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Ambulatory Surgery Nurses' Perceptions of Their Ability to Provide Individualized Patient Care

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AMBULATORY SURGERY NURSES' PERCEPTIONS OF
THEIR ABILITY TO PROVIDE INDIVIDUALIZED PATIENT CARE

By

Rebecca L. Brown

A THESIS

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ABSTRACT

AMBULATORY SURGERY NURSES' PERCEPTIONS OF THEIR ABILITY TO PROVIDE INDIVIDUALIZED PATIENT CARE

by

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This descriptive correlational study examined the extent to which nurses in an ambulatory surgery practice environment perceive their ability to individualize patient care. As patients shift to the outpatient setting, it is important to look at the effect this may have on individualizing patient care, a concept rooted in the foundation of the profession of nursing. Registered nurses from four ambulatory surgery sites within one large health care system in western Michigan were asked to rate the frequency which they performed select nursing care actions using the 45-item Ambulatory Individualized Care Index (AICI), modified from van Servellen's (1988a) Individualized Care Index (ICI). The organizing framework for this study is Ida Jean Orlando (Pelletier's) theory of Deliberative Nursing Process.

Scores from both the total and subfactors of the AICI survey were on the relatively high end of the Likert-type scale suggesting that nurses do perceive that they individualize care. No significant differences in perception were found between free-standing and hospital-based practice settings. Few if any relationships were identified between age, years in practice, years in ambulatory surgery practice, or hours worked per week. A weak positive correlation was found when looking at the educational preparation of the participants.

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CHAPTER 1

INTRODUCTION

Ambulatory surgery is not a recent phenomenon in the current health care environment. Records indicate that civilizations which date back to 3000 B.C. performed ambulatory surgical procedures. During the 1970s and 1980s this way of doing surgery was revitalized (Singer, 1993). The continued growth of the ambulatory surgery movement has been attributed to advances in surgical techniques, improvements in anesthetic techniques, and efforts toward health care cost containment, including reimbursement regulations (Davis, 1993; Kleinbeck, 1993; Macho & Cable, 1994; Parnass, 1993; Singer, 1993). In 1990, 60% of surgeries in community hospitals in the United States were performed on an outpatient basis (Kleinbeck, 1993). It has been predicted that by the year 2000 approximately 70% of all surgeries will be done on an outpatient basis (Michel & Myrick, 1990; Sangermano, 1992). Along with the new approaches to traditional surgeries, the addition of non-surgical invasive procedures such as arteriograms and stent placements has changed the face of the ambulatory surgery arena (Clement, 1992).

The rapidly changing health care environment presents many challenges for nurses. There is a need to stay current with the advancing technological aspects of health care. The competitive business aspect of ambulatory surgery creates an atmosphere where the volume of procedures is stressed. In this case, nurses may feel that they are rushing patients through the system and therefore do not have the time that they would

like to spend with each patient. Despite the limited nursing time with patients as compared to inpatient nurses, ambulatory surgery nursing care involves the same application of all the standards of the nursing process according to Clement (1992). The Standards of PeriAnesthesia Nursing identify the multiple tasks required to prepare patients for surgery including diagnostic tests, patient history, physical assessment data, and perioperative education, including discharge planning (The American Society of PeriAnesthesia Nurses [ASPAN], 1998). The Iowa Intervention Project Nursing Interventions Classification (McCloskey & Bulechek, 1996) has identified 31 activities associated with the pre-operative teaching intervention alone. Also, patient data may be gathered through various means including pre-admission testing programs, telephone screening, physician's offices, as well as from the patient on the day of the procedure.

The current health care environment may be as challenging for patients as it is for nurses. Patients come from a variety of educational, socioeconomic, and cultural backgrounds with diverse expectations for their health care experience. Health care services and information may come from multiple providers at various sites and times. Patients accustomed to a traditional physician-patient relationship, where there is little questioning of physicians' interventions, may be overwhelmed by this system and therefore require that nurses assume an advocacy role. According to Lea & Phippen (1992), patients have a role in the success of their surgical outcomes. The likeliness of success may be in question if, as Heinen & Paul (1992) suggest, more responsibility falls on patients in finding their way through the health care system maze combined with less access to nursing care to help with both physical and psychological preparation.

In this environment where efficiency is stressed there is a risk, perhaps, that nurses' interventions may be aimed at meeting the needs of the perianesthesia/health care system rather than needs patients would have identified for themselves. When patients cannot meet their own needs they become distressed; and it is when patients cannot meet their own needs that they need a nurse (Schmieding, 1993). Therefore, if nurses' interventions are not accurately designed to meet the individual patient's needs, the patient is at risk for distress and undue complications. Any nurse in the ambulatory surgery setting is at risk for allowing this phenomenon to occur. Professional nurses must maintain an awareness of their role in advocating for keeping the patient the central focus of all perianesthesia activities. In developing the plan of care for the patient then, how much emphasis is placed on determining needs which are unique to each individual patient? In promoting optimal patient outcomes, interventions are certainly necessary related to what the perianesthesia/health care system needs. It is equally necessary to determine individual patient's needs and to plan appropriate interventions. With the multiple demands facing the ambulatory surgery nurse, the ultimate challenge is to balance the priorities required by the perianesthesia/health care system and the needs of the patient.

There are documents which support the recognition and treatment of the patient as an individual. Standard VIII of the 1998 Standards for Perianesthesia Nursing Practice addresses planning and implementing the patient's plan of care. Mechanisms for accomplishing this include standardized and/or individualized plans which are developed with, and communicated to the patient. As a resource for the perianesthesia nurse, the publication contains the 1992 American Hospital Association's, *A Patient's Bill of Rights*

and the 1985 American Nurses Association's, (ANA) *Code for Nurses*. Provisions for the patient having the right to decision-making regarding his plan of care are included within *A Patient's Bill of Rights*. The ANA Code for Nurses identifies that "the nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by consideration of social or economic status, personal attributes, or the nature of the health problems" (p. 21). Operationalizing this point involves nurses respecting the individuality of all persons. Nurses are to involve clients as much as possible in planning and implementing their own health care. Additionally,

individual value systems and lifestyles should be considered in planning of health care with and for each patient. Attributes of clients' influence nursing practice to the extent that they represent factors the nurse must understand, consider, and respect in tailoring care to personal needs and in maintaining the individual's self-respect and dignity. (p.21)

Standard IV of the American Academy of Ambulatory Care Nursing (1996) addresses nursing practice. The nature of an assessment in the ambulatory care arena may be related to broad patient populations or to the individual patient's needs. The nurse promotes recognition of the patient as an individual through participation by the patient and family in the assessment of needs, establishing goals, care delivery, and the evaluation/revision of care. Professional nurses are responsible for providing care according to patients' needs. These needs may be determined in any number of ways including those identified by individual patients themselves. As health care continues to move and expand in the ambulatory arena, it is important to recognize the value of the role and the challenges facing the professional nurse in the ambulatory surgery arena. As

aspects of ambulatory nursing continue to diversify, how does the nurse, irregardless of the role played in delivering care to the patient, provide care which will meet the needs of the patient? This study describes the ambulatory surgery nurses' perceptions of their ability to provide individualized nursing care for patients.

CHAPTER 2

LITERATURE AND CONCEPTUAL FRAMEWORK

Conceptual Framework

Ida Jean Orlando (Pelletier's) Theory of the Deliberative Nursing Process is an appropriate framework on which to base a research study on individualized patient care. Orlando's theory is considered a middle-range predictive theory "that specifies the effects of a particular nursing process on the patient's behavior" (Fawcett, 1993, p. 116).

The major concepts in this framework are the patient's behavior, the nurse's reaction, and the nurse's activity (Orlando, 1990). "The patient's behavior is behavior which is observed by the nurse in an immediate nurse-patient situation" (p. 37). Behavior, according to Orlando, may be nonverbal such as trembling or changes in vital signs. There may be nonverbal vocalizations such as a sigh. Verbal behavior may take the form of questions, comments, requests, or demands. Orlando does not believe the initial observations or perceptions of the patient's behavior are adequate in determining what the patient is trying to communicate. "The presenting behavior of the patient, regardless of the form in which it appears, may represent a plea for help" (p. 40). Dismissing, not valuing, or not prioritizing the patient's behavior may result in patients' needs not being individualized.

As Orlando (1990) explained, the second concept, the nurses reaction, results from the nurse's perception of the patient's behavior followed by the thoughts the nurse has about that perception. The nurse's reaction is complete when the nurse has

interpreted the perception or thought. Orlando emphasized two points about the nurse's reaction. One point is that the nurse's perception may not be accurate from the patient's point of view. The second point is that the reaction will be a reflection of the nurse's individuality. If the nurse reacts to what the system defined as needing to be done for the patient rather than the patient's behavior, the individual needs of the patient may go unrecognized.

