THE CONTINUING EDUCATION NEEDS OF NURSES WORKING IN HOSPITAL ENVIRONMENTS IN RURAL PUNJAB, INDIA

by

Brittany Elyse Watson

B.Sc.N., The University of British Columbia, 2008

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2015

© Brittany Elyse Watson, 2015
Abstract

Statistics suggest that 72% of India’s population resides in rural areas, while 75% of physicians practice in urban centers. As a result, nurses are depended upon for knowledge and skills beyond their initial training and education. Currently, in India’s rural health care settings, formalized processes to ensure nurses receive continuing education do not exist. Physicians and nurse colleagues often bridge the education-practice gap, allowing nurses to fill the void in their practice responsibilities. However, the Indian Nursing Council is requiring a five-year renewal process with mandatory requirements for continuing education. Developing appropriate and relevant continuing education programs will require an understanding of nurses’ role in the clinical setting and their learning needs.

This qualitative research study is a secondary analysis of data investigating the continuing education needs of nurses working in rural hospital environments in Punjab, India. Data were obtained from an original study that investigated the roles and responsibilities of nurses working at Guru Gobind Singh Hospital in Punjab, India. Twelve staff nurses and five physicians who expressed familiarity with the role of a nurse participated in focus group interviews.

Interpretive description methodology was used to identify themes and subthemes within the data. Key themes from the analysis revealed nurses’ emphasis on task completion; the knowledge and skills required for clinical practice exceed nurses’ basic education preparation; and recognition of nurses’ capacity for advanced practice roles within the health care system. Physicians also expressed their dependence upon nurses to fulfill their respective responsibilities. Furthermore, mutual respect and honour within the nurse-physician relationship was embedded throughout the focus group interviews. The study findings highlight the need to enhance nursing
capacity through continued education and advanced practice roles to meet the health care needs in rural India.
Preface

This thesis is the original, unpublished work of the student, Brittany Elyse Watson. This study is a secondary analysis, using data from a primary study which is unpublished at this time. The primary study is titled “The Role and Responsibilities of Staff Nurses in Punjab, India – An Interpretive Description” and received ethics approval from the UBC Behavioural Research Ethics Board. The ethics certificate number is H14-00467. I participated in the data collection for the primary study, and conducted focus group interviews alongside a research team. I also transcribed the recorded interviews. The secondary study titled “The Continuing Education Needs of Nurses Working in Rural Hospital Environments in Punjab, India” also received ethics approval from the UBC Behavioural Research Ethics Board. The ethics certificate number is H14-03506. I completed a secondary analysis of the data for this thesis.
Table of Contents

Abstract............................................................................................................................................. ii

Preface.................................................................................................................................................. iv

Table of Contents ............................................................................................................................... v

List of Tables ......................................................................................................................................... vii

List of Abbreviations ............................................................................................................................ ix

Acknowledgements ................................................................................................................................ x

Dedication .............................................................................................................................................. xi

Chapter 1: Introduction ......................................................................................................................... 1

1.1 Background ..................................................................................................................................... 1

1.2 Purpose of Study and Research Questions ..................................................................................... 3

1.3 Overview of the Thesis ..................................................................................................................... 3

Chapter 2: Review of Related Literature ............................................................................................... 5

2.1 Historical and Current Landscape of Nursing Practice in India ................................................... 5

2.1.1 The Punjab State ....................................................................................................................... 9

2.2 Context of Nursing Education in India ............................................................................................ 10

2.3 The Effect of Indian Trained Nurse Migration ............................................................................... 12

2.4 Nurses’ Roles in Rural Environments ............................................................................................. 13

2.5 Governance, Accountability and Conceptualizations of the Nursing Profession ....................... 15

2.5.1 International Council of Nurses ............................................................................................. 16

2.5.2 Indian Nursing Council .......................................................................................................... 17
2.5.3 Canadian Nurses Association ................................................................. 17
2.5.4 State Nursing Councils in India ............................................................... 18
2.5.5 College of Registered Nurses of British Columbia................................. 18
2.6 Summary ..................................................................................................... 19

Chapter 3: Methods ......................................................................................... 20

3.1 Research Design ....................................................................................... 20
3.2 Source of Data (Setting and Sample) ......................................................... 20
  3.2.1 Recruitment .......................................................................................... 21
3.3 Data Collection Procedures ....................................................................... 21
3.4 Data Analysis ............................................................................................. 22
  3.4.1 Interpretive Description ......................................................................... 22
3.5 Strategies to Achieve Rigour ..................................................................... 24
  3.5.1 Representative Credibility .................................................................. 24
  3.5.2 Analytic Logic ..................................................................................... 24
  3.5.3 Disciplinary Relevance ....................................................................... 25
3.6 Ethical Considerations .............................................................................. 25

Chapter 4: Findings ......................................................................................... 27

4.1 Task-driven ................................................................................................ 29
  4.1.1 Nurse as Task Manager and Scope of Practice ..................................... 29
  4.1.2 Basic Nursing Education ..................................................................... 33
4.2 Unpreparedness ......................................................................................... 36
  4.2.1 Physician as Nurse Educator ............................................................... 36
  4.2.2 Staff Nurse Fear and Staff Nurse Requests ......................................... 40
Chapter 5: Discussion of the Findings .......................................................... 55

5.1 Task-driven Nature of Practice ................................................................. 55

5.2 Unpreparedness ......................................................................................... 58
  5.2.1 Critical Thinking ................................................................................... 62

5.3 Advanced Practice ....................................................................................... 64
  5.3.1 Nurse as Physician Educator ................................................................. 66
  5.3.2 Nurse as Patient and Family Educator ................................................ 66
  5.3.3 Professional Development ..................................................................... 67

5.4 Limitations .................................................................................................. 68

5.5 Recommendations for Nursing Practice, Education and Research .......... 70
  5.5.1 Nursing Practice and Education ........................................................... 70
  5.5.2 Nursing Research .................................................................................. 72

5.6 Conclusion .................................................................................................. 72

References ........................................................................................................ 73
List of Tables

Table 1 Demographic Characteristics of Study Participants ................................................................. 28
Table 2 Themes and Subthemes ........................................................................................................... 29
List of Abbreviations

ANM................................................................. Auxiliary Nurse Midwife
BC................................................................. British Columbia
BFUHS........................................ Baba Farid University of Health Sciences
BSc(N)......................................................... Bachelor of Science in Nursing
CNA............................................................. Canadian Nurses Association
CNS.............................................................. Clinical Nurse Specialist
CRNBC.................................................. College of Registered Nurses of British Columbia
GGSH.......................................................... Guru Gobind Singh Hospital
GNM............................................................. General Nurse Midwife
INC............................................................. Indian Nursing Council
MBBS.......................................................... Bachelor of Medicine and Surgery
MD.............................................................. Doctor of Medicine
MPhil.......................................................... Masters of Philosophy
MSc............................................................. Masters of Science in Nursing
NP............................................................... Nurse Practitioner
PhD.............................................................. Doctorate of Nursing
RN.............................................................. Registered Nurse
UBCSoN........................................ University of British Columbia School of Nursing
UK.............................................................. United Kingdom
WHO.......................................................... World Health Organization
Acknowledgements

I would like to acknowledge the staff nurses and physicians at Guru Gobind Singh Hospital, as well as the senior leadership at Baba Farid University of Health Sciences - these individuals supported the research study and provided insight and knowledge into India’s nursing workforce. I would also like to express my sincere gratitude and appreciation to my thesis committee, Dr. Susan Dahinten, Dr. Tarnia Taverner and Dr. Leanne Currie. Thank you for creating an opportunity that allowed me to experience India and the culture of nursing as a reality. I am continually in awe of the support and encouragement each of you has offered me. Your passion for India and desire to promote the advancement and professionalization of nursing practice inspires me. Thank you for a masters’ experience that continues to shape me both personally and professionally today. In addition, I would like to thank my mother and my father for their unconditional love and their words of affirmation, giving me confidence to pursue my dreams. Finally I would like to thank my sister, my brother and my brother-in-law who have faithfully supported me through my masters’ education and all life’s journeys and adventures.
Dedication

I dedicate this thesis to the staff nurses at Guru Gobind Singh Hospital. The staff nurses tirelessly ensure patient care needs are attended to, while treating patients and their families with the utmost dignity and respect. The compassion, knowledge and intelligence exemplified by the staff nurses is inspiring, and I am proud to call these nurses my colleagues.
Chapter 1: Introduction

1.1 Background

Excellence in nursing is facilitated when nurses engage in continuing education opportunities, and learn evidence-based knowledge and best nursing practices (World Health Organization [WHO], 2014). Continuing education is defined as learning activities designed to augment the knowledge, skills and attitudes of nurses, and thereby enrich nurses’ contributions to quality health care (American Nurses Association, 2014). Continuous enhancement of nurses’ knowledge, skills, and judgment is a commitment upheld by professional nursing worldwide including the International Council of Nurses’ Code of Ethics which outlines nurses’ responsibility in maintaining their competence and fitness to practice (Canadian Nurses Association [CNA], 2014; International Council of Nurses, 2012a). Nurses adhere to being accountable and to maintaining their competence through continual learning (International Council of Nurses). In addition, nurses are expected to actively pursue a foundation of research-based professional knowledge that supports evidence-based practice (International Council of Nurses). Research suggests that nurses’ knowledge, quality of provided care and patient outcomes are highly correlated (Lalonde et al., 2013; Ng, Tuckett, Fox-Young & Kain, 2014).

The Indian Nursing Council (INC) was established in 1947 and began regulating nursing education standards (INC, 2014). Since this time, uniform education curriculums for nurses, midwives, and auxiliary nurse midwives (ANMs) have been established; yet requirements for maintaining one’s knowledge and fitness to practice were not identified. Furthermore, nursing registration appears to be managed by the state nursing councils and until recently, there was ‘lifetime’ nursing registration, with no renewal requirements. However, the INC has now mandated a five-year registration renewal process with requirements for continuing education.
The revised registration process has been implemented through some state nursing councils including those in Delhi and Kerala (Delhi Nursing Council, n.d.; Staff Nurse Vacancy, 2013). These nursing councils have executed a five-year registration renewal process, and mandatory completion of 150 hours of continuing education to be eligible for renewal (Delhi Nursing Council; Staff Nurse Vacancy).

Despite a standardized education curriculum, nurses’ scope of practice in India is not regulated. Moreover, in rural India, nurses’ scope of practice is strongly influenced by the availability of physicians (Sharma, Johansson, Prakasamma, Mavalankar & Christensson, 2013). India’s nurse-to-physician ratio and the physician-to-person ratio are well below the WHO standards (WHO, 2012a; WHO, 2012b). However, there is also a rural-urban imbalance. Seventy-two percent of the Indian population resides in rural areas, while 75% of Indian physicians practice in urban locations (University of Pennsylvania School of Nursing, 2013). Attempts to increase the number of rural practicing physicians have had minimal success. However, nurses readily respond to rural employment incentives such as salary increases, when compared to physicians (Rao et al., 2013). As a result, nurses engage in a phenomenon referred to as compelled practice. Compelled practice refers to unendorsed yet extended practice, undertaken due to the circumstance and may involve complex procedures (Sharma et al.).

Considering the recent shift in mandated continuing education, and the phenomenon of compelled practice, it is imperative that nurses’ roles and learning needs are assessed and understood, to support the development of continuing education programs and opportunities to advance the profession.
1.2 Purpose of Study and Research Questions

This study is a secondary analysis of data drawn from a larger study that investigated the roles and responsibilities of staff nurses at Guru Gobind Singh Hospital (GGSH) in Punjab, India. The purpose of the current study is to investigate the continuing education needs of nurses working in hospital environments in rural areas of the Punjab, India. The University of British Columbia School of Nursing (UBCSoN) developed a collaborative partnership with Baba Farid University of Health Sciences (BFUHS) in 2011. BFUHS is the leading health sciences university in the Punjab and is located in the District of Faridkot. Faridkot presents as a rural location. The predominant form of employment is agriculture; there is little industry, there is scant tourism, and there are few amenities such as restaurants, movie theatres or hotels.

The following research questions will guide this qualitative study:

- How well does basic nursing education inform hospital-based nursing practice?
- What are the educational needs of staff nurses?
- How are continuing education needs of staff nurses addressed?

