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AN EXPLORATION OF THE ELEMENTS OF PROFESSIONALISM WITHIN NURSING DOCUMENTATION IN MALAYSIA

REKAYA VINCENT BALANG

A thesis submitted to the University of Huddersfield in partial
fulfillment of the requirements for the degree of Doctor of
Philosophy

The University of Huddersfield

November 2017

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ABSTRACT

Nursing documentation is the key to nursing care in hospitals. According to Pirie (2011) and Wang et al. (2011), nursing documentation that contains evidence regarding the comprehensive level of nursing care has a strong correlation with nurses' professional practice. Nurses in Malaysia are trained to abide by the Code of Professional Practice (1998); therefore, the purpose of this study is to explore how nurses demonstrate the elements of professionalism within their documentation from a Malaysian context. Despite the significance of nursing documentation in nursing practice, no study has been conducted and published on this crucial aspect of nursing practice in Malaysia. Hence, there is a need to explore how nurses demonstrate the elements of professionalism within their documentation.

This study utilises a mixed methods approach (triangulation - convergence model design) in exploring how nurses in Malaysia demonstrate the elements of professionalism within their nursing documentation. This mixed approach enables greater understanding of nurses' views on their documentation and its influence on the way the documentation is prepared. A quantitative approach is employed to analyse retrospective nursing documentation, where a total of 655 case notes were selected from the five participating hospitals in Malaysia. An innovative data extraction tool based on the Registered Nurses' Association of Ontario (RNAO, 2007) model of Professionalism in Nursing was used in the analysis. The RNAO (2007), proposed eight attributes of professionalism in nursing: i) accountability, ii) advocacy, iii) innovation and visionary, iv) ethics and values, v) autonomy, vi) knowledge, vii) spirit of inquiry and, viii) collegiality and collaboration. The presence of all these attributes was assessed in the 655 selected case notes. Simultaneously, a total of 40 semi-structured interviews were conducted with nurses involved in completing the 655 reviewed case notes. In this context, thematic analysis (Braun & Clarke, 2006) was used to identify categories and themes in nurses' accounts of their documentation, in relation to the elements of professionalism in nursing.

In summary, the quantitative findings reveal that there is evidence of the elements of professionalism exhibited in the nursing documentation among the selected case notes. However, the qualitative findings prove that the nurses could not demonstrate their comprehension of the elements of professionalism in their documentation. Several factors and influences were identified, which could be detrimental to nurses' understanding of the elements of professionalism in nursing documentation, such as the working culture and common cultural values, educational backgrounds, different workplace settings and recognition of the profession. Additionally, the findings of this study point towards the creation of an alternative approach to explore and understand the elements of professionalism in nursing within the scope of this study.

The findings of this study suggest that there is room for further, extensive development of nursing documentation and future studies in many other health settings in Malaysia. The findings of this study could inform responsible authorities in health care and nursing educators to focus or to re-emphasise the importance of ensuring the good quality of nursing documentation in Malaysia. Furthermore, the findings could be used as a baseline to guide the relevant nursing authorities and personnel in Malaysia when dealing with complicated documentation issues and to improve the standard of the nursing documentation from a professional perspective in relation to the nursing practice.

DEDICATION AND ACKNOWLEDGEMENTS

The nurse leaders, senior nurses and staff nurses who participated in this study receive my sincere thanks and appreciation. Without their valuable contribution, this study would not have been possible. I would also like to express my gratitude to the Ministry of Health Malaysia for assisting me with the data collection for this study.

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My thanks also go to my employer, the University of Malaysia Sarawak, particularly to the members of the Department of Nursing, staff at the Faculty of Medicine and Health Sciences for their unfailing support throughout my study.

This study would not have been possible without the invaluable and continuous support, love and understanding of my wonderful friends and relatives in the United Kingdom, as well as in Malaysia, the staff at the University of Huddersfield and the people of Huddersfield, West Yorkshire. All of you have filled my life with love, joy and fun over the last four years. I would like to express my gratitude to them for being caring and supportive, particularly when I was unwell for three months in 2015.

Finally, this thesis is dedicated to Mum (*Mak*) and Dad (*Abak*), who have been my biggest supporters throughout.

LIST OF PUBLICATIONS

Journal

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Full Paper

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Proceeding

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Poster Presentation

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FOREWORD

I am an Iban (an indigenous group in Sarawak), born and raised in Sarawak, which is the largest State in Malaysia. I received my primary and secondary education in Miri Division, Sarawak. I completed my tertiary education in the field of nursing at the University of Malaysia, Sarawak (UNIMAS) in 2007. From 2001 to 2007, I worked as a staff nurse in multiple disciplines: Trauma Operation Theatre; Accident and Emergency; Outpatient Clinic; Orthopaedic Ward; and, Mental Health. In 2007 I pursued a Master degree in nursing at the University of South Australia. After my graduation in 2008, I rejoined UNIMAS, as a lecturer at the Faculty of Medicine and Health Sciences in 2008. In this capacity, I have been actively involved in delivering lectures, supervising students' final year projects, supervising students' practicum sessions and was involved in several research projects related to nursing practice and health.

My involvement in the students' practicum sessions, especially Year Four's Nursing Management Practicum, was the genesis of my interest in nursing practice. In particular, it triggered my interest in professional practice and nursing documentation, and subsequently, was the motivating force for this doctoral dissertation. The genesis of this study was in my own understanding of its necessity when I observed a specific incident during the supervision of final year nursing students. One of the students was asked by a senior staff nurse whether she had performed a naso-gastric feeding procedure on one of the patients in the acute bay. It was necessary for the staff nurse to question the student as the procedure had not been recorded in the patient's case notes. The staff nurse proceeded to explain to the nursing student why it is important to record procedures in patient's case notes, i.e. to ensure that any prescribed procedures have been completed.

This one event became the galvanising moment, as well as the starting point for an enquiry into the consistency of nurses and student nurses practice; principally concerning the crucial matter of recording nursing interventions in hospital. An anecdotal review at the start of the enquiry established that most of the contents in nurses' documentation are filled with the words 'completed,' 'done', '√' and 'due'. These notations suggest that nurses' documentation is treated as a medium that contains 'evidence' to confirm when a nurse performs tasks or procedures that he/she has been instructed to do so by the doctor(s).

Specifically, the content of most nursing documentation in Malaysia appears to be brief and is intended to authenticate the instructions of the doctors on that shift, alongside patients' general condition (Ministry of Higher Education Malaysia, 2010). Johnson, Jefferies and Langdon (2010), argue that the reason behind this could be that nurses tend to focus solely on their own activities, the use of too much medical information, their inability to access patient's case notes, and that they are working amidst frequent interruptions, or when agency staff immediately required additional information. This suggests that nurses are the doctors' 'hand maiden'. Barnett, Namasivayam & Narudin (2010), support this claim by stating that nurses continue to be identified as the supporting workforce in the Malaysian healthcare system.

At the beginning of this study, I was already aware of the importance of nursing documentation and the fact that it is crucial to ensure that all care has been recorded accurately and truthfully. I recalled the very first year of my working experience as a scrub nurse at the Trauma Operating Theatre. As a new nurse in that particular setting, the nurse in charge constantly reminded me of a nurse's responsibility to ensure that patient's documentation was completed accurately. The nurse in charge was emphatic that all the necessary forms, ranging from the patient's vital signs, to swab and instrument count-forms, were obligatory and must be completed prior to the patient returning to the ward. Interestingly, the reason for the nurse in charge's emphasis on the importance of ensuring a patient's detailed records, was to provide documented medical evidence of appropriate and effective nursing practice and procedures. She further explained complete and accurate documentation will act as vital evidence to protect nurses if a patient decides in the future to sue the hospital for any potential negligence or malpractice.

I recognise that I held pre-conceived notions and assumptions about the roles of nursing documentation in demonstrating professional practice among nurses. However, after years of working in hospital settings and over the course of the last four years while undertaking my PhD, I now realise that view was due to the lack of understanding of the antecedents of nursing documentation and nurses' professional practice, particularly within the Malaysian context. I also acknowledge that my perspectives when exploring this under-researched topic could, to some extent, affect my positional stance in this study, being both an 'outsider' and 'insider' researcher (Allen, 2004; Dwyer & Buckle, 2009; Urban & Quinlan, 2014).

Being an 'insider' occurs as the researchers intentionally opt to conduct studies upon their research interest and their background (Allen, 2004; Dwyer & Buckle, 2009; West, Stewart, Foster & Usher, 2013; Urban & Quinlan, 2014). The scope and the width of working experience have made me aware of the fact that I might bring potential bias to this study. However, I took advantage of being the 'insider' in this study, in order to gain 'social nearness' from the respondents, besides helping to ensure an authentic account of the findings (Ganga & Scott, 2006). In addition, being a Malaysian, a nurse and an academic were beneficial, as I was well equipped to understand the cultural similarities and differences from the perspective of the researcher and respondents (Allen, 2004). Furthermore, I found that it was easy to familiarise myself with a group of new respondents or new settings (West et al., 2013). For instance, I managed to be flexible and critical when I moderated the interactions with different groups of respondents. Additionally, I shared my own experiences of being a nurse during the interaction, with the aim of establishing trust and to show the respondents that I understood and recognised the nature of their work (Urban & Quinlan, 2014). As a result of this approach, I noticed that the respondents in this study use words, abbreviations and terminology applied at liberty in nursing to discuss or explain aspects during the interviews. This is language that I am well acquainted with due to my years of working as a nurse in a hospital setting.

I could also be acknowledged as an 'outsider' as this study was conducted in a few unfamiliar settings. Being an outsider, I was seen by the respondents, authorities and personnel as a 'visitor' (Merton, 1972). There were times when I felt uncomfortable as a result of interacting with people that I had not met before. Interestingly, several respondents and authorised personnel addressed me as 'Mister', seeing that they were conscious of my position as a lecturer at a local university and as I am currently on leave pursuing my doctoral study. In other words, these respondents and the authorised personnel accepted my presence in their setting, as an outsider who is currently conducting a beneficial study (Burns, Schmied & Sheehan, 2012). These settings contributed to the 'social distance' that made respondents perceive me as being less threatening to them. As a result, the respondents perceived the process of interviews and the case note review in this study with less caution (Allen, 2004; Dwyer & Buckle, 2009).

Both the theoretical knowledge and clinical experience that I have gained as a nurse, an academic and a researcher for the past 16 years have enabled me to gain insights with the unique entity of nursing practice at each of the settings involved in this study. Interestingly,

the respondents and the authorised personnel at these settings recognised me as a postgraduate researcher who was endeavouring to obtain pertinent information for this study.

Thus, I decided to take on the role of a moderator i.e. working as the 'insider' and/or 'outsider' in such a regulatory way, according to the current situation, during the settings and stages of this study. Dwyer and Buckle (2009), mention that there is no point making a stand on where a researcher should place him or herself as insiders or outsiders. I realised throughout the course of this study that the positional stance of the researcher is pragmatically applied, and was constantly shifting and negotiating from insider to outsider and vice versa (Allen, 2004; Urban & Quinlan, 2014), depending on the different stages of this study, according to the different settings and the different respondents. For example, I initiated a more delicate and culturally sensitive approach when accessing unfamiliar settings and respondents who were less familiar with me and initially reluctant to participate in this study (Burns et al., 2012).

Being mindful of my Malaysian indigenous background, professional identity and affiliation, working experience and position in the context of this study led to and provided an appropriate pathway for myself to ensure that the research design and methodology were cohesive with the diversity of the culture (Chacko, 2004) and the current situation of nursing practice in Malaysia, while making this study feasible, practical and effective with respect to exploring the phenomena. I shifted my positional stance from being the insider to outsider when it came to unfamiliar settings and respondents. From this viewpoint, I was conscious from the beginning for the need to be respectful and not to be seen as an outsider who does not understand or is not aware of the respondents' field of work, culture and sensitivity. I ensured that the nature of this study was evident and well understood by the respondents and the authorised personnel at all the participating hospitals. This was done through briefings, informed consent and the distribution of information sheets. As a result, I experienced trust and openness, besides non-judgmental and welcoming responses from the respondents and the authorised personnel at all the participating hospitals throughout this study.

CHAPTER 1: INTRODUCTION

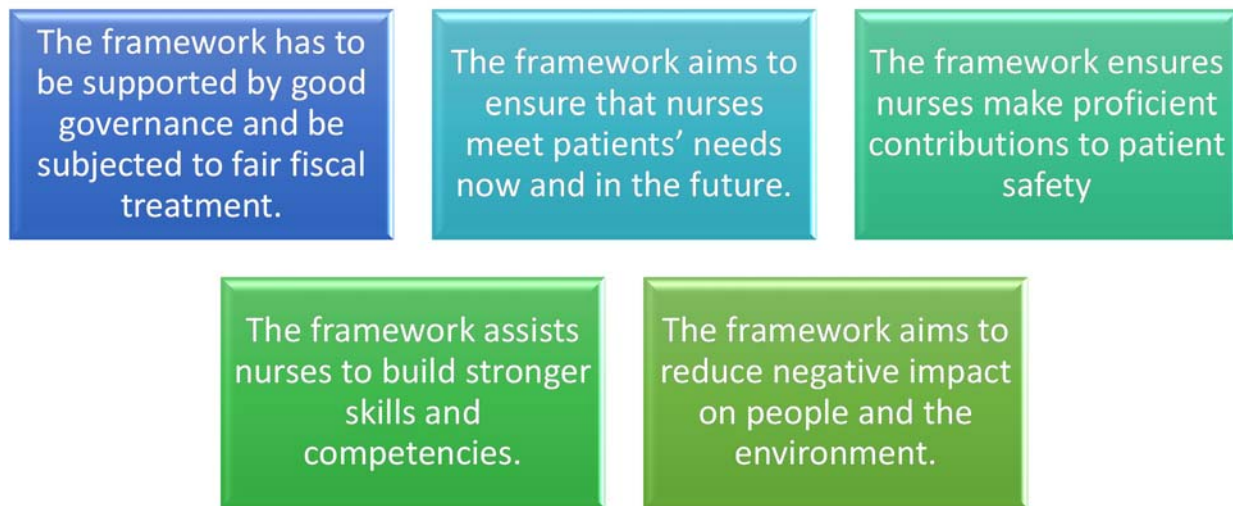
The first chapter of this thesis discusses the background to the problem identified in this study, which particularly outlines the significance of nursing professionalism and how nursing professionalism has not been completely studied in Malaysia, focusing on its elements within nursing documentation. It is subsequently followed by a description of the research aims and objectives, and a brief introduction to the remaining chapters.

1.1 Background of the problem

During, and following the period of British colonisation in Malaysia, healthcare services (including the nursing profession) experienced a significant transformation (Ghani & Yadav, 2008). During this period, a range of healthcare initiatives were introduced with the foremost amongst them being the recognition of 'nursing professionalism'. Professionalism is recognised as a core value, central to the nursing profession because this quality is understood to generally stimulate efficiency and safety at work among nurses (RNAO, 2007). Consequently, in striving to achieve a level of acceptable professionalism, the Nursing Division of the Ministry of Health Malaysia introduced a Code of Professional Practice in 1998 (Nursing Board of Malaysia, 2008). The purpose of this Code is to elevate nursing practice and align it with the standards set by the Ministry of Health Malaysia. Therefore, conferences, seminars, workshops and various teaching and training activities were conducted to develop the nursing profession to an acceptable professional level (Chong, Sellick, Francis & Abdullah, 2010).

The Nursing Division of the Ministry of Health Malaysia also introduced the 'National Core Competency for Malaysian Nurses', which aims to improve nursing practice and to ensure a nursing standard which is equivalent to that of the other developed countries (Nursing Board of Malaysia, 2008). Moreover, the Nursing Division of the Ministry of Health, Malaysia, proposed a framework related to nursing professionalism in 2009 (Ministry of Health, Malaysia, 2012). This framework consists of five significant components, as shown in Diagram 1.1 on the following page.

Diagram 1.1: Five significant components of nursing professionalism (Nursing Division, Ministry of Health, Malaysia, 2009).



(Source: Nursing Division, Ministry of Health, Malaysia, 2009)

Over the years, the Ministry of Health, Malaysia has implemented several initiatives specifically aim at elevating the nursing profession to a professional status. One of the first initiatives was changes to the academic requirements. In this context, the academic requirements to enter the nursing profession in Malaysia were restructured to ensure that future nurses have the requisite knowledge and skills to be empowered to practice innovatively, creatively and autonomously (Chiu, 2005). Nurses are trained in colleges or universities by undertaking a three-year diploma level qualification or a four-year undergraduate degree course. Furthermore, part time nursing degree courses are also available for working nurses (Birks, Francis, Chapman, Mills & Porter, 2009a).

On its own, the restructuring of entry requirements into the nursing profession are not sufficient to improve professionalism among nurses and issues of safety and efficiency still need to be addressed. Hence, in 1998, the Nursing Division of the Ministry of Health, Malaysia introduced a Code of Professional Practice (Nursing Board of Malaysia, 2008). The Code emphasises the importance of the profession in protecting societal interests by ensuring that nurses practice safe nursing. The Code guides nurses to perform their responsibilities by protecting, promoting and restoring the health of patients, preventing illness and, through

compassionate clinical care, alleviate patients' suffering, and provide care to individuals, families and communities.

Birks, Francis and Abdullah (2008) argue that nursing in Malaysia still has a long way to go in terms of its nurses' professionalism. A similar argument was shared by Merican (2006), the former minister for the Ministry of Health, Malaysia, who stated that the public's perception of nursing standards in Malaysia had declined over the years. Merican argues that present-day nurses are less skilled, less caring and less efficient compared to their predecessors. Based on his findings, Merican contended that these nurses lacked professionalism.

Despite these arguments, there has been continued efforts to evaluate professionalism in nursing in Malaysia. For instance, in 2007, the Nursing Division of the Ministry of Health Malaysia conducted a nationwide nursing audit, focusing on specific major nursing skills (Ministry of Health Malaysia, 2007). However, that nursing audit neither evaluated nor explored the level of professionalism among nurses in Malaysia.

Meanwhile, a comparative study on nursing in Malaysia and England was conducted by Ahmad and Oranye (2010). Their study focuses on the empowerment, job satisfaction and organisational commitment of nurses in these two countries. They established that nurses in a hospital in Malaysia had a higher level of empowerment when compared with nurses at a hospital in England. This finding, according to Ahmad and Oranye, arises as nurses in Malaysia were likely to have had enhanced structural empowerment and organisational commitment, as well as a greater job satisfaction than their English counterparts. Ahmad and Oranye (2010) explain that these results could be due to differences in the culture, policies and organisational structures of the two countries. They also argued that their findings could be influenced by the restructuring and financial constraints experienced by the National Health Service in the United Kingdom, at the time of the study. This restructuring, which involved downsizing, may have made nurses involved in the UK case study feel insecure and, consequently, feel less committed to the profession.

Although a considerable amount of research on nursing practice in Malaysia has been conducted, there is a paucity of information and/or lack of literature exploring the elements of professionalism among nurses in Malaysia. In contrast, a vast amount of research pertaining to professionalism in nursing, besides studies exploring the quality of nursing documentation is available internationally. Most of these studies (which are discussed in the

later sections) are from 'Western' countries. As stated previously, the significance of professionalism is unquestionably to motivate nurses to demonstrate professionalism in their clinical practice. Professionalism is an important characteristic in the careers of nurses and it emphasises the values and commitment of their service to the community (Yeoun, Baek & Wynd, 2010).

Girard, Linton and Bestner (2005) extensively defined professionalism in nursing as a commitment to behaviours of compassion, caring and strong ethical values; continuous development of self and others; accountability and responsibility for insightful practice and demonstrating a spirit of collaboration and flexibility. This view is supported by the Registered Nurses' Association Ontario (RNAO) (2007) which suggested that the fundamental principles of professionalism should comprise ethics and values, knowledge, advocacy, spirit of inquiry, innovation and vision, collegiality and collaboration, accountability and autonomy. These attributes are prerequisites for establishing or instilling the precise combination of attitudes, skills and behaviours, all of which are expected from those to whom society has extended the privilege of being considered a professional. Professionalism is also viewed as a process of transition, which is integrated with good critical thinking, motivation for life-long learning, together with skills in technology, communication, management, collaboration and leadership (Karadag, Hisar & Elbas, 2007; Zakari, Alkhamis & Hamadi, 2010).

Morrow, Burford, Rothwell, Carter, McLachlan and Illing (2011) state that professionalism is a complex process. They argue that, although its original context is relatively straightforward to define, it is neither simple nor easy to describe or recognise in absolute terms, whether the behaviour is professional or unprofessional. Furthermore, it is difficult to quantify professional nursing or care unless the rationale and outcomes of a nursing activity are recorded in letters or numbers given that nursing is a profession involving practice (The College of Registered Nurses of British Columbia, 2012).

Hence, several nursing scholars appear to acknowledge the role of nursing documentation as valid evidence to represent nurses' professional practice (Girard et al., 2005; Anderson & Mangino, 2006; Gugerty, Maranda, Beachley, Navarro, Newbold, Hawk, Karp, Koszalka, Morrison, Poe & Wilhelm, 2007). These scholars state that professionalism in nursing is generally concerned with nurses' practice and that documentation forms an integral part of their practice. Allen (2007) and Potter and Perry (2010) indicate that empirical evidence, such as nursing documentation, might be a good indicator to validate the existence of the elements

of professionalism among nurses. Similarly, the College of Registered Nurses of British Columbia (2012) argues that although nursing undoubtedly contributes to the curing of diseases and recovery of health, the effect of nursing could not be proven unless it is documented. Additionally, Alidina (2013) highlights the need to verify the elements of professionalism in nursing which, she argued, must be demonstrated by constructive and concrete evidence.

Meanwhile, a review by Prideaux (2011) indicated that the standards of nursing documentation have a strong influence on the quality of patient care and ability to protect and safeguard the professional accountability of nurses. Concurring with this view, the College of Nurses of Ontario (2008) also emphasises that data from documentation can be used to evaluate professional practice as a part of quality improvement process. Similarly, Riesenber, Leitzsch and Cunningham (2010), explain that professionalism in nursing will improve the ability of nurses to work independently and directly towards achieving patients expected outcomes, as demonstrated by their documentation.

Wang, Hailey and Yu (2011) argue that nursing documentation that contains evidence concerning care has a strong correlation with nurses' professional expertise. Pirie (2011) also specifies that nursing documentation is an important document which adheres to professional standards and legal requirements. Therefore, nurses should devote considerable time and effort to communicate, report and record the process for continuity when providing care, despite major challenges that nurses may encounter to achieve it (Scott, 2007). It should be noted that nursing documentation also contains vital information which is required by relevant policies and authorities, or professionally specified standards.

Since the time of Florence Nightingale, nursing documentation has been identified as a principal component of professional practice within the field of nursing. Nightingale (1859) had described the need to document 'proper' provision of air, light, warmth, cleanliness and diet, with the aim of collecting and retrieving data to aid correct patient management. Nightingale (1859) also observed that nurses should record factual information rather than their mere opinions regarding the patients' current status. She further explained that nurses recorded what physicians neglected to record regarding their patients.

An additional milestone in the theoretical development of modern nursing documentation is attributed to Virginia Henderson, a nurse theorist in the 1930's. She promoted the idea of

using nursing care plans to communicate the levels of nursing care (Henderson, 2006). Since then, nursing documentation has become more significant, as it now reflects the changes in nursing practice, regulatory agency requirements and legal guidelines (Iyer, Levin & Shea, 2006). Consequently, nursing documentation has also evolved as an important mechanism in determining monetary reimbursement for the care provided to patients.

White (2003), for example, emphasises that nursing documentation is the professional responsibility of healthcare practitioners. It was argued that nursing documentation should be to the highest standard to provide written evidence of the practitioner's accountability to the patient, the institution, healthcare providers and society. Therefore, failure to sustain reasonable standards of nursing documentation could be interpreted as professional misconduct that can lead to nurses facing discipline for their professional incompetency (Owen, 2005; Dimond, 2008).

Urquhart, Currell, Grant and Hardiker (2009) state that nursing documentation had been used to support different philosophies of nursing practice. While nurses' own theoretical knowledge and concepts of nursing can be embodied in the written text, the evaluation of nursing documentation should have implications for the advancement of the nursing profession as a whole.

Nonetheless, many studies have shown the predominance of documentation of a biomedical nature and insufficient recording of psychological, social, cultural and spiritual aspects of care (Hegarty, Hammond, Parish, Glaetzer, McHugh & Grbich, 2005; Altken, Manias & Dunning, 2006; Gebru, Ashberg & Willman, 2007; Gunhardsson, Svensson & Bertero, 2007; Tornvall & Wilhelmsson, 2008). The quality, structure and format of nursing documentation are essential aspects that must be considered in ensuring that patients' data are presented systematically to facilitate nurses', as well as other health professionals' easy access to information essential for clinical decision-making (Wang et al., 2011).

Various literature has highlighted numerous issues pertinent to professionalism in nursing and nursing documentation (Campos, 2010; Kim & Park, 2005; Ofi & Sowunmi, 2012). Ofi and Sowunmi (2012) explain that nursing documentation is regularly and negligently omitted from nursing job specifications despite its importance. The study conducted by Kim and Park (2005) on narrative nursing, in their example of a tertiary hospital in Korea, also established that nursing documentation was frequently unreliable and inaccurate. Similarly, Strople and Ottani

(2006), and Campos (2010) also ascertain that the use of fragmentary language and abbreviations that were not in the official lists of abbreviations were commonly found in nursing documentation.

Furthermore, Ball et al. (2012) state that nursing documentation is among those actions or duties that are most frequently left incomplete during nursing shifts. Law, Akroyd & Burke. (2010), Wang et al. (2011) and Jefferies, Johnson, Nicholls & Langdon (2012a) discovered that most nursing documentation contained many omissions. These three studies reported that common gaps in nursing documentation include the omission of patient data, the five steps of the nursing process, incomplete records and charting, and inaccurate use of nursing terminologies.

It should be noted that sub-standard nursing documentation can lead to poor nursing outcomes and unreliable evidence regarding care (Cheevakasemsook, Chapman, Francis & Davies, 2006). Specifically, poor documentation regularly creates a disruption of medical records, which are meant to be reliable and valid sources of information. Moreover, nurses' failure to display their autonomy and accountability in documentation generates questions concerning their ability to deliver correct, safe and appropriate care (Morrow et al., 2011). Consequently, this failure could create a situation whereby it is impossible to implement continuity of care.

Issues pertaining to nursing documentation might arise from several factors, such as rushing to finish sign out reporting, a heavy workload, poor writing skills and lack of attentiveness regarding completion (Sharit et al., 2008; Staggers & Jennings, 2009). Additionally, the occurrence of poor nursing documentation could be due to tension between healthcare providers (Hisar & Karadag, 2010). This tension occurs when one individual's reporting is questioned by a colleague who is taking over the duty apropos unanticipated discoveries of irrelevant and incomplete content in the report (Pirie, 2011; Johnson & Cowin, 2012). This situation may also cause frustration and distraction to the colleague who is handing over.

Apart from the content, the way nursing documentation is presented is also crucial. It was argued that one of the factors that influence the visual presentation of nursing documentation is the use of various formats for written nursing documentation (Wilson, 2007; Sharit et al., 2008). The format of written nursing documentation tends to vary from one hospital to

another. This is principally due to the differences in organisational structures, administrative policies, training protocols, equipment and patient populations (Muller-Staub et al., 2007).

Failure to maintain high quality nursing documentation would not reflect on the level of a nurse's professional care, and whether or not that care was professional, appropriate or complete (Baker, 2010). For example, the quality of the patient handover through complete and accurate nursing documentation has immediate effects on the delivery of care regarding its continuity (Maltman, 2007). Good nursing documentation should contain effective information, which is accurate, concise, complete, specific, relevant and timely (Cheevakasemsook et al., 2006; Carusom, 2007; Welsh, Flanagan & Ebright, 2010). Moreover, nursing documentation should not include statements that reflect nurses' value judgements, which reform the objective or include subjective findings provided by the patient. Conversely, nursing documentation should include crucial data and its relevant supporting documents in a uniform manner (Anderson & Mangino, 2006).

Therefore, Baker (2010) reiterates that nursing documentation is an important medium to note and consolidate patients' current health conditions, to evaluate the effectiveness of the treatment and the nursing care provided to ensure the continuation of care. In this setting, nursing documentation channels the context of interaction between practitioner, patient or service user (Tower et al., 2012) and acts as litigious documentation, particularly related to the nursing intervention or action delivered to a patient (Baker, 2010). Furthermore, the documentation acts as permanent evidence for those who exercise the power of decision-making and nursing activity, and its ethicality. Therefore, it could be argued that there is an interrelation between professionalism and documentation which should be acknowledged and demonstrated.

1.2 Research question

The research question attempts to explore whether professionalism among nurses in Malaysia can be demonstrated within their documentation.

In order to obtain the requisite answers for this research question, a mixed methods approach, which involves both qualitative and quantitative methodologies, was chosen. Due to its nature, the mixed methods approach is expected to provide a comprehensive picture of the elements of professionalism among nurses in Malaysia, demonstrated in their diligent and meticulous use of documentation.

The quantitative strand provides information on the elements of professionalism from the content of the nursing documentation. Meanwhile, the qualitative approach in this study explores nurses' knowledge, perceptions and practices regarding professionalism and their use of documentation. Potential influences and factors that shape the quality of nursing documentation are also investigated.

The integration of the quantitative and the qualitative findings in this study builds an extensive understanding of nurses' perspectives regarding nursing documentation. Such understanding could reflect on their actual professional practice. The amalgamation of the quantitative and qualitative findings will be further discussed in Chapter 6 (Discussion).

This study used the Registered Nurses' Association Ontario (RNAO) (2007) model of professionalism in nursing to explore the elements of professionalism among nurses in Malaysia, as demonstrated by their use of documentation. The use of a theory or model drives a study to be more consistent, concise and systematic in obtaining accurate and effective findings that are essential to answer the researcher's question (Sinclair, 2007).

The RNAO (2007) model of professionalism in nursing identifies eight attributes that should be demonstrated in a nurse who effectively practices nursing professionally. They are the attributes of accountability, advocacy, innovation and visionary, ethics and values, autonomy, knowledge, spirit of inquiry and the attributes of collegiality and collaboration. These attributes are interrelated and together, they form a process of integrated concepts that formulate the essence of professionalism among nurses.

Malaysia is a multicultural nation and owing to that, professional practice among nurses working in Malaysia can be influenced by several socio-cultural factors. These socio-cultural factors create the existence of the RNAO (2007) attributes of professionalism in nursing that is distinctive to Malaysia. These socio-cultural factors are authentic constituents of the modus operandi in which nurses in Malaysia interpret and practice their nursing profession. These socio-cultural factors define nurse-patient relationships, nurse-colleague relationships and society's perceptions of nurses, which is unique and varies from country to country. These socio-cultural factors are explored in a way that demonstrates how these factors could shape nurse's documentation practices from a Malaysian context.

1.3 Research aim

1.3.1 Aim

The key aim of this study is to explore how nurses demonstrate the elements of professionalism within their documentation from a Malaysian context.

1.3.2 Specific objectives

In order to achieve the stated aim, this study focuses on the following objectives:

- i) to identify the evidence of the elements of professionalism among nurses in Malaysia in their nursing documentation; and
- ii) to explore the knowledge, attitudes and practice related to the elements of professionalism of nurses and its association with nursing documentation in Malaysia.

1.4 Purpose of this study

This study, via its findings, seeks to provide information and insights regarding the complexity and diversity in documentation practice among nurses in Malaysia. The continuous evaluation of nursing documentation is essential in contemporary nursing practice because today's modern healthcare system is evolving rapidly due to the development of modern technologies, procedures and policies (Brous, 2009; Bosek & Ring, 2010; Beach & Oates, 2014). Therefore, the purpose of this study is to explore the importance of nursing documentation as a reflection of nurses' actual practice.

The long-term goal of this study is to identify and facilitate a process to improve the quality of nursing documentation in Malaysia. One of the implications of this study is that it could initiate a greater concern for effective nursing documentation in Malaysia; not only by the nurses themselves, but also by the authorities and relevant organisations. The findings from this study could encourage and motivate nursing leaders, scholars and authorities in Malaysia to improve and/or establish comprehensive guidelines related to nursing documentation.

The importance of nursing documentation in professional nursing practice could address the need for the reassessment and restructuring of student nurses' training. This reassessment is imperative, seeing as nursing students can be trained to be more competent, both theoretically and practically. Additionally, an improved nursing curriculum and structure would promote an evidence-based work culture (Keating, 2015).

1.5 Importance of this study

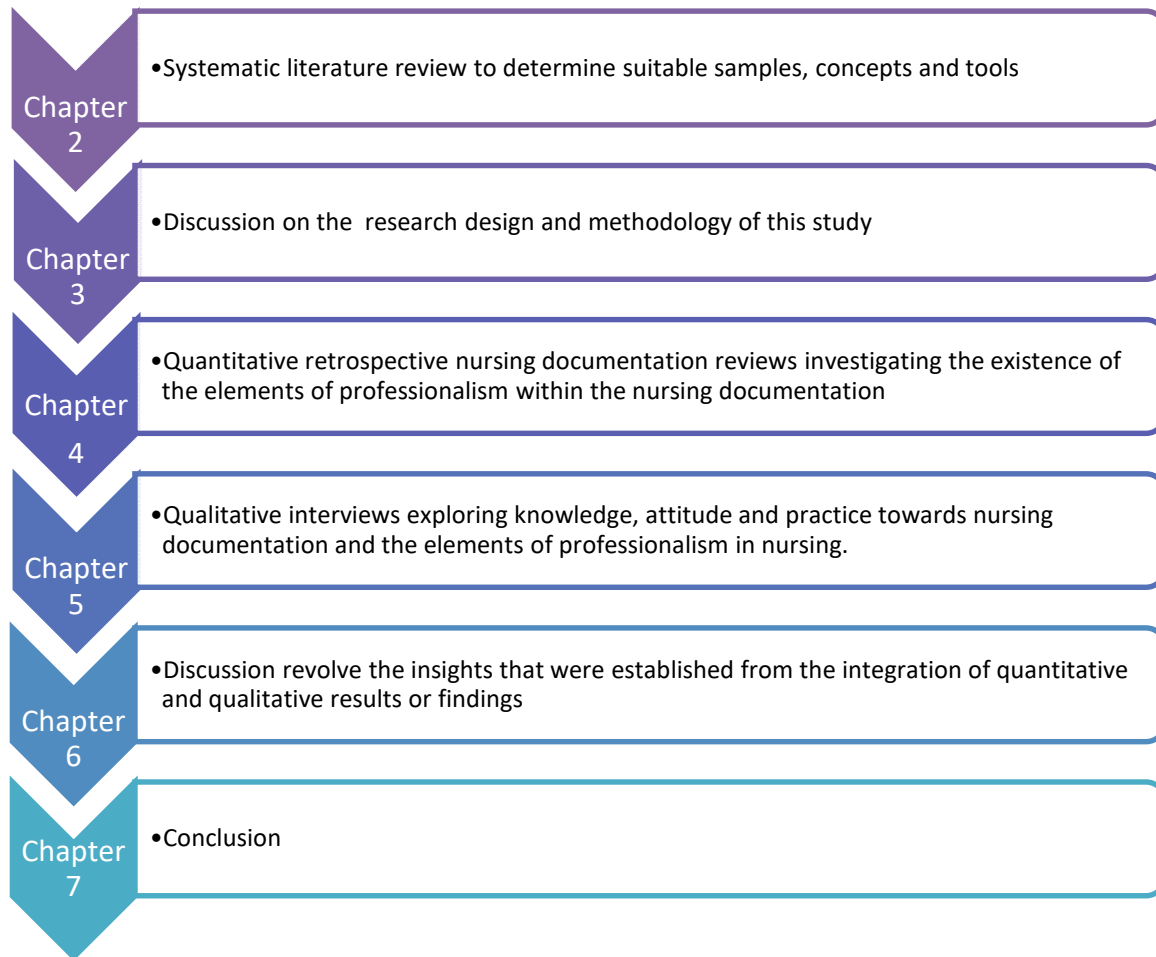
The nature of this study is significant as it provides an opportunity to explore the impact of this study on professionalism in nursing, with its professional practices rooted and grounded in diligently recorded medical documentation from a Malaysian context. This study could also provide insights into the views espoused by nurses in Malaysia concerning professionalism. Moreover, influential factors, including local and national cultural factors, and the norms and tradition of nurses' practice in completing or writing their documentation, and which are pertinent to their professional practice, are also explored in this research.

The exploration of these essential elements that make up nursing professionalism provide a platform to formulate, assimilate and integrate appropriate, effective practice and guidelines for nursing documentation in Malaysia. Findings from this study would be advantageous for further, extensive development of nursing documentation and future studies in many other health settings in Malaysia. The findings also provide evidence to guide the relevant and responsible authorities when dealing with complicated documentation issues.

1.6 Presentation of this thesis

The following sections describe the specific contribution of each chapter as summarised in Diagram 1.2 on the following page.

Diagram 1.2: Structure of the thesis



1.6.1 Chapter 2: Literature Review

The second chapter of this thesis focuses on reviewing literature related to the research subject. This section includes a discussion and theoretical perspective of nursing professionalism in Malaysia by reviewing the relevant literature pertaining to the key constructs involved in this study. This chapter provides a literature background for each construct of the theoretical and conceptual framework employed in this study. Chapter 2 also provides a summary of the core concepts used to describe and to identify the elements of professionalism, within nurses' documentation, in order to select an appropriate approach for further investigation.

A general search of related literature reveals that there is convincing evidence of a relationship between nursing documentation and professionalism in nursing. However, many nursing scholars, particular Wang et al. (2011) have suggested that there is a broad spectrum of concepts and tools that can be used to explore professionalism in nursing and its association with nursing documentation. Therefore, it is uncertain whether professionalism in nursing could be considered a universal phenomenon, as each tool measures a related, but distinct, aspect of professionalism within nursing documentation.

1.6.2 Chapter 3: Methodology and research design

The research methodology and design will be explained in Chapter 3. In general, this chapter explains the decisions governing the choice of the research design, together with the epistemology, data collection and analysis processes. This chapter reviews the distinctions between quantitative and qualitative paradigms and describes how the chosen epistemological position of the scholarly acclaimed 'third paradigm' is able to accommodate the strengths and weaknesses between positivist and interpretative assumptions. The quantitative and qualitative methods were subsequently reviewed to form a feasible strategy for collecting data from various resources. This chapter also explains the rationalisation of the utilisation of quantitative and qualitative to meet the aims and goals of this study.

1.6.3 Chapter 4: Quantitative results

Chapter 4 describes the findings gained from the investigation of the existence of attributes of professionalism in nursing, as recommended by the Registered Nurses' Association of Ontario, (2007) in all the reviewed case notes. This chapter also presents the results tested for revalidation and reliability.

1.6.4 Chapter 5: Qualitative results

Chapter 5 describes the findings derived from the semi-structured interviews. These findings provide insights into the nurses who are directly involved in preparing and completing their reviewed case notes. Moreover, it offers an insight into the association with their perceptions, thoughts, knowledge and practice reflected in their use of nursing documentation and mirrored by their professional practice. Common phrases, subthemes and themes that were constructed from the analysis of the interviews are also presented in this chapter.

1.6.5 Chapter 6: Discussion

Chapter 6 focuses on a discussion which strives to articulate and clarify the quantitative and qualitative findings. It should be noted that these findings complement each other and are subsequently used to form discussions on the subject of interest. In this instance, the discussion generates an explanation of the ways in which the integration of these two distinct types of findings provide a holistic perspective on the elements of professionalism in nursing as demonstrated by the use of nursing documentation from a Malaysian context. Similarities and differences between the quantitative and qualitative findings are extensively discussed. Additionally, several other emergent qualitative findings are also deliberated concerning the influence and practice of preparing nursing documentation in Malaysia.

1.6.6 Chapter 7: Conclusion and recommendations

This concluding chapter summarises the ways in which the aims and objectives of this study have been achieved. Suggestions for both the research and practice implications regarding the application of the results are also elaborated upon in Chapter 7.

1.7 Conclusion

The background to the problem has been discussed and the structure of the thesis introduced. Additionally, the limitations of these findings and their possible applications were also explored.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Nurses' in-depth understanding of the multi conceptual nature of professionalism is an important motivator for nurses to enhance the quality of their nursing care (Maben & Griffith, 2008). Hence, there exists a need to explore professionalism among nurses to further understand the aspects of professionalism in their provision of care, particularly from a Malaysian context. Thus, this study focuses on understanding the concepts of professionalism in nursing and how to empirically assess professionalism. For these reasons, this chapter is dedicated to discussing the core literature and previous studies pertinent to this study.

A comprehensive literature review was conducted using the electronic databases of MEDLINE, the Educational Resources Information Centre (ERIC), CINAHL, PsychoINFO, OVID, PubMed and Academic Search Elite that include literature from the Social Sciences and Science and Technology. The principal search terms used were 'nursing', 'nursing documentation', 'Malaysia' and 'professionalism'. Other keywords that were used to locate the search were 'professional', 'professional identity', 'professional behaviour', 'nursing record', 'record keeping', 'profession', 'professionalisation', 'professional', 'professional development', and 'professional knowledge'. These terms were combined with the terms 'nursing', 'nurse' and 'nurses' to retrieve empirical evidence on 'professionalism in nursing'. These terms were also combined with the terminologies 'Malaysia' and 'Malaysian.'

Additionally, inclusion criteria were established to include all English language full-text articles. This was completed to narrow down the search. Boolean operators such as 'or' and 'and' were used to broaden and narrow the searches respectively. The search for unpublished studies (e.g. dissertations) was conducted using Ethos. Meanwhile, a search of grey literature was undertaken using Google and Google Scholar. Finally, the reference lists of the retained articles were manually searched and sentinel literature was identified.

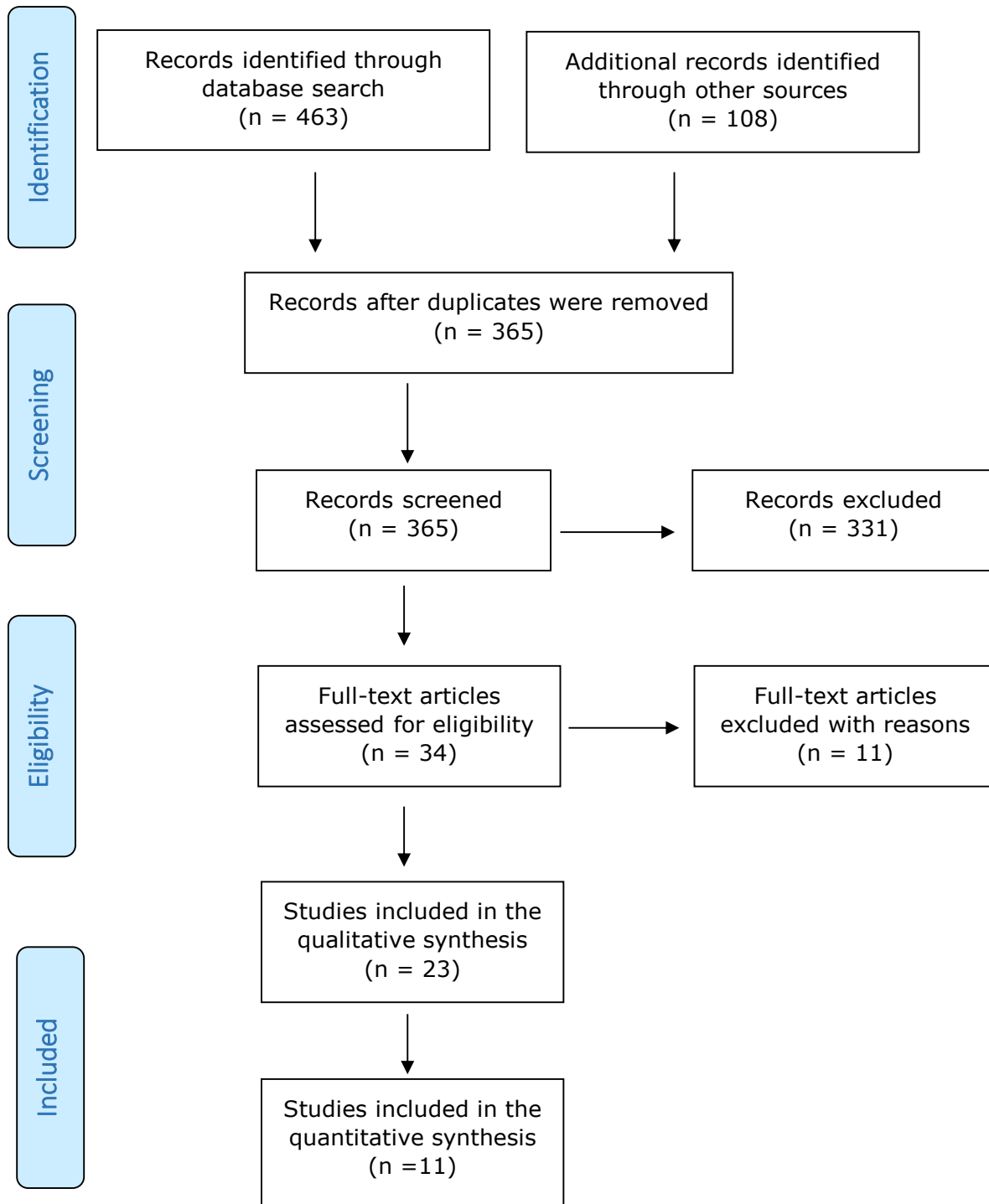
The literature was screened based on the inclusion criteria, which were:

- i) Qualitative and quantitative articles or papers from nursing, social health, public health, management and other medical journals.
- ii) Articles or papers are written in English.

- iii) Captured, explored, discussed or explained the attitudes, perceptions, opinions, behaviours, performances and issues regarding nursing documentation within the context of Malaysia.
- iv) Captured, explored, discussed or explained the attitudes, perceptions, opinions, behaviours, performances and issues of professionalism in nursing within the context of Malaysia.

As revealed in Diagram 2.1 on the following page, 463 papers were identified from a detailed search process across selected databases, as mentioned above. A total of 23 qualitative and 11 quantitative papers and articles were accepted for the review. The studies included in the review were published between 1980 to 2017. From the screening of the literature, it was established that there is an obvious lack of information regarding professionalism in nursing in Malaysia. In fact, there is a dearth of studies investigating and exploring professionalism in nursing from a Malaysian context.

Diagram 2.1: PRISMA 2009 Flow Diagram



Further searches were conducted on several databases as mentioned earlier, on key words such as 'healthcare in Malaysia,' 'Malaysia culture,' 'nurses work culture,' and 'history of Malaysia'. This information is essential to substantiate discussions on the papers or studies pertinent to the subject matter.

This chapter discusses the concepts and aspects related to the subject matter as follows:

- 2.2 Malaysia: at a glance
- 2.3 Healthcare in Malaysia
- 2.4 Conceptualisation of the elements of professionalism in nursing
- 2.5 Sociological influences on the elements of professionalism in nursing from a Malaysia context
- 2.6 The birth of a new era of professionalism in nursing
- 2.7 Championing professionalism as the core of safe and efficient nursing practice
- 2.8 Assessing the elements of professionalism in nursing
- 2.9 Nursing documentation as the source of assessment for the elements of professionalism in nursing

2.2 Malaysia: at glance

Malaysia gained its independence from Britain in 1957 (Harding, 2012). The country has its origins in the Malay kingdoms present in the area, which came under the rule of the British Empire from the 18th century. The first British territory was known as the 'Straits Settlements'. Later the British Empire expanded its territory by giving British protectorate status to the kingdoms of Malay. The territories located on the Peninsular Malaysia were first unified as the 'Malayan Union' in 1946 (known as 'Malaya'). Malaya was subsequently restructured as the Federation of Malaya in 1948, and achieved independence on 31 August 1957. Six years later, the colonies of Sarawak and Sabah, on the island of Borneo, and Singapore joined Malaya to form the Federation of Malaysia on 16 September 1963. However, Singapore withdrew in 1965.

Malaysia is a multi-racial country made up of many ethnic groups. The Malays are the largest group with a population of 63.1% of the total population (Department of Statistics of Malaysia, 2011). Ethnic Chinese constitutes a quarter of Malaysia's population, whilst Indians comprise approximately 7%. Both groups are concentrated on the Peninsular's west coast. Historically, the Chinese and Indians were brought by the British to work in the tin mines and rubber plantations of Malaysia circa mid-19th century (Ghani & Yadav, 2008).

In general, the ethnic groups can be broadly divided into two basic categories. The first group consists of people who are culturally indigenous to the region - 'Bumiputera', and the second group consists of people located culturally outside the region - 'non-Bumiputera'. The *Bumiputera* grouping includes the aborigines (Orang Asli), the Peninsular Malays and the Malay-related groups in Sabah, such as Kadazan, Murut and Bajau, in addition to the Iban, Melanau, Bidayuh and Penan of Sarawak. Meanwhile, the non-*Bumiputera* group consists of the Chinese, Indian, Arabs, Europeans and others. Several of these groups have been present in the Peninsular Malaysia since the early part of the 13th and 14th centuries, i.e. from the era of the Malacca Sultanate, while the others came during the colonial era.

The national language for Malaysia is 'Bahasa Melayu' (Malay Language). 'Bahasa Melayu' is a compulsory subject taught in primary and secondary schools in Malaysia, according to the Constitution of Malaysia: Article 52 (Thirusanku & Yunus, 2014). The English language remains as an active second language with its use being allowed for numerous official purposes under the National Language Act of 1967. Rajadurai (2010) argues that the English language has a long history of institutionalised functions and is used intra-nationally as a second language among fellow citizens in Malaysia. In Sarawak, however, English is an official state language alongside 'Bahasa Melayu' (Satem, 2015).

Besides English and 'Bahasa Melayu', many other languages are used in Malaysia. This is because Malaysia contains speakers of 137 living languages. Forty-one of these languages are spoken in Peninsular Malaysia. The native tribes of East Malaysia have their own languages which are related to, but easily distinguishable from, Malay. Additionally, 'Iban' is the main native language in Sarawak, while 'Dusun' and 'Kadazan' are the principal languages spoken by the natives of Sabah. Chinese Malaysians predominantly speak Chinese dialects from the southern provinces of China while most Malaysian Indians speak and write in Tamil.

The official religion of Malaysia is Islam. However, freedom of religious practice is enshrined in the Malaysian constitution. Since the 14th Century, Islam has been the principal religion in the Peninsula (Muzaffar, 1987). It should be noted that 61.3% of the people in Malaysia embrace Islam making it the most widely-practised religion in the country (Department of Statistics Malaysia, 2011). As a multi-racial nation, there are other religions in Malaysia, specifically Buddhism (19.8% of the population), Christianity (9.2%) and Hinduism (6.3%). The other religions or teachings that are practiced in Malaysia include Taoism and Sikhism. Some Orang Asli tribes practice Animism, whereas others embrace Islam and Christianity.

Both ethnicity and religion are regularly considered as 'one socio-cultural commodity' in Malaysia (Ibrahim, 2007). For example, a Malay person is someone who speaks the Malay language, practices Malay culture and is a Muslim. Furthermore, Malays perceive the concepts of being Malay as not completely relying on their ethnicity (Mohamed et al., 2014). Similarly, a Chinese person will always be identified as either a Buddhist or Taoist and an Indian is frequently identified as a Hindu or Christian. In this respect, culture is considered as a heritage which is permanent and unchangeable.

Malaysian society is rich with varied cultures and norms owing to its diverse demographic background. Khoo (2004) mentions that Malaysians still identify strongly with the other Asian cultures, which uphold the core values of shared values and community orientation as opposed to Western values that promote active competitiveness and individualism. These cultural values, as part of the Malaysians' sense of self, are regularly conveyed into the workplace and influence the way people relate to one another in performing their daily work (Abdullah & Low, 2001). Despite being a multicultural society, where each ethnic group retains its own identity and culture, all Malaysians share common cultural values regardless of ethnicity (Ahmad & Abdul Majid, 2010).

The national culture of Malaysia can be discussed using Hofstede's (1980) 'National Culture' model. Hofstede's (1980) model of 'National Culture' can be summarised as generally hierarchical with a 'high power distance', status conscious with a deep respect for elders and roles in society, paternalistic and relationship-based, instead of being task-orientated (Selvarajah & Meyer, 2008). The model also describes a collective philosophy in relation to approaching work, and an aversion to confrontation, which puts an emphasis upon 'harmony and face-saving' (Zainol & Ayadurai, 2010).

Collectiveness in a society refers to its closely integrated relationships attaching extended families and other members of the community into an 'in-group' (Hofstede, 2001). These 'in-groups' are laced with undoubted and unquestioned loyalty to, and support of each other with other 'in-groups'. In collectiveness, the interest of the group prevails more than the interest of the individual. People are integrated into strong cohesive in-groups that continue to protect them throughout their lifetime and is in exchange for their unquestioned loyalty. Specifically, collectivist cultures stress interdependent activities and, to some extent, suppressing individuals' aims for the welfare of the entire group.

It can be argued that these common cultural values exist due to the Malaysian's practice of 'multiculturalism' (Ibrahim, 2007). Multiculturalism, according to Hall (2009), can be defined as the social characteristics and problems of governance posed by any society where diverse cultural communities live together and attempt to build a common life, while retaining something of their original identity. For that reason, multicultural strategies and policies are adopted to govern or manage the challenges of diversity and multiplicity when they occur within multicultural societies (Ibrahim, 2007).

In 1971, the Malaysian Government enacted a 'National Cultural Policy' (Department of Culture and Art Malaysia, 2015). The development of a national culture for newly independent countries is extremely important to create a stable and united nation. The National Cultural Policy is based on three principles; 1) The national culture must be based on the indigenous culture of this region, 2) Suitable elements from any other culture may be accepted as part of the national culture, 3) Islam is a critical component in the formulation of the national culture.

Besides the National Cultural Policy, the Malaysian Government also enacted affirmative actions to create equity among Malaysians (Lee, 2005). Moro & Norman (2003) define affirmative actions as, "actions that favour those who tend to suffer from discrimination". Malaysia's affirmative action policy differs from that of the other countries in one crucial aspect. In this context, it is the politically dominant majority ethnic group that introduces preferential policies to raise the group's economic status as against that of the more economically advanced minority groups. The predominant ethnic group that has the power to legislate affirmative action policies and, subsequently, receive benefits from those policies are the Malays. Lee (2005), claims that regarding the affirmation action in Malaysia, preferential treatment for the Malays and other indigenous groups was written into the Malaysian

Constitution, under Article 153. In other words, affirmative action in Malaysia is a constitutionally sanctioned and exclusively ethnic-based policy, where only the Malays and other native groups are entitled to receive preferential treatment.

Owing to a race riot in 1969 between the Malays and Chinese, the Government introduced the New Economic Policy in 1971 (Economic Planning Unit Malaysia, 2015). This policy aims to reduce and eradicate absolute poverty by raising the income levels and increase employment opportunities for all Malaysians irrespective of race. The policy was also intended to restructure society by 'correcting' economic imbalances to reduce, and eventually eliminate, the identification of race with economic function. Consequently, the Malay's participation in the economy and their level of education increased. Additionally, the Malays comprise the largest majority within Malaysia's civil service (Lee, 2005).

As the largest group in Malaysia, Malay culture has been assimilated into Malaysian society by means of the constitution and policies, and has eventually had an influence on Malaysia's way of life. The Malays are often described as hospitable, accommodating, forgiving, peace-loving and charitable, besides being extremely compassionate (Mansor & Kennedy, 2000). Meanwhile, Ismail (1988) argues that people are entitled to compassion and magnanimity from those in positions of authority when they demonstrate weakness, providing their behaviour does not threaten the base values of society, including both state and religion.

2.3 Healthcare in Malaysia

Healthcare in Malaysia has been experiencing remarkable transformation since the era of British administration (Ghani & Yadav, 2008). This transformation inevitably occurred due to: (i) limitations and demands because of poor healthcare facilities; (ii) fulfilling the needs of an ever-growing population with unhealthy behaviours; and (iii) institutionalised and de-institutionalised restraints that have greatly influenced an inspiration to serve. These causative factors have also been progressively constructing how Malaysian society perceives healthcare professionals as responsible individuals able to satisfy public expectation. Due to this expectation, healthcare professionals are required to show and epitomise behaviour that demonstrates professionalism in their daily practice (Evans, 2008).

2.3.1 The development of healthcare in Malaysia

The specific characteristics of Malaysia's current healthcare system could be chronologically explained by the history of the country. In general, the history of the Malaysian healthcare services can be divided into two phases. The earlier phase is the era prior to the arrival of Western colonial powers, whereas the subsequent phase is the era after their arrival, where Western medical practices were gradually introduced.

The earlier phase is characterised by the indigenous people who inhabited the Peninsular Malaysia, and Sabah and Sarawak (Ghani & Yadav, 2008). The earliest of the present-day inhabitants, for example the *Orang Asli* (Peninsular Malaysia), *Penan* (Sarawak), *Rungus* (Sabah) have lived in the area for 5,000 years. The next wave of migration (i.e. the second and third waves) was undertaken by the Malays. The first wave, involved Deutro-Malays, who came to the area around 1,000 BC. During this period, health beliefs and practices were based on animism. All illnesses were attributed to 'spirits of the forest' (Ghani & Yadav, 2008). Illness was treated by the appeasement of the spirits and the use of the herbs and roots of forest plants, together with incantations to heal the sick. Moreover, the arrival of the early Indian and Arab traders had introduced elements of Hindu mythology, Muslim Orthodoxy and Arab pharmacopoeia in society and were followed by the early Malays (Ghani & Yadav, 2008).

The later phase began at the beginning of the 16th Century when a large unit of Portuguese soldiers and officials arrived in Malacca. The Portuguese built a royal hospital in the Peninsular Malaysia, which served the needs of the Portuguese officers and men, and a 'poor hospital' for the poor and indigent (Ling, 1991). These hospitals were managed by the Jesuits. Later, in 1641, the Dutch captured Malacca from the Portuguese and a hospital was established for the Dutch citizens and was staffed by a senior surgeon and four junior surgeons (Ling, 1991).

The large-scale immigration of Chinese and Indian labourers at the turn of the century meant that they brought their various treatments with them, such as healers, herbalists and other practitioners. Nevertheless, with the advent of the British State, it was Western medicine that soon predominated. In fact, Western medicine has since been privileged to be the only system of medicine sanctioned and practiced in state-provided services. Thus, by the early part of the twentieth century, the basic structure of the current healthcare system was already established. By 1910, general hospitals were established in each of the states and individuals working in the civil service were entitled to free healthcare.

In the aftermath of the Second World War, the primary ideology, particularly in Western Europe, was that of the liberal welfarist (Ghani & Yadav, 2008). In terms of the healthcare system, the emphasis was on universal provision and equity in finances and access. For example, a national health service was established in Britain by the Labour Government, which was later adopted by the newly independent Malaya. Consequently, prior to 1963, the Malayan national healthcare system that was envisioned, and eventually came into being, was welfare-orientated.

When Britain granted independence to Malaya in 1957, it bequeathed a public hospital system originally developed for the care of the expatriates and local government officials, which later included the care of the general population (Ghani & Yadav, 2008). Hospital care was primarily provided by the public sector; nevertheless, simultaneously, there were non-profit Christian mission hospitals and charity hospitals that were established by the Chinese community. Except for the ubiquitous general practitioners in towns, healthcare services were almost totally provided by the Federal Government and funded by means of the national budget. In the 1980s, this began to change and healthcare demand and utilisation were driven by rising incomes, the emergence of middle classes and increasing urbanisation. International influences and governmental policy also supported private sector growth, thus, resulting in the more complex healthcare system that Malaysia currently has (Ghani & Yadav, 2008).

Government funded hospitals were concentrated in urban areas and a feature that would persist was the civil servants' entitlement and access to these hospitals (Chee & Barraclough, 2007). Civil servants enjoy free or heavily subsidised hospital care in wards that are strictly categorised according to their ranks in the civil service. Despite that, the public hospitals in Malaysia also embodied a welfare model for the general population. Basically, the public could seek free or heavily subsidised inpatient and outpatient care or choose to pay more to be admitted to higher-class wards (Chee & Barraclough, 2007).

Nowadays, Malaysians engage with a system of healthcare that belies its status as a developing nation. The Malaysian healthcare system consists of tax funded and government-run universal services, and a fast-growing private sector (Jaafar et al., 2013). Public sector health services are organised under a civil service structure and are centrally administered by the Ministry of Health Malaysia. The Ministry of Health Malaysia plans and regulates most public-sector health services but so far exerts little regulatory power over the private sector

(Jaafar et al., 2013). Legislation governing healthcare professionals requires them to register with statutory professional bodies. The Ministry of Health Malaysia also regulates the pharmaceutical industry and food safety.

The public sector provides approximately 82% of inpatient care and 35% of ambulatory care, while the private sector provides roughly 18% of inpatient care and 62% of ambulatory care (Hussein, 2009). The Ministry of Health Malaysia offers a comprehensive range of services, including health promotion, disease prevention, and curative and rehabilitative care delivered via clinics and hospitals, whereas special institutions provide long term care. Additionally, several other government ministries also provide health-related services. The private health sector provides health services, principally in urban areas, through physician clinics and private hospitals with a focus on curative care (Jaafar et al., 2013). Private companies run diagnostic laboratories and some ambulance services. Concurrently, there are non-government organisations that provide health services for specific groups. It should be noted that a large section of the population still use traditional medicine, such as Chinese and Malay products.

However, the healthcare system in Malaysia is confronted by several challenges that impact on its uniqueness in delivering care and treatment to the public (Lee, 2005). Firstly, as is regularly seen in any healthcare sector in any part of the world, Malaysia struggles with the cost of providing healthcare. Secondly, poor funding has compromised working conditions and results in low salaries that drive healthcare professionals into the burgeoning private sector. Thirdly, the healthcare system in Malaysia also faces unique health-related issues due to its unique geographical, social, cultural and political elements across both the Peninsular Malaysia and its counterparts in Borneo (Birks et al., 2009a). Fourthly, infectious diseases, for instance dengue fever and malaria remain prevalent in this tropical climate, along with HIV and AIDS (Barracough & Phua, 2007). Fifthly, the rapid growth in population that has led to changes in diet and lifestyle over the years, have seen an increase in cases of cancer, diabetes and cardiovascular disorders, along with an associated rise in mortality from these specific diseases (Ministry of Health Malaysia, 2007). Finally, as is the case in many other countries worldwide, the health of the rural and indigenous populations remains a concern. Inhabitants of remote rural areas, particularly in Sabah, Sarawak and other isolated locations in Peninsular Malaysia, are experiencing difficulties in accessing the healthcare system (Lee, 2005).

2.3.2 The development of nursing in Malaysia

The history of nursing in Malaysia began in 1800 when hospitals for the sick were established in Penang and Singapore under the East India Company (Birks et al., 2008). Nursing of the sick was performed by Catholic nuns and later by nurses who had travelled from England to specifically fulfil that role. Prior to the Second World War, these healthcare facilities had their own nursing services. The training of the staff nurses was conducted by European matrons (or assistant matrons) and doctors, all of whom were also responsible for the management of nursing services at hospital level in each strait/settlement.

2.3.2.1 History of nursing in Malaysia

Miss R. K. Applebee started the Penang School of Nursing in 1947 (Sarawak State Health Department, 2012). She was responsible for establishing and advancing the training of nurses throughout the Federation of Malaya, with the aim of achieving the same standard of nursing training as that in England and Wales. Sixteen nurses were selected for the first Preliminary Training School and refresher courses were offered for the trained nurses. UNICEF supplied the equipment for the schools, while the World Health Organisation (WHO) supplied qualified tutors. Candidates, who did not hold the senior Cambridge certificate qualification, devised the first entrance exams.

The first two local nurses entered the Royal College of Nursing, England, in 1949, to be trained as tutors (Ministry of Higher Education, 2010). Three years later, the Nurses Board Federation of Malaya was enacted. With that enactment, a compulsory federal entrance examination was set. This move has been instrumental in raising the standard of nursing throughout the country. The Nurses Board Federation of Malaya established the Nursing Legislation Nurses Act (1950) and the Nurses Registration Ordinance (1950) to control the practice of nursing in Malaya (Ministry of Higher Education, 2010). These acts and ordinances were the foundation of the Nursing Board in the same year to ensure the training and registration related to the practice of nursing adhered to the induction of the Nurses Registration Regulation in 1956. The Nursing Board is also responsible for monitoring the development of the curriculum for Basic Nurse Training, regulation to control the practice of nursing through registration, issuing of nurses' registration certificates and badges.

In terms of publication development, the first book on manual procedures and the first nurses' magazine for the Federation of Malaya were published in 1955 (Ministry of Higher Education, 2010). In the same year, the first batch of nurses was sent to Australia to complete their training under the Colombo Plan. The establishment of the National Rural Health Development Programme in 1956, which emphasised the importance of maternal child health, received two more qualified local tutors from Edinburgh University and London University respectively (Sarawak State Health Department, 2012). Concurrently, the education committee was formed with the purpose of formulating and guiding policy regarding student training. The formation of this committee resulted in many male and female nurses returning from postgraduate studies overseas between 1956 to 1957. This group included specialist nurses in Psychiatry, Ophthalmology, Tuberculosis Nursing, Paediatrics, Public Health, Midwifery and General Tutors.

In 1969, the 1950 Nurses Act was extended to Sarawak and later, in 1978, to Sabah (Sarawak State Health Department, 2012). In 1985, the Nurses Registration Regulation was revised to include the implementation of the Annual Practicing Certificate. The Nurses Act 1950 remains in use today.

2.3.2.2 Nursing in Malaysia today

Not unlike the scenario related to the global healthcare workforce, registered nurses form the largest group of health professionals in Malaysia, with 80,990 nurses presently working in government and private hospitals throughout Malaysia (Jaafar, Mohd Noh, Abdul Mutallib, Othman & Healy, 2013; Subramaniam, 2015). This figure included community and dental nurses. In the UK, for example, there were 314,966 qualified nursing staff employed in 2015 as compared with 149,808 qualified doctors (NHS Confederation, 2016). The enormous number of nurses in the healthcare system remains essential and considerable in any country because of the expanding and extensive roles of nurses in the environment with high demand for, and high societal expectation regarding healthcare services (Kanchanachitra, Lindelow, Johnson, Hanvoravongchai, Lorenzo, Houn, Wilopo & delaRosa, 2011, Subramaniam, 2015).

Nurses comprise two to three percent of the female workforce in Malaysia and a substantial proportion of the healthcare workforce (Barnett et al., 2010). This situation occurs because of the move made by the Ministry of Health Malaysia to train only small numbers of males to be nurses (Barnett et al., 2010). According to Barnett et al. (2010), more males were trained

as medical assistants because of the historical and cultural reasons. It should be noted that almost all staff nurses work in hospitals and they are diploma holders (Ministry of Higher Education Malaysia, 2010).

Despite the early progression of the nursing profession (i.e. from the early 1950s to the 60s), nurses in Malaysia are still striving to match the professionalism of their Western counterparts (Buncuan & Putit, 2010). This state of affairs has occurred because of the increased awareness of the importance of elevating the status of nursing to be similar to other professions in the Malaysian healthcare system. Additionally, current healthcare trends and the enhancement of health technologies have enlightened nurses to keep on improving professionally. Simultaneously, inevitable factors, such as societal change, advances in medical technology, the rise of the feminist movement and consumerism (Buncuan & Putit, 2010) have influenced the nursing profession in Malaysia and forced it to continue moving forward and upgrading its professional status.

In response, the Ministry of Health Malaysia has attempted to elevate the nursing profession to a professional status. Originally, the academic qualification for nurses to enter the nursing profession in Malaysia was restructured in the early 1990s (Ministry of Higher Education Malaysia, 2010). This strategy helps to equip nurses with the knowledge and skills that will empower them to practice innovatively, creatively and autonomously (Chiu, 2005). Nurses are trained in colleges or universities by undertaking a three-year diploma level qualification or a four-year degree. For the diploma level, the entry requirement is the 'Sijil Pelajaran Malaysia' (SPM), which is equivalent to the UK's GCSE level qualification. Meanwhile, the entry requirement for a degree in nursing is the 'Sijil Tinggi Pelajaran Malaysia' (STPM), which is equivalent to A-Levels in the UK (Lee, 2008). Furthermore, part-time nursing degree courses are also available for working nurses. As nurses have become more aware of the importance of this qualification, the demand for a BSc qualification for Malaysian Nurses has increased tremendously (Birks et al., 2009).

In 1998, the Nursing Division of the Ministry of Health Malaysia introduced a Code of Professional Practice (Nursing Board of Malaysia, 2008). The Code emphasises the importance of the profession to protect the interests of society by ensuring that nurses practice safe nursing. Nursing contributes to the health and welfare of society through the protection, promotion and restoration of health, the prevention of illness, and the alleviation of suffering in the care of individuals, families and communities. In carrying out these responsibilities, the

nursing profession strives to safeguard the interest of the society by ensuring that its practitioners abide by a code of professional conduct.

The Code of Professional Practice offers guidelines for professional behaviour and practice, and can be used as a standard against which complaints of professional misconduct are considered (Nursing Board of Malaysia, 2008). The Code also guides nurses in carrying out their responsibilities in protecting, promoting and restoring health, preventing illness and alleviating suffering while giving care to individuals, families and communities. There are six critical areas highlighted in the Code, specifically professional nursing practice, neglect or disregard of professional responsibilities, abuse of professional privileges and skills, conduct derogatory to the reputation of the profession, advertising, canvassing and related professional offences, and disciplinary proceedings.

In addition to the introduction of the Code of Professional Practice in 1998, the Ministry of Health Malaysia also introduced a framework for professionalism in nursing in 2009 (Ministry of Health Malaysia, 2012). This framework comprises five core components that nurses should continuously apply in performing their daily tasks. First, the framework should meet the client's needs not only now, but also in the future. Secondly, the framework should be supported by good governance and subject to fair fiscal treatment. Thirdly, the framework should make valuable contributions to patient safety. Fourthly, the framework must reduce the negative impact on society and the environment. Finally, the framework aims to build skills and improve the competency of nurses.

2.3.2.3 Professionalism in nursing within the Malaysia context

Although nurses form the largest workforce in the Malaysian healthcare system, historically, the country faced a shortage of nurses (Barnett, Namasivayam & Narudin, 2010). In 2010, Malaysia had 2.78 registered nurses and midwives per 1000 of the population (Ministry of Health, 2010) compared to the average of 4.4 nurses and midwives for upper middle-income countries (WHO, 2011). Much has been said concerning the lack of nurses in Malaysia that resulted in ward closures and the country not being able to meet the World Health Organisation's recommended nurse to population ratio of 1:200 by 2015 (Edwards, 2008).

The demand to fulfil the shortage of nurses led to the rapid growth of nursing schools in the country. Thus, the Malaysian authorities have increased the number of public and private

institutions providing nursing courses and have increased the total number of students (Cruetz, 2006). This move has resulted in the uncontrolled growth of private nursing institutions. It should be noted that the Ministry of Higher Education of Malaysia has placed a moratorium on any application to set up new nursing institutions in the country to prevent an oversupply of nurses and other problems that may arise from graduate employment (The Star Online, 2010).

Moreover, there are concerns that entry standards may fall as schools and colleges compete for the same pool of school graduates (Barnett et al., 2010). This could further impose challenges on the teaching staff and clinicians to provide adequate support to enable a maximum number of students to progress through their course in the minimum time available and to enter the workforce as safe and competent nurses. This situation has deteriorated with the lack of oversight by nursing schools, which has led to the negative media coverage of graduates who are allegedly ill-prepared to work as nurses (Wong, 2010). Subsequently, the public perception of nursing standards in Malaysia has declined over the years and present-day nurses are said to be less skilled, less caring and less efficient than their predecessors and lack professionalism (Merican, 2006).

Similarly, a greater number of new graduates entering the workforce have resulted in changes to the multi-disciplinary healthcare delivery of many hospitals (Barnett et al., 2010). Patient care areas are now likely to be staffed by younger nurses with less experience. Consequently, the Ministry of Health then enhanced the mentoring programme for new graduates, whereby all new graduates must undergo a one-year supervision programme. As the Ministry of Health Malaysia has enacted the mentoring system to all newly graduated nurses, the regular, large influx of new graduates has placed an additional workload on more experienced nurses, who are tasked with the responsibility of guiding novice nurses into a professional role (Barnett et al., 2010).

Interestingly, Enrico and Chapman (2011) established that senior nurses experience the sense of being unprepared and challenged when mentoring young, newly graduated nurses. Enrico and Chapman further suggest that there is a need for training and support to improve the mentorship programme. The workload adjustment and rewards from hospital administrators are critical in ensuring a successful mentoring programme. Besides training and support, the mentorship programme should be re-evaluated regularly to ensure its effectiveness and appropriateness. It should be noted that the mentorship programme should

address current issues and needs, especially in the context of newly graduated nurses practising nursing care (Casey & Clark, 2011).

Work culture could also influence professional practice among nurses in Malaysia. Work culture is defined as the surroundings that are established by the nurses in their workplace (Estrada, 2007). Moreover, work culture projects the group's underlying behaviour and the nurses' decision-making capabilities. Work culture among nurses in Malaysia is unique (please note that every country has its own work culture) and is dependent on the nature of its culture, which in all possibility, may have been formed from several elements imparted from Malaysian culture, and the influence of the diversity and pluralism of Malaysian society.

Hofstede's research into the working culture among Malaysian (1984, 1988, 2001) suggest the concept of 'Power Distance' which could shape the inimitable relationship between senior and junior nurses in Malaysia. Hofstede (2011) explains the concept of 'Power Distance' as the extent to which the less powerful members of organisations and institutions accept (and expect) that power is distributed unequally. It suggests that the followers, as much as the leaders, endorse society's level of inequality. Interestingly, this behaviour can also be witnessed in Western countries, such as the UK, Australia and the United States (Hofstede, 2011). However, the scores for this dimension in these three countries are higher than those for Malaysians. The higher scores in this dimension suggest that these three countries have an expanding work culture of fostering open communication, which perhaps explains the differences in scores between those countries and Malaysia (Garon, 2012). However, the inevitable political influences, such as hierarchical status and seniority in the workplace, continue to exert this unequal power distribution (Garon, 2012).

In the context of Malaysian culture, differences in status between individuals are clearly recognised and acknowledged (Mansor & Kennedy, 2000). Emphasis is placed on the correct use of titles, protocols and rank. Poon (1998) explains that expressing respect to others is used to indicate social status and levels of authority, whereby, in Malaysia, different titles and ranking structures are used based on connections with royalty, religious standing and award for service to the state. Ismail (1988) argues that passive obedience to superiors is one of the fundamental behaviours exhibited within Malay society and that strong reverence for elders and traditional leaders extends itself to a preferred authoritarian style of leadership.

One of the more obvious supporting pieces of evidence regarding this claim is how nurses in Malaysia continue to use nomenclatures as 'Matron', 'Sister' and 'Tutor' in their interactions. This is because the old British system remains intact despite British nursing itself having evolved with time (Ministry of Higher Education Malaysia, 2010). Nevertheless, there is a movement towards the replacement of these colonial relics; therefore, more appropriate designations such as 'nursing officer' and 'director' are being given. Moreover, most nurses in Malaysia continue to believe that they are 'hand maidens' to doctors (Birks et al., 2009). This view is supported by the Ministry of Higher Education Malaysia (2010) which states that nurses are not generally consulted in relation to solutions to health system problems, even though they form the largest group of healthcare providers.

Religion is also one of the elements that influences the working culture among Malaysians. Most Malaysians place their religion on a pedestal when it comes to guiding their daily way of living. According to Mohd Salleh (2005), religion can be another factor that leads to different forms of cultural context (Mohd Salleh, 2005). For instance, religion plays a significant role in communication, especially for Muslims (Abdullah, 1996). Islam teaches Muslims to be forgiving, enduring, calm, tolerant and patient depending on the situation or context.

In terms of leadership, nursing in Malaysia remains subservient to the medical profession because being subservient provides stability (Ministry of Higher Education Malaysia, 2010). A good example of this claim is a medical doctor (who is the Director General of the Ministry of Health Malaysia), and not a nurse, has chaired the Nursing Board of Malaysia for the last 60 years. In Malaysia, nurses are classified as providing support services within the government hierarchy. This view supplements the statement from the Ministry of Higher Education Malaysia in 2010, whereby the nursing profession is referred to as a sub-professional group, regardless of how well paid or well qualified these nurses are.

While nurses in many countries around the world enjoy professional status, nurses in Malaysia still need to fulfil several conditions before they can enjoy the same status (Ministry of Higher Education Malaysia, 2010). The first condition refers to the situation where the nursing profession requires extended education for its members, as well as a basic liberal foundation. Secondly, a profession should have a theoretical body of knowledge that leads to defined skills, abilities and norms. Thirdly, the profession should provide a specific service. Fourthly, the members of the profession should have autonomy in decision-making and practice. Finally, a profession should have a code of ethics concerning practice. Birks et al. (2006)

argue that professionalism among nurses in Malaysia still has a long way to go although professionalism in nursing has been regulated for many years.