The third concept is the nurse's activity. This "consists of any action the nurse carries out" and "includes only what she says or does with or for the benefit of the patient" (Orlando, 1990, p. 62). The outcome of the action may or may not help the patient or, the effects of the nurse's action may not be known. Orlando categorized the nurse's actions as being either deliberate or automatic. Deliberative nursing actions occur as a result of the nurse exploring her perceptions, thoughts, or feelings with the patient. Deliberative actions meet the patient's immediate need. Automatic nursing actions are actions that do not meet the patient's immediate needs. While automatic actions may be designed to help the patient, if the nurse does not investigate her/his perceptions with the patient before acting, the actions may be ineffective in helping the patient. "On the other hand, if the nurse checks her thoughts and explores her reactions with the patient before deciding on which action to follow, what she does is more likely to achieve its purpose and help the patient" (p. 63). In meeting the system needs, the nurse is implementing automatic nursing actions. For example, some diagnostic tests are necessary and done for the benefit of the patient in providing safe anesthetic care. This may not be what the patient would have identified as being a necessary intervention.

Schmieding (1990) identified assumptions in Orlando's theory that focus on the domain of nursing. Nursing is a distinct profession with a distinct function and outcome. There is a difference between lay and professional nursing as "the professional nurse identifies both the cause of the distress and the individual help required to relieve the distress, and designs the activity to meet the need for help" (p. 11). Another assumption about the nurse is that her reaction to each patient is unique.

Orlando's assumptions about the patient, according to Schmieding (1993), are that patients' needs for help are unique requiring that any help be specifically tailored to each patient's immediate need for help. When patients cannot meet their own needs, they become distressed. Two additional assumptions are that patients' behaviors are meaningful and that patients are willing to communicate verbally. Lastly, an assumption is made about the nurse-patient situation. Schmieding (1993) believes the relationship can be viewed as a dynamic whole, meaning what each individual does affects the other and is unique for each situation.

These assumptions may suggest that if nurses do not address the individual needs of patients they are not acting in a professional manner. Their actions could place patients at risk for becoming distressed. In as much as the patient's behavior is meaningful and there is a willingness to communicate verbally, the professional nurse needs to be active in soliciting information. The action taken would then be what was mutually agreed upon between the nurse and patient.

Orlando (1990) refers to the interrelationship of the three concepts as the nursing process. The concept of the patient's behavior relates to the nurse's reaction through the nurse's perception of the patient's behavior. The concept of the nurse's reaction relates

with the nurse's activity through the following sequence of activities. The nurse perceives an object which stimulates a thought. This thought stimulates an automatic feeling resulting in an action. The concept of the nurse's activity relates with the patient's outcome in how the activity affected the patient; by helping the patient, by not helping the patient, or that the result is unknown.

It would be appropriate to apply Orlando's theory in examining the need to address patients' individual needs. The interrelationships of the concepts of the patient's behavior, the nurse's reaction, and the nurse's activity clearly are necessary components in applying the nursing process in the highly interactive ambulatory surgery environment. Automatic nursing activities, which are identified by the system's needs, are implemented as a matter of routine. The deliberative nursing activities, which necessitate meeting the patient's individualized needs, may not be implemented. It would be difficult to measure what effect automatic nursing activities, or the omission of deliberative nursing activities, have on patients in the short-stay ambulatory surgery environment. For example, a patient may voice concern about going home to recover and needing to care for an elderly parent at home. If this need was not addressed during the patient's short surgical stay, the resulting effects on the patient may not be known to the nurse.

Review of Literature

Prior to reviewing research-based literature, selected literature of an opinion nature will be presented which is aimed at adding to the collective understanding of the concept of individualized care.

Individualized care has been identified as a foundation of practice. van Servellen (1982) identified uses for the term Individualized Care in patients' bills of rights, the

nursing process, care planning, quality care and the then-emerging practice of primary nursing. Her attempt at that time was to review the literature in order to attach a more consistent definition to the concept of individualized care. In tracing the origins of individualized care, van Servellen (1982) points out that meaning was made for individualized care through various endeavors as documented in the literature. Nursing was focusing on more patient centered approaches. The nursing process had been operationalized. Descriptions of quality care addressed individualized care as did patients' bills of rights. van Servellen identified that it was in 1961 that Myra Levine stated "that the essential element of patient centered nursing was our ability to individualize our approach to the patient and his care" (p. 482). Levine further asserted "that the entire structure of professional nursing relies on the ability of the nurse to individualize" (p. 482).

van Servellen (1982) identified other sources where the concept was addressed to a greater depth in light of primary care nursing whereby individualized care is accomplished through coordinated care, continuity of care, advocating for patients, holistic care planning as well as the presence of accountability and authority for making patient care assignments. van Servellen described the concept of individualized care in the context of primary nursing as

individualized patient care holds that all standardized procedures and care plans should be translated in terms of the unique peculiarity of each patient situation. Care is separate and distinct as it is applied to a real, basic patient-family case; the right of the patient to protection of his uniqueness is ensured when a modality

(of nursing care) stresses individuality of patients' responses to standardized treatment. (p. 483)

van Servellen recommended several behaviors which would promote individualized care. Among these are to "approach the patient as a unique individual, not just another patient"; "discuss with the patient what he knows about his illness"; "sit down with the patient and his family when you are asking these questions"; "listen, and use language that the patient and his family can understand"; and "prepare him for what he can expect in a 24-hour period and throughout his hospitalization" (p. 483).

Reed (1992) presented a thought-provoking commentary regarding individualized care. While acknowledging that there does seem to be broad approval for the concept, the fact that it is often used differently and without exact definition is offered. Caution is advised as Reed urges that in implementing systems that support individualized care, potential problems be explored which would serve to reduce the potential for creating another nursing 'sacred cow'. While strategies such as the nursing process and primary care have supported the value of individualized care, there are instances where there may be incongruence. Systems theory, group psychoanalytic, and symbolic interactionist theories are named and Reed feels that unless these other perspectives are at least considered, patient care may be adversely affected.

The potential differences in short term and long term care were presented by Reed. The implications are in the reported need for routines which facilitate social and communal networks in long term care wards. This approach would be censured by proponents for individualized care. There may be implications for staff as well if an individualized approach through primary care would be adopted. The author contends

that group cohesion and information exchange may be adversely affected as the team members each focus on those for whom they have an accountability. The effect of individualized care in increasing job satisfaction, at least in the acute care setting where nursing involvement is not sustained over a long period of time, was acknowledged (Reed, 1992).

In relation to individualizing care as a way in which nursing feels rewarded, the realities of every day practice may diminish this sense as nurses ponder decisions related to prioritization in meeting simultaneous needs of patients, and then in trying to implement individualized care to patients simultaneously. As practice does not occur in ideal settings, it is reasonable to expect that situations will arise where "nurses may have to make decisions which infringe the precepts of individualized care, but which are the only response to the needs of the patient group" (Reed, 1992, p.11). While this article is not research based, it certainly adds a reasonable perspective to the concept of individualized care.

Abdullah (1995) looked at individualized care as a goal that health care organizations try to achieve by means of patient-oriented nurses. To accomplish this it is necessary to recognize that nurses need education directed towards addressing the cultural needs of patients. "Providing quality individualized client care cannot be achieved without considering the context of the client as a whole person and factors associated with the personal being, such as culture, belief and tradition" (p.715). Individuals may perceive and respond to illness and nursing interventions differently based on the beliefs and traditions of their culture. How patients and nurses respond to nursing interventions is determined by culture. Being aware of this is necessary in order for nurses to obtain

information required to provide effective care. "Unless they have the sensitivity towards the demands of their clients, they may not be able to focus their interventions in relation to individualized care" (p. 716). Abdullah maintained that the provision of knowledge, skills, and attitude through the education of nurses is key in making it possible for nurses to deliver individualized care.

A review of research literature which incorporates the concept of individualized care in a variety of current patient populations and clinical settings will now be presented. van Servellen (1988a) conducted research in an effort to further define the concept of individualized care. This resulted in the development of an instrument to measure the concept. Using a questionnaire in the form of an 80-item checklist, 838 nurses were asked to judge how well the items in the checklist were in agreement with their perception of the concept of individualized care in nursing. Results indicated that the nurses agreed that 50 of the 80 items were individualized care behaviors. Overall, the results were interpreted as supporting 80% of the nursing care items as being adequate in being considered as individualized care by the surveyed nurses. These results were sufficient to justify preliminary work on an individualized care index. A recommendation was made for further clarification of the concept in order to provide a better understanding of what constitutes an individualized care approach. The self-report nature of the survey and need for further work on reliability and validity testing were identified as considerations in use of the individualized care index according to van Servellen (1988b).