1.3 Overview of the Thesis

Chapter 2 presents the literature review pertinent to the research questions and proposed methods. This chapter provides an overview of the literature regarding the roles, responsibilities and education of staff nurses in rural India. Furthermore, the historical and current context of nursing practice in India is compared to nursing practice in Canada and is discussed from an international perspective. The effect of the ‘brain drain’ phenomenon brought forth by the exodus of Indian-trained nurses is also reviewed. Chapter 3 describes the secondary analysis of collected data, and provides an explanation of interpretive description analytic methods, strategies to achieve rigor and ethical considerations. Chapter 4 presents the subthemes and
themes, illuminating the study findings and Chapter 5 discusses the findings in relation to current literature accounts. Study benefits and limitations are addressed; as well implications for nursing practice, education and research.
Chapter 2: Review of Related Literature

In this chapter, relevant literature pertaining to nursing practice in India specifically the roles, responsibilities and education of staff nurses in rural India is discussed. Considering the limited literature on nursing in Punjab, literature that pertains to nursing in India generally and countries with similar population profiles is included. Furthermore, the context of nursing practice in India is compared to nursing practice in Canada and is discussed from an international perspective. Literature from the following areas is reviewed: the historical and current context of nursing practice in India, the nursing education system in India, nurses’ roles in global rural environments as well as nurses’ roles in India’s rural locations. In addition, regulation of nurses by the INC is outlined and compared with regulation established by the International Council of Nurses and the CNA. Lastly, health worker migration brought forth by the exodus of Indian-trained nurses is investigated.

2.1 Historical and Current Landscape of Nursing Practice in India

India is home to 1.1 billion people and faces an unmatched demand for healthcare relative to the country’s resources (IKP Centre for Technologies in Public Health, 2014). Despite graduating 30,000 doctors, 18,000 specialists, 54,000 nurses and 15,000 ANMs each year (Kumar, 2013), the nurse to physician ratio and the physician to person ratio are below WHO standards (WHO, 2012a; WHO, 2012b). The WHO recommends two to three nurses per physician and one physician per every 1,000 persons (WHO, 2012a; WHO, 2012b). India has an estimated nurse to physician ratio of 1.22 and there is one physician per 1,700 persons (Kumar; Munjanja, Kibuka & Dovlo, 2005; WHO, 2012a). Furthermore, 72% of the Indian population resides in rural areas, while 75% of Indian physicians practice in urban locations (University of Pennsylvania School of Nursing, 2013). Attempts to increase the number of rural practicing
physicians have seen minimal success. Recruitment strategies have focused on: compulsory rural service, monetary and non-monetary incentives and acceptance into specialist training programs in exchange for rural service appointments (Rao et al., 2013). When presented as individual incentives, physicians are unlikely to accept a rural placement, yet when strategies are combined, the additive effect supports rural recruitment initiatives (Rao et al.). Unfortunately, as health resources are limited in India, the costs associated with recruitment ‘packages’ are unaffordable. Furthermore, sustainment of such initiatives would require engagement from health and government departments, creating additional challenges (Rao et al.). However, nurses readily respond to rural employment incentives such as salary increases, particularly at lower levels, when compared to physicians (Rao et al.). As a result, there are 11.3 physicians and 4.3 nurses per 10,000 populations in urban India, compared to 1.2 physicians and 0.7 nurses per 10,000 populations in rural India (Rao et al.).

Lack of healthcare providers in rural India has been a longstanding concern. In an attempt to resolve the nursing shortage and lack of qualified physicians, midwives during the 19th century completed an additional six months of training to provide nursing care (Mavalankar, Sankara Raman & Vora, 2011). During the Second World War, a subsequent shortage of trained nurses led to the development of a six-month training course in nursing and midwifery, creating the role of the ANM as currently regulated by the INC (Mavalankar et al.; Sundaraman & Gupta, 2011). Although considered a specialty designation in many developed countries, in India, midwifery training is a component of basic education for all three nursing designations including an ANM, a general nurse midwife (GNM) and a bachelor’s trained nurse (Sharma et al., 2013).

In India, physicians have historically provided healthcare with limited regard for nurses. Factors that have influenced this outcome include: caste, religion, illiteracy and political unrest
through India’s colonial history (Johnson, Green, & Maben, 2014). Physicians are predominately male, born in urban areas, from higher socio-economic statues and higher castes (Mavalankar et al., 2011). Staff nurses in hospital settings are primarily female, from rural areas, lower socio-economic statuses and lower castes (Mavalankar et al.). These differences have contributed to nurses’ low professional status.

Religion and caste also influence the current status of nursing in India. According to the 2001 census report published by the Government of India, Ministry of Home Affairs, 80.5% of the Indian population identified as people of the Hindu faith, 13.4% as people of the Muslim faith, 2.3% as people of the Christian faith and 1.9% as people of the Sikh faith. However, as Punjab is the birthplace of Sikhism, 60% of people living in Punjab identified as Sikh, 37% as Hindu and the remaining population were Muslim, Buddhist and Christian (Government of India, Ministry of Home Affairs, 2001). Although the religion in the Punjab state is predominately Sikh, nurses migrate between states in India, and thus nurses and nurse educators from other parts of India, who are not of the Sikh faith, practice in Punjab. However, the distribution of religion is significant because religion influences individuals’ understanding of the caste system, and the caste system can effect individuals’ perceptions of the nursing profession.

Caste signifies a system of social stratification, defined by descent and occupation (Patil, 2014). In India, caste is hereditary, imposed upon individuals, and fixed throughout one’s lifespan (Dunham, Srinivasan, Dotsch & Barner, 2014; Patil). In Sikhism, the caste system exists in a diluted form. A defined caste hierarchy does not exist, and occupations are considered equal, as all castes are seen as positively contributing to society (Singh, n.d.). Examples of Sikh castes include: Arora, Ramgarhia, Jat, and Chamar. Arora is a commercial and business caste;
Ramgarhia is an artisan caste, comprised of barbers, blacksmiths and carpenters; Jat is an agricultural caste; the Chamar caste includes shoemakers, farmers and labourers (Singh).

In the Hindu faith, the caste system is hierarchical and divided into four varnas (categories) in descending order: Brahmin, Kshatrya, Vaishya and Shudra (Manian, 2007). The Brahmin caste is composed of priests and teachers; the Kshatrya caste is composed of warriors and rulers; the Vasishya caste includes farmers, traders and merchants; the Shudra caste is comprised of labourers (Manian). Outside of the caste system are dalits, who are responsible for tasks that include toilet cleaning, garbage removal and tasks that require contact with bodily fluids (Manian). Members of the lower castes often experience structural discrimination, and female sex evokes additional challenges. Structural discrimination is defined as rules, norms and behaviours that create obstacles to equal rights and opportunities for subordinate groups (Patil, 2014). In attempt to reconcile the poor treatment received by members of historically disadvantaged castes, the Indian Government has established scheduled castes.

Within the Hindu caste system, rituals and social practices that are identified as ‘purifying’ or ‘polluting’ to the body separate higher and lower class Hindus (Johnson et al., 2014). ‘Purifying’ practices are distinguished from ‘polluting’ practices, based upon whether contact with body fluids is necessary (Johnson et al.). Nursing is a considered a ‘polluting’ occupation, and an inappropriate form of employment for people of the Hindu faith, because contact with bodily fluids is required and social identity is threatened (Johnson et al.). Since caste hierarchy is not as visible in Sikhism compared to Hinduism, identifying with a ‘polluting’ occupation compared to a ‘purifying’ occupation is less concerning for people who are Sikh (Johnson et al.). Since India is a predominately Hindu nation, it has become increasingly difficult to recruit upper class Indians into the nursing profession and to generate an appealing
nursing image (Johnson et al.). The cumulative effect of these factors has contributed to the slow development of nursing in India.

2.1.1 The Punjab State

Punjab is the state of five rivers, situated in northwest India. The historic region straddles the Pakistan Border and the region was divided in partition in 1947 (BBC News, 2007). ‘Punj’ means five and ‘aab’ means water, thus directly translated, Punjab means five waters. There are five rivers that flow through Punjab, each originating near the Himalayan mountains. Punjab is also referred to as the ‘bread basket’ of India, as it produces two thirds of the country’s food grains (Sharma, Kharol, Badarinath & Singh, 2010).

According to the Government of India, Ministry of Home Affairs (2011) census report, the population of Punjab registered at approximately 27 million, ranking Punjab as the 15th (out of a total of 35) most populous state. Punjab’s growth rate is 13%, which is below the national average of 17% and 37.4% of the population lives in urban areas, while 65.2% live in rural areas (Government of India, Ministry of Home Affairs). The primary spoken languages are Punjabi and Hindi and the literacy rate is 73% (Government of India, Ministry of Home Affairs).

Punjab also has the highest proportion of scheduled castes across India. There are 39 scheduled castes in Punjab, and in 2001 it was estimated that 28.9% of the total Punjab population belongs to a scheduled caste (Government of Punjab, 2014; Ministry of Social Justice and Empowerment, 2009). Scheduled castes are under the protection of the Indian government, and include historically disadvantaged Indian castes of low rank (Ministry of Social Justice and Empowerment, 2015). The government recognizes these individuals and, due to historically inferior treatment, they are entitled to certain rights as mandated by the government. Individuals
who belong to a scheduled caste live predominately in rural areas, with poor economic statuses and are primarily employed as agricultural labourers (Government of Punjab).

2.2 **Context of Nursing Education in India**

The development and professionalization of nursing in India was influenced by the British Empire, who entered India in 1608 and remained in control until 1947. The nursing model adopted in Indian hospitals evidences India’s history as a British colony. Titles to distinguish the nursing hierarchy in India reflect the British system (in ascending order: staff nurse, nurse sister and nurse matron) and the combined nurse midwife role originates from the United Kingdom (Nandi, 1977).

Prior to the 20th century in India, males’ predominately occupied the roles of nurses, and females provided nursing care primarily during childbirth. In 1865, Florence Nightingale, having knowledge of Indian working conditions and the nation’s sociopolitical and cultural climates, suggested a revised care delivery model. In 1867, Nightingale’s suggestions were used and St. Stephens Hospital in New Delhi was built; the first hospital to train Indian women as nurses (Nandi, 1977).

In 1947, at the time of India’s independence, the INC was established and began regulating standards of nursing education throughout the nation (Nandi, 1977). Since this time, development of the nursing profession had been influenced by Christian Missionary Hospitals, alongside international agencies including the WHO, UNICEF, the Red Cross and USAID (Nandi; Tiwari, Sharma & Zodpey, 2013). There are also state nursing councils whose role is to manage nursing registration, and to maintain the standards of nursing education.

The regulation of nursing education programs by the INC led to the formalization of seven programs with varying nursing designations including: ANM, General Nurse Midwife
(GNM), Bachelor of Science in Nursing Basic (BSc.), Bachelor of Science in Nursing Post Basic (BSc.), Masters of Science in Nursing (MSc.), Masters of Philosophy in Nursing (MPhil.) and Doctorate of Nursing (PhD) (INC, 2014; Tiwari et al., 2013).

ANM and GNM education programs are 18 months and three and a half years long respectively. ANMs work in community health centers, while GNMs work in primary health centers (i.e., hospitals) (INC, 2014; Tiwari et al., 2013). The BSc. program is four years long and graduates have been typically employed as nurse educators (i.e., that is teachers in schools of nursing) rather than as staff nurses. The MSc. and PhD programs in India are two and five years long respectively and graduates primarily occupy teaching, leadership and administrative roles (INC; Tiwari et al.). However, in the Punjab, the leadership and administrative roles are primarily within nursing education, as opposed to positions within nursing practice or policy.

Within the MSc. program, nurses select a specialty population in which they will concentrate their education. The possible specialties include: medical-surgical, pediatrics, obstetrics and gynecology, mental health and community nursing (INC, 2014). According to the INC, the MSc. program prepares nurses to function as nurse specialists, consultants, educators, administrators and researchers in a variety of professional settings to meet societal needs and national priorities (INC). The anticipated functions of an MSc. prepared nurse are not associated with protected titles or explicit responsibilities, allowing for variability in role enactment.