Based on these conditions, it can be argued that nursing in Malaysia is gradually recognising its professionalism. However, there are several issues that could hinder the process. For instance, there is a lack of information or research pertaining to nursing in Malaysia, either on paper or available electronically (Birks et al., 2006). This setback continues to haunt the nursing profession and, as emphasised by Ong-Flaherty (2012), government sites on nursing and healthcare are of limited use regarding information gathering. The lack of quality and substance related to this information signifies the scholarly immaturity of the nursing profession in the country.

An additional obstacle is the rise in the number of graduate nurses that have opted to work in a 'globalised' workplace and consequently, opt to work overseas (Barnett et al., 2010), primarily in the Middle East, the UK, the US, as well as in Australia. This scenario occurs due to the comparatively low wages, along with the availability of short term employment contracts in such countries that have attracted nurses to retire from the government (public) hospital sector. Conversely, these nurses have sought to enhance their quality of life in their later years by spending time earning significantly more income overseas.

Shamsudin (2006) contends that the future of nursing in Malaysia rests in the hands of nurses who must make the transition from doctor-dependent healthcare to client-centred practice. Thus, in relation to the country's health, the Ministry of Health planned to elevate professional standards among health personnel by publishing the 10th Malaysia Plan a few years ago (Ministry of Health Malaysia, 2011). This ten-year plan will help transform the Malaysian health sector toward achieving contemporaneous, efficient and effective healthcare delivery. For example, the establishment of a new professional grade has also enabled senior nurses to take up positions as hospital directors, a post traditionally monopolised by doctors (Ministry of Higher Education Malaysia, 2010). This strategy is congruent to the observation made by Ghadirian et al. (2014), that professional status can be achieved through the development of education standards and professional certification. Correspondingly, Alidina (2013) concludes that nurses with more professionalism enhance the level of education and training relating to nursing.

To elevate the professional status and standard of nursing in Malaysia, Nik Safiah (2010), one of the most prominent nursing leaders in Malaysia, introduced a Malaysian version of a framework outlining the core competencies of nursing (Ministry of Higher Education Malaysia, 2010). Nik Safiah proposed critical thinking and the intelligent application of knowledge to practice, as the core competencies in nursing. Furthermore, she argued that these core competences could improve the quality of nursing practice in the country. The proposed core competences are shown in Table 2.1 below.

Table 2.1: Nik Safiah's (2010) core competencies for nursing in Malaysia

Core competency 1	Core competency 2
Nurses use critical thinking to gather and interpret information to make sound judgements that contribute to good decisions in many instances. These decisions involve the patients' well-being and even their survival.	Nurses are expected to link, synthesise and coordinate the work output of multidisciplinary teams comprising doctors and other healthcare professionals daily. To this end, nurses are expected to possess the knowledge and skills to perform as coordinators of care.

(Adapted from Ministry of Higher Education Malaysia, 2010)

In her framework, Nik Safiah (2010) emphasises that nurses are expected to provide holistic and comprehensive care involving the use of a scientific approach using six systematic steps, as illustrated in Diagram 2.2 on the following page. Nurses must be concerned with the entire person, under the full range of patient's needs, which among others, may include health teaching, discharge planning, and extending care to the home. However, no published studies are available currently that assess these competencies.

Diagram 2.2: Nik Safiah's (2010) six systematic steps when providing care.



(Source: Ministry of Higher Education, 2010)

With regards to the literature, there is limited information pertinent to nursing practice in Malaysia. Birks et al. (2008) claim that published literature examining the history of nursing in the country is virtually non-existent. Moreover, the current literature review employed in this study suggests that no study has previously been conducted from a Malaysian context. Moreover, Maziah et al. (2012) state that scant research has been conducted concerning nursing professionalism, although there has been a significant increase in the number of nurses in Malaysia. Meanwhile, Ong-Flatherty (2012) mentions the lack of quality, validity, reliability in addition to the lack of information on professionalism among nurses. These statements may be construed as indications of the slow progress that nursing is making in the country. Additionally, the lack of materials and sources regarding nursing in Malaysia also contributes to this situation (Barnett et al., 2010).

Overall, the most profound work on the nursing profession in Malaysia was by Birks and her colleagues (from 2008 to 2010), who published four prominent papers on this subject. One of their papers, entitled 'From Traditional Healers to Telemedicine: A history of Nursing in Malaysia', is one of the first peer-reviewed and published papers which discusses the history and development of Malaysian nursing. Other work primarily focuses on how nurses undertook tertiary education to elevate the image and acquisition of professional practice among nurses in Malaysia. The paper, published by Birks et al., (2009b) entitled 'Women and Nursing in

Malaysia', provides an insight into how the predominantly female workforce within the profession has been subjected to oppressive forces that affected them socio-culturally.

Birks et al. (2010) also explored the impact of post-baccalaureate nursing studies on professional practice among nurses in Borneo by utilising a 'grounded theory' approach. This study provides a picture of how nurses' experience being more professional due to taking tertiary education, even though they are equipped with personal experience. However, this study only focused on exploring nurses' experience of undertaking a nursing degree while they are working with the aim of becoming professional.

Apart from the papers published by Birks et al. (2008, 2009, 2010), a few other nursing scholars have been able to provide debate related to the subject of professional nursing in Malaysia. Buncuan and Putit's (2010) paper discusses the development of nursing in Malaysia, although they appear to omit current professional practice and where nurses in Malaysia stand in this context. Additionally, Lim and Lai (2012) discuss the importance of assimilating the concepts of professional socialisation in nursing into nursing education in Malaysia but they fail to discuss the issues of professionalism among nurses in Malaysia in greater detail.

In 2010, Ahmad and Oranye conducted a study that focuses on empowerment, job satisfaction and commitment to an organisation by comparing nurses in Malaysia to nurses in England. Although this study seems to be well conducted and relatively successful, it does not provide unmistakable evidence and discussion on the elements of professionalism among nurses in Malaysia. Furthermore, the sample size for this study, i.e. a comparison between one hospital in Malaysia and one hospital in England may have limited its findings.

A study by Kulim Hospital in the State of Kedah Darul Aman, Malaysia in 2012, which analyses client satisfaction concerning hospital services included a question in relation to professionalism amongst the hospital staff (Hospital Kulim, 2012). The overall results revealed an appropriate level of satisfaction among the clients towards the services provided by Kulim Hospital. However, the specific characters of 'professionalism' described in this study were vague and had not been explored in any detail.

However, despite their shortcomings, Ahmad and Oranye (2010) and the Kulim Hospital (2012) studies themselves contribute several useful ideas to assist in the exploration of professionalism among nurses in Malaysia. It should be noted that considerable research on

professionalism has been conducted worldwide, but no such study has been performed from a Malaysian context. In fact, no study has been published that explores the relationship between professionalism among nurses in Malaysia and their documentation and professionalism worldwide. Thus, this research seeks to fill the existing gap in the literature.

2.4 Conceptualisation of the elements of professionalism in nursing

It is important to identify the appropriate model or theory that could be used as a framework (Holzemier, 2010). Eventually, this approach could assist in constructing and establishing perspectives when analysing and discussing the findings obtained from a study. Karkkainen & Eriksson (2004) argue that it is important that nurses have a common theoretical basis to examine documentation related to caring and nursing at a practical level. They further emphasise that the creation of a consistent structure of nursing care documentation is feasible when the concepts used originate from a common theoretical foundation.

2.4.1 Chronological and conceptual perspectives of the elements of professionalism in nursing

Professionalism is easy to recognise and yet this term is challenging to define (Salam et al., 2012). According to Morrow et al. (2011), the complexity of defining professionalism is specifically in recognising, in absolute terms, whether a behaviour is professional or unprofessional. In general, the words 'profession' and 'professionalism' come from the Latin word 'professio' which means a public declaration with the force of promise (Friedman, 1970). Professionalism, according to Wilensky (1964), is the degree to which the characteristics of an ideal profession are demonstrated in the everyday practice of the members (Wilensky, 1964). The key to professionalism is that members of any profession should place the interest of those they serve above their own (Brown & Fervill, 2009).

Profession here refers to an established growing body of knowledge that is inherent in education and gives credence to a standard in many parts of the world (Holzemer, 2010). Professionalism in nursing has been discussed since the time of Florence Nightingale (1859); however, debates concerning the act of defining the meaning and comprehension of professionalism in nursing are disputed at a scholarly level among nursing academicians and clinicians. An early discussion on professionalism in nursing was from an academic forum by the Journal of Advanced Nursing (1980). The journal had invited several nurses from various

parts of the world to share their views on the journal's discussion forum. It should be noted that these nursing scholars and clinicians had defined professionalism in nursing differently, as they are basing their definition on their own perspectives and backgrounds.

From the above-mentioned academic forum, it can be concluded that nurses in developed countries are more likely to define professionalism in nursing as the ability to demonstrate autonomy and authorised power, which strengthens the establishment of nursing in clinical settings. In contrast, nurses in the other parts of the world have defined professionalism in nursing as an act that demands a nurse to act responsibly and abides by a code of practice. The differences between these definitions of professionalism in nursing have generated several questions. The key questions are about why do different definitions exist among these nurses? And, what is it that informs nurses' perspectives and influences them to formulate their own understanding of professionalism? These questions, therefore, require a more in-depth exploration. Specifically, this forum has generated intriguing questions that initiated subsequent research into professionalism in nursing, for instance exploring the most appropriate and contemporaneous definition of professionalism in nursing.

In response to the nurses' need to recognise the attributes and behaviours necessary for nursing professionalism, Barbara Kemp Miller (1984) developed a seminal model entitled 'the Wheel of Professionalism in Nursing' (Revell, 2013). This model is visually represented in the shape of the spokes. The hub or centre of the wheel represents two critical attributes, which are education in a university setting and a scientific background that is the basis of professionalism in nursing. The spokes depict attributes and characteristics that are inherent in the behaviours of a professional nurse. These attributes include adherence to the code by nurses, community service orientation, participation in a professional organisation, autonomy and self-regulation, publication and communication, in addition to the development and use of theory and research and continuing education and competencies.

Miller (1988) encourages nurses to have the determination to empower themselves through their professional actions towards patients, organisations and their professional associations. Although this concept seems to have been very inclusive and relatively successful, it focuses primarily on the explicit attitude and behaviour that nurses should demonstrate to achieve professional practice. As such, Miller's model fails to explain its relevance to compensate for the diversity of patients' or clients' backgrounds in the current healthcare system.

Additionally, McCoppin & Gardner (1994) suggest that professionalism comprises of three core elements which are (i) a specialised body of knowledge specific to the occupational practice; (ii) a self-regulatory power, and (iii) state recognition, which is extended from Abraham Flexner's (1910) concepts regarding professionalism in medical practice. Similarly, this concept appears to focus predominantly on the attitudes and behaviours that nurses are expected to demonstrate in their daily practice to achieve professionalism in nursing.

However, McCoppin & Gardner (1994) appear to have omitted the components of sociology, culture and norms, and their roles in nursing the patients of today who come from multicultural and diverse backgrounds. In contrast, Ghadirian et al. (2014) believe that to achieve professionalism, nurses should equip themselves with an understanding of the diversity of the patients to be able to offer a holistic approach in their daily nursing care. It is through cultivating the component of sociology, culture and norms in nursing practice that society's positive perceptions and feelings toward nursing practice can be exerted.

According to The Royal College of Nursing's (2003), guidelines related to professionalism in nursing practice in the UK, professionalism should be reflected in the nurses' capabilities to maximise their clinical judgement in the provision of care. Apart from demonstrating their professional practice, the guideline states that it is desirable to continuously display appropriate behaviours and values in the context of being a professional nurse. Henceforth, these attributes and behaviours, according to the guidelines, will enable individuals to improve, maintain or recover, to cope with health problems, and to achieve the best possible quality of life, regardless of their disease or disability, until their death. However, despite the current population of the UK being highly diverse, there is a dearth of information or detail in the Royal College of Nursing's (2003) concept of professionalism that covers the perspectives of functional sociology, cultural and norms.

Meanwhile, Girard et al. (2005) extend the concepts of professionalism, which were introduced by previous nursing scholars, by defining nurses' individualistic and explicit attitudes and behaviours in a more humanistic, inter-professional collaboration and patient or client-focused characteristics. As such, Girard et al. (2005) define professionalism in nursing as the commitment to behaviours of compassion, caring and strong ethical values, continuous development of self and others, accountability and responsibility for insightful practice, and demonstrating a spirit of collaboration and flexibility. However, Girard et al. (2005) fail to consider the roles of knowledge that enable nurses to apply critical thinking when performing

their daily tasks. Knowledge plays a significant role in supporting nurses' critical thinking and the breadth of knowledge that nurses have gained determine their cognitive skills in relation to analysing, applying and evaluating their nursing practice (Benner, 1984).

Benner (1984), proposed that expert nurses use their 'intuition' when delivering care. Benner was inspired by Dreyfus and Dreyfus (1980), who produced the Model of Skill Acquisition Development. Benner (1984), states that the role of intuitions when giving care to patients is significant, particularly in perceiving the patients' needs and current condition. Payne (2015), published a critical paper examining Benner's (1984) model and suggested that nurses perform well in their practice and could be dependent on their 'intuitions.' Benner explains the process related to how practitioners gain experience, which generates conscious knowledge of practice which subsequently becomes tacit. Benner (1984) and Benner, Tanner and Chesla (2009), discuss further that nursing intuition and competency could concur with nurses being 'consciously' competent in relation to their level of working experience. The role of intuitions in nursing are perceived by Gobet & Chassy (2008), as the central to the understanding of nursing expertise. Gobet and Chassy (2008), emphasise that Benner's (1984) model 'From Novice to Expert' in nursing, provides important insights into the complex interaction between nursing theory and practice through nurses' intuitions.

In her model entitled 'From Novice to Expert', Benner (1984), noted that there are five clinical stages and highlighted that novice nurses tend to be analytical and rule based. At the first (novice) stage, novice nurses tend to perceive their clinical environment as 'procedural' puzzles. At Stage 2 (Advanced Beginner), nurses are liable to demonstrate marginally acceptable performance because the nurse has prior experience in actual situations. As a result, the nurse is efficient and skilful in certain areas of practice and requires supportive cues occasionally.

In Stage 3 (Competent), nurses are primarily in the same or similar clinical setting for two or three years. They are now able to demonstrate efficiency, coordinate and have confidence in their actions. They are also able to establish a plan according to their consciousness, and are able to establish abstract and analytic thinking about the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation; therefore, care is completed within a suitable time frame without supporting cues.

In Stage 4 (Proficient), nurses perceive situations as wholes rather than in terms of divided aspects or aspects. The nurses in this stage begin to understand a situation as being whole because they perceive its meaning in terms of long-term goals. Moreover, proficient nurses learn from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. They can recognise when the expected normal picture does not materialise. This ability improves proficient nurses' decision making; it becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the vital ones. In the final stage, Benner (1984), explains that experienced nurses are able to use their cognitive thinking, which she refers to as the use of non-consciously combined pattern recognition (based on tacit and didactic knowledge) and memory whenever these nurses practice nursing. Expert nurses perform their care based on a deep understanding of the total situation.

In hindsight, Benner (1984), discusses how beginners' intuitions are characterised by anxiety, which impedes their practice; more advanced nurses can rely on a larger repertoire of intuitions, which they use as informative and guiding indications. These indications not only amplify nurses' perceptual awareness, but also influence their clinical knowledge, ethical component of care and emotional involvement with patients and their families. Interestingly, Gobet and Chassy (2008), criticise Benner's model for being unable to provide empirical data or an explanation of the key aspect of the model. They argued that the stages which are proposed in Benner's model are poorly documented in the literature and some of the evidence from nursing practice explicitly adduced to support their existence, is rather weak. In contrast, they agreed that Benner's theory is simple, and one of the most influential models of nursing expertise that captures aspects of experts' development structurally, particularly the progression from slow and hesitant to fast and fluid problem solving behaviour.

Castell (2008) introduced another concept of professionalism in nursing, and describes professionalism in nursing as an act of care that comprises two major components: values and behaviours. According to Castell, values magnify professionalism via clinical competency, humanism and altruism. Castell also observes how nurses can acquire the behaviours of professionalism by way of learning professional boundaries, service to one's profession through organisations, and following a code of conduct within a professional environment.

To date, there are various concepts of professionalism in nursing that have been introduced globally. Consequently, there has been considerable debate among nursing scholars when

advocating their own definitions and concept of professionalism in nursing. Morrow et al. (2011) emphasise that professionalism in nursing is a complex context to rectify as one absolute term. Specifically, professionalism in nursing is relatively easy to define; however, it is not simple nor is it easy to recognise in absolute terms whether a behaviour is professional or unprofessional (Salam et al., 2012). Correspondingly, Cribb and Gewirtz (2015) argue that making use of the implications of professionalism occurs in much more diffused ways and on a much larger scale. Cribb and Gewirtz (2015) further explain that the proliferation of the nursing profession within the context of tremendous changes in today's healthcare system demands a more holistic and multi-faceted definition that represents the true meaning of professionalism in nursing.

Professionalism may be analysed from multi-dimensional viewpoints and many people, or groups of people, think they are professional and use the word differently for a range of reasons. Burford et al. (2011) suggest that there are four primary approaches that could be adopted when reviewing the contextual and conceptual perspectives of professionalism. Firstly, professionalism can be viewed as an element of professional status, such as being labelled as a professional. Secondly, professionalism plays a vital role in the context of an internalised professional identity, i.e. identifying oneself to be a professional. Thirdly, professionalism is represented as a group of specific attitudes and qualities that are appropriate to a profession. Finally, professionalism is an appropriate behaviour which, simply stated, refers to 'doing the right thing' – both professionally and morally. From a nursing perspectives, Karadag et al. (2007) and Zakari et al. (2010) view professionalism as a process of transition, which is integrated with the ability to think critically, motivation regarding life-long learning, together with skills in technology, communication, management, collaboration and leadership.

Nursing scholars who have formulated their own concept of professionalism in nursing (Girard et al., 2005; McCoppin & Gradner, 1994; Miller, 1988; Royal College of Nursing, 2003, Castell, 2008) and their studies have been considered as part of this study. One major drawback concerning all the concepts reviewed so far is that these scholars principally propose the importance of nurses demonstrating professional behaviours and attitudes individually to fulfil the demand for developments in Western healthcare. Owing to globalisation, professionalism in nursing should be more explicit not only toward the nurses but also towards their patients. However, it is important to note that patients' diverse backgrounds may influence nurses' professionalism (Clarke, 2001). Hence, taking this matter into consideration, professionalism

in nursing should include sociological components, such as culture and demographic influences.

The concepts discussed above were based on trends in healthcare worldwide and the complexity of nursing professional practice during that period. Moreover, the concepts of professionalism in nursing should be regarded as a continual developmental process. It should also be emphasised that while practice and wider society have transformed, basic human needs remain the same (McCrae, 2012). The roles of nurses and global healthcare workers have evolved since the introduction of all the above-mentioned concepts; therefore, it is necessary to update these concepts.

2.5 Sociological influences on the elements of professionalism in nursing

The inevitable evolution of today's healthcare demands that healthcare providers extend their competencies not only in their clinical competencies but also in their sociological competencies. Sociological competencies are demonstrated in terms of the act of appreciating and consolidating their treatment and choice of care (Canadian Nursing Association, 2010; Willet & Clarke, 2014). Their choices should not solely depend on the patients' or clients' physiological and psychological needs but also on fulfilling the patients' sociological needs.

Apart from being sensitive and attentive to the holistic needs of patients, healthcare providers are also expected to understand the complexity and dynamism of their working environment, and furthermore, how they relate to each other, specifically in working together as a unit, to provide treatment or care to patients (Willems & Clarke, 2014). Additionally, understanding the diverse backgrounds of colleagues enhances healthcare providers' ability to consider and intervene in cases of any potential sociological and psychological issues.

The term 'culture' explains every aspect of human experience: the way a person lives, how one views things and communicates (Leininger & McFartland, 2006). Culture also refers to the integrated patterns of human thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture determines values and behaviours, although other factors within culture also influence behaviour patterns (Luckmann, 1999). These additional factors include age, gender, education, occupation, residence, level of acculturation, social class, life experiences, individually held beliefs and practices. The latter includes religion.

Regarding nursing practice, culture shapes individuals' experiences, perceptions and decisions besides how they relate to others. In general, culture influences the way clients respond to nursing care and the way that nurses deliver those services (Canadian Nursing Association, 2010). The influences of culture and norms over different perspectives and degrees of nursing care require nurses to be culturally competent when delivering care to culturally diverse patients. Similar competency is required in their relation and interaction with their colleagues from different demographic backgrounds. In other words, nursing care goes beyond the personal everyday experience and knowledge of one's own culture. Therefore, knowledge concerning cultures and the cultural impact on interactions within healthcare is essential for nurses, whether they are practicing in a clinical setting, education, research or administration.

2.5.1 Sociological influences on the elements of professionalism in nursing from a Malaysian context

Malaysia is a 'pluralist' country and has diverse cultures within its societies. According to Hofstede (1984), a pluralist country is defined as a country that consists of a society that is rich in diverse cultures and norms. On the same note, Hofstede (1980, 1984, 2001) has conducted numerous research globally that is pertinent to his own Cultural Dimension Theory, with Malaysia being one of his study samples. Hofstede (2001) argues that even though Malaysia is a pluralist country, Malaysians can live together and interact as one unit. This is because of the existence of, what he termed, a 'national culture'. According to Hofstede's Cultural Dimension Theory, national culture consists of six elements: Power distance index, individualism versus collectiveness, masculinity versus femininity, uncertainty avoidance index, long term orientation versus short term normative orientation, and indulgence versus restraint.

Hofstede's work (1980, 1984 & 2001) was replicated by Ting and Ying (2013), who compared culture dimensions between Malaysians and South Koreans. The results from their study reveal several significant changes in the cultural value as compared to Hofstede's studies (1980, 1984 & 2001) (see Appendix 16). However, the results of Ting and Ying's study could not be generalised due to several limitations. Firstly, their sample size was only 32% out of the 100 questionnaires that were distributed. Secondly, the respondents were limited to small business owners and employers of supervisory positions in Malaysia and South Korea. Finally, the respondents were only recruited from one area in Malaysia and one in South Korea.

However, regardless of these limitations, it is useful to acknowledge their recent findings and compare the results with Hofstede's work. Appendix 16 compares the findings of studies by Hofstede (1984, 1988 & 2001) and Ting and Ying (2013) respectively.

It should be noted that Ting and Ying (2013) did not investigate Hofstede's cultural dimensions of indulgence versus restraint and long-term orientation versus short-term orientation. Furthermore, no findings are evident on these two cultural dimensions in Hofstede's follow up studies. This is because Hofstede's Cultural Dimensions Theory was re-examined in 1984 and 2001. The dimension of indulgence versus restraint and the dimension of long-term orientation versus short-term orientation were either represented or replaced with the dimension of work dynamic in later studies (Hofstede, 2001).

Consequently, Ting and Ying (2013) proceeded to investigate the dimension of work dynamics in their study and established that the Malaysian respondents scored high concerning this dimension. This result implies that their Malaysian respondents acknowledged the value of persistence ordering relationships by status, observing order and having a sense of shame.

2.6 The birth of a new era of professionalism in nursing

Professionalism in nursing has been one of the most debated topics in the investigation into nursing practice. It has been established that research, studies or discussion papers on professionalism in nursing experienced a substantial increase from the late 1990s to the early 2000s. Many nurses and nursing scholars during that period were from 'generation X'. According to Sherman (2006), 'generation X' refers to people born between 1961 and 1980, who are eager for recognition of their talents, creativity and expertise. Keepnews (2010) supports this argument by stating that the generation X nurses generally want to have professional, knowledgeable and experienced mentors besides expecting prompt feedback regarding their performances.

One of the many models and concepts of professionalism in nursing that was introduced after the last millennium is a model by the Registered Nurses' Association Ontario (RNAO) in 2007. The model, entitled 'Professionalism in Nursing Best Practice Guide', is one of the models of professionalism that is the most relevant to nursing in its representation of current nursing professional practice (Zibrik et al., 2010). Professionalism in Nursing Best Practice Guide was developed through a systematic review of the literature and combined with input from an

expert panel of Canadian nurses. The RNAO (2007) suggests that incorporating the attributes of professionalism into the workplace will help nurses to create a healthy working environment.

The RNAO (2007) concept of professionalism has been acknowledged as one of the most important concepts in today's nursing professional practice. This view is supported by Kirkwood (2014) who states that the attributes, as suggested by the RNAO (2007), are among the preferred ways to demonstrate professionalism, with the responsibility to uphold the values of the nursing profession. Alidina (2013) also suggests that nurses adopt the RNAO attributes in exploring the fundamental aspects of nursing professionalism and directing nurses on 'what to do or how to behave in professional situations' (see Diagram 2.3 below).

Diagram 2.3: The RNAO (2007) attributes of professionalism in nursing



Moreover, the RNAO (2007) concept of professionalism supplements Castell's (2008) description of professionalism in nursing. Castell also mentions that nurses can acquire the behaviours of professionalism through learning professional boundaries, service to one's profession through organisations, and following a code of conduct within the professional environment. A further advantage of examining professionalism in nursing via the RNAO attributes are that nurses could collectively demonstrate these attributes according to their competencies (Evetts, 2011). These competencies are established by way of education, training and apprenticeship socialisation and recognised legally.

2.6.1 Accountability

Accountability can be described as a responsibility for one's conduct or the willingness to be answerable for one's actions (Krautscheid, 2013). Milton (2008) explains that accountability is frequently understood, and referred to as an important legal, ethical and moral term reflecting an attitude of human obligation to other persons, groups, organisations and societies. According to the Code of Professional Conduct for Nurses, the Nursing Board Malaysia (1998), accountability focuses on how nurses are able to respond and provide answers concerning their own nursing judgement and actions. When delegating work to a subordinate, the nurse is accountable for the completed work and appropriate supervision, and furthermore, guidance and support must be given to the subordinate.

Accountability is one of the eight attributes of professionalism in nursing proposed by the RNAO (2007), which is exemplified through a nurse's ability to demonstrate, within their scope of practice, an adequate comprehension of self-regulation. This ability has an impact on practice, adherence to legislation, standards of practice and a code of ethics (RNAO, 2007). Nurses should be actively committed to achieving positive outcomes together with patients and be fully engaged in improving the quality of care. Being accountable motivates the individual to accept the consequences of one's behaviour, to answer for their own actions and having a strong interest in being fully responsible for their own actions (RNAO, 2007). This level of accountability will primarily occur in situations where nurses are able to recognise their personal capabilities, knowledge base and areas for development. Additionally, nurses' accountability covers the provision of input into decisions that affect their practice, such as staffing levels, scheduling and setting of quality standards (RNAO, 2007).

Accountability in practice also focuses on the nurses' working environment where they have control over situations or activities, and the ability to accept this control if they deem it necessary (Scrivener et al., 2011). Specifically, accountability may be similar to the concepts of responsibility, autonomy and authority (Milton, 2008). However, these concepts are not interchangeable (Scrivener et al., 2011). For instance, the numerous nursing responsibilities of a professional nurse require the principles of accountability, such as in planning, coordinating and intervening in the provision of patient care. Therefore, nurses should ensure that they are properly informed of the rights and responsibilities of self-regulation, in order to improve the quality of care (Krautscheid, 2013).

2.6.2 Advocacy

The act of supporting or speaking out for a cause demonstrates the element of advocacy in nursing practice (RNAO, 2007). This includes being an advocate or change agent for patients, families and communities besides the profession. In the context of professionalism, advocacy is an understanding of the patient's perspective, assisting the patient with his or her learning needs, and actively participating in professional practice activities (RNAO, 2007). This is to enhance the sense of what healthcare should be and being knowledgeable as regards policies that influence the delivery of healthcare.

These actions are similar and, nevertheless, might be different in terms of the concepts, of which they integrate the patients' autonomy into the nurse-patient relationship. Bunkenborg et al. (2012), for instance, imply that nurses are only able to meet the patients' best interests when they are able to play the role of patient advocate. For example, nurses should provide a patient with the information required for the patient to make informed choices, support his/her right to make informed choices and support the patient throughout the decision-making process and outcomes. Additionally, nurses should be attentive to the patient's needs, expressed wishes and preferences, as well as ensure that these are known and implemented by other nurses and healthcare providers (RNAO, 2007).

As 'front liners' in healthcare teams, nurses should act as advocates or mediators in terms of inculcating advocacy into the practice and toward their patients, families, community and their organisation (Ghadirian, 2014). In other words, nurses contribute to health service planning and decision-making and advocate health policy changes. This is because nurses are

responsible for the delivery of the majority of patients' care and are in a position to influence patient care outcomes (Celik & Hisar, 2012). Similarly, nurses' relationships with patients and their families enables them to appreciate their health needs, expectations of healthcare and responses to healthcare services (Kim-Godwin et al., 2010).

At an organisation level, advocacy is achieved through the responsibility of keeping abreast of developments, writing, joining special interest organisations and be acquainted with the key nursing positions (Walton et al., 2011). Additionally, identifying nurses in influential positions outside of nursing and learning how to communicate their own positions are important parts in the policy process that nurses have to demonstrate. Nurses should also take opportunities to be involved with direct patient care at a micro level through meso and macro level discussions and decision making processes within the organisation (Celik & Hisar, 2012).

One of the more common ways of advocating for policy changes, both within and outside the profession, is by working via committees (Walton, Chute & Ball, 2011). This is achieved through the establishment of, and/or, access to processes to participate in or occupy roles that influence policy and practice directly and indirectly (e.g. dialogue sessions, policy workshops, co-joint policy proposal submission). Nurses also need to recognise and acknowledge each profession's scope of practice, identify and create efficient working relationships with key stakeholders, be literate regarding health policy and health system issues that are affecting patient care, and communicate the impact of these at any level of involvement (Smith, 2012). However, nursing practice is influenced by politics and, therefore, nurses should play the roles associated with being an informed citizen and recognise all these influences (Kim-Godwin et al., 2010). For example, nurses can also teach individuals and groups to advocate on their own behalf and work with communities or groups to effect change at a local level.

2.6.3 Innovation and visionary

Innovation and visionary in professionalism are shown when a nurse can display inventiveness in realising or materialising innovative ideas to enhance nursing practice and patient/family outcomes (RNAO, 2007). Innovation is defined in terms of actions and reflections that bring in breakthrough methods and novel ideas, executing the methods and the ideas first-hand

(O'Sullivan & Dooley, 2009). Specifically, innovation refers to new and challenging methods of delivering care.

In line with innovation, which refers to new methods of care delivery, visionary is defined by Donley (2005) as, the capability to think differently by utilising various cognitive processes. By being a visionary thinker, one could introduce changes into a complex organisation or a system, and could foresee the impact of these changes. Visionary thinking in a nurse can be seen through the deed of being able to predict and provide insight which enable a nurse to formulate, inform and reform policy in a forward-looking manner (RNAO, 2007).

Innovation may also help engender working environments that encourage nurses to be competent in clinical practice (Alidina, 2013), specifically in the structure and the process of management and assisting in nurses' career progression and professional recognition. This environment can be achieved through the integration of autonomy and independence, upholding quality patient care and simplifying the complexity of work among nurses (Primm, 2010). Moreover, innovation among nurses can be fostered through tolerance of experimentation and a willingness to allocate resources to both large and small innovations to improve care (RNAO, 2007; Primm, 2010). Apart from the support of entrepreneurship, acceptance of current ideas and experimental programmes or projects is necessary.

In the context of achieving innovation and visionary of professionalism, nurses should be able to identify opportunities or appropriate channels of inquiry, scrutinise their own practice and question the establishment of practices. The establishment of curiosity and imaginative reflection pertaining to clinical practice is essential (RNAO, 2007). Nurses also need to cooperate with practitioners who introduce a new perspective and/or practice, championing evidence-based practice by way of clinical practice review and best practice guidelines, being influential in, and leading strategic planning processes. Professional nurses who dignify the prevailing values and assumptions and inculcate enhanced nursing practice in changing traditional practices can experience positive impacts on patient outcomes (Donley, 2005).

2.6.4 Ethics and values

Ethics and values in professionalism can be demonstrated through the ability to identify ethical concerns, issues and dilemmas, and applying knowledge of nursing ethics to facilitate decision making and acting on it (Sellman, 2011). It can also be demonstrated by being able to collect

and obtain information from various sources for ethical decision-making, fostering collaboration with colleagues and maintaining a practice environment that supports nurses, while respecting their ethical and professional practice (RNAO, 2007). Nurses who are able to engage the components of ethics and values in their nursing practice would enhance safe, competent ethical care and quality practice that are critical as regards professionalism (Walton et al., 2011).

Despite this attribute being concerned with practice at the individual level, the scope of nursing ethics and knowledge needed to understand that the ethical dimensions of practice have expanded (Fantahun et al., 2014). More importantly, nurses need to recognise their legal and professional obligations and to understand that ethical issues are complex and can be influenced by political and social policies at any level of involvement (RNAO, 2007).

Nikbakht et al. (2003) propose that the nurse practice environment could be representative of a nurse's 'moral climate,' in which he or she can channel his or her moral voice. Recognition of this representation promotes the theoretical ethics and values of the nurse concerning the patients, organisations and systems. It also considers values and decisions from the ethical perspectives of colleagues' and reflects on and discusses ethical values, disagreements and decisions pertaining to ethical dimensions of care.

Hence, nurses should also appreciate colleagues and seek to support nurse colleagues whenever and wherever they practice (Nikbakht et al. 2003; RNAO 2007; Fantahun et al., 2014). Besides supporting their colleagues, nurses need to seek advice from ethical experts and, perhaps, conduct surveys among other staff (RNAO, 2007). These actions could help nurses to elicit any ethical issues that they are facing and have critical incident de-briefings related to practice issues with ethical dimensions and use the information from various sources in decision-making (RNAO, 2007).

2.6.5 Autonomy

Autonomy is defined by Omrod and Barlow (2011) as individuals who are at liberty to make a choice and have the ability to make their own decisions. Autonomy promotes ideas of independence and self-reliance among individuals. In the context of nursing, autonomy refers to the ability and the right to act on what nurses know, in order to make independent clinical decisions and to act in the best interest of the patient. However, autonomy can be

compromised by the context and relationships among nurses and their working environment (Skar, 2008).

Thus, acknowledging autonomy and the effects of the context and relationships on autonomy when making decisions within one's appropriate scope of practice are likely to optimise autonomy (Hewitt, 2002). Furthermore, a professional nurse should be able to seek ways and alternatives to rectify the situation regardless of the barriers and constraints that may interfere with his or her autonomy (RNAO, 2007). Hence, 'True' autonomy develops internally and is dependent on one's own actions (RNAO, 2007). Autonomy among nurses can be hindered by the organisational structure and decentralisation of an organisation. These setbacks can be countered by ways of facilitating the practice of autonomy among nurses and, according to Girard et al. (2005), nurse leaders can facilitate this, seeing as those in formal power cannot give autonomy.

Nurses may also experience some boundaries, which may come from their peers, colleagues, and the administration when nurses attempt to optimise their autonomy (Girard et al., 2005). Nurses may be confined by their colleagues' attitudes, values, traditions, policies and practices in decision-making, in addition to their judgement when rationalising their own practice. Karadag, Hisar and Elbas (2007) determined that autonomy was the lowest reported professional behaviour. This is possibly due to their working environment, which is dominated by hierarchy and a bureaucratic administrative structure, as well as the laws that relegate nurses to the status of auxiliary healthcare personnel. However, Karadag et al. (2007) only focuses on exploring professional behaviours among nurses in one hospital.

In their research, Daly Speedy & Jackson (2015) suggests that, in order to compromise with these boundaries, nurses should promote organisational practices and policies that support them to be autonomous within their practice regarding others in the organisation. For example, nurses should clearly communicate the reasons for their decisions and behaviours, supplemented with evidence, besides explaining their learning and clinical experience, and taking on formal and informal leadership roles. Nurses should also improve their decision-making skills, consult and collaborate with colleagues and experts, and reflect and learn from critical incidents confidently, within the scope of their nursing practice (Nikbakht, 2013). These actions can be achieved through input given into decisions that affect nursing practice and the ability to question organisational processes when first-rate patient care is not supported.

2.6.6 Knowledge

Knowledge can be defined as the understanding of or information about a subject which has been obtained by experience or study (RNAO, 2007). Nurses' ability to apply theoretical, practical and clinical knowledge in formulating appropriate evidence-based rationale for practice is an important indication of professionalism. Knowledge helps nurses to synthesise information from a variety of sources and to use information or evidence from nursing and other disciplines to inform and/or guide practice (Pentland et al., 2011). Knowledge also encourages nurses to share and communicate information with colleagues, patients, family and additional parties to continually improve care and health outcomes (Hatlevik, 2011). Moreover, knowledge enables nurses to identify the nature of the problems and to suggest (and influence) effective interventions in critical care areas, which carries a positive impact on patient's outcomes (O'Brien & Cowman, 2011). The linking of practical and theoretical knowledge, which signify a close relationship between professionalism, education and knowledge development, to strengthen nurses' abilities to achieve the goals in relation to their patients' care (RNAO, 2007). Therefore, nurses should be committed, attentive and embrace the opportunity to attend conferences, workshops, clinical instructors and ward rounds. Nurses also have to continuously review the literature based on critical appraisal techniques, given that this will help to justify their practice.

2.6.7 Spirit of inquiry

Spirit of inquiry is an inquisitive, inquiring approach to one's own practice (RNAO, 2007), which is demonstrated when nurses explore new knowledge and are eager to inquire in relation to patient care, as well as their profession. These actions would lead to the generation of knowledge and refinement of existing knowledge to inform practice and to keep up-to-date with contemporary development.

Spirit of inquiry could also be represented by the urge to understand what is already known, and reviewing what is known based on one's own experiences, by performing multi-faceted activities (Hatlevik, 2011). The multi-faceted activities consist of making observations, asking questions and examining various sources of information using tools to gather and interpret data, proposing answers and explanations, and communicating this process. Moreover, spirit

of inquiry is the awareness of one's self, both personally and professionally, via self-reflection that strengthens the role of nurses (RNAO, 2007).

Therefore, nurses are expected to be able review written and electronic materials, brainstorm, share ideas and perspectives, recognise and develop knowledge patterns by reflecting on self-experience and own practice (Laibhen-Parkes, 2014). Each of these should be considered when reflecting or thinking about their practice. Besides considering one's own practice, nurses should also be observant and keen to ask relevant questions, and to validate new and old ideas (Kirwood, 2014).

With regards to patients' reactions or responses toward the performed interventions, nurses are expected to question current practices and suggest potential alternatives when delivering care that is relevant to an inquiring approach to patient care or reflective practice (RNAO, 2007). Apart from considering the patient's response, spirit of inquiry also accentuates the urge to ask questions about self-practice by comparing and/or setting a standard of care according to research findings or evidence-based practice (RNAO, 2007). These actions foster critical thinking in nursing, seeing as nurses go beyond the obvious findings to confirm informed judgements (Hatlevik, 2011). For instance, inexperienced nurses are more likely to concern themselves with the steps and procedures, while the more experienced nurse is more likely to practice according to the previous experience embedded in the body of knowledge in quality patient care (Revell, 2013).

2.6.8 Collegiality and collaboration

Collegiality and collaboration is a concept of working with colleagues in the same profession and shares power and authority (Kim-Goodwin et al., 2010). Collaboration means working jointly or co-operatively with other health professionals when one's own capabilities are beyond individual requirements (RNAO, 2007). Collegiality, conversely, is demonstrated by taking part in professional organisations, mentoring, role modelling and assisting researchers, and is an important professional attribute (Alidina, 2013).

Collegiality and collaboration includes establishing collaborative partnerships from a professional context, mentoring nurses, nursing students and colleagues to enhance and support professional growth. Collegiality and collaboration also denotes the act of acknowledging and recognising interdependence between healthcare providers. Moreover,

collegiality and collaboration enhances positive patterns of communication, improves teamwork and feedback to staff related to matters that contribute to quality practice settings (in which nurses practice safely, and, thereby positively impact upon patient care) (Alidina, 2013).

Nurses are expected to be secure in their professional roles prior to functioning effectively as team members. Nurses also need to obtain a good understanding of their own roles, as well as that of the other healthcare team members. Work cultures that consist of joint decision-making and communication between nurses and other professionals only become the norm when true collaboration exists (Scotland Health Professional Council, 2012). Apart from working culture, skilled communication, trust, knowledge, shared responsibility, mutual respect, optimism and coordination are also integral elements in a successful collaboration (Smith, 2012).

The attribution of collegiality and collaboration between nurses and patients, organisations and systems can be developed by valuing colleagues by means of finding approaches to support nurses who are practising (Zakari et al., 2010). Nurses need to engage in inter-professional relationships and activities that enhance the quality of their care, responding to colleagues who are experiencing challenges in their professional practice by way of support expressed through dialogue, problem solving and advocacy. For example, helping a colleague, who has a complex task, by working together to secure and maintain a safe, high quality work environment. Eventually, nurses need to form, conduct and provide support processes for team development, acknowledge the existence of colleagues and their achievements, and to critically analyse ways to improve practice (Smith, 2012).

For example, nurses should initiate and participate in interdisciplinary rounds and team meetings and implement peer review/recognition/reward programmes or initiatives, which recognise excellence/professional practice (Bunkenborg et al., 2012). Organisations should also play their part in promoting collegiality and collaboration by developing values, structures and processes for effective intra- and inter-professional collaborative relationships (Moore, 2012). Additionally, nurse leaders need to promote and create a platform for collaborative relationships and teamwork within these organisations when nurses demonstrate their willingness to work effectively with others (RNAO, 2007).

2.7 To champion (championing) professionalism as the core of safe and efficient nursing practice

Professionalism is all about quality of care (Lombarts, Plochg, Thompson & Arah, 2014). Quality of care means that nurses treat everybody equally and do their best to ensure that the highest quality care is provided. This includes a dedication to principles of justice, honesty, respect and integrity (Lombarts et al., 2014). When people require care from nurses, they do not necessarily know the nurse who will be providing their care, but there is always an expectation that the nurse will provide appropriate care, regardless (RNAO, 2007). This is a consequence of the professional reputation that nurses have garnered and it is important that nurses continue to warrant this professional reputation.

Nursing has a 'social contract' with society because the affirmation of the authority related to the practice of professional nursing is consistent with a social contract that acknowledges professional rights and responsibilities (American Nurses Association, 2010). Due to nurses' active participation in society, there is an established relationship between nurses and society, its culture and institutions. In other words, professionalism among nurses is not only prescribed or scripted but also formulated from negotiation and an agreed form of pronouncement among colleagues as well as society.

However, there is a debate which argues that nurses are more likely to establish their own expectations in terms of defining their professionalism (Furaker, 2008). This is because every nurse could construct his/her own perspective on how he/she would like to see themselves as a professional in society. Furaker (2008) explained further that nurses are more likely to engage with the expectation on how society perceives their professional role and profession in today's healthcare setting. Hence, it is important to substantiate the need to examine or to explore deeper how nurses perceive themselves as being professional.

2.8 Assessing the elements of professionalism in nursing

Several pertinent studies focus on exploring nurses' thoughts and perceptions regarding professionalism in recent years (see Appendix 12). It can be concluded that most of the research studies that explore professionalism in nursing principally focused on behaviours and attitudes that nurses demonstrate while caring for patients.

A critical review of studies related to professionalism in nursing by Ghadirian et al. (2014) suggests that professionalism in nursing should be explored both objectively and subjectively. A recent study by Fantahun et al. (2014), attempted to utilise a mixed method approach to explore professionalism in nursing. The findings were subjective within the context of behaviour, attitude and perceptions. However, the study's methodological approach, particularly the self-administered questionnaire to explore professionalism in nursing, could be questioned. Firstly, the reliability and the validity of the self-administered questionnaire were not detailed. The importance of reporting the reliability and validity of self-administered questionnaires is to ensure the process of undertaking these questionnaires is reliable and focused on obtaining the desired information from a proposed sample or population (Polit & Beck, 2014). Therefore, the presentation of the reliability and validity is to collectively gain readers' confidence besides avoiding any doubt regarding the credibility of the researchers, as well as the quantitative results that are presented.

The study by Fantahun et al. (2014) also employed focus group discussion. Focus group discussion can be considered a flexible data collection strategy which allows the moderator to probe identified issues in a comprehensive manner, address topical issues as they arise, and ask respondents to elaborate on responses (when necessary) (Krueger, 2002). Regardless of this advantage, focus group discussion has its limitations. There is a potential for one or more of the respondents being unable to express their actual personal feelings or opinions directly because they are a part of a focus group discussion. This situation could be due to fact that the respondents are not ready to share their thoughts and feelings in a focus group setup (Barribal & While, 1994). Moreover, in the context of Asian cultures, it should be noted that expressing opinions via formal involvement of individuals (the respondents) could be an obstacle (Hostede, 1988; Ting & Ting, 2013). Hence, exploration of the research matter might not be entirely explored by the researchers in a focus group setting.

To obtain complete and unitary evidence of the elements of professionalism in nursing practice is by collecting concrete and structured findings. This argument is supported by Alidina (2013), who concludes that assessing professionalism has to be more concrete and proven by justifiable evidence. Alidina (2013) further explains the need for nurses to recognise and assess their professionalism constructively and systematically to match the increasing demand for healthcare within the framework of available resources. Hence, this action creates an even more dramatic shift in the approach to healthcare delivery.

2.8.1 Various perspectives to assess professionalism in nursing

Based on current literature and studies, it is evident that there is no single method for evaluating professionalism in nursing. Review of the literature also ascertained that there are at least three perspectives of exploring professionalism in nursing. The first of those perspectives are studies which evaluate professional behaviours as part of clinical performance. The second refers to studies that explore each component of professionalism in nursing (e.g. humanism, self-assessment, dutifulness, altruism, empathy and compassion, honesty, integrity and ethical behaviours), while the third is concerned with studies that evaluate only professional behaviour, as a comprehensive entity in and of itself.

These three perspectives are parallel to classifications presented by Burford et al. (2011) pertaining to primary ways to define professionalism. Burford et al. (2011) identified four primary ways which are (i) elements of professional status (i.e. being labelled as a professional), (ii) elements of an internalised professional identity (i.e. behaving in one's own professionalism), (iii) appropriate attitudes and qualities (i.e. holding attitudes and values appropriate to the profession) and (iv) appropriate behaviour (i.e. doing the right thing).

Apart from the different perspectives and views on exploring professionalism in nursing research or studies on professionalism in nursing can be classified into different methodological approaches. The first method is by assessing nurses through surveys (Burford et al., 2011). In these surveys, assessments are categorised as: (i) surveys to measure the professionalism of nurses, and (ii) surveys that utilise 'critical incident techniques' (Burford et al., 2011). Surveys that measure the professionalism of groups focus on the professional behaviours of groups of nurses in candidly tackling whether professionalism can be measured. Surveys that use the 'critical-incident technique' focus on assessing professional behaviours with a comprehensive definition that entails the use of critical incidents to characterise individual nurses (Burford et al., 2011).

Even though the above-mentioned methods offer inexpensive and quicker processes and provide anonymity, they require literacy, achieve poor response rates, and are limited to simple questions, which the interviewer cannot observe. LaForest (2005) indicates that exploring the actual experience or response is vital, given that this information may assist with retrieving answers to the research questions. This argument may be explained by the fact that professionalism is a complex and holistic concept, and more information regarding

the meaning and comprehension of the subject is required by respondents (Scott, 2007; Veloski 2006; Primm, 2010; Revell, 2013).

There are a number of significant studies on professionalism in nursing which adopt the qualitative approach (see Appendix 12). These studies focus on assessing nurses' perceptions and behaviours pertaining to professionalism in nursing. Interviews and observations are among the preferred methods to explore professionalism in nursing in a qualitative manner. Interviews permit direct feedback from the respondents and yield rich data, details and new insights (Zohrabi, 2013). In the context of professionalism in nursing, interviews allow respondents (nurses) to be more expressive and create their own contextualisation of professionalism in nursing.

Consequently, discursive analysis and interpretation of the interviews could lead to a more comprehensive and interesting finding (Filep, 2009). However, it is not an easy task to perform and requires a massive body of knowledge and theoretical understanding to support any of the interpretation (Zohrabi, 2013). Although interviews can produce more in-depth data in a brief time, it is difficult to compare the results from different interviews because each interview is unique. Due to these subjective findings, it can also be challenging to obtain reliable data on attitudes, opinions and values.

2.8.2 Critical reviews on the various perspectives and their assessment

With regards to the discussion in the previous section, there are several studies that have attempted to explore professionalism in nursing; therefore, researchers suggested various methods to explore the topic. Arnold (2002), Veloski et al. (2006) and Jha et al. (2007) conducted several reviews on the assessment of professionalism in nursing and highlighted that current and previous measurements of professionalism, which can be considered scholarly and practical, are actually problematic. They identify many different methods for assessing professionalism, the changing views of professionalism over time and the limited reporting of validity and reliability issues.

As explained in the section related to comprehension of professionalism in nursing (see section 2.4 on p56), the behaviours and attitudes that can signify professionalism among nurses is their ability to work efficiently, independently, and directly towards achieving the patient's expected outcomes. These characteristics can be observed in their approach to the

preparation and completion of nursing documentation (Riesenberg et al., 2010). An alternative explanation is that the theoretical knowledge and concepts of nursing, which nurses have gained, can be embodied in written texts (Urquhart et al., 2009). These written texts may also act as indications to support the different philosophies of nursing practice. Specifically, the interpretation of professionalism should not be indicated only through its subjectivity but, more importantly, be displayed in its empirical evidence. Similarly, nursing practice can only be measured by revealing the importance of clinical indicator statements with behaviour in clinical practice (Gaskin, O'Brien & Hardy, 2003).

2.9 Nursing documentation as the source of assessment of the elements of professionalism in nursing

For the purpose of this study, nursing documentation was used as the source to explore the elements of professionalism among nurses in Malaysia. This is because nursing documentation is written evidence noting the care and other relevant events, or expected outcomes for patients, and that it is an obligation for nurses to complete the documentation throughout their daily practice (Blair & Smith, 2012; Jefferies et al., 2012; King's College London, 2012). These obligatory actions ensure that caring and nursing are visible. Nursing documentation that contains evidence concerning care has a strong correlation with nurses' professional expertise (Pirie, 2010; Wang et al., 2011). Consequently, failing to sustain reasonable standards of nursing documentation could be interpreted as professional misconduct that can lead to nurses facing consequences regarding their professional incompetency (Apesoa-Varano, 2007; Dimond, 2011; Owen, 2005).

Documentation also acts as permanent evidence of the power of decision-making, nursing activity and its ethical basis (Gugerty et al., 2007; Tower et al., 2012). Karlsen (2007) argues that nursing documentation can be viewed as an ideological self-presentation. This ideological self-presentation displays the nurses' ability to demonstrate their attributes pertaining to professionalism. For this reason, the content of documentation parlance may be discursive to highlight the presence of professionalism (Meleis et al., 2000).

Allen (2007), and Potter & Perry (2010) highlight the proposition of using nursing documentation as a distinct source to explore the elements of professionalism among nurses. Evidence in support of this position can be discovered in Anderson and Mangino (2006) and

Hayrinen et al. (2010), who indicate the importance of nursing documentation in the current health paradigm as evidence of patient outcomes and the quality of care.

Whilst good documentation implies diligent care planning and implementation, the opposite is not always true (Griffiths & Hutchings, 1999). Records do not necessarily mirror the reality of the care that has been undertaken. The phrase 'if it is not recorded, it did not happen' (McWay, 2002) bears a legal meaning but, then again, it does not always correspond with the reality of care. Thus, the relationship between documentation omissions or absences and poor standards of care still needs to be investigated. De Marinis et al., (2010) conclude from their literature review that the evidence base for the relationship between the actual care performed and that recorded in the nursing documentation is exceptionally sparse.

Zeger et al. (2011) suggest that the quality of the recorded information in patients' records seems to be a predictor of the quality of care. Zeger et al. (2011) state that better registration of patient information contributes to better patient outcomes and safer healthcare. They further explain that missing components in patients records and the inferior quality of the available patient information probably signify two different underlying problems in hospitals.

The first problem, according to Zeger et al. (2011), is the administrative and process issue. This problem refers to the unavailability of evidence-based standards related to record keeping which, therefore, hinders healthcare providers from creating complete and accurate patient records. The second difficulty is possibly reflecting the performance of healthcare providers, i.e. the diligence with which individual healthcare professionals record patient information and follow the record keeping guidelines for registering patient information.

Hence, Zeger et al. (2011) suggest that the perspectives of looking at documentation should be from its capacity to reflect the element of professionalism in nursing literately, instead of looking for the accuracy and quality of the entire nursing documentation. Lombarts et al. (2014) also mention that the exploration of credible association(s) between professionalism and clinical outcomes would entail a new understanding in the ways in which professionalism can be viewed more empirically. By the same token, it is important to note that it is difficult to quantify professional nursing or care unless a nursing activity, its rationale and its outcomes are recorded in written text or numbers, as nursing is a profession involving practice (College of Registered Nurses of British Columbia, 2012).

Jefferies et al. (2010) introduce seven main characteristics of nursing documentation that would indicate nurses' professional practice. The first characteristic, according to Jefferies et al. (2010) is that nursing documentation should be patient-centred. The second and third characteristics are that nursing documentation must contain the actual work of nurses, including education and psychosocial support, and is written to reflect the objective clinical judgment of the nurse respectively. The fourth characteristic is that nursing documentation must be presented in a logical and sequential manner, while the fifth characteristic, according to Jefferies et al. (2010), is that it should be written contemporaneously, or as events occur. The sixth characteristic is that nursing documentation should record variances in care within and beyond the healthcare record. To conclude, nursing documentation should fulfil legal requirements.

In addition, assessment in the area of professionalism must recognise the specificity of professional behaviours (Ginsburg et al., 2000). Hence, an understanding of what professionalism in nursing is can be viewed more precisely via its characteristics and obligations (Beaton, 2010). Furthermore, professional practice could be demonstrated when an individual is able to acquire the power, prestige and profits accorded to other traditional professions. Ginsburg et al. (2000) remark that acquisitions play an important role in intervening in the emergence of contemporaneous knowledge in nursing and newly established specialisations that lead to the extended roles of nurses in today's healthcare setting.

Moreover, the RNAO (2007) concepts of professionalism supports the argument presented by Karkkainen et al. (2005) on the significance of the roles of documentation. They argued that documentation is always bound up with the nurse's internalised values. These internalised values reflect a picture of the world and those attitudes that characterise the individual nurse and organisation. Based on this point of view, different caring cultures and traditions become visible. These traditions eventually shape how the knowledge of caring and nursing care is conveyed. When documenting nursing care, respecting patients and their views means that the recorded information considers the patient's wishes and needs regarding how they wish to be cared for (Karkkainen & Eriksson, 2004). The nurse should also record such matters as what the patient believes to be important, even if the nurse disagrees.

2.9.1 Nursing documentation

Nursing documentation is described as;

"... any written or electronically generated information pertaining to a patient that details the care or service provided to that patient"

(College of Registered Nurses of British Columbia, 2012, p.6)

The task of completing the documentation encourages nurses to assess patients' progress and determine which interventions are effective or otherwise, and recognise and document changes to the plan of care, as required (Tornvall & Wilhelmsson, 2009). Nursing documentation can also be a valuable source of data for decision-making pertaining to funding and resource management, as well as a starting point to facilitate nursing research (Kuusisto et al., 2014). Nurses could use the outcome information from a critical incident to reflect on their practice and undertake appropriate changes to the documentation. In general, all of these purposes are potentially able to improve the quality of care (Carrington, 2012).

Apart from being valued as written evidence, nursing documentation can be utilised as an appropriate medium for nurses to share their observations, decisions, actions and outcomes with respect to the care delivered (Sharit et al., 2008). Nurses communicate to their colleagues about the patients' current conditions, nursing interventions that are performed and the results of these interventions. All of this information is also reported to a physician or other healthcare provider, the provider's response and evidence of advocacy undertaken by the nurse on behalf of the patient where appropriate.

Consequently, documenting this type of information is more likely to increase the level of verification that the patient has received accurate, consistent and informed care or service. It can be argued that nursing documentation should be an accurate 'account' of what has occurred and whether it took place on an individual basis or as part of a group. In the case of patient groups (e.g. therapy groups, public health programmes), nursing documentation is used to record the service provided and the overall observations when providing a service (De Marinis et al., 2010).

From a broader perspective, nursing documentation considers the needs assessment, plans, actions taken and evaluation of the group outcomes (College and Association of Registered Nurses of Alberta, 2013). Moreover, nursing documentation also acknowledges services

provided to a group of patients and describes the purpose and goal of the group, the criteria for participation, and the intervention activities.

Besides being considerable evidence of care, nursing documentation also decreases the potential for miscommunication and errors (Wu et al., 2015). In this context, nursing documentation may be used as evidence in legal proceedings, such as lawsuits, coroners' inquests and disciplinary hearings via professional regulatory bodies. In a court of law, the patient's health record serves as the legal record of the care or service provided (Reising, 2012).

Nursing documentation can play the role of a medium or a forum in which to develop an appreciation and understanding of the roles of other professionals (Hyde et al., 2005). Nurses learn from, and about each other to improve collaboration and sustain the quality of care regarding nursing documentation, which is the key element in the development of knowledge. Nursing documentation also assists nurses and other medical personnel to identify collaborative learning needs to improve inter-professional care, including a greater range of professional skills, besides the use of evidence from other disciplines to inform practice as suggested (O'Brien & Cowman, 2011).

Nursing documentation can be categorised into documentation by inclusion and documentation by exception (Coleman, 1997). Documentation by inclusion is prepared by combining information together on a continuous and regular basis, and noting all assessment findings, nursing interventions and patient outcomes. Meanwhile, documentation by exception focuses on the negative findings, which are elicited from the assessment findings, nursing interventions or patient outcomes that vary or differ from the established assessment principles or standards of care existing within a particular clinical setting. It replaces the longstanding tradition of considering 'if it was not charted, then it was not done' with a new concrete validation of 'all standards have been met with a normal or expected response unless documented otherwise'. Documentation by exception is applicable when assessment norms or standards of care are clearly prepared and available within a clinical setting.

2.9.2 Nursing documentation in Malaysia

Nursing documentation in Malaysia differs a slightly from nursing documentation in Western countries in terms of the approach, the process and the types of documentation. Among the

common nursing documentation usually available in clinical areas in Malaysia are several types of nursing observation charts, nursing shift reports, nursing care plans, nursing admission forms, incident reports, medication administration sheets and discharge forms (Ling et al., 2011). Apart from these patient related documents, nurses also have to manage the administration documentation, for instance daily census charts, Dangerous Drug Act recording, stocks order forms, 24-hour reports, billings, ward cleanliness reports and cleaner supervisory sheets.

In spite of there being no valid evidence that a study has been conducted, it can be argued, anecdotally, that most of the nursing documentation content in Malaysia is primarily an authentication of the doctors' orders or prescriptions throughout nurses' daily routines in any clinical settings. Nonetheless, an audit study conducted by Arshad et al. (2000), in one of the principal hospitals in Malaysia, focused on reviewing the adequacy of the documentation of biodata and clinical data, and could be considered the earliest study pertaining to medical documentation in Malaysia. The types of documentation that were included in this study related to clinical examination, progress review, discharge process and doctor's identification. Even though this study highlighted several significant findings, such as the illegibility of case note entries and excessive usage of abbreviations, the findings are only within the scope of practice amongst doctors.

A further study, which concerns nursing documentation in Malaysia, was conducted by Ling et al. (2011). This study used an audit on pre-implementation and post-implementation of a new format concerning intake and output records at a public hospital in East Malaysia. This study determined that the types of mistakes identified before implementation include no cumulative balance being calculated, poor accuracy of calculation, and the nature of urine, stool, nasogastric aspiration and drain not being recorded. After the implementation of the new format, there was a significant improvement in compliance in terms of the calculations and the nature of recording.

However, there are several impediments with regards to the study by Ling et al. (2011). Firstly, the validation and reliability of the audit tool that was employed in this study was not reported. Secondly, the number of samples was limited as Ling et al. only covered certain wards. Finally, the use of an audit in this study should require a 'gold' standard guideline to adhere to, which this study did not describe. The role of a 'gold' standard guideline when conducting an audit is to ensure that researchers can compare current practice against the

standards structurally, as well as to highlight problems, which may otherwise have remained unrecognised (Royal College of Psychiatry, 1996).

The most recent study that is pertinent to the nursing documentation in Malaysia is an audit, also known as best practice study, by Coomarasamy et al. (2014), vis-à-vis the insertion and management of peripheral intravenous cannula on the adult medical wards of a university teaching hospital. One of the audit criteria was reviewing whether documentation regarding the condition of the peripheral cannula is completed on every shift. Basically, the audit focuses on whether documentation on the pre-cannulation, post-cannulation information and daily shift-to-shift assessment of the site and the function of the cannula was clear, comprehensive and accurate. The audit study established that there was still a poor level of compliance related to the above-mentioned criteria, as the nurses do not see the importance of documentation. Moreover, there was no observation chart and it was rare to see the procedure and other necessary findings being documented in the case notes.

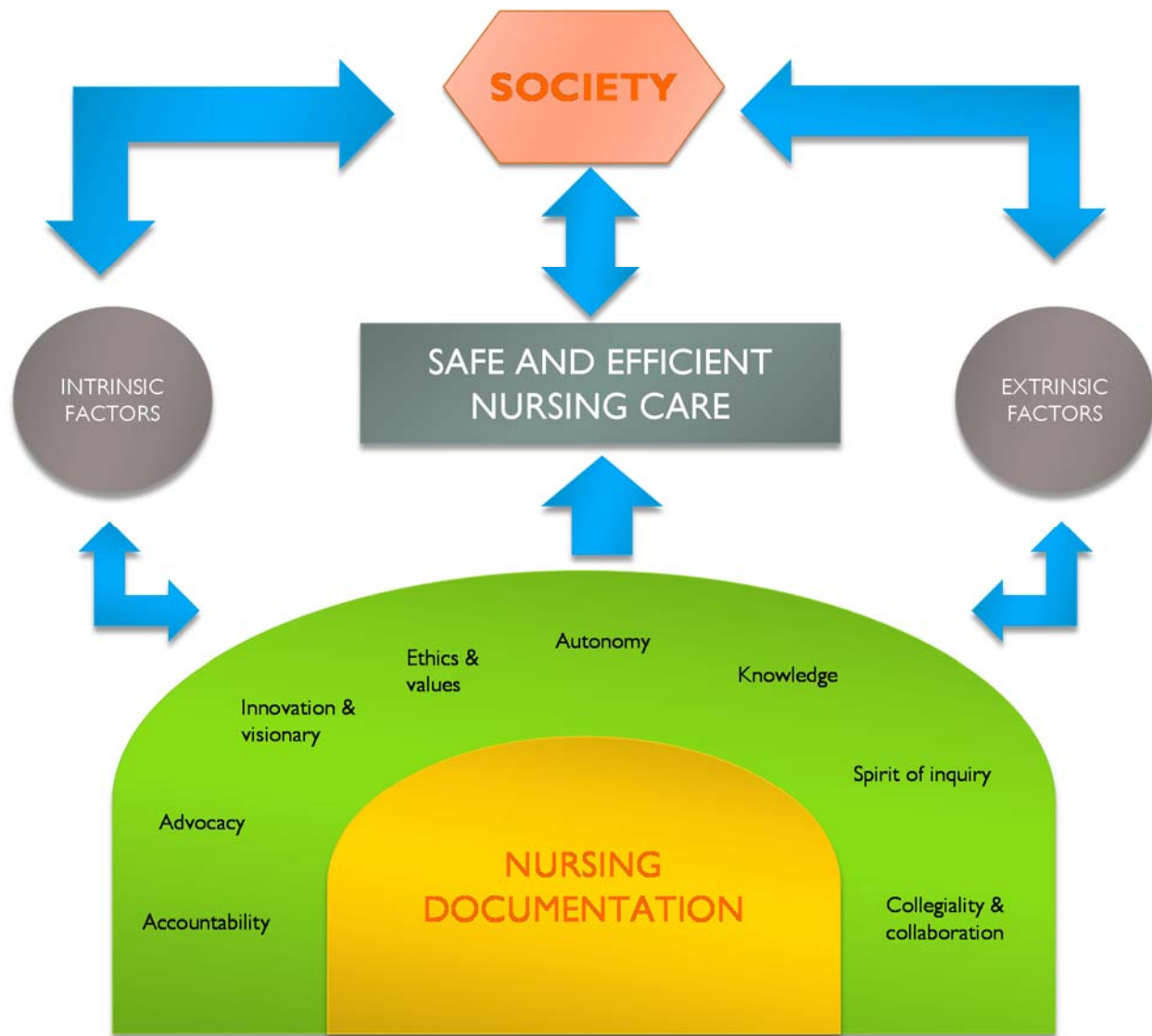
Despite the study by Coomarasamy et al. (2014) having highlighted several issues on nursing documentation in a Malaysian setting, their findings only focus on the documentation of one particular nursing action or procedure: the insertion and management of peripheral intravenous procedure. In addition, the nurses' actual knowledge, their comprehension of documentation and the peripheral intravenous insertion were not explored in detail. In this account, nurses' perceptions and attitude towards the documentation on peripheral intravenous insertion was not investigated. With all these setbacks, this study generally examined the entire perspective pertaining to the insertion and care of peripheral intravenous, and did not merely look at the detail in the documentation.

2.10 Summary

This chapter has discussed professionalism as an occupational value as well as self-presentation within nursing. Professionalism in nursing is one of the essential elements of care that enables nurses to practice safe and efficient nursing. Safe and efficient nursing practice is a common expectation from today's modern society (see Diagram 2.4 on the following page). Documentation is an appropriate indication to elicit the elements of professionalism among nurses. With regards to the explicit descriptions and the rationale of utilising the RNAO (2007) model, described in the earlier sections, it can be concluded that the elements of professionalism in nursing should be shown in nursing documentation.

Evidently, nursing documentation plays the role of noting the care i.e. the care that was given or will be given.

Diagram 2.4 Conceptual framework of the elements of professionalism within nursing documentation



Cribb & Gewirtz (2015) argue that healthcare providers perceive achievement of professionalism in healthcare, particularly in nursing, as a social accomplishment and ultimately as a personal accomplishment (Cribb & Gewirtz, 2015). These levels of

accomplishments are not otherwise achieved by means of an individuals' effort. Moreover, these accomplishments are closely related to 'gaining social rewards' established by society's expectation. Eventually, these notions could be retained and perhaps this interpretation can be recreated for professional work in the service sector. However, the phenomenon of professionalism is continuously changing especially the increasing amount of work among service professionals in large-scale organisations.

For that very reason, the importance of being a professional nurse is essential in not only gaining the public's trust and demonstrating reliability, but to motivate nurses to adhere to the agreed standards of care (Cribb & Gewirtz, 2015). Being professional assists nurses to recognise their roles and responsibilities when it comes to performing their tasks and obligations.

Professionalism within the context of healthcare is dynamic, socially constructed and multifaceted and is applicable to all staff that work as part of the healthcare team, regardless of their role, status, title or designation. This argument is clearly shown in the RNAO (2007) model of professionalism in nursing, as it covers both the essential values nurses require, in addition to focusing on patients' individual needs. The ability to cover these external expectations is achievable as the RNAO (2007) model of professionalism in nursing has the flexibility and cultural sensitivity, and moreover, is capable of representing the elements of professionalism. Consequently, the RNAO (2007) model of professionalism in nursing is appropriate in today's modern healthcare system.

In order to achieve professionalism in nursing, nurses need to demonstrate the attributes of professionalism in their daily practice, as it impacts positively on patient satisfaction and health outcomes (Alidina, 2013). Professionalism provides nurses with an opportunity to grow personally and professionally. However, professionalism does not only mean the acquisition of professional standards, prestige and power, but also the acquisition of professional control based on all the attributes of professionalism, as mentioned by RNAO (2007). The perspective of this theory, according to Clarke (2006), is valueless as the theoretical frameworks did little more than 'cosmetically' enhance the credibility of nursing. Hence, it is essential to examine and validate this theory within nursing practice.

McCrae (2012) argues that broad theories and conceptual models have been overshadowed by empirical evidence for several years, in the episteme of nursing, with the importance of

sustaining professionalism amongst nurses by way of comprehensive structures and theory (Karkkainen & Eriksson, 2004). This will ensure the science of care can purport to be an individual independent domain with its own clearly defined and expressed basis concerning its activities. This perspective of analysing the nursing profession enhances the recognition and articulates nurses' roles and their place in today's ever more complex healthcare environment.

2.11 Conclusion

It has been argued that no studies have investigated and discussed the elements of professionalism among nurses in relation to their documentation. Studies and papers, which were discussed in this chapter, could be categorised into two separate entities, i) professionalism in nursing and ii) quality of nursing documentation. In the context of nursing in Malaysia, little is known about professionalism among nurses in Malaysia. In other words, exploring the elements of professionalism among nurses by means of their documentation Malaysia context is non-existent. In line with the complexity and diversity of the contextual aspects of professionalism in nursing, the findings of this study could provide evidence of the elements of professionalism in nursing that could be demonstrated within nursing documentation.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

In the previous chapter, literature pertaining to nursing in Malaysia, the elements of professionalism in nursing and nursing documentation were discussed. This chapter explains in detail the research methodology of this study. Methodology is described as,

“the framework associated with a particular set of paradigmatic assumptions that can be used to conduct research”

(O’Leary, 2013, p.85)

This chapter outlines the concepts and ideas adopted in the research, to determine the truth concerning a situation through neutral observation and analysis. Methodology is essential in research, seeing as it guides the researcher in analysing, deciding, performing and re-evaluating the most appropriate and effective method to obtain answers to the research question and to validate a certain hypothesis (Polit & Beck, 2011; Dyson & Norrie, 2013).

Prior to formulating the methodology, the first step is to determine the research design (Parahoo, 2014). Research design is a process of the development, testing and evaluation of research instruments and methods used in research investigations (Parahoo, 2014). This process begins with identifying the problem and objectives of the research, and is subsequently followed by selecting the research methodology, which starts with the justification for the research design and instrumentation. This is followed by a description of the population and sampling that were used for this study. Discussion on data collection methods, the validity and reliability of the research instruments, data analysis, and ethical considerations will then be elaborated.

3.2 The research paradigm

A paradigm is a general perception or understanding of a phenomenon (Taylor, Kermode & Roberts, 2007). From the researcher’s perspective, a research paradigm is determined to structure the entire research process and to determine the comprehensiveness and scope of the study, while sustaining the focus on what to explore (Andrew & Halcomb, 2009). The choice of paradigm influences the research via its patterns of beliefs and practices, which formulate inquiry within a discipline (Weaver & Olson, 2006). These patterns provide lenses,

frames and processes via which investigation is conducted. Therefore, selecting the most suitable paradigm to be adopted in research is important, as it helps the researcher to clarify his or her structure of inquiry and methodological choices.

As far as nursing research is concerned, the common paradigms that are utilised include the positivist, post-positivist, interpretive and critical social theory (Weaver & Olson, 2006). In fact, these common paradigms share their philosophical foundation with quantitative methodology (Weaver & Olson, 2006). The positivist paradigm is taken from a philosophy known as logical positivism (Andrew & Halcomb, 2009; Cole, 2006; Weaver & Olson 2006). This philosophy argues that there is one objective reality. Furthermore, exploring a phenomenon through logical positivism is based on rigid rules of logic and measurement, truth, absolute principles and prediction. Consequently, valid research is presented only through the degree of proof for the result of a study, which represents the phenomena (Hope & Waterman, 2003).

In contrast, the interpretive paradigm arises from the philosophy termed 'interpretivism'. Interpretivism explains the nature of subject matter interpreted with consideration given with regards to human interest (Corbin & Strauss, 2008). An interpretive paradigm focuses on social constructions, such as language, consciousness, shared meanings and instruments in creating reality (Myers, 2013). Moreover, the interpretive paradigm usually focuses on meaning and could require more than one method to explore various aspects of the issue being studied (Collins, 2010).

The argument, therefore, is whether the exploration of the specific phenomena adequately confirms the overall view of the phenomena. Bloom & Canning (2000) describe today's healthcare world as a revolution in holistic and individualised care. Furthermore, people tend to seek information as comprehensively as possible. Consequently, a contemporary way of researching, perceiving and interpreting subject matter in healthcare is essential. There is an additional complication here, as the revolutionised and diverse nature of healthcare has drawn researchers to select the most appropriate methods and combine them where applicable (Andrew & Halcomb, 2009). This approach would provide a sophisticated range of evidence on which to base practice. Despite researchers and scholars debating hierarchical dominance, the combination of objectivity and generality of quantitative research and the inductive, subjective and contextual approach of qualitative research, they have proposed an innovative

approach which give the researchers a holistic picture of the phenomena (Andrew & Halcomb, 2009).

With reference to this study, the probability of an in-depth exploration of the complexity of nursing professionalism within nursing documentation should be conducted pragmatically. Specifically, this study is conducted by ways of exploring the practical aspect of research rather than being theoretically focused. The need to integrate the quantitative and qualitative findings of this study is crucial in forming a complete understanding of the unitary and connotative aspects between the elements of professionalism in nursing and the documentation from a Malaysian context. The integration of quantitative and qualitative results supports the argument of Okaisu, Kalikwani, Wanyana and Coetzee (2014), where it was argued that nurses' perceptions and attitudes towards documentation impact on the quality of how and what they document.

The practicality of exploring the complexity of nursing professionalism from documentation, is concerned with an investigation of the research matter, besides explaining the reason behind the findings obtained by the investigation. The emphasis on the concepts of practicality or pragmatism underpins the philosophical structure of mixed methods' research regardless of whether there is a dispute among scholars to decide the most appropriate paradigm to represent mixed methods research. Morris and Buckett (2011) explain that there were three popular perspectives held by those scholars who advocate pragmatic differences in mixed methods research and attempt to reconcile the diverse assumptions regarding the qualitative and quantitative paradigms. These perspectives include:

1. Those who advocated pragmatism as the new third paradigm and consider it to be the basic philosophical underpinning of mixed methods research;
2. Those who are convinced of the superiority demonstrated in research results when using pluralistic methodologies compared to single method research; and
3. Those who viewed methodologies on a continuum of qualitative and quantitative with mixed methods in the middle.

Morris and Buckett (2011), who reviewed the use of mixed methods in nursing research, conclude that the argument, or the complexity of deciding what the best fit is for mixed methods' studies in either a quantitative paradigm or qualitative paradigm, should not transgress the actual roles of mixed methods studies. The reconciliation of mixed methods

needs to be founded within the ability of mixed methods research to be resolved with fluidity, channelling the quantitative paradigm toward a qualitative paradigm, and vice versa, to unravel the complexity of human phenomena.

In terms of research paradigm, there is an interesting and continuous debate among scholars on what constitutes the most appropriate research paradigm: should mixed methods be classified or should mixed methods research be allowed to have its own paradigm? Mixed methods scholars, such as Onwuegbuzie and Leech (2005), Johnson, Onwuegbuzie and Turner (2007), Teddlie and Tashakkori (2009) argued that a mixed methods approach is explicit by its own philosophical essence and establishes 'pragmatic' platform or perspectives in exploring a research subject. The pragmatism of a mixed methods study focuses on the practicality rather than on the ideals (Denscombe, 2008). Pragmatism adopts a methodologically eclectic, pluralist approach to research, drawing on positivism and interpretive epistemologies, based on the criteria of fitness for purpose and applicability, and regarding 'reality' as both objective and socially constructed (Johnson & Onwuegbuzie, 2004). Pragmatism suggests that addressing 'what works' to answer the research questions is the most useful approach to the investigation, be it a combination of experiments, case studies, or surveys, given that such combinations enhance the quality the research (Sutter, 2012).

The mixed methods approach enhances the understanding of the plurality of methodologies that have no affinity to a single paradigm and which enables errors in single approaches to be identified and rectified (Johnson et al., 2007). This approach also enables meanings in data to be probed, and corroboration and triangulation to be practiced, rich(er) data to be gathered, and new modes of thinking to emerge where paradoxes between two individual data sources are observed. Similarly, the principal essence of mixed methods that distinguishes the approach from the simple use of quantitative and qualitative research is that mixed methods researchers should write up their research in such a way that the quantitative and qualitative components are 'mutually illuminating'. The term 'mutually illuminating' describes the integration process which begins from the research question stage to the method design stage.