Athlin, Furåker, Jansson, & Norberg (1993) conducted a study to gain a better understanding of care needs from the perspective of patients, nursing staff, and relatives

of dying cancer patients receiving hospice care in which a modified primary nursing care delivery model was used. Individualized care was one phenomenon which was looked at as it is tied to both primary nursing and the hospice movement and was found to be important to all perspectives. Respect for patients was identified by relatives as important in meeting patients' individual needs. Nurses valued the ability to provide individualized care and gave examples of how much patients' needs varied. Being responsible for just four patients facilitated them in providing individualized care. Thus, the authors felt that the phenomenon of individualized care was among the phenomena that occurred during the study and was influenced by continuity in the contact between nurses and patient/relatives. Since this was a qualitative study, the finding did not show the frequency of, nor the relationship between the phenomena. Findings were based on the perceptions of relatives which may be different from those of patients.

From the perspective of the caregiver, Hallberg & Norberg (1993) looked at strain which nurses experience when providing care for severely demented patients. The presence of certain patient characteristics and difficulties encountered in providing care, as well as nurses' emotional reactions to these, were measured. Through the implementation of clinical supervision along with individualized care the nurse's experience of burden of caring for severely demented patients was reduced. Limitations for this study were, in part, related to the small sample size as some nurses left during the study. Additionally the patient population as well as the nurse population changed over the study year. There was uncertainty as to the ability of the measures to be sensitive or stable enough to detect changes as the measure was developed for this particular study and had not been used in prior interventional studies.

Results of a study conducted in a neonatal intensive care unit demonstrated that there was a reduction in maternal stress and depression and a more positive mother-infant interaction during feeding when individualized interventions occurred as opposed to standardized nursery care for pre-term infants (Meyers, Coll, Lester, Boukydis, McDonough, & Oh, 1994). Individualized interventions were determined based on reports of parents using standardized assessments and conferences conducted by interdisciplinary teams. The care was then coordinated by case managers through the interdisciplinary teams. The small sample size of 34 pre-term infants, in addition to the study being conducted in a single institution would be reasons to use the results with caution. It was also identified that this intervention study may be difficult to replicate.

The ability to gain information in order to provide scientific rationale for interventions was the motivation for a study regarding specific fears of hospitalized children. The study was comprised of 82 children aged 8 to 11 who were admitted to a pediatric-specific unit in one of six participating hospitals in California. The trait scale of the State-Trait Anxiety Inventory for Children (STAIC), the "How-I-Feel-Questionnaire", and the Child Medical Fear Scale (CMFS), which measures children's fearfulness of medical experiences, were administered. A relationship was found between income level and the total CMFS score as well as the subscales fear of the environment, intrapersonal fears and interpersonal fears. The recommendation that came from the researchers was for pediatric nurses to identify fears by implementing tools found to be effective in measuring children's self-reported fears. This would enable nurses to provide appropriate interventions so that hospitalized children would more ably cope (Hart & Bossert, 1994). Due to the small number of subjects as well as the limited age range, the ability to

generalize to other cognitive levels would not be possible without further research. It was also identified that more effective interventions could be implemented if the influence of additional variables affecting fears was studied.

Hallberg, Welander Hansson, & Axelsson (1994) made an assumption that interventions designed to improve quality of care would lead to an improvement in nurse's job satisfaction. The demented patient population involved presented challenges to the skills of nurses due to the difficulty in determining what their needs were. One of the interventions in this study was nursing care in the form of individualized care by implementing nursing diagnoses. An additional intervention took the form of clinical supervision. The focus was to instruct nurses regarding methods of individual care as well as the latest on dementia and to assist in updating the plan of care through reflective learning sessions with staff. The nurses agreed that individualized care did improve the quality of care. The authors concluded that the interventions did result in increased satisfaction with their work by the nurses and with the care they provided for this patient population. An additional implication noted was the importance of individualized care in this patient population due to their inability to speak for themselves. It was identified that statistical analysis may have been influenced by the small number of nurses in the study. Also, the ability to generalize may be limited as the study was conducted in one institution. Organizational changes were occurring simultaneous to the study which may have introduced bias.

Another study within this same nurse and patient population was conducted. The premise was the importance the climate of creativity and innovation held to the provision of nursing care. The implementation of individualized care caused the nurses to reflect

on their practice. This reflection enabled them to see patients as individuals and offer the best care possible. The resulting sharing of views and interpretations regarding patients seemed to support creativity while diminishing tedium and burnout (Berg, Welander Hansson, & Hallberg, 1994). Limitations similar to the previous two studies would be expected. Looking at the three studies, it is difficult to determine if these were done simultaneously or in succession, however, for a small group to be studied for this prolonged period of time it would be reasonable to suspect that bias related to the participants being aware of their involvement in the study would occur.

Individualized care has been linked to quality of life. Engstrom & Nordeson (1995) studied 169 rehabilitation center patients with progressive neurological diseases with respect to their personal descriptions of quality of life. Themes of self and to be seen as an individual came through in responses such as 'to be who I am'. The implications for nurses, according to the authors, stemmed from their ability to "see very clearly the uniqueness of the individual patient's experience of the quality of life" (p. 182), and therefore the need for flexibility based on the needs of the individual. The subjectiveness of the concept may influence measurability and the ability to generalize in this study. Also, it was identified that the response bias of social desirability may have impacted the subjects' responses.

Kolanowski & Whall (1996) used an organizing framework of Life-Span Perspective of Personality Continuity to look at personality changes in dementia. Their review of the literature, identified that practitioners and researchers who consider patient's premorbid personality "may be in a better position to understand and respond to seemingly new behaviors" (p. 317). The loss of personal identity resulting from dementia

places an individual at risk for being devalued. Behavioral alterations are a cause for institutionalization which places these people at risk for routinized care. Their findings indicate that the personality traits of those with dementia tend to be maintained from their pre-dementia state. Adaptive patterns that were used in the past seemed to be exhibited. The authors support that understanding this behavior has implications for the development of interventions which are effective for each individual.

In a study using a small sample, (n=38), Klang, Bjorvell, & Clyne (1996) evaluated the perceived well-being of individuals in the predialysis stage of end-stage renal failure with the objective of improving their care. They looked at the relationship between perceived health, using the Health Index (HI), frequency of symptoms, using the Symptom List, and the Sense of Coherence scale (SOC). The SOC was used to understand the relationship among stressors, coping, and health. They concluded that uremia did influence their well-being pointing to the importance of assessing well-being by administering these tools to patients. The results could be applied to individualized care plans. The authors identified that further work is needed with the instruments to determine their ability to identify changes in well-being over time. Responder drop-out was also reported as possibly having an influence on the results of the study.

Sappington & Kelley (1996) showed how using the Modeling and Role-Modeling Theory enabled nurses to give holistic care based on a patient's individual uniqueness. Among the components of this theory, care is planned and implemented based on an analysis of data. Goals for implementing interventions acknowledge similarities in people while specific interventions address the clients' differences. The care for each patient is different and interventions are more purposeful since each individual is unique.

Using a case-study method, a nurse assessed the patient according to the concepts of self care, affiliated individuation, and adaptive potential. Goals were set which were mutually agreed upon by the nurse and client. While this was a single situation, the use of a theory in this manner did promote the nurse's recognition of the client as an individual. In doing so, interventions were planned and implemented which were specific to the client's needs.

In a small study in England, 10 surgical nurses were interviewed to determine the impact of being pulled between using the principles of 'new nursing' and the influence of the principles of 'scientific management'. These appear to have had an influence in day surgery and may conflict with how surgery is viewed in the traditional sense (Wigens, 1997). The emphasis in the culture of scientific management is on increased productivity and efficiency. It has been suggested that for day surgery patients there is a reduction in nursing input into their care. New nursing espouses to enable the nurses to give holistic individualized care as increased autonomy is emphasized. A key assumption which is fitting to health care scenarios is "that profitability and speed need to be increased, and that labour costs should be kept to a minimum" (p.1117). In the author's opinion, this would seem to be advocating for "routinization" of care by less costly staff. While 'new nursing' "focuses on the quality of care, calling for a reduction in the routinization of care, and for care to be given by registered nurses" (p.1117).

The results could cause the nurses to feel divided between the goals of their employers and their profession leading the author to seek to understand the issues from the perspective of the surgical nurses. From the study, themes emerged relating to how the surgical nurses viewed 'new nursing'; how 'scientific management' affected nursing;

and how they sought to resolve the conflict between the two. Wiggins (1997) concluded that while most nurses associated new nursing with individualized care, there were some who interpreted the conflict as meaningful since efforts within the realm of scientific management have led to benefits such as cost containment and increased access to health care. Participants in the study identified that they felt they had little ability to influence management decisions and consequently came to accept the resultant routinization of care where physical needs may be met but the psychological and individualized care were reduced. While this was most apparent in the day surgery areas, it also was apparent in the inpatient surgical areas. Justification for routinization was in the form of rationalization as a method for resolving the conflict. As an example, patients undergoing minor surgical procedures were "not really ill" (p. 1121). Wiggins identified that having previously practiced in the studied environment, themes may have been missed or mis-judged. Also, spending more time observing participants as well as interviewing more participants may have increased reliability according to the author.