The International Council of Nurses defines advanced practice nursing as registered nurses with expert knowledge, complex decision-making skills, and expanded clinical competencies, as influenced by the context or country where they are credentialed to practice (Sheer & Kam Yuet Wong, 2008). A master’s level degree is recommended for entry level to an advanced practice role. Although specific advanced practice nursing roles have been
differentiated including nurse practitioner (NP), clinical nurse specialist (CNS), nurse anesthetist, nurse midwife and case manager, the United States is likely the only country to have developed all five roles (Sheer & Kam Yuet Wong). Although the International Council of Nurses provides opportunity for countries to interpret the definition of advanced practice nursing as relevant to their healthcare context, India has yet to adopt and regulate defined advanced practice roles.

### 2.3 The Effect of Indian Trained Nurse Migration

India is amongst the top five countries to export nurses, and as a result has reported a workforce ‘crisis’ (Rao et al., 2013; Twigg & McCullough, 2014; Walker, 2010; WHO, 2006). International migration offers economic and social benefits, and escape from traditional obligations within Indian culture (Johnson et al., 2014; Walker). The potential for international migration with a nursing degree is attractive and outweighs low salaries, poor working conditions and perceived lack of career opportunities in India (Johnson et al.). As a result, an increasing number of young Indians from a range of classes, castes, religions, gender and economic backgrounds have enrolled in nursing programs (Johnson et al.). However, the migration of nurses amplifies India’s nursing shortage and imposes financial stress on a health care system already burdened with educating more people (Johnson et al.; Walker).

Although nurse migration is believed to have poorly contributed to nursing’s professional identity within India, Johnson et al. (2014) suggest that nurse migration can positively affect nursing’s identity in India. Migration has made nursing more visible and attractive. Thus, there is opportunity to advertise nursing’s professional profile, while enhancing the status of women. Sheer and Kam Yuet Wong (2008) suggest that the rate at which the advancement of nursing practice occurs is related to the perceived status of nursing and women. Therefore, as migration
supports a renewal of nursing’s identity in India, there are further opportunities to improve the professional status of nurses.

2.4 Nurses’ Roles in Rural Environments

Bushy (2002) investigated rural healthcare settings in Canada, the United States of America and Australia, and noted many similarities across the globe. One notable trend amongst rural settings is a lack of qualified physicians. The WHO (2012b) suggests that when a country’s population distribution is evenly divided amongst rural/remote areas and urban locations, 76% of physicians service urban communities, while 24% of physicians provide care in rural/remote areas. A second commonality amongst rural health care settings is nurses’ inherited role as an ‘expert generalist’ (Bushy). To meet the medical needs of under-served regions, nurses are tasked with functioning as the primary care giver. Furthermore, a third global occurrence amongst rural locations is nurses’ expanded and advanced scope of practice, often without regulation (Bushy). This leads to a fourth trend in rural health care; nurses’ greater autonomy and role overlap with physicians. Challenges to delineating profession-specific responsibilities develop as role expectations are lost and job descriptions become ambiguous (Bushy). These global trends are readily observed throughout India’s rural healthcare settings.

In rural India, nurses’ scope of practice is dependent upon the area and the availability of physicians (Sharma et al., 2013). Nursing practice is ‘circumstance driven’ due to an unclear scope of practice. Sharma et al. categorize rural nurses’ practice as compelled practice. Compelled practice refers to unendorsed yet extended practice, undertaken due to the circumstance and may involve complex procedures (Sharma et al.). Nurses often engage in compelled practice during the most difficult circumstances. In addition, in rural India, flexible and inflexible boundaries of a nurses’ scope of practice are not explicit.
For example, with the objective of understanding the scope of maternity care provided by staff nurses in rural India, Sharma et al. (2013) interviewed staff nurses, midwives, physicians, obstetricians, nursing school principals and nursing school teachers at five different rural hospitals. The five hospitals represented three levels of care within the public health system including: a tertiary hospital, a district hospital and a community health center. The interviews revealed that none of the participants in the study, despite their designated profession, had a written job description (Sharma et al.). Furthermore, none of the health care facilities had written protocols outlining profession-specific actions or responsibilities during procedures (Sharma et al.).

Iyengar and Iyengar (2009) also studied nurses’ experiences in rural health centers in Rajasthan, northern India. Their findings indicated that the nurses independently detected and managed obstetric related complications and when required, contacted a doctor through telephone consultation. Of the 2,771 women who presented in labour at the health center during the study, nurses detected complications in 575 women (Iyengar & Iyengar). This included 324 women with maternal complications and 251 women with fetal complications (Iyengar & Iyengar). Complications managed by the nurses included: antepartum hemorrhage, severe anemia, obstructed labour and antecedent conditions, pregnancy induced hypertension, twin pregnancy, complicated abortion, puerperal fever, and post-partum hemorrhage. The nurses also provided lifesaving treatment such as administering intravenous fluids, magnesium sulphate, antibiotics, oxytoxics after delivery and using ovum forceps for evacuating products of conception. Although a gynecologist visited the health centers once or twice a week, on these days, women in active labour were managed under the guidance of a nurse (Iyengar & Iyengar).
The phenomenon of *compelled practice* is also evident in Iyengar and Iyengar’s (2009) study, as initially nurses referred all women with twin pregnancy to the nearest urban hospital. However, as new circumstances arose when families refused hospital referrals, nurses at the rural health center began managing twin pregnancies. With repeated exposure to twin deliveries, and absent limitations on scope of practice, the nurses’ confidence grew and they began managing twin pregnancies independently (Iyengar & Iyengar).

Although these studies reveal that nurses provide advanced levels of care, the roles and responsibilities at each health centre and in each rural location vary. Throughout India, doctors occupy health care management positions and are recognized by the state, law and society as the primary care givers (Sharma et al., 2013). Although nurses enact an advanced role in rural settings, the provision of care and health outcomes is attributed to the physicians’ knowledge and skills. Consequently, to challenge the public’s perception of nursing and positively influence its professional identity, nurses’ roles and responsibilities must be made explicit (Mackay, 2007; Sharma et al.).

### 2.5 Governance, Accountability and Conceptualizations of the Nursing Profession

The establishment, promotion and enforcement of standards specifying nurses’ practice and roles, cultivates public trust (CNA, 2003). Furthermore, the perceived status of nursing and the need for healthcare services are two factors that influence the advancement of nursing practice (Sheer & Kam Yuet Wong, 2008). Mackay (2007) suggests that when national nursing councils articulate nurses’ roles and responsibilities, the profession’s credibility is strengthened, and development of the profession is supported. The CNA, the International Council of Nurses and the College of Registered Nurses of British Columbia (CRNBC) share a similar
understanding of nurses’ roles, while the perspective articulated by the INC and the state nursing councils is somewhat different.

2.5.1 International Council of Nurses

At a global level, the International Council of Nurses regulates nursing care and sound health policies (International Council of Nurses, 2013a). The International Council of Nurses defines nursing as both autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings (International Council of Nurses, 2013b). Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people (International Council of Nurses, 2013b). Advocacy, promotion of safety, research, education, and participation in health policy and health systems management are also key nursing roles (International Council of Nurses, 2012b; International Council of Nurses, 2013b).

Mackay (2007) suggested that standards, expectations and a defined scope of practice foster accountability on behalf of nurses, trust amongst the public and continued advancement of the profession. Under the CNA and International Council of Nurses respectively, nursing practice has evolved and both bodies regulate advanced practice nursing roles (CNA, 2007; Sheer & Kam Yuet Wong, 2008). When regulating bodies clearly articulate the roles and responsibilities of nurses, they ascertain which activities are within the domain of nursing, and when further consultation and expertise is appropriate to meet the patient’s needs (CNA, 2003). Furthermore, nursing care is safeguarded, and opportunities for innovative role development are highlighted.

Moreover, Mackay (2007) states that lack of role clarity and absence of professional identity impedes nursing’s professional development and advancement of practice. Within the
INC, “protected titles” are lacking and formalized advanced practice nursing roles are absent (Kruth, 2013; Rao et al., 2013). Considering India’s long-standing state of unmet healthcare needs, the scarcity of rural-located physicians and rising healthcare costs, changes to health care delivery are inevitable (Rao et al.; Sheer & Kam Yuet Wong, 2008). The need to understand nurses’ roles and responsibilities are necessary, as the implementation of advanced practice nursing roles await regulation.

2.5.2 Indian Nursing Council

The INC regulates nurses and nursing practice throughout India. The primary function of the council is to establish and monitor a standardized education curriculum for nurses, midwives and ANMs throughout India (INC, 2014). Furthermore, the INC provides approval for Indian and Foreign trained nurses for the purposes of registration and employment in India and abroad (INC). In addition, the council outlines a code of ethics and guidelines for professional conduct. A formal document legislating the roles and responsibilities of a nurse does not exist (i.e., scope of practice). The council’s definition of a nurse is restricted to their educational achievements and nursing’s contributions to the health of populations are not explicit. When compared to the CNA and the International Council of Nurses, the INC appreciates the role of a nurse within conservative boundaries.

2.5.3 Canadian Nurses Association

The definition of nursing practice in Canada, by the CNA, extends beyond nursing education curriculum. The CNA is committed to guiding and advancing nursing excellence to support the safety and wellbeing of patients and positive health outcomes in the public interest (CNA, 2007). The CNA defines a registered nurse (RN) as a self-regulated health care professional who supports individuals, families, groups, communities and populations to achieve
their optimal level of health. RNs coordinate health care, deliver direct services and support clients in their decisions regardless of their age and throughout each stage of life (CNA). Furthermore, RNs have capacity to influence the health care system through direct practice, education, administration, research and policy (CNA). The International Council of Nurses adheres to a similar understanding of nurses.

2.5.4 State Nursing Councils in India

At the state level in India, nursing councils are established that work as autonomous bodies under the government and are monitored by the INC (Karnataka State Nursing Council, 2008). The specific functions of the council vary according to the state; however, primary roles include: maintaining the uniform standard of nursing education; conducting qualifying examinations for the various nursing designations; providing practice registrations for qualified nurses; accrediting training institutions; and managing poor practice and unprofessional nursing conduct (Karnataka State Nursing Council).

2.5.5 College of Registered Nurses of British Columbia

At the provincial level in Canada, regulatory nursing bodies are established. Regulation protects the public and supports best practice amongst nurses by ensuring that nursing care is competent, ethical and upholds societal standards (CRNBC, 2014). The CRNBC is a self-governing body under the Health Professions Act that regulates the practice of 40,000 registered nurses and nurse practitioners in British Columbia (BC). The CRNBC establishes, monitors and enforces standards of practice, requirements for registration, inquiry and discipline procedures, and nursing education programs in BC. Nurses are required to renew their registration annually and commit to ensuring their knowledge and skills align with evidence-based recommendations (CRNBC).
Five pillars guiding the CRNBC (2014) include: a just culture, right-touch regulation, collaborative self-regulation, principle-based approach and continuing professional development. According to the CRNBC, ‘continuing professional development’ is comprised of three interdependent activities: practice, continuous learning and professional development. As a regulator, the CRNBC is responsible for promoting professional practice and providing opportunities for education that enhance nurses’ knowledge, skills and attitudes.

2.6 Summary

India’s current health care system is not adequately resourcing the country. Nurses in India have the potential to support the revitalization of health care, but only if scope of practice and clear job descriptions are established. This will also contribute to a better understanding of a nurse’s role by the public, which in turn will contribute to more informed expectations and trust. To support current nursing practice and foster the advancement of the nursing profession, it is necessary to investigate and understand the roles and responsibilities of staff nurses in rural India and identify their needs and opportunities for continued education and development.
Chapter 3: Methods

The purpose of this research study was to investigate the continuing education needs of staff nurses working in a hospital environment in a rural area of Punjab, India. This chapter outlines the research methods for the study including the sampling strategy and data collection used in the original study, and an explanation of interpretive description analytic methods used in this study, including strategies to achieve rigor and ethical considerations. The study benefits and limitations are also addressed.

3.1 Research Design

The UBCSoN and the BFUHS in Faridkot, Punjab, India have had an ongoing partnership since September 2011 aimed at advancing nursing education, research and practice in both India and Canada. A collaborative research study aimed at investigating the roles and responsibilities of staff nurses at GGSH, of the BFUHS was conducted in April 2014. This qualitative study is a secondary analysis of data collected for the original study.

3.2 Source of Data (Setting and Sample)

Convenience sampling was used. Inclusion criteria for the sample included health care professionals employed at GGSH, who were comfortable participating in an English-speaking interview and familiar with the role of a staff nurse. All participants from the original study were included in the secondary analysis.