However, Symonds and Gorard (2015), argue that a mixed methods paradigm is non-existent. The argument was initiated from the fact that mixed methods research has been taking place for years, before it was given the distinction of being a new paradigm. Furthermore, the foundation of mixed methods relies on the existing paradigm regarding

quantitative and qualitative research. Cohen, Manion and Morrison (2011) questioned whether mixed methods should be considered a new paradigm, as it blends two previous paradigms and makes a powerful case for utilising mixed methods. Symonds and Gorard (2015) also argued that if all methods and evidence can be equally subjective (or objective), then a mixed methods paradigm offers us nothing further in this regard. They had rejected Creswell and Clark's (2007) justification of the advantage of utilising mixed methods to compensate for the weakness of both quantitative and qualitative research, to achieve the true picture of a phenomenon.

In general, mixed methods research does not sit appropriately on its so-called 'established' paradigm. The mixed methods approach is best placed alongside quantitative and qualitative paradigms in a 'fluid' manner, where the choice of using both paradigms is not to overcome the weaknesses of each. Instead, the focal point of research is the use of both paradigms to explore the research matter more comprehensively. Hence, the principal discussion on the most appropriate paradigm for this study focuses on pragmatism from the perspective of utilising both paradigms to obtain an enhanced understanding of the elements of professionalism within nursing documentation, both numerically and narratively.

In the context of this study on the elements of professionalism within nursing documentation, it is not sufficient to explore the complexity of professionalism quantitatively, which refers only to the scientific knowledge, logic and measurement (Weaver & Olson, 2006). This is because the rigid form of this information or data is incapable of accommodating the exploration that concerns the aspects of social and human experiences within this study. Arnolds (2002) proposes that the assessment of professionalism should involve various approaches that should be developed to investigate the diverse nature of professionalism. Given the centrality of this argument, qualitative methodologies were also incorporated into the research design. It should be noted that regardless of the method, it does not indicate that the data is revealing the truth, in fact, data is constituted by the method and there is no such thing as the truth, only different versions (Bryman, 2016; Mason, 2006).

O'Cathain, Murphy and Nicholl (2007) also suggest that mixed methods research is used in health service research for its pragmatic, rather than ideological grounds, to enable it to engage with a variety of questions relevant to the complexity of healthcare. O'Cathain et al. (2007) further explain that mixed methods research is common in health service research and the surge of interest in this approach internationally is highly relevant to the healthcare

community. Therefore, the researcher attempts to combine the positivist (quantitative) paradigm with the interpretive (qualitative) paradigm in this study.

Thus, it is possible to explore the elements of professionalism among nurses in Malaysia from nursing documentation, from the perspective of a mixed methods approach. The principal focus of this study is to obtain corroborating information of the viewpoint and practice of nurses in Malaysia, in this pertinent subject (professionalism in nursing). Such viewpoints encompass matters of sociology, perspectives related to cultural norms, besides examining and evaluating the capacity of nursing documentation as a source of empirical evidence. According to these understandings, it is suggested that not all sociological and health service research fits neatly into the 'quantitative' and 'qualitative' categories (Perry, 1996).

There are boundaries within, as well as between, the two paradigms. The rapidly changing nature of healthcare provision has resulted in a phenomenon where there is more to be discovered about the way in which health services are constructed and delivered (Andrew & Halcomb, 2009). Morris and Burkett (2011), in their review of mixed methods studies in nursing, state that using qualitative data enhances the consistency of quantitative methodologies. Gaskin, O'Brien and Hardy (2003) also agree with this viewpoint, and state that in many cases, there is a discrepancy between nurses' opinions of the regularity of certain nursing practices and the documented evidence of that practice in patient's case notes.

3.3 The research design

There are two specific and contemporary philosophies that could be used as the foundation to develop scholarly knowledge in nursing research: modernism and post-modernism (Johnson & Webber, 2013). These philosophies tend to intensify the application of logical positivism/empiricism and the investigation of phenomena, which occur in the real world. Modernism focuses on providing theory, while post-modernism focuses on the development of new theory through the discovery of meaning without empirical evidence. The differences between these two philosophical theories disseminate into research, the purpose of which is to examine new concepts for the model as they are identified relationship statements linking the concepts, and validated a newly derived set of propositions.

Thus far, the earlier section explains the chosen paradigm concerning this study, which underpins this research. The research design signifies the structure and the process of the

study and leads the researcher throughout the implementation of this study (Burns & Grove, 2014). Prepared and based on the outcome of a series of decisions made by the researcher to conduct a study which maximises control over factors that could interfere with the validity of the findings. Essentially, a research design is (i) the researcher's overall premise for answering the research question; (ii) testing the research hypothesis, which suggests the inclusion of the entire research process from conceptualising a problem to writing the research questions, subsequent data collection, and (iii) the analysis, interpretation and report writing (Creswell, 2014).

The research design of most quantitative studies is highly structured, while its qualitative counterpart is more fluid (Morse & Niehaus, 2016). In general, research design varies according to the researcher's flexibility in the numerical and structural imposition of the research throughout the process of completing this study. In this study, a qualitative approach is also adopted and incorporated in the research design. This inclusion of both approaches (i.e. mixed methodology) is an effective strategy to explore the phenomenon of professionalism.

One study that could support the need for utilising mixed methods in exploring professionalism in nursing is that conducted by Lombarts et al. (2014). Their study determined that professionalism scores are at relatively low levels of agreement with statements related to physicians and nurses' professional responsibilities. Particularly, it is more prominent when addressing attitudes reporting medical or nursing errors and incompetent colleagues, despite the reported high overall levels of professionalism of physicians and nurses. These low scores could be due to the fact that professional cultures and a 'blame culture' do not tolerate mistakes (Killbridge & Classen, 2008). Hence, Lombarts et al. (2014) explored this culture qualitatively, and discovered that, due to blame cultures, professionals' rarely disclose medical errors related to patients, or report under-performance of colleagues. These scenarios raise several significant concerns in terms of nurses delivering high quality care to patients.

The integrated mixed methods approach utilises various methods and purposely merges or combines methods to support the exploration of the research matter philosophically and theoretically (Andrew & Halcomb, 2009). This research design aims to provide a well-regulated approach to comprehend the relevant issues or components and how they influence the research matter. The integrated mixed methods approach is increasingly acknowledged

among social sciences researchers as a contemporaneous and valuable research approach (Creswell & Clark, 2011). Similarly, Morris and Burkett (2011) assert that mixed methods studies are gaining credibility in nursing as evidenced by their increasing numbers in the literature. This phenomenon may be attributed to the abilities of this approach in optimising the strengths of both quantitative and qualitative strands to achieve the desired research goals.

Additionally, adopting both quantitative and qualitative strands enables researchers to corroborate findings; generate more complete data and perhaps use results from one method to enhance insights attained from another method to better understand the findings. Similarly, this method drives the researcher's specific aims concerning each method and determines the value of the expected data to be obtained from this study (Brannen, 2005).

In this study, the intended relationships between the types of data to be collected were finalised before deciding on the mixed method research design. It is relatively common to begin with an open approach that strives to identify the relevant issues or topics for research in an area about which there is a lack of information (Holzemier, 2010). The explanation of the research matter is nonetheless formulated and strengthened by conceptual works and a theoretical framework, which acts as the foundation for this study. Moreover, the primary justification for using mixed methods approach in this study is its comprehensiveness. In this context, mixed methods research provides strengths that offset the weaknesses of both quantitative and qualitative research (Creswell & Clark, 2011).

The most common approach to mixing methods in social science research is triangulation design (Creswell & Clark, 2011). Triangulation is used to ensure 'completeness' which is important in research, seeing as it allows for recognition of multiple research paradigms. This approach, according to Creswell (2012) is predominantly used when researching less explored or unexplored research problems. Essentially, triangulation design is an effective method used to perform cross-checking and to provide confirmation and completeness, which brings balance between two or more distinct types of research (Creswell, 2012). Specifically, this approach can also be achieved by using different research techniques.

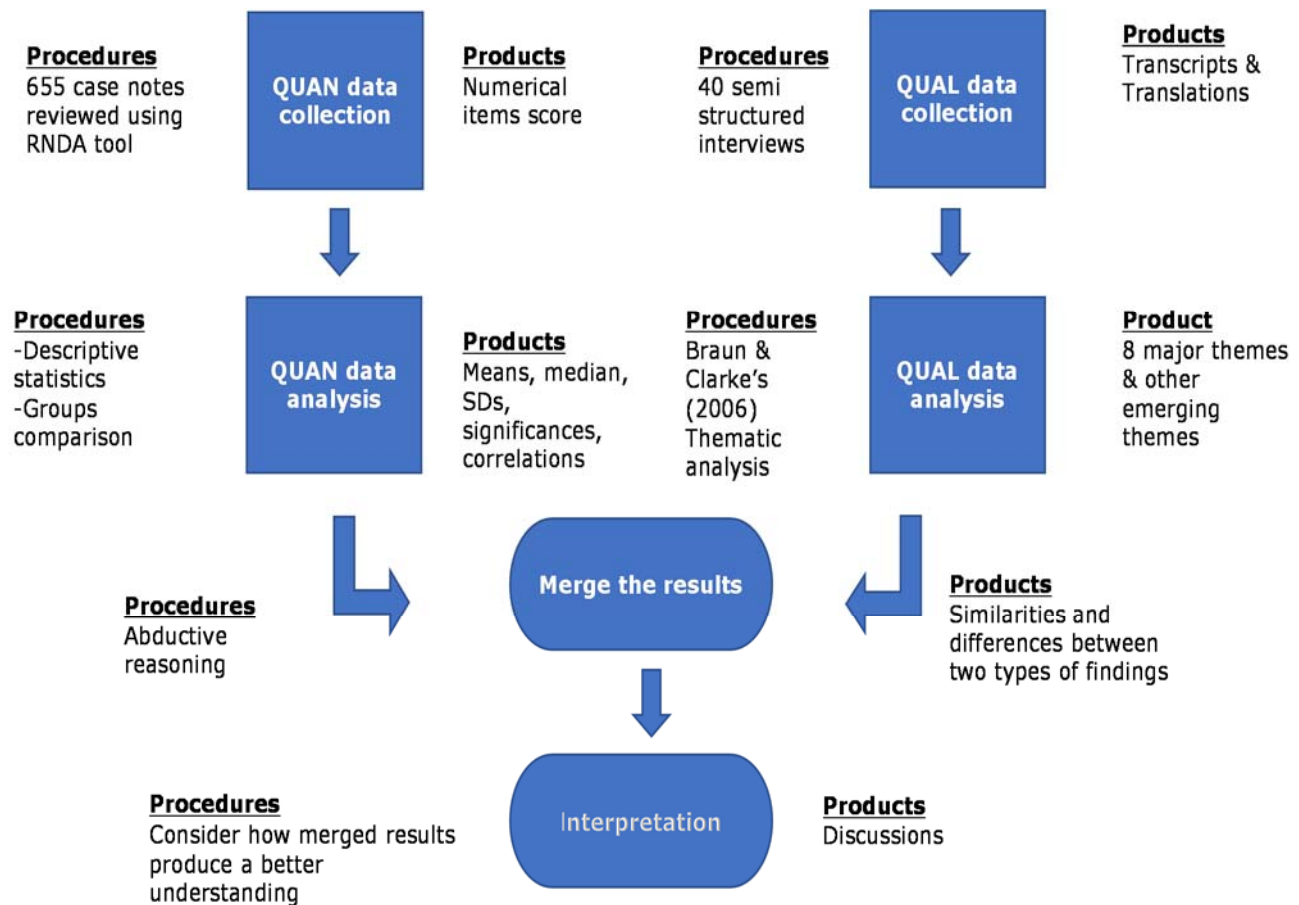
The aim of triangulation design is to obtain different sets of data that complement each other on the same topic, and therefore, provide a greater understanding of the research problem (Teddle & Tashakkori, 2009). Furthermore, triangulation design is intended to minimise the weaknesses of the quantitative methods by complementing it with data obtained via

qualitative methods. The obvious advantage is that the approach results in stronger and more reliable data.

It should be noted that triangulation design is performed concurrently, where a parallel process of collecting and analysing quantitative and qualitative data is conducted (Creswell & Clark, 2011). In the following stage, the researcher attempts to merge the two data sets (i.e. qualitative and quantitative data sets), typically by bringing separate results together in the interpretation, or by transforming the data to facilitate the integration of the two data types during data analysis. Specifically, triangulation design is achieved when the researcher implements the quantitative and qualitative methods within the same time frame and with equal weight in a single phase. In this context, the design has also been referred to as concurrent triangulation design (Creswell & Clark, 2011).

There are four variants related to triangulation mixed methods design: the convergence model, the data transformation model, the validating quantitative data model and the multilevel model. As for this study, the triangulation – convergence model was chosen as the research design (See Diagram 3.1 on the following page). Creswell (2013), for example, states that the convergence model is the traditional model of a mixed methods triangulation design. In this study, the researcher has collected and analysed the quantitative and qualitative data separately, although in one phase. Subsequently, the quantitative and the qualitative results are converged by comparing and contrasting the different results during the interpretation process. The convergence of these two different results is used to validate, confirm or corroborate quantitative results together with qualitative results. The outcome of the convergence model is a valid and well-substantiated conclusion concerning a single phenomenon.

Diagram 3.1: Stages in the implementation of the triangulation-convergence model in this study



(adapted from Wittink et al., 2006)

In the following sections, both the quantitative and qualitative approaches will be explained separately. In each section, the data collection process, research instruments, data analysis and ethical considerations will be elaborated in detail.

3.4 Ethical considerations of this study

Ethical considerations are concerned with the protection of human and animal research subjects (Schneider, Whitehead, LoBiondo-Wood & Haber, 2013). Ethical regulations aim to ensure the absence or minimisation of harm, trauma, anxiety or discomfort being caused to participants. It is not permissible to conduct research without ethical approval from an

institutional review board. The role of institutional boards in giving ethic approval for any sort of study is to ensure that appropriate measures are taken to protect the rights and welfare of humans participating as subjects in research (Gearing, Mian, Barber & Ickowicz, 2006). Therefore, obtaining approval from the institutional review board(s) for retrospective research is of significance. Furthermore, it is becoming standard practice that researchers conducting retrospective studies publish their ethics board approval in the methods section.

While the requirements for institutional review boards are standard, each board has its own protocols and policies for applicants (Vassar & Holzman, 2013). Hence, the researcher has to contact the institution's research ethics board committees as they are able to offer valuable and timesaving site-specific information and assistance. An ethics application is a standard process and if there are any changes to the research protocols, a resubmission is required.

This study obtained full ethical approval from the School Research Ethics Committee, School of Human and Health Sciences, University of Huddersfield on 20 April 2013 (see Appendix 9). Subsequently, this study was registered at the National Medical Research Registry (NMRR), Ministry of Health, Malaysia (see Appendix 6). The proposal was later submitted to the Malaysia Research Ethics Committee (MREC), to gain approval from the Ministry of Health Malaysia. A letter of approval from the National Institute of Health (NIH) and the Malaysia Research Ethics Committee (MREC) was obtained prior to analysis of documents in the case notes beginning (see Appendix 7). Prior to that, this study had obtained written approval from the directors and the matrons in charge of the participating hospitals (See Appendix 8).

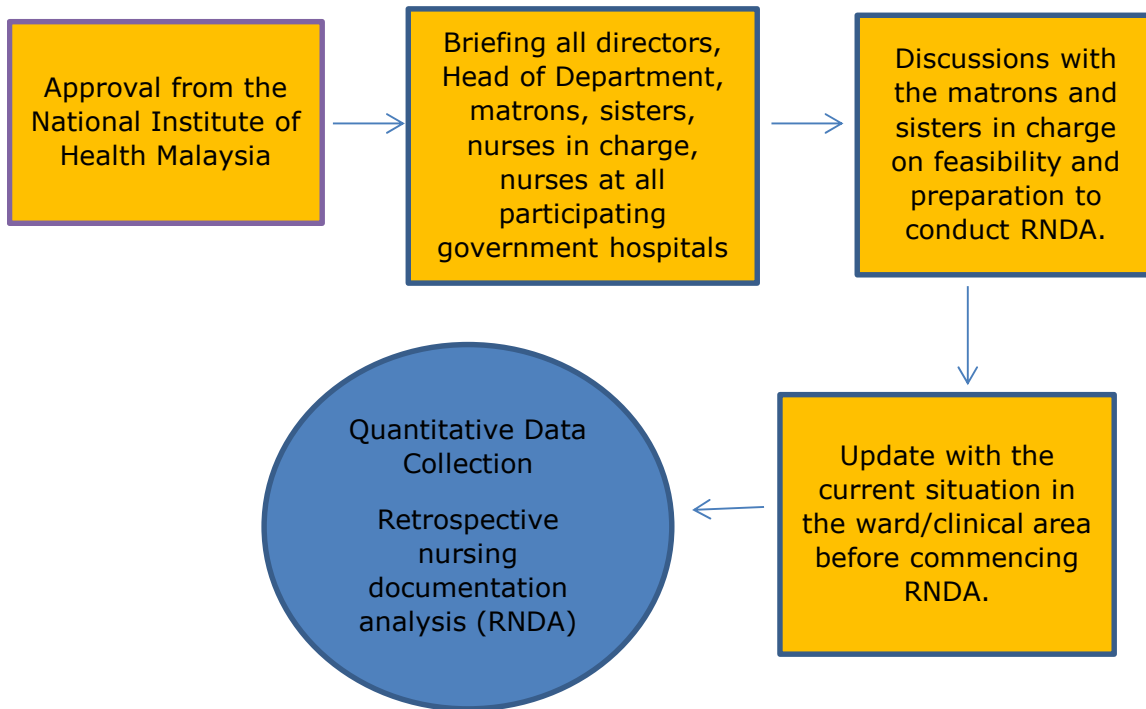
Subsequently, the directors, heads of departments, matrons, sisters, nurses in charge and staff nurses of the participating wards were briefed about this study (see Diagram 3.2 on p101). A copy of an information sheet explaining this study was distributed to each of them, besides the other medical personnel and affiliated members of the participating hospitals. Meanwhile, informed consent was sought from nurses acting as respondents prior to their interviews (see Appendix 4). This process will be explained later in this section.

The retrospective nursing document analysis or RNDA was conducted carefully, depending on the current situation, the settings and the protocols of the ward at the time of the interview. Hence, the nurse in charge and the sister of the ward were approached before every data collection session. No records or any forms of documentation were removed from the ward. The RNDA was conducted in a specific area, for instance at the nursing station or in the

patients' cubicles, depending on the availability, and where the case notes or other documentation were located. The researcher also informed the nurse and doctor in charge regarding which of the patient's case notes were being reviewed. There were several times when the case notes were needed, requiring the researcher to return them immediately to the nurse and/or doctor in charge. The previously mentioned measures are vital as they ensured that misunderstandings were avoided and that the process of RNDA did not interfere with the settings' interdisciplinary workflows, processes or patients' current conditions and needs.

In this study, the researcher ensured that the surroundings were safe and convenient before conducting RNDA or interview. This measure was performed by seeking the views of the nurse in charge about the current situation on the ward. All related information and outcomes from the interviews and reviews of the case notes were kept confidential and anonymous at all times. Furthermore, interviews with respondents were conducted in a private setting which was identified prior to the scheduled interview. Since participating in the interview was undertaken on a voluntary basis, respondents were told that they had the right to withdraw at any point during the study. Diagram 3.2 on the following page illustrates the process of accessing nursing documentation in this study.

Diagram 3.2: Process of accessing nursing documentation for this study



As mentioned earlier, informed consent was obtained prior to the interview. Informed consent is vital in any form of research, seeing as it is valid evidence that the potential respondents understand and that they are willing to contribute or participate in a study (Polit & Beck, 2011). The respondents were informed that all related information and outcomes from the interviews conducted in this study are confidential (Polit & Beck, 2011; Wood & Ross-Kerr, 2011). Seeing that the interview was conducted on a voluntary basis, the respondents/interviewees have the right to withdraw from the study at any point. Prior to their interviews, the respondents were briefed about the research and consent forms completed before any data was collected. It should be noted that the interviews were recorded via digital voice recorder and transferred immediately onto a password-protected computer after every session.

Several briefing sessions with prospective respondents and the hospital's administrators were conducted. This exercise was conducted to ensure that they would have a clear understanding of this study, besides the measures taken by the researcher to ensure respondents' confidentiality, anonymity, in addition to protecting the interests of the respondents throughout this study. No data that can identify either the patients receiving care or health

workers providing the care were collected. Prior to the analysis, the respondents were identified by ways of assigned pseudonyms or fictitious names to ensure confidentiality.

All the information (obtained data from the RNDA and the transcripts of the interviews) is kept on a PC with a secured password. The original RNDA checklists and all the respondents' details were kept securely under lock and key in a steel cabinet. Only the researcher was involved in the entire process of the actual data collection and analysis. The researcher had ensured that the entire process of conducting the research would abide by the Data Protection Act (1998) and adhere to the University's regulations specifically on confidentiality and anonymity, which was maintained at all times. The University's regulations state that research data has to be kept for a maximum of ten years.

3.5 The quantitative strand of this study

The quantitative strand of this study aims to investigate the existence of the elements of professionalism among nurses in Malaysia from their nursing documentation in a heuristic manner. This is because the quantitative approach has the ability to explain phenomena by collecting numerical data that are analysed using mathematically based methods (Polit & Beck, 2011). The adoption of the quantitative approach in a study is beneficial, as it provides hard data, resulting from the evaluation of numerical and measurable information (Bowling, 2009). Specifically, quantitative research is concerned with the quantifying (measuring and counting) of phenomena (Langdrige & Hagger-Johnson, 2009). The quantitative approach can be precise when it comes to measurement, and be controlled in terms of design (Cohen et al., 2011). Hence, the quantitative approach is able to make claims pertaining to causation and has the predictive power that can be generalised to include other settings on the basis of some finding in a particular setting.

3.5.1 Population and sample

Population is defined as the group to which a researcher would like the results of this study to be generalisable by using the most practical procedures possible to gather a sample that best represents a larger population (Richardson, 2007; Wolfer, 2007). The population of a study is a representative set of all cases of interest and might cover almost any geographical area. Additionally, it is a process that is continuously strategic and occasionally mathematical (Gay & Diehl, 1996; Wolfer 2007). Bynard and Hanekom (2005) claim that the sampling of a

population is used to simplify the research, given that it is easier to study a representative sample of a population than to study the entire population. In general, sampling saves time and reduces cost.

In their study, Gearing et al. (2006) suggest that each review of the case notes requires statistical power analysis to determine the appropriate sample size. They also emphasise the calculation of the appropriate sample size as a necessary component in all research proposals. Moreover, the literature generally holds ten events per predictor or variable as an accepted norm to obtain results that are accurate and useful (Findley & Daum, 1989; Harell et al., 1985; Sackett, Haynes, Guyta & Tugwell, 1991), others have suggested that it is acceptable to have a minimum of seven or five events per predictor (Raykov & Wideman, 1995).

In this study, a sample power calculation was performed although convenience sampling only requires the available sample over one period of time. This could be a limitation regarding this study; however, the sample is not likely to represent or to generalise the entire population. Furthermore, the scope of this study is predominantly to explore the subject matter, which is intended to establish an early comprehension of the subject or the research area. Recommended sample size calculations by Charan & Biswas (2013) were used to determine the minimal sample size for this study.

As the population is unknown, the sample size can be derived by computing the minimum sample size required for accuracy in estimating proportions, by considering the standard normal deviation set at a 95% confidence level (1.96), percentage picking a choice or response (50% = 0.5) and the confidence interval (0.05 = ±5). The formula is:

$$n = \frac{z^2(p)(1-p)}{c^2}$$

Where:

z = standard normal deviation is set at a 95% confidence level

p = percentage picking a choice or response

c = confidence interval

Therefore,

$$\begin{aligned}n &= \frac{1.96^2(0.5)(1-0.5)}{0.05^2} \\&= \frac{(3.7828)(0.5)(0.5)}{0.0025} \\&= \frac{0.9457}{0.0025} \\&= 378.28 \\&= 379\end{aligned}$$

In conducting any case notes review, sampling refers to the method by which study cases or records are selected from the target population or database (Worster & Haines, 2004). Three commonly used sampling methods in case notes reviews are convenience sampling, quota sampling and systematic sampling. In this study, convenience sampling was chosen. Convenience sampling is the use of the most readily accessible persons or objects as subjects in a study (Schneider et al., 2013). This form of sampling was preferred as it is an acceptable approach provided that the period is lengthy enough to include seasonal variations or other changes over time that are relevant to the research question (Hulley, Cummings, Browner, Grady & Newman, 2013). Additionally, convenience sampling was chosen due to the time and logistic constraints that the researcher encountered throughout this study.

3.5.2 Process of accessing nursing documentation

A convenience sample of 655 patient case notes was collected from six government hospitals in Malaysia. Both elective and acute admissions were included in this study. The choice of population setting is based on the researcher's personal association with these settings, along with the inevitable time and logistic constraints. Each of these hospitals are located in Malaysia and are fully funded by the Government of Malaysia. These hospitals are primarily major or state hospitals and offer various health services. Table 3.1 and Map 3.1 on the following page present the details and the locations of the selected hospitals.

Table 3.1: Descriptions of the six hospitals participating in this study

Descriptions of the six participating hospitals					
Hospital Descriptions	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Geographical location	Northern part of Peninsula Malaysia	Capital city of Malaysia	Southern part of Peninsular Malaysia	Sabah, in Borneo	Sarawak in Borneo
Hospital Classification	General	General	Mental Health Institution	General	General
Bed capacity	314	2300	1132	400	931
Type of healthcare services available	Multi-disciplinary	Multi-disciplinary	Mental Health	Multi-disciplinary	Multi-disciplinary
Number of staff nurses	479	3101	208	531	1597

(Source: Matron in charge at all participating hospitals)

Map 3.1: Locations of the hospitals participating in this study



(Source: <http://geology.com/world/malaysia-satellite-image.shtml>)

Information from paper based nursing records, for instance patient case notes and other related medical records, which can be found in patient case notes in clinical settings were collected and collated. It was the documented evidence of this that was reviewed. The criteria for the selection of the case notes are described in Table 3.2 below. These criteria are set in response to all the recommended documents that should generally be available from that period.

Table 3.2: Inclusion criteria for selecting case notes for this study

Case Notes inclusion criteria	
1.	Cases that have been in the clinical setting for more than 48 hours from the time of admission.
2.	All writings and recordings should be in English and/or <i>Bahasa Melayu</i> .
3.	Nursing admission forms, nursing care plans and nursing shift reports are completed and available in patient's case notes.
4.	Patient's case notes should be registered and available on the ward.

In determining whether a case note is included in the study, a few criteria were established. Any case that has been in the clinical setting for more than 48 hours from the time of admission is eligible for inclusion in the study. Ling, Ling, Chin, Wong, Wong, Nasef & Zainuddin (2011) mention that most nursing documentation, such as admission sheets, patient assessment and nursing care plans should be prepared within 48 hours of the patient's admission onto the ward. Moreover, the patient's monitoring sheets, such as Intake and Output charts, besides the patient's Temperature, Pulse and Respiratory (TPR) chart were continually updated and completed.

It is obligatory for nurses to complete all the documents mentioned above within 24 to 48 hours of the patient's admission (Ling et al., 2011). This obligation was however, based on the mutual working norms between nurses and other healthcare providers to ensure that patient care could be executed immediately after the patient's admission. Currently, there are guidelines available on how these documentations should be completed. The nurses are fully aware of the importance of these documents; however, it was established that not all of the participating hospitals make these guidelines available on the wards.

Three principal types of nursing documentation were reviewed: the patient admission form, nursing care plan and nursing shift report. These types of documentation were selected because of their availability and as they are the mandatory forms that nurses have to complete throughout the patient's admission to a ward or any clinical settings. This argument produces a number of assumptions or expectations concerning these documentations. First, a patient's admission form should generally be completed during a comprehensive assessment.

Secondly, the nursing care plan should be fully drafted based on the assessment that was conducted during admission. The nursing care plan should be amended and updated based on the patient's current status and the evaluation of the intervention that is stated in the nursing care plan. A nursing care plan outlines the nursing care to be provided for an individual/family/community (Carpenito-Moyet, 2009). The plan is a set of actions which the nurses implement to resolve/support nursing diagnoses, which were identified from their nursing assessment. The creation of the plan is an intermediate stage of the nursing process. The plan guides the ongoing provision of nursing care and assists in the evaluation of that care. Thirdly, a nursing shift report, which is defined as exchanging essential patient care information with other nursing staff at the change of a shift (Urquhart et al., 2007), is also a

critical document in this study. It is mandatory that all nursing activities throughout the shift are recorded in the nursing shift report. A patient's current condition should be recorded at the beginning and at the end of each shift. Moreover, a nursing shift report should also include each patient's individual needs. According to Ortega (2013), appropriate and concise nursing shift reports signify the nurses' professional practice, as they cover the holistic care and nursing process that demonstrate the nurses' ability to deliver optimal care to the patient.

Here, the researcher performed an initial observation prior to the actual data collection in order to understand the specific requirements of each site. This step is necessary to determine the procedures, as well as in endeavouring to familiarise oneself with the data extraction tool. While many parallels exist across institutions in relation to conducting a review of the case notes, there are common differences among institutions relating to the procedures for chart procurement, retrieval rates and access to patients' notes. Several issues need to be considered, such as who may access the charts (e.g., hospital employee), the availability of space provided to read the charts (few institutions allow charts to be removed), operation hours and access to the site, and moreover, policies regarding photocopying and the use of institutional or personal computers. Any one of these can potentially influence effective data extraction; therefore, clear guidelines are required before the study can commence.

Missing data is another issue that was considered in this study. How missing data is managed poses methodological limitations in conducting case notes review research (Hellings, 2004). In reviewing case notes, missing data can result in hidden or non-response bias in the results, where cases with missing information may differ from the other cases (Worster & Haines, 2004). There is no universal method for managing missing data although it is imperative that researchers who are designing, implementing and conducting a review of the case notes and research develop protocols to address this central issue. While missing data can be case-specific, strategies to manage this problem can be garnered by anticipating common concerns associated with missing data.

Hence, rules pertaining to how missing data are handled in research should be devised before data collection commences (Wu & Aston, 1997). Any missing values in the data are treated either by the deletion of the case or variable, or by imputing the missing values via averaging or maximum likelihood strategies (Worster & Haines, 2004). It is also assumed that missing data is randomly absent. The maximum likelihood strategy that was utilised in this study was performed by assigning the missing value as one response, such as with a 'yes' or 'no'

question where the absence of a 'yes' results in an immediate 'no'. Similarly, a pilot study was conducted (refer to Section 3.5.6) in this study, in accordance with Worster & Haines' (2004) argument that a pilot study is a valuable way to address the problem of missing data.

An additional significant aspect of a successful review of the case notes is the regulating of appropriate reviewers. As this study required an extra reviewer for the inter-rater agreement analysis (during validating the tool), the researcher applied several measures, as recommended by Allison, Wall, Sheftell, Calhoun, Faragason, Kobylinski, Farmer and Kiefe, (2000) and, Pan, Fergusson, Schweitzer and Hebert, (2005). Firstly, reviewers must become familiar with a health record, know where the information is located and strive to remain objective. Reviewers should be carefully trained with the data extraction instrument and the accompanying protocols and guidelines. It has also been reported that the accuracy of reviewers increases when the individuals recognise they are being monitored (Wu & Ashton, 1997). Furthermore, it is preferable to select reviewers with experience of retrospective research or the area under investigation. It is also advantageous to select reviewers from healthcare professions, preferably those with advanced levels of education. Therefore, a registered nurse with a degree qualification and adequate clinical experience was appointed as the reviewer for this study.

3.5.3 Data collection

According to Burns and Grove (2014), data collection is the accurate and systematic gathering of information relevant to the specific objectives and questions of a study. As aforementioned, the Retrospective Nursing Documentation Analysis (RNDA) approach was selected as an approach regarding quantitative data collection for this study. RNDA refers to any study that uses pre-recorded, patient-focused data as the primary source of information to answer the research question (Worster & Haines, 2004). RNDA involves some direct matching of information, which is available in the record of the data required, but also includes operations on the data, for instance categorising, coding, transforming, interpreting, summarising and calculating.

This approach to data collection is based on several expectations regarding the validity of the data (Eder, Fullerton, Benroth & Lindsay, 2005). These include: (a) data required for the research is present in the record; (b) data in the record is in a form that can be extracted, or manipulated, for research purposes; (c) data in the record accurately represent the actual

event that occurred; d) data addressing any single item that is recorded in more than one place in the medical record is consistently recorded by one or more individuals who enter that data; and, (e) medical record entries are interpretable in a manner common to all those who access the record (Allison et al., 2000). These measures result in a summary of information related to answering research questions. RNDA is a retrospective review of the case notes, which can be described in two parts (Panacek, 2007). Firstly, the term retrospective refers to looking back in time and, at this point, at nursing events (Hess, 2004). Secondly, the information in the patient admission sheet, nursing care plan and nursing shift report were used as data sources.

The advantages of using RNDA for quantitative data collection are that the data required for the research are presented in the record and the data in the record are in a form that can be extracted, manipulated or is for research purposes (Alison et al., 2000). Additionally, the data in the record is by right, accurately representative of what was in fact, data addressing any single item that is recorded in more than one place in the medical records and consistently recorded by one or more individuals (Alison et al., 2000). Thus, entries in the medical records were interpreted in a manner common to all those who access the record.

In the context of this study, conducting RNDA is a relatively inexpensive venture to research rich, readily accessible and existing data (Worster & Haines, 2004). Although the design of the study and its data collection methods should be based on the most rigorous way of answering research questions, the RNDA method has its own advantages that persuade researchers to adopt it. For instance, RNDA has been touted as an 'easy' option because the clinical data already exist and has to be extracted from the case notes (Hess, 2004). Another advantage of a retrospective review of the case notes includes its relatively low cost compared to prospective trials (Hess, 2004) and the fact that nursing documentation is generally accessible to researchers and can be a source of clinical richness and accuracy (Dicenso, Guyatt & Ciliska, 2005).

However, there are several factors that could hinder RNDA. Chief among them are limitations due to incomplete documentation, which include missing records or documentation, and information that is unrecoverable or unrecorded (Hess, 2004). RNDA may also be constrained by the difficulty of interpreting the information discovered in the documents (e.g. due to jargon, acronyms and quality of the photocopies), problematic verification of information and difficulty in establishing the cause and effect, and variance in the quality of information

recorded by medical professionals (Pan et al., 2005). The lack of a clear procedure for data extraction and ways to handle missing or incomplete data, and inconsistencies or mistakes in coding chart information are argued to have discouraged researchers from adopting this methodology (Gearing et al., 2006). Together, these limitations may adversely affect the validity and reliability of the case notes review method, and any subsequent study findings.

To overcome these limitations, several guidelines on how to extract data effectively and systematically from historical records have been introduced by researchers (Worster & Haines, 2004; Gearing et al., 2006; Engel et al., 2008). These guidelines and the steps involved, which will be described in greater detail in Section 3.5.4, it can be argued increase the scientific rigour through a standard process. This process has guided the researcher particularly pertaining to research conception and development, defining variables and deciding on sampling issues in this study. The strategies outlined for procurement and extraction of data has assisted greatly in minimising the limitations and, consequently, strengthens the reliability of the data.

3.5.4 The research instrument

Development of the data extraction tool involved consideration of the variables in this study, in a review consisting of two interconnected and iterative components (Gearing et al., 2006). In the first component, the variables in this study needed to be defined and were generally determined by the nature and focus of the investigation. In the second component, study variables were then reviewed in the literature to determine how other researchers have employed them in similar or related investigations (Gearing et al., 2006).

Understanding the design of existing health records and how the data is recorded are considerably important. Hence, the following strategies were utilised. First, the flow of information was examined, specifically from patient to health record (Jansen et al., 2005) to identify established charting protocols, accepted processes regarding documentation, and the nature of standard documentation (e.g. emergency notes, diagnostic information, consultations and discharge reports). Secondly, a careful inspection of a few types of nursing documentation (three to five nursing records are recommended) was performed (Findley & Daum, 1989). This step provides critical information pertinent to the process, where the patient's chart/health record are constructed and documented. Thirdly, consultations were conducted with site-specific nursing and hospital administration authorities to ascertain how

patient information is recorded and documented in multi-site studies. A clear definition of the variables in this study and a good understanding of nursing documentation provide the essential base for researchers to develop a standardised RNDA extraction tool (Jansen et al., 2005).

In this study, the structure of the data extraction tool began at the conceptualisation stage. At this stage, two types of measures were performed, comprising research formulation and a 'clinical scan'. Research formulation involves the process of articulating the research questions (Gearing et al., 2006), which subsequently determines the feasibility of RNDA. This strategy facilitates an informed approach that assists decision-making throughout the subsequent stages in this research.

Meanwhile, a 'clinical scan' of the research question was determined at the conceptualisation stage. Gearing et al. (2006), for example, describe 'clinical scan' as the process by which nursing and other related clinical expertise were sought to rule out unanticipated benefits and to identify any potential methodological barriers. The clinical scan can be conducted via general observation of the proposed sample and settings, and by seeking adversarial inputs from individuals who are directly involved in a proposed setting. This step was performed as early as possible. According to Hess (2004), the earlier an investigation seeks to incorporate wider input from others, the sooner the benefits of support, expertise, sample recruitment and promotion can be achieved.

The design of the data extraction tool is derived from several validated nursing audit tools (Larson, Bjorvell & Wredling, 2004; RNAO, 2007; Johnson et al., 2010; Paans et al., 2010; Wang et al., 2010; Nottinghamshire Healthcare, 2011). These nursing audit tools were chosen to assist in formulating data extraction tools in this study because these variables, or components, listed in these tools could directly elicit the elements of professionalism among nurses. This strategy is supported by Wang et al. (2011), who argue for a systematic review on the existing audit instruments of the quality of nursing documentation. Wang et al. (2011) established that these instruments were developed for different study purposes and settings where specific documentation systems were used, or standardised terminologies were required. Wang et al. (2011) further suggested that these instruments are concerned with the documentation of each step of the nursing process.

Several studies that were reviewed by Wang et al. (2011) included comprehensiveness in recording (Bergh et al., 2007), 'Cat-ch-Ing' (Bjorvell et al., 2000), Quality of Diagnoses, Interventions and Outcomes (Muller-Staub et al., 2007) and D-Catch (Paans et al., 2010). However, it can be concluded from the systematic review by Wang et al. (2011), that none of the tools in these studies were designed to focus on evaluating the elements of professionalism within nursing documentation. Therefore, a new data extraction tool was developed for this study by synthesising relevant approaches from previous studies (Larson et al., 2004; RNAO, 2007; Johnson et al., 2010; Paans et al., 2010; Wang, 2010; Nottinghamshire Healthcare, 2011) and customising them to this study's objectives.

To reiterate the aim of this study, which is to investigate the elements of professionalism from the nursing documentation, the aim is translated into criteria for the final extraction tool. These criteria were structured according to the eight attributes of professionalism recommended by the RNAO in 2007. Several guidelines recommended by the literature were assimilated when formulating the extraction tool for this study (Schwartz & Panacek, 1996; Smith, 1996; Banks, 1998). Initially, the data extraction was designed to portray the essential criteria, such as organisation, simplicity and clarity, to enable the development of a uniform data extraction instrument. Next, the data collection was organised in a logical order and, when possible, parallel with the flow of the information in the nursing documentation (Smith, 1996).

The variables or items included in the standardised extraction tool are related to the research questions and objectives in order to help the reviewer(s) collect the data from the records (Schwartz & Panacek, 1996). Furthermore, the format of the tool and wording of the questions were considered. Questions within the standardised extraction tool were synonymous with the language and time frame used within the data source. Additionally, the order of the questions within the tool corresponded to the order of information in the chart to facilitate efficient extraction and decrease reviewer fatigue (Allison et al., 2000; Banks, 1998).

The data extraction tool (see Appendix 1) consists of two sections, and eight themes with 10 questions each. The latter was designed in such a way that responses for each question were given in the form of a five Likert type scale, 0 = none (components are not present in any of the written texts/any reports in a single case note) to 4 = All (components are always present in the written texts/any reports in a single case note). Loss of data and the listing of data in an incorrect category during the extraction process can be minimised by creating appropriate

categories for each variable, in addition to categories for missing and undetermined variables (Allison et al., 2000). The data extraction tool is designed in simple English and the items in it are presented in a logical order to minimise any stress or confusion associated with completing the questions. The variables on the tool were arranged according to the availability of information as they appear in the model of professionalism forwarded by the RNAO (2007) and the orders of all the related nursing documentation, or records, in the patient case notes (Banks, 1998). (The example of the data extraction tool can be viewed in Appendix 1).

Each nursing documentation or record is assigned an identification number (ID) to ensure confidentiality so that the ID number and not the chart or person identifying information is indicated on the front page of the RDNA tool (Engel et al., 2008). Additionally, the ID numbers are indicated on the top, right-hand corner of the document for ease of retrieval once the tools are filed. The RNDNA tool has an easy to read layout that uses number based variable choice and the amount of text is minimised. Checking options supports ease of extraction and, because of this, a checking option was chosen. This reduces the need to complete information (see Appendix 1). Consideration of whether a variable is a 'missing/not noted' option is also included. In this instance, completing the data extraction tool was relatively straightforward, as the researcher/rater/reviewer are only required to place a tick in the appropriate boxes or columns, followed by explanatory notes, as explained in Table 3.3 below.

Table 3.3: Explanation notes for reviewing the case notes

Criteria	Descriptions
ALL	Components always present in all sections/all notes/all reports in a single case note.
MOST	Components practically present in all sections/all notes/all reports in a single case note.
SOME	Components occasionally present in all sections/all notes/all reports in a single case note.
FEW	Components rarely present in all sections/all notes/all reports in a single case note.
NONE	Components not present in all sections/all notes/all reports in a single case note.

Meanwhile, the RNDA tool comprises two principal sections, specifically;

i) Section 1

This section contains information on the date of the review, reference ID number, the ward to which the patient was admitted and the length of stay from the time of admission.

ii) Section 2

In this section, the researcher focuses on questions that address the evidence of variables that represent each of the attributes, formulated according to the model of Professionalism in Nursing by the Registered Nurses' Association of Ontario (RNAO) (2007).

As a precaution, these types of nursing documentation or records were distinguished because a variable is not mentioned in the nursing documentation, or a record may not necessarily indicate that the variable is missing. For example, when there is no nursing care plan available in the nursing documentation or record, it may not necessarily indicate that the care plan data is missing. Another possibility is that the nursing care plan was simply not recorded. In these cases, the option of 'none' is inclusive of all possible responses that might have occurred. (Refer to Appendix 1 and Appendix 2).

Each variable was set out in a simple, yet clear manner. This form of standardisation is important to ensure the validity of the study. For example, Jansen et al. (2005) state that internal validity and reproducibility of any retrospective study are significantly enhanced in the standardisation of the data. Besides, a scoring system was developed for the data extraction process (see Appendix 2). For any data extraction tool, it is essential to develop a coding manual that provides a clear set of protocols and guidelines to instruct the reviewers in data collection (Hess, 2004). This coding manual serves as a reference manual as to how the data is extracted from the nursing documentation or record. The manual was created to explain how the variables are captured in the data extraction instrument, describe where the variables are located in the nursing documentation or record; and provide the required protocols to extract the data. It was argued that protocols with explicit criteria are designed to increase the inter-rater reliability of data extraction (Goldman, 1992; Vonkoss Krowchuk, Moore & Richardson, 1995). Consequently, protocols generally require revisions, specifically following the piloting of this study, which will be explained in Section 3.5.5.

The utilisation of data extraction tool helps the researcher to stay on the path and maintain the same focus throughout the exploration of the subject matter. This argument is not unlike that forwarded by Ghadirian et al., (2014), who conclude in their article, that the use of assessment tools to evaluate and investigate this concept can result in further research and extension of the body of knowledge in nursing. Arnold (2002) also suggests that measurement tools would be best focused on professional behaviours. These professional behaviours are labelled as expressions of value conflicts, which would produce a more reliable and valid instrument. These tools would also be more useful in evaluating daily nursing routines and occasional lapses into unprofessional behaviours.

Furthermore, the researcher and reviewer applied techniques specifically aimed to reduce errors in recording numeric variables. These techniques include providing an exact number of boxes for the number of digits and, in the case of single digit values in a two-box field, using a leading zero (Hess, 2004). The researcher recorded the data on paper initially, and subsequently transferred the data into the computer after every session. Duplicate data recording, i.e., on paper and then into a computer, may increase the opportunity for errors; therefore, an anonymous second person was appointed to verify the researcher's database (Gearing et al, 2006). This step potentially minimises the number of omitted, illegible, missed, or transcribed entries.

3.5.5 Validity and reliability

Validity refers to whether a measurement instrument accurately measures what it is supposed to measure (Strauss et al., 2005). According to Babbie (2007), validity can be considered an empirical measure that adequately reflects that real meaning of the concept under consideration. Validity determines whether the research truly measures what it was intended to measure, or how truthful the research results are.

Validity of the data extraction tool in this study was tested for face validity and construct validity. Face validity (which determines whether the measure appears to make logical sense as an indicator of a concept) and content validity (which is a test of whether the measure covers the full range, or all the dimensions of the concept's meaning) have been used as mechanisms to re-confirm whether whatever was supposed to be measured, had been addressed (Gavin, 2008; Kimberlin & Winterstein, 2008). In this study, face validity of the

data extraction tool was performed by seeking the opinions of experts on the subject matter (Kimberlin & Winterstein, 2008). For this purpose, informal reviews of the data extraction tool were conducted by five experts, ranging from nursing lecturers to experienced registered nurses. All the comments, suggestions and ratings by these experts were considered in the reformatting, instruction, explanation and restructuring variables.

Besides face validity, construct validity was also examined. Construct validity is concerned with the legitimacy of a test, instrument or scale in measuring a theoretical concept that it is intended to evaluate (Gavin, 2008). Here, several tests were conducted to examine the construct validity of the tool. Additionally, AMOS version 20 was used to analyse the fitness of the model that was created based on the priori that supports the exploration of the research problem (Gavin, 2008; Field, 2012; Boduszek & Dhingra, 2014).

AMOS, which stands for analysis of a moment structures, is a statistical software specifically used for Structural Equation Modelling, path analysis and confirmatory factor analysis (Gavin, 2008; Field, 2012; Boduszek & Dhingra, 2014). It is an added SPSS module, which is also known as analysis of covariance or causal modelling software. AMOS is a visual programme for structural equation modelling (SEM) (Field, 2012), which quickly performs computations for SEM and displays the results.

Confirmatory factor analysis (CFA) was chosen as the validation test for the tool because the design of the tool is based on the support specification of a model (e.g. diagram, equations) from the review of relevant theory and research literature (Field, 2012). Specifically, a CFA test is used because the quantitative component of the research has a model as a 'piori', which is based on a model supported by theory in previous research. Additionally, several factors and items are loaded on to each factor (Kline, 2013).

Cronbach's Alpha Coefficient was also completed in the pilot study, seeing as it has a theoretical relationship with factor analysis and it assumes all items are equivalent; thus, it can be used with dichotomous or continuous data (Zinbarg et al., 2006). Larson et al. (2004) suggest that Cronbach's Alpha Coefficient is an appropriate statistical test to examine the reliability of the score and Confirmatory Factor Analysis for testing the variables in the extraction tool. Cronbach's Alpha Coefficient was chosen for the reliability test, seeing as it measures internal consistency or the relatedness of items that are assembled as a group (DeVellis, 2016). Cronbach's Alpha Coefficient is extensively used for reliability testing

because it can be calculated after the single administration of a single instrument (Field, 2012). Concurring with the Cronbach's Alpha Coefficient and Confirmatory Factor Analysis (CFA) test results, a few concerns pertaining to the listed items or variables, and the scales were elicited. (The post pilot study results of Cronbach's Alpha and CFA can be seen in Table 3.4, p120). Based on this result, careful reviews and amendments were performed on the data extraction tool.

Reliability refers to the extent to which the instrument can produce the same results in repeated measurements and that the results are consistent over time, which is an accurate representation of the total population under study (Schneider et al., 2013). The reliability of a research tool is measured in terms of its consistency, precision, stability, equivalence and homogeneity. It is the researcher's responsibility to demonstrate to the readers that the data is extracted in a reliable and an unbiased manner (Gilbert et al., 1996).

Therefore, several data extraction strategies have been implemented in this study, and their implementations were enhanced by the application of several aspects which Horowitz et al. (1984) term 'extraction behaviours'. Firstly, no hypothesis is formulated for this study as formulating hypotheses to guide the study could decrease subjectivity in classification in relation to personal theories regarding the aims of the study (Gilbert et al., 1996). Secondly, explicit criteria were used to extract variables, which then resulted in higher inter- (during the pilot study) and intra-observer reliability as they reduce subjectivity in interpretation (Boyd et al., 1979).

The next stage is where the researcher established unambiguous variable definitions and inclusion and exclusion criteria priori (Boyd et al., 1979; Horowitz et al., 1984). These inclusion and exclusion criteria were established based on several considerations, specifically the conditions of the current clinical settings, discussions with the stakeholders and the nurses in charge, besides the nurses who had to handle the reviewed case notes (see Table 3.2 on p106). The structured unambiguous rules regarding the management of missing or conflicting data were also determined (Wu & Ashton, 1997). As explained in the previous section on research instruments, any information missing from the reviewed case notes are classified as not recorded.

Apart from data extraction strategies, RNDA had to be measured and reported to ascertain if the results obtained from the data extraction by one observation were reproduced on

subsequent observations, relating to the same record. An inter-rater reliability test was conducted in this study to examine the uniformed agreement between two raters in estimating the same subject matter or source (Gwet, 2008). Inter-rater reliability is the degree of agreement among people collecting data, when gathering the same data from the same data sources for the same cases using the same instructions (Langdridge & Hagger- Johnson, 2009). Specifically, inter-rater reliability is measured as a percentage of agreement when two or more reviewers collect data from the same chart (Allison et al., 2000).

The aim of an inter-rater reliability test is to measure how objectively the coding or measurement system performs. Dixon & Pearce (2010) claim that an inter-rater reliability test measures the percentage of agreement when several people collect data from the same sources for the same cases. Dixon & Pearce further recommend this test to assure the reliability of clinical 'audit' data. Moreover, Wang et al. (2013) suggest that inter-rater reliability is estimated by calculating the percentage agreement between the two reviewers (the researcher and one reviewer) for each of the instrument questions. Percentage agreement is calculated from the number of ratings, following Mokkink et al. (2010), for each instrument item, whereby agreement, in this case, means that either two or three auditors give the sample the same rating.

However, this definition does not specify how much of that agreement could have occurred by chance. This is the advantage of Cohen's kappa (k) as a measure of inter-observer agreement (Mi et al., 2013). Kappa is a valuable statistical measure because it corrects for agreement that may arise based on chance alone (Mi et al., 2013). The seminal work by Cohen in 1960 suggested that Kappa could be reported as a value from -1 (perfect disagreement) to 1 (perfect agreement). When using the kappa statistic, it is generally recommended that researchers strive to achieve a minimum level of inter- observer agreement of 60% beyond chance agreement, i.e., a kappa value of 0.6 or greater. However, the kappa statistic limits the assessment of reliability to 'agree or disagree' and does not measure partial agreement. For a more complex, multivariate analyses, tests such as the weighted kappa are more suitable (Cohen, 1960). Therefore, Kappa, along with a percent agreement for the inter-rater agreement was also calculated for this study. The inter-rater agreement test was performed at the beginning of this study. (The results can be seen in Appendix 14).

3.5.6 Pilot study

A pilot study was completed from January 6th-10th 2014, at one government-funded hospital in Malaysia. The researcher and a reviewer selected 20 case notes for the pilot study. Each file chosen for the sample was allocated a number to preserve anonymity. The researcher only worked with these numbers and not the file numbers of the patients. A pilot study is defined as a smaller version of a proposed study (Burns & Grove, 2014) and is critical in any study design (Perry, 2001; Van Teijlingen & Hundley, 2002).

The pilot study enabled the researcher to assess the feasibility of the planned investigation, determine the adequacy of the instrumentation, and evaluate any potential methodological pitfalls, such as data collection strategies (Hammond & Wellington, 2013). Moreover, the pilot study provided the researcher with an opportunity to evaluate the reliability of their data extraction tool (Dixon & Pearson, 2010), clarify the data extraction protocols and determine the frequency with which items are missing from the chart (Wu & Ashton, 1997). Furthermore, it also provided information on the institution's chart retrieval rates and the process of pulling charts and evaluating any potential sampling concerns or impact resulting from the inclusion and exclusion criteria (Jansen et al. 2005). The pilot study is staged to test the instrument for any inaccuracies and ambiguity (Polit & Beck, 2011). A pilot test of data collection regarding documentation analysis tests, estimates the time and resources that the researcher requires, and practises data checking for completeness, accuracy, and the displaying and presenting of the data from the clinical group.

The findings from the pilot study were analysed using SPSS version 20 and AMOS 20. The inter-rater reliability, Cronbach's Alpha and Confirmatory Factor Analysis results are summarised in Table 3.4 below. All the input in the forms of comments, suggestions, ideas, proposals, corrections and views were considered to improve, improvise and upgrade the level of reliability of the instrument.

Table 3.4: Results of Inter-rater reliability, Cronbach's Alpha Coefficient and Confirmatory Factor Analysis for this study

Inter- rater reliability		
Tests	Results/Findings	Remarks
Measure of agreement Kappa	0.412	Moderate agreement

co-efficient (<i>K</i> - value)		
<i>p</i> value	0.006	Good
Cronbach’s Alpha Test Results		
Variables/Items/subscales	Results/Findings	Remarks
Accountability	-0.171	Need to check the scoring
Advocacy	0.884	Good
Innovation and visionary	0.856	Good
Ethics and values	0.174	Need to revise items
Autonomy	0.817	Good
Knowledge	0.805	Good
Spirit of inquiry	0.838	Good
Collegiality and collaboration	0.805	Good
OVERALL for all items	0.691 (Acceptable)	
Confirmatory Factor Analysis		
Model fit indices	Results/Findings	Good Fit/Remarks
<i>P</i> value	0.186	Not
CMIN/DF	1.271	Not
GFI	0.791	Yes
AGFI	0.624	Yes
CFI	0.962	Acceptable
PCFI	0.687	Yes
RMSEA	0.116	Not
PCLOSE	0.233	Yes
Loading factors for		
Accountability	0.09	Poor
Advocacy	0.78	Good
Innovation and visionary	0.86	Good
Ethics and values	1.12	Good
Autonomy	0.81	Good
Knowledge	0.53	Acceptable
Spirit of inquiry	0.93	Good
Collegiality and collaboration	0.70	Good

Apart from performing the tests, the researcher also observed several intriguing findings, particularly the visual presentation of the nursing documentation. The researcher ascertained that there were various writing styles, abbreviations, formats and content in the nursing reports based on the sampled case notes. Moreover, it was established that nurses had written different content or information in their documentation, particularly in the nursing shift report (See Appendix 13).

3.5.7 Analysis

The findings from the RNDA were processed and analysed using Statistical Package for Social Sciences (SPSS) version 20. SPSS is one of the principal software packages that have multi functions and the ability to analyse an extensive range of quantitative data (Polit & Beck, 2011). SPSS allows for in-depth data access and preparation, analytical reporting, graphics and modelling based on the data analysed. SPSS translates the data extraction tool into an electronic form that can be used for data input, quality control and the management of the data (e.g. statistical analysis and reporting) (Engel et al., 2008).

The outcome of the analysis from cross-tabulation and significant statistical relationship tests for this study is presented in descriptive format and supported with the relevant literature. Data analysis only involves descriptive and inferential statistics as this study is focused on whether or not the items recorded in the data extraction tool have been performed. This is because the data obtained from the measurement scale is predominantly ordinal (Field, 2012).

Descriptive statistics were utilised to describe the respondents' characteristics and to assess the levels of professionalism. Categorical data are presented as frequency counts and percentages. Descriptive statistics like frequencies, percentages, medians, means, standard deviations, and ranges were used to describe the subjects of this study. Inferential analyses including Analysis of Variance (ANOVA) and Correlation were used to determine the differences in professionalism and its attributes, while Pearson product-moment correlation was used to identify factors correlated with professionalism (Fantahun, Demessie, Gebrekirstos, Zemene & Yetayeh, 2014). A *p*-value of less than 0.05 was defined as statistically significant (Field, 2012). The Mann-Whitney U-test and the Chi-squared test were

also performed when appropriate, to compare data concerning the variables. The level of significance was set at 0.05 (Gavin, 2008; Field, 2012).

3.6 The qualitative strand of this study

The second part of this study is the qualitative research, which explores nurses' perceptions of professionalism in nursing and its relation to nursing documentation in a Malaysian context. Besides reviewing the nursing documentation, it is important to ask for nurses' understanding and experience of their practice, given that the interaction they have with society is as valuable as the development of the practice. A seminal paper by Berger and Luckmann (1967) explains how interactions within a society construct the reality of a society via dissemination of an individual's knowledge and conceptions of what reality is.

Qualitative research is defined as research that is concerned with the quality or qualities of some phenomenon (Polit & Beck, 2011). The strengths of qualitative research are the ways in which it recognises the subjective experience of the participants and how it regularly produces unexpected insights into human nature through an open approach to research, and moreover, enables an inside perspective on different social worlds (Langdridge & Hagger-Johnson, 2009). The qualitative approach is defined as empirical research where the data is not in the form of numbers, involving an interpretive, naturalistic approach concerning its subject matter (Polit & Beck, 2014). It is a method that observes things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.

Qualitative research offers a rich and rigorous descriptive base data of people's experiences, beliefs and attitudes and illuminates the processes of change, both at individual and organisational levels (Schneider et al., 2013). This may involve clarifying the decision-making processes, exploring health or illness behaviour, or identifying how organisations respond to change. Quantitative research infers cause and effect either directly through experimental studies, or indirectly through correlations in cross-sectional studies, whereas qualitative research examines the specific processes that an intervention sets in motion and examines how these lead to a specific outcome (Cohen et al., 2011).

3.6.1 Population and sample

Purposive sampling was used for the qualitative part of this study. According to Polit and Beck (2008), purposive sampling could be appropriately defined as a non-probability sampling method where the researcher selects respondents according to his or her own discernment regarding which respondent will be most informative. Here, nurses who complete the type of documentation reviewed quantitatively were purposefully recruited across five hospitals, covering seven different disciplines.

The interviews were conducted at five government funded hospitals in Malaysia: three of which are in Peninsular Malaysia, while the other two are situated in eastern Malaysia. Respondents in this study are registered nurses from the participating hospitals, with more than a year's working experience in the same clinical setting. This is because these nurses had completed their preceptorship programme and were deemed to have the experience to head the team in their clinical settings (Enrico & Chapman, 2011).

3.6.2 Process of accessing and recruiting respondents

A letter of approval from the National Institute of Health (NIH) of Malaysia was obtained before interviews with the nurses commenced. Subsequently, the directors, head of departments, matrons, sisters, the nurse in charge and the staff nurses of the selected wards were briefed about this study (see Appendix 5). The briefing sessions were conducted with the purpose of identifying and acknowledging not only the prospective respondents but also any ambiguities and questions regarding this study. The importance of this study's outcomes was emphasised, and could contribute to an improvement for the respondents, hospital administrators and the Ministry of Health Malaysia. Additionally, a copy of the information sheet pertaining to this study was distributed to the respondents, besides other medical personnel and affiliated members of the participating hospitals (see Appendix 5).

Respondents for the semi-structured interviews were recruited from a population of nurses on the participating wards. The researcher had approached them individually during their free time, before and after their shift, or during their day off. The nurse in charge had kindly assisted the researcher throughout the data collection by identifying the staff nurses who were available to be interviewed during those periods.

Lists of staff nurses were also retrieved from the hospitals' administration departments and the researcher contacted them personally to schedule interview sessions according to their availability. Respondents were approached individually, at an agreed time before or after their shifts. No interview was conducted during the respondents' short break from their duty or while they were working. This rationale of not interviewing respondents during their break is to allow nurses to have a proper, short and valuable break from their long working hours. Witkoski & Dickson (2010) suggests that nurses who work long hours require breaks to sustain their maximum level of cognitive, psychomotor and affective functions when delivering care to their patients.

3.6.3 Data collection

Forty semi-structured interview sessions were conducted individually with the respondents from the five participating hospitals. The semi-structured interview was chosen because it is a moderate form where a great amount of data can be elicited from the interviewee (Hauxwell, 2012; Zohrabi, 2013). The advantages of the semi-structured interviews selected for this approach are that they allow the researcher to examine an event or context experienced by the respondent managerially and structurally (Hammond & Wellington, 2013). In using semi-structured interviews, the researcher could explore, probe and ask questions that illuminate a certain subject, and the respondent is able to determine the kinds of information produced pertaining to the subject, and the relative importance of each of them (Green & Thorogood, 2014).

Moreover, semi-structured interviews allow the respondents to direct the course of discussion as much as possible (Lofland, 2006). This format allows the respondents to identify and describe concerns or concepts that may not have been anticipated or considered by the researchers. The nature of the interview provides room for interaction between the researcher and the interviewees. As such, the interviewer aims to be responsive to the language and concepts used by the interviewee.

Semi-structured interviews are more commonly used in healthcare-related qualitative research (Saks & Allsop, 2013). In the field of healthcare, interviews are an appropriate tool to be employed if the research is concerned with interpersonal aspects of care or if the available evidence is limited (Locke, Silverman & Spirduso, 2010). Such interviews are characteristically based on a flexible topic guide that provides a loose structure of open-ended questions to

explore experiences and attitudes. This technique has the advantage of great flexibility; thus, enabling the researcher to enter new areas and produce richer data.

Semi-structured interviews elicit people's own views and descriptions and have the benefit of uncovering issues or concerns that have not been anticipated by the researcher (Zohrabi, 2013). Interviews are commonly used when the aim is to obtain information on the perspectives, understandings and meanings constructed by people regarding the events and experiences of their lives. However, this type of interview is said to reduce the researcher's control over the interview situation and take a longer time to conduct and analyse.

While a structured interview has a rigorous set of questions which does not allow one to divert, a semi-structured interview is open, allowing current ideas to be raised during the interview, owing to what the respondents say (Barriball & While, 1994). The questions that make up the interview guide are usually open-ended to encourage the respondents to elaborate their views regarding the topic. To further focus attention on the respondents and their views, the interviewer generally says very little (Langdridge & Hagger-Johnson, 2009).

In this study, each of the interviews took approximately 30 to 45 minutes and were recorded with a digital voice recorder. The respondents were briefed on the purpose of the interview and informed consent was obtained prior to the interview (see Appendix 4). Respondents were approached individually, at a previously agreed time and place of the respondent's choosing. The interviews were conducted alternately with reviews of case notes. For instance, the interviews were conducted in the morning, while the reviews of the case notes were performed in the afternoon. The choice of when to conduct either the interview or reviewing case notes was dependent on the current situation on the participating wards.

It should be noted that qualitative interviewing such as this requires rather different skills from the interviewer compared to those required for more structured interviewing (Green & Thorogood, 2014). The researcher used his social skills to ensure that the respondent was at ease, and to ensure that trust was established and the respondents felt comfortable in discussing their experiences and attitudes (Green & Thorogood, 2014 & Zohrabi, 2013). This is known as good rapport. In qualitative interviews, the aim is frequently to recreate the flow of a non-biased or a non-judgemental conversation, which requires additional skills in listening and asking appropriate questions.

During interviews, the researcher listened attentively, without being judgemental, and used prompts and probes appropriately and sensitively to encourage the respondents to expand on their ideas. All interviews were recorded with a digital voice recorder. Interviews were conducted in English and *Bahasa Melayu* to allow for an excellent rapport to develop between the respondents and the researcher/interviewer. This step allowed the researcher/interviewer to fully analyse the interview based on the respondent's real words. By being an active listener, the interviewer accessed his ability to use neutral, non-judgmental language which encouraged respondents to speak in detail (Edwards & Holland, 2013; Langdridge & Hagger-Johnson, 2009). Simultaneously, the interviewer was both vigilant and attentive to achieve of the goals of the interviews. The data gathering was controlled, as the researcher asked the correct questions to obtain the relevant information, and gave appropriate verbal and non-verbal feedback.

It should be noted that an interpreter was not involved in the interview sessions. Using an interpreter for multilingual or dual lingual interviews could result in a situation known as 'triple subjectivity', whereby the subjectivity of a subject could occur on three distinct levels, in relation to the interactions between interviewee, researcher and interpreter (Temple & Edwards, 2002). Furthermore, the researcher in this study has the advantage of being polylingual, speaking fluently and write intelligibly in English and *Bahasa Melayu*. Consequently, when the use of specific terms and names differ from one language or cultural context to another, the researcher knows these terms or their local equivalent in different languages, and could use them in the precise context. In doing so, the communication problem or even conflictual (interview) situations were avoided (Filep, 2009).

Furthermore, in the context of the translation process, the researcher also used several techniques to ensure a concise and precise translation. Firstly, the researcher employed Birbill's (2000), back translation methods: i) the translation of items from the source language to the target language and iii) the comparison of the two versions of items in the source language, until ambiguities or discrepancies in meaning are clarified or removed.

Secondly, the translation process took into consideration the aspect of consultation: the researcher had several discussions with two Malaysian academics who are bilingual, concerning the use and the meaning of words and phrases identified as problematic, and consequently, made decisions pertaining to the most appropriate tense to use (Birbili, 2000). Finally, the researcher had emailed the transcripts and the translation to the respondents and

asked the respondents not only for their answers, but also for their interpretation of the item's meaning (Birbill, 2000).

The researcher used a verbatim approach during the translation process in this study (Birbill, 2000; Filep, 2009). Birbili (2000), contends that a verbatim translation (i.e. word by word translation) could perhaps be perceived as more justifiable pertaining to what the respondents have shared. This approach assisted the researcher to grasp the actual disposition of the respondents regarding the subject matter in greater detail. However, the drawback with this approach is that such practice could reduce the readability of the text, which, in turn, can test the researchers' patience and even their ability to follow the flow of conversation during the interviews (Birbili, 2000).

Therefore, in this study, quotes from the respondents' literal texts were quoted judiciously to avoid misinterpreting the respondents' thoughts. Conversely, the researcher would be justified in changing the structure of a quote by adding the missing fragments of the sentence (as in the case above), to make it more easily understood by those who are not familiar with the context. (An example of the translation can be seen in Appendix 10).

3.6.4 Interview guide

An interview guide was formulated to guide the interviews in this study (refer to Appendix 3). Waltz, Chute and Ball (2010) define an interview guide as a series of topics or broad interview questions which the researcher is free to explore and probe during interviews. The interview guide consists of several pre-set questions, designed in a pre-determined order. However, this type of interview is not completely reliant on the rigorous application of the interview guide (Langdridge & Hagger-Johnson, 2009). The rationale of utilising the interview guide for this study is that whenever the respondents wandered off the question, then the interviewer or the researcher would generally go with that direction rather than attempt to return immediately to the next question in the interview guide (Zohrabi, 2013). Furthermore, with respect to the established questions, the interviewer uses prompts and probes to clarify concepts, elicit detail, and extend the narrative.

The interview guide for this study contains questions to be asked by the researcher, with a preface and an introductory statement, along with explicit instructions for both the interviewer and the respondent (see appendix 3). Additionally, it follows by way of a closing statement.

Introductory information is directed towards providing the basis for informed consent. The questions in the interview guide are in simple English and in *Bahasa Melayu* (for interviews conducted in *Bahasa Melayu*). The questions are in sequential order concerning the knowledge, attitude and practice based on good nursing documentation and their reflections on the association between nursing documentation and professionalism in nursing. Overall, the interview guides help researchers to focus an interview on the topics at hand without constraining them to a specific format (Flick et al., 2004). This freedom helps an interviewer or a researcher to tailor his/her questions to the interview context/situation and to the people he/she is interviewing.

Locke, Silverman & Spirduso (2010) recommend that researchers revisit the aims of the study during the first stage of designing an interview schedule. The aims of the study were then translated into 'mini research questions' from which possible interview topics and questions can be developed. Next, the researcher decided on the type of interview and questions to be asked (Green & Thorogood, 2004). For this study, the interview guide was designed based on the subject matter (elicit the attributes of professionalism in nursing from the nursing documentation and the previous studies on the matter (RNAO, 2007; Paans et al., 2010; Nottinghamshire Healthcare, 2010; Wang et al. 2011; Bunkenborg, Samuel, Akeson & Poulsen, 2012) (See Appendix 3).

The approach mentioned previously is suggested by Green and Thorogood (2014), who highlight how the findings from earlier works have increasingly been used as a facilitator for further research. However, the concepts drawn from earlier work are frequently tentatively held and are subjected to reformulation or rejection by the researcher, while this study develops, evolves and progresses. Reformulation and rejection are dependent on the degree of flexibility regarding the design, and it is, therefore, crucial that the design is flexible and yet framed around the topic and the aims of the study (Zohrabi, 2013). The questions in the interview schedule sheet are in an open-ended format. This format allows the respondents to express their views freely and spontaneously without bias (Reja, Lozar, Freda, Hlebec & Vehovar, 2003).

After the content has been specified, the actual questions that researchers are going to ask and their potential responses are subsequently drafted (Green & Thorogood, 2004). This involves translating the purposes of the research into questions, which would yield the

required information and enables the researcher to design 'lead-ins' or explanatory statements that would motivate the respondents to provide the required information.

The wording of each question must allow the meaning to be clear to the respondent and sufficiently precise to convey what is expected without biasing the content of the response. In designing the interview guide for this study, several guidelines suggested by Waltz et al. (2010) were adhered to (see Table 3.5 below).

**Table 3.5: Guidelines for designing the interview schedule for this study
(Waltz et al., 2010)**

Items in the interview guide	Actions/strategies that were performed in this study
Wordings	<ol style="list-style-type: none"> 1. The wordings were accurately ensured in order for the words to convey their intended meanings.
Sentences and phrases	<ol style="list-style-type: none"> 1. Sentences and phrases were kept short as some people have difficulty in understanding and remembering complex ideas. Using simple terms that can be understood by the least educated respondents is encouraged. 2. If technical terms are necessary, each term must be clearly defined. The use of a list of possible synonyms might help in defining technical terms.
Questions	<ol style="list-style-type: none"> 1. Each question is limited to only one idea to avoid questions with multiple parts. Additionally, terms that are derogatory, emotionally laden, or that might trigger biased responses are avoided. Furthermore, the researcher did not ask questions in ways that suggest an answer. 2. The researcher avoided using words with multiple or ambiguous meanings and personal or delicate content that the respondent may be reluctant to answer. If such content must be addressed, questions were worded as delicately as

	<p>possible. Moreover, researchers might consider placing them near the end of the interview.</p> <p>3. Questions that may potentially lead the respondents to express sentiments that imply approval of things generally considered good or behaviours that are expected by society are avoided to minimise the effect of social desirability. Hence, filter questions were used to ensure that the respondents were not being asked to provide answers about topics which they are unfamiliar with.</p>
Probes	<p>1. The researcher also uses probes to elicit additional information or clarification. Lead-in information is provided at the beginning of the interview and additional, reorienting information is occasionally included throughout the interview to set the stage for the next questions. This lead-in also helps to provide a context where the respondents are to interpret them. Such information is helpful when the interview shifted from one topic to another.</p> <p>2. In this study, the interviews are predominantly structured interviews, whereby the scripts are provided for the interviewer to read. The scripts are identical for every respondent. However, the interviewer may be permitted to design lead-in or transitional statements that are individualised for each respondent.</p>

Once the questions were designed, an appropriate sequence is then determined. The principal criterion for determining the sequence is that questions or items should be organised in a logical and realistic order so that they make sense to the respondents (Waltz et al., 2010). The sequence begins with questions that are likely to capture the interest of the respondents and, thus, increase their motivation to cooperate. In this study, less interesting questions and those that are more difficult to answer are placed towards the end of the interview.

Furthermore, questions in the interview guide are arranged on a certain topic to ensure that the interviews flow smoothly (Edwards & Holland, 2013). The configuration of questions is grouped in such a way that the open-ended questions are asked first, followed by the close-ended questions, and, similarly, from general questions to more specific ones within the same cluster. These arrangements of the questions help to avoid the earlier questions and suggest responses to questions that follow. Thus, in this way, the researcher managed to minimise bias in the responses.

All questions in the interview guide in this study are open-ended questions. Open-ended questions allow respondents to include more information including feelings, attitudes and their understanding of the issue. Hence, researchers have better access to the respondents' true feelings on an issue (Marks & Yardley, 2004). Additionally, development of an advanced interview guide design for a study of the data collection is preferred. This is in line with Bryman's (2004) view that an increasing number of qualitative researchers appear ready to define a research question and develop an interview guide prior to starting data collection. Thus, the researcher concurs with this view as the phenomenon studied must first be discovered and then described as emergent (Flick, 2004).

3.6.5 Trustworthiness

The term 'trustworthiness' was introduced by Guba & Lincoln (1989) in their seminal paper entitled 'Fourth Generation Evaluation.' In their paper, trustworthiness in qualitative research is presented in three components: credibility, transferability and dependability. Credibility is concerned with how a researcher describes and interprets his or her experience as a researcher. Furthermore, transferability is defined by Guba and Lincoln (1989) as the possibility that recent findings can fit outside that current study. In other words, the term transferability represents the potential that the findings could bring the meaning of one group and be applied to another context. Transferability can occur when the findings from a qualitative study fit into another context outside the study setting and any individual perceives the findings as meaningful and applicable to their own experiences (Sandelowski, 1986). In contrast, dependability may be demonstrated as dependable, as opposed to consistent, and moreover, this process is eligible to be evaluated (Guba & Lincoln, 1989).

In relation to this study, the three components in Guba & Lincoln (1989) were achieved by way of several measures. Measurement experts can regularly recognise ambiguous or unclear

wording or questions that are unlikely to produce the desired response. It is also helpful to enlist the help of individuals who are not familiar with the content of the interview reviews. These individuals are then able to critique the clarity of meaning, the precision of the questions, and the use of readily understandable terms. Here, the researcher took advice from measurement experts and experts in the content area regarding the questions in the interview guide. This process involved the scheduling of several discussions with his research supervisors, besides meetings with nursing scholars and nursing clinicians in Malaysia.

After several amendments to the interview guide, a pilot interview was conducted. This approach aims to evaluate the feasibility of the interview guide. In this study, the researcher conducted a pilot test to ascertain the effectiveness of the questions and interview process with individuals whose characteristics and experiences are similar to those for whom the interviews are designed (Waltz et al., 2010). The pilot interview provides the opportunity to detect problems with the wording of the instructions or questions, as well as determine the time involved and assesses the reliability and validity of the instrument (Hennink, Hutter & Ajay, 2011; Edwards & Holland, 2013; Zohrabi, 2013). Additionally, an opportunity was provided to 'debrief' the pilot test subjects to elicit their opinions, critiques and experiences of the interviews. The pilot interview also helps to ensure the suitability and feasibility of the designed interview guide concerning how the respondents interpret the questions (Hennink et al., 2011).

The pilot interview was conducted on 10th January 2014 with a respondent, from an appropriate nursing background. The session was recorded and transcribed (see transcript in Appendix 10). Several considerations as recommended by Hennink et al. (2011) were deliberated during the pilot test to ascertain whether the respondent understood the questions easily, with the aim of establishing whether the concepts, sentences and words are adapted to the context of the respondents. This facilitates any rephrasing and reordering of the questions so that they are logical for the respondents to follow. Finally, it helped to ensure the questions generated data that would inform the study aim and to determine whether the interview guide is too long or too short. After the pilot interview, the interview guide was revised before the actual interviews were conducted.

As mentioned previously, interviews were recorded. Several key issues were identified and rectified through the researcher's use of the voice digital record, resulting in an improvement in his moderating technique and a general enhancement of the interview guide. Further

discussions with supervisors (who are nurses with appropriate clinical experience) regarding the outcome of the pilot interview helped to improve the interview guide and the process of moderating the interview before the actual data collection commenced.

3.6.6 Risks to the respondents

At no time either during the interviews or resulting from the nature and demands of the research, were any of the respondents subjected to any stressful episodes which could cause them psychological distress. However, should any of these scenarios have emerged during this study, several measures had been structured into the sessions to curb any possibility of emotional and/or psychological issues among the respondents. Firstly, the interview process would be stopped and the respondents would be advised to seek advice and assistance from the Department of Psychological Medicine, if required. Moreover, this service is available at all participating hospitals. The respondents are fully aware of the staff counselling facility available at the Department of Psychological Medicine at their respective hospitals and were reminded of this at the end of each interview.

Secondly, appropriate alternatives were suggested if the possibility of psychological issues emerged. Any psychological issues that might be experienced by the respondents in a study could have a negative influence on the information that the researcher wishes to obtain. This is because the respondents who experience mental distress would not be able to cooperate in the interview (Flick, 2004; LaForest, 2009). Therefore, the researcher could offer several options for the respondents, such as giving time for the respondents to compose themselves before and during the interview, and/or offering the respondents the option of ending the session according to their feelings. Thirdly, the respondents were informed and/or reminded that they were free to withdraw from this study at any point and at any time. This information was also highlighted in the information sheet, which is attached to the consent form (see Appendix 5 & Appendix 4).