Implications for Study

It is apparent that there continues to be value for the concept of individualized care in nursing from both a subjective and objective perspective. The term individualized care is still frequently utilized in professional nursing practice arenas. There is support for the concept from a variety of patient and nurse populations as has been shown in the preceding literature review. Themes such as enhanced patient outcomes, patient well-being, nurse satisfaction, nurse burnout, and quality of life were demonstrated. Ida Jean Orlando (Pelletier's) Theory of the Deliberative Nursing Process supports that nurses who give individualized care are acting in a professional manner as they are

implementing deliberative nursing actions as opposed to automatic or routine nursing actions.

The concept of individualized care continues to be used despite further validation of earlier work done by van Servellen in developing a tool to measure the concept. An additional purpose of this study then was to replicate her 1988 work (van Servellen, 1988a) from an ambulatory surgery perspective. This would serve to further efforts aimed at measuring the concept of individualized care as well as fill an apparent void in research studies involving ambulatory surgery nurses.

As practice settings for nursing continue to diversify in response to the fast-changing health care environment, it is important to continue to maintain a professional perspective on the patients we provide care for irregardless of the practice setting.

Research Questions

This study investigated the following research questions:

1. "Is there a difference between the setting where care is delivered (practice setting) and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the Ambulatory Individualized Care Index (AICI)?"

2. "Is there a relationship between the level of nursing education and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?"

3. "Is there a relationship between the number of years in nursing practice and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?"

4. "Is there a relationship between the number of years in nursing practice in ambulatory surgery and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?"

5. "Is there a relationship between the number of hours worked per week and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?"

Definition of Terms

1. Ambulatory Surgery: Burden (1993) describes ambulatory surgery as organized, formal programs in which patients are typically admitted and discharged on the same day for medical as well as surgical procedures. Ambulatory surgery can occur in hospital settings as well as free-standing facilities.

2. Individualized care: "Individualized patient care holds that all standardized procedures and care plans should be translated in terms of the unique peculiarity of each patient situation" (van Servellen, 1982, p. 483).

3. Perception: include "only the stimuli the nurse experiences directly through her senses" (Orlando, 1990, p. 37).

CHAPTER 3

METHOD

Design

This study replicated *Nurses' perceptions of individualized care in nursing practice* by Gwen van Servellen (van Servellen, 1988a). A nonexperimental, descriptive, correlational design was utilized for this research study. The dependent variable studied was the nurses' perceptions of their ability to provide individualized patient care in an ambulatory surgery setting.

Study Site and Subjects

Approval for this study was obtained from Grand Valley State University's Human Research Review Committee and the healthcare system's research and human rights committee. See Appendices A and B respectively.

This study was conducted in a large healthcare system which was recently created as a result of a merger. It is located in mid-western Michigan. This diverse system provides for tertiary inpatient care needs as well as having multiple outpatient settings at various locations. The system has 953 licensed inpatient beds. Included within this healthcare system are two in-hospital ambulatory surgery care units and two off site, free-standing facilities which provide nursing care to patients in the preprocedure phase of care as well as care prior to discharge to home (phase II postprocedure recovery). Combined, the free-standing ambulatory surgery facilities see about 58 patients per day and the in-hospital units see approximately 165 patients each day. Although staffing

patterns vary somewhat between the four sites, all have a high percentage of RNs due to the amount of assessment and teaching related functions.

A convenience sample of all registered nurses (RNs) from each of these sites with a minimum of one year of ambulatory care experience who provide direct patient care were invited to participate in the survey. The invitation was given through a letter of participation attached to the survey detailing the nature of the study.

Instruments

The Individualized Care Index (ICI), modified to reflect an ambulatory surgery perspective, was used to measure the extent to which nurses in an ambulatory surgery setting perceive their ability to provide individualized patient care. The ICI is a 45-item survey developed by van Servellen (1988a) for a study which looked at the extent to which inpatient nurses individualize their care. Results of an exploratory factor analysis identified the presence of a bureaucratic factor and three individualized care factors. Factor I was determined to be patient-centered comprehensive care. Factor II was patient-centered coordinated care. Factor III was patient-centered inquiry/assessment (van Servellen, 1988b). Appendix F identifies which survey items are associated with which Factors.

Content validity for the ICI was established by a panel of three graduate faculty and two graduate students. They were asked to evaluate a questionnaire in the form of an 80-item checklist and to differentiate nursing care behaviors from bureaucratic care behaviors. Another validity test was conducted by having 41 graduate students, who also practiced part-time, evaluate the 80 items. Reliability was established by having a group of 10 students take part in a test-retest trial. A correlation coefficient of .86 was found

(van Servellen, 1988a). Further reliability occurred as 838 RNs were administered the survey. The internal consistency of the items was calculated, using Cronbach's alpha, on each of the subscales of the ICI. The Alpha score for Factor I was .85, Factor II was .91, and Factor III was .91 (van Servellen, 1988b).

For the purpose of this study, the ICI was modified to reflect an ambulatory surgery environment. Content validity was established by having the Ambulatory Individualized Care Index (AICI) reviewed by a graduate faculty advisor as well as a clinical manager and an educator, both of whom have extensive background in ambulatory surgery. The resulting proposed AICI was then reviewed by Dr. van Servellen before being administered to the participating RNs. Permission to use/modify the ICI was obtained. (see Appendix C). Reliability was established using Cronbach's alpha following the administration of the survey to the ambulatory surgery nurses in this study. A correlation coefficient of .93 was found on the total AICI. For Factor I, the Alpha score was .83. The Alpha score for Factor II was .81. Factor III was .77.

The survey was scored using a Likert-type scale ranging from 1-5. For each of the 45 questions, participants were asked to rate the frequency with which they perform the identified nursing care actions in their daily practice. They chose a response from 1; 'with none of my patients' to 5; 'with all of my patients'. Overall scores could range from a low of 45 to a high of 225. Scoring occurred through calculation of mean scores and standard deviations on the AICI as a whole as well as on each subfactor of the AICI. Scoring for each of the subscales indicated the degree of frequency of practice in the various categories of individualized care.

A demographic questionnaire was also constructed for this study. The demographic variables collected included: age, nursing educational level, years in nursing practice, years in practice in ambulatory surgery, number of hours per week regularly scheduled to work, most recent practice area prior to ambulatory surgery, the primary role assumed in ambulatory surgery practice (e.g., pre-operative telephone assessment, bedside pre-operative, post-operative bedside phase II, or bedside both pre-op & post-op), and majority of ambulatory surgery practice within the hospital setting or free-standing setting. Aside from describing the sample, demographics were chosen in order to depict potential influences that various aspect of this relatively new ambulatory nursing specialty may have on individualizing patient care.

Procedure

The number of RNs who currently work in the study sites was solicited from each of the clinical managers. At this time the research objectives were discussed. The clinical managers were asked to provide time in a staff meeting whereby the researcher had an opportunity to provide verbal information by means of a prepared script (see Appendix D) about the purpose of the survey, including directions for completion. Time was allotted for answering questions. The complete survey packet (see Appendix E), including a return envelope, was then distributed to the attendees with a deadline of two weeks for completion identified. The survey packets were distributed to those RNs who were absent from the meeting via their unit-based mail box or through the clinical manager. A box for returned surveys was placed in the clinical manager's office. Arrangements for sharing the results of the survey with each of the sites were made through the clinical manager by means of a return visit to a staff meeting.

Nurses were assured of their anonymity and that results would not be used other than for cumulative data purposes. Return of the survey implied consent to participate. There were no anticipated risks to the subjects.

CHAPTER 4

DATA ANALYSIS AND RESULTS

The intent of this study was to describe the extent to which ambulatory surgery nurses perceive their ability to provide individualized care for their patients. Surveys were distributed to 98 registered nurses working in four ambulatory surgery units. Seventy-one surveys were returned for a 72% return rate. Eight surveys were excluded due to the exclusion criteria of not having worked in the ambulatory surgery environment for at least one year, leaving 63 valid surveys for a return rate of 64%.

Responses from the 45-item AICI survey, adapted from van Servellen's (1988a) ICI, were used to answer the five research questions in this study. Data analysis occurred by means of the Statistical Package of the Social Sciences (SPSS), $p=0.05$. In reporting the scores, 22.2% (14) of the sample had missing data. To maximize the sample, the statistical mean was used to impute the values for the samples with less than 10% of the missing data ($n=11$).

Characteristics of Subjects

The mean age of the nurses in the study was 46.73 years (SD 8.27). The range of their ages was from 27 to 67 years. The educational level of the nurse participants was divided among the three most basic types of nursing education with the predominate found to be diploma. See Table 1.