Ethics approval was received from the University of British Columbia Behavioural Research Ethics Board and the Ethics Committee at BFUHS prior to the commencement of the study. Ethics approval for the secondary analysis was also obtained from the University of British Columbia Behavioural Research Ethics Board.
3.2.1 Recruitment

Researchers from the UBCSoN delivered a presentation about the research study to the nursing faculty at BFUHS. Recruitment posters were available to all specialty departments at GGSH, and healthcare providers had eight days to opt-in to participate in the study, as the research team was then returning to Canada.

Interested participants spoke with nursing faculty at BFUHS, who confirmed that participants met eligibility criteria and scheduled a time for the focus group interview. Written consent was received from each participant prior to beginning the focus group. The final sample consisted of 17 participants, 6 physicians and 11 nurses. Eight nurses had completed their Bachelor of Science degree in nursing, and three nurses had received their diploma in general nursing and midwifery. The participants’ years of experience in their profession ranged from three months to 12 years.

3.3 Data Collection Procedures

Canadian research team members conducted focus group interviews at GGSH. The five focus groups occurred over a period of three days and on each day a different multi-purpose room at GGSH was assigned for the focus groups. Each room was located off a main corridor and each focus group took place in the morning. Although the door to the room was closed, considering the similar time of day for the focus groups, the amount of background noise from the corridors was relatively consistent. Each focus group was comprised of two to six participants, two researchers and lasted between 30 to 60 minutes. At the beginning of each focus group, the researcher explained the purpose of the interview and ensured voluntary informed consent. A researcher conducted the focus groups using a semi-structured interview guide with open-ended questions designed to elicit an understanding of nurses’ roles and
responsibilities within the hospital setting. Each focus group was audio recorded and the interviewer composed written notes throughout. After each focus group, the researchers collaborated, reflected and documented field notes, capturing their analysis of the representativeness of the sample population and their decisions to modify research questions. Upon returning to Canada, the audio recordings were transcribed verbatim by two of the researchers and written transcripts were prepared. Identifiable information was removed and participants were assigned a unique participant code such as Participant #1, and Participant #2. Upon completion of the written transcripts, a member of the research team verified each transcript against the audio-recordings for accuracy. The written transcripts from the original study were used to conduct the secondary analysis.

### 3.4 Data Analysis

Secondary analysis of the data (i.e., transcripts of the focus group interviews) was conducted using interpretive description. Transcripts were reviewed and coded by the research team to identify ‘themes’ that were common across the focus groups. Data were coded using N-Vivo, a qualitative data analysis software application that is used to organize data, and analyzed iteratively. Data analysis occurred in collaboration with the writer’s supervisory committee. Demographic data were used to describe the sample and assisted with interpretation of some of the findings from the qualitative data.

#### 3.4.1 Interpretive Description

The primary goal of interpretive description is to generate knowledge relevant to the clinical context of health disciplines (Hunt, 2009; Thorne, 2008; Thorne, Reimer Kirkham & O’Flynn-Magee, 2004). Interpretative description differs from other qualitative methods and attempts to uncover thematic patterns and variations, believed to characterize the phenomenon of
interest (Hunt; Thorne; Thorne et al.). While original qualitative studies attempt to generate new knowledge, the results of an interpretive description do not represent new truths, but rather a truth claim regarding a clinical phenomenon (Thorne).

In qualitative research studies, data collection often occurs through participant interviews and observations (Hunt, 2009; Thorne, 2008). Interpretive description methodology also uses interviews and observations, in addition to collateral data sources to strengthen the evidence and support the evolution of nursing knowledge (Thorne; Thorne, Reimer Kirkham & MacDonald-Emes, 1997). Thorne uses the term “construction” in relation to data collection processes in interpretive description. “Construction” captures the researcher’s active role in influencing the data included in the research study (Thorne). Researchers using interpretative description methodology are encouraged to document field notes after each focus group/interview. The field notes inform the subsequent focus groups/interviews and provide a clear audit trail to record the process of data collection, leading to the data analysis (Thorne).

Data for the secondary analysis were coded using N-Vivo software. To prevent premature coding, data with similar properties and themes were grouped with broad initial codes to help organize the data, without being restrictive. Thorne (2008) suggests that initial codes may bring thematically related data together. Examples of initial codes included: requirement for continuing education, education-practice gap, and physician as nurse educator. The initial codes helped the researchers understand the data, while assessing relationships and discrepancies between codes. The initial codes also provided insight into the evolving data analysis. As the analysis progressed, the codes were organized by the following questions:

1. How well does basic nursing education inform nursing practice?
2. What are the educational needs of staff nurses?
3. How are continuing education needs of staff nurses addressed?

Similar to the coding process, appropriate methods were employed during the data analysis to confirm identified patterns and relationships amongst the data.

### 3.5 Strategies to Achieve Rigour

Quality criteria are essential to support the credibility of a qualitative study (Thorne, 2008). The criteria used to achieve rigour in this study included: representative credibility, analytic logic, and disciplinary relevance.

#### 3.5.1 Representative Credibility

Representative credibility suggests that knowledge claims and inferences from a study are thoughtfully constructed within the context of the phenomenon being explored (Thorne, 2008). Considering that nursing education is being studied within the context of India, a cross-cultural inference must be made cautiously, and universal inferences across all cultures will not be attempted. Furthermore, recommendations for practice will be suggested, and nurses from India will have the opportunity to inform the recommendations, considering their understanding of the context of nursing in India.

#### 3.5.2 Analytic Logic

Analytic logic refers to process that makes explicit the reasoning of the researcher, through to the interpretations and knowledge claims made on the basis of what has been learnt through the research (Thorne, 2008). In this study, an audit trail comprised of reflections and field notes were recorded during the coding process and throughout the data analysis. These notes supported the researcher’s reasoning and logic behind establishing data codes, and the evolution of thematic patterns and relationships.
3.5.3 **Disciplinary Relevance**

Disciplinary relevance refers to the appropriateness of the knowledge generated by the study to continue the development of the disciplinary science (Thorne, 2008). Currently in India, there are no requirements for continuing nursing education. However, to support the advancement of the profession and evolution of advanced practice roles an understanding of nurses’ education needs is required and may lay the foundation for where and how this work can or should begin.

3.6 **Ethical Considerations**

Prior to beginning the research study, ethics approval was received from the University of British Columbia Behavioural Research Ethics Board. The original study received approval from University of British Columbia Behavioural Research Ethics Board and the Ethics Committee at the Baba Farid University of Health Sciences in Faridkot, Punjab, India. To ensure participant protection throughout the duration of the study, the following considerations were adhered to in the original study:

1. All potential participants were informed verbally, and in writing, of the study’s purpose, the data collection procedures, and the voluntary nature of their participation in the study.
2. The researchers and the potential participants mutually agreed on dates, times, and locations for the focus group interviews.
3. At the time of the interviews, all participants were informed verbally and in writing that participation was voluntary and withdrawal from the study could occur at any time.
4. At the time of the scheduled focus group, prior to beginning the interview, the researcher reviewed the consent form and the study procedures with the participants. The participants could choose to sign the consent form, indicating their participation in the
study or choose to not participate.

5. Only those participants who signed the consent form were included in the focus groups. Participants were told they had the option to not answer a question(s) during the interview and that they could withdraw from the study at any point during the interview, without repercussion.

6. Upon completion of the focus groups, computer files holding the recorded interviews were password protected and only the research team, as identified in the proposal, had access to the data. Participants’ names were not included in the transcribed data and no individual identifiers or data were reported in the findings.

7. The audio-recordings and digital files will be erased at completion of the five-year storage period. Paper documents associated with the study will also be shredded in a confidential shredder at the end of the five-year storage period.

8. For this study, ethics approval was again received from University of British Columbia Behavioural Research Ethics Board and the written transcripts were used in their original form, without modifications to the participants’ responses.
Chapter 4: Findings

In this chapter, details of how nurses’ preparation from their basic nursing education inform practice in a rural hospital setting in Punjab, India is provided. These findings are based on nurses’ and physicians’ experiences in the clinical setting and the interpretations from the data. Considering three of the 11 nurses interviewed are GNM-prepared versus BSc. prepared, and two different education curriculums are used for the designations, basic nursing education refers to nurses’ initial education required for completion of the GNM and BSc. programs, as determined by the INC.

Demographic characteristics of the study participants are presented in Table 1. All study participants were employed as either a physician or a staff nurse at GGSH. Of the 17 participants, 13 were female and 4 were male. The sample included 11 staff nurses and 6 physicians with degrees ranging from GNM diploma, Bachelor of Science in Nursing (BScN), Bachelor of Medicine and Surgery (MBBS) and Doctor of Medicine (MD). The mean number of years of experience in the role of a nurse or a doctor was 3.6 years.
Themes and subthemes are presented from the transcribed data, which was collected during the primary research focus group interviews using Interpretive Description methodology. The initial phases of data analysis identified 27 broad-based codes. Patterns amongst the 27 codes were analyzed, revealing 11 subthemes. Relationships between the subthemes were reviewed, generating 3 main themes. The themes presented are: task-driven, unpreparedness and advanced practice. The themes and associated subthemes are presented in Table 2.
4.1 Task-driven

The analysis of collected data suggests that basic nursing education emphasizes the importance and necessity that nurses complete tasks. For the purposes of this study, “task” is understood as work nurses complete to ensure patient care requirements are attended to either directly or indirectly. Tasks require independent nursing judgment and knowledge, based on nursing expertise, to ensure patient care decisions are adapted to the individual patient and the context of the clinical environment (Glazer, 2000). As nurses described their roles and responsibilities within a clinical setting and physicians affirmed the nurses’ roles, the theme of task-driven evolved.

4.1.1 Nurse as Task Manager and Scope of Practice

A subtheme within task-driven is nurse as task-manager. Throughout the focus group interviews, nurse participants identified their role and responsibilities by tasks they attended to and completed. This role description was not localized to one department of the hospital, but was a consistent response from nurses across a range of inpatient wards at GGSH. Furthermore, nurses’ conceptualization of their task-manager role influenced how they perceived their contributions within the healthcare team. Nurses used phrases including ‘backbone of the healthcare team’ and ‘the hospital is nothing without us’ to emphasize their added value to the
team and the hospital. These comments were interpreted as the healthcare team’s dependence
upon nurses to complete tasks and ensure patient care is attended to. A nurse described her roles
and responsibilities when patients are admitted to the intensive care unit as follows:

“Firstly we check the vital signs, and we also do the medicine of the patient and do the
daily care, like back care, mouth care and all that care that patient needs.” (Interview 2,
March 27th, 2014)

A nurse from the medicine unit described her patient admission duties as:

“Monitoring the patient, checking their vitals, doing their medications, then maintaining
the cleanliness, patient should be clean, ward should be proper.” (Interview 4, March 31st,
2014)

A nurse from the surgical unit offered a similar representation of a nurse’s role:

“Firstly when we come in on duty in mornings, firstly we maintain the wards, thika
[okay], teach the patient for personal hygiene and dressings and maintain biohazard and
provide information to the patient’s relatives and the other responsibilities pre-op, like
she said, prepare the patients in early morning, shaving areas, then give pre-op injectables
and after that vital signs…” (Interview 2, March 27th, 2014)

A nurse from the pediatric unit shared her description of a nurse’s role:

“Firstly we check vital signs. Then if patient need to oxygen administration, then we will
administer oxygen, then IV fluids, sample taking, inform the doctor.” (Interview 3,
March 30th, 2014)

The above statements offer a consistent representation of nurses’ roles and
responsibilities in terms of managing tasks. Evidence to support this perspective is observed in a
nurse’s explanation of the repercussion associated with incomplete biomedical waste duties:
Nurse: “We are going to be blamed, nurses are going to be blamed.”

Interviewer: “[The responsibility] comes back on the nurses if something goes wrong?”

Nurse: “Yes.” (Interview 2, March 27th, 2014)

The anticipated blame associated with task incompletion, suggests that tasks are associated with the title “nurse” and nurses are accountable to fulfill these duties. The reports of nurses’ task completion appear to resemble a checklist, each awaiting a checkmark in the adjacent box. The presence of a checkmark equates with satisfaction on behalf of the healthcare team.