Finally, the researcher ensured that the settings for the interview sessions were comfortable, calm and quiet. The space was also equipped with chairs and tables and free of any distractions, for instance phones and visual displays (a television or computer), whilst noise was continuously minimised. A well-set up venue for interviews encourages the respondents to feel comfortable and experience less intrusion when giving their responses (Laforest, 2009). Moreover, the interviews were not conducted on the ward or when the respondents

were performing a task or procedures. This was to avoid any unforeseen circumstances that could occur which could interfere or delay the respondents' task in giving care to their patients.

3.6.7 Data Analysis

Information from the interviews was later transcribed and categorised into appropriate themes which were relevant to this study. This step was undertaken using a thematic content analysis approach, which according to Anderson (2009), is the most foundational of qualitative, analytical procedures and, in some ways, informs all qualitative methods. The collected information was sieved, sorted, grouped and assembled according to the question numbers that acted as the coding system. This process enabled the researcher to solicit the emerging issues, or points, and to establish certain patterns in all the answers.

In general, thematic analysis is similar to content analysis, but pays greater attention to the qualitative aspects of the material analysed (Marks & Yardley, 2004). Thematic content analysis is also a tool to identify and describe the embedded and obvious ideas in the data that creates identifiable themes (Langdridge & Hagger-Johnson, 2009; Braun & Clarke, 2006). Thematic analysis is the accepted method of investigating texts, particularly in mass communications research (Marks & Yardley, 2004). Most thematic analysis results are in a numerical description of the features of a given text, or a series of images.

Thematic analysis has several distinctive features that make it a useful measurement technique for nursing research, education and practice (Waltz et al., 2010). First and foremost, thematic analysis can be applied to recorded information, that is, information written or recorded for another purpose, or materials produced, and can be used for a particular investigation. Examples of materials that can be thematically analysed include books, plays, newspaper articles, editorials, films, web pages, letters, notes, diaries or other personal documents, speeches, documents, such as laws or minutes of meetings, or tape-recorded responses to questions, and audio or video recordings of communication.

Secondly, the emphasis is on the content of the written and verbal communication rather than its process or para-lingual features (e.g. pitch, volume, rate, accompanying gestures) (Waltz et al., 2010). This is not to negate the significance of para-lingual elements but to suggest that the procedures of thematic analysis are best suited to a focused content. Thirdly, the

procedure of thematic analysis, specifically quantitative thematic analysis, is designed to maximise objectivity by incorporating explicit rules and systematic procedures (Waltz et al., 2010). It is systematic and standardised, in that specified criteria are consistently applied in selecting and processing the content to be analysed. Therefore, it is arbitrary. Finally, thematic analysis involves deliberate simplification or reduction that may potentially result in the loss of some of the individuality and richness of meaning in the original material in the interest of discerning regularities, patterns and themes (Waltz et al., 2010). Generally, thematic analysis is unobtrusive and can provide insight into complex interactions (Waltz et al., 2010).

Thematic analysis involves a multistep procedure that is guided in every aspect by the purpose of the investigation, i.e., the questions to be answered and the hypotheses to be tested (Anderson, 2007). In the initial step, the universe of content to be examined is defined. The universe of content refers to the totality of recorded information about which characteristics are described or inferences drawn. In the second step, the identified characteristics or concepts are subsequently measured. The identification of characteristics or concepts are conceptual decisions, and, therefore, they varied extensively from one investigation to another and from one field of the study to another (Braun & Clarke, 2006). This step in the analysis consisted essentially of answering or learning about the content of the recorded information.

In the third step, the researcher selected the unit of analysis to be employed. Once the universe of content is available and the variables to be measured had been identified, the researcher had to decide on which elements or sub-units of the content to analyse or categorised in one common theme. In the fourth step, a sampling plan was developed. Once the unit of analysis was identified, it was necessary to determine how the universe of content would be sampled. Thus, in the fifth step, a scheme for categorising the content and explicit coding was developed.

Themes were derived from the theory that guides the investigation before the data was analysed. The coding scheme includes explicit definitions which potentially demonstrate the association between professionalism in nursing and nursing documentation, the coding rules and examples of each coding category. A well-constructed code is one that captures the qualitative richness of the phenomenon (Boyatzis, 1998). Through the encoding of the information, data is organised to identify and develop themes from them. Boyatzis defines

this as an orderly scheme in information which describes and organises the possible observations and interprets certain perspectives of a phenomenon. The scheme may be predetermined but must frequently be modified halfway through the data analysis to accommodate unanticipated nuances in the data (Fereday & Muir-Cochrane, 2006).

The categories and coding instructions were pretested in step six. If the categorical scheme was predetermined, it was pretested by applying it to small portions of the content to be analysed. The researcher had appointed two coders to analyse the same material so that inter-rater reliability could be assessed and discrepancies clarified (Braun & Clarke, 2006).

Owing to the pretesting, categories or instructions may had to be redefined, added or deleted, and the entire scheme pretested again prior to use. Finally, the analysis was performed whereby data was coded according to the prescribed procedures or subjected to computer-assisted analysis. Each element of the content universe was coded using the same procedure. If multiple content characteristics were examined, the same content was processed several times to extract all of the information required (see Appendix 11).

The translations and interpretations that were undertaken after the analysis were checked by two bilingual Malaysian nursing academics. It should be noted that these two nursing academics are not involved in this study. In addition, two English postgraduate researchers from universities in the UK examined the transcripts with the analysis of the findings to confirm that data in this study is thorough and transparent to others. They were all unaware of the respondents' names, given that only code numbers were revealed. Any identifiable details, such as the name of the wards, hospitals, area or region were removed from the translations, transcripts and interpretations.

Additionally, the researcher sent the transcripts to the respondents to encourage them to read, amend and verify the accuracy of the interview dialogues. This process enables the respondents to confirm that they had said what they meant and allowed them the option to expand and explain their answer (Kvale, 1996). This step ensures rigour by establishing the reliability and validity of the interview data (Polit & Beck, 2011). Eventually, the transcripts were emailed to the respective respondents before and after the translations to affirm their agreement concerning the content (See Appendix 17). This is also a means of informing the researcher of any additions, corrections, explanations or amendments, which the respondents

thought the interview might require. All the respondents agreed and verified their interview transcripts and translations without any amendments or re-editing.

In the context of analysis, NVivo version 10 software was employed to create a systematic analysis of the transcripts. NVivo is a software used to identify consistency or inconsistency in the data analysis (Bazeley & Jackson, 2013). This software is capable of managing large amounts of and different types of data. Basically, NVivo is intended to help users to organise and analyse non-numerical or unstructured data. This software allows users to classify, sort and arrange information; examine relationships in the data; and combine analysis with linking, shaping, searching and modelling (Bazeley & Jackson, 2013). Furthermore, the researcher or analyst can test theories, identify trends and cross-examine information in a multitude of ways using its search engine and query functions. Researchers can make observations using the software and build a body of evidence to support their case or project.

In NVivo, codes are derived from common words or short phrases that are shared by the respondents in this study. These codes or phrases represent the selected data (Bazeley & Jackson, 2013). The codes are then stored in NVivo in the form of 'nodes' (Bazeley & Jackson, 2013). Nodes, according to Bazeley & Jackson (2013), are containers for the themes in order to organise ideas to answer the research questions (Bazeley & Jackson, 2013). These codes are later analysed based on the common ground that can be narrowed into the newly organised themes. At this stage, these themes are again organised into groups on the basis of the content to represent the similarity of themes within a group and differences between groups (Attride-Stirling, 2001; Braun & Clarke, 2006). The analysis also includes the examination of revealing overlapped codes and nodes.

3.7 Integration of the quantitative and qualitative findings

Integration of the quantitative and qualitative findings was undertaken and, subsequently, drawn together in Chapter 6. This is parallel to Creswell's (2013) description that a triangulation – convergence model design is demonstrated through the process of combining both quantitative and qualitative data. It was argued that both types of data are connected and/combined in the intermediate stage. The amalgamation of these quantitative and qualitative findings provides a comprehensive and particular holistic data which enables discussions on the multiple statistical analyses of the data. These data were elicited from reviews of the nursing documentation.

The quantitative and qualitative data was combined by means of three processes proposed by Green (2007). The three processes are: 1) using the qualitative work to identify issues or obtain information on variables not obtained by quantitative surveys, 2) using qualitative data to understand unanticipated results from quantitative data, and 3) verifying results from quantitative data using qualitative data. Weaver and Olson (2006) state that the combination of positivist and interpretive paradigms can be demonstrated when these paradigms complement each other in the data accumulation and output purposes.

Consequently, the merging of this data created new insights and a general understanding, on the part of the researcher, regarding the complexity of knowledge, attitude and behaviour among nurses toward professionalism and, more importantly, their association with the nursing documentation. Moreover, the data offered a further level of understanding concerning the uniqueness and aesthetic values that are embedded in nurses, specifically from a Malaysia context. Morris and Burkett (2011), for example, determine that most researchers used a combination of data analysis methods from quantitative and qualitative paradigms. They also discovered that the most common blends were a type of thematic analysis with or without qualitative software (e.g. NVivo) and statistical analysis of numerical data.

This level of understanding, which derives from connecting, combining and emerging both quantitative and qualitative data, could be driven by the concepts of 'Abductive Reasoning'. Abductive reasoning is a form of reasoning which deals with the scarcities of these paradigms, where new ideas emerge by considering various clues and restrictions, and by searching and combining existing ideas in novel ways (Raholm, 2010). Abductive reasoning is not aimed at the construction of any order but at the discovery of an order which fits a surprising fact, or simply solves the practical problems that arise from both quantitative and qualitative data, within a mixed method research design (Reichertz, 2010). Abductive reasoning was greatly discussed by Pierce (1931 -1958), who constructed the definition of 'abduction' as the first stage of inquiry within which hypotheses are invented, and subsequently explicated through deduction and verified via induction.

Deductive reasoning alone focuses on the cognitive mental processing from general to specific, which adequately maximises one's capability and intelligence to relate all existing and acquired knowledge (Shook, 2016). In contrast, inductive reasoning is concerned with

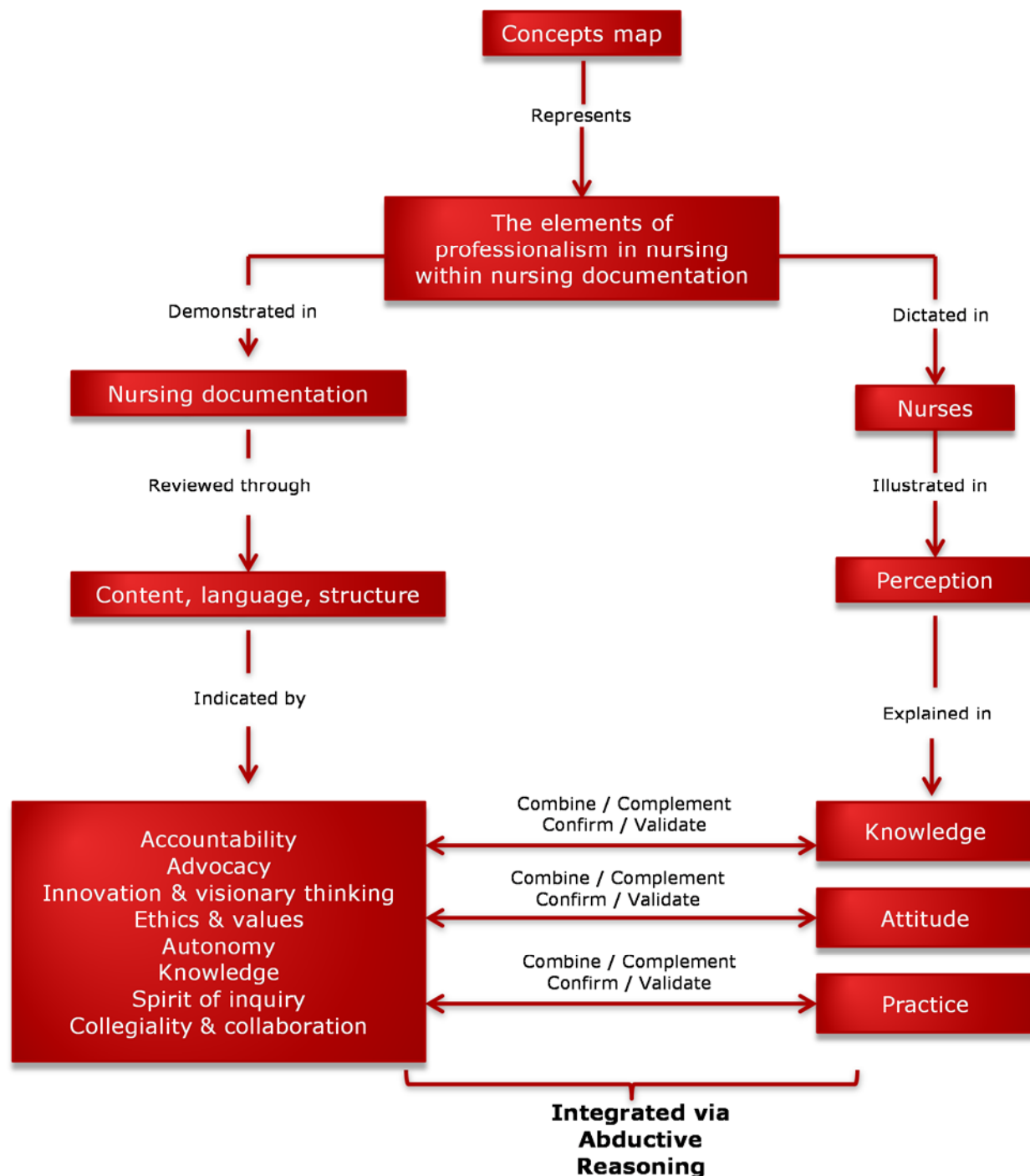
magnifying the extension of a subject and, therefore, expanding the generality of the conclusion exceeding the threshold of reasoning when considering specific information (Walton, 2005). Thus, this type of reasoning generates a broader generalisation that probably can suggest that the conclusion might not be accurate.

Therefore, Morgan (2007) suggests that regulating 'back and forth' along the line between induction and deduction reasoning could perform abductive reasoning. In this way, understanding based on the shared meaning can benefit from the different approaches to research. Specifically, abductive reasoning could generate an explanation from one finding to another (vice versa) regarding the research matter. Abductive reasoning allows for tentative explanations to emerge through the research process based on the expertise, experience and intuition of the researcher (Schurz, 2002). Through this iterative approach, these tentative explanations can be tested both theoretically and empirically.

In abductive reasoning, the research matter presents a plausible but not necessarily logical conclusion when an anticipated condition is categorised as correct (Danermark, 2001). Evidence is seen as abiding to a rule, which gives new insight related to the phenomenon. The abductive reasoning approach focuses on the particularities of a specific situation, which differ from the general or usual structure of similar situations rather than concentrating only on generalisations and/or their specific indications (Danermark, 2001).

As for this study, the quantitative and the qualitative data were interpreted within a contextual framework. In other words, this study aims to understand a phenomenon in a new way, from the perspective of a new conceptual framework (Dubois & Gadde, 2002). The constructed themes, which were inducted from the qualitative data, were then subtracted (from general to particular) and the quantitative data, which were deducted from the contextual framework of this study, were aligned. Thus, introducing the notions of predesigned path to a new framework (see Diagram 3.3 on the next page). Consequently, this approach led the researcher in revealing new insights about the existing phenomena by examining these notions from a new perspective. Specifically, abductive reasoning has provided the researcher with a new set of understandings with respect to a new phenomenon.

Diagram 3.3: Concept map for exploring the elements of professionalism from the nursing documentation



Wheeldon (2010) argues that the integration of quantitative and qualitative approaches and findings through abduction reasoning could be appropriately explained in a concept map.

Creswell and Clark (2011) recommend the use of a variety of diagrams, figures and maps to visually present mixed methods approaches, strategies and procedures. They emphasise that concept maps provide a more structured approach to explore the connections between and among concepts. This is undertaken by linking word and mind maps that can be categorised as more flexible tools in which central governing concepts are explored using groupings or areas. The concept map explains the associations between the quantitative approach on reviewing the elements of professionalism among nurses from their documentation and the qualitative approach, which aims to explore their knowledge, perceptions, attitudes and practice among nurses in relation to their documentation (see Diagram 3.3 on the previous page).

Abductive reasoning was used to explore the actual phenomenon and that the researcher had gained a new insight from both quantitative and qualitative findings in this study. Abductive reasoning leads the direction of the analytical exploration of a phenomenon when the quantitative (Deductive) and qualitative data (Inductive) complement each other within this study (Bryman & Bell, 2015). Even though abductive reasoning is not obligatory and is a uncertain type of reasoning (Lipscomb, 2012), abductive reasoning remains the preferred choice of many scholars. The reason is that abductive reasoning assists them to create a new type of a relationship with a common association that could generate creative insights and new ideas (Shook, 2016).

The process was strengthened by several innovative methods, as suggested by Walton (2005) and Shook (2016). These two scholars argue that these methods could produce new insights and ideas to affirm or confirm any potential fallacy which lies in the findings of this study. First, the association between the quantitative and qualitative findings that injected several similarities and differences between them were explored. Second, the causative aspects, which were obtained from the qualitative findings, were highlighted to explain the quantitative findings and vice versa. Finally, any other emerging qualitative findings that were discovered were highlighted to explain the occurrences in the quantitative and qualitative findings.

In general, it was evident that there was congruency across the findings, besides the findings from each data set. The RNDA supported the overall themes of the sub-themes (from the interviews), which were drawn according to the model of professionalism advocated by the RNAO (2007). The awareness of these similarities and differences in the findings of this study

had enabled the researcher to combine together ideas that subsequently, gave new insights in discovering new ideas.

3.8 Conclusion

This chapter explained and discussed the research methodology adopted by this study. In general, mixed methods design was chosen, seeing as a mixed methods approach could make a significant contribution to existing knowledge and understanding (Gelling, 2014). It is important, however, that the researcher adopts this approach for the correct reasons and considers the additional challenges faced by other mixed methods researchers. Notwithstanding its advantages, undertaking a mixed methods study could be challenging in terms of researcher's abilities and resources, which could be compounded by the shifting definitions in relation to design, analysis and the integration of the data (Larkin, Begley & Devane, 2014).

Combining both the quantitative and qualitative data could intensify the process of exploring the research matter by ensuring that the limitations of one type of data are balanced by the strengths of another (Bryman & Bell, 2015). This combination has ensured that understanding is improved by integrating different ways of knowing. Despite the fact that a mixed methods study is challenged to implement, from planning the study's sample, data collection and, more crucially, when connecting, combining and merging the quantitative and the qualitative data, the researcher managed to obtain rich and comprehensive data to understand in relation to the research matter. From a different perspective, the mixed methods design provided an opportunity to provide the respondents with justice by ensuring that the findings were grounded in the respondents' experience.

The data analysis and interpretation and discussion related to the findings will be discussed in Chapters Four, Five and Six.

CHAPTER 4: QUANTITATIVE RESULTS

4.1 Introduction

This chapter discusses the quantitative findings related to this study, based on data collected using the Retrospective Nursing Documentation Analysis (RNDA) tool (refer to Appendix 1). The quantitative results are presented in numerical forms. Numerical representation, according to Plowright (2011) is concerned with counting and measuring, and the use of a logical code of mathematics, such as frequencies and numbers of reviewed case notes, which purposely identify the evidence of professionalism in nursing among nurses in Malaysia in their nursing documentation.

This chapter will initially present the population and component response rates and/or frequencies of reviewed case notes demographic descriptors. Subsequently, the findings related to the total score for each professionalism attribute is presented. This is followed by discussions concerning correlations of the test results. A comparison of the results across the types of population in this study will be discussed. Finally, the analysis model fit for the Retrospective Nursing Documentation Analysis (RNDA) tool is explained and presented.

The overall scores of the existence of the elements of professionalism in the reviewed case notes are reported based on the frequencies of occurrence, percentage and median scores. The median score is appropriate for analysing ordinal data, as the data is not skewed (Munro, 2005). Ordinal data is categorical data where the data occur in order and on a scale (ranking) (Field, 2012). As discussed in Chapter 3, the Retrospective Nursing Documentation Analysis (RNDA) tool has 80 statements, measured on a 0 to 4 point Likert- Scale corresponding to 0 (None), 1 (Few), 2 (Some), 3 (Most) and 4 (All). Each statement represents a component that could be ascertained in the documentation. The scoring is based on the frequency that these components are detected in the documentation. A median is the middle value of a set of ordered numbers, which is the point or value, which falls below 50% of the distribution (Field, 2012). Consequently, 50% of the sample will be below the median regardless of the shape of the distribution.

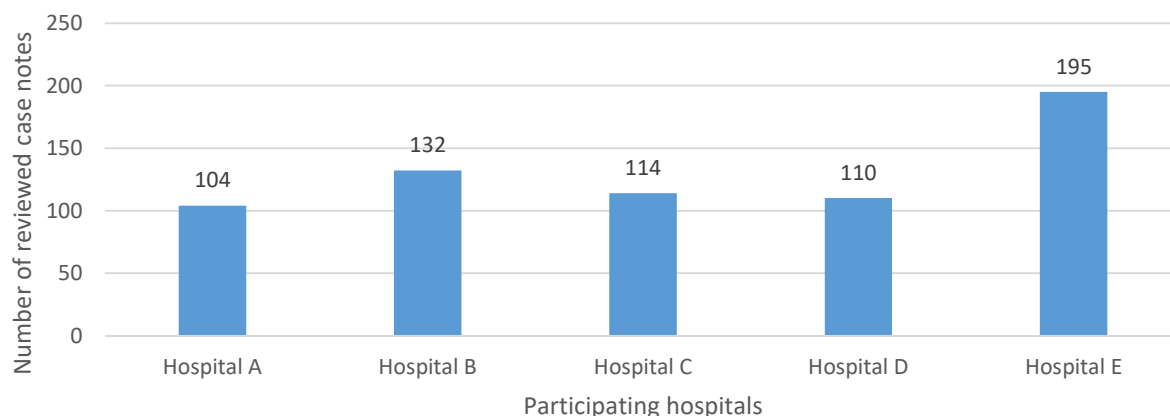
The mean is also presented together with the median to represent the frequencies although median is a simple statistical model of the centre of a distribution of scores. This is because the Shapiro-Wilk test, histogram and Q-Q plot result (see Appendix 15) suggest that data in

this study are not normally distributed (Ghasemi & Zahediasi, 2012). However, when the data is in the form of ordinal data, the median is generally preferred (Gavin, 2008, Field, 2012). Therefore, it is appropriate to present the median and mean to represent the frequencies of the quantitative findings of this study. For example, Boslaugh (2012) states that presenting both the median and mean could help the researcher or the reader to understand the statistical properties of the data in general. This preconceived idea of making sense of the data would guide the researcher to decide on the type of tests that could be applied to the obtained data.

4.2 Sample size and reviewed case notes details

A total of 655 case notes, from five different government hospitals in Malaysia, were reviewed by the researcher from October 2014 to February 2015. Three of the hospitals are located on Peninsular Malaysia and two hospitals in East Malaysia. Overall, four of these participating hospitals are multidisciplinary hospitals, while one is a specialised hospital. The latter is a mental health institution. Several types of nursing documentation were reviewed including the patient admission form, observation charts, nursing care plans and nursing shift reports (Ling et al., 2011). All these documents were essentially available or, in some cases, were present in the patient case notes on the participating wards. Figure 4.1 below contains descriptions on the participating hospitals in this study.

Figure 4.1: Total number of reviewed case notes for all participating hospitals.



Regarding these documentations, 541 were primarily written in English and 114 in *Bahasa Melayu*. The writing system for *Bahasa Melayu* is based on the Latin Script (Adelaar, 1999). *Bahasa Melayu* is predominantly used in documentation at the specialised hospital (Hospital C). Information regarding the reviewed case notes' details is presented in Table 4.1 below.

Table 4.1: Details of reviewed case notes in this study (N=655)

Characteristics	n	%
Length of stay		
25-48 hours since admission	12	1.8
49-72 hours since admission	156	23.8
73-96 hours since admission	101	15.4
Prior to discharge	25	3.8
Other cases (more than 96 hours since admission)	361	55.1
Type of ward		
Medical	234	35.7
Surgical	124	18.9
Orthopaedics	95	14.5
Maternity	32	4.9
Psychiatry	113	17.3
Paediatrics	35	5.3
Others	22	3.4

From the above Table 4.1, most of the reviewed case notes were from the other case notes category, i.e. with more than 96 hours since admission. There is a total of 361 out of 655 case notes in this category, which is equivalent to 66.1%. By contrast, only 12 case notes within 25-48 hours since admission were reviewed. Table 4.1 also reveals that most of the reviewed case notes (234 out of 655; 35.7%) were from the medical wards.

Generally, many of the reviewed case notes scored between 193-256 points with 468 out of 655 case notes reviewed. This score point range is interpreted as a good indicator of the existence of professionalism in nursing, in these case notes (refer to Appendix 2 for the scores). A total of 119 out of 655 reviewed case notes were an excellent indicator of the existence of professionalism in nursing documentation (scored between 257-320 points).

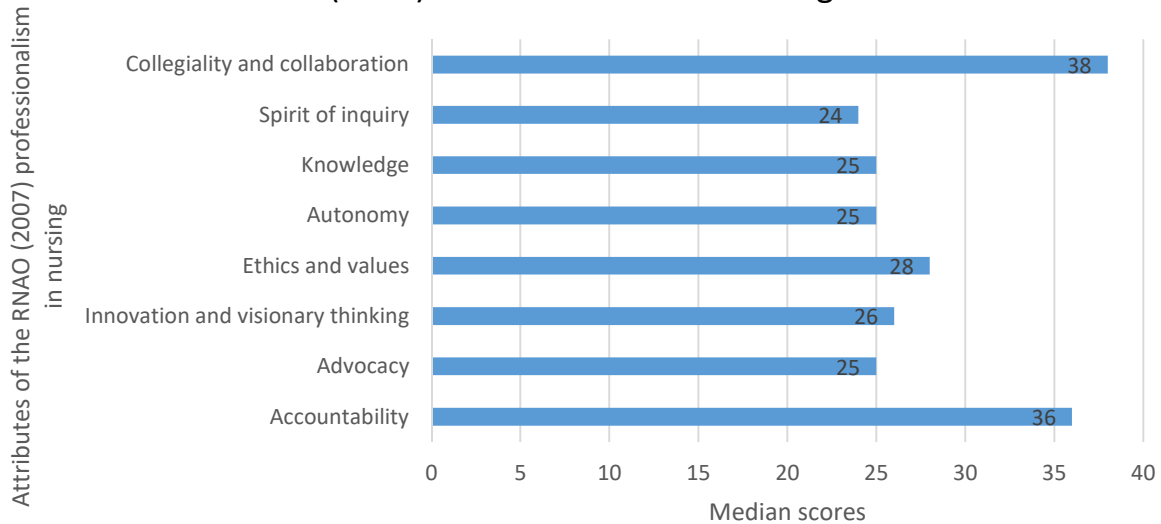
The results demonstrate that most of the reviewed case notes scored between 32-40 points, with 617 out of 655 reviewed case notes for the attribute of collegiality and collaboration (see Table 4.2 below). This range of score is interpreted as an excellent indicator of the existence of professionalism in nursing based on these case notes (refer to Appendix 2 for the scores).

Table 4.2: Frequencies, median scores and mean related to all attributes of the RNAO (2007) professionalism in nursing

Attributes	≤ 8	9-17	18-22	23-31	32-40	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Accountability	1 (0.2%)	0	1 (0.2%)	48 (7.3 %)	605 (92.4%)	36	36.1	2.9	36.3	35.9
Advocacy	0	52 (7.9%)	142 (21.7%)	319 (48.7%)	142 (21.7%)	25	26.1	5.9	26.5	25.6
Innovation and visionary	0	19 (2.9%)	150 (22.9%)	375 (57.3%)	111 (17%)	26	26.1	5.1	26.5	25.7
Ethics and values	2 (0.3%)	45 (6.8%)	89 (13.6%)	371 (56.6%)	148 (22.6%)	28	27.1	5.8	27.6	26.7
Autonomy	1 (0.2%)	26 (4.0%)	144 (22%)	402 (61.4%)	82 (12.5%)	25	25.6	4.9	26.0	25.2
Knowledge	0	22 (3.4%)	187 (28.6%)	406 (62%)	40 (6.1%)	25	24.8	4.4	25.1	24.4
Spirit of inquiry	0	26 (4.0%)	185 (28.2%)	369 (56.3%)	75 (11.5%)	24	25.5	5.0	25.9	25.1
Collegiality and collaboration	0	0	0	38 (5.8%)	617 (94.2%)	38	37.2	3.1	37.5	37.0

Figure 4.2 on the following page contains the median scores for each of the RNAO (2007) attributes of professionalism in nursing. Figure 4.2 indicates that the highest occurrence that is interpreted as an excellent indicator in terms of the existence of the attribute of collegiality and collaboration, with a median score of 38, is the attribute of accountability, with a median score of 36.

Figure 4.2: Median scores for each attribute of the RNAO (2007) Professionalism in Nursing



However, there was only one reviewed case note that was interpreted as having a poor indicator regarding the existence of the attribute of accountability and autonomy (score points ≤ 8). Additionally, two reviewed case notes were interpreted as poor indicators regarding the existence of the attribute of ethics and values (score points ≤ 8). Regarding the attribute of knowledge, only 40 out of 655 reviewed case notes were interpreted as an excellent indicator of the existence of this attribute (score points = 32-40).

The analysis indicates that the median scores across the attributes reveal some interesting findings. The results indicate that the attribute of spirit of inquiry has the lowest median score of 24 (see Figure 4.2 above). Conversely, the attribute of collegiality and collaboration has the highest median score of 38. These results suggest that all the reviewed case notes contain the highest level of existence with regards to the attribute of collegiality and collaboration and the least level of existence concerning the spirit of inquiry attribute.

It should be noted that a Chi-square test was performed to examine the relationship between the scores of each attribute and the overall score of professionalism in nursing. The Chi square test is a test employed with a set of categorical data to determine whether there is an association between two variables (Field, 2012). The result of this test reveals that there is an association between each attribute and professionalism in nursing (with $p \leq 0.01$) concerning the existence in nursing documentation.

4.3 Correlations between scores for each attribute and the overall scores

Further analysis was undertaken employing Spearman's Rho test to determine the correlation between the components, the total score for each attribute and the overall score for all the attributes. Spearman's correlation coefficient is defined as:

"... a standardised measure of the strength of relationship between two variables that does not rely on the assumptions of a parametric test"
(Field, 2012, p.271).

This test is a non-parametric statistic based on the rank or ordinal data. Table 4.3 below displays the correlation between the total score for each attribute and their overall scores.

Table 4.3: Correlation between the total score related to each attribute and overall score for professionalism in nursing.

Cross Tab Items with overall scores	Spearman's Rho Correlations
Accountability	0.22
Advocacy	0.62
Innovation and visionary	0.68
Ethics and values	0.60
Autonomy	0.63
Knowledge	0.59
Spirit of inquiry	0.61
Collegiality and collaboration	0.22

Based on Table 4.3 above, the Spearman's Rho test results reveal that there is a positive correlation between the total score for each attribute and the overall score for professionalism in nursing. However, the correlation between total score for accountability, and collegiality and collaboration, with the overall score for professionalism, is weak ($r \leq 0.3$). The results of Spearman's Rho test between the total rating score for each attribute and each component in all the attributes were also performed. The results of these tests will be presented later, when describing each attribute in greater detail.

Additionally, a Kruskal-Wallis test was conducted to evaluate the differences between the length of stay, participating hospitals, besides the type of wards, with the overall score for professionalism from the reviewed case notes. The Kruskal-Wallis test is used to determine the differences between groups of scores when those scores derive from different entities in multiple independent groups, which are from different populations (Field, 2012).

The Kruskal-Wallis test is a non-parametric test (i.e. distribution free) where there is no assumption that there is a normal distribution concerning the sample. Before further quantitative analysis, a normality test was conducted to determine whether the distribution of each group is normal. The result indicated that the data was not normally distributed with a Shapiro-Wilk value of $p \leq 0.005$.

Results from the Kruskal-Wallis test suggest that there is a statistically significant difference between the overall score for professionalism ($p \leq 0.01$) with a mean rank of five types of length of stay (significance level is 0.05). There is a statistically significant difference between the overall score regarding professionalism with the type of hospital ($p \leq 0.01$) with a rank related to 5 different hospitals and type of ward $p \leq 0.01$, with a mean rank for 7 types of wards. These results suggest the overall score for professionalism in nursing within the reviewed case notes is influenced by certain factors: types of wards and length of stay.

4.4 Accountability

It is apparent from Table 4.4 on the next page, that 605 out of 655 reviewed case notes in this study score between 32-40 points. These point scores are interpreted as an excellent indicator of the existence of the attribute of accountability. The median scores for all components were high, with all being either most (median score = 3) or all (median score = 4), as shown in Table 4.4. Notable in the component of 'the continuous care/treatment that occurs from one shift to another' appears in all sections in one case note, with a total of 624 out of 655 (equivalent to 95.3%) of the reviewed notes. Additionally, 'care has been performed and recorded by the assigned nurse', was present in all reports, with 625 out of 655 (95.4%) of the reviewed case notes.

Table 4.4: Frequencies, median scores and mean related to the attribute of accountability

Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Entries are legible, etc	0	0	4 (0.6%)	394 (60.2%)	257 (39.2%)	3	3.4	0.5	3.4	3.4
All records kept in a proper folder	0	0	3 (0.5%)	127 (19.4%)	525 (80.2%)	4	3.8	0.4	3.8	3.8
All records are sorted and arranged	0	0	5 (0.8%)	117 (17.9%)	533 (81.4%)	4	3.8	0.4	3.8	3.8
All entries are recorded at least daily	0	0	3 (0.5%)	86 (13.1%)	566 (86.4%)	4	3.9	0.4	3.6	3.5
All admission documents should be completed within 48 hours	0	0	97 (14.8%)	110 (16.8%)	448 (68.4%)	4	3.5	0.7	3.6	3.5
No duplication of data values	0	0	1 (0.2%)	211 (32.2%)	443 (67.6)	4	3.7	0.5	3.7	3.6
Continuous care/ treatment	0	0	1 (0.2%)	30 (4.6%)	624 (95.3%)	4	4.0	0.2	4.0	3.9
Care has been performed and recorded	0	0	1 (0.2%)	29 (4.4%)	625 (95.4%)	4	4.0	0.2	4.0	3.9
Care/treatment has been amended or rewritten	1 (0.2%)	0	4 (0.6%)	26 (4.0%)	624 (95.3%)	4	3.9	0.3	4.0	3.9
Corrections or errors corrected	225 (34.4%)	38 (5.8%)	35 (5.3%)	119 (18.2%)	238 (36.3%)	3	2.2	1.8	2.3	2.0

It is interesting to note from Table 4.4 above that 225 out of 655 (34.4%) of the reviewed case notes do not contain the 'corrections corrected by crossing through with a single line, signed, timed and dated' in any section of a case note. Overall, the median scores for all the components in the attribute of accountability are acceptable. This score suggests that all the reviewed case notes contain either most of the components of the attribute of accountability, with median scores of 3 and 4 (see Table 4.4 above).

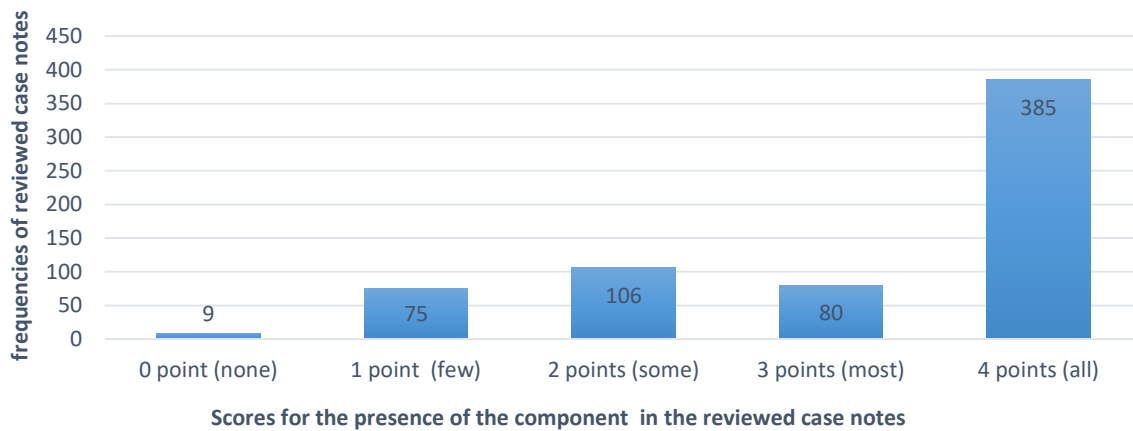
A Chi square test was performed to examine whether there is any association between each of the components and the existence of the attribute of accountability. The result reveals that there is an association between each component and the attribute of accountability (with $p \leq 0.01$). Meanwhile, Spearman's Rho test was also performed to determine the correlation between the components and the total score for the attribute of accountability. The results denote that all the components in this attribute are lower than $r = 0.4$. These results indicate that all the components in this attribute are relatively weakly correlated with the total score for the attribute of accountability. Moreover, the component of 'corrections corrected by crossing through with a single line, signed, timed and dated' has a very weak correlation with the total score (with $r = 0.10$).

4.5 Advocacy

Table 4.2, p147 proves that most of the reviewed case notes scored between 23-31 points for the attribute of advocacy. That is equivalent to 319 out of 655 case notes. The score for these reviewed case notes represents a good indicator of the existence of the attribute (refer to Appendix 2 for the scores). Based on Table 4.5 on page 154, it is evident that the median scores for components in the attribute for advocacy varied between 1 and 4.

The component of 'information on admission procedure and orientation to the clinical setting already given to the patient/family/carer' appears in all of the contents in 385 out of 655 (58.8%) reviewed case notes (see Figure 4.3 on the next page). Additionally, 49.3% or 323 out of 655, case notes display the component of 'the patient's urgencies/priorities are clearly stated' in most reports, in a case note, respectively. It also confirms that only 9 out of 655 (1.4%) did not contain information on the admission procedure and orientation to the clinical setting already given to the patient/family/carer' across the reviewed case notes (see Figure 4.3 on the next page).

Figure 4.3: Existence of the component of information on admission and orientation in reviewed case notes



Within the attribute of advocacy, the component of 'health needs assessment' scored rather poorly with a median score equal to 1 (shown in Table 4.5 on the next page). Moreover, 344 out of 655 reviewed case notes (i.e. 10.8%) displayed this component in a few reports in a case note and only 3 out of 655 reviewed case notes (0.5%) demonstrated it in all reports, in a certain case note. The median score for this component is the lowest when compared to the other component with a median score = 1. Similarly, 59 of 655 reviewed case notes (i.e. 9%) did not contain a nursing care plan. It also discovered that 58 out of 655 case notes (equivalent to 8.9%) displayed no relevant information throughout the reports.

Table 4.5: Frequencies, median scores and mean related to the attribute of advocacy

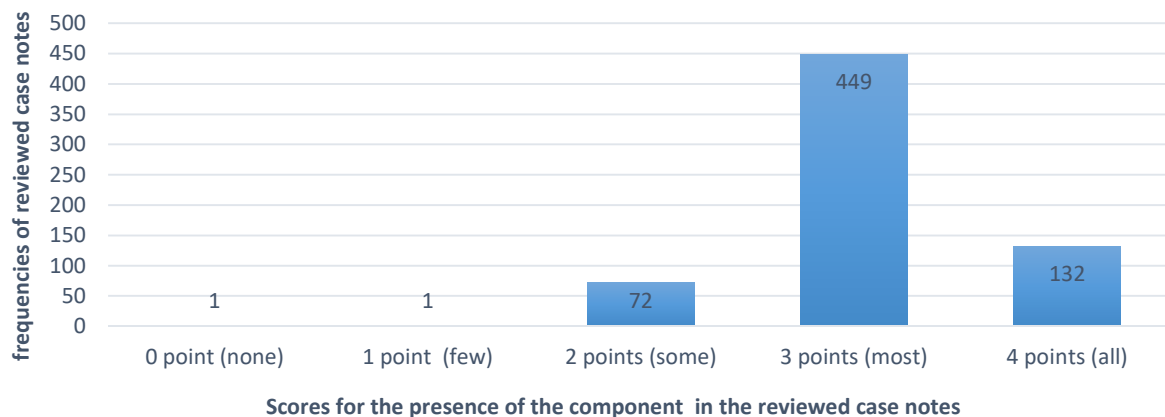
Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Provide adequate information	0	9 (1.4%)	323 (49.3%)	282 (43.0%)	41 (6.3%)	2	2.6	0.7	2.6	2.5
Evaluation is clear	0	10 (1.5%)	266 (40.6%)	315 (48.1%)	64 (9.8%)	3	2.7	0.7	2.7	2.6
Problem updated	0	10 (1.5%)	208 (31.8%)	339 (51.8%)	98 (15.0%)	3	2.8	0.7	2.9	2.8
Individual plan of care	1 (0.2%)	26 (4.0%)	265 (40.5%)	291 (44.4%)	72 (11.0%)	3	2.6	0.7	2.7	2.6
Care reflects changes	1 (0.2%)	9 (1.4%)	241 (36.8%)	326 (49.8%)	78 (11.9%)	3	2.7	0.7	2.8	2.7
Patient urgencies	1 (0.2%)	2 (0.3%)	21 (3.2%)	323 (49.3%)	308 (47.0%)	3	3.4	0.6	3.5	3.4
Health needs assessment	24 (3.7%)	344 (52.5%)	267 (40.8%)	17 (2.6%)	3 (0.5%)	1	1.4	0.6	1.5	1.4
Care plan discussed	59 (9.0%)	103 (15.7%)	212 (32.4%)	157 (24.0%)	124 (18.9%)	2	2.3	1.2	2.4	2.2
Relevant information	58 (8.9%)	96 (14.7%)	192 (29.3%)	120 (18.3%)	189 (28.9%)	2	2.4	1.3	2.5	2.3
Information on admission	9 (1.4%)	75 (11.5%)	106 (16.2%)	80 (12.2%)	385 (58.8%)	4	3.2	1.1	3.2	3.1

A Chi-square test was also performed to examine the relationship between each of the components and the attribute of advocacy. The result reveals that there is an association between each component and attribute of advocacy with $p \leq 0.01$. Overall, the results of Spearman's Rho test demonstrate that all the components in this attribute (i.e. advocacy) are moderately strongly correlated with the total score with $r \geq 0.4$.

4.6 Innovation and visionary

As can be seen from Table 4.2 on p147, a total of 375 out of 655 reviewed case notes scored between 23-31 points with a median score of 26. The scores for these reviewed case notes represent a good indicator regarding the existence of the attribute (refer to Appendix 2 for scores). Moreover, most of the reviewed case notes in this study have the amended care or treatment approaches according to the patient's current status, clearly written in all sections in a case note, with 449 out of 655 reviewed case notes (76%) (See Figure 4.4 below).

Figure 4.4: Existence of the component of amended care



However, 368 out of 655 reviewed case notes (equivalent to 56.2%) displayed only a few approaches that were supported and presented with a clear rationale. Conversely, only 3 out of the 655 reviewed case notes that include information regarding care or treatment have clear identified outcomes and can be evaluated in all sections, in a case note (see Table 4.6 on the following page).

Table 4.6: Frequencies, median scores and mean related to the attribute of innovation and visionary

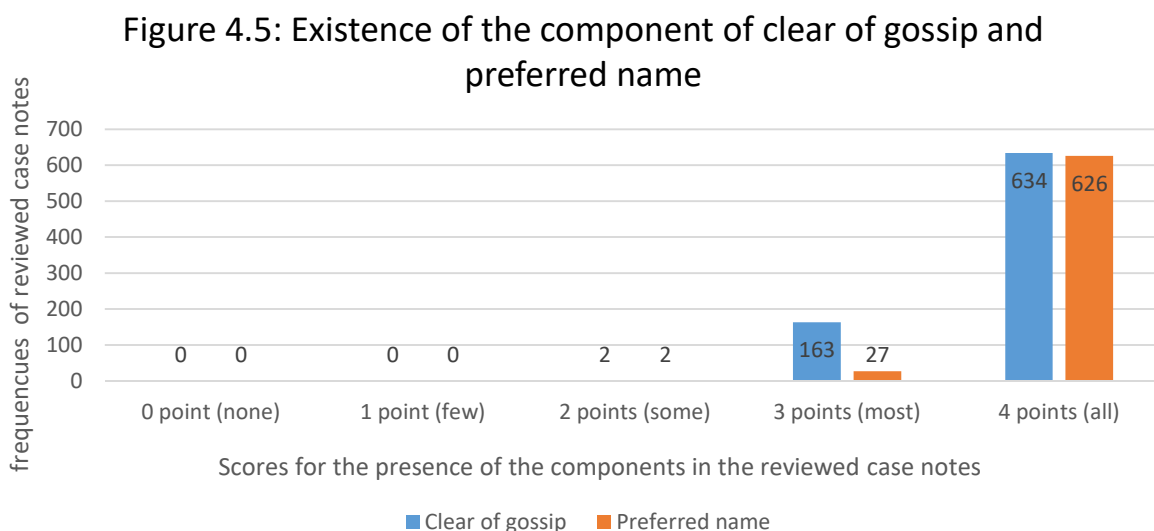
Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Care stated	0	7 (1.1%)	308 (47.0%)	296 (45.2%)	44 (6.7%)	3	2.6	0.6	2.6	2.5
Prevention clear	1 (0.2%)	2 (0.3%)	83 (12.7%)	399 (60.9%)	170 (26.0%)	3	3.1	0.6	3.2	3.1
Content is easy	0	0	17 (2.6%)	385 (58.8%)	253 (38.6%)	3	3.4	0.5	3.4	3.3
Amended care	1 (0.2%)	1 (0.2%)	72 (11.0%)	449 (68.5%)	132 (20.2%)	3	3.1	0.6	3.1	3.0
Identified outcomes	17 (2.6%)	251 (38.3%)	209 (31.9%)	148 (22.6%)	3 (0.5%)	2	1.9	0.9	2.0	1.8
Supported clear rationale	75 (11.5%)	368 (56.2%)	177 (27.0%)	31 (4.7%)	4 (0.6%)	1	1.3	0.7	1.3	1.2
Method or approach clearly recorded	5 (0.8%)	57 (8.7%)	233 (35.6%)	255 (38.9%)	105 (16.0%)	3	2.6	0.9	2.7	2.5
Risk factors	9 (1.4%)	17 (2.6%)	252 (38.5%)	242 (36.9%)	135 (20.6%)	3	2.7	0.9	2.8	2.7
Action taken	6 (0.9%)	19 (2.9%)	252 (38.5%)	241 (36.8%)	137 (20.9%)	3	2.7	0.9	2.8	2.7
Plan for reassessment	8 (1.2%)	19 (2.9%)	252 (38.5%)	244 (37.3%)	132 (20.2%)	3	2.7	0.9	2.8	2.7

The Chi-square test reveals that there is a relationship between each component and the attribute of innovation and visionary, with $p \leq 0.01$. Spearman's Rho test was also completed to determine the correlation between the components and the total score for the attribute of innovation and visionary. Here, the results reveal that all the components of this attribute are

$r \geq 0.4$. Furthermore, the variable of 'plan for reassessment' could be considered to have a strong correlation with the total score for innovation and visionary ($r = 0.78$).

4.7 Ethics and values

As presented in Table 4.2 p147, a total of 371 out of 655 reviewed case notes in this study scored between 23-31 points with a median score of 28. This result displays that these reviewed case notes can be classified as a good indicator of the existence of the attribute (see scores in Appendix 2). As shown in Figure 4.5, 634 out of 655 (96.8%) reviewed case notes were always clear of any innuendo, hearsay or third-party comments in all of the reports in a case note. It also ascertained that 626 out of 655 reviewed cases (i.e. 95.6%) have the patient's preferred name clearly stated and it appeared in all sections, in a case note.



Based on Table 4.7 on the following page, it is suggested that very few reviewed case notes have no written evidence on what a patient actually said. Only 2 out of 655 (0.3%) of the reviewed case notes fall under this category. However, slightly more than half (i.e. 359 out of 655, or 54.8%) of the reviewed case notes have few specific corresponding interventions for any patient's unique needs that were clearly written in all the reports, in a case note.

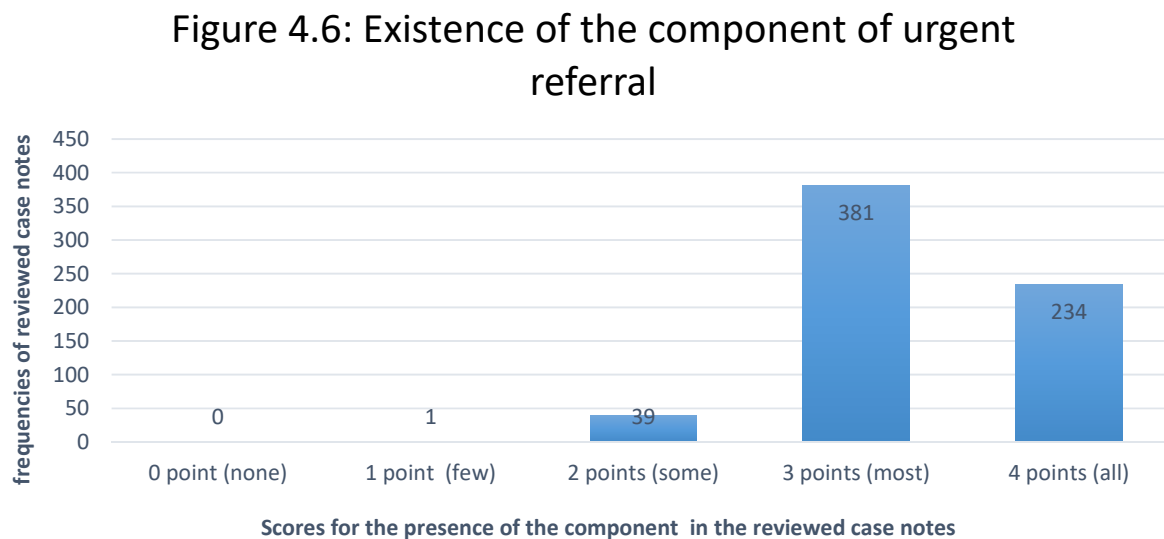
Table 4.7: Frequencies, median scores and mean related to attribute of ethics and values

Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Clear of gossip	0	0	2 (0.3%)	163 (24.9%)	634 (96.8%)	4	4.0	0.2	4.0	4.0
Preferred name	0	0	2 (0.3%)	27 (4.1%)	626 (95.6%)	4	4.0	0.2	4.0	3.9
Patient's family informed of current status	56 (8.5%)	45 (6.9%)	55 (8.4%)	211 (32.2%)	288 (44.0%)	3	3.0	1.3	3.1	2.9
Patient briefed	51 (7.8%)	94 (14.4%)	138 (21.1%)	216 (33.0%)	156 (23.8%)	3	2.5	1.2	2.6	2.4
Patient consent	61 (9.3%)	51 (7.8%)	116 (17.7%)	268 (40.9%)	159 (24.3%)	3	2.6	1.2	2.7	2.5
Valuable information	62 (9.5%)	99 (15.1%)	133 (20.3%)	195 (29.8%)	166 (25.3%)		2.5	1.3	2.6	2.4
Unique needs	107 (16.3%)	359 (54.8%)	126 (19.2%)	44 (6.7%)	19 (2.9)	1	1.3	0.9	1.3	1.2
Clear record prepared	3 (0.5%)	13 (2.0%)	108 (16.5%)	350 (53.4%)	181 (27.6%)	3	3.1	0.8	3.1	3.0
Written in terms of what patient said	2 (0.3%)	12 (1.8%)	111 (16.9%)	378 (57.7%)	152 (23.2%)	3	3.0	0.7	3.1	3.0
Specific corresponding interventions for any unique needs clearly written	100 (15.3%)	358 (54.7%)	119 (18.2%)	54 (8.2%)	24 (3.7%)	1	1.3	1.0	1.4	1.2

Similar to the attribute testing described earlier, the Chi square test result reveals that there is a relationship between each component and the attribute of ethics and values (with $p \leq 0.01$). Meanwhile, the results of Spearman's Rho test suggest that all the components of this attribute are above $r = 0.4$. Overall, this result demonstrates that all the components in this attribute are moderately strongly correlated with the total score. However, the results indicate that the component of 'clear of gossip' ($r = 0.02$) and component of 'preferred name' ($r = 0.01$) has an extremely weak correlation with the total score for ethics and values.

4.8 Autonomy

Figure 4.6 below illustrates the frequencies and median scores for all the components regarding Autonomy. More than half of the total reviewed case notes in this study contain information on urgent identified needs/problems that are referred to the doctor and clearly written in all reports for 381 out of 655 (58.2%) reviewed case notes.



Furthermore, all of the reviewed case notes included the findings from the evaluation of care or treatment that was performed. Urgent identified needs or problems referred to the doctor has a median of three.

As presented in Table 4.8 on the next page, the abbreviation of 'SOAPIER' made the least appearance in all the reviewed case notes, with only 3 out of 655 reviewed case notes (i.e. 0.4%) revealing that these components are constantly (All) present in notes from each shift. SOAPIER is the standard acronym for seven perspectives of nursing documentation: S = Subjective information, O= Objective information, A = Assessment, P= Planning, I = Intervention, E= Evaluation and R = Revision (Martin & Ludwig, 2014).

Table 4.8: Frequencies, median scores and mean related to the attribute of autonomy

Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Evaluation of care performed	1 (0.2%)	11 (1.7%)	325 (49.6%)	269 (41.1%)	49 (7.4%)	2	2.5	0.7	2.6	2.5
Urgent referral	0	1 (0.2%)	39 (6.0%)	381 (58.2%)	234 (35.7%)	3	3.3	0.6	3.3	3.3
Entries written incidents	0	1 (0.2%)	26 (4.0%)	342 (52.2%)	286 (43.7%)	3	3.4	0.6	3.4	3.4
Interventions discontinued	13 (2.0%)	5 (0.8%)	65 (9.9%)	353 (53.9%)	219 (33.4%)	3	3.2	0.8	3.2	3.1
Reassessment undertaken	17 (2.6%)	17 (2.6%)	237 (36.2%)	246 (37.6%)	138 (21.1%)	3	2.7	0.9	2.8	2.7
Action by nurse when finding charge	4 (0.6%)	7 (1.1%)	215 (32.8%)	279 (42.6%)	150 (22.9%)	3	2.9	0.8	2.9	2.8
SOAPIER	58 (8.9%)	271 (41.4%)	306 (46.7%)	17 (2.6%)	3 (0.5%)	1	1.4	0.7	1.5	1.4
What to do	4 (0.6%)	150 (22.9%)	293 (44.8%)	156 (23.8%)	52 (7.9%)	2	2.2	0.9	2.2	2.1
When to do it	5 (0.8%)	150 (22.9%)	291 (44.4%)	160 (24.4%)	49 (7.5%)	2	2.2	0.9	2.2	2.1
How to do it	6 (0.9%)	189 (28.9%)	329 (50.2%)	124 (18.9%)	7 (1.1%)	2	1.9	0.8	2.0	1.9

The Chi square test confirms that there is a relationship between the scores for each component and the attribute of autonomy with $p \leq 0.01$. Referring back to Table 4.2, p147, 402 of the total reviewed case notes achieved a good indicator of the existence for the attribute of Autonomy, with a median score of 25 (see Appendix 2). Overall, the results of Spearman's Rho test indicate that most of the components of this attribute are above $r = 0.4$. This result demonstrates that all the components in this attribute are moderately strongly correlated with the total score. However, Spearman's Rho test signifies that the component of 'utilising SOAPIER' has a weak correlation with the total score of Autonomy with $r = 0.3$.

4.9 Knowledge

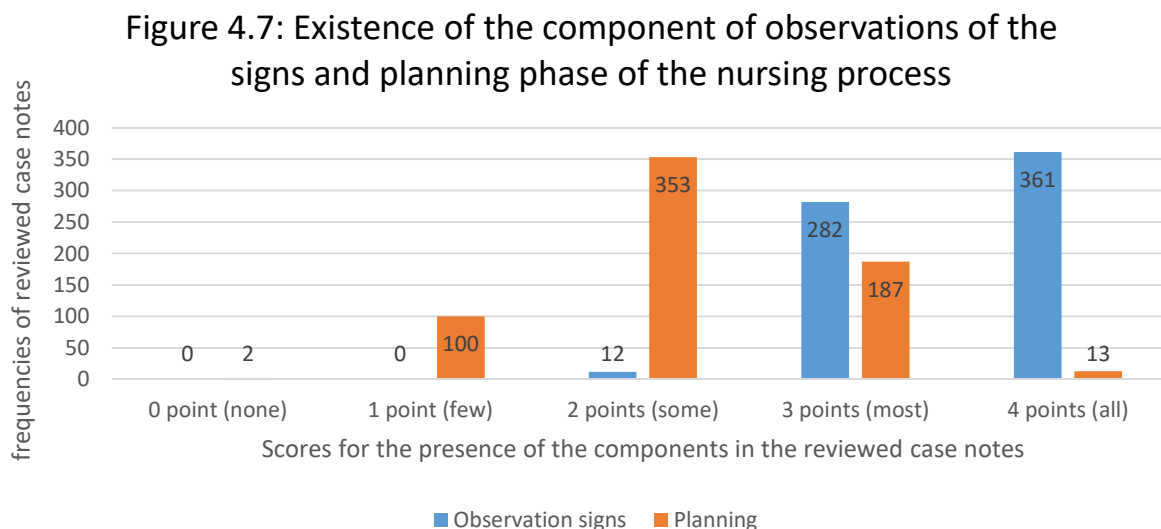
Referring to Table 4.2 p147, a total of 402 reviewed case notes, which is approximately 61.3% scored 23-31 points regarding the knowledge attribute. This result indicates that these reviewed case notes demonstrate convincing evidence of knowledge (see Appendix 2). Further analysis reveals that 551 out of 655 (84.1%) of the reviewed case notes occasionally contain the component of 'appropriate type of assessment has been used' and the component of 'there is analysis of the assessment' in the text (see Table 4.9 below).

Table 4.9: Frequencies, median scores and mean related to the attribute of knowledge

Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Appropriate assessment	0	35 (5.3%)	551 (84.1%)	64 (9.8%)	5 (0.8%)	2	2.1	0.9	2.2	2.0
Changes to treatment	0	5 (0.8%)	106 (16.2%)	485 (74.0%)	59 (9.0%)	3	2.9	0.5	3.0	2.9
Observation signs	0	0	12 (18.5%)	282 (43.1%)	361 (55.1%)	4	3.5	0.5	3.6	3.5
Information recorded provides adequate info	1 (0.2%)	4 (0.6%)	185 (28.2%)	371 (56.6%)	94 (14.4%)	3	2.8	0.7	2.9	2.8
Evidence from others is used	0	6 (0.9%)	206 (31.5%)	373 (56.9%)	70 (10.7%)	3	2.8	0.6	2.8	2.7
Appropriate detailed care based on patients' needs recorded	1 (0.2%)	6 (0.9%)	221 (33.7%)	364 (55.6%)	63 (9.6%)	3	2.7	0.7	2.8	2.7
The rationale regarding plan of care is clearly stated	89 (13.6%)	269 (41.1%)	239 (36.5%)	55 (8.4%)	3 (0.5%)	1	1.4	0.8	1.5	1.4
Analysis	3 (0.5%)	103 (15.7%)	354 (54.0%)	192 (29.3%)	3 (0.5%)	2	2.1	0.7	2.1	2.0
Diagnosis	2 (0.3%)	100 (15.3%)	352 (53.7%)	186 (28.4%)	15 (2.3%)	2	2.2	0.7	2.2	2.1
Planning	2 (0.3%)	100 (15.3%)	353 (53.9%)	187 (28.5%)	13 (2.0%)	2	2.2	0.7	2.2	2.1

The analysis of the quantitative findings also clarifies that 361 out of 655 (55.1%) of the reviewed case notes have the component of observations of the signs or symptoms were recorded concerning what the nurse observed and was not based on the nurse's assumptions in all written text in a case note (see Figure 4.7 on the next page). Interestingly, the findings

of this study also reveal that only 13 out of 655 (19.8%) reviewed case notes present the planning phase of the nursing process in all reports, in a case note (see Figure 4.7 below).



The most striking result to emerge from the data is that all the reviewed case notes consist of information on the appropriate type of assessment used and changes to treatment or care are made clear. All the reviewed case notes also comprise observations of the signs or symptoms, which are recorded concerning what the nurse observed and were not based on the nurse's assumption, and the information and evidence from nursing and other disciplines to inform practice in any report in a single case note.

The Chi square test result confirms that there is relationship between each component and the attribute of knowledge, with $p \leq 0.01$. The results of Spearman's Rho test indicate that all the components of knowledge are above $r = 0.4$. This result demonstrates that all of the components in this attribute have a moderately strong correlation with the total score. Additionally, Spearman's Rho tests were also conducted for all the components in the attribute of knowledge. However, the results imply that the component of 'rationale for plan of care is clearly stated' has a weak correlation with the total score for the attribute knowledge, with $r = 0.3$.

4.10 Spirit of inquiry

As illustrated in Table 4.2 p147, 369 out of 655 reviewed case notes (i.e. 56.3%) scored between 23-31 points, which is considered a good indicator regarding the existence of the attribute of spirit of inquiry (see Appendix 2). The results prove that 55.3% of the reviewed case notes (i.e. 362 out of 655) have complete patient admission and assessment forms (see Table 4.10 below).

Table 4.10: Frequencies, median scores and mean related to the attribute of spirit of inquiry

Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Patient's urgent and individual needs and problems identified	0	4 (0.6%)	167 (25.5%)	379 (57.9%)	105 (16.0%)	3	2.9	0.7	2.9	2.8
Any change in patient's status indicated and objective data recorded	0	3 (0.5%)	93 (14.2%)	413 (63.1%)	146 (22.3%)	3	3.0	0.6	3.1	3.0
Admission and assessment form completed	0	2 (0.3%)	45 (6.9%)	246 (37.6%)	362 (55.3%)	4	3.5	0.6	3.5	3.4
Physical and psychological assessment findings recorded	2 (0.3%)	129 (19.7%)	296 (45.2%)	171 (26.1%)	57 (8.7%)	2	2.2	0.9	2.3	2.2
Assessment findings are written according to IPPA	68 (10.4%)	401 (61.2%)	172 (26.3%)	12 (1.8%)	1 (0.2%)	1	1.2	0.7	1.3	1.2
Patient's response to care stated	3 (0.5%)	40 (6.1%)	340 (51.9%)	224 (34.2%)	48 (7.3%)	2	2.4	0.7	2.5	2.4
Patient's response to medication stated	2 (0.3%)	35 (5.3%)	334 (51.0%)	228 (34.8%)	56 (8.5%)	2	2.5	0.7	2.5	2.4
Appropriate reassessment of the patient's current status undertaken	5 (0.8%)	30 (4.6%)	334 (51.0%)	222 (33.9%)	64 (9.8%)	2	2.5	0.8	2.5	2.4
Clear care planning	3 (0.5%)	29 (4.4%)	317 (48.4%)	230 (35.1%)	76 (11.6%)	2	2.5	0.8	2.6	2.5
Prescribed investigation	0	17 (2.6%)	289 (44.1%)	215 (32.8%)	134 (20.5%)	3	2.7	0.8	2.3	2.7

Analysis also establishes that 413 out of 655 (63%) reviewed case notes in this study comprise information regarding any change in the patient's status indicated and objective information documented in most of the reports, in a case note. However, only 48 out of 655 (7.3%) reviewed case notes contain information on a patient's response to care/treatment, in all the reports. Meanwhile, only 56 out of 655 (8.5%) reviewed case notes include information on a patient's response to medication in all the reports. Strikingly, there was only one out of the total reviewed case notes containing assessment findings written according to IPPA (Inspection, Palpation, Percussion and Auscultation–physical examination process) mnemonics collectively in all reports, in a case note.

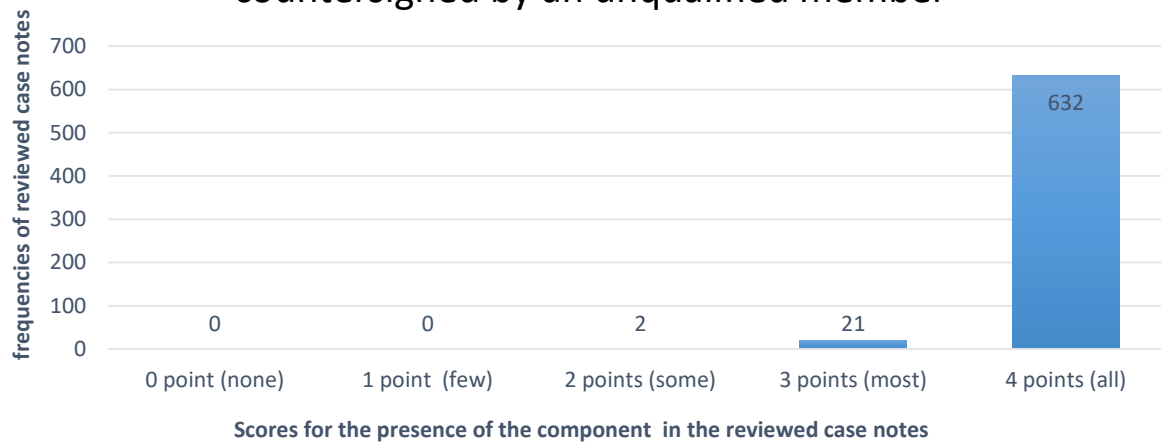
The Chi square test result reveals that there is relationship between each component and the attribute of spirit of inquiry with $p \leq 0.01$. Overall, the results of Spearman's Rho test indicate that all the components of this attribute are above $r = 0.4$ (see Table 4.3, p149). This result demonstrates that all the components in this attribute have a moderate to strong correlation with the total score.

An additional Spearman's Rho Correlation test was performed between the scores for each of the components in this attribute. Consequently, it is determined that the score for the component of 'assessment findings are written according to IPPA' is the weakest positive correlation, with the total score for spirit of inquiry, with ($r = 0.2$).

4.11 Collegiality and collaboration

The analysis of quantitative findings reported that 617 out of 655 (94.1%) reviewed case notes) scored between 32-40 points for the attribute of collegiality and collaboration (see Figure 4.2 on p148).

Figure 4.8: Existence of the component being countersigned by an unqualified member



The results also explain that 430 out of 655 (65.6%) of the reviewed case notes in this study contain statements which are understandable and without jargon, and show records with only standard abbreviations e.g. O₂, BP, SPO₂ in all written texts, in a case note.

Notably, it can be seen from the data in Table 4.11 on the following page that 632 out of 655 (96.5%) reviewed case notes in this study contain evidence of a qualified practitioner who countersigned every entry made by an unqualified member in all reports, in a single case note.

It is apparent from Table 4.11 on the following page, that 21 out of 655 (3.2%) reviewed case notes did not contain information on the 'distribution of responsibilities' among colleagues in care or treatment in the record in any of the written text, in a case note. Moreover, 20 out of the 655 reviewed case notes (i.e. 3.1%) did not detail 'information on discussion and decision on patient's care or treatment' in the records in any of the written texts. Overall, all the components in the attribute of collegiality and collaboration were rated 'most' or 'all', which indicates all the components were always present in reports, in a case note.

Table 4.11: Frequencies, median scores and mean related to the attribute of collegiality and collaboration

Variable	None 0	Few 1	Some 2	Most 3	All 4	Median scores	Mean	SD	95% Confidence Interval	
									Upper	Lower
Countersign unqualified	0	0	2 (0.3%)	21 (3.2%)	632 (96.5%)	4	4.0	0.2	4.0	4.0
Countersign student	2 (0.3%)	1 (0.2%)	17 (2.6%)	140 (21.4%)	495 (75.6%)	4	3.7	0.6	3.8	3.7
Clear formal handover	1 (0.2%)	4 (0.6%)	48 (0.7%)	244 (37.3%)	358 (54.7%)	4	3.5	0.7	3.5	3.4
Without jargon	0	0	19 (2.9%)	206 (31.5%)	430 (65.6%)	4	3.6	0.5	3.7	3.6
Standard abbreviation	0	0	13 (2.0%)	180 (27.5%)	462 (70.5%)	4	3.7	0.5	3.7	3.7
All referral completed	0	2 (0.3%)	15 (2.3%)	92 (14.0%)	545 (83.2%)	4	3.9	1.6	4.0	3.7
Report prepared	1 (0.2%)	1 (0.2%)	14 (2.1%)	90 (13.7%)	549 (83.8%)	4	3.8	0.5	3.9	3.8
Personnel reviewed report clearly written	0	1 (0.2%)	12 (1.8%)	80 (12.2%)	562 (85.8%)	4	3.8	0.4	3.9	3.8
Discussion held	20 (3.1%)	6 (0.9%)	21 (3.2%)	83 (12.7%)	525 (80.2%)	4	3.7	0.8	3.7	3.6
Distribution of responsibilities	21 (3.2%)	4 (0.6%)	16 (2.4%)	83 (12.7%)	528 (80.6%)	4	3.7	0.9	3.8	3.6

The Chi square test result signifies that there is relationship between each component and the attribute of collegiality and collaboration with $p \leq 0.01$. The results of Spearman's Rho Correlation test specify that there is a weak correlation between each component with the total score as evidence that the results of Spearman's Rho Correlation test for all of these components are below $r = 0.4$.

4.12 Attributes of the RNAO (2007) Professionalism in Nursing for all types of participating wards

The highest number of reviewed case notes in this study were taken from the medical wards, with 234 out of the 655 (35.7%). None of the reviewed case notes scored less than 128 points across all the participating wards, which is interpreted as a moderate indicator of the existence of professionalism in nursing (See Figure 4.9 below).



Further analysis reveals that there 90 out of 95 reviewed case notes (94.7%) from the Orthopaedic wards scored 193-256 points, which is interpreted as a good indicator of the existence of professionalism in nursing (see Appendix 2 for scores).

Table 4.12: Frequencies for overall scores of professionalism in nursing for reviewed case notes, across participating wards

Overall scores (n/%) Types of ward	≤ 64 points	65-128 points	129-192 points	193-256 points	257-320 points
Medical wards	0	0	23 (9.8%)	160 (68.4%)	51 (21.8%)
Surgical wards	0	0	14 (11.3%)	103 (83.1%)	7 (5.6%)
Orthopaedic wards	0	0	1 (1.1%)	90 (94.7%)	4 (4.2%)
Maternity wards	0	0	13 (40.6%)	19 (59.4%)	0
Psychiatry wards	0	0	0 (0%)	56 (49.6%)	57 (50.4%)
Paediatric wards	0	0	1 (2.9%)	34 (97.1%)	0
Other wards	0	0	16 (72.7%)	6 (27.3%)	0

Table 4.12 above reveals several interesting findings. First, the psychiatry wards in this study have the highest number of reviewed case notes, with a score between 257-320 points (50.4% of the sample falls under this category), which is interpreted as an excellent indicator of the existence of professionalism in nursing. Secondly, Table 4.12 also reveals that none of the reviewed case notes on the paediatric wards and other wards scored 257-320 points. Finally, none of the reviewed case notes from all the participating wards scored less than 128 points below.

Table 4.13: Frequencies for reviewed case notes which scored 32-40 points for each attribute of the RNAO (2007) Professionalism in Nursing across all participating wards

Wards \ Attribute	Medical	Surgical	Orthopaedic	Maternity	Psychiatry	Paediatrics	Others
Accountability	218 (93.2%)	105 (84.7%)	0	32 (100%)	111 (98.2%)	34 (97.1%)	15 (68.2%)
Advocacy	76 (32.5%)	7 (5.6%)	5 (5.3%)	0	49 (43.4%)	3 (8.6%)	1 (4.5%)
Innovation & visionary	64 (27.4%)	5 (4.0%)	3 (3.2%)	0	39 (34.5%)	0	0
Ethics & values	57 (24.4%)	24 (19.4%)	10 (10.5%)	0	57 (50.4%)	0	0
Autonomy	31 (13.2%)	12 (9.7%)	4 (4.2%)	0	35 (31.0%)	0	0
Knowledge	19 (8.1%)	1 (0.8%)	74 (77.9%)	0	20 (17.7%)	0	0
Spirit of inquiry	42 (17.9%)	4 (3.2%)	4 (4.2%)	0	25 (22.1%)	0	2 (9.1%)
Collegiality & collaboration	223 (95.3%)	117 (94.4%)	92 (96.8%)	32 (100%)	110 (97.3%)	34 (97.1%)	16 (72.7%)

Table 4.13 above also presents several interesting findings. All reviewed case notes from the maternity wards scored 32-40 points, which is interpreted as an excellent indicator of the existence of the attributes of accountability, and collegiality and collaboration. Conversely, none of the reviewed case notes from the maternity wards scored 32-40 points for the remaining attributes of professionalism in nursing.

Table 4.14: Median scores for each attribute of the RNAO (2007) Professionalism in Nursing for all participating wards in this study

Attributes Type of Ward	Accountability	Advocacy	Innovation and visionary	Ethics and values	Autonomy	Knowledge	Spirit of inquiry	Collegiality and collaboration
Medical	36	27	27	27	27	25	27	38
Surgical	34	23	24	28	23	23	23	37
Orthopaedic	36	22	24	27	25	25	23	39
Maternity	35	23	21	23.5	20	20	21	33
Psychiatry	39	31	30	32	30	29	29	40
Paediatric	37	24	24	25	23	25	21	39
Others	33	22	21	22	19	18	19	34

The combined case notes from the psychiatric wards in this study scored the highest median for the attribute of collegiality and collaboration with a median score of 40 (see Table 4.14, above). All reviewed case notes from all other wards also achieved a median score above 32 for collegiality and collaboration. This median score denotes that all reviewed case notes in this study were an excellent indicator of the existence of the attribute of collegiality and collaboration regardless that all reviewed case notes were from various participating wards (see Appendix 2). All reviewed case notes from the other wards scored the lowest median of 18 for the attribute of knowledge. Furthermore, all the reviewed case notes on the other wards also achieved the lowest median score for the attribute of autonomy (Median score =19) and the attribute of spirit of inquiry (Median score =19) in comparison to other types of wards.

The Chi square test result reveals that there is a relationship between the scores for each participating wards and the overall score of professionalism in nursing with $p \leq 0.01$. A Kruskal-Wallis test was performed to examine whether there are any differences in scores among all participating wards. The results demonstrate that there was a statistically significant difference in the overall scores for professionalism in nursing, along with in the score for each attribute across participating wards ($p < 0.01$).

The Mann-Whitney U test results highlight several interesting findings. First, there is a statistically significant difference across the scores for all the attributes between the psychiatry wards and all other participating wards ($p < 0.01$). Additionally, there are also

statistically significant differences between the scores for all attributes between reviewed case notes on paediatric wards and the scores for all reviewed case notes on other types of wards ($p < 0.01$).

4.13 Attributes of the RNAO (2007) Professionalism in Nursing with length of stay

In terms of length of stay, the highest number of reviewed case notes were from those case notes that have been on the respective wards for more than 96 hours since the patients' admission. This was represented by 361 out of 655 reviewed case notes (see Table 4.1, p146). Furthermore, a total of 116 out of 156 (74%) reviewed case notes which are categorised as other cases with an extended period scored between 193-256 points. It should be noted that this score is interpreted as a good indicator of the existence of professionalism (see scores in Appendix 2). None of the reviewed case notes scored below 128 points for this study (see Figure 4.10 below).