Table 1
Distribution of Nursing Educational Preparation

Education	<u>n</u> (63)	% of total
Diploma	28	44.4
ADN	21	33.3
BSN	14	22.2

In general, the nurses in this study were not novice practitioners. The number of years in practice as a registered nurse ranged from 2 to 40 years with the mean being 21.29 years (SD 8.99). The mean number of years that the sample RNs had worked in ambulatory surgery was 7.75 (SD 4.69) with a range of one to 18 years. Many of the RNs worked less than full-time. The hours worked per week ranged from 8 to 40 hours with a mean of 30.57 hours (SD 9.06).

As depicted in Table 2, many nurses currently practicing in ambulatory surgery brought with them an extensive background from other acute care areas. The majority of the RNs worked in a medical-surgical setting prior to ambulatory surgery.

Table 2
Distribution of Previous Practice Area

Area	<u>n</u> (63)	% of total
medical-surgical	31	49.2
float	6	9.5
critical care/intermediate	6	9.5
miscellaneous	6	9.5
pre-procedure/testing/ambulatory surgery	3	4.8
pediatrics/neonatal	3	4.8
post anesthesia care unit	3	4.8
office	2	3.2
surgery	1	1.6
obstetrics	1	1.6
emergency department	1	1.6

Due to the diverse practice areas available within ambulatory surgery, nurses were asked to identify the areas in which they practiced the majority of time. The majority of the respondents identified that they currently practiced at the bedside providing care an equal amount of time both pre-operative/procedurally and post-operative/procedurally. Still, 20-35% of their time was in practice away from the bedside eliciting and providing information over the telephone. Table 3 presents the distribution of the areas the study nurses practiced within the ambulatory surgery arena.

Table 3
Distribution of Practice within Ambulatory Surgery

Area	n (63)	% of total
bedside; both pre-operatively/procedurally and post-op/proc. equally	27	42.9
telephone assessment: pre-operative/procedure	13	20.6
combination of phone and any other area	10	15.9
bedside; post-operative/post-procedure	8	12.7
bedside; pre-operative/pre-procedure	5	7.9

In another differentiation of practice, the study nurses were asked to identify the site where they worked. The majority, 47 (74.6%), of the sample participants practiced in the in-hospital environment while 16 (25.4%) represented practice in a free-standing environment.

Results

Ambulatory Surgery nurses were asked to rank the frequency with which they performed the various nursing actions contained in the 45-item Ambulatory Individualized Care Index (AICI) survey, modified from van Servellen's (1988a) Individualized Care Index (ICI). Subdimensions of the ICI that had been identified

through exploratory factor analysis were the presence of a bureaucratic factor and three individualized care subfactors. Factor I consisted of 10 items which were determined to be patient-centered comprehensive care. Factor II was patient-centered coordinated care and also consists of 10 items. The nine items determined to be factor III were patient-centered inquiry/assessment (van Servellen, 1988b). The results were scored on the total AICI as well as the three subfactors of individualized care factors. These are presented in Table 4.

Table 4
Total and Subscale AICI Scores (n=60)

AICI	possible range	actual range	<u>M</u>	<u>SD</u>
Total AICI	45-225	119.00-219.00	195.55	19.35
Factor I-comprehensive	10-50	26.00-50.00	45.10	4.56
Factor II-coordinated	10-50	24.00-50.00	41.86	5.34
Factor III-inquiry/assessment	9-45	24.00-44.00	36.71	4.53

Research Question Number One

“Is there a difference between the setting where care is delivered (practice setting) and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the Ambulatory Individualized Care Index (AICI)?” As demonstrated by the *t*-Test for independent samples, the *t* values are not significant. This would indicate that the hospital-based ambulatory nurses and the free-standing ambulatory nurses do not differ in perception of their ability to provide individualized care to their patients. See Table 5.

Table 5

t-Test for Independent Samples comparing Hospital and Free-Standing Practice Areas

AICI	t-value	p
Total AICI	-.32	.313
Factor I-comprehensive	-1.18	.115
Factor II-coordinated	-.96	.597
Factor III-inquiry/assessment	1.22	.775

Research Question Number Two

“Is there a relationship between the level of nursing education and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?” Although weak, a positive correlation was identified based on the total AICI and each of the subfactors using Spearman’s rho. This might suggest that the higher the educational preparation, the higher the nurse’s perception of their ability to give individualized care. See Table 6.

Table 6

Correlation between Educational Level and Ambulatory Individualized Care Index Scores

	AICI	Factor I	Factor II	Factor III	Edu
AICI	1.000				
Factor I-comprehensive	.8470	1.000			
Factor II-coordinated	.8890	.7669	1.000		
Factor III-inquiry/assessment	.8718	.6586	.6751	1.000	
Education	.2654	.2256	.2706	.2964	1.000

Research Question Number Three

“Is there a relationship between the number of years in nursing practice and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?” There was little if any overall

negative relationship demonstrated using Pearson Product-moment correlation. As compared to the total AICI, and Factor I and II scores, Factor III showed a stronger, although still quite weak, negative correlation at -0.1334 . See Table 7.

Research Question Number Four

“Is there a relationship between the number of years in nursing practice in ambulatory surgery and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?” Using Pearson Product-moment correlation, the total AICI showed essentially no positive correlation while Factor I showed a stronger ($r=0.1455$) but still weak positive correlation. Factors II and III showed little if any negative correlation. See Table 7.

Research Question Number Five

“Is there a relationship between the number of hours worked per week and the extent to which nurses perceive their ability to provide individualized patient care in an ambulatory surgery setting as measured by the AICI?” Essentially no systemic relationships exist. While Factor I demonstrated a negative relationship, the total AICI along with Factors II and III showed a positive relationship as measured by Pearson Product-moment correlation. See Table 7.

Table 7

Correlation between Years in Nursing Practice, Years in Ambulatory Surgery, Hours/Week Worked, and Ambulatory Individualized Care Index Scores

	AICI	Factor I	Factor II	Factor III	Yrs. Practice	Yrs. Amb. Surg	Hrs/wk. worked
AICI	1.000						
Factor I- comprehensive	.9458	1.000					
Factor II- coordinated	.9322	.8765	1.000				
Factor III- inquiry:assessment	.8464	.7085	.7020	1.000			
Yrs. Practice	-.0879	-.0629	-.0729	-.1334	1.000		
Yrs. Amb. Surg	.0252	.1455	-.0483	-.0590	.4061	1.000	
Hrs/wk. worked	.0451	-.0034	.0968	.0503	.1691	-.1674	1.000

Other Findings of Interest

An unexpected result was that the survey item "write missing orders for the patient on the care plan" received one of the lowest individual scores. The average was 3.13, with the possible range being from 1 to 5. This is a surprising score given that the care plan is such a standard aspect of the practice of professional nursing. Additionally, despite instructions, participants chose to respond to certain questions by writing in "na" or "not applicable" adjacent to the item(s). This occurred in 11 of the 14 surveys which had missing data. Of the 11 with "na" identified as a response, eight (73%) identified pre-operative/procedure telephone assessment as one of the practice areas they worked most often. A higher percentage of the total population who responded with "na" worked in a free-standing facility; 4 (25%) of the RNs worked in a free-standing facility and 7 (15%) worked in a hospital-based setting. Five of the 11 (45%) of the surveys with "na"

response(s) included the item identified above as receiving one of the lowest scores. “write missing orders for the patient on the care plan”, a principle component of individualization of care.

The mean score for each of the 45-items on the AICI survey, along with the identification of which Factor the item is associated, is displayed in Appendix F. Note: if no Factor is identified, the item is classified as a bureaucratic item. Table 8 compares the total of the means scores, as calculated from Appendix F, along with the average of this total. It is interesting that, while Factor I does have the highest mean, the bureaucratic factor has a higher mean than either Factor II or III.

Table 8
Comparison of Means of Factors and Bureaucratic Item Scores of the AICI

	Total of Mean Scores	Mean of Total of Mean
Bureaucratic (n=16)	71.93	4.49
Factor I-comprehensive (n=10)	45.22	4.52
Factor II-coordinated (n=10)	41.78	4.18
Factor III-inquiry/assessment (n=9)	36.63	4.07

A random look at seven of the surveys which were among those with the lowest scores, including the lowest, was done with the thought that perhaps these represented a more critical, non-biased evaluation of the survey items. Findings were similar to those identified in Table 7 with Factor I and the bureaucratic factors essentially having similar means and Factor II and III having lower mean scores.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion of Findings

The findings in this study, which described the extent to which ambulatory surgery nurses perceive their ability to provide individualized care, suggest that the nurses in this ambulatory surgery environment, irregardless of setting or other variables tested, perceive that they provide individualized care as measured by the AICI, adapted from van Servellen's (1988a) ICI. Mean scores from both the total and subfactors of the AICI were on the relatively high end of the Likert-type scale. No significant differences in perception were found between free-standing and hospital-based practice settings. Few, if any, relationships were identified between age, years in practice, years in ambulatory surgery practice, or hours worked per week. A weak positive correlation was found when looking at the educational preparation of the participants. Guidelines for judging the scores was based upon interpretation of the scores as being high or low as determined by the average total and subfactor scores of the nurses in the population being studied, according to van Servellen, (1988b). In that the mean scores for the total AICI and for each of the individualized care subfactors in this study were relatively high, this would suggesting that nurses do perceive that they provide individualized care.