The association of nurses with tasks also appears to influence the allocation of non-nursing tasks as a default-nursing role. Biomedical waste segregation, although a joint responsibility amongst patients, families and the healthcare team, appeared to be translated into nursing’s responsibility. The following statement supports this claim:

“The main thing is that the biomedical waste management is not only the responsibility of the nurses it is the joint responsibility of all the health care team members, whether it is a sweeper, whether it is doctor. It is written in the biomedical waste management, the person who will create the waste, if he or she is a doctor or he or she is a nurse then he will only destroy the waste, but generally it is the responsibility of the nurses only.”

(Interview 2, March 27th, 2014)

Although a shared responsibility, nurses assume primary ownership for biomedical waste segregation. The nurses did not state why they are charged with primary responsibility; however, they indicated their preference to not discuss this matter with physicians at the hospital. Considering the overwhelming number of tasks within a hospital environment, it appears that tasks within the clinical setting are considered nurses’ responsibility.
Physicians also describe the role of a staff nurse in terms of tasks. This description suggests their dependence upon nurses to ensure patient care is complete.

“[Nurses] first they monitor all the patients vitals, vital monitoring, which be done by all the staff nurses.…” (Interview 3, March 30th, 2014)

“Whatever the patient who is coming, the basic nursing has to be with the staff nurse only, she is handling the patient, she is in charge of the admitting, she is providing the routine care, she is also changing the linens, in order to prevent sore whatever and executing orders given by the doctors.” (Interview 1, March 26th, 2014)

“I just want to say nurses they are most responsible first and fore for the ward, they are most responsible for the patient, for the care of the patient … It depend on the nurse what she will do for the patient. For example, if nurse is not responsible, the patient will die soon. If nurse is responsible for her work maybe patient will live, not die.” (Interview 3, March 30th, 2014)

The physicians’ remarks demonstrate their understanding of nurses’ essential role and reveal their expectations of nurses. The similar conceptualizations of nurses’ roles amongst physicians and nurse participants suggests that nursing education may shape nurses’ perceptions of their role by emphasizing the importance of task completion.

Nurses’ ability to complete tasks appears to support physicians through staffing shortages in rural Punjab. An excerpt from a physician illustrates this point:

“Like if the patient is dying at that spot and we take some time to came it’s only the staff nurse that is going to resuscitate the patient at that spot. Most doctors may, late for some time, and it’s only staff nurse that is going to intubate, sometimes we train the staff nurse like this, they can intubate the patient at the spot.” (Interview 3, March 30th, 2014)
Intubation is an advanced skill completed by physicians, respiratory therapists and nursing professionals with certified training in North America. In India, intubation is a task nurses complete, at times, to meet patient needs and bridge the void in physician absence. Physicians instruct nurses regarding the technical procedure for intubation, as this skill is not a component of nurses’ basic education. The apparent need for advanced skills training during basic nursing education led to the development of the subsequent subtheme.

4.1.2 Basic Nursing Education

The subtheme basic nursing education emerged as nurses described the tasks they complete when providing emergency and non-emergency care. Nurses’ actions are guided by the principle that patients do not experience harm; therefore, they function to optimize safe patient care and patient survival. One of the nurse participants illustrated this standard in her comment:

“We can’t put the patient’s life at risk … and that is because [we] have learnt that from school, that [we] need to start the oxygen right away.” (Interview 2, March 27th, 2014)

Another staff nurse participant reported:

“Because ultimately we have one goal to save the child, huna [isn’t it?], so that’s why we perform independently those things [emergency care].” (Interview 1, March 26th, 2014)

These nurses’ comments suggest that basic nursing education teaches the impact of nurses’ skills and knowledge on patient outcomes, and a primary function of nurses’ work is to minimize patient harm. A physician participant also affirmed the goal of nurses’ actions:

“I am just telling you about if some emergency need is there, new nurse can take her decision or his decision for the life of the patient. She can also take.” (Interview 3, March 30th, 2014)
Physicians appear to perceive nurses as individuals capable of completing tasks, regardless of nature or complexity. However, the tasks taught during basic nursing education, and the tasks physicians expect nurses to fulfill in a clinical setting appear misaligned. Physicians are aware of their dependence on nurses, and evidenced this reliance through statements including:

“Without staff nurses, hospital would not work at all.” (Interview 3, March 30th, 2014)

Physicians attempt to capitalize on the instruction received by nurses during their basic education and rely on nurses’ basic knowledge to stabilize patients and at times, provide initial emergency care. As one nurse stated:

“Sometimes some conditions, patient will be arrest, and then we will start CPR immediately and give atropine. Given through the IV [intravenous] given to patient and then inform to doctor and doctor comes and extra orders to carry out.” (Interview 2, March 27th, 2014)

A physician shared his dependence on nurses to prescribe and administer appropriate medications:

“For example, I have seen the patient and I have decided to give some treatment and I had given and I’m gone. And now the responsibility depends on the nurse. For example, I have given some treatment but now patient has some other symptom or sign. It is also duty of a nurse to give, if she has some knowledge about that sign or symptoms, she can also give some medicine or she can call her higher command for example, dear doctors and decide to take a treatment.” (Interview 3, March 30th, 2014)

The challenge within the physician-imposed expectation to provide medication based on knowledge is revealed in nurses’ education. Basic nursing education teaches medication management as a nursing task. Furthermore, nurses are taught prescribed medications and
dosages for administration based upon specific clinical presentations. The following interview exchange describes a clinical scenario where a patient developed a blood transfusion reaction and the nurse was preparing to administer medications.

Interviewer: “So how do you know how much medication to give?”

Nurse: “Yes, we know the dose, injection phenamine one ampoule and injection hydrocortisone 100mg.”

Interviewer: “Who taught you that?”

Nurse: “I have studied when I was doing BSc. nursing.”

Interviewer: “There is no protocol or policy?”

Nurse: “No, there is no such policy.” (Interview 2, March 27th, 2014)

Considering nurses’ ability to correctly administer medications in the above scenario, physicians appear to assume that nurses have sufficient knowledge to navigate and intervene in new clinical situations without consultation. Although nurses gain knowledge during their basic education, their ability to critically examine and translate knowledge to a different patient presentation appears limited. This impression is evidenced in nurses’ initial emergency management of patients. One nurse explained her lack of understanding when a patient arrested and prescribed interventions did not lead to anticipated outcomes.

“Like patient is going in arrest, cardiac arrest, then no doctor is available and we don’t understand what to do. We will give oxygen, check the vitals then nothing, is problem, no pulse then what to do. We can give atropine, that no effect. We cannot declare patient, that’s why then we feel uncomfortable.” (Interview 4, March 31st, 2014)

Basic nursing education appears to teach normal versus abnormal, and expected versus unexpected outcomes. However, nursing tasks appear to be memorized in accordance with
specific patient presentations. Yet, nurses appear to understand that with continued education, their ability to critically think and expand their scope of practice is possible. This is evidenced in the following statements:

“But we need education we don’t know the rationale behind it [nursing tasks].”

(Interview 4, March 31st, 2014)

“Like one time I asked them to conduct some seminars or like some lecture studies … [T]hat I want to be improved so that our knowledge will be updated….” (Interview 5, March 31st, 2014).

Nurses’ awareness for the necessity of continuing education demonstrates initial development of critical thinking. These comments reveal nurses understanding that education focused on tasks is limited, and continuing education creates opportunity to improve their support in the clinical environment.

4.2 Unpreparedness

Through reflection and continued data analysis, the theme of unpreparedness evolved. This theme reflected nurses’ unpreparedness from their basic education for practice in the clinical setting. The following three sub-themes contributed to the development of the theme: physician as nurse educator, staff nurse fear and staff nurse requests and unidentified critical thinking.

4.2.1 Physician as Nurse Educator

Despite the established hierarchy between physicians and nurses in India, both nurse and physician participants described a mutually beneficial relationship amongst the two professions. Evidence of this rapport became apparent through words used to describe the health care team.
Nurses and physicians both referenced their relationships amongst the health care team as a “family”, “team” and “teamwork”. One nurse explained:

“We are working as a team, not individually as a nurse or a doctor.” (Interview 5, March 31st, 2014)

Physicians share a similar perspective and offer greater support for the camaraderie amongst the health care team:

“Doctor alone can’t do anything in hospital, nurse alone can’t do anything in the hospital. Every man is needed, so it’s a teamwork.” (Interview 3, March 30th, 2014)

Another physician noted:

Physician: “Actually sometimes this hierarchy is followed not every time.”

Interviewer: “So not very strict.”

Physician: “No not strict, because our thinking is this hierarchy should not harm the working of the hospital or management of the patient, so if everyone running of the um, um management of the patients. First idea is to management of the patient, rather than follow hierarchy.” (Interview 1, March 26th, 2014)

The physicians’ decision to resist hierarchy at the expense of patient care provides continued support for the physician’s adopted role as a nurse educator. Considering the absence of a nurse educator at GGSH, nurses and physicians both attested to physician involvement in nursing education. ‘In the moment’ physician education translates as a compensatory mechanism for inadequate preparation during basic nursing education. One nurse stated:

“The doctor behave good with us and like they also teach us…[I]f they are interested to teach us only, they will teach us and support us in this manner because they want from us
to work in better manner, in this way I think doctors support us because they want good care of the patient from us.” (Interview 2, March 27th, 2014)

A physician explained his motivation in providing nurse education:

“Physicians or are senior they just came to visit patient at the first time, they take this at the first time, what to do, but after that but after that nurse is the care for the patient…We [physicians] are giving [education] for just, for their [nurses] care, warning, caution. Maybe if this can happen so what you can do there.” (Interview 3, March 30th, 2014)

The physicians’ adopted role as nurse educator suggests awareness of their dependence upon nurses to meet role expectations and responsibilities. Physicians’ willingness to teach nurses demonstrates their inherent trust and acknowledges their understanding of nurses’ potential scope of practice. As a result, components of the education provided by physicians are outside nurses’ domains of knowledge, as taught during their basic nursing education. This phenomenon is observed in teaching nurses how to perform advanced medical procedures. One nurse reported:

“During BSc. we will just learn NG [nasogastric], NG during degree time. Intubation [endotrachial] is done after, during this period.” (Interview 5, March 31st, 2014)

In the above example, “NG” is the abbreviated form of nasogastric, referring to a nasogastric tube. This tube is inserted through the nose, past the throat, and ends in the stomach. The primary purpose of this tube is for feeding and drug administration (Mosby’s Online). “This period” is interpreted as after graduation from the nurse’s basic nursing education, based on the context of the interview question. Although intubation is taught upon completion of basic nursing education, according to physicians, based on the hospital system alone, nurses require the skill of intubation to support patient care. One physician stated:
“Most doctors may late for some time, and it’s only staff nurse that is going to intubate, sometimes we train the staff nurse like they, they can intubate the patient at the spot.”

(Interview 3, March 30th, 2014)

Nurses echo this account of being taught intubation and also report additional skills taught by physicians, including central line insertion, as reported below.

“And some procedures like central line insertion and intubation, the doctor teaches us.”

(Interview 2, March 27th, 2014)

“Like sometimes baby extubate from endotracheal tube so they can teach us how to check the position of the tube, is it out or is it in.” (Interview 1, March 26th, 2014)

“Yes ma’am they [physicians] also help us to like, in many cases like if there is intubation, intubation they also guide us....” (Interview 5, March 31st, 2014)

In addition to emergency life-saving measures, physicians provide practical knowledge to nurses. According to physician participants, nurses receive adequate theoretical knowledge during their basic nursing education, but lack knowledge for practice in the clinical setting. One physician reported:

“We used to give them practical knowledge, theoretical knowledge they are qualified already. They are working after their qualification completion. Some practical knowledge drug dose calculation, um how to make formula huna [isn’t it?] and how to calculate calories for patients and practically what problems they will face when they give education of dietary and drugs to solve that problems and sometimes immediately management like sometimes patient has drug reaction to what should be done at that particular moment.” (Interview 1, March 26th, 2014)
Nurses also describe the pharmacology and the pathophysiology education provided by physicians:

“They will teach us what the reaction of the drug is, we don’t know, then they will tell us, we will ask them, they tell us about the action, how this drug acted on the patient and the benefit the patient will take from this drug.” (Interview 2, March 27th, 2014)

Interviewer: “Can you think of an example of a question that you might have asked?”