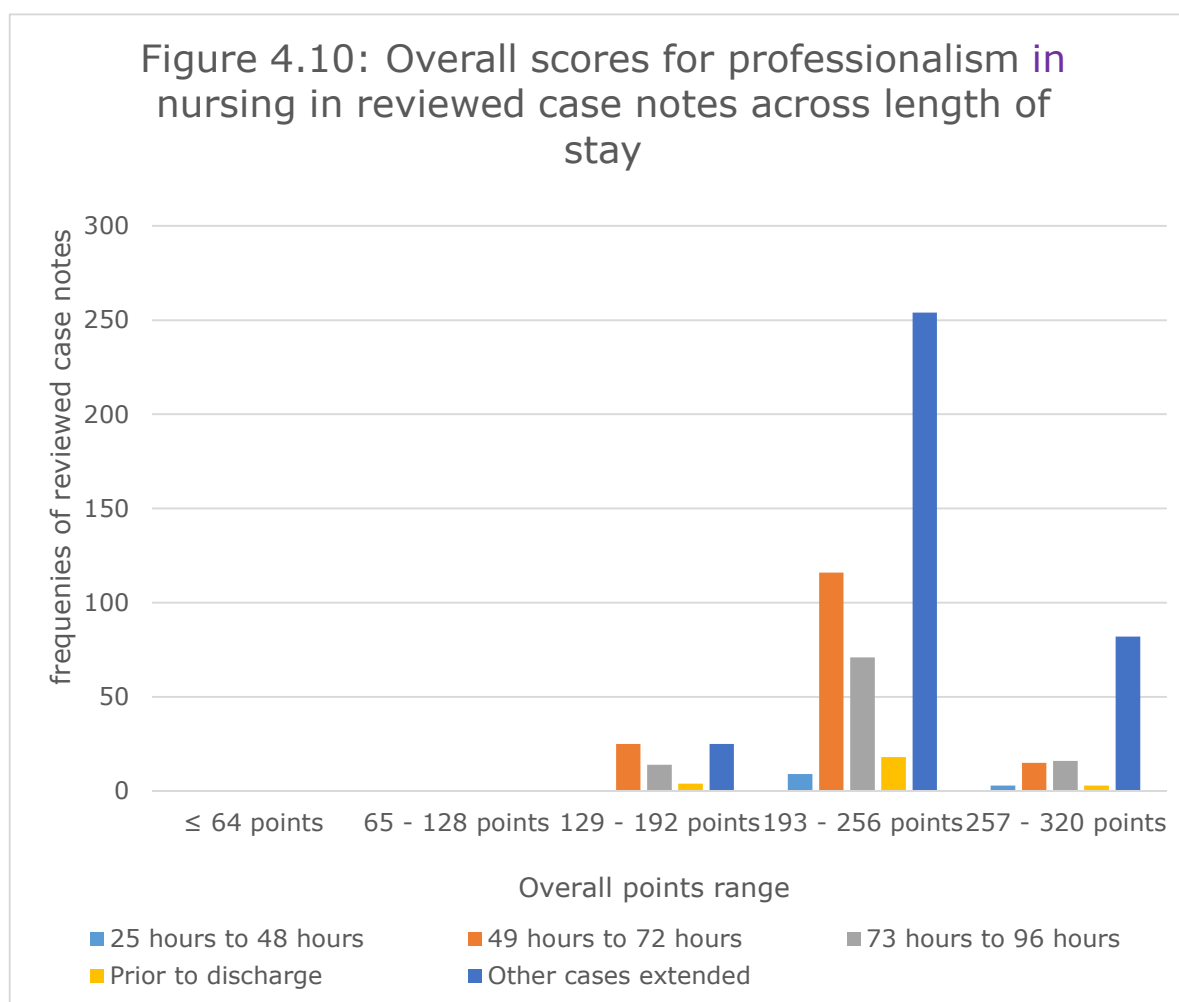


Table 4.15: Frequencies for reviewed case notes for each length of stay which scored 32-40 points for each attribute of the RNAO (2007) Professionalism in Nursing

Length of stay Attribute	25 hours to 48 hours	49 hours to 72 hours	73 hours to 96 hours	Prior to discharge	Other case extended
Accountability	12 (100.0%)	139 (89.1%)	93 (92.1%)	24 (96%)	337 (93.4%)
Advocacy	1 (8.3%)	22 (14.1%)	19 (18.8%)	9 (36%)	90 (24.9%)
Innovation & visionary	5 (41.7%)	20 (12.8%)	15 (14.9%)	2 (8%)	69 (19.1%)
Ethics & values	3 (25%)	30 (19.2%)	18 (17.8%)	7 (28%)	88 (24.4%)
Autonomy	0	12 (7.7%)	12 (11.9%)	2 (8%)	53 (14.7%)
Knowledge	3 (25%)	6 (3.8%)	7 (6.9%)	17 (68%)	27 (7.5%)
Spirit of inquiry	12 (100%)	12 (7.7%)	11 (10.9%)	3 (12%)	46 (12.7%)
Collegiality & collaboration	0	140 (89.7%)	99 (98.0%)	23 (92%)	343 (95%)

It is apparent from Table 4.15 above, that 100% of the reviewed case notes where patients were on the ward for 25-48 hours scored 32-40 points for the attributes of accountability and spirit of inquiry. However, none of the reviewed case notes where patients were on the ward for 25-48 hours scored 32-40 points for the attributes of autonomy, and collegiality and collaboration. Additionally, only 8% of the reviewed cases where patients were about to be discharged scored 32-40 points for the attributes of innovation and visionary, and autonomy.

Table 4.16: Median scores for each attribute of the RNAO (2007) Professionalism in Nursing with length of stay

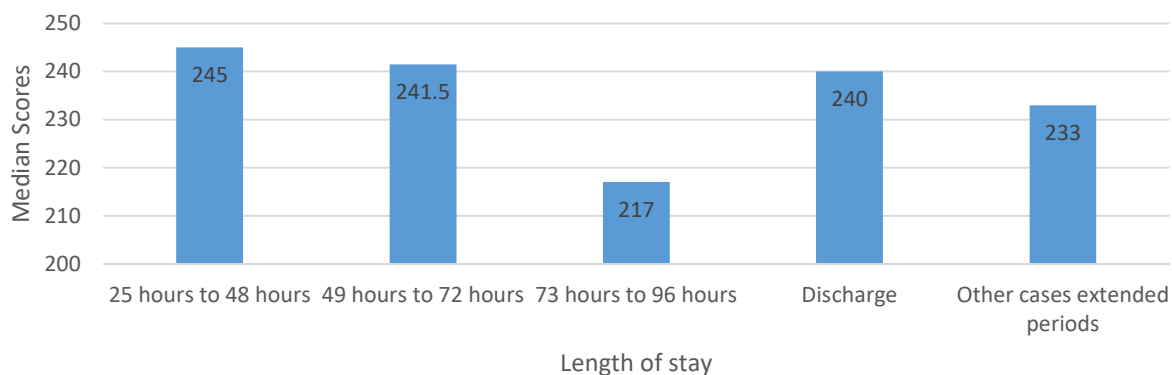
Length of stay Attributes	25 hours to 48 hours	49 hours to 72 hours	73 hours to 96 hours	Prior to discharge	Other case extended
Accountability	39	36	35	35	36
Advocacy	27.5	23	25	28	27
Innovation and visionary	31	24	25	26	27
Ethics and values	28.5	26	25	27	28
Autonomy	29	24	24	25	26
Knowledge	24	24	23	25	25
Spirit of inquiry	26	23	24	28	26
Collegiality and collaboration	38	37	38	39	39

Reviewed case note where patients were on the ward between 25-48 hours from admission, prior to discharge and reviewed case notes for an extended period, has the highest median score of 39 for the attribute of accountability (see Table 4.16 above). Based on the scoring system (see Appendix 2 for scores), the median score for these reviewed case notes are interpreted as an excellent indicator of the existence of the attribute. All reviewed case notes of patients who were on the ward for 73-96 hours since admission scored the lowest median for the attribute of knowledge, with a median of 23 (See Table 4.16, above). However, this median score is interpreted as a good for indicator of the existence of professionalism (See Appendix 2).

Overall, the attribute of accountability has the highest median score (median score = 39) throughout all varieties of length of stay followed by the attribute of collegiality and collaboration (median score = 38) (see Figure 4.11 on the following page). According to the scoring system (see Appendix 2), these median scores are interpreted as an excellent indicator of the existence of both the attributes of accountability, and collegiality and collaboration (see Appendix 2).

The reviewed case notes that were on the ward between 25-48 hours from admission achieved the highest median score for professionalism in nursing, with a median of 245 (see Figure 4.11). This result confirms that these reviewed case notes are interpreted as a good indicator regarding the existence of professionalism. Conversely, the reviewed case notes for patients who were on the ward from 49-72 hours achieved the lowest median score for professionalism in nursing (median score =214.5), although this median score for the reviewed case notes is interpreted as a good indicator of the existence of professionalism (see Figure 4.11). It should be noted that none of the reviewed case notes demonstrate either an excellent, satisfactory, moderate or poor indicator of the existence of professionalism in nursing.

Figure 4.11: Median scores for professionalism in nursing for reviewed case notes across length of stay



The Chi square test result reveals that there is relationship between the scores for each of length of stay and overall score of professionalism in nursing with $p \leq 0.01$. A Kruskal-Wallis test was used to explore whether there are any differences in the scores for all attributes across all types of length of stay, in the reviewed case notes. The findings reveal that there is a statistically significant difference in the overall score for professionalism in nursing across all types of length of stay ($p < 0.01$). However, there is no statistically significant difference for the attribute of collegiality and collaboration in all attributes for all types of length of stay, in the reviewed case notes ($p > 0.05$).

A Mann-Whitney U test was used to determine the differences in scores for each types of length of stay across all the reviewed case notes, in this study. There was a statistically significant difference between the reviewed case notes of other extended periods and reviewed case notes, which are from 49-72 hours since admission ($p < 0.05$). However, the

results reveal that there was no statistically significant difference for all attributes between the reviewed case notes that were prepared or completed for discharge, and the reviewed case notes of other extended periods ($p > 0.05$). Interestingly, a similar finding was discovered between all other types of length of stay for the attribute of collegiality and collaboration ($p > 0.05$).

These results suggest that the length of stay is not likely to have an influence on the existence of collegiality and collaboration in the reviewed case notes, particularly for reviewed case notes of discharged patients, or for any other extended period of admission. However, reviewed case notes which are from 49-72 hours suggests that length of stay could influence the score for professionalism.

4.14 Attributes of the RNAO (2007) Professionalism in Nursing for all participating hospitals

Analysis of the results also reveal patterns and variety in the scores for each of the attributes of professionalism in nursing for each of the participating hospitals, which is presented in Table 4.18 on page 179. The results show that all reviewed case notes at Hospital D scored the lowest median score compared with all other attributes and other participating hospitals with median scores equal to 21 for the attribute advocacy. This result demonstrates that all these reviewed case notes were interpreted as a satisfactory indicator of the existence of the attribute of advocacy. Conversely, all reviewed case notes at Hospital C were interpreted as an excellent indicator of the existence of the attribute of accountability, as Hospital C scored the highest median score (median score = 39).

Table 4.17: Frequencies for reviewed case notes for all participating hospitals which scored 32-40 points for each attribute of the RNAO (2007) Professionalism in Nursing

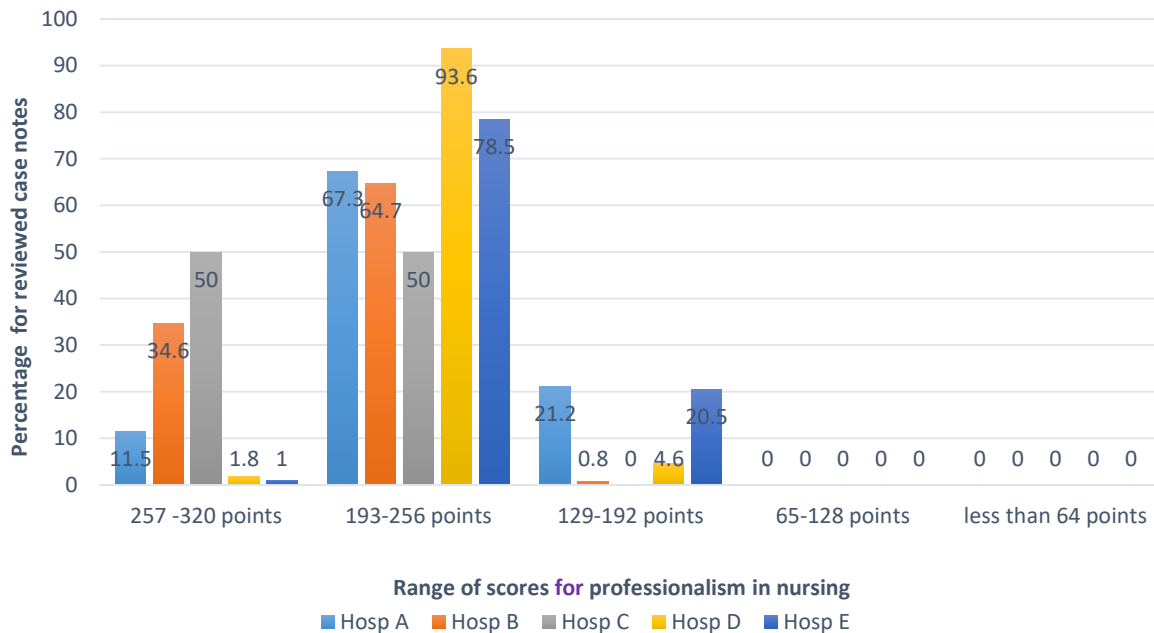
Attribute \ Hospital	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Accountability	87 (83.7%)	129 (97%)	112 (98.2%)	108 (99.1%)	169 (86.7%)
Advocacy	7 (6.7%)	74 (55.6%)	49 (43%)	2 (1.8%)	9 (4.6%)
Innovation & visionary	16 (15.4%)	51 (38.3%)	39 (34.2%)	2 (1.8%)	3 (1.5%)
Ethics & values	26 (25%)	48 (36.1%)	57 (50%)	10 (9.2%)	7 (3.6%)
Autonomy	16 (15.4%)	26 (19.5%)	35 (30.7%)	2 (1.8%)	3 (1.5%)
Knowledge	1 (1%)	19 (14.3%)	20 (17.5%)	76 (69.7%)	95 (48.7%)
Spirit of inquiry	4 (3.8%)	39 (29.3%)	25 (21.9%)	5 (4.6%)	2 (1%)
Collegiality & collaboration	102 (98.1)	124 (93.2%)	111 (97.4%)	104 (95.4%)	176 (90.3%)

Another interesting finding is that none of the participating hospitals scored 128 points and below (65-128 points was interpreted as a moderate indicator of the existence of professionalism and less than 64 points interpreted as a poor indicator of the existence of professionalism)(See Figure 4.12, on the following page). Here, Hospital D has the highest percentage of 193-256 points which can be interpreted as a good indicator concerning the existence of professionalism with 93.6% (See Figure 4.12). Overall, the results appear to suggest that all the reviewed case notes at all the participating hospitals demonstrated a positive indicator regarding the existence of professionalism.

In the case of using frequencies for reviewed case notes at each participating hospital which scored 32-40 points for each attribute, Hospital D has the highest number of reviewed case notes that scored 32-40 points for the attribute of accountability, with 99.1% (see Table 4.17 above). In contrast, only 1% of reviewed case notes at Hospital A scored 32-40 points for the

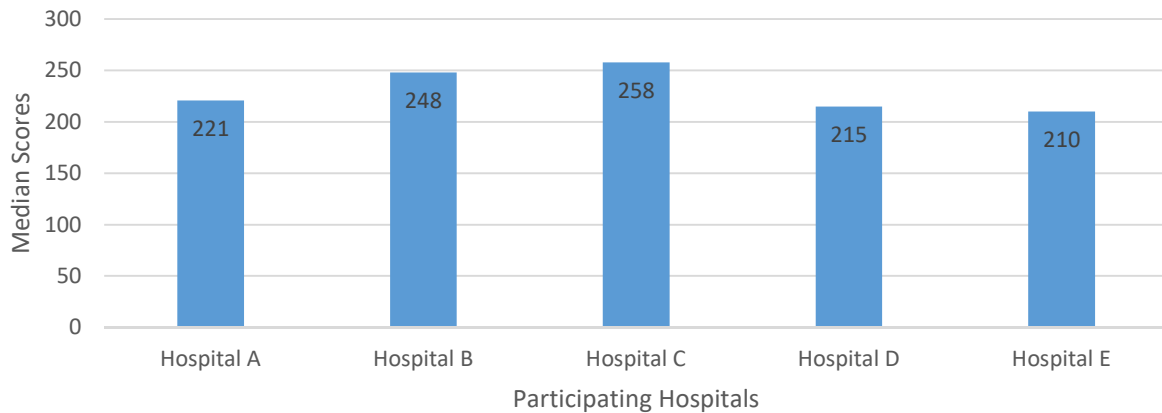
attribute of knowledge. Similarly, only 1% of the reviewed case notes at Hospital E scored 32 to 40 points for the attribute of spirit of inquiry.

Figure 4.12: Percentage of overall scores for indicators of professionalism in nursing at participating hospitals.



As mentioned previously, five government-funded hospitals participated in this study (3 in Peninsular of Malaysia and 2 in East Malaysia). Figure 4.13 shows the median score for each of these participating hospitals. Hospital C scored the highest overall median score for professionalism in nursing, with a median equal to 258. Conversely, Hospital E scored the lowest overall median score for professionalism in nursing, with a median score of 210.

Figure 4.13: Median scores for professionalism at all participating hospitals



Furthermore, further analysis reveals that there is a similar pattern for all reviewed case notes at all participating hospitals. As shown in Table 4.18 on the next page, the median scores for the attribute of accountability, and collegiality and collaboration for all reviewed case notes across all participating hospitals are more than 32, which is interpreted as an excellent indicator the existence of for these attributes (see Table 4.18 on the following page). Alternatively, there is a pattern for the lowest median scores for all the reviewed case notes across all participating hospitals for the attributes of autonomy, knowledge and spirit of inquiry. Furthermore, hospital E had a median score lower than 23 for all these attributes, which is interpreted as a satisfactory indicator concerning the existence of these attributes mentioned above.

Table 4.18: Median scores for each attribute of the RNAO (2007) Professionalism in Nursing for all participating hospitals.

Attributes	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Accountability	37	36	39	35	35
Advocacy	24	32	31	21	23
Innovation & visionary	26	29	29.5	24	22
Ethics and values	22	29	32	26	25
Autonomy	27	28	30	25	23
Knowledge	24	26	28.5	25	22
Spirit of inquiry	24	29	29	23	22
Collegiality and collaboration	38	38	40	36	38

The Chi square test result signifies that there is an association between the scores for each of the participating hospitals and the overall score of professionalism in nursing, with $p \leq 0.01$. A Kruskal-Wallis test was used to explore the differences in overall scores across the participating hospitals. The results reveal that there were statistically significant differences in the overall score for professionalism across all the participating hospitals ($p < 0.01$).

Moreover, the Mann-Whitney U Test results show that there was a statistically significant difference to scores across all the participating hospitals for the attributes of ethics and values, autonomy and knowledge ($p < 0.05$). Additionally, there were significant differences to scores across all the attributes between Hospitals B, D and E respectively ($p < 0.05$). Likewise, there were statistically significant differences to scores for all of the attributes between Hospitals C, D and E ($p < 0.05$). There were statistically significant differences to scores for the attributes of advocacy, innovation and visionary, ethics and values, autonomy and knowledge between Hospitals A, D and E ($p < 0.05$). Scores for all the reviewed case notes at Hospital C are statistically significantly different to scores for all other participating hospitals for all the attributes ($p < 0.05$), except for the attribute of innovation and visionary ($p > 0.05$).

4.15 The psychometric properties of the Retrospective Nursing Documentation Analysis (RNDA) tool

Confirmatory Factor Analysis was chosen to validate the RNDA tool as the researcher uses knowledge of the theory or model, empirical research, or both, to postulate the relationship pattern a priori (Suhr, 2006) recommended by Larson et al. (2004).

Prior to the Confirmatory Factor Analysis, Cronbach's Alpha Coefficient was performed as it is extensively used for reliability tests because it can be calculated after the single administration of a single instrument (Field, 2012).

Moreover, Cronbach's Alpha Coefficient also has a theoretical correlation with factor analysis and it assumes all items are equivalent, which can be used with dichotomous or continuous data (Zinbarg, Revell, Yovel & McDonald, 2006). The results of Cronbach's Alpha Coefficient indicate a good internal consistency for the research tool. The results of the Cronbach Alpha Coefficient tests between the scores for each attribute and the overall score for professionalism in nursing, are presented in Table 4.19.

Table 4.19: Cronbach Alpha Coefficient Test between scores for each attribute with overall scores for professionalism in nursing

Cronbach's Alpha Test Results		
Variables/Items/subscales	Results/Findings	Remarks
Accountability	0.52	Poor ($\alpha \leq 0.6$)
Advocacy	0.87	Good ($0.8 \leq \alpha \leq 0.9$)
Innovation and visionary	0.88	Good ($0.8 \leq \alpha \leq 0.9$)
Ethics and values	0.74	Acceptable($0.7 \leq \alpha \leq 0.8$)
Autonomy	0.88	Good ($0.8 \leq \alpha \leq 0.9$)
Knowledge	0.84	Good ($0.8 \leq \alpha \leq 0.9$)
Spirit of inquiry	0.87	Good ($0.8 \leq \alpha \leq 0.9$)
Collegiality and collaboration	0.47	Poor ($\alpha \leq 0.6$)
OVERALL for all items	0.78	Acceptable($0.7 \leq \alpha \leq 0.8$)

The initial Confirmatory Factor Analysis was conducted at the beginning of this study and revealed promising results regarding the possibility of replicating the tool to utilise for the actual data collection. Although this analysis was completed in the earlier stage of this study, Moreover, it is necessary to determine whether the chosen model (the RNAO Model of

Professionalism in nursing) is possible with the research tool (RNDA), in relation to the study sample.

Table 4.20: Confirmatory Factor Analysis and Model Fit

Goodness-of-Fit Indices	80 items
Chi-Square	59.194
Degree of freedom	20
<i>p</i> -value	0.00
CFI	0.977
GFI	0.977
AGFI	0.959
RMSEA	0.055
Factors loadings for:	
Accountability	0.05
Advocacy	0.59
Innovation and visionary	0.55
Ethics and values	0.46
Autonomy	0.52
Knowledge	0.47
Spirit of inquiry	0.54
Collegiality and collaboration	0.05

As shown in Table 4.20 above, the model provided a statistically significant chi-square statistic, χ^2 (20, n=655) = 59.194, $p=0.00$. The ratio of Chi square to the degree of freedom, $\chi^2/df= 2.96$, was in the acceptable range of below 3. The goodness of fit index, CFI= 0.977 was at an acceptable level regarding the recommended cut-off point (Hu & Bentler, 1999). The acceptable cut off value should be $p= 0.9$ or more (Hair et al., 2006), nonetheless, the adjusted goodness of fit, AGFI = 0.965 and GFI =0.977 were above the cut-off point $p =0.9$, indicating a good fit for the sample in this study.

The Root Mean Square Error of Approximation (RMSEA) was 0.055, which is slightly more than the cut-off point of $p =0.05$ and signifies a good fit (Browne & Cudeck, 1989). Hair et al. (2006), for example, suggest that the RMSEA value should be interpreted together with the CFI value to determine the model fit. Factor loadings for each of the attributes indicate positive

results except for the attributes of accountability, and collegiality and collaboration. As the CFI value in this study was more than 0.9, the acceptable fit of the model in this study could be justified. Thus, altogether, the Confirmatory Factor Analysis indicated that the tool that is designed for this study could be replicated.

Kappa Inter-rater was not performed after the actual data collection due to several limitations. These limitations will be further explained in Chapter 7 in the Conclusion (Section: Limitations of this study, p265). Concerning factor loadings for each of the attributes of the RNAO (2007) Professionalism in Nursing Model, the factor loading for the attributes of accountability, and collegiality and collaboration was 0.005, which is far below the cut-off point $p = 0.4$ (Bowen & Gou, 2011).

Based on the results for factor loadings, the attributes of accountability, ethics and values, knowledge, and collegiality and collaboration (factor loading below cut off point, $p = 0.5$) contribute to a poor fitting regarding the CFA model. These results suggest that the variables items in the tool should have undergone or followed up with another test, for instance Exploratory Factor Analysis or EFA (Boduszek, 2014, Schmitt & Sass, 2011) to investigate the appropriateness of the variables for a study sample (Field, 2012).

Ordinarily, EFA can be used to explore poorly fitting CFA models and to determine factor structures without strong hypotheses (Boduszek, 2014). Specifically, EFA could be considered when an adequate fitting CFA model can only be obtained by model re-specification based on the modification indices, which resulted in the CFA model re-specification being impractical (Field, 2012). Similarly, the exploratory factor analysis is a test that examines the inter-correlations between all variables in a scale and from that reduces the data into a smaller number of dimensions (factors). However, this claim does not suggest that modification indices cannot be used and/or CFA models should never be re-specified after the test (Schmitt & Sass, 2011). Alternatively, the researchers should carefully consider any potential events that could occur when a model does not fit and realise that EFA is frequently more suitable for further exploration of poor fitting CFA models.

4.16 Conclusion

Overall, the quantitative findings confirm that there was evidence of the existence of the elements of professionalism within nursing documentation. It can be argued that the patterns

and/or nature of the existence of the elements of professionalism in nursing within the nursing documentation is consistent across the five different participating hospitals in this study. None of the reviewed case notes here, show moderate or poor indicators of the existence of professionalism in nursing. Furthermore, results regarding the validity and reliability of the RNDA tool could be considered acceptable, concerning the model fit tests. However, these results only reflect the physicality and the content of the presentation in the documentation. Hence, it is important to explore the nurses' perceptions, attitude and practice about their documentation. These inputs will be discussed in the next chapter.

CHAPTER 5: QUALITATIVE RESULTS

5.1 Introduction

The qualitative findings were derived from the interviews with the respondents (nurses) who are directly involved in the preparation of their documentation. The central questions in this section focus on the respondents' (the nurses') knowledge, perceptions and their practice regarding their documentation. These interviews were later transcribed, translated (for those interviews that were conducted in *Bahasa Melayu*) and analysed using NVivo software (refer to Chapter 3, Section 3.6.7 for further details).

The qualitative findings obtained from this study will be presented in narrative forms. Narrative form deals with words and media texts, which draw on conventional codes of meaning that are based on the use of language, visual or auditory imagery, with all their complexities and ambiguities (Plowright, 2011). The presentation of the qualitative findings in this study is divided into three major sections. The first section explains the brief demographic background of the respondents who were interviewed in this study. The second section elaborates on the major themes formulated from the thematic readings (see Appendix 11). The third section of this chapter discusses the emerging findings, which are then used to construct significant themes that demonstrate the relationship with the nursing documentation from a Malaysian context.

5.2 Respondents' socio-demographic profile

This section presents the detailed socio-demographic background of the respondents who have participated in the interviews. The details of respondents' backgrounds are summarised in Table 5.1 on the following page. It should be noted that there is no information pertaining to the respondents' age as well as the specific ward or clinical setting that these respondents were attached or assigned to. This information was not collected, nor was it collated. This decision was made as this information is not relevant to the aims and objectives of this study.

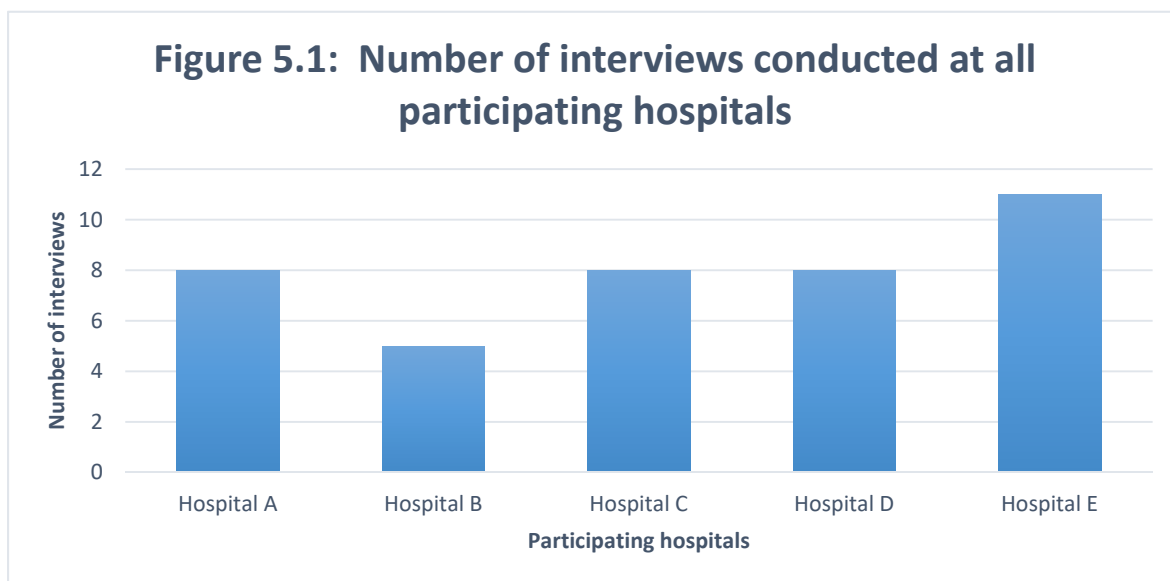
Table 5.1: Respondents' demographic details

Respondents' backgrounds	Findings	n	%
Gender	Males	4	10
	Females	36	90
Race	Malay	25	62.5
	Chinese	4	10
	Indian	3	7.5
	Kadazan Dusun	5	12.5
	Iban	1	2.5
	Bidayuh	2	5
Religion	Islam	25	62.5
	Christian	11	27.5
	Buddhist	1	2.5
	Hindu	3	7.5
Highest Nursing Education	Diploma	17	42.5
	Degree	2	5
	Diploma with Advanced Diploma	14	35
	Degree with Advanced Diploma	7	17.5
Work Experience	Less than 5 years	17	42.5
	More than 5 years	23	57.5
Job Positions	Sister	8	2
	Staff Nurse U29	30	75
	Staff Nurse U41	2	5
Region	Peninsular Malaysia	21	52.5
	East Malaysia	29	72.5
Hospital	General	33	82.5
	Specialised	7	17.5

As shown in Table 5.1 above, there are two types of entry related to a staff nurse position in the Ministry of Health Malaysia. Staff nurses with a U29 grade are the nurses who have a diploma in nursing, while staff nurses with a U41 grade are those with a degree in nursing. Seventeen respondents selected for the interviews are staff nurses with a U29 grade, whilst only two respondents are staff nurses with a U41 grade. Moreover, seven nurses have degrees who have obtained their advanced diploma in a speciality area. Meanwhile, seven of the

respondents who have a diploma have also attained an advanced diploma. It should be stated that 23 out of 40 respondents have been working as a nurse for more than five years. As can be seen from the above table, most of the respondents in this study are female, Muslim and from the Malay ethnic group.

In this study, a total of 40 interviews were successfully conducted and transcribed. The interviews were conducted at five participating hospitals in Peninsular Malaysia, besides East Malaysia (Sarawak and Sabah). Figure 5.1 below contains descriptions of the participating hospitals. It should be noted that the number of respondents in this study were not definitively based on the actual number of nurses in Malaysia. Hence, the actual study sample is not considered to be representative of the entire population.



Eight interviews were conducted in English and the other thirty-two semi-structured interviews were accomplished in *Bahasa Melayu*. Interviews in *Bahasa Melayu* were translated, as explained in greater detail in Chapter 3, Section 3.6.8. Each interview lasted from 25 to 45 minutes. The duration of each interview ranged from 31 minutes to one hour and forty minutes. The total duration of all the interviews was 21 hours, 32 minutes and 33 seconds.

As described in Chapter 3 (Methodology, Section 3.6.7), all the interview transcripts were thematically analysed by applying Braun & Clarke's (2006) approach. The total number of words for the interview transcripts is 160,482 words. Initial common phrases were formulated

based on the similarity and differences of keywords shared by the respondents in the interviews. Common phrases were allocated to themes to encapsulate a distinct set of ideas, represent the boundaries to the idea, along with the relationship to other developed themes.

5.3 Results from the thematic analysis

The constructed themes from the thematic analysis are presented in Table 5.2 below. The findings from the analysis suggest that the constructed themes echo the attributes of professionalism in nursing promoted by the RNAO (2007). Each of these attributes espoused by the RNAO (2007), makes a systematic, structured and broad understanding of the existence of the elements of professionalism within the respondents' (nurses') perceptions and views on their nursing documentation.

Table 5.2: Constructed themes via thematic analysis

Common phrases	Subthemes	Themes
Countersign Credibility Date and time of documentation Do not depend on theories Obligation to complete documentation Report actual event	Responsibility Truthfulness Accuracy	Accountability
Good listener Individualised care Patient benefits Patient needs Policies Unique or individualised needs of patients	Patient deserves care they are entitled to Patient prioritisation	Advocacy
Care patients equally Etiquette Patient safety Patient welfare Respect the patients	Critical thinking Corporate culture Altruism	Ethics and values

Leave space for report writing Paperless Prepare documentation early Preventive measures	Systematic Creative	Innovation and visionary
Evidence based practice Importance of nursing care plan Goals and targets Re-evaluate interventions	Nursing Process Updating knowledge	Knowledge
Assessment Clinical judgement Scope of works Self-belonging to the profession Think and write fast	Early and Quick Response Differentiation of nurses works and tasks	Autonomy
Attending courses, seminars Education background Enthusiasm to learn Eager to know	Alertness Observant	Spirit of inquiry
Collaboration Rapport with colleagues Rapport with patients Delegation Role modelling	Team work Continuity of care Communication	Collegiality and collaboration

5.3.1 Accountability

Thirteen respondents in this study describe 'accountability' as being a responsible healthcare provider and to ensure that their documentation is fully completed prior to the end of their shift. Table 5.3 displays the common phrases and constructed subthemes that represent the existence of accountability shared by the respondents in this study.

Table 5.3: Common phrases and subthemes related to accountability

Common phrases	Frequencies	Subthemes	Frequencies
Countersign	4	Responsibility	13
Date and time of documentation	3	Truthfulness	15
Obligation to complete documentation	7	Accuracy	19
Report actual event	2		

Nineteen respondents emphasised the importance of accuracy in the documentation. This accuracy refers to all aspects, including reporting patients' current conditions and the care that they have offered or are going to deliver.

"All the tasks that you performed for the patient should be in detail. Mmmm... for example... the time you administered the drugs, the dosage, the name of the drugs, any side effects ... it has to be jotted. When you do your checking on the patients, the things that you found out, you have to jot down exactly the same ... mmmm ... For example, the nursing care plan, the nursing interventions and the nursing diagnosis, has to be accurate to the actual problems that the patients experience ... sometimes, they just write in simple terms ... and very general ... patient is stable, slept well ... and that's it ... that is not enough ... otherwise ... what is the point of having documentation?"

(Mastura)

Respondents explained that a nurse's attitude is a significant factor when preparing documentation. They mention that it is essential that nurses are truthful when reporting patient's conditions. In other words, the respondents describe 'truthful' as being ingenuous when reporting the actual representation of the current status of their patients. One nurse, Annikka shared her experience,

"I know some of my colleagues just jotted down things that they actually did not perform ... even, they just duplicate or copy the previous reports as if it was their actual finding or something that they performed... I know, if the patient is in a normal condition or state, it means there is little to look for and it is all the same... In cases where they simply recorded ... patient is normal and alert, and CST ... continue same treatment I know that they did not actually assess their patient."

(Annika).

Therefore, it can be established that most of the respondents admitted how important accuracy and truthfulness are in the context of delivering information in the documentation. The sense of accountability could be motivated by the fact that the importance of providing accurate information and being honest when delivering information are also mentioned in the Code of Professional Practice (1998) published by the Ministry of Health Malaysia.

5.3.2 Advocacy

Fourteen respondents in this study express the importance of being attentive to their patients to retrieve the exact information regarding the patient's issues and needs (see Table 5.4 below). This information eventually helps to facilitate the formulation of individualised nursing care for their patients. Each patient requires special attention and care depending on their current conditions.

Table 5.4: Common phrases and subthemes related to advocacy

Common phrases	Frequencies	Subthemes	Frequencies
Good listener	1	Patient deserves care they are entitled to	7
Individualised care	5		
Patient benefits		Patient prioritisation	14
Patient needs	4		
Policies	1		
Unique or individualised needs of patients	5		

Therefore, these respondents placed great emphasis on the significance of conducting their own assessment, particularly by interviewing the patient individually and routinely. These steps are to ensure that the primary source of information is adequately recorded in the documentation.

"Nursing shift report, for example, we have to look at the patient's needs ... Every patient has different needs and problems. That's why when we tend to write our nursing shift report, we have to do it in front of the patient. Not just sit in one corner, because you don't know what happen to your patient, and you do not know what you going to write."

(Saptuyah)

Three respondents argued that nurses should also include patients' personal requests in the documentation. This inclusion, according to the respondents, will not only assist patients in fulfilling their physiological needs, but also their psychological needs. Hence, patients' personal requests or needs should not be ignored but instead be recorded in the documentation,

"Some patients say, I want to wait for my family, so we have to call the doctor, inform our doctor, then inform the family to come and meet them la. We have to write in the report"

(Rohana)

Additionally, five of the respondents in this study state that the nursing documentation could demonstrate the nurses' ability to ensure that the individualised needs of the patients are always included in the content of their documentation (see Table 5.4 on the previous page). Jamayah mentions how the documentation can play a role as a source of confirmation of the treatment and/or care that has been offered or planned for the patients throughout the patients' hospitalisation.

"All the way until the patient is discharged, as a nurse, we have to keep on looking at the documentation. If the treatment or care is not enough or adequate, we shall continue."

(Jamayah)

Another interesting finding was when Cindy shared her opinion on how the nurses are to be responsible for ensuring that all the patients' needs and problems are addressed, intervened and recorded in the documentation. This, according to Cindy, has been enacted in the nursing act or policies. She states that:

"It is already mentioned in our nursing policies ... errrr ... the nursing acts, that we have to serve our patient and try our best to help the patients ... make sure that care is given and their needs are fulfilled ... It is just like you, when you are at the government counters, the individuals who serve you at the counter should serve you nicely ... professionally ... so, our patients are also our patients ... because it is in our policy, we have to write or record it, to prove that we did it ..."

(Cindy)

Cindy's excerpt could portray an indication that she is aware and understands that the care that she provides to patients is parallel to Malaysia Nursing Board's acts and policies.

5.3.3 Innovative and visionary

From the transcripts, all of the respondents in this study seem to fail in articulating and conceptualising the component of innovation and visionary by eliciting it straightforwardly from their documentation. Instead, it appears that the respondents have attempted to identify innovative methods of documentation.

The findings reveal that six respondents mentioned that a nurse should be creative in formulating and composing their daily work to ensure that their work is efficient and effective (see Table 5.5 below). In this context, the respondents share the methods that they have been utilising to assist in completing or preparing their documentation.

Table 5.5: Common phrases and subthemes related to innovation and visionary

Common phrases	Frequencies	Sub themes	Frequencies
Leave space for report writing	1	Systematic	6
Paperless	1	Creative	6
Prepare documentation promptly	2		
Preventive measures	1		

Hani explains how a personal notebook can assist in documentation. She states that a personal notebook is used to list all the tasks or orders that they need to do. This approach helps her to remember or recall all the necessary tasks or interventions that they need to accomplish before the end of their daily routine.

"No trick lah, during the handover, we will write in a book. Example lah, anything we forget, we refer back to the book."

(Hani)

However, this statement could not be associated with one of the RNAO (2007) components, specifically the innovation and visionary part, where the respondents failed to show initiative regarding different approaches to improving practice and being involved by means of working.

In contrast, three of the respondents also described the use of their own note book in writing information regarding a patient's current status and the necessary interventions before transferring those details into patients' case notes, or to be exact, the nursing shift report.

"I have my own way ... I have a little note book, which I use to jot down all the things that I need to record and mention. Then, I transfer everything to the nursing shift report. This will help me not to forget the things that I need to mention or I have done to the patient."

(Dora)

In the same context, Harris, a nurse who works on a male surgical ward mentions applying visual presentations to support her report writing. The visualisation of the condition of the wound is presented in the form of a drawing, which the respondent found useful to support the narrative explanation on the condition of the wound:

"Yah, about the dressing. It is like we draw, draw the wound, so, stage of like stage one, stage two, stage three, stage four, the worst one is four la. So, we need to explain in our documentation, we need... how many cm, how many cm, and if the wound has the slough or not, ahh, better or worse, like that."

(Harris)

The above quotes also imply that the respondents had generally failed to highlight or directly imply the aspect of 'innovation' and 'visionary' in the context of their documentation during the interviews. Nevertheless, the respondents did highlight that they always performed their duty systematically to prevent any unsuspected or sudden setbacks, specifically with regards to those patients who are in the acute phase.

5.3.4 Ethics and values

From the interviews, it was determined that the attribute of ethics and values in relation to their documentation were not eloquently described by all of the respondents. It could be established that the attribute of ethics and values indirectly revolved around other discussions pertaining to their own definition of being professional.

Notably, the respondents predominantly discussed respecting the patients as well as their welfare and safety when delivering care. It should be noted that the respondents state the importance of being respectful and the need to treat all of their patients equally regardless of

the patients' background when delivering care. For example, the nurses should address their patients correctly and appropriately. These respondents also put great emphasis on not referring or addressing their patients according to their demographic backgrounds. Najwa, one of the respondents who placed an emphasis on this matter, mentions that:

"We must respect our patients also ... Ahhh ... We must call them by their names, not to, some of them, let say if Chinese patient, that Chinese like that. Cannot call like that, we must mention, we must give respect, call them by their name ... So and so ..."
(Najwa)

Meanwhile, Alin clarifies that, in her approach when giving care to patients, she treats her patients the same and uniformly, regardless of their background. This, according to her could be considered as the act of being professional.

"You are ready, every time, you become a nurse. Being professional is very important, and as a nurse you must ready regardless of race and religion. This action is considered professional."
(Alin)

The other themes that were mentioned in this section are presented in Table 5.6 below. Based on Table 5.6, it can be seen that the respondents could only comprehend how ethics and values can be highlighted through documentation, i.e. from being able to consider the patients' welfare and also by respecting the patient with appropriate etiquette.

Table 5.6: Common phrases and subthemes related to ethics and values

Common phrases	Frequencies	Subthemes	Frequencies
Care for patients equally	1	Critical thinking	3
Etiquette	1	Corporate culture	2
Patient safety	1	Altruism	1
Patient welfare	3		
Respect the patients	3		

Additionally, Ah Mei mentions that it is essential to establish rapport not only with the patients but also with their colleagues, as illustrated in the existence of ethics and values in nursing professional practice. The excerpt below exemplifies the above findings:

"You must know how to establish rapport with your patient. For example, you should greet your patient when you are near to their bed, but just say "hello, how are you today?" and so on. You should not do this whenever you need to approach patients to perform procedures or conduct observations. Being able to communicate with your patient is a basic thing in order to be a professional nurse."

(Ah Mei)

5.3.5 Autonomy

The attribute of autonomy was described by thirteen respondents, as the ability to act or respond early, and quickly, to manage and fulfil the patients' current status and prioritised needs (see Table 5.7 below). This action exemplifies respondents' ability to work independently and make a precise decision in their nursing practice. Table 5.7 below shows the details of common phrases and constructed themes that represent the existence of autonomy in the nursing practice.

Table 5.7: Common phrases and subthemes related to autonomy

Common phrases	Frequencies	Sub themes	Frequencies
Assessment	4	Early and quick	13
Clinical Judgement	9	Response	
Scope of works	1	Differentiation of nurses	11
Self-belonging to the profession	2	works and tasks	
Think and write fast	4		

Vimala, a senior staff nurse who has been working for more than five years, argues that work experience significantly affects nurses' abilities to make clinical judgements in their nursing practice. These abilities denote their level of critical thinking in planning and implementing their nursing interventions. In other words, nurses understand that autonomy from the inclusive findings, from the assessment and their actions are based on their findings in the documentation. This evidence reflects their ability to work and to exercise decision-making independently, within one's scope of practice.

"... with work experience, you know what happened. You have the experience that helps you to decide what is best ... the longer you have worked, the more experience you have that will help you to make decisions ... like when you find abnormalities in a patient, you immediately inform the doctors. If you don't have enough experience, you won't be able to detect these abnormalities..."

(Vimala)

Mariam explains her approach when she was intervening with a patient on the ward who was experiencing a low-grade fever:

"Temperature spike? Aaaa... aaaaaa .. if low grade 37.5, we will intervene. For example, if patient can drink, shower, drink plenty of plain water, then we check the next vital signs, we recheck and if it's still high, we will inform the doctor. For example, if a temperature is 38.0, 38.5 or 39, we can offer tepid sponging and inform the doctor."
(Mariam)

The following excerpt illustrates how the respondents recognised autonomy in their nursing documentation:

"For example, if the patient experiences a heart attack, or anything related to it, a nurse should listen to the order, listen to all the patients' complaints and immediately we have to do our nursing actions. For example, if a patient complains of chest pain, we have to inform the doctor, or if there is GTN PRN prescribed, its ok, aaaa But if a patient ... experiences severe pain, we have to inform the doctor and we have to take the vital signs as well. Vital signs? We have to write them on the observation chart. To ensure that we won't write a long report, it is important that we jot down our observations, what we observe after the patient complains of pain. That means if the BP shoots up, the patient actually experiences pain, at that time ... Aaaaa ..."
(Josephine)

Based on the above excerpts, it can be established that the respondents in this study perceive autonomy as the ability to implement their actions based on their critical thinking, and their interpretation of the findings they have obtained from the patients.

5.3.6 Knowledge

From the analysis of qualitative findings, four respondents mentioned that good content and presentation in documentation can demonstrate the nurses' ability to use evidence-based practice. These respondents then further explained that the quality of the information in the documentation is representative of the depth of the nurses' knowledge, particularly in applying the knowledge to perform assessments of their patients.

One respondent states that:

"A professional nurse writes good documentation. From their documentation, you can see, they really assess their patients. The information that they have recorded is more detailed than the usual one. I mean, more than just patient is stable, patient is alert and so on. Also, you can see their nursing care plan is so detailed, as they have the knowledge to help them to write."

(Alicia)

Subsequently, the amount of information from the assessment determines the specificity, appropriateness and effectiveness of their nursing care plan. Specifically, the content in the nursing documentation is achieved when the information that is shared in the documentation demonstrates the nurses' ability to apply the body of knowledge to practice. Elina, a staff nurse with less than five years working experience, argues that the more knowledgeable the nurse has, the more information that they can record in the nursing documentation.

"Aaaaaaa ... aaaaa ... My knowledge is not adequate because I document only basic information. I believe this is because I do not have enough knowledge to help me to write. So, the content in the nursing report is basic and too general. This is not good."

(Elina)

Table 5.8 below presents the common phrases and the constructed subthemes which demonstrate the existence of knowledge in the respondents' way of practice, particularly in preparing or completing their documentation.

Table 5.8: Common phrases and subthemes related to knowledge

Common phrases	Frequencies	Subthemes	Frequencies
Evidence based practice	4	Nursing Process	8
Importance of nursing care plan	1	Updating knowledge	7
Goals and targets	2		
Re-evaluate intervention	1		

Seven respondents agree on the importance of updating their knowledge. This is essential in order to achieve the expected level of care that they have to demonstrate throughout their daily practice. Attending courses, seminars and workshops are among the most common activities that they have undergone to ensure that they have obtained the latest information pertaining to their duty and tasks. Siti, one of the respondents who believes in the importance of updating knowledge, says:

"Beside the skills, nurses need to improve their knowledge. They have to attend CME, courses. That is important because when she or he attends courses, such as post basic and all that, they will be able to learn more about illnesses and procedures. For example, cataracts. Those staff who has undergone eye nursing courses, she or he will be able to know the needs of the patients during pre-op, intra-op and post-op, for nursing care."
(Siti)

One particular respondent believes that the level of knowledge is influenced by the seniority of the nurses in the clinical setting.

"Lack of knowledge. Maybe the junior staff, maybe they didn't, they don't know how to write. Maybe the way they want to express their words, but they did not, don't know how to write in proper way."
(Auguste)

Conversely, Liza, a senior nurse, shares her experience in relation to when she had just started her career as a nurse.

"Perhaps we don't know anything. When we first start working, we lack knowledge related to writing up the nursing shift report ... aaa ... and we tend to copy what the doctors' plan."
(Liza)

Therefore, it can be concluded that the level and amount of knowledge which is acquired from years of working experience was perceived as a significant influence on the details and the content of the respondents' documentation. Knowledge is unseen; as existing within the respondents themselves, particularly in the ability to demonstrate, synthesise and apply knowledge in practice, which is challenging for the respondents.

5.3.7 Spirit of inquiry

Evidently, spirit of inquiry in this study could be attributed by eighteen respondents, as the eagerness to update their knowledge by way of attending courses, workshops and seminars

(see Table 5.9 below). Table 5.9 below shows the common phrases and subthemes which form the existence of spirit of inquiry among the respondents in this study.

Table 5.9: Common phrases and subthemes related to spirit of inquiry

Common phrases	Frequencies	Sub themes	Frequencies
Attending courses and seminars	18	Alertness	15
Education background	7	Observant	5
Enthusiasm to learn	1		
Eager to know	1		

The acquisition of current knowledge, specifically in providing care or delivering treatment to patients, is viewed as a lifelong learning commitment. Patricia, for example, shares her thoughts on this matter:

"As a nurse, we need to keep on updating our knowledge. In the medical field, new things like treatment, diseases and procedures are always happening. Things change rapidly. All the machines, the new technologies, make you learn. If you have the latest information or knowledge, then it would help you to assess the patients and understand more about them. That's why, the nursing board requires nurses to attend courses, seminars and workshops, it is a must. If you don't go, you can't renew your annual practice licence."

(Patricia)

In other words, the spirit of inquiry could drive the respondents to obtain more information about the patients' current status and to acknowledge that they can offer patients more options.

The respondents were asked what criteria are important for nurses to be considered professional when it comes to documentation. Fifteen respondents state that sense of alertness is vital. 'Sense of alertness' was perceived as being attentive and sensitive to their patients' needs and current status. They believe that by being alert, it would drive them to be more attentive and eager to obtain more information about their patient's problems and needs.

"But ... when we recheck the patient's body temperature and the temperature still spikes, it could be due to bacterial infection, aaaaaa.... If that is the case, we have to recheck the patient's body temperature again. Once again, the patient's body temperature is still spiking, so we have to inform the doctor immediately. So, the doctor can start antibiotics and do a further investigation like taking blood culture specimen."
(Nafisah)

Five respondents mention that nurses should be observant whenever they are delivering care to patients. For example, Faizal, a nurse who is attached to a psychiatry ward, expressed his thoughts,

"... if you choose to be observant and you do not observe the patient properly, your nursing care would be lacking something. Maybe that patient, passed a motion in the morning. You simply write down patient not passing motion this morning. So, it's like, when the PM shift ask the patient, have you passed a motion? The patient says, yes. But the morning shift said that you did not pass a motion. It's like lacking something. So, it shows that you are not doing your job properly."
(Faizal)

To summarise. The spirit of inquiry was demonstrated through nurses' eagerness and sensitivity towards patient's current status and needs, particularly on the wards.

5.3.8 Collegiality and Collaboration

From the interviews, it was established that fourteen respondents in this study had discussed the roles of their documentation, as an essential medium for them to ensure the continuity of care throughout their daily tasks (see Table 5.10 on the next page). All the information pertinent to patients' current status and latest treatment and care were emphasised by all of the respondents, as crucial documentation that should be available and shared by all medical personnel.

Table 5.10 on the next page reveals the common phrases and subthemes which form the existence of collegiality and collaboration among the respondents in this study.

Table 5.10: Common phrases and subthemes related to collegiality and collaboration

Common phrases	Frequencies	subthemes	Frequencies
Rapport with colleagues	3	Team work	18
Rapport with patients	1	Continuity of care	14
Delegation	6	Communication	7
Role modelling	7		

Rohana, a nurse on a medical ward, shares her thoughts regarding how her documentation plays a significant role as a medium of communication, particularly during handover sessions and ward rounds. She argues that effective team work is a vital element in ensuring that the continuation of care is delivered effectively.

“General condition. Initially the general condition, the vital signs, and then if the patient has any issues, complaints, can’t pass urine, we need to jot down what we need to do. Maybe we will inform the doctors. What is the treatment the doctors want us to do? We have to document everything, and then if the problems settle during our shift, it is ok. But if the problems don’t settle during our shift, we have to make sure the PM shift know about that. Yeah ... we need to let the PM shift know what has happened during the morning shift.”

(Rohana)

Six respondents in this study also mention the role of nursing documentation as a medium of reference when it comes to delegating tasks or work to colleagues. In this context, task delegation that occurs during the shift between the nurse who is managing to the nurse who is the ‘runner’, or to other colleagues in the next shift, could be performed according to the piece of information in the documentation, which is literately shared among the nurses. Alin, who has managed the ward for a few years, remarks that,

“For example, if I have requested my runner to do a dressing, we will write in the documentation, who did the dressing, what type of dressing ... The runner will inform the in-charge that she or he will use this type of dressing method and what she or he found when assessing the wound. The runner could give an opinion or suggestion to the in-charge and this is recorded in the documentation.”

(Alin)

Another respondent, Christine, justifies that the documentation could act as a medium to communicate or channel concrete evidence from one nurse to another. In this context,

evidence could represent the current changes, and the treatment and care of the patients. She further explains that such information engages and encourages nurses to continue assessing the care that they offer to the patients throughout patients' hospitalisation period to ensure that it is current and effective.

"Yes! It would reflect because aaaaa ... each time is not the same personnel handling the case. So, if the documentation is done properly, whoever is doing it, after you do the follow up, will have a clear picture of what is happening and what needs to be done after that. So, that is one of the reasons why it is very important, especially because I am not the sole person who is handling that particular patient. You may not always be around, you see. At least when you come back after a few days off and when you go to continue with the same patient, or anyone else wants any details about the patients, if they want to follow up or want to know what's happening, at least your documentation is there."

(Christine)

Furthermore, all the respondents shared their perception related to their colleague's view on their documentation. For instance, Noryn who is a nurse in a mental institution shares her perception on how the doctors recognise their documentation.

"Let say, suddenly, in the afternoon, the patient sometimes gets aggressive, they don't know what the patient did in the early morning. Sometimes, they could fight with another patient, fall or get restless. Or, when the doctor asks, what did she do in the morning, they can tell, they can read through our report, and they can tell the doctor. We normally write in report how the patient has slept, so, when the doctor asks how the patient slept we can read through the documentation from last night and tell the doctor what she did on night shift. Whether she slept well. Sometimes, patients like to walk around all night. They can't sleep and they sometimes hear "voices".

(Noryn)

Eighteen respondents also mention how good teamwork will encourage them to improve their documentation. For example, Pauline, a senior nurse, remarks that the implication of working together through learning from each other, particularly in improving the documentation, can lead to good teamwork.

"We have to remind each other that maybe they will forget sometime. Will you advise each other. Yeah...its team work. If you think that your colleague did something incorrect, you tell them. Same things when I make a mistake, they must tell me. Not to demotivate or scold others. By the end of it, it's for the patients' safety. With this, teamwork can be established."

(Pauline)

The respondents perceived good teamwork among the nurses, besides other healthcare providers as a good mutual understanding among themselves. Fourteen respondents describe the impact of mutual understanding between the staff to work together, so that the care or treatment given to the patients can result in positive outcomes for the patients. This claim could be demonstrated from Nurul's statement:

"Team work enhances the spirit of helping each other. This is because we are in one team. If anything happens to a patient, for example, the patient collapses and you don't really care about others, people who work with you will ... of course will do their own thing. Eventually, we end up in big trouble. The patients will also not get any benefit from it. Haaa ... team work in documentation ... means aaaa ... like ... from the perspective of ... aaaa ... like us ... Like in one shift. We surely have the person who is in-charge, and runners, and we have ... suppose we do have the in-charge and runner. Because, when you're in-charge, you will be responsible for taking care of the patients and should know the ins and outs about each patient. And, the runner will help the in-charge.

(Nurul)

Another respondent also states that:

"Thanks to my colleagues, I have learnt a lot regarding my documentation, even though they sometimes teach me briefly about it. They have taught me how to improve the quality of my documentation, especially in making sure that the documentation is accurate, easy to understand and how to make sure you finish your documentation on time. I also help them by telling them and they also learn from me. You know, learning from each other. Sometimes, you don't get everything from your training, and there are things you learn from your colleagues."

(Fauzi)

It could be argued that collegiality and collaboration is one of the most significant key themes, collectively shared by the respondents in this study. In summary, it can be argued that the respondents were able to define that collegiality and collaboration are pertinent to the role of their documentation as a medium of communication between themselves and other healthcare providers.

5.4 Additional emerging themes

Several other emerging themes were also highlighted from the interviews. These themes arose from several codes that were revealed directly and indirectly by the respondents. Specifically, these codes emerged from the respondents' sharing experiences, thoughts and opinions as well as from commenting on a specific matter related to their documentation

practice. It is essential to consider these other emerging themes as they could assist in the construction, support or rationalisation of the actual research matter, or the explored phenomenon (Fereday & Muir-Cochrane, 2006).

Among the other interesting themes that were identified from the interviews are the factors related to the 'Blame Culture'. The blame culture, according to the respondents, is one of the factors that influences the respondents' current practice, including preparing their documentation. This factor may create barriers to nursing documentation, prioritisation of nursing documentation (dilemma between delivering care and completing the documentation) and the definition of professionalism in nursing. Further details on these emerging themes are outlined in Table 5.11 below.

Other potential themes, such as exploring nurses' comprehension of professionalism and its relation to their nursing documentation were also elicited. Furthermore, other issues and relevant matters that potentially affect the presentation of their nursing documentation and, therefore, could contribute to the qualitative findings are also reported. These emerging themes were added as they arise from a more vigorous analysis of the transcripts.

Table 5.11: Subthemes related to other emerging themes

Subthemes	Frequency	Themes	Frequency
Scolded	1	Blame culture	15
Scared	1		
Advanced users	6		
Working process	4	Roles of nursing documentation	38
Procedures	2		
Monitoring	5		
Medium for communication	1		
Medico-legal matters	26		
Evidence of care	9		
Effectiveness of provided care	2		
Continuity of care	14		
Confirmation of work completed	26		
Influence of religion	1	Factors that influence	20
Gender	1		
	2		

Diploma nurses are better than graduate nurses Prioritising documentation than care (Dilemma)	17	documentation practice	
Poor attitude Dishonesty Laziness Ignorance Forgetfulness Difficult to change	9 7 4 14 5 3	Intrapersonal barriers related to nursing documentation	18
Too many patients Too much documentation Time restraints Sudden events No standard guidelines A struggle for case notes Overwork Shortage of staff	5 4 11 4 11 3 9 12	Interpersonal barriers related to nursing documentation	10
Professional behaviours Hardworking Good nursing management Discipline Determination Dedicated	2 3 2 6 2 3	Association between documentation and professionalism in nursing	18
Smart Responsibility Patience Emotion stability Discipline Compassion Communication Caring Maturity	3 12 2 4 6 8 7 6 2	Definition of professionalism in nursing	6
Seniority Pressure from senior staff	3 2	Power-Dynamic and Authority	19

Learn from seniors	2		
Junior Senior	19		
Follow senior	3		
Doctor's hand maiden	1		
Doctor's order	12		
Doctor checking out nurses' work	10		
Visual presentation	33	Presentation/	3
Language	15	Quality of nursing documentation	
Time management	7	Strategies to	3
Standard guidelines for documentation	11	improve nursing documentation	
Staff welfare	1		

Each of the above-mentioned themes were constructed based on the respondents' understanding of their work processes and current working conditions, particularly ensuring that their documentation is well prepared and properly documented. It should be noted that all these themes were not shared across all the respondents. The themes are not as significant as when it comes to the frequencies of these themes mentioned in the interviews. However, these themes were constructed from the way the respondents gave their opinions and thoughts on their documentation practice in their interviews.

5.5 Conclusion

It can summarised from the qualitative findings that the respondents associated themselves with being able to demonstrate their professionalism on the documentation by means of four prominent achievements; i) completing all the necessary procedures or prescriptions besides recording patients' complaints, ii) being able to execute the doctors' or the physicians' orders and requests could be considered professional, iii) the length and the detail of the information that is recorded in their documentation, and iv) completing or preparing their documentation according to their code of conduct. The respondents argued that the primary role of their documentation is to act as valid evidence to legally protect them if there is any litigation due to suspected malpractice or negligence of care in the future.

From these findings, it can be argued that most of the respondents in this study were able to convey their understanding of the existence of the elements of professionalism in their documentation. However, their understanding of the existence of the elements of professionalism in their documentation in the account of their scope of practice could be greatly influenced by their level of knowledge that revolves within their practice and within themselves. Additionally, there was not much theoretical knowledge and knowledge application in the context of professionalism and its relation to nursing documentation that could be established from the interview data.

Consequently, the respondents were unable to discuss the actual attributes of professionalism in nursing that are listed in the RNAO (2007) professionalism in nursing, when asked during the interviews. All the respondents in this study admitted that they have not heard of the RNAO (2007) professionalism in nursing, or any other theories or models that discuss professionalism in nursing. The qualitative findings also revealed several emerging themes, which potentially dignify the similarity and differences between the quantitative and qualitative findings in this study. These similarities and differences will be further discussed in the following Chapter 6 (Discussion).

CHAPTER 6: DISCUSSION

6.1 Introduction

The quantitative and qualitative results indicated several interesting findings in response to the research objectives. As aforementioned, this study has two primary research objectives:

- i) To identify the evidence of the elements of professionalism among nurses in Malaysia from their documentation, and
- ii) To explore the knowledge, attitude and practice related to the elements of professionalism among nurses and its association with their documentation in Malaysia.

In this chapter, the core findings from the quantitative data are discussed concurrently with the related qualitative information, parallel to Creswell's (2012) triangulation – convergence model design. The merging of these two types of data is the key to evaluating the effectiveness of mixed methods design and the success of integrating the two data sources concerned with meeting the aim and the objectives of this study.

The chapter will also discuss the pragmatic perspectives of the professionalism model developed by the Registered Nurses' Association of Ontario (2007) concerning the results of this study. The concluding section will discuss the psychometric properties of the Retrospective Nursing Document Analysis (RNDA) tool that was employed in this study.

6.2 Evidence of professionalism among nurses in Malaysia in their documentation

The quantitative findings of this study report that more than half of the total reviewed case notes in this study revealed a good indicator of the existence of professionalism (see Appendix 2). A total of 468 out of 655 reviewed case notes, which is equivalent to 71.5%, are a good indicator of the existence of professionalism. Comparatively, a study by Setz and D'Innocenzo (2009), assessing the quality of the records discovered that approximately 26.7% of the reviewed records were considered poor, 64.6% as regular and 8.7% as good. Nevertheless, they indicate that no files were evaluated as excellent.

The reliability and validity of their research findings can be questioned. It can be argued that their study failed to describe or explain the validity and reliability of their documentary research methodology, specifically the research tool. It is imperative to report or to disseminate the validity and reliability of a research tool in a study, specifically in the field of social sciences. This is to ensure the tool complies with the degree to which the tool and its procedures are stable and produce consistent results, and how good the tool is at measuring what it is purported to measure (Field, 2012).

The qualitative findings, when the respondents were asked to give their own definition of professionalism in nursing suggest that nurses appear to 'struggle' to define and comprehend the concept of professionalism. Their definitions merely explained the concepts regarding professional nursing practice. One respondent's definition of professionalism was;

"... professionalism in nursing is the way we practice ... We as nurses ... must be professional when nursing patients ... Professionalism in nursing is important. Every nurse should be able to show it ... you know ..."

(Farzana)

"OK ... what is your own definition of professionalism in nursing with relation to your nursing documentation?"

(interviewer)

"...mmm.. when you record the patient's findings and the procedures that are ordered by the doctor, your documentation is good. That is professionalism."

(Farzana)

Sheila, a nurse who is attached to an orthopaedic ward, defines professionalism in nursing within the nursing documentation as:

"... aaaaa ... professionalism is treating patients the same ... Make sure all the work is completed and recorded ... otherwise the doctors are not happy ..."

(Sheila)

Conversely, Khatijah defines the existence of professionalism in nursing in the nursing documentation as:

"... if we manage to use critical thinking and have lots of knowledge, we can write more and our documentation is more detailed ... We are professional ... We can be better if we have more knowledge ..."

(Khatijah)

All the respondents in this study struggled to connect the ideology of professionalism in nursing with their documentation. Comparatively, the respondents in a study by Salam et al. (2012) were also unsure about the meaning of 'professionalism'. As the study by Salam et al. was conducted among medical students in one of the public universities in Malaysia, it is possible that the different thoughts and experiences of the respondents in this study to respondents in the current study might have influenced their understanding of professionalism. Akhtar-Danesh et al. (2013) also reported that little is known regarding nurses' perception of the concepts of professionalism, although they have been clinically applying the attributes of professionalism in the context of their practice, either in clinical care, research, education, policy or administration.

The findings of this study also echoed a study by Karadag, Hisar and Elbas (2007) and a study by Zakari et al. (2010), which reveals that the level of professionalism is low in nurses' behaviour and that nurses have a low perception of professionalism. Both studies further discussed how low evidence of professionalism in nurses' behaviour and perception in their study could be related to the workplace itself, besides the nurses' personal background. The latter includes personal interest in the nursing profession, along with the family's, society and consumers' views of the profession.

However, the above findings could not be considered compelling evidence to substantiate that nurses demonstrate their ability to think non-conventionally. The reason for these findings is not clear, although it may be related to the nurses who prepared this documentation being unable to demonstrate the ability to utilise their critical thinking in defining or discussing professionalism in nursing. Here, these nurses were unlikely to be unable to rationalise any actions that they have performed or will do to the patients (Laitinen et al., 2010).

In their research, Paans et al. (2010) mention how critical thinking in nursing practice is closely related to nurses' ability to apply the nursing process to their documentation. Moreover, they suggest that the stages of the nursing process are internationally used as a scientific framework for accurate nursing documentation. It also promotes individualised care and enhances patient's participation in care. The relativity of the nursing process within nursing care includes nursing documentation, which basically illustrates the practice of professionalism in nursing (Michalopoulos & Michalopoulos, 2006). Hence, the nursing process helps to organise and prioritise patient care, focusing on what is vital, such as a patient's

health status and quality of life, and create thinking habits that help in boosting confidence and improving the skills required to think critically (Riley & Beal, 2010).

In Malaysia, nursing is practiced, for most part, to the extent that doctors' orders are met, and not according to the nursing process (Ministry of Higher Education Malaysia, 2010). Ofi & Sowunmi (2012), for example, argue that nurses' lack of knowledge and implementation in the nursing process could be a significant factor that causes deficiencies in proper documentation. They further explain that diploma graduates are only expected to 'implement' care orders and since current practice does not expect nurses to perform a health assessment, make a nursing diagnosis and plan for care, the orders in question would only have to come from doctors.

The qualitative findings of this study suggest that respondents with a diploma found it a struggle to explain, in detail, about work or processes that they must encounter whenever they are completing their documentation. Findings of this study reveal that most of respondents were those with less than five years' experience and were Diplomas holders (see Table 5.1, p185). For example, Maziah et al. (2012), ascertained that 91.9% of the respondents in their study had diplomas. Similarly, Ahmad and Oranye (2010) also reveal that approximately 72.9% of their respondents hold Diplomas. These findings support claims made by the Ministry of Higher Education Malaysia (2010) that almost all staff nurses working in hospitals and the community are diploma holders. This, according to the Ministry of Higher Education (2010) is a result of the considerable number of nursing institutions offering diploma programmes (i.e. 88 out of 98 nursing institutions in Malaysia offer diploma programmes).

Consequently, diploma graduates dominate almost the entire nursing service, placing nursing in the sub-professional group within the government structure. Birks et al. (2008) propose that there is a different working process between nurses with degrees and nurses with diplomas. They argued that nurses with degrees are more capable of rationalising their actions or interventions that they offer to patients compared to nurses with diplomas. This advantage encourages these nurses to initiate a research culture amongst themselves. This is more likely due to the structure of the degree programme which places greater emphasis on evidence based practice.

For example, Patricia, a registered nurse with a diploma, who was asked to explain her preparation to complete the nursing documentation, stated:

"Ideal eh ... You know ... I am just a diploma holder (laughing). Like I said, after we receive the report, we must see the patient. We look at the patient, the condition, can he get up or move ... We assess the patient first. After we assess the patient, we look at the patient's activities. Can he perform his own activities? Does he need assistance or help? We must see this. What sort of assistance or help does he need? Does he like to lie down, sit or like to be in a wheel chair. Then, we look at his diet ... How is his diet? Did he take his food? Does he have diabetes? If so, we serve a diabetic diet. If it's a diabetic diet, we usually monitor his glucose level ..."

(Patricia)

Alternatively, Gwen, a registered nurse with a degree, explains her preparation to complete her documentation;

"Right after hand over, I would go and approach the patient. I would assess his conditions and whether the patient is alert and responsive ... and his vital signs. Does he experience any pain? ... Whether he can perform his ADL (Activities of Daily Living), diet and the treatment. We should check the report to see if any of the procedures have been done ... We should assess from head to toe. For example, a patient with asthma. We need to assess his breathing patterns, SPO₂ (Oxygen saturation level) and check the skin is not pale. We check if he breathes using accessory muscle. Is the patient's diaphragm elevated whenever he inspires ... You may even need to check the patient's breathing using a spirometer. Say, the patient is on medication, assess the effectiveness of medication and the side effects. So much to say ... with all this information, you should write on your documentation. Ohhh ... one more thing. From the problems that you have found, you should do some interventions ... so that the problem can subside ... This also must be written down... You need to record whether things that you did were effective. Worse case, nothing changes or is very urgent. With all this information, you need to inform the doctors ..."

(Gwen)

These two excerpts may explain why nurses with a diploma work in a manner that is based on training and what they have been assigned (Birks et al., 2008). The effects of the protracted adoption of the innovative approaches to nursing and nursing education, as indicated by the late adoption of the diploma in 1990, is seen clearly in the ways in which nursing is taught (Shamsudin, 2006). Emphasis remains on achieving competency in technical skills. Student learning processes regarding the diploma programme are tutor-led activities, not student-centred (Chuan & Barnett, 2012; Said, Rogayah & Hafizah, 2009). A contributory factor in the inability to break away from the traditional approach may be due to the lack of a qualified faculty or trained manpower (Achike & Nain, 2005). It is generally accepted that

diploma nurses are task orientated, obedient and passive, possibly the result of low entry requirements and being a teacher-centred, didactic approach to education (Ministry of Higher Education Malaysia, 2010).

In their study, Ofi and Sowunmi (2012) concluded that the nursing process has become a symbol of contemporary nursing along with professional ideology. The nursing process has been incorporated into nursing education because it is a rational and systematic problem-solving approach used as a scientific framework to organise individualised nursing care (Jasemi et al., 2012). This systematic approach involves phases of assessment, diagnosis, planning, implementation and evaluation which should be documented. Somehow, in this study, none of the respondents mentioned the application of the nursing process when structuring their shift reports. However, eight of the respondents stated the ability to demonstrate the nursing process in their care plans. For example, Hani stated that:

"... with nursing care plans, we know the patient's problems or needs. From there, we can plan the most appropriate actions to deal with the patients' problems, mmm ... For example, if a patient complains that she is in pain, we should ask, where is the pain? Then, we can write in our nursing care plan, what we offered the patient, like painkillers, or ask the patient to do deep breathing exercises, or we could inform the doctor if the pain continues... This shows, we can assess the patient, can think what is good for her and we know whether our nursing care is good for the patients ... This is how nurses should function and show they use their brain to think and to work..."

(Hani)

The action of critical thinking and judgement was also congruent to King's (1996) 'Interacting Systems Framework' and 'Theory of Goal Attainment', where she emphasises nurses' ability to think critically and the collation of specific information essential for decision making to meet individuals' needs at a particular point in time. The accuracy of clinical decision making and relevance for a situation could be presented via documentation of patients' problems, nursing care and patient outcomes (Zegers et al., 2011). This practice is vital for the safety of the patient and the quality of nursing care, besides the credibility of the nursing profession. Moreover, King (1996) explains that the process of nursing reflects the science of nursing, which enables critical thinking to discover the rationale for the actions taken.

Nursing documentation is also defined by nine respondents in the study as evidence that differentiates nurses work from other healthcare professionals (see Table 5.11, p204). In this regard, Talib, one of the respondents explained that nursing documentation helps to segregate nurses' roles in in-patient care from the other healthcare providers. Modern

medicine and health create a situation where nurses' roles in some way, overlap with the roles of other healthcare providers. Talib states that:

"... nurses' roles are always overlapping with that of the other healthcare providers, particularly with the Medical Assistants in a specialised hospital ... That's the reason why nurses write their documentation differently in terms of content, compared to that of the... What's the name of the new post? Assistant Medical Officer? ... Ya ... nurses write different things to the AMO..."

(Talib)

Talib's thoughts are parallel to that of Henderson's (2006) argument on how nurses should be able to master the unique and authentic roles of becoming independent practitioners. From a distinctive perspective, Talib's opinions concurs with Barnett et al. (2010). In the study, Barnett et al. (2010) discovered that a grey area exists concerning nurses and medical assistants in Malaysia, specifically with regards to male nurses. Barnett et al. (2010) claimed that, due to historical and cultural reasons, there are very few male nurses and only a small number have been taught nursing skills and prepared as 'medical assistants'. This claim was made based on the Ministry of Health Malaysia's (2008) strategic plan and the 2007 health facts.

However, Talib's quote demonstrates that nurses can differentiate their work from other healthcare professionals. The sense of ownership of work is perceived as a professional achievement among nurses (Stievano et al., 2012). Professional achievement is concerned with how other healthcare providers perceive or treat nurses as colleagues and able to contribute to the care and treatment of patients (Siew et al., 2011). They added that 'professional status' is perceived to be the appreciation shown by patients, physicians and other healthcare providers: the nurses felt that they are 'treated as important people in the hospitals'.

The differences between the quantitative and the qualitative findings in this study in terms of the existence of the elements of professionalism in the respondents' documentation and the respondents' understanding about professionalism in nursing can be explained by numerous factors. For example, it can be explained using Benner's (1984) proposition on 'conscious' competency, which relates to the level of working experience of a nurse. In her paper entitled 'From novice to expert', Benner (1984), noted that there are five clinical stages and emphasised that novice nurses tend to be analytical and rule based. In the first stage, novice nurses are liable to perceive their clinical environment as 'procedural' puzzles. In contrast,

the final stage, according to Benner (1984), is where experienced nurses can use their cognitive thinking. These stages of competency development refer to the use of non-consciously combined pattern recognition (based on tacit and didactic knowledge) and memory among nurses, whenever they practice nursing. Therefore, there is a possibility that the respondents in this study are 'not conscious' (i.e. aware) that they had demonstrated professionalism in nursing, particularly concerning their documentation. This situation particularly occurs in Stage 2 (competent) of Benner's (1984) work, where nurses have less than five years working experience, and Stage 3 (proficient), where they have more than five years working experience, like the majority of the respondents in this study (see Table 5.1, p185).

Nonetheless, it is debatable whether these respondents were 'unconsciously' competent in their professional practice or demonstrated a lack of understanding regarding professionalism in nursing. Specifically, do they lack knowledge on the concepts of professionalism in nursing? Payne (2015), for instance, published a critical paper examining Benner's (1984) model of skill acquisition in nursing and suggested that nurses perform well in their practice and could be dependent on their 'intuitions.' These intuitions were demonstrated in the qualitative findings of this study, whereby both inductive and reductive reasoning were incorporated in the respondents' responses on the association between professionalism in nursing, and their documentation and definition of professionalism in nursing (see Farzana and Khatijah quotes above, p209).

Another possible explanation that contributes to explaining the differences between the quantitative and qualitative findings in this study is the nursing language acquisition among the respondents (see Patricia and Gwen's excerpt, p212). For example, Thoroddsen et al. (2010) mention that knowledge and the use of standardised nursing languages in clinical practice provide more reliable and meaningful data than unstructured texts. However, the terminologies remain unfamiliar to many nurses and implementation has been difficult to sustain. Meanwhile, Law et al. (2010) remark that several the respondents from their study find a lot of the language used in nursing documentation ambiguous.

This argument can also be seen from the qualitative findings of this study. Three of the respondents suggested that the element of ambiguity made them cautious about documenting their findings because they are worried about using ambiguous terminology. One of these respondents stated:

"... that they find it difficult to understand what other colleagues have written in the documentation. Furthermore, they mentioned the use of different abbreviations and words that are not standardised throughout the medical records."

(Christine)

There are occasions where fragmentary language (Jefferies et al. 2011b) and abbreviations not found on official abbreviation lists are used in documentation (Brous, 2009 & Burke 2010) and frequently makes it difficult to comprehend what is being written. The frequently incomplete nature of nursing documentation compromises patient safety (Burke, 2010, Laudermilch et al. 2010). Additionally, this set back does not favour the nurses, as there is the possibility that nurses are not able to recognise incorrect or inappropriate usage of abbreviations and acronyms (Koh et al., 2015). Consequently, nurses tend to misinterpret the medical and nursing practice, which could potentially cause medical/nursing errors (Dimond, 2008; Kuhn, 2007).

In terms of the nursing language, approximately 90% of the respondents in this study prepare their documentation in English. They acknowledged the importance of acquiring a good command of English in enabling them to express or better explain the content in their documentation. However, they have admitted that their level of English was not sufficient to achieve the expected level that they could consider as a good standard of English. Saptuyah who has been working as a nurse for three years stated that

"... I know my English is not good. English is hard to learn... but when you write your nursing documentation, it is easier to write it in English. This is because all the medical terminologies are in English, so it's better to write your report in English. At the beginning, when I was just started working as a nurse, it was hard but now I am used to it."