These findings are consistent with van Servellen's (1988a) who found overall responses toward the positive end of the Likert scale. Similarly, insignificant differences were found with regard to job and educational variables adding substance to her

conclusion of stability of the measured behaviors in nurses giving care at the bedside. van Servellen (1988b) attributed the fact that her study findings could not discriminate between nursing care modalities to the possibility that nursing may not be practiced in pure enough form to discriminate between modalities. This may have meaning for the current study as well in that no significant differences were found between free-standing and hospital-based practice settings. The diversity of practice areas within this ambulatory surgery practice setting may also contribute to the lack of relationships being identified among the study variables.

In that the bureaucratic items had a higher mean score than two of the three subfactors may indicate that nurses cannot, or do not discriminate between interventions. They may value other interventions equally as important as those interventions which are only associated with the individualization of care. Who is to say what a particular patient needs at any point in time except for that patient's nurse which could be characterized as individualization. Another explanation may be that nurses truly do not understand or value the meaning of individualizing care.

Orlando's theory of Deliberative Nursing Process was the organizing framework for this research study. The major concepts in this framework are the patient's behavior, the nurse's reaction, and the nurse's activity (Orlando, 1990). According to Orlando, the interrelationship of the three concepts constitutes the nursing process. If the perception of the patient's behavior is not validated by the nurse, the patient's needs may not be met on an individual basis. If the nurse's action does not take into account the patient's point of view or the nurse's own individuality, the patient's needs may not be met on an individual basis. Lastly, the nurse's action in meeting the patient's immediate needs

would be considered deliberative, as opposed to automatic, if the action occurred as a result of the nurse exploring perceptions with the patient. These are among the features of a nurse who is acting in a professional manner.

The relatively high total AICI might suggest that nurses in this study functioned in a professional capacity and therefore would be engaging in the nursing process as conceptualized in Orlando's theory. Additionally it was found that there was a weak positive relationship between the educational preparation and the AICI scores. This would give substance to an interpretation and the perception, that with higher education there is a potential for a more professional approach to the RN role.

One purpose for this study was to obtain further validity and reliability on earlier work done by van Servellen (1988a) by developing a tool to measure the concept of individualized care from an ambulatory perspective. Alpha scores on the total AICI and the three subfactors confirmed reliability. Coefficient scores of .70 are sufficient for making group comparisons according to Polit & Hungler (1995). Additionally this study addressed a void which is apparent in the lack of research in the ambulatory surgery nursing practice environment.

Value for the concept of individualized care is apparent based on the frequent use of the term in every-day nursing practice. This is also demonstrated in the literature whereby individualized care is recognized as beneficial through research from both the patient's and nurse's perspective.

While findings in this study might suggest less importance being placed on the inquiry/assessment subfactor of individualized care, other studies link assessments as key in identifying interventions which would support individualized care. Meyers et al.

(1994) found that multidisciplinary review of standardized assessments and interviews, as opposed to standardized care, allowed for individualized interventions thereby reducing maternal depression and stress. This promoted a more positive interaction with infants during feeding. Kolanowski & Whall (1996) identified that a detailed health assessment was key in interpreting dementia patients' behaviors over time in order to develop effective individual interventions. Assessment and the analysis of data were components of "The Theory of Modeling and Role-Modeling" which facilitated the implementation of purposeful interventions for patients (Sappington & Kelley, 1996).

While this study suggests there is less value for the care plan in the ambulatory nurse population, it is one vehicle for communicating individual needs of patients. Hart & Bossert (1994) and Klang et al. (1994) identified enhanced individualization of care for specific patient populations when specialized assessment results were incorporated into their plans of care.

Finally, we need to be alert to prevent outcomes such as were found in a study which was conducted in England. Wiggins (1997) identified a conflict whereby nurses seemed caught between two worlds: the world of new nursing, which is associated with individualized care, and that of scientific management, which is equated with routinization of care. Nurses in the study felt they had little ability to influence management decisions and therefore came to accept routinization of care. This certainly seems to parallel Orlando's (1990) view of deliberative nursing actions as opposed to automatic actions, as well as support the underlying premise for this study. New nursing equates with deliberative nursing in that the action taken by the nurse is designed to meet

the patient's immediate need. Nursing actions under scientific management, or in meeting the system needs, may not serve to meet the patient's immediate needs.

Application to Practice

Because the concept of individualized care is so ingrained in the profession, there are broad implications for nursing. The fact that weak, if any, relationships were identified in tying the test variables as influencing the delivery of individualized care may have meaning in its own right. This concept may indeed be innate to the practice of professional nursing.

It is important that these findings are communicated to the nurses involved in this study as well as their managers. Nurses who may feel inadequate with the fast pace of this practice environment, or feel they are compelled to meet system needs over patient needs may feel somewhat reassured when informed of the findings. The recognition of the level of professional nursing practice may be meaningful to the morale of nurses in these ever-changing and challenging times in the current health care environment. Because no differences or relationships were identified, all of these nurses may see themselves on an equal practice field. This could serve to unite these health care settings which are experiencing multiple changes due to recent corporate reorganization.

As this study adds to the body of knowledge that certain behaviors constitute individualized care, these characteristics may be looked for in potential employees during an interview process. In that these behaviors may be observable, it could be incorporated into a peer review process or employee evaluation as well as self-report of behaviors.

If individualized care behaviors are meaningful to quality care, patient satisfaction, and part of a patient's right, do nurses have the exclusive right or obligation

to incorporate them into their practices? Other disciplines have direct responsibilities for patient care and may benefit from the meaning of individualized care practices as well.

Educational programs should be evaluated to determine if there are expectations that individualized care behaviors are validated. If these are basic components to the practice of professional nursing, how are they incorporated into academic curricula and hospital orientation programs?

Nursing administration and/or advance practice nurses need to look for and support efforts for nurses individualizing care and recognize its meaning for patient outcomes and enhanced nurse satisfaction. Because individualizing care is in the domain of the professional nurse, this has implications for skill mix shifts which are occurring in nursing care delivery models. Due to nursing shortages and cost containment efforts, nursing administrators are being forced to consider meeting staffing needs by way of supplementing care with non-licensed care-givers.

The support and implementation of standards of care which contain the essence of individualized care concepts are essential. This may serve to distinguish the various subdimensions of individualized care from the bureaucratic dimensions which may further support the actualization of individualized care. There are implications for researchers as well. The credibility of findings may be enhanced if a clearer definition of the concept is used. Applications to practice may be enhanced or bear more meaning.

The item "writing missing orders for the patient on the care plan" should be investigated. The average score for this item, as well as the number of responses, was among the lowest at 3.13 (n=56). Could this be due to the faster patient turn-over so there is less time to interact with the plan of care? Or a belief, perhaps, that the patient

type, due to their short stay have needs which are perceived to be more predictable. The perception may be that it is not necessary to communicate individualized patient needs on a care plan as it is assumed that other care givers already know what the patient's needs will be. Terminology may be a factor as the plan of care may take on different forms or meanings in this practice environment. Communication of needs may occur, but verbally from one care-giver to another. This may be a plausible explanation in a free-standing environment which tends to be more self contained.

Knowledge deficit is another possible reason. Again, considering that the average age of nurses in this study was approximately 46 years, along with the fact that the majority of the participants had a Diploma education, may contribute to this knowledge deficit as there may not have been the emphasis on care plans in their nursing education.

Limitations

While a response rate in excess of 60% should minimize differences and maximize generability to the population it may still be difficult to make generalizations from these findings related to the overall small size of the sample. A larger sample size may also have been more beneficial in identifying if relationships existed. The inability to infer causality is not possible as the study used a descriptive survey design (Talbot, 1995).

A factor in how individuals responded may be attributed to the influences of a distinct homogeneous Western Michigan culture. Western Michigan is seen by some as a family-oriented community where religious ties are strong. There may be ties to a particular work ethic which may be inherent in, or attributed to a culture such as this.

The self-report nature of the survey tool, as well as a convenience sampling design, may also have influenced responses and contributed to a social desirability response bias. The perception that the nursing actions in the survey were actions that, as nurses, we should be doing for all patients may be responsible for some responses.

Another factor which might have influenced responses is that all of the participants work in one organization. Additionally, responses may have been influenced by the many organizational changes occurring within the institution compelling the sample to choose more positive responses which could then be interpreted as pleasing.