Nurse: “Yes we have patients in the ward that are, that is taking aminoglycosides. And one day he will stop it then we will, I asked Dr. ___ why we have stopped it. Then he say all the pathophysiology why we are stopping this and when we will start it, then he will answer all the questions.” (Interview 4, March 31st, 2014)

The interpretation of the education provided by physicians appears to reinforce inattention towards the context of clinical practice within basic nursing curriculum. Thus, examples of physician led education suggest that nurses lack knowledge necessary for effective practice. Although nurses are educated to function in one capacity, within the clinical setting they appear unprepared for aspects of their actual role. Thus, the role of the physician as nurse educator appears to be a reactive response towards unpreparedness.

4.2.2 Staff Nurse Fear and Staff Nurse Requests

Nurses’ unpreparedness for clinical practice is further revealed in the subtheme staff nurse fear and staff nurse requests. Nurses’ expressed fears and their requests for continuing education appear as possible outcomes when nurses are unprepared for clinical practice. The excerpts below provide insight into the fear and distress nurse participants experienced:

“Sometimes when patient condition is very serious, and nobody it’s not possible [is available], the doctor’s not there. Sometimes if any conditions happen then we will fear
to how to handle … If doctor’s not here, then we will face problems.” (Interview 5, March 31st, 2014)

The potential for nurses to work alone, without support from other nurse or physician colleagues, is reality for nurses at GGSH. Nurse and physician participants both reported “an extreme shortage of staff” at GGSH, translating into one nurse being responsible for a 20-bed hospital ward. At times, the most readily available resource is a nurse colleague who has completed his or her shift and left the hospital, but is available through cell phone.

Nurse: “Otherwise we have our cell phones, any doubt they have they [nurses] can ask us any time because we are not supposed to switch off our cell phones.”

Interviewer: “So when you go home after, after your shift is finished, it is expected that you keep your cell phone on?”

Nurse: “No ma’am, hospital is not told us keep to switch on”

Nurse: “But we think it’s our responsibility.”

Nurse: “It’s our responsibility, it’s our responsibility for our staff call us then we will answer them. If any order is missing, like in morning duty if I am busy, I don’t follow any care any instruction or any medicine, if I am busy, any order is missing then I will told our new staff on phone….”

Interviewer: “So that is not something that the hospital has asked you to do, that is something that you have decided to do?”

Nurse: “By ourselves.” (Interview 4, March 31st, 2014)

Nurses’ decision to remain available through cell phones suggests awareness to workplace demands and their desire for dependable and available resources. Thus, the interpretation of nurses’ decision to implement the cell phone intervention appears as an attempt at compensating
for their expanded scope of practice, in an inadequately resourced environment that lacks organizational structure.

Nurses did not shy away from acknowledging their feelings of unpreparedness or inadequacy when providing patient care. They readily shared their desire for educational resources and formalized continuing education opportunities. When asked whether nurses required additional education, one nurse responded with “We need it bad.” Another nurse participant, when asked how prepared she felt for her role at GGSH, responded as follows:

“I think like whatever we are doing we are learning, still we are learning. So I don’t think so I am well prepared for whatever I am doing because side by side every day whenever I come to the duty I learn new things. So I am learning sideways.” (Interview 5, March 31st, 2014)

The phrase “side by side” is interpreted as referring to nurses’ constant learning while working in the staff nurse role. The word “sideways” is interpreted as learning that occurs when confronted with new experiences in clinical practice and knowledge is gained as an aside, as opposed to a formal learning process. Although nurses acquire and translate new knowledge into practice throughout the duration of their professional career, nurses require a foundation of knowledge to build their capacity for decision-making and care planning. A primary request from nurse participants was education to support the rationales for their decisions. The following excerpt provides insight into this request:

Interviewer: “Are there any skills that you think or the decisions that you have to make, I would like more education or more knowledge?”

Nurse: “Yes, we need it bad.”

Interviewer: “Can you tell me more about that?”
Nurse: “Sister nurse that you have met yesterday, she will teach mostly us things, but we need education, we don’t know the rationale behind it [tasks].” (Interview 4, March 31st, 2014)

In the example above, the words “things” and “it” in the respective sentences, “she will teach mostly us things”, and “we don’t know that rationale behind it” were both interpreted as referencing “tasks”.

As data analysis continued, further insight into a subsequent avenue of nurses’ knowledge acquisition was obtained. As a result, the importance of nurses’ request for understanding the rationale underlying their actions became increasingly apparent. Nurses acquire knowledge and understanding through physicians, peers, basic nursing education and experientially through clinical observations. The description below provides support for this interpretation:

Nurse: “Well in neonatal ICU we start with dextrose 10% or 5% because they are neonates.”

Interviewer: “And these kinds of procedures are they protocoled or is this something you do because it is understood this is what we need to do? Where does this come from?”

Nurse: “Experience actually.”

Interviewer: “So nowhere is it written.”

Nurse: “It is not protocoled that you have to do this, you have to do this, that is our responsibility.” (Interview 2, March 27th, 2014)

Experiential knowledge informs nurses’ clinical decision-making. Although nurses desire further education, their ability to resolve complex care situations provides support for their higher level thinking capacity. Thus it appears that nurses have great knowledge, but may not
be aware of their knowledge. Although possibly not an explicit objective within their educational programs, it seems that nurses’ basic education, and their clinical experiences construct a foundation for critical thinking.

4.2.3 Unidentified Critical Thinking

A third subtheme contributing to unpreparedness is unidentified critical thinking. Nurse participants demonstrated their capacity for critical thinking through conversations and oral recounts of their decision-making processes. However, lack of formalized engagement and development of this skill may contribute to nurses’ feelings of unpreparedness in the clinical setting.

Nurses’ perception of their role provides support towards their capacity for critical thinking. The following statements reiterate nurses’ perspectives on their role:

“We are the backbones of the health care team.” (Interview 4, March 31st, 2014)

“Without staff nurses, hospital would not work, at all.” (Interview 3, March 30th, 2014)

“Ma’am I think staff nurses backbone of the hospital.” (Interview 3, March 30th, 2014)

“Without staff nurses, doctor would not survive.” (Interview 3, March 30th, 2014)

During two separate interviews, nurses referred to themselves as the “backbone” of the health care team or the hospital. These perspectives evidence nurses’ insight into their role, beyond daily patient care tasks, and demonstrate an understanding of their function within the health care system. Nurses’ ability to articulate their role, contrary to the adopted and dominant perspective in India, suggests capacity for critical thinking.

Nurses’ ability to think critically appears in their decision-making processes. Nurses are conscious that poor patient outcomes will occur without their interventions. Thus, basic nursing
education appears to teach nurses about patient presentations that require immediate action or physician consultation. The excerpts below evidence nurses’ decision-making abilities.

“Like if there is low saturation or there is low BP [blood pressure] we’ll inform the doctor and according to that we’ll start the inotropes.” (Interview 2, March 27th, 2014)

Interviewer: “Who tells you to start oxygen?”

Nurse: “We independently, we have independent decision if oxygen saturation is low, below 50 percent.” (Interview 2, March 27th, 2014)

Nurses’ capacity for critical thinking is further observed in their recommendations to physicians regarding patient care.

Interviewer: “So, you [nurse] may provide information [to the physician] that says this treatment wasn’t working today for this patient, maybe we need to make some changes?”

Nurse: “Yes, because sometimes if the doctor forget the days of antibiotic, antibiotic course, the staff nurse can remind the doctors it’s now 14 days, 7 days.” (Interview 3, March 30th, 2014)

Despite evidence of critical thinking, identification of higher level thinking processes remained unnamed throughout the focus group interviews. Furthermore, nurses and physicians did not reference the concept of critical thinking. Although critical thinking may be an unknown term, physicians are reliant upon nurses’ abilities for higher-level thinking. This reliance is further affirmed in physician’s desire for nurses to occupy extended roles. The excerpt below provides an example of a physician’s desire for a nurse in an extended role as a nurse educator.

“So whenever new nurses comes from other department then there should be some formal educator available so that they can facilitate that particular skill. That would be a really good idea.” (Interview 1, March 26th, 2014)
Considering that physicians understand nurses’ capacity for extended roles and these roles are not implemented at GGSH, unnamed critical thinking appears to result in missed opportunities to better prepare nurses for clinical practice.

4.3 Advanced Practice

Throughout the interviews, nurses consistently voiced their engagement in advanced nursing practice, as means of supporting patients and compensating for obstacles within the health care system. Subthemes that contributed to the theme of advanced practice include: nurse as physician educator, nurse as patient/family educator and professional development.

4.3.1 Nurse as Physician Educator

Both nurse and physician participants in the study described the education nurses provide to physicians. Initially, nurses were resistant in attesting to their role as physician educator; however, eventually they explained the support they provide to physicians in the clinical setting, especially junior doctors. As one nurse shared her experiences, others in the focus group revealed their experiences. According to one nurse, “Mostly in first year, they [physicians] learn all the things from the staff nurses.” (Interview 4, March 31st, 2014) Another nurse participant shared the support she provides in the clinical setting:

“Like UG students [physician students] are not taught the practical works, whenever they ask us, we have time to insert cannulas, and how to give medications, how to administer medication and what are all the timings and how to take samples. During degree time, we have been with many various intern students we made them to do these things also with us because they ask us to help them to learn things.” (Interview 5, March 31st, 2014)

A subsequent nurse participant listed examples of skills she teaches physicians:
“Like drawing the samples, inserting the cannula, how to give blood transfusion, they ask to us.” (Interview 4, March 31st, 2014)

Physicians did not hesitate to share the knowledge imparted by nurses. Physicians reported their dependence upon nurses for teaching clinical skills, especially at the beginning of their clinical rotations. The physicians affirmed nurses “expert practical knowledge,” and explained how nurses’ knowledge supports them in the clinical setting. One physician stated:

“Nurses are helpful for the practical knowledge for the newly, new comers, for the students, or the newly doctors who are join post graduation or whatever.” (Interview 3, March 30th, 2014)

Nurses also reported providing education to physicians, focused on specific patient populations. For example, one physician reported that he received support from the nurses when he was assigned to the pediatric department. The physician participant reported:

“Mostly it happen, for example when we are going for the post-graduation I am newly joined here after my GPS in post-graduation. I didn’t know much work. For example, I was appointed in the pediatric department, we didn’t know what to work with the children and the, then the staff nurses are helping us….” (Interview 3, March 30th, 2014)

This excerpt suggests that physicians may be dependent upon nurses to provide education when working with specialty populations, particularly pediatric populations. This interpretation is further supported by the comment that in the pediatric department, the nurses are “Helping us, how to intubate.” (Interview 3, March 30th, 2014) The data suggests that physicians teach nurses the skill of intubation in non-specialty areas; however, there is possibility that physicians lack specialty population knowledge and thus, are dependent on nurses for this information.
The education nurses reported providing to physicians appeared most prevalent during the time that physicians transition from a student or resident role, to the role of a qualified physician. The following quote provides support for this claim:

“Mostly it happen, for example, when we are going for the post graduation I am newly joined here after my GPs in post-graduation.” (Interview 3, March 30th, 2014)

Considering the context of the conversation during this exchange, the word ‘it’ in the phrase “mostly it happen,” is interpreted as education from nurses, and “GPs” is the abbreviated form for ‘general practitioner’. Thus, physicians require education as they transition from resident doctor to qualified physician. Although nurses provide education to physicians, their adopted educator role also manifests itself in relationships with patients and their families.

### 4.3.2 Nurse as Patient and Family Educator

The subtheme nurse as patient and family educator also contributes to the theme of advanced practice. The nurses reported that basic nursing education reinforced their responsibility in teaching patients and families; nurses reported they were responsible for assessing learning needs and providing required education. The following exchange demonstrates this point:

Interviewer: “How do you know as a nurse what type of education you need to provide to the families?”

Nurse: “According to the disease condition of the patient and his or her prognosis.”

Interviewer: “Is there, does anybody tell you this is what you have to educate the family on or is that your own decision?”

Nurse: “We studied, we studied that and nobody told us but we observe as per the patient’s condition.” (Interview 5, March 31st, 2014)
Another nurse shared her assessment of patient learning needs:

“We are seeing what is the need of the patient will he need that care at home, then we have to teach, like that.” (Interview 1, March 26th, 2014)

A different nurse explained how she discerns the education required by patients and families:

Interviewer: “Okay, so the education that the patients require, how do you know what you need to teach them?