(Saptuyah)

Meanwhile, Laskhmi shared her opinions,

"... I have been working as a nurse for more than 10 years. As senior nurses, we get used to English. We speak and write in English mostly. Preparing nursing documentation is in English and it is easier as all medical terminologies are in English. But you know, the young nurses nowadays, they cannot write their report in English properly, incorrect terminologies, grammar errors and poor structure."

(Lakshmi)

This could be due to their working experience which has exposed them, both directly and indirectly, to their ability to prepare their documentation in English. Furthermore, their experiences are influenced by the senior nurses, who were primarily trained in English during the post-colonial era. Unlike the senior staff, junior staff nurses in the study highlighted their difficulty in communicating verbally in English, particularly during handover or when referring patients. Nonetheless, they find it relatively easy to write their nursing documentation in English, as they have been taught to write or prepare their documentation in English since their training.

Moreover, Ong-Flaherty (2012) also established that the other issue hindering physician-nurse communication is language. Specifically, Ong-Flaherty argues that the mastery of the English language among nurses in Malaysia is considerably low. However, these observations were limited to two private medical institutions in Peninsular Malaysia. In contrast, several respondents in this study shared their thoughts about their ease in communicating with the medical personnel in English as several of the medical terminologies are in English. These respondents added that they are more expressive if they are to write their nursing documentation in English.

Three of the respondents explained how the ability to acquire and possess a good command of English reflects their intellectual level. For example, Cindy believes that:

"... people will look up to you if you can speak and write in English ... All the medical and nursing terminologies and other medical documentation are written in English, even the text books ... the reference books ... So, it would be very difficult for a nurse to become more knowledgeable in their practice, if they could not speak, or write, and to understand what has been written in English ... Being able to converse and write English, makes you look smarter and you gain more respect from your colleagues particularly your superior ..."

(Cindy)

Other possible contributing factors that could explain the differences between the quantitative and qualitative findings on the existence of the elements of professionalism in nursing concerning nursing documentation are the sociological factors. In this study, these sociological factors have been elicited from the interviews with the respondents (see Table 5.11, p204). These sociological factors can generate unique thoughts and perceptions on 'what they say and what they do', particularly in preparing or completing their documentation. Among the sociological factors that were elicited from the interviews is the working culture among nurses, the sense of belonging, professional achievement and collegial respect, the generation gap

and working experience, power dynamics and authority in a hierarchal organisation, plus educational background.

6.2.1 Working culture among nurses

Returning to the quantitative findings in this study, it is reported that six out of eight of the RNAO (2007) attributes are strongly correlated with the overall score of professionalism in nursing, with $r \geq 0.5$ (see Table 4.3, p149). Specifically, the correlation between attributes of accountability, and of collegiality and collaboration with an overall score of professionalism in nursing could be considered weak, with $r \leq 0.3$. This indicates the attribute of accountability, and collegiality and collaboration are different entities, which do not solely fall into the context of professionalism in nursing. This may be explained by the fact that these attributes could stand on their own with professionalism in nursing to form a complete platform for nurses to practice safe and effective nursing.

Safe and effective nursing is the pedestal for nurses to ensure that they are socially accepted as trusted personnel in the healthcare system (Page, 2008). This is because members of the public have significant expectations of nurses, who play key roles in ensuring safe and competent practice within the expected standards, and in collaboration with other healthcare providers. Meanwhile, Moore (2015) highlights that nurses that carry professionalism into their practice create improved patient outcomes and safe and effective nursing practice. This argument is in response to Donabedian's framework (1988), which emphasised how the impact of care on the patient's outcome is significantly influenced by the nurses' ability to provide care to the patient, according to agreed standards of care.

Working culture among respondents in this study may be due to the influence of the authentic, distinct work and organisational culture that has existed in Malaysia for many years (Hofstede, 2001; Kennedy & Mansor, 2000). Poon (1998) and Ismail (1988) also explain how Malaysia's working and organisational culture emphasises social status and superiority, which includes respecting and being obedient for leaders. Khoo (1999) mentions that these phenomena occur among healthcare providers. On the matter of nurses' respect for their superiors, particularly doctors, nurses in Malaysia do not challenge the status quo or question 'orders', as they are accustomed to a subservient role in a culture that emphasises harmony and face-saving, hierarchy, status, roles and titles. This subservient role, according to Zainol and Ayadurai (2010), can be described as generally hierarchical with a prominent level of power distance,

status conscious with a deep respect for elders and roles in society; paternalistic; relationship-based instead of task orientated; largely collective in approaching work; and confrontation-averse, emphasising 'harmony and face-saving in Hofstede's model (1980). This claim could be elicited from one of the qualitative findings in this study, which revealed that eight respondents perceived themselves as important healthcare providers ensuring that the doctors' orders are completed or performed besides completing their documentation. Josephine shares her story:

"The doctors only look at the charts ... and the investigations. They don't usually look at the rest of the documents, especially the nursing shift report. They will look at the nursing shift reports if they want to check whether their orders have been carried out, or something wrong or abnormal happens to the patient ... They are the ones who treat the patients. Whatever they order us (the nurses) to do, we must follow or fulfil. That's the ways we work in the hospital."

(Josephine)

From the above excerpt, it is possible to conclude that the respondents in this study must make sure all these prescriptions or doctors' orders are eventually written in the documentation. A possible explanation for this might be due to the lack of assertiveness among nurses in Malaysia, where questioning is not encouraged and the physicians-nurse relationship is paternalistic (Ong-Flaherty, 2012). Evidence in support of this position, can be found in the quantitative findings of this study, whereby the result revealed that the attribute with the lowest median score was the attribute of spirit of inquiry with a median score of 24 out of 40 (refer Table 4.2, p147).

From another perspective, the qualitative findings have revealed evidence showing a lack of empathy among the senior nurses towards their juniors or younger nurses. The findings indicate that the senior nurses seem to blame junior nurses regarding poor documentation and care. If this culture of community and loyalty were to include these junior nurses, then the senior nurses would surely see the significance of their roles in supporting, encouraging and overseeing the work of their junior counterparts. This argument could be demonstrated from one of the respondent's excerpts, who expressed her dissatisfaction towards some of her colleagues (junior staff) for not completing their documentation.

"The junior nurses always say they always forget to sign the medication administration sheets. It is very dangerous. You are not sure whether that particular patient has been administered with the right medications. The patient would not know ... This issue has become worse and the doctors or the specialists would definitely be angry if they found out that the documentation is not completed and detect a mistake. The doctors and the

specialists even question whether the nurse actually did or will do what they have recorded in the documentation ..."

(Karen)

However, all thirteen junior nurses in this study shared their thoughts about how they followed the advice of their senior or superior on how to write the nursing shift report, along with completing or preparing the nursing documents (see Table 5.11, p204). Additionally, these junior nurses perceived the senior nurses to be more experienced and to have superior perceptions regarding care giving. Azizah's story highlights this claim:

"The seniors taught us how to write the documentation and we have to follow the way they want the documentation to be. They have been here longer than me, surely they mmm ... know the best way to write the documentation ... mmm ... We did learn how to write the documentation during training, but when I started working on the wards, the senior taught me the actual way to write, even though sometimes the juniors write better than the seniors."

(Azizah)

As aforementioned, Malaysia is a multicultural country dominated by the Malay ethnic group and in Malay culture, high ranking or senior staff are well respected by their subordinates (Abdullah & Low, 2001). Acceptance from people in the organisation has been gained through respect and obedience that is given to those in authority. The behaviour of deriving satisfaction from respect from colleagues and giving respect to hierarchy, authority, senior and elderly people are crucial factors that influence collectiveness among respondents in this study (Abdullah & Lim, 2001). This influence appeared to be present where a nurse respects their colleagues as team members. Furthermore, influence is also seen in how the junior nurses or those in subordinate positions are obedient and follow the instructions that have been communicated by their superiors. All of these aspects are among the priorities that a nurse tries to inculcate in their practice to fit in with the other healthcare team members.

This working culture that exists among nurses in Malaysia, which Abdullah & Low (2001) regard as a 'common cultural value', is part of the Malaysian's sense of self. This notion is regularly carried into the workplace and, to some extent, influences the way people relate to one another in performing their daily work. Ahmad and Abdul Majid (2010) argue that 'common cultural value' emphasises upholding the core values of the shared values and community orientation, as opposed to Western values that promote active competition and individualism. Nevertheless, Ahmad and Abdul Majid argue that all Malaysians, regardless of

ethnicity, share these common cultural values despite being a multicultural society where each ethnic group retains its own identity and culture.

There are several common cultural values amongst Malaysian citizens (Abdullah, 1996; Abdullah & Low, 2001). Firstly, Malaysians are considered to be a collective group of people in whom group interest is more important than the needs of the individual. Secondly, Malaysians favour the concept of 'being a family unit' and to maintain and remain loyal to the group. Thirdly, Malaysians uphold the concept of a hierarchical society where there is inequality in the distribution of power between the rulers and those being ruled. Finally, the elderly must be respected, as they are considered older and wiser and, therefore, deserve the status of leader.

Likewise, most nurses in any healthcare setting in Malaysia, uphold these common cultural values. For instance, nurses tend to help each other whenever necessary; thus, where others' needs or a team's needs are put before individual needs (Abdullah, 1996; Abdullah & Lim, 2001; Abdullah & Low, 2001). This value could create strong bonds and encourage teamwork besides increasing friendliness, healthy relationships and a sense of belonging to the profession. This scenario could also explain the rationale of another interesting finding of this study, whereby the attribute that has the highest median score is the attribute of collegiality and collaboration (see Table 4.2, p147).

Moreover, the common cultural value among healthcare providers in Malaysia's healthcare system could be influenced by the different ethnic entities from Peninsular Malaysia, Sabah and Sarawak (Montesino, 2011). Chandratilake et al., (2012) highlight that there are regional similarities and dissimilarities in understanding professionalism, most of which can be explained by cultural differences consistent with the theories of cultural dimensions and cultural value. This argument was ascertained from the quantitative findings in this study. The results reveal that there is a statistically significant difference between the median scores related to professionalism in the documentation across the participating hospitals (refer to results on p179).

Similarly, there is an interesting and obvious pattern of difference in median scores for professionalism in nursing in the reviewed case notes between hospitals in Peninsular Malaysia and the hospitals in East Malaysia (see Table 4.17, p176). Geographically, Malaysia is a country that is divided into two regions by the South China Sea. Peninsular Malaysia, attached

to the main land of Asia comprises 12 states and is separated from Sabah and Sarawak by the South China Sea (Ghani & Yadav, 2008). Malays, Chinese and Indians primarily populate these states. Kuala Lumpur is the capital of Malaysia and is located on Peninsular Malaysia. Conversely, East Malaysia comprises two states; Sarawak and Sabah which are located on the island of Borneo, together with Kalimantan (a part of Indonesia) and Brunei Darul Salam, an Islamic monarchy.

6.2.2. Sense of belongingness, professional achievement and collegial respect

One of the interesting qualitative findings of this study also reveals the possible influences of a sense of belongingness among respondents that could also contribute to the differences and similarities concerning the quantitative and qualitative results.

Belongingness as "... a deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group; (b) connected with or integral to the group; and (c) that their professional and/or personal values are in harmony with those of the group"

(Levett-Jones & Lathlean 2009, p.382).

The importance of belongingness among nurses is more likely to have escalated from the experience of staff relationships (Mohamed et al., 2014). One respondent shares her thoughts on this matter:

"... you ... you work better if everyone is nice and helps each other ... you know ... We help each other, for example, if I am managing the patients, my colleagues will help me to make sure all the orders are completed ... even ... if any abnormalities happen to the patients ... they will tell me ... I will do the same if they are managing and I am the runner. ...So, teamwork is important ... We have to be good each other ... Love your colleagues."

(Lily)

Abdullah (1996) in his seminal paper explains the generation of excellent staff relationships through strong 'collectivism'. Collectivism includes teamwork, cooperation, a keen sense of belonging, according priority to group interests, deriving satisfaction from respect from colleagues and giving respect to hierarchy, authority, senior and elderly people, as essential factors. Nevertheless, there is a tendency for staff to be more 'reserved' and not to reveal their genuine thoughts and opinions whenever they are asked about their working nature or any subject that could jeopardise their position and their colleague in the team.

The nurses occasionally 'suppress' their knowledge to some degree (Maben et al., 2006). Moreover, although they may know better or observe other nurses' unethical behaviours, due to a sense of respect towards higher authority and hierarchy or people who are older (Mastor et al., 2000), they may choose to remain silent due to nurse-nurse domination and a desire to maintain approval from colleagues (Yeh, Wu & Che, 2010). Furthermore, nurses have been found to sometimes hide their insecurities behind the masks of competence and self-confidence to become part of teams (Anderson & Edberg, 2010). Therefore, it is more likely that nurses in Malaysia prefer to be more reserved to avoid being socially segregated in their workplaces (Mohamed et al., 2014).

Hofstede's Cultural Dimensions Theory (2001) explains much of Malaysian culture and its influence on how other people work and organisational culture. A combination of these cultural influences and affirmative action, which has seen the leadership of nursing in Malaysia confined largely to Muslim women, may have played a role in the major change in the nursing profession in the country (Parboteeah & Cullen, 2003; Ong-Flaherty, 2012). This policy comes in the form of affirmative action. Since Malaysia's independence, the policies of affirmative action in education and employment for the majority of Bumiputera (comprising largely Malay Muslims) have created an imbalance in the already complex racial relations (Lee, 2005; Montesino, 2011). In the context of healthcare in Malaysia, polarisation of Bumiputera who work in the Malaysia's healthcare workforce has become apparent.

Hofstede's (2001) explains that generally, affirmative action policies have created a situation where most people working for the Malaysian government are Malay Muslims. This claim could be demonstrated from the result of this study where it was revealed that most of the respondents in the interviews are Malay and Muslim (corresponding to 63% of total respondents). This is similar to Ahmad and Oranye's (2010) findings where most of their respondents were Malays, i.e. approximately 86.4% of the total respondents in their study. Chatman, Polzer & Barsede (1998) argue that the work culture could be determined by the culture that is inducted by the largest group of people who have the same norms and sociological value. This 'demographic decomposition influence' is likely to shape the organisation through driving people in the organisation to seek and settle with one common work culture.

Another interesting aspect of the Malay culture is that it is rare for an individual to claim his or herself to be more competent than others (Mansor et al., 2000; Adelaar, 2004). Mastor et al. (2000) state that the Malays do not openly voice their dissent. Malays tend to demonstrate indirectness in sharing their opinions in their conversations. Salleh (2005), in turn, explains that this indirectness is elicited from the nature of the Malay language which is an analogue language. Therefore, nurses in Malaysia may seem to 'play it safe' in order to avoid being social outcasts in their workplaces. Therefore, this form of 'playing safe' is more likely to influence how nurses are look at or judge themselves. Hence, in part, these factors could have contributed to their behaviour of being not opinionated and expressive when it comes to sharing their thoughts about themselves, particularly when sharing their work experience. This argument could be found in Pauline's story (see Pauline's quote, p202).

Throughout the education system in Malaysia, from primary school all the way to nurse training, Malaysian youngsters are embedded with the above-mentioned culture that may result in not having any platform or opportunities to raise questions concerning the world (Adnan & Smith, 2001). In Malaysia, teachers, educators and the education system force youngsters to learn things that they have to learn in order to excel in examinations or qualification examinations (Adnan & Smith, 2001). Specifically, the education system and educational environment in Malaysia are primarily focused on strengthening the knowledge and comprehension of things that they have to learn. However, when it comes to degree level and beyond, an understanding of the world increases with the level of application of knowledge that individuals have gained.

These cultural obstacles preventing individuals in Malaysia from moving forward in a timely manner cannot be overstated. Birks, Francis and Chapman (2009b) describe the influence of religion, tradition and gender which may have resulted in the lack of professional recognition for nursing in Malaysia (Ahmad and Oranye, 2010). Religion and ethnicity greatly influence the working culture in Malaysia. The three principal races: Malays, Chinese and Indians bring with them the influence of Islam, Confucianism, Taoism, Buddhism and Hinduism to their work (Bhaskaran & Sukumaran, 2007; Selvarajah & Meyer, 2008).

6.2.3 Generation gap and working experience

Ah Mei, who is a senior nurse, expressed how different generations of nurses could influence the way nurses' practice, particularly when it comes to the matter of documentation:

"... But a lot of our young nurses nowadays. I don't know, I think maybe because of that ahh, they have chosen this profession not because they are really interested in nursing. Because of that, when you do not have a passion for what you are doing, then, everything is lacking. You don't give 100%. So, they feel that it is adequate to write little. That is not right because whatever you write is going to be the decision taken about the patients' care."

(Ah Mei)

Based on the excerpt above, it seems that Ah Mei perceives the younger generation of nurses as tending to display these negative personality traits. According to Ah Mei, the nurses' lack of passion is the reason behind the younger generation's lack of passion for being a nurse. This situation may be the result of a situation where the young generation of school leavers opted to pursue nursing as their career due to better prospects and/or their parents insisting that they enter the nursing profession (Vaksalla & Hashimah, 2015).

As discussed in the previous section, there has been an influx of both public and private institutions offering nursing courses in Malaysia in order to combat the shortage of nurses (Barnett et al., 2010). This situation was identified as one of the contributing factors that enables the nursing profession to be perceived as having better job prospects. Therefore, there are individuals who choose nursing as a job despite not really having an interest or passion for being a nurse. Consequently, a larger number of new nursing graduates are entering the workforce, which has created a situation where patient care areas are now more likely to be staffed by younger nurses with less experience in patient care (Barnett et al., 2010). It should be noted that this new generation of graduates can also have different attitudes toward patients and those in authority than their predecessors.

Furthermore, there are also issues related to the recognition of these nursing courses as the Malaysian Government strives to ensure the quality of these nursing programmes (Birks et al., 2008). This step has, to some extent, slowed down the momentum of the institutions from fully implementing their courses. Hence, these events have influenced both the public and political perception regarding nurses' abilities to provide adequate and safe care to patients (Chua, 2006). Although the Ministry of Health of Malaysia have introduced several programmes, such as the '7 soft skills' programme, the lack of passion for nursing still exists (Barnett et al., 2010).

In contrast, Gwen, who is junior nurse shared her story,

"If we write in our own format, some of the senior staff will say to the junior, "ohhh just follow, follow our format like this". For me, because I think using their format, they didn't assess patient. They only write carry forward and their report is not really informative, for me. So, the senior staff will pressure junior staff to follow their style."

(Gwen)

The above excerpts could conclude that there are interesting differences in opinions among junior nurses toward their senior nurses, and vice versa, as a result of different generational cohorts among respondents in this study. Zemke et al. (2000) describe generational cohorts as groups of people who share birth years, history and a collective personality because of their defining experiences. Keepnews (2010) mentioned that there are three generational cohorts that could influence the way one performs in today's nursing practice: the baby boomers, Generation X and Generation Y. This is because many members of the veteran's cohort retired from nursing organisations (Sherman, 2006).

'Baby boomers' are described as idealistic, hardworking and dedicated, valuing promotions, position and titles. Members of this generation currently occupy most of the leadership roles in nursing globally (Sherman, 2006). Keepnews' (2010) literature suggests that members of 'Generation X' are likely to be realistic, team-orientated, have advanced technological skills, prefer working independently and seek a working environment where they can apply their ability and expertise. In particular Generation X-ers' confidence in technology can contribute to their work productivity. Moreover, Generation X nurses generally want to have professional, knowledgeable and experienced mentors and they expect prompt feedback regarding their performance. Members of Generation Y are characterised as dynamic, confident, straightforward and opinionated. Hence, there is a possibility the experience or 'the way they look at the world' is different from one generation to another.

As presented in Table 5.1 (p185), the demographic data reveals that the respondents comprise two distinct groups regarding working experience. There were 23 respondents with more than five years working experience and 17 respondents with less than five years working experience. Analyses of the interviews suggest that the detail and the amount of information shared by these two groups of respondents can vary. For example, the respondents in this study who are senior staff nurses argued that the junior nurses were unable to write more detail in their documentation due to a lack of knowledge, which they perceived as unprofessional.

"As you know, I have checked the junior nurses writing. They need to improve their writing. I frequently found that their documentation is incomplete, missing information and sometimes, they write it down even though they have not performed the task that they recorded. I am disappointed with this. By right, you should only write down something if you have done it. This is not the way to be a professional nurse. "

(Annikka)

From Annika's thoughts concerning her junior nurses, it could be suggested that working experience plays a significant factor in shaping nurses' understanding when discussing the importance of nursing documentation in their daily practice. These findings are similar to Hill's (2010) argument on the influence of working experience over a period of time on the way they practice nursing. Furthermore, Hassan et al. (2013) discovered that experienced nurses were able to ask more questions and clarify concerns to less-experienced nurses when discussing an issue pertinent to their practice.

6.2.4 Power-Dynamic and Authority in a hierarchal organisation

Ong-Flaherty (2012) claims that the working culture among nurses in Malaysia is related to the collectivist relation-based approach to work and high-power distance among Malaysians. This claim could be elicited from the qualitative findings whereby: i) ten respondents in this study stated that the most influential and/or perceptive factor for them to perform adequately in their practice was the impact of their supervisor or senior staff engagement on their practice; ii) twenty of the respondents in this study also mentioned that sisters or staff nurses in charge were responsible for checking their documentation pertaining to the execution of the doctors' orders besides the quality of their documentation (see Table 5.11, p204). Matrons, sisters or senior staff are perceived to be role models for the junior staff.

These findings are consistent with the findings of Othman and Nasurudin's (2013) study. Othman and Nasurudin reveal that supervisor's support is a significant predictor of work engagement among public hospitals in Malaysia. They further explained that supervisory support could play an extrinsic motivational role because a resourceful work environment drives an individual's willingness to contribute his/her efforts and abilities to complete tasks. Overall, Othman and Nasrudin's (2013) study has provide valuable insight for the Ministry of Health Malaysia and nursing management to offer more training for nurse supervisors to encourage a greater range of support to nurses.

Furthermore, effective and systematic nurse mentoring programmes may promote and develop strong social support networks among nurse supervisors and nurses (Barnett et al., 2010). Consequently, nurse supervisors are able to provide greater support in terms of showing concern for staff nurses' feelings and needs, providing help and information, and constructive feedback. Therefore, nurse executives and middle managers can create a working atmosphere with minimal conflict where staff nurses perceive opportunities to increase their professionalism and improve professional practice (Zakari et al., 2010). To perform these functions, managers need to understand the nature of conflict and the concept of professionalism.

However, the results of this study do not support Tornvall and Wilhelmsson's (2008) findings, which established that doctors usually use the nursing documentation as the foremost source of information for follow up treatment. Nonetheless, they argued that it is difficult to search for relevant information on this issue because of the enormous number of routine notes. Moreover, Tornvall and Wilhelmsson (2008) also report that approximately 74% of care unit managers used the records for statistical purposes, while only half of them used the records to evaluate care. It can be argued that the respondents experience a sense of power distance and struggle to justify their professional practice regarding documentation because of doctors or higher authority's rulings on nursing documentation. Additionally, a study by Wu et al. (2013), ascertained that the relative strictness of policies or regulations can also affect the quality of documentation.

This situation could occur owing to the nursing profession's struggle with the issues of power and status that have occupied a position of oppression over the course of its history (Fletcher, 2007). From the beginning of modern nursing in Malaysia, nurses in the country have continued to experience problems with image and status which, in turn, reduces their effectiveness as healthcare professionals (Bryant, 2003). Although changes have taken place over the decades which have mitigated this situation, these changes have not occurred uniformly on a global scale (Birks et al., 2008). On account of not being recognised as being equal members in multidisciplinary healthcare teams, nurses in Malaysia tend to feel that they are not important employees in hospitals (Siew et al., 2011).

6.3 Accountability

It can be noted in Table 4.2, p147 that most of the reviewed case notes in this study scored 32-40 points which is interpreted as an excellent indicator of the existence of the attribute of accountability (See Appendix 2). This finding indicates that nurses use the principle of accountability to justify their nursing documentation practices. This practice, according to Prideaux (2011) explains that nurses feel defensive because of the fear of litigation. Prideaux's arguments could explain why all of the respondents in this study described the significance of keeping their documentation accurate and complete so as to ensure they would not be blamed if any medico-legal issues arise in the future. For example, if nurses feel defensive because of their colleagues' criticism about extensive and detailed records, which they felt were clinically essential to produce.

Furthermore, two respondents in this study explained that if an adverse event, abnormalities or causative issues occur involving a particular patient, the doctors or specialist, and the matron, sisters and staff nurse in charge will immediately look at the nurses' documentation (see Table 5.11, p204). Nurses always become the first person in line to be interrogated whenever an abnormality occurs affecting a patient. One respondent shares her story,

"As you know, if anything happens to a patient, we can get sued by family members ... So, you have to make sure your documentation is complete and clearly stated and you have done your work. Otherwise, you can be blamed for not doing your work. Doctors will also look at you first if something bad happens to the patients ..."

(Pauline)

This excerpt suggests that there is the possibility of the existence of a 'Blaming Culture' among healthcare providers, particularly among the doctors, specialists and nurses. This concept of being blamed if anything happens to a patient may have affected the responses made by 90% of the total respondents in the qualitative part of this study. These respondents mentioned a fear of being scolded or of being blamed if anything happened to the patients, or whenever any medico legal issues may arise due to suspected malpractice and neglect when providing care to patients. There is a similarity between this finding and those described by Blake-Mowatt & Bennett (2013), where the respondents shared their belief that documentation is exceedingly important as it protects them legally.

This is because nurses are perceived to be the first line of healthcare providers and are fully accountable for anything that occurs concerning the patients (Law et al., 2010). Therefore, it can be assumed that the respondents in this study must be extra cautious and ensure that their documentation is well written and completed. This claim is demonstrated in the quantitative findings of this study, which reveals that 624 out of 655 (i.e. 95.3%) of the reviewed case notes included information on the care that has been performed and recorded by the assigned nurse. Law et al. (2010) further explain that incomplete and careless documentation might be an indicator of wider problems within an individual nurse's practice.

Concerning the legal dimension of nursing documentation, it can be postulated that the work has not been completed if it is not documented (Blair & Smith, 2012). The above mentioned qualitative findings corroborate findings by Salam et al. (2011) who suggested that awareness of legal and ethical issues is an important aspect of professionalism. It is not surprising that the above discussion could also explain why the majority of reviewed case notes demonstrate the attribute of accountability superbly across all types of reviewed case notes (see Table 4.2, p147 and Mastura's story on p189).

Furthermore, thirteen respondents suggested that accountability corresponds with responsibility pertaining to their documentation (see Table 5.3, p189). College and Association of Registered Nurses of Alberta (2013) argues that registered nurses are responsible for their own nursing practice, and moreover, documentation is a part of that responsibility.

Griffith (2015) explains how health professionals regularly use the terms accountability and responsibility interchangeably as though they have the same meaning. Scrivener et al. (2011), for example, define responsibility as a concept that is equivalent to the duty of care in law. In contrast, in the Code of Professional Conduct for nurses established by the Nursing Board Malaysia (1998), accountability is demonstrated when a nurse reacts and provides answers or justifications to his/her own nursing practice and actions.

Echoing the above definitions, it could be argued that accountability and responsibility are two different components. However, both concepts complement each other and it is another way of identifying accountability towards their patients. The interrelated concepts between accountability and responsibility can be acknowledged as professional accountability (Krautscheid, 2014). Professional accountability, according to Porter-O'Grady & Finnigan

(1984) is defined as taking responsibility for one's nursing judgments, actions and omissions. Professional accountability is related to lifelong learning, maintaining competency and upholding both quality patient care outcomes and standards of the profession, while being answerable to those who are influenced by one's nursing practice (Krautscheid, 2014).

Being accountable is in line with the code of professional practice for nurses in Malaysia (1998). According to the core competency standard for Malaysian nurses (1998), two of the three core competencies for delivering safe and quality nursing care relate to providing accurate and timely information to other healthcare providers, and to document nursing care and related activities. This core competency standard is in line with Prideaux's (2011) discussions on the accuracy of nursing documentation. Prideaux concluded that accuracy in documentation can be viewed from three perspectives: a true reflection of nursing care, comprehensive and thorough detail of the patient's journey and finally, clarity in use of the terms. The foundation of these competencies is the nurses' obligation to ensure that the nursing documentation is complete and accurate (see Table 4.2, p147 and Mastura's story on p189).

Analysis of the quantitative findings of this study however reveals that approximately 225 of 655 of the reviewed case notes have no corrections or errors that have been corrected by either crossing through with a single line, signed, timed and dated. It seems possible that these results could be due to the nurses not taking the responsibility to indicate mistakes that they themselves made, or mistakes made by others. Lombarts et al. (2014) speculate that there is a relatively low level of agreement with statements related to nurses' responsibilities, especially regarding addressing attitudes reporting medical or nursing errors, or incompetent colleagues. They further deliberate that the low level of agreement between nurses may reflect the deeply rooted idea in professional cultures that mistakes are not tolerated, an idea that does not fit in with the new civic professionalism that calls for transparency and systematic improvement of care at individual patient and population levels.

6.4 Advocacy

One example that best demonstrates the attribute of advocacy was when one respondent in this study mentioned about being a good listener in obtaining the information required to ensure care and treatment benefits the patient (refer to Table 5.4, p190). Another important finding was when four respondents strongly believed that the patients deserve what they are

supposed to have and prioritising patients individualised and unique needs. These understandings portray that these respondents acknowledged the significance of ensuring that the patients' needs and rights are fulfilled. Battie and Steelman's (2014), for instance, explain that all the above values can be achieved through the nurses' ability to speak up on behalf of the patient in situations when issues regarding safety arise. Speaking up needs to be conducted in a respectful, yet assertive manner that promotes high quality care from the entire team.

Two respondents in this study also mentioned the importance of looking at the documentation whenever there is a doubt or uncertainty in terms of whether the patient's treatment or care is effective (see Table 5.4 on p190). These respondents explain that every patient requires special attention depending on the patient's current condition. This attention and ability to meet his/her needs not only comprise physiological fulfilment but also psychological fulfilment. These responses explain how advocacy is concerned with the capability of a nurse to speak up on behalf of the patient in situations when there are safety concerns (Battie & Steelman, 2014). Battie and Steelman (2014) further argue that the role of nurses is to verify that the correct patient is present, the correct procedure is performed and that it occurs at the correct site.

Furthermore, nine respondents in this study expressed how nurses have to be a patient's advocate when it comes to identifying the patient's current and individual needs. This is illustrated in one of the excerpts from a respondent's interview:

"... when you write your nursing report, you have to go and ask the patient first. Do not simply write. You have to get the information from the patient first hand. Ask the patient what treatment and medication he has had. If he has had a bath and what he has eaten. ... From this kind of information, you know whether the patient is being taken care of. ... If there are things that still need doing then you need to do it or ask a colleague to do it ... Sometimes, patients also complain that the doctor did not come and see them, so we have to write this in the report and inform the doctor."

(Dewi)

From the above excerpt, it could be noted that the respondent was able to acknowledge and act on the patients' interests, needs and problems. This perspective could also be seen in one of the quantitative findings in this study, whereby most of the reviewed case notes contain the patient's urgencies or priorities in most notes from all shifts (see Table 4.5, p154). As they are at the forefront of providing healthcare, nurses should be able to convey the patients'

interests, needs and problems to other healthcare providers to ensure that patient care is undertaken holistically (Kolanowski et al., 2013; Cribb & Gewirtz, 2015). Furthermore, The Nursing Board of Malaysia (1998) highlights the roles of advocacy in professional practice in its Code of Professional Conduct for nurses. The document states that nurses must act to promote and protect the interest of the patients when the patients are incapable of communicating their needs and protecting themselves.

Analysis of the quantitative findings of this study reveals that the highest median score is for the component of 'information pertaining to admission procedure and orientation to the clinical setting already given to the patient, their family or carer' in all the reviewed case notes (Median = 4). This finding is consistent with the finding of a study by Paans et al. (2010) where they ascertained that domain 'admission' had the highest scores: 80% of the records have a scale over five. This finding could be because the information was immediately obtained by a member of staff after the patient is admitted to the ward (i.e. gathering all the necessary information for admission). In this context, the admission form is the first form that nurses need to complete to begin the patient's case notes (Lees, 2010).

To ensure the nurses are able to meet the patients' best interests and act as the patient's advocate, it is important for nurses to complete the admission form along with the orientation form (Bunkenborg et al., 2012). For instance, nurses should provide a patient with the information required for making informed choices, supporting their right to make informed choices and supporting them throughout the decision-making process and the outcomes. Furthermore, nurses should be attentive to the patient's needs, expressed wishes and preferences, and ensure these are known and implemented by the nurses besides other healthcare providers (RNAO, 2007). The present findings seem to be consistent with Blake-Mowatt and Bennett's (2013) study, which demonstrates that most nurses followed the documentation guidelines for admission by recording the patients' past complaints, medical history and assessment.

In this study, there is a standard orientation form that is attached together with the admission form. These are the forms that nurses need to tick in the appropriate boxes regarding the information that they have delivered to the patient and family members. All these forms have to be completed before filling the other type of documentations and before a doctor assesses the patient. However, this work process was not clearly written, stated or recorded as a gold standard across all the participating hospitals and wards in this study. This scenario could

contribute to the quantitative evidence, whereby only 385 out of 655 reviewed case notes contain information pertaining to the admission procedure and orientation to the clinical setting already given to the patient/family/carer.

Another notable quantitative finding reveals that only 72 out of 655 reviewed case notes, which is equivalent to 11% of the reviewed notes, contain information on the individual plan of care for each problem or health need, in all the notes from every shift (refer to Table 4.5, p154). This finding is similar to that of O'Brien and Cowman's (2011) study, which explored nursing documentation concerning pressure ulcer care in an acute setting in Ireland. That study established that approximately 45% of the charts had some evidence of documented care planning. Furthermore, 53% of these charts had no evidence that the care plan was implemented, while another 66% had no evidence of an evaluation of the outcome. There is one possible causative factor that appears to create differences between the findings of this study and the findings of O'Brien and Cowman's (2011) study. O'Brien and Cowman's (2011) study was conducted at one large academic teaching hospital in an urban setting. This research gathered data from four participating multi-disciplinary acute hospitals and one Mental Health Institution. Additionally, no teaching hospitals are involved in this study. Teaching hospitals, according to Shanian et al. (2014), offer advanced clinical capabilities, educate the next generation of providers, care for disadvantaged urban populations, and are leaders in healthcare research and innovation.

Another possible explanation for the above findings is that nurses' standardised care plans may hinder patients' involvement in care. This situation could occur because of the nurses' tendency to focus too much on following the standard care plan and not understanding what patients really express (Andreae et al., 2011). Hence, it is important for nurses to be sensitive and to recognise the individual patient's views regarding their own condition and the treatment, even though the care is governed by a standardised care plan. In a way, the standard care plan should be flexible and may need to be adjusted according to patients' wishes and needs (Andreae et al., 2011). This argument agrees with Liza, one of the respondents in this study. She argued,

"One patient's needs are different to another patients' needs. As a nurse, we have to look at the patients owns needs and problems first ... You cannot see all patients as the same ... they are different from one to another ... So, that means, when you want to write in the case notes, you have to write down what the patient needs, their problems, because different illnesses will have different impacts on the patients. Patients' conditions are not the same, even though they are on the same ward."

The quantitative findings also reveal that all reviewed case notes scored the lowest in terms of the median score for the 'health need assessment' component. In contrast, Kim et al. (2011) report that nursing documentation focused primarily on capturing assessment data. However, a lack of diagnosis items was expected as they are usually documented as free of text. Thus, the entry field labels related to the forms and templates are unlikely to reflect specific diagnosis concepts. The health needs assessment enables nurses to plan and deliver the most effective care to patients (Rowe et al., 2001). That assessment also helps nurses to apply the principles of equity and social justice in practice and to ensure that limited resources are allocated where they can give maximum health benefits.

6.5 Innovation and visionary

From the quantitative results, a total of 375 out of 655, or equivalent to 57.3%, reviewed case notes fall into the good indicator of the existence of the RNAO (2007) attribute of innovation and visionary (see Table 4.2, p147). This result implies that there was a possibility that several of these nurses are able to bring in new ideas to improve patient care and promote positive outcomes (RNAO, 2007). The qualitative findings of this study, provide no clear evidence that they are inculcating the attribute of innovation and visionary in their documentation, despite evidence showing that the respondents proposed several approaches pertaining to preparing documentation.

For example, Dora mentions the use of her own pocket book, which she carries with her throughout a shift and makes notes regarding patient's current status and the necessary interventions before transferring it to the patient's case notes or, to be exact, the nursing shift report (see quote from Dora, p193). Harris mentions applying visual presentations to support his report writing (refer to p193). In Harris' example, the visualisation of the condition of the wound was presented in the form of a drawing, which he found to be useful to support the explanation of the wound's condition. This drawing is an addition to the usual narrative of written text (see Appendix 13 for the example of the visualisation of the wound).

However, the effort to inculcate a new approach as described above could not be considered a creative and innovative initiative that enhances the nurses' performance in their daily tasks. The RNAO (2007) explains that professionalism in nursing can be demonstrated by nurses

showing initiatives for new ideas and being involved through their actions. For this reason, the application of curiosity and imaginative reflection concerning clinical practice is essential (RNAO, 2007). With the inculcation of these values in nursing practice, nurses are able to identify opportunities or appropriate channels of inquiry, and to scrutinise practice and question established practices and the status quo.

It can be argued that the ideas of having a pocket note book to record anything regarding the patient before transferring it to the patient's case notes or using visual aids to describe surgical wounds are nothing new. There are two possible explanations for this. Firstly, there is a possibility that these respondents do not really understand the meaning and the concept of being innovative and utilising visionary within nursing practice. For example, De Veer et al. (2011), explain that by understanding the roles of being innovative and having visionary could only be initiated by the nurses' acceptance and the ability to adopt new 'things' that could improve their performance. Secondly, due to cultural influences and limited levels of autonomy, these nurses do not have the appropriate platform to maximise their abilities and motivate them to be critical and be able to question practice (Fleuren et al., 2004). Consequently, these nurses would be able to contribute to the improvements in patient care and treatment. Isfahani et al. (2015) also mention that nurses regularly encounter unexpected situations in their restricted scope of works which could hinder them from expressing their inventiveness into improving the way care is delivered to patients.

Additionally, these limitations would not allow the nurses to have the capability to even advocate and make a change on either a micro or macro scale in their organisation, which, on a bigger scale, cannot play a role as the change agent that could influence policy in the nursing profession. Despite these setbacks, convincing statements among the respondents regarding the perception of being innovative can be positively scrutinised as something they can be proud of. The approaches that they have mentioned can be seen as effective and, evidently, have improved the ways to ensure their documentation are completed and satisfactory.

6.6 Ethics and values

Correspondingly, analysis of the quantitative findings in this study reveal some compelling comparisons with the findings from research by Johnson et al. (2010). The most prominent comparison between these studies is that Johnson et al. (2010) report that 154 out of 193 of

the records that they studied had the component of the patient's problem written in terms of what the patient actually said or what the nurses had observed. This information was present in the records. Conversely, this same component appears predominantly in any written text, in more than half of the reviewed case notes in this study (corresponding to 378 out of 655 notes). Furthermore, nearly all of the reviewed case notes contain components that are always present in the notes from all the working shifts are clear of any gossip, hearsay or third-party comments (corresponds with 634 out of 655, or 96.8% reviewed case notes) (refer to Table 4.7, p158).

These differences could be related to nurses being keen to acknowledge the patients' actual and current experiences. There was a possibility that the nurses did not assess the patients thoroughly, particularly when interviewing the patients. Therefore, the findings that were stated in the nursing documentation were likely to be the information that they could gather from the vital signs and their subjective observation on the patient's condition. As one of the respondents shared her story:

"... We just jotted down the patient's vital signs and ask the patient whether they are OK. If the patients are normal, no complaints ... I just write vital signs because there is no point in writing it again ... if the patient's condition is still the same ... I mean stable ... repetition ... waste time ... It's understood where you can see the vital signs from the observation charts ... I know it's not the correct way to do nursing but I have too many other things to do."

(Elina)

Evidently, the above findings demonstrate nurses' ability to emulate the principles of nursing ethics and nursing values in the process of making the most appropriate nursing and clinical decisions when intervening or planning patient care. From a broader perspective, the quantitative findings reported that more than half of all the reviewed case notes fall into the category of good indicator of the existence for the attribute of ethics and values (see Table 4.2, p147). The RNAO (2007) concurs with the finding, and has stated that nurses value the ability to provide safe, competent and ethical care that allows them to fulfil their ethical and professional obligations to the people they serve. For example, the qualitative results reveal one of the respondents mentioned giving care to patients, in terms of treating patients equally, regardless of their backgrounds (see quote from Alin, p194). This argument is supported by the correlation test results which indicate that it is possible that the component of 'clear of gossip' ($r=0.02$) and component of 'preferred name' ($r= 0.01$) is very weakly correlated with the total score for ethics and values.

The National Core Competency for Malaysian Nurses published in 1998 also mentions that one of the major strategies of being responsible in ethical practice is to respect and demonstrate sensitivity to diversity (cultural and religious, beliefs, race, age and gender, physical/mental state and other) (Nursing Board of Malaysia, 1998). The qualitative findings also reveal that one respondent, Najwa described the importance of being respectful when caring for patients (see her quote on page 194). The Code also describes how nursing practice in Malaysia is guided by the Code of Professional Conduct, which involves ethical decision making with respect to a nurse's professional responsibilities, where ethical issue arises.

Furthermore, the RNAO (2007) also states that the attribute of ethics and values is demonstrated when a nurse is able to obtain information from various sources concerning ethical decision-making, fostering collaboration with colleagues and maintaining a practice environment that supports nurses and respects them in their ethical and professional practice. Therefore, identifying the problem and desired goals is a significant step in an ethical and deliberate decision-making process, particularly when making decisions for the reason behind completing the documentation either for personal or professional image, or the goal of achieving compliance with the accreditation standard (Bosek & Ring, 2010).

The above argument has been elicited from sixteen respondents in this study who have expressed their thoughts about prioritising their patients first, rather than focusing on their nursing documentation (see Appendix 11). Fauzi, one of the respondents in this study explains that:

"Documentation ... I will do last ... aaaa ... after the doctor's round. First, I will see my patient first, and then review the vital signs, make sure everything is stable and then I will check anything due, like x-ray, tracing, appointments and other matters that are due. ... After all of these have been done, only then will I start writing my reports. Except for TPR (temperature, pulse and respiratory) charts, that I have to keep on updating."
(Fauzi)

However, these respondents also mention how difficult it is for them to ensure that all of their documentations are completed by the end of their shift. This problem arises due to the fact that they can only get the documentation completed after all the nursing care has been delivered to the patients. Additionally, the unpredictable situations on the wards, excessive documentations as well as staff shortages can all hinder nurses from completing their documentation. It should be noted that the nurses intend to write in detail about what they

have performed or completed when it comes to their nursing care but sometimes this intention did not materialise due to other pressing matters. For example, based on her experience, Dora explains that:

"Of course, you have to put your patient first. After you finish all your work, only then, can you go back to your documentation, but, sometimes you cannot, as the doctor suddenly calls you to do this, ordering this and that. One time, a patient collapsed ... How could you have enough time, plus, you know nowadays, there are so many things to write or to fill in. There's no time ... And then, there's not enough staff. Sometimes you have to be a runner and manage at the same time, because your colleagues are on a course ... So, because of all these problems, you have to extend your working hours ... I have to make my reports simple and short, not detailed ... quite problematic."

(Dora)

The information in these nursing shift reports principally focus on the tasks or procedures that the nurses have achieved or completed. The lack of this type of information could suggest that these reviewed case notes, particularly for the nursing shift reports, primarily suffer from a lack of 'patient focused' information. This claim seems to be consistent with the findings of Laitinen et al. (2010), whereby they find that nurses sometimes exclude the patient as a person. Laitinen et al. (2010) also establishes that the focus when writing the documentation was evaluating the medical treatment with short comments such as 'no problems with the infusion.'

Similarly, Jefferies et al. (2012) also state that nursing documentation frequently presented nothing more than just the tasks performed by the nurse during his/her shift. It is difficult to identify the patient's condition and/or response to the care received. Hence, it was proposed that the patient's own perceptions of their condition and their response to care should be the basis of the content of nursing documentation (Jefferies et al., 2010). This proposal requires the nurse to record anything that the patient might say to describe their condition(s) or any observations that the nurse makes concerning the patient's condition. According to Broderick and Coffey (2012), quality nursing documentation demands that the nurse positions the patient at the centre of this documentation. Therefore, a modification in the nurse's perception of nursing documentation from a platform to protect the nurse in a legal situation to focusing on the patient is necessary.

6.7 Autonomy

From analysis of the quantitative findings of this study, it is also ascertained that 402 of the total reviewed case notes, which is equivalent to 61.4% of the sample, fall into the good indicator category for the existence of the attribute of autonomy (see Table 4.2, p147). This finding is parallel to that of Siew et al. (2011) who argue that nurses who are satisfied with their autonomy are highly committed to their organisations. Burton and Ormrod (2011) explain that this form of satisfaction could be experienced by the nurses once they have acquired sufficient responsibility, being trusted to perform their tasks, being able to take control over their work activities and have authority to make decisions to provide nursing care.

Further analysis of the quantitative results also reveals that none of the reviewed case notes demonstrate the absence of the component of 'evaluation of care or treatment is performed clearly stated' and 'urgent identified needs/problems are referred to the doctor/physician/surgeon are clearly written in the record.' Interestingly, the possible explanation of these quantitative results lies in the qualitative findings of this study. Most of the respondents described their ability to make nursing decisions quickly and accurately based on their findings or assessment (see Table 5.8, p197). The respondents argued that the role of working experience as a nurse has enabled them to work independently and exercise decision-making within one's scope of practice. One of the respondents, Mariam, for instance, explained in detail how her work experience has helped her to intervene with a patient who was experiencing a low-grade fever, starting from making an assessment all the way to offering some interventions to reduce the fever (see quote on p196). However, autonomy is only limited within the nursing scope. When it comes to the multidisciplinary collaboration or from the organisational perspective, nurses seem to undertake what they have been ordered or told to do (Cribb & Gewirtz, 2015). This scope limits the opportunity among the nurses to demonstrate and maximise their ability in work and respond independently in giving care to the patient.

This study also determined that the quantitative findings actually reveal a poor result for the component of SOAPIER in all the reviewed case notes (see Table 4.8, p160). SOAPIER is the standard acronym for seven perspectives of nursing documentation which are S = Subjective information, O= Objective information, A = Assessment, P= Planning, I = Intervention, E= Evaluation and R = Revision (Blair & Smith, 2012). Blair and Smith (2012) highlight that

SOAPIER is the preferred form of documentation for nursing notes, as it provides a format that is clear, succinct and supports good problem solving and is a method used by many health professionals as a means of recording patient care information.

Despite that, according to Blair and Smith (2012), SOAPIER has several disadvantages. These disadvantages include how reports do not regularly include important information related to the specific patient problems or contain irrelevant information making the reports text-laden and time consuming to read. This situation occurs due to the nurses' tendency to use SOAPIER to write a full retrospective shift report rather than a single problem entry.

It should be noted that this study did not ascertain the extent to which the new nurses were orientated on SOAPIER and/or if there is any continuous training and assessment of the SOAPIER method. It is a concern that only the respondents at Hospital D were exposed to SOAPIER. Therefore, SOAPIER only appears in the reviewed case notes at Hospital D. Moreover, there is no policy or concrete evidence provided by the Ministry of Health Malaysia on the utilisation of the SOAPIER format for nursing diagnosis.

6.8 Knowledge

It is interesting to note that 361 out of 655 (55.1%) of reviewed case notes comprise the component of observation of signs or symptoms were recorded in terms of what the nurse observed only and was not based on the nurses' assumptions in all written text (see Table 4.9, p161). Furthermore, virtually all of the reviewed case notes (84%) occasionally contain the component of 'appropriate type of assessment has been used'. These findings could be due to either a lack of knowledge or an inability to articulate basic nursing care in writing, particularly in nursing care plans (O'Brien & Bowman, 2011). Another possible explanation for the aforementioned findings could also be due to the nurses' lack of comprehension on the utilisation in the nursing care plan, which could be demonstrated from the qualitative findings in this study (See Alicia's quote on p197). Two of the respondents in this study admitted to completing nursing care plans as a compulsory task that they needed to complete, as it was one of the documents that had to be done. For example, Auguste remarked:

"I am not sure if a nursing care plan is important or not. Whenever I write a nursing care plan, it's just repetition and sometimes I just copy from the previous or other nursing care plan. If that's the case, what is the point of having a nursing care plan? It is more important to write the current condition of patients and what has been done."

(Auguste)

The above excerpt implies that the respondent has failed to establish the unique perspective of nursing relationships in the context of nursing process elements, such as nursing diagnosis, nursing interventions and nursing outcomes in presenting information regarding her patient's problem and needs (Thoroddsen et al., 2010). Eventually, the failure of nurses to link diagnoses, interventions, progress and outcome evaluations cannot support the nursing documentation systems effectively (Paans et al., 2010).

The essentiality of assessment was mentioned in the Core Competency Standard for Malaysian Nurses (1998) and emphasises that the nurses should conduct a systematic and continuous assessment and monitoring of patients' health status (Division of Nursing, Malaysia, 1998). Adequate assessment is essential in guiding interventions and evaluating the effect of care. Assessment includes gathering, validating and analysing subjective (symptoms) and objective (signs) information related to a patient's health status. Assessment, according to Taylor et al. (2011), directly influences the nurses' plan of care.

The above findings could suggest that the nurses who prepare or complete these case notes were unversed in rationalising the most effective and appropriate interventions. Specifically, the nurses were not able to interpret the findings from the assessment and to constitute the availability of equipment or props that make the planned intervention feasible (RNAO, 2007). Eventually, this situation could affect the nurses' ability to formulate accurate nursing diagnoses based on the patients' current problems and needs. Evidently, the quantitative analysis reveals that extremely few reviewed case notes have the component of the assessment, planning and diagnosis phase of the nursing process applied appropriately (see Table 4.9, p161).

Blake-Mowatt and Bennett (2013) also report that only 26% of the records in their study had a nursing diagnosis which corresponds to the current medical diagnosis. This finding suggests that the nurses in this study may have found it difficult to apply theoretical, practical and clinical knowledge and to utilise those elements in with assimilating evidence-based rationale for their practice. It should be noted that this element is one of the important indicators of the existence of professionalism (RNAO, 2007). Ordinarily, a low level of knowledge hinders nurses' ability to synthesise information from a variety of sources and to use that information or evidence from nursing and other disciplines to inform and/or guide practice (Wang et al., 2011). Consequently, nurses could not share and communicate with colleagues, patients,

family and others to continually improve care and health outcomes. The influence of level of knowledge to ability to demonstrate professionalism in nursing within the nursing documentation is confirmed by the correlation test result of this study, which reveal that there is a strong correlation with the total score for professionalism (see Section 4.3).

It is suggested that nurses should uphold a strong base concerning their specialised education. All of the respondents in this study agreed that there is a need to enhance their level of education (see Appendix 11 and Siti's quote on p198). This can be achieved by obtaining a degree in nursing, which they believed they could achieve. Additionally, more in-depth knowledge, according to the respondents, will assist them to understand and justify any part of the care that they offer to their patients. This argument is exceedingly similar to that of Birks et al. (2008), who indicate that education is recognised as a crucial element in professional identity development for nurses. Furthermore, the acceptance of learning as an unending process ensures that practice at the individual level is enhanced and the status of the profession as a whole is secured.

The Division of Nursing of Ministry of Health, Malaysia has also set a requirement in its Code of Professional Conduct for Nurses published by the Nursing Board of Malaysia (1998) that each nurse is required to keep up with developments in nursing, medical and health practices to maintain competency in nursing knowledge and skills. The minimum continuing nursing education sessions attended by the nurse every year should not be less than 10 hours (Nursing Board of Malaysia, 1998). However, the effectiveness of this requirement in improving nursing practice could be questioned, i.e. whether attending these continuing education sessions (at least 10 hours annually) could actually improve the nursing documentation.

Regarding tertiary education in nursing in Malaysia, Chiu (2005) highlights how nurses recognise the importance of education on their professional development and, therefore, seek opportunities to pursue their nursing study at a higher level. Consequently, Chiu (2006) also explores the impact of professional learning on registered nurses in Malaysia. From that particular study, Chiu (2006) determines that there was an increased level of awareness regarding nurses' professional role and responsibility after her respondents completed their offshore post-registration nursing degree programme. Chiu explains how these programmes lifted these nurses' self-confidence, knowledge, self-fulfilment, critical thinking ability, interpersonal skills, interest in research and research utilisation, and life long-learning.

Arunasalam (2013) supports Chiu's (2006) findings. In her research in Malaysia on nurses' evaluation of transnational higher education courses, Arunasalam finds that the nurses who undertook these courses experienced positive personal and professional transformation. Arunasalam further explains that the type of transformation could greatly be influenced by the cultural perspectives or sociological factors among nurses in Malaysia (see p63 for further discussion on this cultural perspective and sociological influences on nurses in Malaysia).

6.9 Spirit of inquiry

Although the overall quantitative results reveal positive findings for the attribute of spirit of inquiry (see Table 4.2, p147), further analysis suggests that the reviewed case notes in this study are a poor indicator regarding the existence of the component of 'assessment findings are written according to IPPA (Inspection, Palpate, Percuss, Auscultate) mnemonics collectively' as well as for the component of 'assessment findings are written according to IPPA (see Table 4.10, p163). These results imply that the reviewed case notes in this study demonstrate a lack of application of IPPA assessment when examining the patient. These mnemonics are important, specifically in conducting physical examinations, as they offer a comprehensive and systematic assessment that provides findings, which are more likely to be complete and sufficient for the investigation of patient's problems and identify further actions (Kauffman & Roth-Kauffman, 2006).

However, IPPA is not the only mnemonics that can be used to assess a patient's condition. There are various mnemonics available that can be used to assess patients individually and according to their chief complaints (Kauffman & Roth-Kauffman, 2006). Therefore, it is unfair to perceive the respondents lack of ability in assessing patients. This argument is supported by the correlation test result of this study, where the correlation between IPPA and the total score of spirit of inquiry is the weakest compared with other components. Jarvis et al. (2012) indicated that an adequate health assessment, particularly a physical examination, would provide nurses with a broad range of information related to their patients. The information obtained from an adequate health assessment helps nurses in decision making.

Overall, the ability of a nurse to assess the condition of the patients can contribute to a more critical and wider scope of information that could be elicited from the patient (Polit & Beck, 2011). As presented in Faizal's quote (see quote on p200), the importance of asking

appropriate questions led him to retrieve correct and actual information regarding his patient's current and specific status and needs. Asking the correct question is one of Eklund & Konishi's (2013) arguments on how spirit of inquiry encourages evidence based practice among nurses.

Spirit of inquiry always works closely with evidence based practice which can only be initiated if there is a strong sense of keenness among the nurses to acquire information about their patients' problems and needs, besides questioning the feasibility and the effectiveness of care that is given to the patients (Laibhen-Parkes, 2014). It is interesting that the sense of alertness and of being observant are perceived by the respondents as an important stimulus for them to gather data, establish interpretations and to gain relevant and logical explanations that allow them to associate presenting situations with their current theoretical and practical knowledge (RNAO, 2007).

It is also interesting that fifteen of the respondents in this study state that it is important for them to be attentive which, in turn, drives them to assess their patients' needs and current status (see quote by Nafisah, p200). These respondents also mention that a nurse should be observant whenever he/she is caring for patients. These respondents define being observant as an attitude that should be a priority for all nurses to be able to detect or identify the patients' problems with necessary sensitivity and empathy (see quote by Nafisah, p200).

However, the above findings demonstrate that there is lack of existence of spirit of inquiry among respondents and in the reviewed case notes in this study. There is a possible reason behind this. As discussed in the earlier section (section 6.2.1), the culture of "dare not ask" and respecting their elders or superiors could hamper nurses from encouraging their sense of curiosity to raise questions and to challenge traditional and existing practices, and seek creative approaches to problem solving. This argument is also supported by the discussions on how nurses in Malaysia perceive themselves as playing the subservient role (see Section 6.2.1). Similarly, the findings on innovation and visionary in Section 6.5 explicitly explain that the respondents were unable to demonstrate their creativeness in seeking new ways to improve care.

6.10 Collegiality and collaboration

According to both the quantitative and qualitative results in this study, it can be postulated that the existence of the attribute of 'collegiality and collaboration' was strongly indicated in all the reviewed case notes, along with from the interviews with the respondents. There are several possible explanations for this result. Six respondents in this study agree that one of the principal roles of their documentation is as a medium to delegate work among nurses in a clinical setting (see quote from Alin, p201). The delegation of work through nursing documentation also encourages excellent team spirit among the nurses, as well as with the other medical personnel. For example, Christine described how teamwork is established when there is a mutual understanding between the staff who work together to provide continuous care or treatment to the patients (see quote on p202).

This corresponds to one of the components of the Code of Professional Conduct for Nurses (introduced by the Nursing Board of Malaysia in 1998), where teamwork is defined as a situation where 'the nurse works in collaboration and co-operatively with the other members of the healthcare team.' The results of this study are similar to the study conducted by Mohamed et al. (2014), in which they ascertained that nurses relied heavily on teamwork from colleagues and other healthcare team members. Furthermore, the respondents' in Mohamed et al. (2014) intended to fit in, which was based upon maintaining group harmony. The notions of 'practising teamwork in all tasks' and 'cooperating with each other' were given priority in the strategies to 'fit in' with colleagues, for both newly graduated nurses and senior nurses. This diverges from previously reported strategies, which include 'seeking acceptance' and 'having respect for authority and seniority', that are more commonly associated with newly graduated nurses (Anderson & Edberg, 2010; Paton, 2010).

Kuusisto et al. (2014) argue that multi-professional collaboration in healthcare between nurses and physicians requires the pivotal roles of nursing documentation to support communication and the fluent exchange of information. This is because different professional healthcare groups have their own roles, needs and professional responsibilities. Another interesting point that could contribute to strong teamwork among respondents in this study is the culture of personal value in the workplace (Siew et al., 2011). As Malaysia still strongly conforms to traditional Asian cultures, which sustain the core values of shared values and community orientation (Khoo, 1999), the value is upheld by most healthcare providers. Nurses tend to help each other whenever necessary whereby others' needs or team's needs

are put before individual needs (see Fauzi's quote on p203). This value can create strong bonds and encourage teamwork besides increasing friendliness, healthy relationships and a sense of belonging to the profession.

In relation to the positive findings for the attribute of collegiality and collaboration, another possible influential factor is the involvement of other healthcare providers, particularly doctors, in ensuring the documentation is complete and concise. This aspect has been discussed by Daniella:

"... Doctors normally see our documentation, to see a patient's current condition and they will ask the nurse if anything needs to be clarified ... We also see the documentation and whether the doctor has seen the patients. When a patient's medication is finished, we will tell doctor... That's why, during the ward round, nurses have to be there with the specialist ... it's so ... easy like that..."

(Daniella)

The excerpt demonstrates the observations of Petri (2010) that physicians and nurses should possess equal decision-making ability, responsibility and power. However, two of the respondents in this study believe that the doctors only examine their documentation if there is any abnormality or condition with the patients (see quote from Noryn, p202). This finding corresponds to that of Kuusisto et al. (2014), who establish that the physicians' opinions on nursing documentations are unhelpful and negative. Kuusisto et al. (2014) discovered that five physicians in three health care organisations, did not read the nursing documentation and did not consider them useful. Additionally, the physicians ascertained that nursing documentation is difficult to access and understand.

Law et al. (2010) also report that many respondents believe that other health professionals would not read the documentation that they completed. This situation could be because both physicians and nurses working in the hospital setting possess different attitudes towards the importance and quality of physician-nurse collaboration because of a complex interpersonal process between them (Tang et al., 2013). Therefore, it is essential that high quality information is recorded in nursing documentation to promote good quality information that can be accessed and used by other professionals, as part of their multidisciplinary care for patients (Saranto & Kinnunen, 2009). The authors comment that the role that nursing records play in communicating information to all health professionals and informing their care decisions means that good quality records can contribute to good quality care. Likewise, these positive results are parallel to the RNAO (2007) attribute of collegiality and collaboration that

focuses on joint working or co-operating with other health professionals when one's own abilities are beyond individual requirements.

6.11 Professionalism in nursing within nursing documentation across different types of length of stay

The quantitative results in this study reveal several significant findings in relation to the overall score for professionalism regarding all the reviewed case notes differs across types of length of stay. The median score for professionalism in nursing for reviewed case notes that is more than 73-96 hours and reviewed case notes for patients that are to be discharged and extended period (more than 96 hours since admission) case notes are higher than the median score for the reviewed case notes of 25-49 hours since patients' admission. This indicates that the duration of stay on the ward could influence the level of existence of the elements of professionalism in the nursing documentation. Specifically, the longer a patient stays on the ward, the more complete and detailed the nursing documentation is, and the higher the level of existence of the elements of professionalism in nursing will be in the nursing documentation. This implies that the nurses require adequate time to complete their documentation.

However, there are cases where the documentation was not fully completed even after the patient had been admitted to the ward for more than 24 hours. For instance, the reviewed case notes for patients who have been on the ward from 49-72 hours since admission have the lowest median score for professionalism. Four respondents in this study describe the large amount of documentation that they need to complete or to prepare in their daily tasks (see Table 5.11, p204). These respondents argue that dealing with large amounts of documentation is not beneficial and, at the end of the day, these documents are principally repetitive. One respondent explains that:

"I feel, that we need to write too much documentation. It's repetition and repetition... This is actually happening. It's not worth it because we seem to concentrate more on the writing and not the patient care. Time allocated to patient care is limited."

(Lily)

Enormous amounts of documentation, which comprise primarily routine notes, has made it difficult for nurses to search for any important information when needed (Brown et al., 2011). Despite considerable literature mentioning that considerable effort has been made to reduce nurses paper work (Siew et al., 2011), the nature and the demands of these documentation

are becoming more focused and specific, which means that nurses spend more time ensuring that complicated forms and paper work are completed and written correctly (Collins et al., 2013).

Another important finding was that all of the respondents in this study shared their stories about how the current situation in their work place could influence or encumber them from spending enough time completing their documentation appropriately (see Table 5.11, p204). For instance, answering phone calls, sending and picking up patients from other clinical settings, scrambling for patient case notes with other staff, administrative paper work such as ordering stock, sudden patient collapse or an emergency, ward rounds, demands from the doctors and the specialists could all prevent them from focusing entirely on their documentation.

Harris also expresses his concern:

"... by right ... you should do your documentation like an observation once you first see your patient ... but ... you do not have enough time. You're busy with doctors performing procedures ... Sometimes, there is a sudden event like a patient suddenly collapses ... You have to attend first ... You know ... that you will only get the chance to complete or prepare your documentation at the end of the shift ... Also, you have to extend your shift just to get the documentation completed "

(Harris)

These findings are congruent with that of Blake-Mowatt and Bennett's (2013) findings obtained from focus group discussions. Blake-Mowatt and Bennett report that telephone calls to the ward and the unavailability of records when they were needed for documentation are among the limiting factors that affect nurses' documentation. Furthermore, some of the nursing documentation cannot be completed, as it is required by the other health professionals, such as doctors, who jointly complete some assessments and to record information on a patient's plan of care or treatment.

These unpredictable and unanticipated changes, especially in the acute care-working environment, disrupt nurses' commitment to complete documentation (Reising, 2012; Kent & McCormack, 2010). Consequently, nurses may prepare or complete the documentation with less information because they only make a special effort to begin with and, afterward, think that the notes are only an extension of the original information. A profound example of this

can be elicited from Elina's quote (see p197). Along the same line, Ammenwerth et al. (2011) also discover that duplicating information is a common, and careless mistake that is constantly found among nurses. It seems possible that these results are due to nurses having problems with the ambiguous language commonly used in the nursing documentation (Law et al., 2010). O'Brien and Bowman (2011) see this issue as an indicator of either a lack of knowledge or an inability to articulate basic nursing care in writing.

Additionally, the overwork and staff shortages in various participating wards could also prevent the nurses from completing their documentation, according to the agreed standard (Table 5.11, p204). Twelve respondents in this study stated that staff shortages limit the time that they have to give care to the patients, in addition to the documentation. This finding supports O'Brien and Bowman's (2011) argument which stresses that there is a shortage of nurses globally and, thus, limits the capability of healthcare systems to provide the expected quality of care. Blake-Mowatt and Bennett (2013) also highlight this setback in their study. In their study, they imply that registered nurses suggest that heavy workloads and high patient/staff ratios had affected their documentation.

Seventeen respondents in this study agreed that attending to patients is the first priority before anything else. However, these respondents mention that they are worried about prioritising as they are unable to prepare their documentation properly and completely (see Table 5.11, p204). They further explained that they normally resume their documentation towards the end of their shift. Therefore, they have to extend their working hours, as they need to complete their documentation. Eventually, due to the limited time towards the end of their shift, the respondents tend to simplify their documentation by recording the most significant findings and important information regarding the care and treatment given to patients during the shift. Gina mentions that:

"... There is so much nursing care that you need to complete ... When a manager and your runner is so busy, you have to do the runners' jobs, because you know ... towards the end, if any work is not complete, you have to be responsible. That's why, you do not have time to write your report. So, I tend to write the important things, like the general condition and what has been done. Most of the time, I just 'tick' the doctor orders and if the patient's condition is normal, I just write, normal ... unless his condition is not stable or not normal, then I write more ... Sometimes the TPR chart is there to, you do not have to write everything..."

(Gina)

Interestingly, the same sentiment was expressed by eleven of the respondents in this study. This sentiment embodies the view that the respondents, could not always document all the tasks or care that they have offered to their patient in the documentation, despite the fact that they are fully aware of the significance of nursing documentation in their practice. One respondent shared her view on this issue:

"... I don't know which one to prioritise first, I know documentation is important ... but attending the patient always comes first ... That's why my documentation is not always good ... I think ... because I'm busy attending patients ... and ... at the end of shift ... I have to get my documentation completed ... so ... I have to simplify the content and just put the important information in it..."

(Najwa)

Blair & Smith (2012) also highlight how nurses always leave the completion of documentation until last. Hence, this move leads to hurried entries that lack details, risks losing important data and potentially lead to poorer patient outcomes. Research by Poissant et al. (2005) found that nursing time spent in a patient's room was approximately 31% of the total observation session, while the remaining 69% was spent outside the patient's room. The latter includes the time spent collecting medication or equipment, documenting and communicating with others. Based on this finding, Poissant et al. (2005) suggest that the outcome, i.e. the quality of the documentation, can be questioned.

From a different perspective, nursing documentation repeatedly takes nurses away from the bedside environment and the routines of the clinical area (Blair & Smith, 2012). Nurses in acute care settings can spend up to 25 to 50% of their time on documentation, which essentially results in less time being spent with patients, or having to resort to working overtime to complete nursing progress notes (Gugerty et al., 2007). A problem identified by Frank-Stromberg, Christensen and Elmhurst (2001) demonstrates that nurses may regard several aspects of nursing care as so fundamental that they are oblivious and, therefore, feel that there is no need to document that provision of care. This assumption of the so-called fundamental care being too 'routine' to be recorded can potentially expose nurses to accusations of patient neglect owing to the lack of documented evidence around care for that patient. Wu et al., (2013) argue that completing forms and managing documentation are overtaking the time that nurses could be spending with their patients.

This consistency is in line with the existing literature (De Marinis et al., 2010) which observed that nurses regularly do more than they record. This underlines how limited the assumption

is that suggests nurses do not perform tasks that are not recorded. The truth about 'performed' and 'recorded' care decreases significantly during days when more activities were undertaken (i.e. when the nurses were busier). Hence, this assumption continues to put nurses at risk: the claim regarding poor documentation practices was made, in part, by nurses who would be perceived by others as simply disregarding the importance of documentation in comparison to hands on nursing care (Karkainen et al., 2005).

6.12 Professionalism in nursing within nursing documentation across different types of wards

Kruskal Wallis tests suggests that there is a statistically significant difference between the overall median score for professionalism in the documentation with the type of wards (see results on p170). It should be noted that the finding is contrary to the studies conducted by Jefferies et al. (2012a) and Blake-Mowatt & Bennett (2013), who establish that there are no statistically significant differences in the quality of documentation between the participating wards in their respective studies. This contradictory result may be due to the fact that their research studies were conducted in one hospital setting. Whereas, this study was conducted at five different government hospitals in Malaysia (three in Peninsular Malaysia and two in East Malaysia).

In terms of the overall median score for professionalism in the reviewed case notes across the wards in this study, it is determined that the reviewed case notes on the psychiatry wards have the highest median score for professionalism in nursing (see Table 4.13 on p169). This high score may be due to the distinctive perspectives in care and the patients' conditions in a mental health setting. This form of specialised care requires the nurses to have advanced knowledge and skills to be able to care for mental health patients. Furthermore, according to the Psychiatry and Mental Health Services Operational Policy in 2011, all nurses who are attached to mental health institutions should have an advanced diploma in Mental Health Nursing (Ministry of Health Malaysia, 2011). This is because a mental health institution is a specialised area of clinical practice.

Specialised areas such as Psychiatry or Mental Health require nurses to utilise standardised language in a specialised area, enhanced content or information regarding the patients' conditions (Thoroddsen et al., 2010). As might be expected, specialised knowledge refers to a specific nursing diagnosis and interventions found in each specialty and the unique

knowledge of each specialism should be reflected in the relationships between nursing diagnoses and the interventions.

Moreover, this unique and specific knowledge is less likely to be used to identify specific nursing diagnoses and interventions in other specialties, settings or populations. Thus, nurses on psychiatric wards are able to prepare more comprehensive information in their documentation. This, evidently, is related to the quality and better content of the elements of professionalism in nursing. This condition could also contribute to findings whereby all the reviewed case notes from Hospital C appear to contain information pertaining to patients' experiences regarding the illnesses or treatments that they are receiving. This information is an addition to information on the confirmation of the work that has been undertaken. It may be that the reviewed case notes from Hospital C benefitted from being a Mental Health Institution. Hence, the above arguments could justify that the result of the Mann-Whitney U test indicate that there is statistically significant difference across the scores for all the attributes between psychiatric wards and all other participating wards (see results on p170).

Nursing documentation, particularly in nursing shift reports in a mental health setting, requires nurses to document subjective findings which are primarily the patients' experiences regarding their mental health problem and related treatment (Poh et al., 2013). Emotion, mood, cognitive and mental state are the principal findings that the nurses have to record in this context. All these subjective findings are demonstrated from the patients' experiences. Specifically, it can be said that this sort of information is an indicator that the focus of the documentation is on the patients.

It is important to note, however, that the reviewed case notes from the maternity wards scored the lowest median regarding professionalism (see Table 4.14, p170). This result may be explained by the fact that the maternity wards can be categorised as 'short stay' wards. This is because most of the wards admit patients while the patients are in the pre-delivery stage. In other words, the maternity ward can be considered a 'temporary setting' for patients in pre-labour. The pre-labour stage is an unpredictable and tense condition, for which any form of care and treatment cannot be planned in advanced (Freemantle, 2013). Due to this factor, the respondents do not have much time and opportunity to ensure that all of the documentation is completed (see Appendix 11).

6.13 Pragmatic perspectives of the RNAO (2007) model of professionalism in nursing and nursing documentation

The correlation test results show that there is a strong relationship between the total score for each attribute with the overall score for professionalism (see Table 4.3 on p149). These results suggest that all these attributes are interrelated in forming the concept of professionalism in nursing, as purported by the RNAO (2007). It should be noted that the RNAO (2007) has highlighted that all these attributes support or complement each other and have to be equally presented or demonstrated. This is because these attributes are part of a puzzle to provide an actual representation of professionalism in nursing. Several authors have discussed the integration and interrelation of these attributes within the context of professionalism in nursing.

The RNAO (2007) explains in greater detail the specific collection of attitudes and actions which supports the argument of Karkkainen et al. (2005) on the important roles of documentation. They argue that documentation is always bound up with the nurse's internalised values which, in turn, reflects a picture of the world and those attitudes that characterise the individual nurse and the organisation. Based on this point of view, the different caring cultures and traditions become visible. These traditions eventually shape how the knowledge of caring and nursing care is conveyed. Moreover, assessment in the area of professionalism must recognise the specifics of professional behaviours (Ginsburg et al., 2000). Hence, an understanding of what professionalism in nursing is, can be viewed more precisely from its characteristic and obligations (Beaton, 2010).

Alidina (2013) and Kirkwood (2014) explain how professionalism in nursing is a multi-conceptualised framework that comprises attitude, aptitude and characteristics which articulate a sufficient level of expectation related to nursing practice. The RNAO attributes could be shared identity according to the competencies, which are established from education, training and apprenticeship socialisation and, from time to time, qualifications by licensing (Evetts, 2011). These competencies have been illuminated predominantly by the qualitative findings.

The above results also suggest that the RNAO (2007) model of professionalism in nursing is an appropriate model of professionalism to be assimilated into the context of Malaysian nursing practice. The RNAO (2007) has managed to elicit a holistic picture of nursing documentation practice in Malaysia, which emphasises a particular consolidation of cultures, norms and organisational structure in healthcare. Gabe et al. (2004), Furaker (2008) and Alidina (2013) have collectively highlighted that the model of the RNAO (2007) could be viewed through the lens of various sociological perspectives. This was explained in the earlier sections (see Section 2.5, Chapter 2, p62).

6.14 The psychometric properties of the RNDA tool

The practicality of the RNAO (2007) model of professionalism in nursing in investigating the elements of professionalism in the nursing documentation also corresponded with the confirmatory factor analysis of the RNDA tool in this study. The analyses were performed after the pilot study, as well as after the data collection.

As mentioned in Chapter 3, the RNDA (Retrospective Nursing Documentation Analysis) was designed, validated and tested for its reliability at the commencement of this study. This tool was based on the model of Professionalism in nursing introduced by the Registered Nurses Association Ontario (RNAO) in 2007. Referring to Table 4.20, p181, confirmatory factor analysis indicates that the model of the RNAO (2007) could be acceptable and can be considered as a good fit for the observed data and sample in this study. These results are consistent compared with the confirmatory factor analysis results that were performed during the pilot study. It should be noted, however, that these results must be interpreted with caution.

The factor loadings tests for the RNDA tool in this study suggest that the factor loading for the attribute of 'accountability' and 'collegiality and collaboration' are below the cut-off point 0.4 (Bowen & Gou, 2011). These results propose that the attribute of accountability and collegiality and collaboration could be considered as unwanted factors in the model. It is important, however, to note that these results cannot be extrapolated to affirm that the RNDA tool is unfeasible. To respond to this claim, confirmatory factor analysis is a theoretically driven analytic procedure (Field, 2012), whereby the acceptability of a theoretical model is judged in terms of how well it 'fits' the observed data. Additionally, the principal tests, such

as CFI, TLI, RMSEA and SRMR have demonstrated positive results that adequately justify the acceptability of the model fitting for the sample or data (Boduszek & Dhingra, 2014).

Having said that, two papers claim that 'accountability' and 'collegiality and collaboration' work together with professionalism in nursing to act as a catalyst for safe nursing (Padgett, 2013). This is motivated by the nurses having to demonstrate professional behaviour and, simultaneously, be accountable and a team player in a multi-professional approach when it comes to offering safe care or treatment to patients (Sammer, Lykens, Singh, Mains & Lackan, 2010).

The introduction of a validated and standardised tool ensures that the researcher is focused on a specific area, or sections of the documentation throughout the process of the data collection. All these measures are significant, as the scientific and systematic investigation of existing health records is a crucial and valued, methodology in healthcare research, specifically in epidemiology, quality assessment studies and medicine (Worster & Haines, 2004). While many notable limitations to the retrospective chart review research remain (e.g. incomplete or missing documentation, poorly recorded and absent information), as a methodology, the retrospective chart review continues to offer numerous advantages.

6.15 Conclusion

The quantitative and qualitative findings of this study identified the evidence of professionalism among nurses in Malaysia from their documentation, and moreover, explored the knowledge, attitude and practice related to the professionalism of nurses and its association with nursing documentation in Malaysia. Furthermore, the integration between quantitative and qualitative findings in this study provides a position on where do nurses place themselves professionally in relation to their documentation. Superficially, the findings of this study seem to reveal that there is evidence of the existence of professionalism in the nursing documentation. However, in reality, the nurses could not demonstrate their comprehension of the existence of professionalism in their documentation. There are several factors and influences that have been identified from the qualitative findings, which could be detrimental to nurses' understanding of the existence of professionalism in nursing documentation. These factors are specifically the working culture and common cultural values, educational backgrounds, different workplace settings and recognition of the profession.