The tool may not be sensitive enough to identify differences in practice settings or relationships among the tested variables. This was an observation made by van Servellen (1988a) when looking at her results in the original study.

Clearer directions may have prevented "na" responses which resulted in responses being coded as missing data and perhaps having an influence on the overall score. It was intended rather, that questions would be answered using a "1", or "with none of my patients". This could possibly have made for a clearer understanding by the participants that a "1" score is not necessarily a bad score as it is certainly reasonable that there is the potential that certain aspects of individualized care may not be possible when conducting a phone interview for example.

Suggestions for Further Research

Replication in other ambulatory surgery settings would add diversity to the practice setting studied. It would also serve to further validate the tool as a way of measuring the concept of individualized care. Further validation may also serve to differentiate bureaucratic items from individualized care items more closely. With larger

populations being studied, it may also be possible to examine more closely any relationships that may be present, especially in the area of telephone assessment. A simultaneous study in an inpatient setting may identify any differences attributed to a higher ratio of RN to non-licensed staff. Due to the high assessment and teaching aspects, a higher ratio is often the norm in the ambulatory surgery arena. It may also be of interest to correlate nurse satisfaction with the ability to provide individualized care to patients.

It would be advisable to measure the delivery of individualized care from the patient's perspective simultaneous to measuring the nurses' perceptions. This would be in keeping with Orlando's (1990) belief that by validating our perception of patients' needs, we make meaning for what we are doing for patients in meeting their immediate needs. It would also be consistent with van Servellen's (1988b) belief that individualized care is also associated with patient satisfaction and quality care. Nursing care delivery models must incorporate practices that patients value

While the contribution by Reed (1992) was thought-provoking, it would be valuable to explore the meaning from a research perspective. Among his concerns were differences in individual need as opposed to the needs of a group. He also urged caution in that the term individualized care is often used without exact definition. If indeed there are hazards to individualized care from a total patient population perspective, the nursing profession should be on the alert and incorporate methods in practice to avoid these hazards.

In conclusion, these findings have strengthened nurses' abilities to measure individualized care, a valued concept in the practice of professional nursing. More

importantly, nurses in this relatively new specialty perceive that they provide individualized care. This would suggest that they are meeting patients' needs in a professional manner. It is important that, as more and more people seek health care in the ambulatory arena, patients be assured of receiving care which is unique to their needs. This study suggests that this is occurring in this practice setting in many cases.

APPENDICES

APPENDIX A

Grand Valley State University Human Research Review Committee Approval Letter



GRAND VALLEY
STATE UNIVERSITY

1 CAMPUS DRIVE • ALLENDALE, MICHIGAN 49401-9403 • 616/895-6611

June 30, 1999

Rebecca L. Brown
15430 Shaner NE
Cedar Springs, MI 49319

Dear Rebecca:

Your proposed project entitled *Ambulatory Surgery Nurses' Perception of Their Ability to Provide Individualized Patient Care* has been reviewed. It has been approved as a study which is exempt from the regulations by section 46.101 of the Federal Register 46(16):8336, January 26, 1981.

Please add my phone number (616-895-2472) to the information sheet in Appendix C.

Sincerely,



Paul Huizenga, Chair
Human Research Review Committee

APPENDIX B

Spectrum Health Research and Human Rights Committee Approval Letter



Spectrum Health

Downtown Campus

100 MICHIGAN STREET NE GRAND RAPIDS MI 49503-2500
616 391 1774 FAX 391 2745 www.spectrum-health.org

August 11, 1999

Rebecca Brown, BSN, RN
15430 Shaner, NE
Cedar Springs, MI 49319

Dear Ms. Brown:

By means of the expedited review process your project entitled, "Ambulatory Surgery Nurses' Perception of Their Ability to Provide Individualized Patient Care", was given approval by the Spectrum Health Research and Human Rights Committee. The Spectrum Health number assigned to your study is #99-142. Please use this number as a reference in all correspondence to the Research Office regarding your study.

This approval does not include the awardence of any monies for your study.

Please be advised that any unexpected serious, adverse reactions must be promptly reported to the Research and Human Rights Committee within five days; and all changes made to the study after initiation require prior approval of the Research and Human Rights Committee before changes are implemented.

The Research and Human Rights Committee and the F.D.A. requires you submit in writing, a progress report to the committee by **July 1, 2000**, (sample form enclosed) and you will need reapproval should your study be ongoing at that time. Enclosed are some guidelines, entitled "Protocol Points", for your convenience in working with your study.

If you have any questions please phone me or Linda Pool at 391-1291\1299.

Sincerely,

Jeffrey S. Jones, M.D.
Chairman, Spectrum Health Research and Human Rights Committee

JSJ/jfn

c: Jan Hodges, RN
File

APPENDIX C

Permission to Use/Modify Individualized Care Index

December 8, 1997

Gwen van Servellen, R.N., Ph.D.
U.C.L.A. School of Nursing
Los Angeles, California

Dear Dr. van Servellen,

This is to request a copy of your Individualized Care Index as well as permission to use/modify it. This will facilitate my work on my thesis which is looking at how nurses perceive their ability to individualize care in an ambulatory surgery practice environment.

I appreciate your taking time out of your busy schedule to do this for me.

Thank-you. 

My mailing address is:

Becky Brown
15430 Shaner N. E.
Cedar Springs, MI. 49319

Becky -

12/9/97

*Please modify items in WJNR
Article - needs to be adapted
for an outpatient setting.*

You have my permission.



12/15/97

Your fax did not receive this

J.S.

APPENDIX D

Survey Introduction Script for Staff Meeting

Greeting/Introduction: Hello, my name is Becky Brown. I would like to thank _____(insert clinical manager's name) for allowing me to take a few minutes of your meeting time. I am a graduate student completing my MSN degree at Grand Valley (State University). My reason for being here is to ask you to participate in a survey I am doing for my thesis. I am looking at the frequency that various nursing actions occur by ambulatory surgery nurses in taking care of your patients pre-operatively, including pre-op phone calling, and post-operatively. While I currently am in clinical education, my most recent clinical practice was in Same Day Surgery so I do have an interest in this beyond completing my thesis.

Are there any questions before I read the instructions? *Read instructions.*

Again, individual responses are anonymous and I will come back and give you a summary of the final results when they are available. If there are no more questions, I will let you get on with your meeting. Don't hesitate to contact me if you have any questions. My number is on your instructions and your clinical manager knows how to get ahold of me. I will be putting surveys in your mailbox so if there are additional questions or concerns, please encourage your peers to contact me at the number indicated on the survey instructions. Thank-you and have a good day.

APPENDIX E

Nursing Care Survey

Dear Research Participant: In the course of delivering care to their patients, nurses perform many nursing care activities. I am asking you to provide specific information about the extent to which you perform certain nursing care actions with your patients. This survey consists of two parts.

Part I, demographic data, asks a number of questions about you and your background. The purpose of these questions is to assist the researcher in developing a profile of the participants in the study.

Part II of the survey, performance of nursing actions, asks you to specify the extent to which you practice certain nursing actions. Your task is to judge the frequency you perform these activities and circle the response that best fits your judgment. Your answers will remain anonymous.

Please proceed in completing the enclosed survey. You may take as long as you need to complete the survey but it should only take you only about 20 minutes to complete. After you have completed the questionnaire, please enclose and seal it in the envelope provided. Return it to the box labeled "Nursing Care Survey" in your clinical manager's office within two weeks. A summary of the study will be made available to you at an upcoming staff meeting when the data analysis is finished.

Completion of the survey implies permission to participate in this research study.

Thank you for your contribution to this research effort. Please feel free to contact the researcher, Becky Brown if you have any questions or concerns at (616) 391-8671, Paul Huizenga at (616) 895-2472, Human Research Committee chair at Grand Valley State University, or Linda Pool at (616) 391-1291, Spectrum Health human rights representative.

I. Demographic Data: Please complete by filling in or checking the blank as appropriate.

1. Your age is: _____.

2. The highest level of **nursing** education that you have attained is:

_____ Associate's Degree (ADN)

_____ Diploma

_____ Bachelor's Degree (BSN)

_____ Master's Degree (MSN)

_____ Other

3. The number of years that you have practiced as an RN is: _____.

4. The number of years that you have practiced as an RN in ambulatory surgery is: _____.

5. The number of hours **per week** that you regularly work are: _____.

6. The area where you practiced (e.g., critical care, pediatrics) immediately prior to ambulatory surgery was: _____.

7. The area within ambulatory surgery that you practice in the **majority** of time is:

_____ bedside; pre-operative/pre-procedure

_____ bedside; post-operative/post-procedure, phase II

_____ bedside; both pre- & post- operative/procedure fairly equally

_____ telephone assessment; pre-operative/pre-procedure

8. Your practice is:

_____ within the hospital

_____ free-standing

II. Performance of Nursing Actions: Ambulatory Individualized Care Index as modified from van Servellen's (1988a) Individualized Care Index.

