's whilst understanding their

thoughts and feelings on whether it prepares them for admission to hospital.

The issues of 'credibility', 'fittingness', 'applicability' and 'confirmability' have been acknowledged throughout the proposal. One area of the study that may be criticised is its lack of generalisability (Reed and Proctor 1996). However this is not my intention with the only aim being to explore orthopaedic pre assessment clinics and whether they prepare the patients for admission. If however the study is conducted with sufficient rigour it may prompt further research which would be beneficial in confirming fittingness. Further exploration of this area may highlight the importance of patient's feelings in medical and nursing interventions. Therefore it will be my intention to present this study to my colleagues and to write it up for publication because as White (1987) maintains the dissemination of new knowledge to improve patient care is crucial to the practice of nursing.

Declaration of Work

I, Student Number 98047241, certify that all the information included in this dissertation unless referenced as to source is my own work and that this work has not been submitted to any institution for either professional or academic work.

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APPENDICES

Appendix A - Example of a letter to the patient

Dear……,

I am an experienced Trauma and orthopaedic nurse undertaking a masters degree program with the University of Manchester. As part of this program I have chosen to undertake a research study to explore whether orthopaedic pre-assessment clinics prepare patients for admission to hospital. As a patient who is to be admitted for orthopaedic surgery and is attending the pre-assessment clinic I would be grateful if you could take part in this research.

My study will involve you taking part in a 20-minute interview one week after your operation. I will undertake the interviews myself and assure you that they will not interfere with the care you will be receiving.

Although I would like you to take part the decision is entirely yours and what ever the decision I have to reassure you that there will be no change to the care that you receive. If you agree to take part then I will require you to complete a consent form that will state the subject of the research and specify your right to confidentiality and anonymity.

The interview it's self will take place in a private room and will with your permission be tape-recorded. You will have the right to withdraw from the study at any time. The results of the study will be made available to you following completion of the study.

If you need any further information please do not hesitate to contact me. However if you are interested in participating in the study please complete the enclosed form and hand it to the nurse who is running the clinic before you leave. I will contact you on your admission to confirm your inclusion in the study.

Thank you very much for your time,
Yours sincerely,

Appendix B - Example of the patient consent form

Organisation/Department ----------

CONSENT FORM

Title of the study ----------

Researchers name ----------

Researchers position ----------

Aim of the study ----------

This interview will take approximately 20 minutes and will be tape recorded. The tapes will not be shared with anyone other than the research supervisor. Tape recordings and tape manuscripts will be destroyed following analysis of the data. In the final report only excepts from the taped conversations will be given and all quotations will be anonymous. Participants will be given a numerical code to preserve confidentiality. Participants are free to withdraw from the study at any time.

This is to show that I, ----------consent to participate in this study. I understand that I will not be identified in the research report and am free to withdraw from the study at any time.

Signature of the participant: ----------

Signature of the researcher: ----------

Date: ----------

Adapted from Holloway and Wheeler 1996.

Appendix C - Example of a letter to the director of nursing

Dear……,

I am an experienced Trauma and Orthopaedic nurse undertaking a master's degree with Manchester University. As part of this degree, I am undertaking a research study with the intention of investigating whether orthopaedic pre-assessment clinic prepares the patient for admission to hospital.

In order to pursue this study, I am seeking to interview a small number of patients from the orthopaedic pre-assessment clinic within your hospital. I would like to ask your permission to approach the staff of the clinics for access and then the patients for their permission to take part.

My study will involve participants in an individual semi- structured interview one-week following their surgery. I anticipate the interviews will take approximately twenty minutes and will be undertaken by myself within a private area of the ward.

With permission of the participants the interviews will be audiotaped. At all times during and after the study the identity of the participants involved will not be revealed and all information will be treated confidentially. I will be seeking approval from the research ethics committee and will ensure that you know their response before the commencement of the study.

The results of the study will be available for your trust to review following their collation and I would be more than willing to present them to an audience within the trust who have an interest in this subject area.

Should you agree to my proposal I will contact the manager of orthopaedic clinic and the orthopaedic ward to ensure permission for access to the participants.

I would be grateful for your consideration and look forward with anticipation to your reply.

Yours sincerely,

Appendix D - Example of a letter for access to clinic and the ward

Dear……..,

I am an experienced Trauma and Orthopaedic nurse undertaking a Master's degree with the University of Manchester. My intended research study is to explore whether orthopaedic pre-assessment clinic prepares the patient for admission to hospital.

In order to pursue this work I need to interview a small number of patients who have attended orthopaedic pre-assessment clinic. Accordingly, I wish to seek your permission to approach the patients within your area to determine whether they would be interested in participating.

The research will involve the participants being interviewed within the clinical area, which will last approximately 20 minutes. I will conduct the interviews myself in a private area of the ward if that is convenient and acceptable to you. With the permission of the participants the interviews will be audiotaped.

The results of the study will be available for review once the results are collated and I would be more than willing to come and discuss them with any interested parties.

I assure you that at all stages during and after this study, the identity of the participants and the ward areas will not be revealed and the source of any information received will remain confidential.

Should you agree in principle to this proposal I am approaching the trusts research ethics committee for approval and will contact you with their decision.

Yours Sincerely,

Appendix E - Example of a semi-structured interview guide

1. Do you know why you attended the pre-assessment clinic?

2. What did you do there?

3. Did you feel that you learned anything that helped you prepare for your admission to hospital?

4. Who gave you your information?

5. How was the information given?

6. Was there anything else you would have liked to have known?

7. When you arrived at hospital did you feel ready to come in?

8. Did you feel after you were admitted that you could have been told more?

These examples are only a guide. The way that they would be introduced into the dialogue would depend on the individuals responses. It ensures that the data collection is consistent despite the variations in dialogue that may be required to extract the information.

Appendix F - Colaizzi (1978) structured approach

1. All subjects' oral or written descriptions are read in order to obtain a feel for the whole.

2. Significant statements and phrases pertaining directly to the phenomenon are extracted.

3. Meanings are formulated from these significant statements and phrases, known as formulating meanings.

4. Meanings are clustered into themes.

    A. Refer these clusters of themes back to the original protocols in order to validate them.
    B. At this point discrepancies may be noted among and/or between the various clusters
    C. Researchers must refuse temptation of ignoring data or themes that do not fit.

5. Results are integrated into an exhaustive description of the phenomenon.

6. Researcher returns to participants with descriptions for validation. Any additional new data is incorporated into the fundamental structure of the experience.

Appendix G - Timetable and Budgeting

Completion of my study would be guided through the use of the following timetable:

Literature Review	4 Months
Gaining Access	2 months
Data Collection and Analysis	12 months
Writing Final Report	6 months
TOTAL	**24 MONTHS**

The resources required to undertake this study are approximately budgeted to the following costs:

Researcher Salary Grade G*I* 2 Days a Week over 24 Months	£18,000
Telephone	£50.00
Postage and stationary	£50.00
Travel Expenses	£100.00
TOTAL	**£20,000**