As there is no existing study to compare this study with, the findings of this study could be considered as significant empirical evidence of the existence of professionalism among nurses concerning their nursing documentation in the context of Malaysia. Similarly, this study has indicated that nursing documentation is a reliable source of assessment to demonstrate whether nurses are nursing in a professional manner.

The purpose of this study is to explore how nurses demonstrate the elements of professionalism within their documentation from a Malaysian context. The findings of this study provide a new understanding on the actual representation of the nursing documentation that could demonstrate professionalism among nurses. Essentially, the findings of this study have revealed an innovative way to empirically assess or explore the concept of professionalism among nurses by reviewing the content of their documentation. This was undertaken by conducting interviews with the nurses who are directly involved in completing or preparing the documentation. It has been an interesting discussion revolving around the practice of completing the documentation, which has generated a new understanding on how complex sociological factors and the attitude, perceptions and practice of professionalism among nurses could galvanise genuine nursing practice in Malaysia.

The implications of this study indicate that there needs to be greater concern regarding effective nursing documentation in Malaysia; not only by the nurses, but also by the authorities and relevant organisations, and will be discussed in the subsequent chapter. For instance, findings from this study would be advantageous for further, extensive development of nursing documentation and future studies in many other health settings in Malaysia. The findings also provide evidence to guide the relevant and responsible authorities when dealing with complicated documentation issues.

CHAPTER 7: CONCLUSION

7.1 Introduction

The findings of this study presented in Chapters 4 and 5 are summarised and their implications are discussed in this chapter. The strengths and the weaknesses of this study, together with the researcher's insights and reflections on the subject matter are also synthesised and discussed as an outcome of the journey of completing this study. Furthermore, this chapter discusses several limitations which have been experienced throughout the process of this study. At the end of the chapter, suggestions for future research will be proposed.

7.2 Review of the principal findings

This study updates and provides insights into the nature and complexity of professional practice among nurses working in Malaysia. The study focuses on examining the nature and complexity of nursing practice by ways of referencing empirical evidence specifically from nursing documentation. As discussed in Chapter 6, the differences and similarities between the quantitative and qualitative findings of this study has generated an interesting argument. The discussions on the differences and similarities between the quantitative and qualitative findings suggest that what the respondents (nurses) wrote on paper represents the nature of professionalism in nursing among them. The attributes of accountability, advocacy, innovation and visionary, ethics and values, autonomy, knowledge, spirit of inquiry and collaboration as proposed by the RNAO (2007) were consistent within the reviewed case notes, besides the respondents in this study.

The quantitative results in this study provide compelling evidence that the existence of the attributes proposed by the RNAO (2007) was comparatively elicited. Based on these findings, it can be concluded that all the reviewed case notes in this study indicate the existence of all the attributes of professionalism in nursing, as recommended by the RNAO (2007). Additionally, because it can be claimed that both the nurses who were involved directly and indirectly had successfully ensured that their documentation was of excellent quality, it can be considered that this demonstrates their actual professionalism or professional practice. Overall, the quantitative results entail a convincing indication of the existence of the elements of professionalism in the nursing documentation in Malaysia.

The qualitative findings in this study provide a strong confirmation of the quantitative findings via emerged codes and themes obtained from interviews. These codes and themes have elicited the potential indication of the existence of all eight attributes of professionalism, as proposed in the RNAO (2007) professionalism in nursing model.

The majority of the respondents perceived the task of completing their documentation as a preventive measure, in case of inadequate care, a breach in nursing procedures or treatment, which could result in departmental condemnation or civil litigation. Specifically, nurses are obliged to complete all their documentation given that the document forms legal evidence that could support or defend them whenever patients challenge the quality, efficiency and professional expertise of the nurses' care and treatment. This extremely worrying scenario arises when there is a disparity between the patients' expectations regarding health and pain, and the nurses' care and treatment.

7.3 Implication of further research

The integration of the quantitative and qualitative findings demonstrates that professionalism in nursing needs to be explored rather than investigated or identified. The findings of this study also suggest that more studies on professionalism in nursing, within Malaysia, should be conducted. Currently, no comprehensive study has been conducted in Malaysia on this particular topic, although a handful of discussion papers and excerpts on the matter have been established. The findings of this study also suggest the need to explore the factors that could hinder professional practice among nurses in Malaysia in greater detail.

Multicultural society in Malaysia is a significant factor that shapes life in the country. Policies, history, races, religions besides community norms influence Malaysia's way of life, particularly in their working practice. This influence also applies to the work culture of nurses in Malaysia. The multi-racial population of nurses in Malaysia results in different ideologies and perspectives among nurses towards themselves, along with others, despite a strong Malay identity that influences organisational and working culture among nurses. Hence, further research on these aspects is required to establish an improved and single ideological framework related to professional practice that fits into the nature of nursing practice in Malaysia and can be shared by all nurses regardless of multi-demographic background.

Further research needs to be undertaken within private medical institutions. One of the limitations of this study is that no private medical institutions were included in the study. This is due to the discretionary policies of the private institutions in protecting information in their medical and nursing documentation. This lack of support from private institutions has produced these questions: are these private institutions ready to be evaluated regarding performance? Or, is the supply of patients and subsequent benefits to the organisation greater than the benefits gained from the research.

The RNDA (Retrospective Nursing Documentation Analysis) tool was designed at the beginning of this study and was based on the RNAO (2007) best practice guidelines for professionalism in nursing. As mentioned previously, a pragmatic composition of the tool was tested using a proper validity and reliability test: Kappa's Inter-rater test, Cronbach's Alpha Co-efficient and Confirmatory Factor Analysis. Despite the unpromising results, it can be suggested that the designed tool in this study remains applicable. Boduszek (2014), for example, highlights that developing a tool based on theoretical perspectives, such a theoretical framework and/or model, could be used to investigate the research matter with the condition that the results of the model fit test are acceptable (Boduszek, 2014). However, a further validation test, such as an Exploratory Factor Analysis could be suggested to validate the tool. Exploratory Factor Analysis reduces a large number of variables into a smaller set of variables and establishes the underlying dimensions between measured variables and latent constructs, thereby allowing the formation and refinement of the theory (Williams, Brown & Onsman, 2010).

The utilisation of the RNAO (2007) model in this study has ensured that the elements in the nursing documentation are systematically and structurally assessed to obtain concrete evidence of the existence of the elements of professionalism in nursing and in nursing documentation. Considering the positive results from the confirmatory factor analysis, besides the support from the literature, the RNAO (2007) model of professionalism in nursing can be considered a feasible theoretical framework to explore the existence of professionalism in nursing in the nursing documentation. Regardless of the validity and reliability of the tool, it could be argued that the tool managed to guide the researcher to elicit the components that exist in the nursing documentation, which, in turn, could justify the existence of the elements of professionalism in nursing.

The results of the Confirmatory Factor Analysis in this study reveal that it is conceivable that the RNAO (2007) best practice guidelines of professionalism in nursing can be employed to explore the research matter for this study. Hence, the importance of theories and models as a framework for nursing practice should be highly accentuated. Until the nurses value the unique contribution that they make to healthcare and the special body of knowledge that informs their practice, their subordinate role to that undertaken by the doctors will continue (McCrae, 2012). Nonetheless, nurses should not stand on the side lines complaining about their resistance towards objective science (McCrae, 2012). This resistance would perpetuate their perceived deficits in research literacy and the power imbalance in healthcare. All healthcare practitioners apply a mixture of personal and professional knowledge, not all of which is supported on a casual analysis.

7.4 Implication for practice

The need to improve the standard of practice pertinent to the nursing documentation practice among nurses in Malaysia requires substantial involvement from every organisational level (micro to macro) (McDonald & Foster, 2013). Hence, to initiate an improvement in practice requires a change in the organisational culture of nursing practice in Malaysia, particularly in nursing documentation practice. Johnson's (1992) Cultural Web is a theoretically diverse and inclusive framework for the study of culture in organisations. Johnson's Cultural Web (1992) also specifies the type of change required and highlights aspects of culture that act as facilitators or block change (Johnson, Scholes & Whittington, 2011). In this model, six cultural elements (i.e. power structures, organisational structures, control systems, stories, rituals and routines and symbols) are depicted as contributing to, and perpetuating, an organisational cultural paradigm(see Diagram 7.1 on p263). The power of this model lies in the fact that it is, on the one hand, a simple, clear presentation of cultural elements and, on the other, a complex integration of several approaches to the study of culture that have regularly been segregated in management literature (McDonald & Foster, 2013).

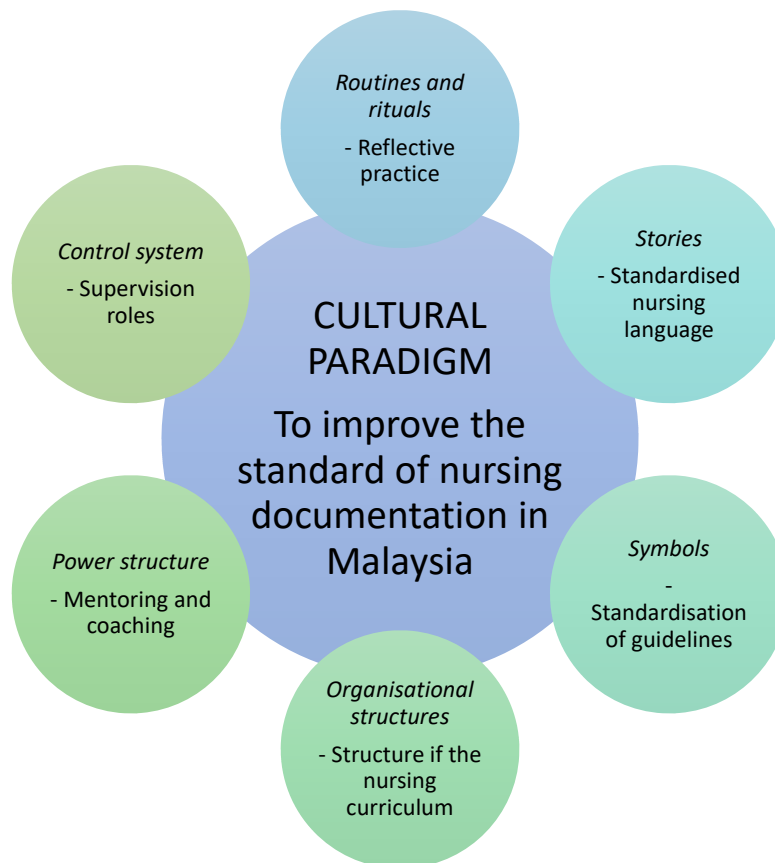
Changes were considered using each of the six interrelated and overlapping factors in terms of how they might influence and be influenced by a new paradigm. The cultural web model offers a visual analytical framework to understand this complex phenomenon and consider change that challenges the taken for granted assumptions within the cultural paradigm. It can be employed for incremental or fundamental change. Analysis and understanding of culture allows the design, innovation and the mapping out of the changes using the six

interrelated factors of the web. This can be extended to identifying, a desired future culture, which aligns with strategy (Freemantle, 2013).

As the cultural paradigm influences, and is influenced by the six interrelating factors of the model, each aspect should be considered regarding mapping out and designing the necessary changes (Johnson, Scholes & Whittington, 2011). These six interrelating factors or aspects are influenced by elements of the web, such as historical, organisational and power structure. The six interrelating factors that form a cultural paradigm are specifically, routine and rituals, stories, symbols, organisational structure, power structures and control systems. It is incumbent upon those seeking to bring about change to explore the six influencing factors and the cultural elements that emerge from them to plan and implement the necessary changes in practice and service provision.

The process of Johnson's Cultural Web of organisational change and how consideration of the dominant cultural paradigm is necessary to ensure that change is timely, appropriate and effective, with clear benefits to service users and providers alike. In considering each aspect as set out in the model, it enables the change agent to fully explore the factors that comprise and contribute to organisational culture. It also creates a need to change and what innovations might be introduced (Freemantle, 2013).

Diagram 7.1: Johnson's (1992) Cultural Web of Organisational Change



Based on diagram 7.1 above, there are several recommendations that could be introduced to improve the standard of nursing documentation in Malaysia to demonstrate greater indication of the existence of professionalism in nursing. Firstly, the findings of this study demonstrate the need to substantiate and improve the quality of nursing documentation. Such a move is essential to ensure that patient care remains at its best level and to achieve consistency in safe nursing practice.

In the interviews, four respondents mention the need for coaching or writing documentation workshops that could help them to increase their level of awareness on the important roles and concepts of nursing documentation (see Table 5.11, p204). It is argued that the coaching and workshops would enable nurses to eventually improve the quality of their

documentation. Therefore, it is recommended that the relevant authorities and stakeholders invest in and organise workshops or coaching programmes to improve, as well to ensure the standardisation and quality of the documentation. In the context of a clinical setting, mentorship systems can be promoted. In this case, the more experienced nurses, who have undergone workshop or coaching programmes, can guide the newly graduated nurses in their documentation practice. This step would ensure that nursing documentation is assiduously followed, with the required standard to achieve documentation which is of excellent quality.

Supervisory roles among senior staff nurses are imperative to measure and ensure that junior nurses meet the expected standard of documentation continuously. From a broader perspective, the scope of supervisory roles should not only apply to junior nurses, but also to senior staff as well. It is essential for nurses to collaborate in reviewing each other's performance or, in the context of documentation, assess the quality of each other's documentation (Beach & Oates, 2014). Through this coaching programme, nurses could discuss the strengths and weaknesses of their documentation and devise strategies and interventions to overcome and rectify any weaknesses, while maintaining their strengths.

What has also emerged clearly in the findings of this study is that it is vital for supervisors or senior nurses to continue to monitor and supervise younger or junior nurses, particularly in reviewing and guiding them to improve the quality of their documentation. Most nurses with less than five years working experience, who were interviewed, mention their struggles to meet their seniors' expectations on the quality of their documentation. Thus, senior leaders have a fundamental role in, and responsibility for, setting the conditions for professional work and the option for, and 'health' of, professionalism (Cribb & Gewirtz, 2015).

Thirdly, the universities, colleges and training institutes in Malaysia should focus more on nursing documentation, with particular emphasis on improving nursing students' ability to prepare nursing shift reports. Emphasis should also be placed on how to raise their awareness regarding the importance of nursing documentation. Besides the nursing shift report, other types of documentation should also be focused upon. The professional discipline of nursing documentation and/or record keeping, should be initiated from the very beginning of the nursing programme or training. At the nursing education level, the structure of the nursing curriculum should inculcate the discipline of enforcing the roles of nursing documentation throughout the course, from fundamental nursing care, to more complex nursing care.

Fourthly, standardised guidelines on nursing documentation are essential to ensure nurses are able to continuously produce the expected quality documentation. Complying with established practices and ward routines have been identified as the quickest way for newly graduated nurses to 'fit in' (Etheridge 2007; Maben et al., 2006). A critical review paper reviewed by Kim et al. (2010) concludes that documentation quality improved by establishing a clear documentation model that reflects the nursing practice of an institution. The paper also highlights that evaluating the quality of the documentation could be a challenging task when an established reference standard does not exist. Conceivably, as has been highlighted throughout this study, the attributes of the RAO (2007) professionalism in nursing guidelines could be utilised as the framework to structure the standardised guidelines for the nursing documentation.

Fifthly, the standardisation of nursing language will also be beneficial to ensure uniformity of the quality of content of nursing documentation. As language is the core of our collective understanding, it needs to have the ability to describe the condition of the patients and the concepts that are meaningful to nurses (Thoroddsen et al., 2010). By using standardised nursing language, it is possible to describe patients' responses to health problems, nursing interventions and patient outcomes, i.e., to represent nursing knowledge. Saranto and Kinnunen (2009) also stress that coherent and universal nursing terminology needs to be formulated in nursing documentation, to improve the standards of care and ensure that what is recorded in the documentation is consistent with the care it describes. Hence, it is suggested that the nursing authority, or organisations in Malaysia, develop standardised and nationwide guidelines related to nursing language that can be used by nurses in Malaysia. These guidelines should also be introduced to nursing education programmes to expose nursing students to it as early as possible.

Finally, reflective practice can be defined as an unstructured approach directing understanding and learning, a self-regulated process, commonly used in health and teaching professions (Kinsella, 2009). Reflective practice is a learning process taught to professionals from a variety of disciplines with the aim of enhancing abilities to communicate and make informed decisions. Reflective practice allows nurses to uncover and expose thoughts, feelings and behaviours that are present in a period of time (Driscoll & Teh, 2001). With regards to nursing documentation, reflective practice encourages nurses to be more critical and constructive when reviewing their documentation and retrieving any important points from others to collate

in forming the most effective and systematic nursing documentation (Bulman & Schutz, 2013).

Reflective practice could also be promulgated to improve the quality of documentation among nurses in Malaysia. Although, reflective practice was introduced by the Nursing Board of Malaysia (2008) and has been extensively adopted in the last 20 years (Kinsella, 2009), there is limited information regarding reflective practice among nurses in Malaysia that could justify the rational inculcation of reflective practice in nursing. Notably, there are two studies which explore reflective practice from the Malaysian nursing context (Chong, 2009; Blackman et al., 2014). Despite the findings of these studies suggesting the positive impacts of utilising reflective practice in nursing practice in Malaysia, the studies only explored the effectiveness of reflective practice that were introduced to the diploma course for nursing students.

Hence, reflective practice could be enhanced by way of several considerations. The first consideration is related to the involvement of the higher nursing authority, or nursing organisations in promoting reflective practice among nurses (Howatson-Jones, 2016). Contributions in terms of feedback and ideas regarding the quality of documentation should not be the only solution. The higher authority in healthcare and the nurses should negotiate and consolidate the processes to improve and sustain best documentation practice. The second consideration is that standardised guidelines should be introduced to nurses in Malaysia to promote structured, reflective practice among nurses, particularly in nursing documentation.

Although, the Nursing Board of Malaysia (2008) Continuous Professional Development (CPD) guidelines mention the roles of reflective notes, so far, there are no detailed guidelines indicating the establishment of a methodology which would demonstrate the use of reflective practice, even anecdotally. Finally, the assimilation of reflective practice into a multicultural society or work place, should also be considered. As the Malaysian nursing workforce comprises nurses from a variety of demographic backgrounds, reflective practice must cover each nurse's own principles and the ways in which he or she looks at life, which is influenced by the way they were brought up, influenced by the tenets of religions, cultures and community/ society norms.

7.5 Limitations of this study

Although this study has provided valuable information for healthcare professionals and created pointers for future research, it also has a few limitations. Firstly, this study has examined case notes and conducted interviews with nurses at five government-funded hospitals in Malaysia. Furthermore, no private hospitals participated in this study (for reasons of confidentiality and the policies of the hospitals). One university teaching hospital did agree to participate in this study but a major flood occurred on the scheduled date for data collection. This natural disaster resulted in the failure to collect data from that hospital. Consequently, this study only focuses on data from five government funded hospitals. Unfortunately, this small and limited sample means that the findings of this study could not be generalised to the entire nursing population in Malaysia.

The sampling did not include other healthcare providers' information concerning the qualitative findings. It would indeed be exceedingly beneficial for future research to assess other healthcare providers' policies and to explore their perspectives and opinions about nursing documentation. Hence, the researcher suggests that further research on professionalism in nursing documentation comprises other healthcare providers.

Additionally, it was difficult to determine the exact number of respondents engaged in the practice of documentation, as it depends on the number of patients who are admitted to the ward. There were also cases when patients were discharged after a short admission, passed away or were referred to other wards. Aside from that, the number of respondents also depended on the person-in-charge, responsible for allocating respondents for the data collection.

Moreover, the researcher was able to access only several types of medical disciplines, such as medical and surgical wards, to include in the sample of this study. This was due to the hospital authority's decision to assign the researcher to certain wards. It was beyond the researcher's ability to choose or select wards for the purpose of data collection. Apart from medical and surgical wards, the researcher also managed to collect data from other sub-specialised wards such as psychiatry, oncology, maternity and orthopaedics.

In the context of the literature review, most of the available literature is, in the main, out of date. It should be noted that most of the literature was published more than five years from

the commencement of this study. Based on the review of literature, it can be concluded that there is a period of time in which nursing documentation and professionalism were the main agenda of nursing research (i.e. from the end of the 1990s to the early 2000s). The one exception is a handful of recent, relevant studies or papers on nursing documentation and professionalism which were published in East Asia (e.g. in countries like Korea and Taiwan). However, no such studies have been conducted in Malaysia or within the context of Malaysian nursing. Thus, there is an urgent need to explore this topic through research and scholarship to enable it to be reinstalled and substantiated globally.

During the data collection process, the researcher discovered how poor handwriting had complicated the process. This difficulty arose as some notes are illegible or difficult to interpret, and, consequently, demonstrate one aspect of unprofessional nursing practice. Respondents were aware that this study was underway in their respective areas and, to some extent, this may have influenced the quality of their documentation during this study period.

It is standard for all the documentation related to the patient should be in one case note or folder. However, the practice at one of the participating hospitals is to have separate folders, so that the entire patient's observations and doctors' notes were in one folder, while simultaneously, all the nurses' notes, including the nursing care plan and nursing shift report, were in other folders. Hence, there were a number occasions where it was difficult to locate all these folders and they were not available either at the nurses' station or in the patient case notes trolley.

In this study, the researcher met the in-charge nurses to explain the study and they kindly offered to help in recruiting nurses for the interviews. Within a few days of this initial contact, the in-charge nurses had arranged for the nurses to be interviewed. The in-charge nurses approached the nurses and, rather than allowing the researcher to explain the study to them, they informed the nurses that the researcher wanted to ask them some questions. They then proceeded to usher the potential respondents into the interview room. The protocol and procedure for consent were explained before interviews were conducted.

These arrangements could however raise bias that could hinder the researcher's attempt to obtain genuine responses during the interviews. For example, the respondents may have preconceived notions on what to expect from the interviews as the in-charge nurses could have briefly introduced the study to the respondents. Consequently, there is a possibility that the respondents sought answers to support their preconceived notions prior to the interviews

(Gill et al., 2008). Consequently, the results or findings may not be the actual representation of the actual phenomena (Hammersley & Gomm, 2008).

As previously explained, the inter-rater agreement to validate the actual sample of this study was not performed. Financial and logistical restrictions limited this study from obtaining adequate data for the analysis of the inter-rater agreement. However, in this study, the researcher conducted the inter-rater agreement test after the pilot study and the beginning of this study. An inter-rater reliability test was conducted to examine the uniformed agreement between two raters in estimating the same subject matter or source (Gwet, 2008). The aim of an inter-rater reliability test is to measure how objectively the coding or measurement system performs.

Additionally, the convenience sampling that was selected for the quantitative strand of this study had sustained a setback in relation to the sampling biases. According to Gavin (2008), convenience sampling relies on choosing the items for the sample arbitrarily and without structure. The limitation of utilising convenience sampling is that it can lead to under representativeness or over representation of a specific group or sample (Field, 2012). Consequently, it is not feasible to accept the findings of a study that uses convenience sampling to generalise the chosen sample for the actual population.

The reason that convenience sampling was preferred for this study was that it enables the researcher to complete the data collection within the logistical and time constraints. Additionally, there was not a proportionate number of case notes. Schneider et al. (2013) support this sampling method as it is valuable when the total population is unknown or unavailable. Furthermore, this study did not aim to conduct any testing of hypothesis or inferential tests. And, adopting convenience sampling creates flexibility when dealing with unpredictable conditions on the participating wards.

The factor analysis results related to the Retrospective Nursing Documentation Analysis (RNDA) tool reveal that the factor loading results for the variable (attribute) of accountability, and variable (attribute) of collegiality and collaboration were considered poor in these sampling tests ($p \leq 0.5$) (Comrey & Lee, 1992). However, in a structural equation model, as a 'rule of thumb', an incremental fit index can be applied to evaluate whether the model fit should be considered (Marsh, Hau & Wen, 2004). Regardless of this argument, exploratory factor analysis was not performed to elicit the unnecessary observed variables in the tool. This is because the tool is based on a theoretical foundation and the ability of confirmatory

factor analysis is to report whether the model that is used as a framework for the tool is fit to the sample (Boduszek, 2014).

Specifically, confirmatory factor analysis is only able to inform the researcher to 'fail to reject' the model whether the model can be used as the framework to develop the research tool. Overall, it can be argued that RNDA is a valuable tool with distinct advantages, which has the potential to provide researchers with valuable research opportunities. (Gearing et al., 2006). A validated and standardised tool ensured that the researcher focused on the specific information that needed to be highlighted from the source (Gearing et al., 2006, Engel et al., 2008).

One of the major strengths of this study is the use of mixed methods design to tease out the complex and contemporaneous nature of professionalism in nursing in relation to nursing documentation. Integration is the heart of the mixed methods design because its purpose is to access information from multiple sources. Therefore, the validity and reliability of studies through the increased trustworthiness of the data and its interpretation can be achieved (Andrew & Halcomb, 2009). By means of utilising mixed methods, this study identified the differences between quantitative and qualitative data.

From the research design perspectives, integrated quantitative and qualitative data are not limited to just one approach or form of analysis. The integration of this data should be perceived as a multidimensional approach that is capable of allowing researchers to choose the most appropriate approach to adopt to obtain answers to their research questions (Creswell, 2013). The advantages of using more than one approach to integrate data allows researchers to explore in greater depth the relativity, similarity and dissimilarity, and complementary perspectives between quantitative (numerical or narrative) besides qualitative (narrative) data (Teddle & Tashakkori, 2009).

However, the disadvantages of using more than one approach to integrate the data are that the researchers are more likely to divert or move away from the focus of the research, as it can be disorganised and complicated. Consequently, the researcher had to keep reminding himself of the aims and objectives of his study. Gorard and Taylor (2004), for instance, argue that the ethical duty of researchers is to find the most appropriate mix of methods that would produce high quality research, and that adhering or following just one approach in all circumstances would be erroneous. The use of the concept map in explaining the process of

data integration is essential to ensure that researchers are always aligned with their process of analysis. This step enables researchers to gain a constructive and systematic understanding of what they are exploring.

Besides, these differences pose the question as to whether nursing documentation is a sufficiently strong enough evidence to explore the existence of the elements of professionalism in nursing. The findings of this study imply that professionalism in nursing exists superficially in the documentation. However, the respondents' opinions and comprehensions did not strongly support or complement these quantitative findings. Despite all these doubts, the researcher believes that it was appropriate to utilise mixed methods for this study as this approach contributes to eliciting the above discussions.

Qualitative and quantitative studies work as better partners by restricting its focus on the measurement of error, incomplete information, omitted variables and estimating the certainty of its conclusions (Field, 2012). Statistical data can be factual and straightforward, and data from interviews can bring the issue alive. In contrast, qualitative data can be dense in nature, and the use of statistics can help to provide focus. Thus, the use of several methods in research provide a sense of completeness and confirmation. In this instance, the qualitative material can be useful in the work for policy sponsors, where qualitative material can give policy makers a sense of the effects of policies in the real world beyond government (Field, 2012).

7.6 Conclusion

Overall, this study has highlighted the existence of elements of professionalism in nursing documentation, as recommended by the RNAO (2007) within the context of Malaysia. However, there is evidence of numerous perceptions and a fundamental understanding among the nurses in participating hospitals towards the meaning of professionalism in nursing. This form of understanding also revolves around the methods to integrate the element of professionalism in nursing into their practice, specifically in their documentation.

The findings of this study also point towards the creation of an alternative methodology or approach to explore and understand the existence of the elements of professionalism in nursing within the scope of this study. These results are likely to conclude that the quality of nursing documentation at five participating government hospitals in Malaysia demonstrates a

good indication of the existence of the elements of professionalism among nurses. The results of this study are likely to suggest that there is a need to place greater emphasis on the quality of nursing documentation in nursing practice and education and, that it is essential in order to improve the level of professionalism among nurses. Duclos-Miller (2016) also remarks that the quality of care can only be measured by the quality of the nursing documentation.

More importantly, this study offers new insight and entity into professional practice among nurses in Malaysia, with special focus on the nursing documentation. The essence of the findings of this study demonstrate the uniqueness and complex construct regarding the macro and micro level of the collective representation of professional practice among nurses in Malaysia. Essentially, the findings add another set of viewpoints in addressing the authenticity of global nursing practice. This study also emphasises the significance of nurses to prepare patient-driven or focused nursing documentation to achieve the level of care that society and organisations expect.

The findings of this study can be used as a baseline to elevate the quality of nursing documentation along with the nurses' understanding and ability to apply and integrate this appropriate knowledge of the elements of professionalism into their practice. The findings have also potentially enlightened and facilitated an incremental change among the nurses and hospitals which participated in this study. This is particularly relevant as the research, its extent, and revelations have provided insights into current nursing practice in Malaysia, which includes nursing documentation. The findings may inform policy makers and nursing educators to focus more on improving the quality of nursing documentation in Malaysia. Hence, it can be argued that this study is the starting point for nursing scholars, besides nursing practitioners, to further explore nursing practice in terms of the elements of professionalism in nursing and their documentation from the context of Malaysia.

As for nursing practice in Malaysia, the elements of professionalism in nursing is a distinct entity greatly influenced by Malaysia's diverse backgrounds. The awareness of the unique entity of professionalism among nurses in Malaysia should not avert the nurses from demonstrating the elements of professionalism in their practice but, instead, encourage them to be more culturally competent and, at the same time, consciously competent in assimilating the attribute of professionalism into their practice. The ability to demonstrate the elements of professionalism, while being culturally competent, creates a desired appreciation and recognition from society together with nurses' colleagues and patients. Until nurses,

themselves, value the unique contribution that they make to healthcare, and the special body of knowledge that informs their practice, the subordinate role to that undertaken by doctors will continue.

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Appendices

Appendix 1: Retrospective Nursing Documentation Analysis (RNDA) Tool

RETROSPECTIVE NURSING DOCUMENTATION DATA ANALYSIS (RNDA) TOOL

Instructions:

- a) Use ONE form for each review
- b) The review focuses on admission forms, nursing assessment form, nursing care plans and nursing progress notes, which should be available in the patient case notes.

SECTION 1

Please fill in the box provided

Reference Number:

Date:

Place a tick (✓) at the most appropriate box/response.

Length of stay since admission:

- ☐ Between 0 and 24 hours since admission.
- ☐ Between 25 hours to 48 hours since admission.
- ☐ Between 49 hours to 72 hours since admission.
- ☐ Between 73 hours to 96 hours since admission.
- ☐ Prior to discharge.
- ☐ Other cases extended periods (describe the situation):_____

Please fill in the box provided

Type of Ward:

SECTION 2

Instructions:

Place a tick (✓) in the most appropriate box/response. Explanatory notes as follows:

NONE- components not present in any of the written texts/any reports in a single case note

FEW - components rarely present any of the written texts/any reports in a single case note

SOME- components occasionally present any of the written texts/any reports in a single case note

MOST- components almost present in any of the written texts/ any reports in a single case note

ALL – components always present in any of the written texts/ any reports in a single case note

NOT APPLICABLE (N/A) - components not applicable to the case note

a) Accountability

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	Patient medical record entries are legible, completed in black or blue ink and authenticated by the authorised personnel with name/signature and date/time.						
2.	All records were kept in a proper official folder.						
3.	All records are sorted and arranged in the correct, chronological order according to the sections.						
4.	All entries are recorded and/or written at least daily according to the local clinical settings' regulation throughout admission.						
5.	All documents/records for admission should be completed/						

	<p>prepared within 48 hours of admission. For example:</p> <ul style="list-style-type: none"> a) Administration form b) Nursing assessment form c) Nursing Care Plan d) Nursing Progress Note 						
6.	There is no evidence of duplication of data values (entries in documentation appear uniquely) in the same chart.						
7.	The continuous care/treatment occurs from one shift to another.						
8.	The care/treatment has been performed and recorded by the assigned nurse.						
9.	The care/treatment plan clearly is amended or rewritten where necessary to avoid confusion.						
10.	<p>Corrections/ errors is corrected by:</p> <ul style="list-style-type: none"> a) Crossing through with a single line. b) Signed. c) Timed. d) Dated. 						

TOTAL SCORE:

/40

b) Advocacy

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	The details recorded provide adequate information for informed care planning.						
2.	Evaluations clearly relate to the outcomes identified in each care/treatment plan.						
3.	Problem/needs are updated where appropriate.						
4.	There is an individual plan of care for each problem /health need.						
5.	The care/treatment plan reflects changes in care in response to evaluation.						
6.	The patient's urgencies/ priorities are clearly stated.						
7.	Health needs assessment has been fully completed.						
8.	The care/treatment plan has been discussed with the patient/family/carer.						
9.	Relevant information has been given to the patient.						
10.	Information pertaining to admission procedure and orientation to the clinical setting already given to the patient/family/carer.						

TOTAL SCORE:

/40

c) Innovation and visionary

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	Care/treatment is clearly stated immediately after findings from assessment are distinguished.						
2.	Preventive intervention/measures is clearly stated.						
3.	Written content is easy to understand.						
4.	Amended care/treatment approaches according to the patient's current status are clearly written.						
5.	The care/treatment has clear identified outcomes, which can be evaluated.						
6.	The approach is supported with a clear rationale.						
7.	The plan is clearly recorded, stating its method or approach and the time when it was performed.						
8.	Significant risk factors identified for the patient.						
9.	Actions have been taken.						
10.	Plans for reassessment.						

TOTAL SCORE:

/40

d) Ethics and values

There is evidence that:

<i>No</i>	<i>Components</i>	<i>Scale</i>					
		<i>All</i>	<i>Most</i>	<i>Some</i>	<i>Few</i>	<i>None</i>	<i>N/A</i>
1.	The record is clear of any gossip, innuendo, hearsay or third party comment.						
2.	The patient's preferred name is clearly stated.						
3.	It is stated that the patient, family and others are informed of the current status, the care/treatment and the outcomes.						
4.	The patient has been briefed on his/her health problem and the care/treatment that will be given.						
5.	The patient's consent is recorded where appropriate.						
6.	Any important information from the patients and family/carer are clearly stated.						
7.	Any unique needs are identified.						
8.	There is a clear record prepared by other medical personnel according to the referral.						
9.	The patient's problem is written in terms of what the patient actually said or what the nurse observed.						

10.	Specific corresponding interventions for any unique needs clearly written.						
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TOTAL SCORE:

/40

e) Autonomy

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	The evaluation of care/treatment is performed clearly stated.						
2.	Urgent identified needs/problems are referred to the doctor/physician/surgeon are clearly written in the record.						
3.	Entries were written as incidents occurred.						
4.	Interventions are discontinued when resolved.						
5.	Reassessment is clearly undertaken.						
6.	The action taken by a nurse when finding change in the patient's status is recorded.						
7.	The principles of SOAPIER* applied appropriately in the nursing shift report.						
Each care/plan clearly prescribes of:							
8.	"What to do?"						

9.	"When to do it?"						
10.	"How to do it?"						

***S- Subjective, O- Objective, A- Assessment, P-Planning, I-Intervention, E-Evaluation, R- Rationale**

TOTAL SCORE:

/40

f) Knowledge

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	The appropriate type of assessment has been used.						
2.	Changes to treatment or care are made clear.						
3.	The observation, signs or symptoms, are recorded in terms of what the nurse observed only and was not based on the nurse's assumptions.						
4.	The information recorded provides adequate information for informed care planning.						
5.	Information or evidence from nursing and other disciplines to inform practice is used.						
6.	Appropriate detailed care/treatment based on the						

	patient's needs/ problems is clearly stated.						
7.	The rationale of planned care/treatment is clearly stated.						
8.	There is analysis of the assessment.						
9.	The diagnosis phase of nursing process applied is appropriately.						
10.	The planning phase of nursing process applied is appropriately.						

TOTAL SCORE:

/40

g) Spirit of inquiry

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	Any patient's urgent and individual needs and problems were identified and stated.						
2.	Any change in the patient's status was indicated and objective information documented.						
3.	The appropriate patient admission and assessment form been completed.						
4.	Assessment findings of the patient, physically and psychologically are appropriately recorded.						
5.	Assessment findings are written according to IPPA* mnemonics collectively.						

6.	The patient's response to care/treatment was stated.						
7.	The patient's response to medication was stated.						
8.	Appropriate reassessment of the patient's current status undertaken.						
9.	Clear care/treatment planning as a result of the assessment has occurred.						
10.	The prescribed investigations and results have been traced and collated.						

* **IPPA (Inspection, Palpation, Percussion and Auscultation – four key steps in physical examination)**

TOTAL SCORE:

/40

h) Collegiality and collaboration

There is evidence that:

No	Components	Scale					
		All	Most	Some	Few	None	N/A
1.	A qualified practitioner countersigned every entry made by an unqualified member.						
2.	The relevant professionally qualified practitioner countersigns every entry made by students.						
3.	There is a clearly stated of a formal handover from one shift to another.						
4.	Statements are clear and understandable without jargon.						

5.	The record of only standard abbreviation e.g. O ₂ , BP, SP O ₂ .						
6.	All referral forms are completed and sent to the appropriate medical personnel.						
7.	There is a report prepared by the referred medical personnel.						
8.	The name of the medical personnel who reviewed the patient is clearly written at the end of their report.						
9.	Discussion and decision on patient's care/ treatment in the record.						
10.	Distribution of responsibilities among colleagues in care/treatment is recorded.						

TOTAL SCORE:

/40

OVERALL SCORE:

/320

Comments/ Remarks:

Name of reviewer:

Signature of reviewer:

Date of review:

(Adapted from Larson et al.2004; RNAO, 2007; Johnson et al, 2010; Wang et al.,2010;Nottinghamshire Healthcare 2010; Paans et al., 2010)

Appendix 2:

SCORING SYSTEM FOR RETROSPECTIVE NURSING DOCUMENTATION ANALYSIS

4 Points

ALL – components always present in all sections/all notes/all reports in a single case note.

3 Points

MOST- components practically present in all sections/all notes/all reports in a single case note.

2 Points

SOME- components occasionally present in all sections/all notes/all reports in a single case note.

1 point

FEW - components rarely present in all sections/all notes/all reports in a single case note.

0 point

NONE- Components not present in all sections/all notes/all reports in a single case note. .

NOT APPLICABLE (N/A) - Question not applicable to this reviewed case note.

****There is always a certain amount of subjectivity when measuring patient records. It is important, therefore, that two different persons perform the measurement independently.***

*** FOR PATIENT DEMOGRAPHICS**

4 points

Personal details (e.g., patient full name, the hospital's registration number, and full address, date of birth, marital status, and ethnicity), the reason for admission, the next kin and emergency contact details, any known allergies and current medication are fully documented.

3 points

Personal details are basically available, the patient's name and address or information about the reason for admission are missing.

2 points

Personal details are partially incomplete, both name and address and information about the reason for admission, the next kin and emergency contact details are missing.

1 point

Personal details are incomplete, both name and address and information about the reason for admission, any known allergies, the next kin and emergency contact details are missing.

0 point

Personal details and the reason for admission are not documented.

TABULATION OF SCORES

Score	Indications
32 – 40 points	Excellent indicator of the existence of the attribute
23 - 31 points	Good indicator of the existence of the attribute
18 – 22 points	Satisfactory indicator of the existence of the attribute
9 – 17 points	Moderate indicator of the existence of the attribute
≤ 8 points	Poor indicator of the existence of the attribute

TABULATION OF OVERALL SCORES

Score	Indications
257 – 320 points	Excellent indicator of the existence of professionalism
193 - 256 points	Good indicator of the existence of professionalism
129 – 192 points	Satisfactory indicator of the existence of professionalism

65 – 128 points	Moderate indicator of the existence of professionalism
≤ 64 points	Poor indicator of the existence of professionalism

Appendix 3: Interview guide

INTERVIEW GUIDE

AN EXPLORATION OF THE ELEMENTS OF PROFESSIONALISM WITHIN NURSING DOCUMENTATION IN MALAYSIA

Opening

My name is Rekaya Vincent Balang and my research study is entitled "An exploration of the elements of professionalism within nursing documentation in Malaysia". I would like to ask you some questions about your nursing documentation. The interview should take between 30 to 45 minutes. If you agree to participate in this session, I would like you to complete the informed consent before we start the session.

- 1. What is your definition of nursing documentation?**
- 2. During your typical shift, how would you prepare your nursing documentation?**
- 3. What do you write in your nursing documentation? For example, your nursing shifts report?**
- 4. What is/are the ideal and professional ways/approach to prepare your documentation?**
- 5. Apart from preparing your nursing shift report, what other documentation do you need to complete? Why?**
- 6. Do you have any difficulties or any barriers that impact you preparing or completing your documentation?**
- 7. Could you tell me how important is nursing documentation in your daily professional practice? Why? Could you give an example?**

8. What are your steps or working process/norms when preparing your documentation? Do you have your own format when preparing your nursing shift report?

9. In your opinion, what is an ideal nursing documentation?

10. What sort of criteria do you think a nurse requires in preparing an appropriate nursing documentation?

Closing

It has been a pleasure talking to you. I really appreciate your kind assistance and for having time to be interviewed on this interesting topic. Let me briefly summarise our session. You have mentioned..... Is there anything else you want to add that you think it is helpful for me? I should have all the information I need. Thank you very much and if you do have any doubts or further inquiries, please do get in touch with me.

Adapted from: (RNAO, 2007; King et al., 2009; Paans et al., 2010; Nottinghamshire Healthcare, 2010; Wang, 2010; Bunkenborg et al., 2012)

Appendix 4: Informed Consent



CONSENT FORM

Title of Research Project: An exploration of the elements of professionalism within nursing documentation in Malaysia

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research ☐

I consent to taking part in it ☐

I understand that I have the right to withdraw from the research at any time
without giving any reason ☐

I give permission for my words to be quoted (by use of pseudonym) ☐

I understand that the information collected will be kept in secure conditions
for a period of five years at the University of Huddersfield ☐

I understand that no person other than the researcher/s and facilitator/s will ☐
have access to the information provided.

I understand that my identity will be protected by the use of pseudonym in the ☐
report and that no written information that could lead to my being identified will
be included in any report.

If you are satisfied that you understand the information and are happy to take part in this project please put
a tick in the box aligned to each sentence and print and sign below.

Signature of Participant: _____ Print: _____ Date: _____	Signature of Researcher: _____ Print: _____ Date: _____
---	--

(one copy to be retained by Participant / one copy to be retained by Researcher)

Appendix 5: The information sheet

AN EXPLORATION OF THE ELEMENTS OF PROFESSIONALISM WITHIN NURSING DOCUMENTATION IN MALAYSIA

INFORMATION SHEET

You are being invited to take part in this study entitled "An exploration of the elements of professionalism within nursing documentation in Malaysia". Before you decide to take part, it is important that you understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?

The purpose of this study is to explore how nurses in Malaysia demonstrate the elements of professionalism within nursing documentation.

Why I have been approached?

You have been asked to participate because you have met the eligible criteria for the study which is you are registered staff nurses who has worked in the same clinical setting for more than one year.

Do I have to take part?

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you and your privileges and benefits in your organisation. You may also skip any question during the interview, but continue to participate in the rest of the study. However, it is not recommended for you to withdraw from the study particularly when the study is at its stage of analysis onwards as this might affect the validity of the findings.

What will I need to do?

If you agree to take part in the study, you will take part in the interview. The interview will be conducted in a private room and will be recorded via digital voice recorder. The interview will take approximately 30 to 45 minutes. You will be asked several questions pertaining to your knowledge, attitude and practice of professionalism and its relation to your documentation. As you agree to participate in this study, you will be required to sign the consent form before the interview commences.

Will my identity be disclosed?

All information disclosed within the interview will be kept confidential, except where legal obligations would necessitate disclosure by the researchers to appropriate personnel. Any findings of the study will not reveal any specific individuals and organisations.

What will happen to the information?

All information collected from you during this study will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the study will, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. The final PhD thesis will be available to the public via the University of Huddersfield repository.

Who can I contact for further information?

If you require any further information about the study, please contact me on:

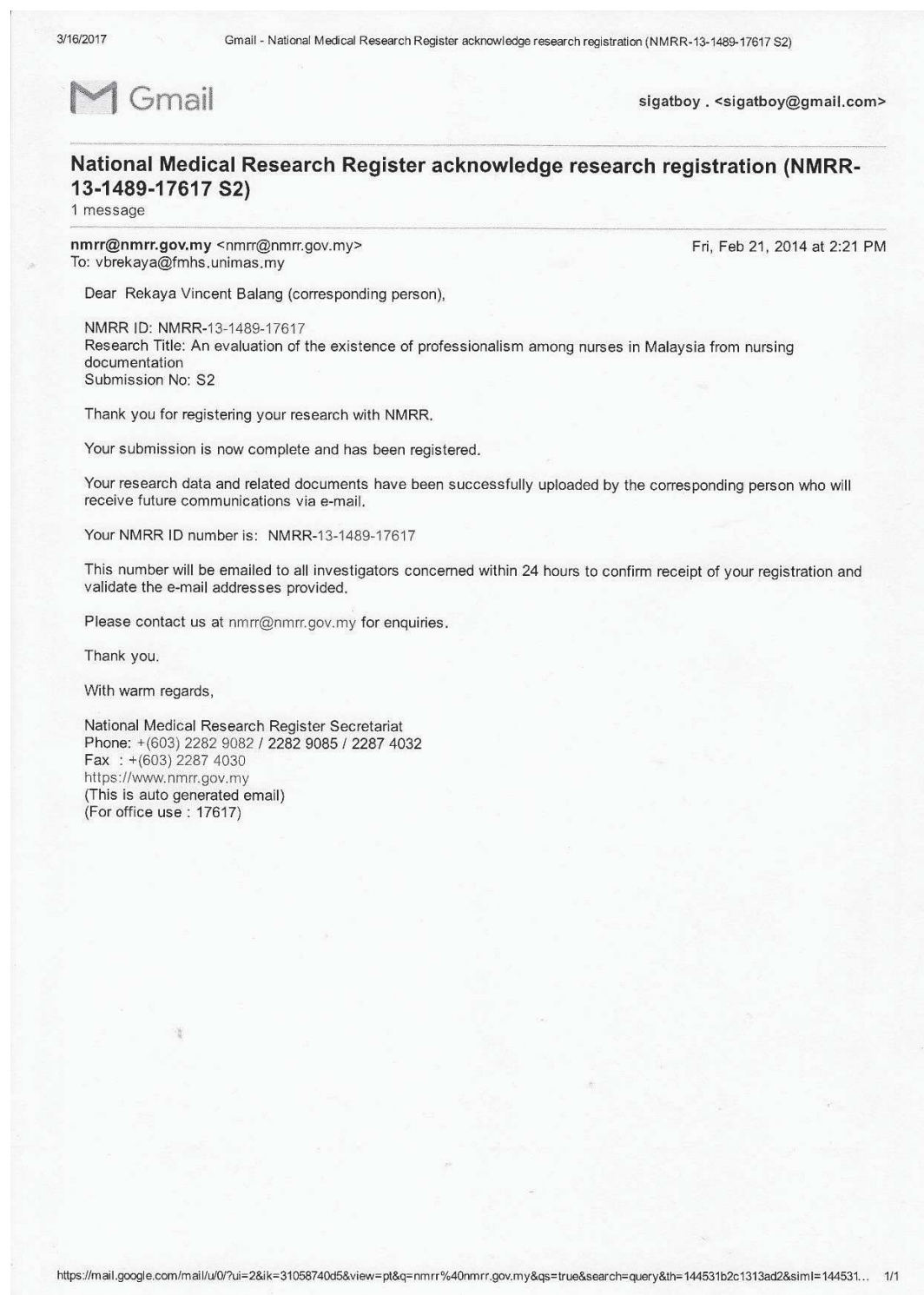
Name: Rekaya Vincent Balang

E-mail: U1276369@hud.ac.uk or sigatboy@gmail.com

Telephone: +447979546303 or +60198892379

Date:
Version No:

Appendix 6: National Medical Research Register acknowledge research registration



Appendix 7: Approval Letter from Medical Research & Ethics Committee



JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN

(Medical Research & Ethics Committee)

KEMENTERIAN KESIHATAN MALAYSIA

d/a Institut Pengurusan Kesihatan

Jalan Rumah Sakit, Bangsar

59000 Kuala Lumpur

Tel. : 03 2282 9082/03 2282 9085

03 2287 4032/03 2282 0491

Faks : 03 2287 4030

Ref : (3) KKM/NIHSEC/P14-369

Date : 20 June 2014

Rekaya Vincent Balang
Faculty Medicine & Health Science
University Malaysia Sarawak (UNIMAS)

Sir,

NMRR-13-1489-17617

An Evaluation Of The Existence Of Professionalism Among Nurses In Malaysia From Nursing Documentation

Project Site : Sarawak General Hospital

With reference to the above matter.

2. The Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia (MOH) has no objection or restriction in terms of ethics for the conduct of the above named study. MREC takes note that the study above has no clinical intervention on the subject and involves interviewing subject only for data collection.

3. All records and data are to be kept strictly CONFIDENTIAL and used only for this research purpose and all procedures on *data confidentiality* should be practised and maintained. Permission from the Hospital Director/ State Health Director of the project location should be obtained prior to the commencement of the above study. You are required to comply with their requirements.

4. Please be informed that this approval is valid for one year until 20th June 2014. You are required to send in the *Continuing Review Form* at least 2 months before the expiry of this approval for the renewal of the ethical approval. You will also be required to send in the study completion report and all *adverse events, both serious and unexpected* (if relevant) to the Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia (MOH) upon completion of this study. All the document is available in the MREC website (<http://www.nih.gov.my/mrec>).

Thank you.

Yours sincerely,

(DATUK DR CHANG KIAN MENG)

Chairman

Medical Research & Ethics Committee

Ministry of Health Malaysia

Appendix 8: Written approval from participating hospitals.

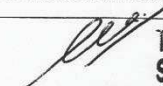
Versi 2.0 Tarikh 15 Feb 2008
INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL
PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.


Dokumen ini adalah untuk penghantaran atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikan. Borang ini dikeluarkan sebagai gantikan dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbakkan dokumen ini dan hantar atas talian.

NMRR ID	17617
Research Title: [Tajuk Penyelidikan]	An evaluation of the existence of professionalism among nurses in Malaysia from nursing documentation.
Protocol Number if available: [Nombor protokol jika ada]	

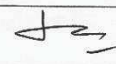
Investigator agreement [Persetujuan Penyelidik]
I have understood the above titled proposed research and I agree to participate in the research as an investigator. Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik

Name of Investigator [Nama Penyelidik]	Rekaya anak Vincent Balang
IC Number [Nombor KP]	790302-13-5867
Institution [Institusi]	Human and Health Research Centre, University of Huddersfield
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 THE UNIVERSITY OF HUDDERSFIELD School of Human and Health Sciences
Date [Tarikh]	3/10/2013

Head of Department Agreement [Persetujuan Ketua Jabatan]
I agree to allow the above named investigator to conduct or to participate in the above titled research. Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head [Nama Ketua]	NGAU YEN YEW
Name of Department and Institution [Jabatan dan Institusi]	Dept of medn Hkl.
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 DR. NGAU YEN YEW M.D.(USM), M.MED.(UKM), MRCP(UK) Senior Consultant Physician Department of Medicine Kuala Lumpur Hospital
Date [Tarikh]	10 Nov 2014

Institutional approval [Pengesahan Institusi]
This section may be omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details /Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut
I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research. Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director [Nama Pengarah]	
Name of Institution [Nama Institusi]	 11/11/14
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	DR. DING LAY MING (MPM: 2260) Timbalan Pengarah (Perubatan) II b.p. Pengarah Hospital Kuala Lumpur

Versi 2.0 Tarikh 15 Feb 2008

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL
APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

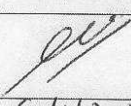
This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.

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NMRR ID	17617
Research Title: [Tajuk Penyelidikan]	An evaluation of the existence of professionalism among nurses in Malaysia from nursing documentation.
Protocol Number if available: [Nombor protokol jika ada]	

Investigator agreement [Persetujuan Penyelidik]

I have understood the above titled proposed research and I agree to participate in the research as an investigator.
Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik

Name of Investigator [Nama Penyelidik]	Rekaya anak Vincent Balang
IC Number [Nombor KP]	790302-13-5867
Institution [Institusi]	University of Huddersfield, UK
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	
Date [Tarikh]	6/1/2014

Head of Department Agreement [Persetujuan Ketua Jabatan]

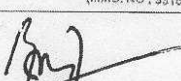

I agree to allow the above named investigator to conduct or to participate in the above titled research
Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head [Nama Ketua]	
Name of Department and Institution [Jabatan dan Institusi]	
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	
Date [Tarikh]	

Institutional approval [Pengesahan Institusi]

This section may be omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details [Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.
Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director [Nama Pengarah]	
Name of Institution [Nama Institusi]	DR. HJ. RAZAK BIN TAMBI A.D.K. PENGARAH HOSPITAL QUEEN ELIZABETH II KOTA KINABALU, SABAH (MMC, NO: 33187)
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 


This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.

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
NMRK ID	17617
Research Title [Tajuk Penyelidikan]	An evaluation of the existence of professionalism among nurses in Malaysia from nursing documentation
Protocol Number if available: [Nombor protokol jika ada]	

I have understood the above titled proposed research and I agree to participate in the research as an investigator.
Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik

Name of Investigator [Nama Penyelidik]	Rekaya anak Vincent Balang
IC Number [Nombor KP]	790302-13-5867
Institution [Institusi]	Human and Health Research Centre, University of Huddersfield

Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 THE UNIVERSITY OF HUDDERSFIELD School of Human and Health Sciences 2/7/2014
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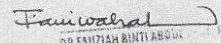
I agree to allow the above named investigator to conduct or to participate in the above titled research.
Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head [Nama Ketua]	DR MOHD RUHAIFI ALI
Name of Department and Institution [Jabatan dan Institusi]	
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 DR MOHD RUHAIFI ALI Perakuan Pendaftaran Penuh 46586 Pegawai Perawatan Rawan (Penaduan / Klinikal) Hospital Kulim, KEDAH
Date [Tarikh]	10/7/14

This section may be omitted if one of the NHI institute is authorized to approve on behalf of institution. Refer NHI for details [Bahagian ini tidak perlu jika salah satu daripada institusi NHI diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NHI untuk maklumat lanjut]

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.

Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director [Nama Pengarah]	
Name of Institution [Nama Institusi]	
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 DR FAUZHIAH BINTI ABDU Perakuan Pendaftaran Penuh PENGARAH Hospital Kulim, KEDAH 10/7/14

Versi 2.0 Tarikh 15 Feb 2008

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL
APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

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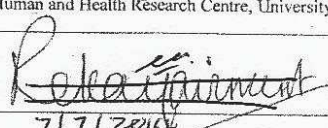
Dokumen ini adalah untuk penghantaran atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikan. Borang ini dikeluarkan sebagai gantikan dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbasan dokumen ini dan hantar atas talian.

NMRR ID	17617
Research Title: [Tajuk Penyelidikan]	An evaluation of the existence of professionalism among nurses in Malaysia from nursing documentation.
Protocol Number if available: [Nombor protokol jika ada]	

Investigator agreement [Persetujuan Penyelidik]

I have understood the above titled proposed research and I agree to participate in the research as an investigator.

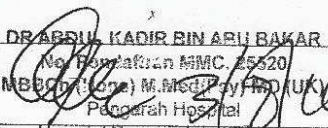
Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik

Name of Investigator [Nama Penyelidik]	Rekaya anak Vincent Balang
IC Number [Nombor KP]	790302-13-5867
Institution [Institusi]	Human and Health Research Centre, University of Huddersfield
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	
Date [Tarikh]	7/7/2014

Head of Department Agreement [Persetujuan Ketua Jabatan]

I agree to allow the above named investigator to conduct or to participate in the above titled research

Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

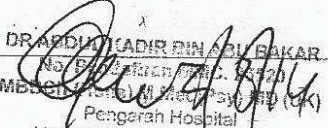
Name of Head [Nama Ketua]	
Name of Department and Institution [Jabatan dan Institusi]	
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 DR ABDUL KADIR BIN ABU BAKAR No. Pendaftaran MMC: 25520 MBBCh (Hons) M.Med.Psy (Hd) (UK) Pengerah Hospital Hospital Permat, Johor Bahru.
Date [Tarikh]	

Institutional approval [Pengesahan Institusi]

This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details [Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.

Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director [Nama Pengerah]	
Name of Institution [Nama Institusi]	
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 DR ABDUL KADIR BIN ABU BAKAR No. Pendaftaran MMC: 25520 MBBCh (Hons) M.Med.Psy (Hd) (UK) Pengerah Hospital Hospital Permat, Johor Bahru.
Date [Tarikh]	

Versi 2.0 Tarikh 15 Feb 2008

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

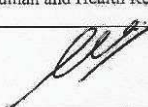
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NMRR ID	17617
Research Title: [Tajuk Penyelidikan]	An evaluation of the existence of professionalism among nurses in Malaysia from nursing documentation.
Protocol Number if available: [Nombor protokol jika ada]	


Investigator agreement [Persetujuan Penyelidik]

I have understood the above titled proposed research and I agree to participate in the research as an investigator. Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik

Name of Investigator [Nama Penyelidik]	Rekaya anak Vincent Balang
IC Number [Nombor KP]	790302-13-5867
Institution [Institusi]	Human and Health Research Centre, University of Huddersfield
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 THE UNIVERSITY OF HUDDERSFIELD School of Human and Health Sciences
Date [Tarikh]	3/10/2013

Head of Department Agreement [Persetujuan Ketua Jabatan]

I agree to allow the above named investigator to conduct or to participate in the above titled research. Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

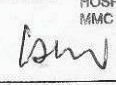
Name of Head [Nama Ketua]	SA-REAH BINTI WAHET
Name of Department and Institution [Jabatan dan Institusi]	HOSPITAL umum SARAWAK
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	 SA-REAH BINTI WAHET KETUA POKOK JAJURURAWAT HOSPITAL LJH 15767 Hospital Umum Sarawak
Date [Tarikh]	17 OCT 2013

Institutional approval [Pengesahan Institusi]

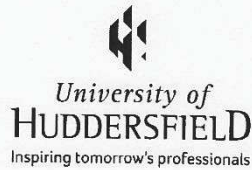
This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details /Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut

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Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director [Nama Pengarah]	
Name of Institution [Nama Institusi]	
Signature & Official Stamp [Tandatangan dan Cop Rasmi]	DR. ABDUL RAHIM B. ABDULLAH PENGARAH HOSPITAL UMUM SARAWAK MMC NO: 25483 
Date [Tarikh]	16/10/13

Appendix 9: School Research Ethic Committee approval letter.



14 August 2013

Mr Rekaya Vincent Balang
PhD Student
School of Human and Health Sciences
University of Huddersfield

Dear Rekaya

School Research Ethics Panel (SREP) Submission
Title of Study: "An evaluation of the existence of professionalism among
nurses in Malaysia within nursing documentation"
Reference: SREP/2013/63

I confirm that your project as titled above has received ethical approval from the School of Human and Health Sciences Research Ethics Panel, University of Huddersfield.

I also confirm that indemnity for this project will be covered by the insurance policy held by the University of Huddersfield, as it falls within the normal range of research activity.

With best wishes for the success of your research study.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Nigel King'.

Prof Nigel King
Chair, School Research Ethics Panel (SREP)
School of Human and Health Sciences

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Appendix 10: Transcript and translation

The original transcript

Date: 04/11/2014 (001_141104_1117B0)

Venue: Disclosed

Interviewer: Rekaya Vincent Balang

Duration: 32 minutes 30 seconds

(I): Ok ya, Selamat Pagi ia, nama saya Rekaya, saya adalah pelajar PHD untuk projek dan explorasi elemen - elemen professionalism dikalangan jururawat di Malaysia berkenaan dokumentasi kejururawatan. Jadi before, before kita start interview ini, kita nak puan faham tentang content kajian saya ini dan bersetuju untuk menyertai apa, temu ramah ini. Jadi dengan ini, saya memohon untuk turun tandatangan setuju. Ya.. Hmm..

(R): Sini?

(I): Ia, sign lepas tu nama, lepas tu tarikh. Ok..aahh?? Ok terima kasih.

(R): Sama.

(I): OK, Jadi aaa, temu ramah ini aaa akan mengambil masa dalam 30 minit hingga 35 minit terpulang dengan "am am" apa nama? Aaaa...movement interview kita aa temu ramah kita pada hari inilah. Aaaa... biar kita mulakan dengan satu soalan. Apa dia definasi puan, mengenai dengan dokumentasi kejururawatan ataupun nursing documentation?

(R): Nursing documentation?

(I): Emk..

(R): Aaaa...dia adalah satu..Aaa..tatacara untuk kita memberi rawatan kepada pesakit, dan kita dokumen apa kita telah lakukan kepada pesakitlah.

(I): Emmm...

(R): Aaaa.. Contohnya, kita membuat apa..memberi **static (1:49)** sponging, membuat observation, dressing, apa penemuan tu, kita kena recordlah dalam dokumentasilah, sebagai bukti aaa..dan sebagai.. continuous kita punya treatmentlah..pas

(I): Hmmm..Dari segi..Aaa..sorry. Teruskan

(R): Pass..untuk pass over report si ******* (2:09)** tulah.

(I): Aaaa...nampaknya macam dalam hospital ini..aaaa..dari segi hospital ini..macam mana puan melihat dari segi nursing dokumentasi..ehh..nursing documentation di hospital ini?aaa..apa pendapat puan, adakah ia merupakan satu yang sangat penting ataupun mungkin nombor 2 penting, ia ataupun...

(R): Pendapat saya, aaa...dalam hospital ini, nursing documentation memang sangat penting..

(I): Hmmm..

(R): Aaaa..because kalau ada sesuatu perkara yang bangkit, dia akan melihat apa kita tulis sebelum tu kejadian.

(I): Hmmm...

(R): Itu sangat-sangat penting

(I): Pernah ada kes tak? Contoh?

(R): Kepada pesakit dan kepada inilah kepada staff yang terlibatlah.

(I): Staff yang terlibatlah.

(R): Emk...so far...aaa..dari pengalaman saya memang adalah.

(I): Emk...

(R): Memang ada.

(I): Memang ia merupakan macam satu bahan atau medium yang penting

(R): Ia.

(I): Rujukan sekiranya ada sesuatu yang berlaku.

(R): Emk..ya.

(I): Ok...aaa..dalam sesuatu shift ini,satu shift ini, macam mana puan..aaaa..melengkapkan atau menyediakan... aaaa ..dokumentasi ini. Apakah cara dia, puan guna untuk...aaa..cara puan untuk melengkapkan nursing documentation ini?

(R): Nursing documentation? Macam kita ada cubical cubical, satu cubical

(I): Emk..ok

(R): Satu staff yang jagakan?

(I): Emk..

(R): So tiga cubical, tiga staff lah..so semua runner. So pagi selalu empat orang staff yang bekerja, petang pun macam tu, malam dua orang. So setiap cubical yang dia orang jaga, dia akan take care patient dan mesti lengkap documentation.

(I): Emmm...

(R): Sebelum pass over shift.

(I): Nursing documentasi, termasuk apa dia puan?

(R): Nursing dokumentasi termasuk tulah, keadaan pesakit hari tu, lepas tu pesakit ada aliran apa macam **on drip** ke, **inclusion** apa-apa **(4:11)**, semua kena record, lepas tu water sign patient, apa procedure yang kita buat, sponging ke, dressing ke, semua kena masuk. Lepas tu kita doctor round, kita carry out apa yang doctor dokumen. Carry out. So kita update lah apa yang tak yang diperlukan..Aaaaa..sebelum kita pass over, tu aaa...shift lain lah untuk staff lain shift lain lah. So kalau kita tak dapat penuhi masa tu, kita akan pass over lah supaya next punya staff akan carry out balik lah yang apa yang kita tak dapat capai lah pagi tu.

(I): Kalau contoh bagi saya pun pernah berlaku juga yang mana saya tak sempat nak siapkan dokumentasi saya sebab mungkin sibuk you know lah. Sama kita tak ada cukup staff kan dan jadi ada saya point yang memang saya langsung tak sempat pun nak siapkan aaa..dokumentasi yang harus sepatutnya siap sebelum shift saya habis. Kalau sekiranya keadaan itu berlaku, apa pendapat puan?

(R): Pendapat saya, setahu yang terlibat itu dia perlu dia kena siapkan juga walaupun shift dia habis dia kena stay back dan siapkan juga. Dia tak boleh tak tulis. Dia kena tulis juga apa yang terjadi masa time dia mara sakit tu. Aaa..dia tak boleh escape, dia tak boleh tinggalkan.

(I): Sekiranya, perkara itu berlaku dia tak buat, apa apa berasa yang akan terjadi?

(R): Kalau dia tak buat, kita akan selidikkan apa dia tak buat. Kenapa dia tak tulis, kenapa dia tak rawat patient tu..aaa.

(I): Emk...

(R): Aaa..kita akan selidik kenapa dia tak buat. Padahal orang lain, staff lain boleh buat, kenapa dia tak boleh buat. So, kita akan bagi dia motivasi lah..

(I): Emk...Emmm..

(R): Tanya dia sebab dan kita akan memberi motivasi kenapa dia tak buat. So kita akan bagi amaran lah. Next time, masih juga tak buat kita akan aaa .. apa surat tunjuk sebab lah kenapa tak lakukan.

(I): Aaah.. Ok ok..Kalau dari segi macam..aaa..penerangan puan tadi, seperti nurse dokumentasi kejurawatan ini sangat penting seperti dia mencerminkan bagaimana seorang jururawat tu melakukan tugas beliau secara professional.

(R): Ia begitu..

(I): Apa pendapat puan kalau..dengan statement yang saya...ok

(R): Ia betul, memang memang penting, report memang penting setiap kali kita merawat pesakit. Itu sebagai bukti, walaupun di mahkamah pun dia akan tengok bukti.

(I): Emm..Emmm..ok

(R): Sebagai bukti kalau apa apa terjadi di masa akan datang aaa..

(I): Emm..

(R): Tu memang penting..documentation jururawat

(I): Emm..so kalau imbas kembali masa puan, ketika puan satu tugas puan kena siapkan..aaaa..nursing shift report..aa..saya ingat puan, apa-apa isi kandungan yang puan tulis untuk..aaaa...aaaaa... apa nursing shift report tu?

(R): Aaa..macam saya cakap tadi lah..

(I): Apa apa kandungan dia?Aaa..puan puan guna apa? Adakah dia macam puan mengikut masa ataupun descriptive ataupun??

(R): Tak mengikut masa, mengikut masa..aaa

(I): Em..ok mengikut masa..em kenapa puan pilih mengikut masa?

(R): Mengikut masa kita kita take over report ok pukul 7 kan, ok..masa tu lepas habis report je, kita tulis condition patient taking over report macam mana macam mana, so bila kita pass over report tu back to bed, bukan dekat pangking. So kita akan observe patient. Ya

(I): Yes..yes. By right lah..

(R): Ah..observe patient then kita tengok apa dia on apa dia aaa...apa ni? Inclusion yang ada apa dia? Drip ke apa? CBD ke? So kita akan document, macam mana aliran ya, tak da apa, **tombubaitis (8:16)** kan..aaa..kita juga kena record urine dia, clear ka? Blood ka? Kita kena record. Masa pagi, take over report, lepas tu, water sign, kalau water sign normal, kita kena tulis jugalah. Walaupun normal ka, tak normal ka, drip, record juga. Kalau didapati tak normal, terus segera inform doctor. Doctor sentiasa adakan, dekat ward. So kita kan apa...beritahu doctor segera. Lepas tu doctor round, kita akan tengoklah, carry out apa yang doctor order macam mana nak ultrasound ka? X-ray ka? Kita akan sediakan semua barang semua then carry out lah. Itu sangat penting.

(I): Dalam berapa lama sebenarnya, kalau mau siapkan satu nursing shift report kalau ikut pengalaman puan...rasa-rasa nya.

(R): Untuk siapkan satu patient ke? Macam mana?

(I): Ya, satu patient.

(R): Satu patient..

(I): Rasa-rasa nya..

(R): Untuk satu patient...aaa..because kita satu bed, satu cubical tu, lebih kurang kita ada enam pesakit lah, enam pesakit, tapi tak semestinya ada enam, sebab kadang-kadang ada lapan, lapan patient.

(I): Emm...emm...

(R): So kita...yang mana penting kita buat dululah. Yang patient yang critical kita attend dulu lah..aaa

(I): Emm..emm..

(R): Kita tumpukan dekat, dekat dia dulu so kita akan tulis masa tulah, kita ada masa je tulis jangan delay delay. Because delay dia akan menyebabkan kita lupa apa yang kita nak tulis lah document.

(I): Tulis..

(R): So kita bagi priority yang ill patient..aaa...***** **mumble words (9.52)**

(I): Ok..selain daripada nursing shift report, apa jenis dokumentasi yang lain yang harus seorang jururawat complete ataupun siapkan sebelum kita...

(R): Banyak kita ada paper memang banyak bahagian nursing macam macam charting chart tu memang macam macam chart ada..aaaa...observation chart, DST chart, **RED INJURY (10:23) glasscosmaty chart**. Lepas tu..aaa..counting bundle, macam patient ada CVP ke, ada CVD semua kena record, lepas tu position chart, turning patient.

(I): Aaa..Ya, kalau..ya ya betul

(R): Lepas tu kena chart entry to hours tu lagi..aaa..**tombybiatist chart (10:44)** lepas tu kena record..aaa..so memang banyak documentation lah untuk nursing.

(I): Kalau banyak macam tu, you rasa tugas nak memperlengkapkan dokumentasi ini, adakah dia satu boleh dianggap sebagai satu yang mengganggu tugas seorang jururawat lakukan tugas sebenar jururawat?

(R): Tapi kalau kata mengganggu tu, tidaklah. Memang tu tanggungjawab. Tanggungjawab.

(I): Ok

(R): So dia kena, buat! Mau ke tak mau, dia kena buat. So bila buat observation, dalam masa observation tu, you boleh tengok siap siap dah. Apa dokumentasi, so you terus document.

(I): Betul

(R): Aaaa. Bukan satu-satu satu..aaa..so you tengok lah Drip dia, ok ke? **Trombobrociatis dia (11:27) ke**, aliran urine elok, pernafasan semua elok, bp semua ok, you terus tulis lah. So sekali tengok sahaja setiap kali buat observation lah. You boleh record semua. Emm..

(I): Aaaaa..Rasanya apa jenis halangan yang mungkin seorang jururawat tu akan alami semasa dia memperlengkapkan ataupun menyiapkan dokumentasi beliau?

(R): Selalunya, aaaaaaa...macam satu cubical tu, mungkin ada patient yang collapsed, so akan mengganggu lah, lain lain punya dokumentasi lah dan kita perlu attend patient tu. Nak in to bed lah, sometimes lah, so nak bathing, nak sediakan ubat-ubat sometimes ambil masa kan, so itu akan mengganggu lah dokumentasi pesakit-pesakit lah.

(I): Selain daripada itu, contoh mungkin dari segi faktor-faktor lain?

(R): Faktor-faktor lain, saya rasa kalau kes masuk emergency kes, preparation untuk ***** (12:42) akan menghalang juga lah kalau ada dokumentasi untuk pesakit lain, kalau pesakit tu, ok lah, kita tumpu kepada dia kan, untuk pesakit-pesakit lain mungkin akan terganggu juga lah tapi kita kena buat juga sebelum balik.

(I): Rasanya puan, apa sebenarnya yang diperlukan oleh seorang jururawat tu untuk menghasilkan dokumentasi yang dikirakan bagus ataupun baik. Apa yang diperlukan oleh seorang jururawat?

(R): Jururawat, oh. Dia kena kenal pesakit dia kena tahu diagnosis pesakit dia, lepas tu apa pesakit tu sedang menerima rawatan kan. That's means dia tahu lah apa keperluan pesakit tu lah. Macam pesakit yang macam **Immunizing care (13:28)** maksud saya dia kena apa tak boleh bergerak, patient lie down atas katil. So, apa apa yang kita kena buat? Just sponging, semua semua kita tugas kita lah. Kalau pesakit yang boleh berjalan, kita boleh arah pergi mandi kan. Dekat bilik air, lepas tu, dia akan balik ke katil, kalau kita buat observation kat dia semua pergi makan semua macam pesakit pesakit yang tak boleh jalan tu, memang memang kita ada plan lah. Ok Patient kita tak boleh berjalan, so apa kita kena buat? Sponging. First sekali pagi pagi, sponging. So kita akan buat, lepas tu buat water sign, dan doctor datang round dan kita follow doctor round lah. Itu pun, penting lah untuk record semua.

(I): Emmm..aaaa...bagaimana dengan dari segi mungkin pelengkap dari segi ilmu, ataupun dari segi personaliti seorang jururawat perlu adakah ia akan mempengaruhi quality dokumentasi tersebut.

(R): Ia betul, ini bergantung kepada senioriti staff tu lah. Selalunya saya observe bahagian nursing tu, report writing tu, untuk senior senior staff dia orang akan banyak lah dia orang dapat tulis eh. Apa yang yang diperlukan lah.

(I) Apakah kandungan dia orang tulis selalunya? Kalau kalau..

(R): Boleh saya cakap condition condition semua tu

(I): Aaa...ok! Assessment?

(R): Assessment semua. Some yang junior junior ni, dia orang belum kuat lagi lah minda dia orang, dia orang akan tulis secara biasa sahaja lah. Tak secara detail lah.

(I): Apa yang diperlukan oleh jururawat jururawat junior ini supaya dia orang boleh prepare seperti senior dia orang. Apa rasa dia orang perlu?

(R): Saya rasa..aaaa...selalu kita akan bagi tunjuk ajar lah. Macam menulis kan. Lepas itu kita pantau dia lah tengok dia tulis macam mana terutamanya report report mengenai kematian kan.

(I): Banyak tak?

(R): Saya akan tengok dulu lah dia orang tulis macam mana. Apa yang tak kena, saya akan bagi tahu segera lah. Next time buat macam ni macam ni. Kalau nak tulis macam ni macam ni. Supaya perkara yang apa ni apa orang kata tak berlaku kesalahannya di masa yang akan datang lah.

(I): Emm.. ok...aaa...Sekarang saya nak tentang soalan sedikit yang berkenaan tentang professionalism. Apa definisi puan..tentang apa..aaa..apa sebenarnya professionalism ini dari segi kejururawatan?

(R): professional.

(I): Ya, professionalism. Professional

(R): Professional? Kalau saya

(I): Aaaa..definisi puan sendiri.

(R): Professional, maknanya seseorang tu dia..aaa..dia.. terhadap sesuatu kerja dia. Jadi dia tahu apa yang berkaitan dengan kerja dia lah. Seorang tu dikatakan professional lah terhadap tugas yang dia kena kena aaaa....apa? jalani lah. Dia professional sebagai jururawat dia kena tahu apa tugas jururawat.

(I): Balik dengan dokumentasi tu, bagaimana puan boleh relates, boleh kaitkan dengan aaaa...dengan professionalism? Rasa rasanya pendapat puan

(R): Pendapat saya,

(I): Adakah puan setuju, ataupun ataupun puan rasa macam ok ada berkaitan..

(R) Emmm...profession memang lah. Sebagai jururawat dia kena dokumen apa yang dibuat sebagai jururawat. So profession dia sebagai jururawat, dia kena buat lah apa yang dia laporkan kepada pesakit itu penting. Sangat penting. Ini ada berkaitan lah profession dia. Macam seseorang yang tak professional tu, dia akan tak da tanggungjawab. Dia tak bertanggungjawab. Dia akan buat ikut dia je. That's means apa apa berlaku, dia buat dunno je lah. Sebagai jururawat dia akan bertanggungjawab. So dia kena ada sifat apa dalam diri dia lah untuk bertanggungjawab untuk setiap sesuatu yang dia lakukan lah.

(I): Jadi apa benda yang dia tulis tu kena mencerminkan..

(R): Betul, jangan tulis yang salah. Apa yang berlaku, itu sepatut dia tulis. Jangan mereka rekakan cerita.

(I): Sekiranya berlaku kalau macam tu, apa pendapat puan sekiranya ada jururawat yang buat macam dia tulis apa

(R): So far saya belum jumpa lah.

(I): Kalau pendapat puan lah, apa yang terjadi apa sebenar yang impact terhadap mungkin pesakit ataupun terhadap jururawat yang lain kalau benda ini berlaku, apa rasanya akan terjadi kepada..

(R): Kalau perkara ini berlaku, apa yang dia tak buat tapi dia document, perkara ini akan berlaku, because kita dapat detect, kita dapat detect apa yang terjadi kepada pesakit, dia buat ke, contohnya observation dia tak buat, charting sahaja kan, time dia, time next next staff nurse, dia buat betul so kita akan dapat BP patient tu, ataupun temperature patient tu dia ada demam, tiba tiba kawan ini catat loji sahaja. Orang yang second tu buat betul betul. So kita dapat kesan tak kan temperature tiba tiba sahaja boleh naikkan..aaaa

(I): Betul..betul

(R): BP tiba tiba boleh naik. Dia mesti dari increase increase dari bawah kan. Aaa..so kita akan dapat detect dari tu. Itu boleh menyebabkan keadaan pesakit jadi jadi, teruk lah.