Nurse: “Mostly, it depends upon the literacy, we have patients that don’t know how to care their child at home. Firstly we observe, if I notice anything unmeaningful, we will teach according to them.” (Interview 4, March 31st, 2014)

Considering the context of the conversation, the word “unmeaningful” was interpreted as a learning need. Therefore, if the nurse recognized gaps in the patient’s or family’s knowledge, then education would be provided according to need. Nurses also reported taking into account the patient’s and family’s level of literacy to ensure education is relevant and understandable.

The role of a home care or community nurse does not exist in India, thus nurses in the hospital ensure education is provided to support the patient and family upon discharge. For example:

Interviewer: “So when the patient goes home from the hospital, is there a nurse that goes and looks after the patient in their house?”

Nurse: “No.”

Interviewer: “No?”

Nurse: “Homecare nurses not in India.”

Interviewer: “So it is only the responsibility of the patient’s family, so you have to teach the family to be like a homecare nurse?”
Nurse: “At the time of discharge, at the time of discharge.” (Interview 2, March 27th, 2014)

Hospital-based staff nurses are responsible to ensure patients and families are equipped with knowledge and skills necessary to provide care in the community setting. Examples of education provided by nurses prior to discharge from the hospital including:

“Sometimes there is need of dressing to do when they are discharged after that at home, we will teach them the steps of dressing maybe spiral exercise, we will teach them to do at home.” (Interview 2, March 27th, 2014)

“We are also providing knowledge, also providing education to the mother in our nursing like how to breastfeed to the baby, like KMC [Kangaroo Mother Care], we are also teach them how to give KMC.” (Interview 5, March 31st, 2014)

“Like if that is a chronic patient with a T piece [tracheostomy] they will go, so we have teach them how to do suctioning, because also at home they will do this. We have taught them how to give NG [nasogastric] feed, all of this we have to teach them.” (Interview 1, March 26th, 2014)

Kangaroo Mother Care is an intervention prescribed for mothers’ with low birth weight infants that focuses on skin-to-skin contact and unlimited breastfeeding. Research suggests that Kangaroo Mother Care is associated with a reduction in infant mortality, enhanced mental development and motor test results for preterm babies and decreased risk of infant hypothermia (All Indian Institute of Medical Sciences, Neonatal Intensive Care Unit Protocol, 2008).

The above examples of provided education reveal nurses’ responsibility when preparing families for discharge. Furthermore, embedded within the nurse educator role is continued support for patients’ and families’ psychological needs.
“Second is the, in the hospital setting we have to medication of the patient and care of the patient and to hear, to give the patient psychological support because the patients are psychologically very weak in the hospital and their family also needs the psychological support in the hospital.” (Interview 2, March 27th, 2014)

Another nurse stated that she “consoles” patients and family members; however when the nurse was asked how she felt providing emotional support, she replied with “difficult”.

4.3.3 Professional Development

The subtheme professional development represents nurses’ desire for opportunities to advance them selves both personally and professionally. Although professional development is not a hospital priority, nurses appeared to be motivated by opportunities to enhance their practice. Data suggested that nurses facilitated their own opportunities for professional development, and as a result some nurses reported a desire to enroll in graduate studies and complete a master’s degree in nursing.

“I want to do MSc. like post-graduation, and after that in oncology.” (Interview 5, March 31st, 2014)

Nurses also appeared to create opportunities for professional development by engaging physicians’ knowledge. The following dialogue explains the reason some nurses inquire about advanced skills and evidenced nurses use of resources to supplement their learning.

Interviewer: “Okay, so when you talk about intubation, is that a nursing role here at the hospital, to intubate patients?”

Nurse: “No ma’am it depends upon our interest.”

Interviewer: “Sorry, it depends upon?”

Nurse: “Our interest.”
Interviewer: “What do you mean by that?”

Nurse: “Ma’am if I want to learn that, I will ask to doctor, I want to learn how to intubate.” (Interview 4, March 31st, 2014)

As the conversation continued, the same nurse participant reported that “curiosity” drives some nurses to request additional training.

Interviewer: “Okay, so why would a nurse want to learn intubation then?”

Nurse: “Curiosity ma’am.” (Interview 4, March 31st, 2014)

The interpretation of this conversation suggests a curiosity aimed at new knowledge acquisition and continued professional growth. Furthermore, nurses’ professional development appears to contribute to their reported job satisfaction. Higher degrees of satisfaction appeared to correlate with opportunities for professional development.

Interviewer: “Are you satisfied as a nurse?”

Nurse: “Still not.”

Interviewer: “Still not.”

Nurse: “Cause I want to learn many things more.”

Interviewer: “Okay, right, by continuing that education are you hoping that will provide you with more satisfaction?”

Nurse: “Yes.” (Interview 5, March 31st, 2014)

Nurses’ desire for continuing education was interpreted as an opportunity for professional development. In addition, physicians also consider continuing education for nurses as a “chance of improvement” that appears beneficial.

Interviewer: “Are you happy with the role of the staff nurse or would you like to see it developed in different way?”
Physician: “Actually in one way we are very happy but if we will be satisfied then there will be more chance of improvement so, obviously there are chances of improvement.”

Interviewer: “What kind of improvements do you think there should be?”

Physician: “There should be formal classes of in-service education.”

Interviewer: “So in-service education specific to your area?”

Physician: “Um, yes that is a need that should be there.”

Nurse: “Bed side education is there nicely but in-service should be, because too many technologies are coming day by day and we are not aware about them.” (Interview 1, March 26th, 2014)

In addition to education, the data suggested that the nurses’ desired formalized advanced roles to support their professional growth.

“We would like nurse educators, to update and support is that is it.” (Interview 1, March 26th, 2014)

Although a formal nurse educator role does not exist at GGSH, the role has been implemented in other hospitals in India, and nurses appear to understand the associated advantages.

Interviewer: “How much do you understand about the role of a nurse educator, have you seen them working in other hospitals?”

Nurse: “Earlier I was working with a multi-specialty hospital so they are having nurse educator, they are having infection control nurses, so twice a week they used to take class, they used to take pre-test, deliver a lecture on a particular thing then take a post test. So that is very nice we are updated with the latest things. Last lecture I attended was on chemo changes, so infiltration that is a major problem for cancer patients so that is...”
updated so it is good if we are having in service education.” (Interview 1, March 26th, 2014)

Beyond the opportunities for personal development, data also suggested that nurses considered professional development as necessary to advance the nursing profession and heighten the standard of care in India.

“We must have regular classes so that we are also should be updated. That is a must to improve the care. If we want to improve the standard of nursing practice that is a must.” (Interview 1, March 26th, 2014)

4.4 Summary

Nurse and physician participants provided information about nurses’ roles, responsibilities and scope of practice, in relation to their basic nursing education. Furthermore, nurses and physicians both identified knowledge gaps within clinical practice, and interventions the health care team have implemented, as attempts to compensate. Although nursing education did not appear to explicitly teach critical thinking, nurses’ capacity for decision making suggested a foundation for higher-level thinking.

Using interpretive description methodology, 11 subthemes and 3 main themes were identified in the data. The three themes included: task-driven, unpreparedness and advanced practice. Nurses and physicians both voiced their request for continuing education and formalized advanced practice roles, specifically the implementation of a nurse educator role. Although nurses’ acknowledged the benefits of professional development through the nurse educator role, they also described the potential for continued advancement of the nursing profession in India. In Chapter Five, findings from the analysis will be discussed and implications for professional nursing practice, education and research will be suggested.
Chapter 5: Discussion of the Findings

The purpose of this research study was to investigate the continuing education needs of staff nurses working in a hospital environment in a rural area of Punjab, India. Interpretive description methodology was used to conduct a secondary analysis of data collected for a collaborative research study between the UBCSoN and the BFUHS. The primary research study investigated the roles and responsibilities of staff nurses at GGSH.

Focus group interviews with staff nurses and physicians from GGSH revealed 11 subthemes, which created three main themes: task-driven nature of practice, unpreparedness and advanced practice.

In this chapter, findings from the research study are discussed, corroborated and contrasted with the literature. Limitations of the study are identified and recommendations for nursing practice, education and research will be described.

5.1 Task-driven Nature of Practice

Nurse and physician participants often described the role of a nurse in terms of their completed tasks. A “task” is defined as work nurses complete that requires both judgment and knowledge, based on nursing expertise, to ensure patient care requirements are met (Glazer, 2000). Tasks require independent nursing judgment and knowledge, based on nursing expertise. Examples of completed tasks include: vital sign monitoring, back care, mouth care, medications and biomedical waste management. Tasks appeared to be informed through nurses’ basic nursing education or taught post-graduation by physicians and through clinical experiences. Conceptualization of a nurses’ role through tasks was further reinforced by physician’s expectations of nurses, and nurses’ recounts of “blame” when tasks are incomplete.
Nurses’ description of their role in terms of tasks is not an isolated occurrence (Hicks & Hennessy, 1997). In the United Kingdom (UK), ambiguity around nomenclature, educational qualifications and scope of practice has resulted in NPs articulating their role in terms of performed tasks (Hicks & Hennessy). Similarly, in sub-Saharan Africa, lack of empirically established nursing roles has evolved into a task-informed scope of practice (Uys, Chipps, Kohi, Makoka & Libetwa, 2013). In rural India, although some tasks spanned the breadth of responses from all participants, an undefined scope of practice and the context of the clinical environment appeared to influence the tasks nurses performed.

In Africa and the UK, context also dictates nurses’ practice responsibilities and an all-inclusive definition of a nurses’ role is challenging to articulate. Although a generic definition of a nurse’s role invokes flexibility and allows nursing tasks to be customized to specific areas of practice, literature suggests that variations in job interpretations lead to challenges for nursing education and establishing standards of quality (Hicks & Hennessy, 1997). Knowledge and skills necessary for nursing practice cannot be identified nor can the effectiveness of the education programs be evaluated (Uys et al., 2013).

An undefined scope of practice impedes the advancement of the nursing profession (Hicks & Hennessy, 1997; Pulcini et al., 2010; Uys et al., 2013). In rural India, participants’ reports of practice responsibilities evidenced variability in scope of practice and nurses informal functioning in advanced practice roles. Since the INC does not regulate advanced practice roles, nurses provide advanced levels of care with unclear standards of education, training and an unclear framework for clinical practice. As a result, credibility for nurses and the possibility of advancing the profession may be hindered.
Pulcini et al. (2010) suggested that a task-informed description of a nurse’s role is associated with a low status of nursing in the associated country. In India, the nursing workforce is primarily comprised of women, from rural areas, low socio-economic statuses, and low castes. As a result, nursing has a long-standing low professional status. Furthermore, the historical influence of the caste system perpetuates this image; individuals responsible for managing body fluids occupy the lowest social standing, and experience unequal rights and opportunities (Patil, 2014).

Role theory is a sociological framework that defines how individuals behave in social situations and how behaviours are perceived by external observers (Brookes, Davidson, Daly & Halcomb, 2007). This theory considers roles as being socially constructed and associated with rights, duties, expectations, norms and behaviours for those occupying the position. Nurses’ perception of their professional role is influenced by societal attitudes, government policies and trends in professional issues (Brookes et al.; Major, 2003). Thus, role theory appears to provide further insight into nurses’ perception of their role as articulated through tasks. The tasks nurses account for are reflective of the socially constructed image embodied in the daily work of a nursing professional.

Assigning tasks to nurses is apparent in the concept of “nursing rounds,” which refers to task oriented care as means of ensuring patient’s basic care needs are attended to (Castledine, Grainger & Close, 2005; Meade, Bursell, & Ketelsen, 2006). Nursing rounds is not a new concept, but rather a re-invented concept, re-integrated into nurses’ workflows to address the reported neglect of basic care and to support vulnerable patient populations in receiving timely and appropriate care such as toileting, nutrition, and pain management. According to the United
States and the UK, positive patient outcomes appear to be associated with the implementation of nursing rounds (Castledine et al.; Meade et al.).

5.2 Unpreparedness

Nurse participants openly shared their perception of being inadequately prepared for independent clinical practice upon completing their basic nursing education. Physicians echoed nurses’ unpreparedness, and articulated their role in bridging nurses’ education-practice gap. Reports of nurses’ feelings of unpreparedness for the clinical environment are well documented (Hatlevik, 2011; Numminien, 2014; Watt & Pascoe, 2013). Duchscher (2009) referred to nurses’ education-practice gap as a period of transition when nurses encounter a deficiency between knowledge acquired during basic nursing education and knowledge required for clinical practice. The first year post-graduation is often described as a trying time, characterized by continued growth and development for the novice nurse (Watt & Pascoe). Criticism regarding nurses’ ‘readiness for practice’ revolves around education curriculums considered irrelevant and distant from the context of practice (Watt & Pascoe). As a result, education assumedly presents students with the ideal rather than the reality of nursing practice.