Nurses complete many activities in caring for patients. Some of these activities may be performed more frequently than others. You are asked to judge how frequently you do these things by indicating the proportion of patients for whom you complete these activities. That is, how frequently do you perform these behaviors in the administration of nursing care to the patients to whom you are assigned?

- Choice 1: With **none** of my patients
- Choice 2: With a **few** of my patients
- Choice 3: With **some** of my patients
- Choice 4: With **most** of my patients
- Choice 5: With **all** of my patients

Circle the answer that best reflects your judgment.

	With none of my patients	With a few of my patients	With some of my patients	With most of my patients	With all of my patients
1. Discuss with the family what role they would like to assume in providing care for patients during the recovery period following discharge.	1	2	3	4	5
2. Give patients an opportunity to explain their feelings.	1	2	3	4	5
3. Discuss patient problems with other nurses involved in providing care for the patient.	1	2	3	4	5
4. Sit down with patients to discuss their care.	1	2	3	4	5
5. Make sure patients know what roles physicians will play in their care.	1	2	3	4	5

6. Allow patients time to talk about their fears or concerns.	1	2	3	4	5
7. Assesses patient's need for adequate pre-operative hygiene.	1	2	3	4	5
8. Discuss with patients the care that is planned for them while they are in the ambulatory surgery care unit.	1	2	3	4	5
9. After completing the nursing assessment, validate with the patient what you have identified as his/her needs.	1	2	3	4	5
10. Discuss with the patient any dietary implications resulting from his/her procedure.	1	2	3	4	5
11. Allow patients to assume as much responsibility for their own care as they can.	1	2	3	4	5
12. Make sure patients know who other care providers are who will be taking care of them.	1	2	3	4	5
13. Ask patient what they already know about their procedure.	1	2	3	4	5
14. Ask patients if they have any preferences about any aspect of their care.	1	2	3	4	5
15. Allow patients an opportunity for input into the pace of progression-to-discharge activities, e.g., ambulation, diet, pain control.	1	2	3	4	5
16. Help patients accept dependence/independence (as appropriate to their condition).	1	2	3	4	5

17. Find out if the patient has ever talked with anyone who has had the same procedure.	1	2	3	4	5
18. Seek input from other nurses regarding your patient's care needs when appropriate.	1	2	3	4	5
19. Assess patient's hydration and elimination in determining readiness for discharge.	1	2	3	4	5
20. Adapt expected patient activities to the physical and mental capabilities of the patient.	1	2	3	4	5
21. Make sure the patients know the roles of the persons responsible for specific procedures and/or treatment throughout the periprocedure period.	1	2	3	4	5
22. Include the patient's family in planning the patient's care upon discharge.	1	2	3	4	5
23. Make sure patients understand about their medications, such as reason why and side effects.	1	2	3	4	5
24. Write nursing orders for the patient on the care plan.	1	2	3	4	5
25. Support patients in learning about their care following discharge.	1	2	3	4	5
26. Talk with patient about what they know about the reason for their procedure.	1	2	3	4	5
27. Review the information that you gave the patient to be sure that he/she understood.	1	2	3	4	5

28. Carry out medical and surgical asepsis during treatments and special procedures.	1	2	3	4	5
29. Approach patients in a kind, gentle, and friendly manner.	1	2	3	4	5
30. Discuss with the patient the impact their procedure will have on their lives and families.	1	2	3	4	5
31. Complete all "hands-on" nursing procedures for the patient with skill and sensitivity to patient needs.	1	2	3	4	5
32. Keep informed of your patients' condition and whereabouts during your assigned shifts.	1	2	3	4	5
33. Ask patients what their usual daily activities are, such as work, hobbies, and recreation.	1	2	3	4	5
34. Report the pertinent information of the patient's condition during interaction with other staff.	1	2	3	4	5
35. Protect patients sensitivities and right to privacy.	1	2	3	4	5
36. Through talking with patients and/or their families, determine what nursing care needs the patient has that are different from the expected or anticipated needs.	1	2	3	4	5
37. Inform the patient that you are the patient's nurse.	1	2	3	4	5
38. Ask patients if they have any questions about their care.	1	2	3	4	5

39. Give patients explanations and verbal reassurances when needed.	1	2	3	4	5
40. Ask patient and/or families if they understood all the things that their physician has told them.	1	2	3	4	5
41. Communicate clearly ideas, facts, and concepts about the patient in documentation.	1	2	3	4	5
42. Make sure that changes in care and the care plans of your patients reflect the continuous evaluation of nursing care given.	1	2	3	4	5
43. Make decisions that reflect knowledge of facts and good judgment.	1	2	3	4	5
44. Assess the patient's emotional state.	1	2	3	4	5
45. Discuss with patients what the effects having the procedure will have on them and their family.	1	2	3	4	5

APPENDIX F

Mean Score per AICI Survey Item

Survey Item	n	Mean Score	Factor
1. Discuss with the family what role they would like to assume in providing care for patients during the recovery period following discharge.	62	3.74	III
2. Give patients an opportunity to explain their feelings.	63	4.65	
3. Discuss patient problems with other nurses involved in providing care for the patient.	63	3.65	I
4. Sit down with patients to discuss their care.	62	4.18	III
5. Make sure patients know what roles physicians will play in their care.	62	4.23	II
6. Allow patients time to talk about their fears or concerns.	63	4.52	I
7. Assesses patient's need for adequate pre-operative hygiene.	63	3.41	
8. Discuss with patients the care that is planned for them while they are in the ambulatory surgery care unit.	63	4.86	II
9. After completing the nursing assessment, validate with the patient what you have identified as his/her needs.	63	3.98	II
10. Discuss with the patient any dietary implications resulting from his/her procedure.	63	4.25	II
11. Allow patients to assume as much responsibility for their own care as they can.	62	4.66	I
12. Make sure patients know who other care providers are who will be taking care of them.	63	4.27	II
13. Ask patient what they already know about their procedure.	63	4.35	

14. Ask patients if they have any preferences about any aspect of their care.	62	3.92	III
15. Allow patients an opportunity for input into the pace of progression-to-discharge activities, e.g., ambulation, diet, pain control.	61	4.30	II
16. Help patients accept dependence/independence (as appropriate to their condition).	63	4.38	
17. Find out if the patient has ever talked with anyone who has had the same procedure.	63	2.94	III
18. Seek input from other nurses regarding your patient's care needs when appropriate.	63	4.10	
19. Assess patient's hydration and elimination in determining readiness for discharge.	61	4.35	
20. Adapt expected patient activities to the physical and mental capabilities of the patient.	62	4.66	
21. Make sure the patients know the roles of the persons responsible for specific procedures and/or treatment throughout the periprocedure period.	63	4.35	II
22. Include the patient's family in planning the patient's care upon discharge.	63	4.59	I
23. Make sure patients understand about their medications, such as reason why and side effects.	63	4.46	I
24. Write nursing orders for the patient on the care plan.	56	3.13	II
25. Support patients in learning about their care following discharge.	61	4.51	I
26. Talk with patient about what they know about the reason for their procedure.	63	4.57	III
27. Review the information that you gave the patient to be sure that he/she understood.	63	4.67	I
28. Carry out medical and surgical asepsis during treatments and special procedures.	61	4.69	

29. Approach patients in a kind, gentle, and friendly manner.	63	4.92	
30. Discuss with the patient the impact their procedure will have on their lives and families.	63	4.03	III
31. Complete all "hands-on" nursing procedures for the patient with skill and sensitivity to patient needs.	60	4.70	I
32. Keep informed of your patients' condition and whereabouts during your assigned shifts.	59	4.51	
33. Ask patients what their usual daily activities are, such as work, hobbies, and recreation.	62	3.68	II
34. Report the pertinent information of the patient's condition during interaction with other staff.	61	4.66	
35. Protect patients sensitivities and right to privacy.	62	4.85	
36. Through talking with patients and/or their families, determine what nursing care needs the patient has that are different from the expected or anticipated needs.	60	4.57	I
37. Inform the patient that you are the patient's nurse.	62	4.73	II
38. Ask patients if they have any questions about their care.	62	4.89	I
39. Give patients explanations and verbal reassurances when needed.	62	4.94	
40. Ask patient and/or families if they understood all the things that their physician has told them.	61	4.43	III
41. Communicate clearly ideas, facts, and concepts about the patient in documentation.	62	4.50	
42. Make sure that changes in care and the care plans of your patients reflect the continuous evaluation of nursing care given.	63	4.17	
43. Make decisions that reflect knowledge of facts and good judgment.	61	4.79	
44. Assess the patient's emotional state.	62	4.82	III

45. Discuss with patients what the effects having the procedure will have on them and their family.

62 4.00 III

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