(I): Jadi dalam katanya, macam seperti puan terangkan tadi macam pentingnya apa skill assessment untuk untuk memperlengkapkan apa nursing dokumentasi apa pendapat puan tentang tersebut ataupun mungkin ada sikit yang lain yang perlu untuk membantu seorang jururawat itu untuk memperlengkapkan dokumentasi?

(R): Skill seorang staff nurse tu, dia kena ada dia kena banyak membaca, pergi kursus,

(I): Emm..ok

(R): CME CME semua dia kena attend.

(I): Ok

(R): Kursus kursus jangka pendek dia kena attend untuk tambah pengetahuan lah. Supaya supaya orang kata memberi rawatan pesakit yang professional.

(I): Bagaimana ilmu itu boleh diaplikasikan ke dalam penghasilan dokumentasi kejururawatan ini? Sebab dia orang dah pergi attend CME mungkin pergi post basic, apa sebenarnya peranan ilmu yang dia orang perolehi lebih lebih lagi bila dia orang nak buat penghasilan nursing dokumentasi?

(R): Itu penting, because bila dia pergi attend kursus, macam post basic apa, dia orang dah tahu mengenai sesuatu penyakit tu apa dia punya procedure kan. Macam cataract, ada staff pergi untuk kursus entomology, so dia balik dia akan tahu lah apa keperluan pesakit tu sebelum pre op, post op, untuk nursing care patient lah. Jadi itu menambah pengetahuan seseorang jururawat tu lah terhadap kerja dia. Aaa... itu sangat penting juga lah. Memang penting lah staff kena tahu pengetahuan terutamanya kita bahagian disini kita ada audit audit. So dari situ kita akan dapat detect lah staff ni tahu tak mengenai macam contohnya all those medication, injection, blood transfusion dia orang follow tak SOP? Dressing, empat perkara tu. Kita ada buat audit untuk cross audit lah. Kita pergi ward lain, ward lain datang sini untuk checking skills staff nurse lah. Every staff nurse lah.

(I): Ok Ok..so selain daripada training macam tu adakah, apa pendapat puan tentang dokumentasi dalam setting ini? Adakah dia memuaskan ataupun ada benda yang puan rasa yang boleh improve untuk lebih baik dari segi nursing dokumentasi yang puan hasilkan sebelum ini?

(R): Nursing dokumentasi ini..

(I): Sebelum tu puan puas hati tak dengan dokumentasi puan sendiri? Puas hati tak dengan apa puan buat selama ini untuk nursing?

(R): Saya rasa saya rasa puas hati

(I): Bagus...rasanya kenapa you rasa you puas hati dengan?

(R): Sebab kita buat apa yang kita, kita tulis apa yang kita buat, so setiap doctor order itu, kita carry out. That's means kita puas hati lah. Macam doctor order X-ray ka, ultrasound ka, ambil darah patient ka, so kita buat. That's means doctor daripada keputusan itu doctor dapat buat rawatan lebih baik untuk pesakit tu lah. Jadi tu sangat penting lah.

(I): Rasa doctor tengok tak apa nurses tulis?

(R): Ada. Doctor akan tengok terutamanya round pagi doctor akan tengok everything.

(I): Apa yang dia orang akan tengok dekat nursing documentation? Apa yang dia orang utamakan kalau tengok nursing shift report? Ya puan rasa?

(R): Dia orang tengok selalunya selalu dia orang order nurses ada carry out tak? Dia orang akan check apa macam ultrasound, ada tak patient tu tak buat lagi ultrasound? Ada tak staff nurse itu carry out? Apa berlaku kan..like sometimes kita tunggu bilik macam pakar 2 panggil untuk ultrasound ke apa kan? Aaa..tunggu dia orang panggil. Aaa..kita tak boleh sendiri hantar lah..

(I): Aaa..ok.

(R): So kita akan pandu pada tu lah.

(I): So doctor akan tengok sama ada benda ini dah buat ke tak buat ke sebab macam puan cakap tadi, apa benda yang dia orang buat, dia orang kena record dokumen..kalau dia tak aaa...

(R): Macam space semua dia order kita akan tick ke, taken atau dispense ke. Doctor akan tengok situ lah

(I): Pernahkah jadi contohnya macam puan menyediakan dokumentasi puan puan dah buat benda tu tapi puan mungkin tak ingat atau tak sempat letak dalam dokumentasi puan. Pernahkah terjadi kes macam tu?

(R): Emmmm....saya rasa tak ada lah.

(I): Tak ada eh..

(R): Tak ada

(I): Contoh dia seperti kita memang tugas seorang jururawat ni dia memang sepatutnya membuat sesuatu penerangan kepada pesakit kan..

(R): Orientasi.

(I): ya contoh orientasi sebab kita ada borang kita tak letak dalam dokumentasi orientasi itu telah dilakukan masa ketika sebab kita ada borang dan signature. Rasa cukup tak borang tu untuk membuktikan kita dah buat tugas tu ataupun perlu tak kita letakkan tulis balik dekat...

(R): Saya rasa tak perlulah because kita sudah ada on admission. So bila on admission automatic kita akan buat orientasi kepada pesakit kan. That's means siapa yang buat apa orientasi tu ada nama di***** (25:51) dengan nama pesakit yang kita signature lah penyakit nama dia diatas dan signature kat bawah. Maknanya kita ada bagi penerangan kepada pesakit tu lah. That's means tak perlu tulis dalam tu because panjang sangat pun

(I): Tak elok juga lah

(R): Tak elok juga lah makan ruang banyak kan so kita banyak kerja lagi nak buat so kita tak kan nak buat dokumentasi kan.

(I): Adakah dia macam sebab terlalu banyak dokumentasi ini..you rasa ada interfere sikit lah dengan I mean memang dia tugas yang harus di buat tapi pada pendapat puan sendiri adakah dengan banyak sangat dokumentasi kena buat ini ia memakan masa yang banyak?

(R): Betul..memang. Pendapat saya.

(I): Puan rasa apa benda ataupun idea yang boleh mengurangkan beban seorang jururawat tu untuk memperlengkapkan dokumentasi?

(R): Emmm....saya rasa...dokumentasi itu memang kena tulis tapi bahagian charting yang carta carta tadi yang saya bagitahu tu mungkin kita boleh berpandukan bahagian situ macam water sign kalau normal water sign taken. Normal. Kalau adnormal baru kita tulis...aaa..macam tu lah. Kalau tidak doctor akan berpandu kepada..

(I): Chart.

(R): Chart. Tu lah saya kata..normal kita tulis. Kalau adnormal tak perlu tulis lah.

(I): Ok sekiranya kalau contoh tadi, dia punya water sign adnormal, kita catatlah, ok kita tulis dalam nursing shift report, kemudian kita letak pada pengalaman puan puan letak tak doctor was inform that..aaa

(R): Ya tulis tulis,

(I): Ok

(R): BP scan scan BP tinggi macam ni, heart rate berapa doctor scan scan informed. Pukul berapa. Then apa dia cakap. Tulis kat situ.

(I): Emm...ok

(R): Order apa apa ke, tulis record kat situ. Tapi sejak dulu saya practice macam tu. Tapi sejak ni budak budak junior ni kan, dia orang dia orang saya perasan dia orang punya dokumentasi ni kan dia orang follow balik apa yang doctor tulis. Itu masalah.

(I): Ahh...ok

(R): Itu masalah.

(I): Jadi apa sebenarnya impact kalau dia orang buat macam tu

(R): Tak that's means dia orang copy down balik apa yang doctor tulis, apa yang dia orang buat kat patient dia orang tak tulis.

(I): Emm.....

(R): Banyak dah saya observe macam tu. Dulu lain. Dulu pembelajaran kita lain. Sekarang kat counter saya perasan lain. Mungkin sebab tu lah.

(I): Apa rasanya sebab dia orang menulis dengan cara begitu rasa nya?

(R): First kan, salah satunya dia orang dia orang tak nak fikir apa nak tulis. Just follow follow follow. Doctor tulis for only water sign. Dia pun tulis for only water sign. Done ke not done ke pun tak da.

(I): Aaa..tak tak. ok

(R): Kebanyakan yang junior junior. Yang senior senior ok.

(I): So apa pendapat puan yang harus dia orang buat untuk improve?

(R): Itu lah saya rasa kat peringkat poly poly, tutor tutor disana patut kena ajar macam mana cara nak menulis report dekat pesakit bila ada dia orang qualified kerja lah kah. Peringkat kolej lagi lah tutor kena dah dah tahu dah macam mana nak ajar macam mana nak tulis report. Itu penting. Bila datang sini tengok. Sister macam mana I nak cakap? Bukan sister tu sentiasa nak pantau dia orang. Kerja sister pun banyak lagi..aaa

(I): Betul Betul..

(R): Bukan nak ikut dia orang sahaja.

(I): Emm...Emm...So rasanya..aaa..sebab kita dah penghujung temu ramah ini, jadi biar saya recap balik apa puan yang telah kongsi dengan saya. Puan menekan kepada pentingnya dokumentasi ini. Sebab...alamak..sebab tanggungjawab nurses untuk menulis, merekod apa yang dia orang buat dari segi accountability. Kalau dia orang tak buat dia orang tak boleh rekod. Ia juga merupakan satu result maksudnya hasil daripada bagaimana seseorang nurses tu melakukan practice mereka seharian. Ia?? Selain daripada tu ada benda benda lain yang puan ingin tambah mengenai professionalism in nursing dengan documentation?

(R): Emm...Saya rasa saya cakap akhirat dulu..hehe

(I): hahaha...Apa harapan sebenarnya puan?

(R): Harapan saya itu lah, staff nurse ni kena ubah dia punya pemikiran. Jangan asyik copy down apa yang doctor tulis. Doctor doctor. Bahagian nurses nurses . Dulu kita separate kan kita punya laporan. Nurses satu file. Doctor satu file. Lepas tu kita combine sekali kan?

(I): Kes mixed tu.

(R): Bila combine sekali, kita bezakan pen hitam untuk doctor, pen biru untuk nurses.

(I): Aaa...I remembered.

(R): Ya.. Aaaa..so..aa.. tu lah nurses saya tu lah saya suggestkan supaya peringkat boleh lagi bagitahu dah tentang cara menulis report yang betul. Jangan asyik copy down dari doctor sahaja. Doctor tulis apa, kita tulis itu. Tak nak , tak nak. Kita observe apa kita dapati kat patient tu kita report dan inform doctor. Jangan copy down sahaja. Itu penting.

(I): Ok la..rasanya itu sahaja lah untuk temu ramah kita untuk kali ini. Saya ingin ucapkan terima kasih atas kerjasama puan.

(R): Sama-sama

Translation

Date: 04/11/2014 (001_141104_1117B0)

Venue: Disclosed

Interviewer: Rekaya Vincent Balang

Duration: 32 minutes 30 seconds

(I): Ok, Good morning, my name is Rekaya, I am a PhD student who is doing on Project and "Exploration of the elements of professionalism within nursing documentation in Malaysia." So, before we start this interview, I need you to understand the content of this research and agree to do this interview. With this, I require you to agree upon signature. Ya..hmmm..

(R): Sign here?

(I): Yes, sign here and put your name and date. Ok.aaaa?? Thank you.

(R): Welcome

(I): So, this interview will take around 30 to 35 minutes depends on the movement of the interview today. So, let us start with a question. What is your definition regarding with nursing documentation?

(R): Nursing documentation?

(I): Yes

(R): Aaaa....it is...aaaa...a way for us to give treatment to the patient and we document what we have done to the patient

(I): Emm..

(R): Aaaa...for example, what we do...let's say giving static sponging, observation, dressing, all those things, we have to record it done in the documentation as a proof and for continuous treatment.

(I): Hmmm...from the aspect..aaa...sorry. Please continue

(R): Pass...for pass over report ***** (2:09)

(I): Aaaa...let's say from this hospital what aspect that you would discuss about the way of nursing documentation..eh..nursing documentation in this hospital? What is your opinion, is it that this documentation is very important or the second most important thing or...

(R): From my opinion, aaaa....in this hospital, the nursing documentation is very important

(I): Hmmm...

(R): Aaaa...it is because, when an issue occurred, we can see what happen before it

(I): Hmmm...

(R): It is very important

(I): Ever happened? Example?

(R): To the patient and staff that are into it

(I): Staff that are into it

(R): Emmm...so far...aaa...from my experience, there is

(I): Emk...

(R): There is

(I): So it is one thing or a medium that is very important

(R): Yes

(I): It will be a reference when something happened

(R): Emm..yes

(I): Ok...aaa....in a specific shift, in one shift, how do you prepare the documentation? What way do you use to prepare the nursing documentation?

(R): Nursing documentation? For example, we have cubicles

(I): Emk..ok

(R): One staff will take care of a cubical

(I): Emk...

(R): So, three staff will be assigned to three. So, in the morning, we often will have four staff working and in the evening it is similar. However, in the night, only two will be working. So for each cubical, a nurse will take care of the patient and complete the documentation.

(I): Emmmm....

(R): Before they pass over the next shift

(I): What that is included in the nursing documentation?

(R): Nursing documentation will include the patient's condition, the flow of the drip, inclusion and all those things, the patient's water sign, the procedures that were done on the patient; sponging, dressing, and all those. After that, when the doctor is going on rounds, we will carry out what the doctors have documented. So then we will update what that is needed. Aaaa...before we pass over our shift..aaa...to the next staff. So, if we can't carry out what that is needed, then the next staff will carry out during the next shift.

(I): For example, it happened to me once when I can't finish documenting because I was too busy and we do not have enough staff back then. The point is that the documents have to be completed before my shift ends. So, for example that situation happens to you, what will you do?

(R): From what I know, those who are involved should complete the documentation even though his or her shift is over by staying back. He or she cannot go without completing it or cannot escape and not doing it.

(I): If that issue occurred, and he or she did not complete the documentation, what do you think might happen afterwards?

(R): If he or she did not do the documentation, we will probe into it and query the nurse why this happen.

(I): Emk...

(R): Aaa...we will query what the nurse did not do when the other staff can finish, why he or she cannot be up to the task. So we will give motivation to that specific staff.

(I): Emk...emm...

(R): We will ask why and give motivation as well as a warning to the nurse. If this still happen the next time, we will ask for a letter from that nurse.

(I): Aaaa...ok ok ...if from the aspect...aaa...from the discussion earlier on, you mentioned that the nursing documentation is important because it reflects the way a nurse carries out his/her job with professionalism.

(R): Yes

(I): From your point of view, with that statement

(R): Yes is true, it is very important, the report is important every time when we treat the patient. It is a proof even when we are in court, they will look at this.

(I): Emmm...emmmm..ok

(R): As a proof if something happens in the future

(I): Emm...

(R): That is very important..the nursing documentation

(I): Emmm...so if we look back, when you complete a task, what will be inside the report, or what will be written in the nursing shift report?

(R): Aaa...like what I mentioned earlier on

(I): What are the contents inside? Aaa...what you use? Is it following the time system or descriptive discussion or?

(R): I write following the time system

(I): Em.. Ok, why do you choose to do that?

(R): Following the time we take over the report, for example at 7, and after that we will record the patient's condition and so on. So, when we pass over the report to the next nurse, we will observe the patient.

(I): Yes..yes..by right

(R): Ah...observe the patient by monitoring what they are doing. Inclusion, drip, CBD, so we will document it, do the patient have, **tombubaitis (8:16)** we will also record the urine, is it clear? The patient's blood? We will record. In the morning, when we take over the report, we have to look at the water sign, if it is normal, we will also have to write it down. Whether is normal or not we still had to write it down. If we found out that it is not normal, then we have to inform the doctor at once. After that, when the doctor is on rounds, we will carry out what the doctor instructs us to do, such as, ultrasound, X-ray. We have to even prepare all the equipment and carry out the treatment. That is important.

(I): In the nursing shift report, how long do you need to complete it based on your experience?

(R): To complete for one patient? How?

(I): Yes for one patient.

(R): One patient

(I): What do you think?

(R): For one patient.....aaa....because we have one cubical, so at least we will have six patients or sometimes eight

(I): Emm...emm...

(R): So we.....which is more important we will do them first. Example, the patient with critical condition we will attend to first

(I): Emm...emm...

(R): We have to focus to the one with serious condition first and we will document at once without delaying. By delaying, we sometimes might forget what we want to write

(I): Write

(R): So we have to set our priority to the ill patient first...aaa...***** **mumble words (9.52)**

(I): Ok, beside the nursing shift report, what kind of documentation that a nurse ought to complete or finish?

(R): We have lots of paper work and charting, lots of charts to do...aaa...observation chart, DST chart, **head INJURY (10:23) Glasgow coma scale chart**. Besides, we have counting bundle, like the patient have CVP, CVD, we have to record it down, and we have the position chart, turning patient.

(I): Aaa...yes,

(R): Besides, we have to record entry to hours, record the **Thrombopheblits chart (10:44)** and record....aaa...there are so much documents for nursing

(I): If it is so, do you feel that to complete the nursing documentation, is it a distraction that will affect your job as a nurse to fulfil your primary role as a nurse?

(R): If distracting, I would say no it won't. It is our responsibility.

(I): Ok

(R): Which is why we have to do it. Like it or not, we have to do. So, when we do our observation, we can complete it at the same time.

(I): True

(R): Aaaa...So you will check the drip? Thrombopheblits, whether the urine flow is good, breathing is good, bp ok, and you will right them? So after your observation you will record all of them. Emm..

(I): Aaaa....what do you think are the challenges that a nurse would face when completing the nursing documentation?

(R): Often, aaaaa....in one cubicle, there might be a patient that collapsed, so this might be disturbing to document other things as which we need to attend to that patient. We have to do in bed processes, taking bath for the patient, prepare the medication and sometimes this may consume time, so this will disturb our documentation process.

(I): Besides, what other factors that might influence the documentation process?

(R): I feel like an emergency case is an example of the other factor that influence. The preparation for ***** (12:42) will prevent us to complete the documentation for the patient because we will pay more focus on that patient while neglecting the others. Nevertheless, we have to complete the documentation before going back.

(I): What do you feel that you need as a nurse to produce a good documentation? What is needed from a nurse?

(R): For a nurse, oh.. He/she must know her patient well, know the diagnosis of the patient. Besides, what treatment that the patient is undergoing. Which means, that the need of the patient must be attended. For example, a patient like **Immunizing care (13:28)** I mean that the patient is unable to move, must lie on the bed. So, what we have to do is sponging, all of these. If the patient is mobile, then we can instruct the patient to take bath, after that, the patient can go back to the bed. If we make observation, for the patient that not mobile, we have other plan for them to take their meals. So for the immobile, what we will do is we do the sponging in the morning, afterwards, we do the water sign, then the doctor will make rounds and we will follow the doctor for rounds and record everything which is important.

(I): Emmm...aaa...from the aspect of personality, knowledge of a nurse, does it influence the quality of documentation?

(R): Yes true, it depends on the seniority of the staff. Often, I observe in the nursing department, the writing of report will be on if the staff is more senior.

(I): What is the content that normally the nurses will document?

(R): Can I say that all the conditions?

(I): Aaa...ok! Assessment?

(R): For the assessment, some juniors who do not have enough knowledge will write just a normal report. Not in detail.

(I): What that is needed by the junior nurses, so that they can prepare the documents like the senior nurses?

(R): I feel...aaaa...often, we will guide them. For example, in writing, and observe them when they write especially in writing when there is a death.

(I): Will it be a lot?

(R): I will normally look at their writing and if there it is not up to the standard, I will inform them at once. So in future they will not repeat the same mistake.

(I): Emmm..ok..aa...I would like to ask more on professionalism. What is your definition relating to professionalism of a nurse?

(R): Professional.

(I): Yes, professionalism.

(R): Professional? For me..

(I): Aaaa... your own definition

(R): Professional to me is one will know in detail to what that is related to his/her work. A person is said to be professional when he/she is professional towards the job as a nurse and does the job well.

(I): Going back to the documentation, how do you relate with professionalism? What is your personal opinion?

(R): From my point of view.

(I): Do you agree, or you feel that way?

(R): Emmm...profession is important as a nurse, you have to document what you are doing. So, profession as a nurse, you have to report what the patient is going through. It is very important. For a person that is not professional, the person will not be responsible for his/her action. As a nurse, you have to be responsible. So, you need to have character to be responsible for everything you do.

(I): So, in other words, what you write will reflect your personality.

(R): true, do not write what is not true in the report. What ever happen, that is what you have to record. Do not fake up a story.

(I): If such things happen, what do think will happen?

(R): So far, I have not come across this situation.

(I): Based on your opinion, what will give the greatest impact to the patient or a nurse, if the scenario mentioned above happens? What do you think will happen afterwards?

(R): If that happens, we will be able to detect that from the outcome of the patient, for example, did the nurse do the observation, charting, and when the next nurse take over,

from the BP of the patient, or from the temperature if it is done correctly afterwards, we can detect that the first did not do it correctly.

(I): True, true.

(R): BP cannot suddenly just shoot up for no reason. It must be increasing gradually from below. Aaa..so we can detect if this happen. This will cause the condition of the patient to worsen.

(I): So, from what you have discussed, it is essential to have skill to complete the nursing documentation and from your opinion, is there anything else that will help a nurse in completing the documentation other than the skills?

(R): Skill of the nurses, he/she must read a lot and go for courses.

(I): Emm...ok

(R): attending the CME.

(I): Ok

(R): Short term courses to add on to their knowledge to provide them enough training for professional treatment to the patient.

(I): How can the knowledge learned from these courses help in the documentation process? It is because, some might attend the CME and some might go for post basic, and through this, what is the objective for these knowledge learned in the application of completing the nursing documentation?

(R): It is important because when we attend courses, like post basic, we will know and be informed of diseases and sicknesses and the procedure to treat them. For example, cataract, the staff will go for entomology training, so after they are back, the staff will be able to address the specific needs before pre op, post op. So, this will enhance the knowledge of the nurses. Aaaa...it is essential. It is important, that staff know the knowledge because in this hospital, we have the auditing process. So, from there, we can detect staff that are not well equip especially in those medication, injection, blood transfusion whether or not they follow the SOP? Dressing, and the four aspects in nursing. We will do the auditing process to cross audit. We will go to the other ward and nurses from the other wards will come over to check the skills of nurses here. Every staff nurse will be involved in this process.

(I): Ok..ok..so beside training, do you feel that the nursing documentation here is satisfactory or do you think that it can be improved further?

(R): Nursing documentation..

(I): Before this, are you satisfied with the document that you have done?

(R): I feel that I am satisfied.

(I): Good..so what you said so?

(R): This is because, what we write what we do, and what the doctor require us, we carry out. That's means that we are satisfied. For example, doctors order us to carry out X-rays, ultrasound, to take blood samples, we will do it. That's means that from what we do, the doctor can give a better treatment to the patient and that is important.

(I): Do you think that the doctor look at what the nurses have written in the report?

(R): Yes. The doctors will look into it especially when the doctors are doing their rounds in the morning.

(I): What they look for in the nursing documentation? What do you think is their priority if they look at the documentation?

(R): The doctors will often look into the order that they asked the nurses to do. Whether or not the nurses have carried out of what they asked for. They will check for example the ultrasound, whether the patient have gone through the ultrasound.

(I): Aaa...ok

(R): So we have to refer back to the document

(I): So the doctor will check whether the nurses done their job or not like you mentioned earlier.

(R): For example, the space provided whether it is tick, taken or dispense, the doctor will look at that

(I): Has it happen to you before that you have done the task but forgotten to record?

(R): Emmm...at the moment I do not think so.

(I): Nope?

(R): No.

(I): For example, as a nurse, we have to explain to the patient.

(R): Orientation

(I): Yes, because from the orientation, we will have some forms that we will not include in the documentation so do you think that the forms will be enough to proof that we have done our job or we have to write it again in the documentation

(R): I think, we do not have to because, we have done that during the admission. So, during the admission process we have done the orientation with the patient. Which means that during the orientation, we have ***** (25:51) name of the patient with the signature below. This means that we do not have to record down again because it will be very long

(I): Not necessary

(R): It is not necessary as it will take up space and add on workloads on us.

(I): Do you feel that too much documentation might interfere your work process and take too much of your time?

(R): true..from my point of view.

(I): Can you give your idea or view point of what can be done to reduce the burden of a nurse and the nursing documentation?

(R): Emmm...I feel...the documentation is a must but the charting section which I mentioned earlier on, can be in an objective form. For example, the water sign if its taken, then we tick it if it is normal. If abnormal only we write it down..aaa.. that's it.

(I): Chart

(R): Chart. If is normal we write, if not then we do not have to write.

(I): Ok, for example the water sign is abnormal, we jot it down in the nursing shift report and from your experience, do you put there "doctor was informed"?

(R): Yes, I do

(I): Ok

(R): BP scanned for high BP, reading of heart rate, the doctor was informed at what time. Then what was said by the doctor. Everything has to be written

(I): Emm..ok

(R): what was ordered also have to be written down. I have practiced that since before but currently, the new nurses, I noticed that they only follow what the doctors have written. That's the problem.

(I): Ahh...ok

(R): That's a problem

(I): So what are the consequences of them doing that?

(R): They are copying again what that has been written by the doctors, what they perform on the patient, they do not record.

(I): Emm...

(R): Often I notice this occur. Back then it was different. What we have learned back then was different compare to what is it today.

(I): What do you think that influence the way the write nowadays?

(R): Firstly, many junior nurses do not want to think when they write. They just follow what the others write. The doctors write for example "for only water sign", they will repeat the same sentence.

(I): Aaa...no..ok

(R): Most of the juniors do this. But for the senior nurses, they are ok

(I): So from your opinion, what should be done to improve this situation?

(R): At the poly school stage, the tutor must teach them the proper way of writing a report. The poly stage, the tutor must know the proper way to educate these nurses on how to write a report. That is important because when they are here, they always go to the sister to ask, and the sister is not always free to entertain them. The sister has her own work to do as well.

(I): True..true

(R): Not that the sister want to always follow them

(I): Emm...emmm...so I feel...aaa...because we have reach the end of our interview, just let me recap back what we have discussed. You have emphasised the importance of nursing documentation. This is because a responsibility of a nurse is to write and record what they have performed and is accountability of their actions. If they do not carry out that task, they are not allow to record it down. It will also be a product of what they done for the whole day. True? Besides, what do you want to add on regarding professionalism in nursing with the aspect on documentation?

(R): Emm...I think that's all..hehe

(I): Hahaha..so what is your hope?

(R): My hope is that the staff nurse need to change their mind set and not just copy blindly what the doctor write. Nurses section. Previously, we separate our report. The nurses have one file and the doctors have theirs. But not we combine both to one.

(I): So the case are mixed up

(R): When you combined once, we differentiate them with black ink pen for the doctors and the blue ink will be for the nurses.

(I): Aaa...I remembered

(R): Yes...aaa...so...aaa..that's it, for nurses, I suggest that they can improve their writing by writing correctly. Do not just copy what the doctors have written. We have to observe the patient only then we record down and inform the doctor. That is important.

(I): Ok..i feel that is all for this interview. Before ending, I would like to thank you for your cooperation.

(R): welcome.

Appendix 11: Nvivo Output

Nodes

Name	Sources	References	Created On	Cre
Accountability		1	1 8/6/2015 4:42 PM	R
Accuracy		12	19 7/13/2015 6:48 PM	R
counter sign		3	4 7/27/2015 4:14 PM	R
Credibility		1	1 7/28/2015 1:50 AM	R
Date and Time of documentation		3	3 7/22/2015 5:41 PM	R
Dont depend on theories		1	1 7/28/2015 2:15 AM	R
Obligation to complete documentation		7	7 7/10/2015 5:30 PM	R
report actual event		2	2 7/27/2015 11:26 PM	R
Responsibility		10	13 8/8/2015 12:07 AM	R
Truthfulness		8	15 7/10/2015 9:05 PM	R
Advocacy		0	0 8/6/2015 4:46 PM	R
Good listener		1	1 7/27/2015 10:24 PM	R
Individualised care		5	5 7/28/2015 2:30 AM	R
Patient benefits		2	2 7/27/2015 10:45 PM	R
Patient deserve what they supposed to have		7	7 7/22/2015 6:05 PM	R
Patient needs		4	4 7/9/2015 4:12 PM	R
Patient prioritisation		11	14 7/10/2015 9:57 PM	R
Policies		3	3 7/10/2015 9:45 PM	R
Unique or individualised needs of patients		1	1 7/22/2015 10:50 PM	R
Attend courses, seminar, workshops		1	1 8/17/2015 5:50 PM	R
Autonomy		0	0 8/6/2015 4:44 PM	R
Assessment		3	4 7/22/2015 4:15 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="radio"/> Clinical judgement		7	9 7/10/2015 8:47 PM	R
<input type="radio"/> Differentiation of nurses works and tasks		9	11 7/10/2015 6:27 PM	R
<input type="radio"/> Early and quick response		11	13 7/10/2015 9:53 PM	R
<input type="radio"/> Scope of work		1	1 7/22/2015 6:12 PM	R
<input type="radio"/> Self belonging to the profession		2	2 7/27/2015 4:17 PM	R
<input type="radio"/> Think and write fast		4	4 7/21/2015 4:48 PM	R
<input type="radio"/> Barriers to complete nursing documentation		0	0 7/28/2015 2:50 AM	R
<input type="radio"/> Interpersonal barriers		0	0 8/4/2015 5:05 PM	R
<input type="radio"/> Barrier Outsourcing		1	1 8/4/2015 5:06 PM	R
<input type="radio"/> Barrier shortage of staff		8	12 8/4/2015 5:06 PM	R
<input type="radio"/> Barrier surroundings		9	10 8/4/2015 5:06 PM	R
<input type="radio"/> Mindset		1	1 7/28/2015 2:02 AM	R
<input type="radio"/> Not enough exposure during training		1	1 7/22/2015 5:34 PM	R
<input type="radio"/> Over workload		7	9 7/10/2015 5:38 PM	R
<input type="radio"/> Poor patient's relative cooperation		1	1 7/13/2015 4:26 PM	R
<input type="radio"/> Sharing Patient Case Notes		0	0 8/8/2015 12:50 AM	R
<input type="radio"/> Scramble with computers		1	1 7/27/2015 8:27 PM	R
<input type="radio"/> Scrambling for case notes		2	2 7/27/2015 5:53 PM	R
<input type="radio"/> Standard guidelines for documentation		9	11 8/8/2015 12:40 AM	R
<input type="radio"/> Sudden events		4	4 7/27/2015 4:51 PM	R
<input type="radio"/> Time restraints		10	11 7/10/2015 5:36 PM	R
<input type="radio"/> Too many documentations		3	4 7/21/2015 4:07 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="radio"/> Too many patients		5	5 7/20/2015 6:10 PM	R
<input type="radio"/> Too many ward rounds		1	1 7/27/2015 4:58 PM	R
<input type="radio"/> Tradition		1	2 7/28/2015 1:53 AM	R
<input type="radio"/> Old tradition		1	3 7/28/2015 1:58 AM	R
<input type="radio"/> Intrapersonal Barriers		0	0 8/4/2015 5:04 PM	R
<input type="radio"/> Difficult to change		3	3 7/13/2015 6:29 PM	R
<input type="radio"/> Disorganized		1	1 7/28/2015 2:12 AM	R
<input type="radio"/> Forgetfulness		4	5 7/10/2015 4:06 PM	R
<input type="radio"/> Ignorance		10	14 7/7/2015 5:55 PM	R
<input type="radio"/> Insecurity		1	1 7/13/2015 6:29 PM	R
<input type="radio"/> irresponsible		1	1 7/27/2015 8:47 PM	R
<input type="radio"/> Laziness		4	4 7/13/2015 4:50 PM	R
<input type="radio"/> No affection to work as a nurse		1	1 7/22/2015 4:10 PM	R
<input type="radio"/> poor attitude of the nurses		5	9 7/7/2015 7:30 PM	R
<input type="radio"/> Dishonesty		6	7 7/10/2015 8:42 PM	R
<input type="radio"/> Format of nursing shift report		0	0 8/4/2015 6:52 PM	R
<input type="radio"/> Refuse		1	1 7/22/2015 6:50 PM	R
<input type="radio"/> Stress		1	1 7/13/2015 4:54 PM	R
<input type="radio"/> Blaming culture		9	15 7/10/2015 7:12 PM	R
<input type="radio"/> Advanced end users		6	6 7/7/2015 7:15 PM	R
<input type="radio"/> Scare		1	1 7/27/2015 5:19 PM	R

Nodes

Name	Sources	References	Created On	Cre
Scolded		1	1 7/27/2015 10:54 PM	R
Collegiality and Collaboration		0	0 8/6/2015 4:49 PM	R
Collaboration		2	2 7/27/2015 4:34 PM	R
Communication		6	7 8/8/2015 12:31 AM	R
Rapport with colleagues		1	1 8/8/2015 12:31 AM	R
Rapport with patients		3	3 8/8/2015 12:31 AM	R
continuity of care		6	14 8/8/2015 12:29 AM	R
Delegation		5	6 7/20/2015 6:17 PM	R
Role modelling		6	7 7/7/2015 7:23 PM	R
Team work		9	18 7/10/2015 6:02 PM	R
Definition of professionalism		5	6 7/9/2015 4:01 PM	R
Caring		4	6 7/21/2015 6:05 PM	R
Communication		6	7 7/20/2015 6:51 PM	R
Rapport with colleagues		1	1 7/27/2015 10:22 PM	R
Rapport with patients		3	3 7/20/2015 6:43 PM	R
Compassion		5	8 7/10/2015 10:01 PM	R
Confident		1	1 7/22/2015 6:26 PM	R
Discipline		3	6 7/10/2015 9:35 PM	R
Efficient		1	1 7/27/2015 4:23 PM	R
Emotion Stability		4	4 7/10/2015 6:13 PM	R
Empathy		1	1 7/27/2015 10:25 PM	R

Nodes

Name	Sources	References	Created On	Cre
Endurance		1	1 7/27/2015 11:30 PM	R
Manners		1	1 7/28/2015 2:01 AM	R
Maturity		1	1 7/27/2015 10:19 PM	R
Patience		2	2 7/21/2015 4:20 PM	R
Responsibility		9	12 7/10/2015 3:53 PM	R
Serious		1	1 7/27/2015 4:17 PM	R
Smart		2	3 7/20/2015 6:45 PM	R
Division time of care and documentation dilemma		1	1 7/27/2015 5:47 PM	R
Not much skills		1	1 7/22/2015 10:48 PM	R
Poor quality of care		1	1 7/22/2015 10:41 PM	R
Ethics and Values		0	0 8/6/2015 4:52 PM	R
Altruism		1	1 7/27/2015 3:57 PM	R
Care patients equally		1	1 7/22/2015 10:51 PM	R
Communication		6	7 8/8/2015 12:31 AM	R
Rapport with colleagues		1	1 8/8/2015 12:31 AM	R
Rapport with patients		3	3 8/8/2015 12:31 AM	R
Corporate culture		2	2 7/22/2015 6:29 PM	R
Critical thinking		2	3 7/22/2015 6:03 PM	R
Etiquette		1	1 7/27/2015 5:33 PM	R
Patient safety		1	1 7/27/2015 10:36 PM	R
Patient Welfare		3	3 7/13/2015 4:42 PM	R
Respect patients		2	3 7/21/2015 4:21 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="radio"/> Factors influencing Professionalism in Nursing		0	0 8/6/2015 10:30 PM	R
<input type="radio"/> diploma nurses are better than graduate nurses		1	1 8/8/2015 12:45 AM	R
<input type="radio"/> Gender		1	1 7/21/2015 7:20 PM	R
<input type="radio"/> Religion Influence		1	1 7/22/2015 6:06 PM	R
<input type="radio"/> Factors influencing the quality of nursing documentation		0	0 8/4/2015 6:51 PM	R
<input type="radio"/> Accreditation		1	1 7/27/2015 10:35 PM	R
<input type="radio"/> Amount of information or content		2	3 7/20/2015 6:54 PM	R
<input type="radio"/> Different clinical settings		3	4 7/21/2015 4:44 PM	R
<input type="radio"/> Different shift		1	1 7/27/2015 4:03 PM	R
<input type="radio"/> diploma nurses are better than graduate nurses		1	1 7/28/2015 2:03 AM	R
<input type="radio"/> Education Background		0	0 8/7/2015 10:53 PM	R
<input type="radio"/> Diploma		1	1 7/27/2015 10:50 PM	R
<input type="radio"/> Post Basic		1	1 7/27/2015 11:31 PM	R
<input type="radio"/> Tertiary Education		1	1 7/27/2015 10:12 PM	R
<input type="radio"/> Training		4	5 7/10/2015 7:17 PM	R
<input type="radio"/> Experience		4	5 7/21/2015 4:22 PM	R
<input type="radio"/> New nursing post		1	1 7/27/2015 10:36 PM	R
<input type="radio"/> Patients' condition influence		2	2 7/10/2015 5:29 PM	R
<input type="radio"/> Rules and regulations		1	2 7/21/2015 3:55 PM	R
<input type="radio"/> Young nurses		4	5 7/27/2015 5:01 PM	R
<input type="radio"/> Format for nursing documentation		4	5 7/7/2015 7:41 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="radio"/> Chronological Format		5	5 7/10/2015 9:09 PM	R
<input type="radio"/> Decision on type of format		1	1 7/27/2015 10:29 PM	R
<input type="radio"/> Retrospective format		5	5 7/10/2015 9:10 PM	R
<input type="radio"/> Innovation and Visionary		0	0 8/6/2015 4:47 PM	R
<input type="radio"/> Creative		5	6 7/10/2015 10:00 PM	R
<input type="radio"/> Leave some space for report writing		1	1 7/27/2015 8:46 PM	R
<input type="radio"/> Paperless		1	1 7/27/2015 8:27 PM	R
<input type="radio"/> Prepare documentation early		2	2 7/10/2015 5:21 PM	R
<input type="radio"/> Preventive measures		1	1 8/17/2015 8:52 PM	R
<input type="radio"/> Systematic		6	6 7/10/2015 5:53 PM	R
<input type="radio"/> Knowledge		0	0 8/6/2015 4:29 PM	R
<input type="radio"/> Evidence based practice		2	4 7/21/2015 5:30 PM	R
<input type="radio"/> importance of nursing care plan		1	1 7/10/2015 6:45 PM	R
<input type="radio"/> Nursing process		7	8 7/7/2015 7:16 PM	R
<input type="radio"/> Goals and Targets		2	2 7/22/2015 5:44 PM	R
<input type="radio"/> Reevaluate intervention		1	1 7/27/2015 10:30 PM	R
<input type="radio"/> Updating Knowledge		6	7 7/10/2015 4:08 PM	R
<input type="radio"/> No relationship between professionalism and documentation		2	3 7/21/2015 4:55 PM	R
<input type="radio"/> Nursing skills is more important		2	3 7/21/2015 4:55 PM	R
<input type="radio"/> Non verbal gestures		3	5 7/21/2015 4:04 PM	R
<input type="radio"/> Perception toward nursing documentation		0	0 8/8/2015 12:33 AM	R

Nodes

Name	Sources	References	Created On	Cre
Colleagues view		14	17 7/9/2015 4:20 PM	R
Doctors look at their own documentation		1	1 7/28/2015 1:54 AM	R
New houseman		1	1 7/27/2015 4:18 PM	R
Self's views		0	0 8/8/2015 12:34 AM	R
Dissatisfaction		2	2 7/27/2015 4:21 PM	R
Regrets		1	1 7/10/2015 7:09 PM	R
Perceptions toward nurses		3	3 7/10/2015 7:04 PM	R
Power and Authority Dynamic		0	0 8/6/2015 11:57 PM	R
Authority influence on nursing documentation		14	19 7/9/2015 6:31 PM	R
Doctors and Nurses		0	0 8/7/2015 1:08 AM	R
Doctor checking out nurses' works		8	10 7/22/2015 6:49 PM	R
Doctor's order		9	12 7/10/2015 9:09 PM	R
Doctor's right hand		1	1 7/28/2015 1:59 AM	R
Senior Nurses with Junior Nurses		0	0 8/7/2015 1:08 AM	R
Follow senior		3	3 7/22/2015 5:12 PM	R
Junior Senior		13	19 7/7/2015 7:50 PM	R
Learn from seniors		1	2 7/27/2015 6:00 PM	R
Pressure from senior staff		2	2 7/13/2015 6:26 PM	R
Senior corrects my documentation		1	1 7/27/2015 6:02 PM	R
Senior staff documentation		1	1 7/27/2015 6:01 PM	R
Seniority		3	3 7/22/2015 6:47 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="checkbox"/> Presentation of nursing documentation		0	0 8/4/2015 11:56 PM	R
<input type="checkbox"/> <input type="radio"/> Language		9	15 7/10/2015 8:46 PM	R
<input type="checkbox"/> <input type="radio"/> Visual presentation of the nursing documentation		0	0 8/4/2015 5:28 PM	R
<input type="checkbox"/> <input type="radio"/> clean		1	1 7/27/2015 6:16 PM	R
<input type="checkbox"/> <input type="radio"/> Grammar		3	5 7/13/2015 6:33 PM	R
<input type="checkbox"/> <input type="radio"/> Handwritings		5	5 7/10/2015 8:45 PM	R
<input type="checkbox"/> <input type="radio"/> Layout of documentation		1	1 7/21/2015 7:19 PM	R
<input type="checkbox"/> <input type="radio"/> Sentence structures		6	6 7/9/2015 5:02 PM	R
<input type="checkbox"/> <input type="radio"/> Spellings		2	2 7/27/2015 5:54 PM	R
<input type="checkbox"/> <input type="radio"/> Usage of mnemonics in documentation		6	7 7/10/2015 6:01 PM	R
<input type="checkbox"/> <input type="radio"/> Usage of words		2	6 7/13/2015 6:37 PM	R
<input type="checkbox"/> <input type="radio"/> Priority documentation or nursing care		12	16 7/7/2015 7:31 PM	R
<input type="checkbox"/> <input type="radio"/> Quality of nursing documentation		3	3 7/10/2015 6:12 PM	R
<input type="checkbox"/> <input type="radio"/> Good quality of nursing documentation		0	0 8/4/2015 6:04 PM	R
<input type="checkbox"/> <input type="radio"/> clear writings		1	1 7/10/2015 9:51 PM	R
<input type="checkbox"/> <input type="radio"/> More detail and information		1	1 7/22/2015 4:58 PM	R
<input type="checkbox"/> <input type="radio"/> neat		1	1 7/27/2015 6:15 PM	R
<input type="checkbox"/> <input type="radio"/> Simple and complete		1	1 7/27/2015 10:23 PM	R
<input type="checkbox"/> <input type="radio"/> Write necessary		1	1 7/27/2015 5:36 PM	R
<input type="checkbox"/> <input type="radio"/> Poor quality of nursing documentation		0	0 8/4/2015 6:04 PM	R
<input type="checkbox"/> <input type="radio"/> Duplication of information		6	10 7/10/2015 6:06 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="radio"/> Incomplete		2	2 7/27/2015 10:08 PM	R
<input type="radio"/> Improper documentation		1	1 7/28/2015 12:00 AM	R
<input type="radio"/> Lack of details		8	10 7/10/2015 6:05 PM	R
<input type="radio"/> No idea to write		2	2 7/20/2015 6:31 PM	R
<input type="radio"/> Repetitions		1	1 7/27/2015 8:51 PM	R
<input type="radio"/> Too simple		2	2 7/22/2015 10:52 PM	R
<input type="radio"/> Weak in medical terms		1	1 7/27/2015 5:57 PM	R
<input type="radio"/> Relationship between professionalism and nursing documentation		14	18 7/9/2015 4:06 PM	R
<input type="radio"/> Dedicated		3	3 7/13/2015 4:51 PM	R
<input type="radio"/> Determination		1	2 7/28/2015 2:26 AM	R
<input type="radio"/> Discipline		3	6 8/8/2015 12:28 AM	R
<input type="radio"/> Good nursing management		2	2 7/21/2015 4:43 PM	R
<input type="radio"/> Hardworking		3	3 7/10/2015 6:31 PM	R
<input type="radio"/> Professional behaviours		2	2 7/10/2015 6:13 PM	R
<input type="radio"/> Roles of Nursing Documentation		0	0 8/4/2015 5:26 PM	R
<input type="radio"/> Confident		1	1 8/8/2015 12:46 AM	R
<input type="radio"/> Confirmation of work had been done		13	19 7/10/2015 5:31 PM	R
<input type="radio"/> Justification of works		4	5 7/13/2015 4:33 PM	R
<input type="radio"/> Long content of report		1	1 7/27/2015 10:56 PM	R
<input type="radio"/> no need to ask the nurse		1	1 7/27/2015 4:19 PM	R
<input type="radio"/> continuity of care		6	14 7/10/2015 4:03 PM	R
<input type="radio"/> Effectiveness of provided care		1	2 7/22/2015 6:07 PM	R

Nodes

Name	Sources	References	Created On	Cre
<input type="radio"/> Evidence of care		6	9 7/13/2015 6:11 PM	R
<input type="radio"/> Good nursing management		2	2 8/8/2015 12:26 AM	R
<input type="radio"/> Medicolegal matters		9	21 7/7/2015 5:44 PM	R
<input type="radio"/> Self protection		4	4 7/10/2015 9:56 PM	R
<input type="radio"/> Witness		1	1 7/20/2015 6:36 PM	R
<input type="radio"/> Medium for communication		1	1 7/27/2015 4:25 PM	R
<input type="radio"/> Monitoring		1	1 7/27/2015 11:53 PM	R
<input type="radio"/> Patients' condition		4	4 7/10/2015 4:04 PM	R
<input type="radio"/> Procedures		2	2 7/22/2015 6:42 PM	R
<input type="radio"/> Working process		3	4 7/9/2015 4:29 PM	R
<input type="radio"/> Spirit of Inquiry		0	0 8/6/2015 4:33 PM	R
<input type="radio"/> Alertness		8	15 7/10/2015 5:35 PM	R
<input type="radio"/> Attending Courses, Seminar		1	1 7/10/2015 3:59 PM	R
<input type="radio"/> Education Background		0	0 8/7/2015 11:01 PM	R
<input type="radio"/> Post Basic		1	1 8/7/2015 11:01 PM	R
<input type="radio"/> Tertiary Education		1	1 8/7/2015 11:01 PM	R
<input type="radio"/> Training		4	5 8/7/2015 11:01 PM	R
<input type="radio"/> enthusiasm to learn		1	1 7/28/2015 1:57 AM	R
<input type="radio"/> Keen to know		1	1 7/27/2015 3:53 PM	R
<input type="radio"/> Observant		3	5 7/20/2015 6:51 PM	R
<input type="radio"/> Strategies to improve documentation		4	5 7/7/2015 7:25 PM	R

Nodes

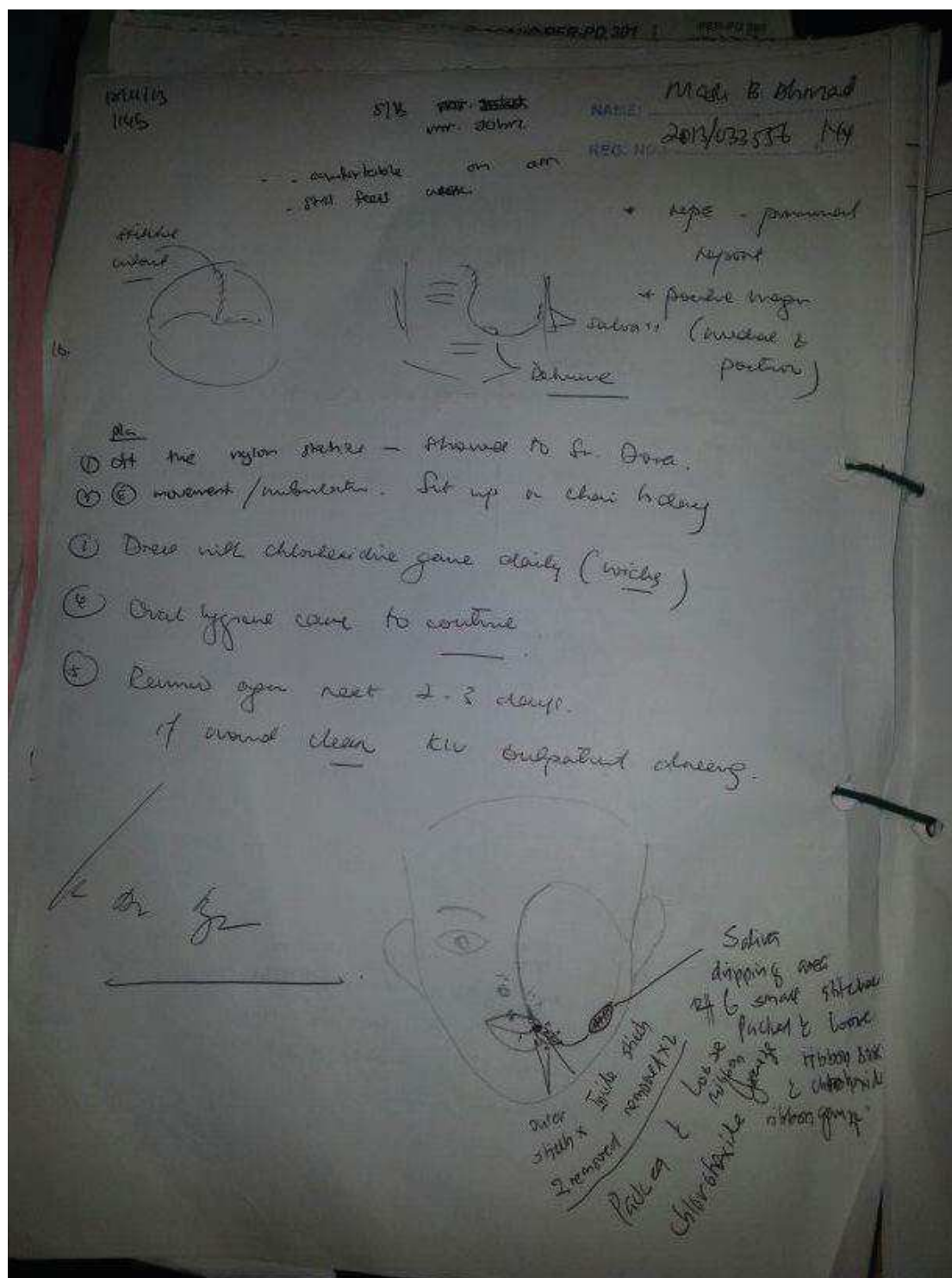
Name	Sources	References	Created On	Cre
<input type="radio"/> Staff welfare		1	1 7/27/2015 10:12 PM	R
<input type="radio"/> Standard guidelines for documentation		9	11 7/10/2015 6:48 PM	R
<input type="radio"/> Time management		7	7 7/10/2015 6:16 PM	R
<input type="radio"/> Types of nursing documentation		0	0 8/4/2015 5:26 PM	R
<input type="radio"/> Charting		2	3 7/27/2015 11:16 PM	R
<input type="radio"/> Hand over book		1	2 7/28/2015 2:23 AM	R
<input type="radio"/> Nursing care plan		1	2 7/27/2015 11:29 PM	R
<input type="radio"/> Yeahhh ... because the the patient taken care by you aaa... we must know the		1	1 1/23/2017 10:35 AM	R

Appendix 12: Pertinent studies on professionalism in nursing in recent years

Authors and Year	Title of study/Paper	Methodology	Significant findings	Focus
Zakari, N.M., Al Khamis, N.I. & Hamadi, H.Y. (2010)	Conflict and professionalism : perceptions among nurses in Saudi Arabia	Quantitative study using Perceived Conflict Scale and Valiga Concept of Nursing Scale	Conflict had significant correlation with perception of professionalism	Perceptions
Akhtar-Danesh, N., Baumann, A., Kolotylo, C., Lawlor, Y., Tompkins, C. & Lee, R. (2013)	Perceptions of Professionalism among nursing faculty and nursing students	Q- Methodology was used to identify common viewpoints about professionalism.	Four viewpoints: humanists, portrayers, facilitators and regulators	Behaviours and characters of professionalism
Fantahun, A., Asrat, D., Gebrekirstos, K., Zemere, A. & Yetayeh, G. (2014)	A cross sectional study on factors influencing professionalism in nursing among nurses in Mekelele Public Hospitals, North Euthopia, 2012	Institutional based cross sectional study supplemented by qualitative design was employed.	Mean score for nurses in Mekele public hospitals on professionalism = 140.50, Knowledge = 25.06, followed by ethics = 25.00, Significant association between the attributes and the characters of nurses. Focus group discussion – factors affection professionalism were workload,	Behaviours, attitude and perceptions

			no vision, not appreciated by the authority, weak support by the nursing association.	
Tanaka, M., Yonemitsu, Y. & Kawamoto, R. (2014)	Nursing professionalism : A national Survey of Professionalism among Japanese Nurses	Quantitative study utilised Japanese version of Behavioural Inventory for Professionalism in Nursing (Miller, 2008)	Japanese nurses have low level of professionalism.	Behaviour (self-identification)
Solomon, Y., Beker, J. & Belachew, T. (2015)	Professionalism and its predictors among Nurses working in Jimnia Zone Public Hospitals, South West Ethiopia	Institution based cross-sectional study design supplemented by qualitative data was conducted among nurses who were working in Jimma zone public hospitals, Jimma, Ethiopia.	The results of this study indicate that the professionalism levels of nurses are at a low level and factors associated with this were; age, marital status, sex, societal factor, organisational culture and educational level.	Behaviour

Appendix 13: Examples of nursing shift report



Clinical Notes	Date	Treatment
<p>Nursing Progress Notes Date: 2/1/14 (Am/Pm/N) Ward Paed Ortho</p> <p>- warded @ 9³⁰am accompanied by family member</p> <p>- alert + look comfortable</p> <p>- vital signs: T: 36.6°C PR: 112/min RR: 23/min Pain score: 0/10</p>		<p>- electively admitted</p> <p>- For op cm ↓ TOT</p> <p>- U7 card - available</p> <p>- consent for op } due</p> <p>- anaest review }</p> <p>- OT list</p>

<p>DATE: 2/1/2014 NURSING PROGRESS NOTES SHIFT: AM/PM/ND</p> <p>9.45hr/12.</p> <p>NO URTI.</p> <p>Pain score: 0/10.</p>	<p>- for op cm (Gastrostomy & Autoclave test log) - 2nd date listed.</p> <p>- consent for op } available.</p> <p>- for xx consent }</p> <p>- NPO of 8am - 6am instructed.</p> <p>- IV line inserted @ left hand.</p> <p>- FBC } taken & sent.</p> <p>- U&H }</p> <p>- Bile/cord }</p> <p>- FBC result available.</p> <p>- IV replacement 750mg prepared to 07.</p>
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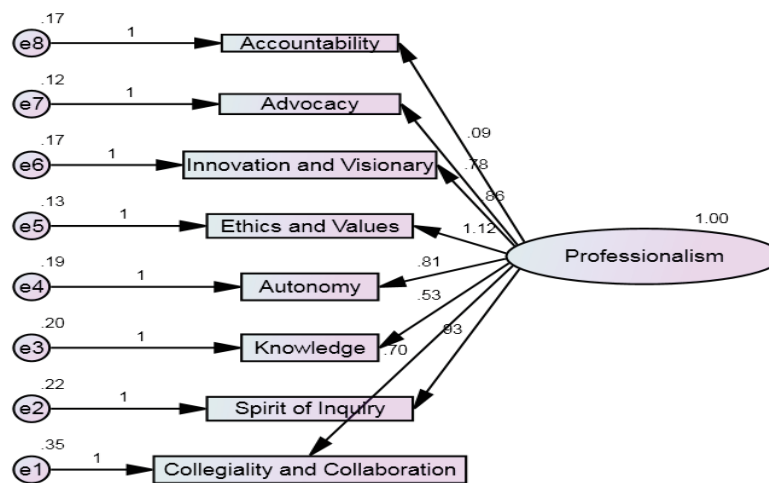
Appendix 14: Confirmatory Factor Analysis & Model fit test post pilot study

Table 1: Results for Inter- rater reliability, Cronbach's Alpha and Confirmatory Factor Analysis

Inter- rater reliability		
<i>Tests</i>	<i>Results/Findings</i>	<i>Remarks</i>
Measure of agreement Kappa co-efficient (K- value)	0.412	Moderate agreement
p- value	0.006	Good
Cronbach's Alpha Test Results		
<i>Variables/Items/subscales</i>	<i>Results/Findings</i>	<i>Remarks</i>
Accountability	-0.171	Need to check the scoring
Advocacy	0.884	Good
Innovation and Visionary	0.856	Good
Ethics and values	0.174	Need to revise items
Autonomy	0.817	Good
Knowledge	0.805	Good
Spirit of inquiry	0.838	Good
Collegiality and collaboration	0.805	Good
OVERALL for all items	0.691	(Acceptable)
Confirmatory Factor Analysis		
<i>Tests</i>	<i>Results/Findings</i>	<i>Good Fit/Remarks</i>
Chi square (X^2)	25.419	Yes
df	20	Yes
GFI	0.791	Yes
AGFI	0.624	Yes
CFI	0.962	Yes
TLI	0.947	Yes
RMSEA	0.116	Not
PCLOSE	0.233	Yes
Loading factors for		
<i>Accountability</i>	0.09	Poor
<i>Advocacy</i>	0.78	Good
<i>Innovation and Visionary</i>	0.86	Good
<i>Ethics and Values</i>	1.12	Good
<i>Autonomy</i>	0.81	Good
<i>Knowledge</i>	0.53	Acceptable
<i>Spirit of inquiry</i>	0.93	Good
<i>Collegiality and collaboration</i>	0.70	Good

Analysis of Confirmatory Factor Analysis and Cronbach's Alpha co-efficient tests

Confirmatory Factor Analysis for all attributes of professionalis



Model Fit Summary

CMIN

Model	NPAR	CMIN	DF	P	CMIN/DF
Default model	16	25.419	20	.186	1.271
Saturated model	36	.000	0		

Model	NPAR	CMIN	DF	P	CMIN/DF
Independence model	8	171.346	28	.000	6.119

RMR, GFI

Model	RMR	GFI	AGFI	PGFI
Default model	.030	.791	.624	.439
Saturated model	.000	1.000		
Independence model	.530	.245	.029	.190

Baseline Comparisons

Model	NFI Delta1	RFI rho1	IFI Delta2	TLI rho2	CFI
Default model	.852	.792	.964	.947	.962
Saturated model	1.000		1.000		1.000
Independence model	.000	.000	.000	.000	.000

Parsimony-Adjusted Measures

Model	PRATIO	PNFI	PCFI
Default model	.714	.608	.687
Saturated model	.000	.000	.000
Independence model	1.000	.000	.000

NCP

Model	NCP	LO 90	HI 90
Default model	5.419	.000	22.525
Saturated model	.000	.000	.000
Independence model	143.346	105.770	188.427

FMIN

Model	FMIN	F0	LO 90	HI 90
Default model	1.271	.271	.000	1.126
Saturated model	.000	.000	.000	.000
Independence model	8.567	7.167	5.289	9.421

RMSEA

Model	RMSEA	LO 90	HI 90	PCLOSE
Default model	.116	.000	.237	.233
Independence model	.506	.435	.580	.000

AIC

Model	AIC	BCC	BIC	CAIC
Default model	57.419	83.601	74.131	90.131
Saturated model	72.000	130.909	109.603	145.603
Independence model	187.346	200.437	195.702	203.702

ECVI

Model	ECVI	LO 90	HI 90	MECVI
Default model	2.871	2.600	3.726	4.180
Saturated model	3.600	3.600	3.600	6.545
Independence model	9.367	7.489	11.621	10.022

HOELTER

Model	HOELTER .05	HOELTER .01
Default model	25	30
Independence model	5	6

Estimates (Group number 1 - Default model)**Scalar Estimates (Group number 1 - Default model)****Maximum Likelihood Estimates****Regression Weights: (Group number 1 - Default model)**

	Estimate	S.E.	C.R.	P	Label
Colleague <--- Professionalism	.704	.175	4.021	***	
Spirit <--- Professionalism	.932	.183	5.096	***	
Know <--- Professionalism	.534	.133	4.013	***	
Auto <--- Professionalism	.808	.163	4.966	***	
Ethics <--- Professionalism	1.121	.196	5.715	***	
Inno <--- Professionalism	.862	.166	5.204	***	
Advoc <--- Professionalism	.777	.146	5.328	***	
Account <--- Professionalism	.092	.096	.964	.335	

Standardized Regression Weights: (Group number 1 - Default model)

	Estimate
Colleague <--- Professionalism	.765
Spirit <--- Professionalism	.891
Know <--- Professionalism	.764
Auto <--- Professionalism	.878
Ethics <--- Professionalism	.951
Inno <--- Professionalism	.902
Advoc <--- Professionalism	.915
Account <--- Professionalism	.216

Variances: (Group number 1 - Default model)

	Estimate	S.E.	C.R.	P	Label
Professionalism	1.000				
e1	.352	.117	3.008	.003	
e2	.225	.082	2.733	.006	
e3	.204	.068	3.009	.003	
e4	.195	.070	2.791	.005	
e5	.132	.063	2.101	.036	
e6	.169	.063	2.673	.008	
e7	.118	.045	2.588	.010	
e8	.173	.055	3.157	.002	

Cronbach's Alpha co efficient for each of the attributes of professionalism

Scale: Accountability

Case Processing Summary		
	N	%
Valid	15	71.4
Cases Excluded ^a	6	28.6
Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha ^a	N of Items
-.171	10

a. The value is negative due to a negative average covariance among items. This violates reliability model assumptions. You may want to check item codings.

Item Statistics

	Mean	Std. Deviation	N
Entries are legible etc	2.6000	.82808	15
Patient demographic	2.8000	.94112	15
Name signatory	3.2667	.59362	15
Designation signatory	3.3333	.61721	15
Name of doctor	3.4000	.63246	15
chronological sequence	2.8000	.56061	15
Pages numbered	2.1333	1.45733	15
Patient name on every sheet	1.7333	.88372	15
Care amended	2.6000	.91026	15
Corrections corrected	1.6667	1.44749	15

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
26.3333	7.667	2.76887	10

Scale: Advocacy

Case Processing Summary

		N	%
Cases	Valid	17	81.0
	Excluded ^a	4	19.0
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.884	10

Item Statistics

	Mean	Std. Deviation	N
provide adequate information	2.6471	.78591	17
Evaluation clear	2.5294	.87447	17
Problem updated	2.8824	.48507	17
Individual plan of care	2.5294	.87447	17
Care reflects changes	2.5882	1.00367	17
patient urgencies	2.7647	.75245	17
Health needs assessment	2.4118	.87026	17
Care plan discussed	2.2941	.77174	17
Relevant information	2.2941	.68599	17
Information on admission	2.2353	.75245	17

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
25.1765	31.029	5.57040	10

Scale: Innovation and visionary

Case Processing Summary

		N	%
Cases	Valid	17	81.0
	Excluded ^a	4	19.0
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.861	10

Item Statistics

	Mean	Std. Deviation	N
Care stated	2.6471	.99632	17
Prevention clear	2.4118	1.12132	17
content is easy	2.8824	.85749	17
amended care	2.8824	.69663	17
identified outcomes	2.7059	.77174	17
supported rationale	1.8235	1.07444	17
clearly recorded	2.5294	.71743	17
risk factors	1.9412	.96635	17
action taken	2.8235	.52859	17
plans for reassessment	2.2941	.98518	17

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
24.9412	35.184	5.93160	10

Scale: Ethics and Values

Case Processing Summary

		N	%
Cases	Valid	15	71.4
	Excluded ^a	6	28.6
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.174	10

Item Statistics

	Mean	Std. Deviation	N
clear of gossip	5.6000	10.39093	15
preferred name	2.7333	.96115	15
patient religion	2.5333	1.68466	15
patient briefed	2.8000	.56061	15
patient consent	3.4000	.73679	15
important information	2.7333	.59362	15
Unique needs	2.5333	1.12546	15
clear record prepared	2.8667	.51640	15
written in term	2.8000	.56061	15
specific corresponding	2.6000	.91026	15

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
30.6000	137.114	11.70958	10

Scale: Autonomy

Case Processing Summary

		N	%
Cases	Valid	16	76.2
	Excluded ^a	5	23.8
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.812	10

Item Statistics

	Mean	Std. Deviation	N
Intervention performed	2.8750	.61914	16
urgent referred	3.1250	.71880	16
Entries written incidents	2.9375	.68007	16
Interventions discontinued	2.9375	.99791	16
Reassessment	2.6250	.95743	16
Discussion	2.6250	.95743	16
SOAPIER	2.3750	.71880	16
what to do	3.3750	.71880	16
when to do	3.1875	.75000	16
how to do	2.3750	.88506	16

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
28.4375	24.396	4.93921	10

Scale: Knowledge

Case Processing Summary

		N	%
Cases	Valid	17	81.0
	Excluded ^a	4	19.0
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.825	10

Item Statistics

	Mean	Std. Deviation	N
appropriate assessment	2.6471	.93148	17
Changes to treatment	2.7059	.58787	17
observation signs	2.7647	.56230	17
informed patient	2.4706	.87447	17
evidence from others	2.4118	.79521	17
nursing care plan	2.1176	.92752	17
appropriate prescribed	2.6471	.60634	17
analysis	1.8235	1.18508	17
diagnosis	1.9412	1.02899	17
planning	1.7647	.97014	17

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
23.2941	29.346	5.41716	10

Scale: Spirit of inquiry

Case Processing Summary

		N	%
Cases	Valid	18	85.7
	Excluded ^a	3	14.3
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.745	10

Item Statistics

	Mean	Std. Deviation	N
patient condition	2.3889	1.37793	18
patient status indicated	2.7778	.94281	18
patient admission	2.5556	.78382	18
assessment findings	2.8333	.38348	18
IPPA mnemonics	1.5000	1.24853	18
patient response tx	2.3889	.97853	18
patient response med	2.1111	1.07861	18
appropriate reassessment	2.5000	.70711	18
clear care planning	2.5000	.61835	18
prescribed investigation	2.8889	.47140	18

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
24.4444	25.320	5.03192	10

Scale: Collegiality and collaboration

Case Processing Summary

		N	%
Cases	Valid	17	81.0
	Excluded ^a	4	19.0
	Total	21	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.817	10

Item Statistics

	Mean	Std. Deviation	N
countersign unqualified	2.5882	1.50245	17
countersign student	2.4706	1.62472	17
clear statement	2.7647	1.14725	17
without jargon	2.5882	.87026	17
standard abbreviation	3.7647	.43724	17
all referral completed	3.3529	.60634	17
report prepared	3.3529	.70189	17
personnel review	3.5294	.51450	17
Discussion held	2.8235	.80896	17
distribution of responsibilities	2.4706	1.17886	17

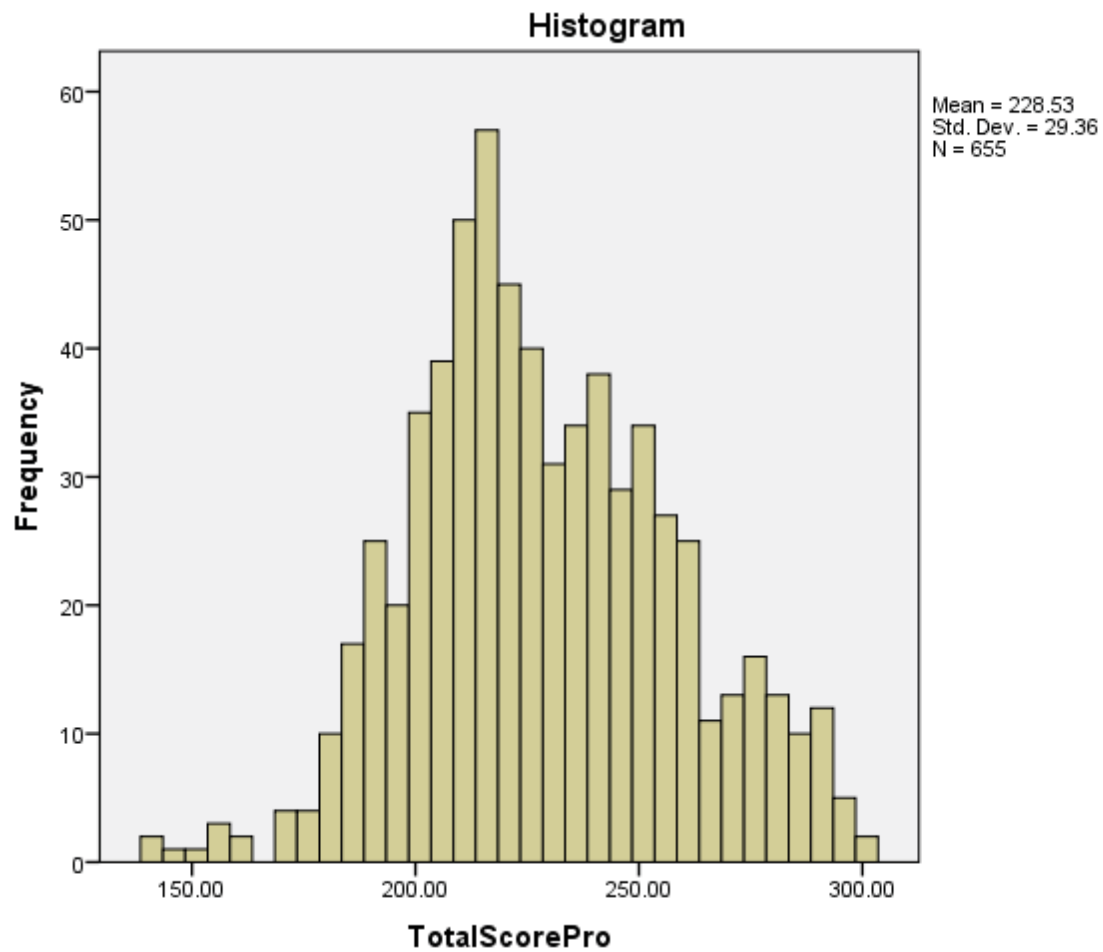
Scale Statistics

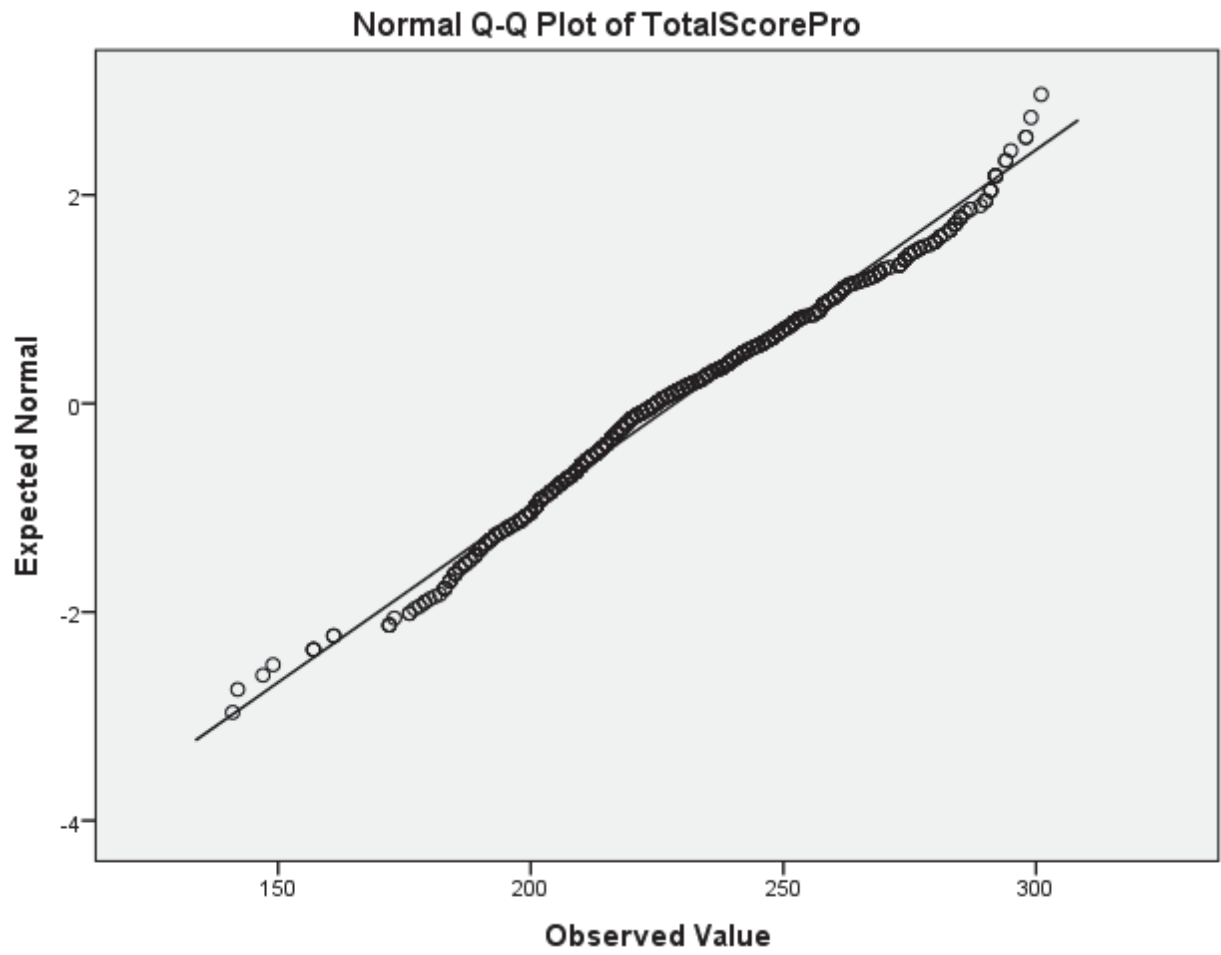
Mean	Variance	Std. Deviation	N of Items
29.7059	38.971	6.24264	10

Appendix 15: Tests of normality

Tests of Normality						
	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
TotalScorePro	.065	655	.000	.989	655	.000

a. Lilliefors Significance Correction





Appendix 16:

Table 2.2: Comparisons of findings between Hofstede's (1984, 1988 & 2001) and Ting & Ying's (2013) studies.

Hostede's (1984, 1988, 2001) Cultural Dimensions Theory	Descriptions by Hofstede (1984, 1988, 2001)	Hostede's (1984, 1988, 2001) findings on Malaysians	Ting & Ying (2013) findings on Malaysians
Power distance index	The extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally.	Scored very highly in this dimension (score of 100), which implies that Malaysians in the sample accept a hierarchical order in which everybody has a place and which needs no further justification.	Scored relatively average for Power Distance Index. This result indicates that their Malaysian respondents still perceived that there is an unevenly power distribution in society. However this situation could be better over the times.
Individualism versus collectiveness	The degree of interdependence that a society maintains among its members.	Scored 26 points and implies Malaysians are a collectivistic society. This is manifested in a close long-term commitment to the 'member' group, be that a family, extended family or extended relationships and being loyal.	Scored a high collectivism value.
Masculinity versus femininity	Motivates people, wanting to be the best (Masculine) or	Scored an intermediate score of 50, a preference for this dimension could	Scored high in Masculine.

	liking what you do (Feminine).	not be determined in 1980. Follow up studies in 1984 and 2001 saw high score in Masculine. This score implies that the society will be driven by competition, achievement and success. In this context, success is defined by the winner/best in a field which a value system that starts in school and continues throughout organisational life.	
Uncertainty avoidance index (UAI)	The way a society deals with whether the future is unforeseeable and can be controlled.	Scored 36 on this dimension and, thus, implied a low preference for avoiding uncertainty. This result suggests that the respondents maintain a more relaxed attitude in which practice counts more than principles and deviance from the norm is more easily tolerated.	Respondents seems to have high uncertainty avoidance value.
Long term orientation versus short term normative orientation	Society has to maintain some links with its own past while dealing with the challenges of the present and the future, and societies prioritise these two	The low score of 41 in this dimension implies that Malaysia has a normative culture. People in such societies has a strong concern about establishing the absolute truth and exhibit great respect for traditions, a relatively small inclination to save	Was not investigated. Replaced with work dynamic.

	existential goals differently.	for the future, and focus on achieving quick results.	
Indulgence versus restraint	The extent to which people try to control their desires and impulses based on the way they were raised.	Malaysia's high score of 57 implies that culture is one of the indulgences. Individuals in a society that is classified by a high score in indulgence are commonly displaying willingness to acknowledge their impulses and desires to enjoy life and to make life fun.	Was not investigated. Replaced with work dynamic.

Adapted from Hofstede (1984, 1988, 2001) and Ting and Ying (2013)

Appendix 17: An example of respondent's email regarding translation of the interview.