Nurse participants’ reports of unpreparedness and physicians’ accounts of education to support nurses’ clinical practice reflect a neglect of context in India’s basic nursing curriculums. Considering the shortage of health care providers in rural India, physicians teach advanced skills to nurses, beyond their initial education. Furthermore, physicians attest that these skills are necessary to enable nurses to support patients towards optimal health outcomes, as physician presence is minimal.

In addition to non-contextualized education curriculums, literature also suggests that nurses’ unpreparedness originates from a lack of belongingness to the clinical practice.
environment (Watt & Pascoe, 2013). Belongingness refers to feeling secure, accepted, respected and connected to the health care team. Conversely, participants’ reports of nurses’ unpreparedness do not align with this finding; both nurse and physician participants evidenced a sense of belongingness amongst the health care team, as they described the relationships within the team as a “family.” Furthermore, positive nurse-physician partnerships were readily observed throughout the focus group interviews and within the clinical environment.

The nurse-physician relationships established at GGSH may serve as positive examples for health care providers in North America. Poor working relationships between nurses and physicians can lead to decreased job satisfaction, heightened nurse turnover rates, and suboptimal patient care (Vahey, Aiken, Sloane, Clarke & Vargas, 2004). The collaboration between nurses and physicians at GGSH, as observed in the data, is a benefit to the Indian health care system and further substantiates evidence to support changes and improvements to these relationships in Canada.

Due to the positive nurse-physician relationships at GGSH, physician participants were able to support nurses in clinical practice by assuming the role of nurse educator and providing education to nurses, who were receptive to instruction. In rural India, despite evolution of the caste system; a male domineering society; the predominance of males occupying physician roles and females occupying nurse roles; and low regard for the nursing profession, physician hierarchy did not appear to disrupt professional partnerships at GGSH.

Literature suggests that feelings of connectedness amongst the health care team may enhance clinical learning (Watt & Pascoe, 2013). Physicians’ decision to forego their heightened status invoked by hierarchy and to work collaboratively alongside nurses, supports successful adoption of the physician’s ‘nurse educator’ role.
Verrapen and Purkis (2014) suggested that the historical hierarchy amongst physicians and nurses continues to thrive in healthcare environments and presents a barrier to collaborative nurse-physician relationships. Seemingly, hierarchy creates power imbalances, causing physicians to fear nurses’ reactions when they lack knowledge and further shy away from seeking nurses’ support (Verrapen & Purkis). Amongst nurses, hierarchy invokes fear of being reprimanded by physicians, leaving nurses in a perpetual state of strategizing how to approach and communicate with physicians (Veerapen & Purkis). Hierarchy creates complex nurse-physician interactions; in rural India, there appeared to be humility on behalf of nurses and physician participants, reconciling hierarchical processes and dissolving socially constructed identities, leading to joint participation in patient care.

Another potential reason for nurses’ unpreparedness in the literature is disconnection between academic faculty and clinical faculty within undergraduate nursing education (Watt & Pascoe, 2013). This disconnect refers to lack of overlap between academic and clinical faculty, leading to silo teaching practices without appreciation for the context and the content taught by faculty in the opposite setting. To bridge the faculty divide, Watt and Pascoe recommend enhanced communication and shared clinical and academic teaching responsibilities. In India, nursing faculty members are required to provide both clinical supervision and classroom teaching. Clinical supervision responsibilities occur during the morning, and classroom teaching in the afternoon. Therefore, faculty has good exposure to the challenges nurses face within the practice environment.

The INC is an autonomous body that regulates nursing education and practice. A primary function of the council is to create and ensure adherence to a standardized education
curriculum for nurses, midwives and ANMs across India. Regardless of the state or an urban versus rural location, each nurse is educated using the same curriculum.

Literature suggests that nurses who work in rural settings require specialized skills and function as generalist clinicians (Jukkala, Henly & Lindeke, 2008). In addition to specialized skills, rural settings require nurses to recognize signs of impending complications, respond to emergencies with informed confidence and draw upon foresight to plan ahead (Jukkala et al.). Considering the broad spectrum of services delivered in rural health care settings, often with fewer professional resources, physicians and nurses assume greater responsibility for patient care (Jukkala et al.).

Nurse participants’ experiences at GGSH aligned with reports of rural nursing practice in the literature. For example, nurses reported engagement in an expanded scope of practice including specialized skills such as endotracheal intubation and insertion of central venous catheters. Furthermore, nurses reported responding to patient emergencies using life saving measures, often without the presence and direction from a physician.

Rural medicine is classified as a specialty in some developed countries and rural-specific training is offered to physicians. Although evaluations of undergraduate nursing curriculums reveal that basic education may not be sufficient for effective rural practice, similar to India, specialized rural nursing education is rare (Jukkala et al., 2008). Literature suggests that a skill required of nurses in rural locations is the ability to incorporate research into care and to practice according to evidence (Seright, 2011). Findings from the study align with the literature; nurse participants actively translated evidence into practice, and also requested continuing education to support evidence-informed practice.
5.2.1 Critical Thinking

Internationally, critical thinking is considered a professional nursing attribute, enhancing awareness and decision-making skills, and supporting positive patient outcomes (Burrell, 2014; Kong, Qin, Zhou, Mou & Gao, 2013). Wilgis and McConnell (2008) defined critical thinking as a purposeful, complex phenomena involving analysis, interpretation and evaluation of information for sound decision-making processes. The term ‘critical thinking’ was not voiced during the focus group interviews; however, the data provided evidence of critical thinking within the nurses’ recorded thinking patterns and problem solving capacities.

The lack of any discussion regarding critical thinking amongst the study participants creates challenges when ascertaining the presence of critical thinking theory and practice in India’s basic nursing education. Christensen and Hewitt-Taylor (2006) suggested that quality assurance measurements in health care are focused on quantitative data. Thus, attempting to measure qualitative indicators of expertise and the effect of expert nursing knowledge poses challenges. As a result, qualitative nursing measurements are often left undetermined, and nursing expertise and critical thinking is often unnoticed and underappreciated (Christensen & Hewitt-Taylor).

However, physician participants appeared to recognize nurses’ capacity for complex decision-making and requested that nurses occupy extended roles, such as a CNS or a nurse educator. Furthermore, physicians demonstrated their reliance upon nurses’ capacity for complex decision-making and promoted critical thinking amongst nurses by teaching advanced clinical skills, beyond the knowledge gained during their basic nursing education.

Environments that promote critical thinking are characterized as empowering learning spaces where individuals feel valued, respected and invited to participate in decision-making
processes (Burrell, 2014). Relationships between individuals in these environments are distinguished by trust, mutual respect and approachability (Burrell). Physicians’ willingness to forego their hierarchical status, and affirm nurses’ capacity for advanced practice, created an open space, welcoming nurses’ participation in patient care decisions. An appreciation and recognition for the interdependence between nurses’ and physicians’ roles, built a mutually beneficial partnership.

The necessity for nurses to establish comfortable relationships with physicians is further heightened in rural settings. Seright (2011) suggested that nurses collaborate with colleagues to assist their decision-making processes. Considering the challenges embedded in the context of rural practice, in addition to limited resources, nurses require confidence and competence in approaching physicians to ensure patient care is attended to.

*Naturalistic Decision Making* theory suggests that decisions are made with an emphasis on the relevant context, as rules, guidelines and algorithms cannot be simply translated to complex situations (Seright, 2011). Seright proposed that nurses in rural locations adhere to this decision-making theory in the clinical setting. Rural settings generate challenges in the development of expert nursing practice due to the variety and variability seen in patient acuity and presentation (Seright). As a result, proficiency in pattern recognition related to illness-specific signs and symptoms may not occur. Furthermore, in rural locations, nurses’ decision-making processes reveal absent engagement with best-practice evidence and research, yet consistent engagement of colleagues’ support (Seright).

*Naturalistic Decision Making* is observed in recounts of nurse participants’ clinical experiences. Nurses reported a lack of hospital policies or procedures to guide patient care decisions. Instead, nurses based their decisions upon knowledge gained during their basic
nursing education, or insight gleaned from their Sister Nurse (charge nurse), physicians, nurse colleagues and clinical experiences. Benner (1984) suggested that guidelines and protocols support the formation of nursing expertise; however, relying on protocols or algorithms to direct care is often observed amongst novice practitioners. Expert nurses rely on their intuitive judgment and one’s ability for sound clinical judgment is enhanced as capacity for critical thinking increases (Benner; Mann, 2012). As nurses transition from a reliance on protocols to confidence in their experiences, a different decision-making process develops. Thus, considering that nurses at GGSH are taught to practice from the beginning of their career without the support of defined protocols, algorithms and procedures, the transition from novice to expert nurse may occur more rapidly.

In addition, the contextual focus of Naturalistic Decision Making theory was also emphasized in the nurse-enforced expectation to remain available through cell phones upon completion of shift duties. Due to limited resources and staffing shortages amongst nurses and physicians, nurses compensated for the challenges in the clinical context and ensured availability of a colleague for consultation, as necessary.

5.3 Advanced Practice

The International Council of Nurses defines advanced practice nursing as registered nurses with expert knowledge, complex decision-making skills, and expanded clinical competencies, as influenced by the country where they are credentialed to practice (Sheer & Kam Yuet Wong, 2008). Although specific advanced practice nursing roles have been differentiated by the International Council of Nurses including: NP, CNS, nurse anesthetist, nurse midwife and case manager, the International Council of Nurses supports countries in interpreting the definition of advanced practice as relevant to their context of healthcare.
The INC has not adopted advanced practice nursing titles, nor does the council regulate these roles. However, nurse participants frequently explained their engagement in advanced practice to support both physicians and patients, and to navigate obstacles within the health care systems. The emergence of unregulated advanced practice in rural India aligns with literature findings. Sheer and Kam Yuet Wong (2008) suggest that advanced nursing practice arises from a need to contain costs, improve access to care, reduce wait times and maintain health among specific population groups.

Nurse participants described their engagement in advanced practice through their expanded scope of clinical practice, as well as through their role as physician educator and as patient/family educator. Although nurses’ advanced scope is not regulated, nurses’ reports revealed that without their extended role, a patient’s opportunity for survival would be compromised.

Bushy (2002) suggested that expanded scopes of practice, without appropriate regulation, are common amongst nurses in rural health care settings. Sharma et al. (2013) suggest that nursing practice is ‘circumstance driven’ due to an unclear scope of practice, and thus rural nurses often engage in compelled practice. Compelled practice refers to assumed practice due to difficult circumstances and often involves complex procedures (Sharma et al.). The phenomenon of compelled practice was observed through nurses’ reports of initiating, providing and evaluating life-saving treatment measures for patients, due to absent physician support. This flexibility observed in nurse participant’s scope of practice aligns with literature descriptions of rural health care practices.
5.3.1 Nurse as Physician Educator

During physicians’ first year of clinical practice, nurses reported providing extensive educational support. Physicians affirmed nurses’ practical knowledge and willingly engaged and received nurse-led education. However, Verrapen and Purkis (2014) suggest that physicians report ‘othering’ on behalf of nurses and fear nurses’ perception. As a result, physicians isolate themselves and work independently as they feel inadequate (Verrapen & Purkis).

However, the rural health care setting may be a possible reason for the discrepancies between nurse-physician interactions observed in this study and the literature. The scarcity of physicians in rural health care is a longstanding concern in India. The physician participants appeared to recognize this issue, and further affirmed their dependence upon staff nurses at GGSH, to ensure patient care. Bushy (2002) suggested that a symptom of providing care in rural health care settings is lost profession-specific responsibilities and ambiguous job description. With limited resources, care providers are prepared to assume an array of roles and welcome lent support to ensure patient survival remains the primary concern.

5.3.2 Nurse as Patient and Family Educator

In addition to the role as physician educator, nurse participants adopted the role of patient and family educator. As previously discussed, a common trait amongst nurses working in rural settings is their inherited role as an ‘expert generalist’ (Bushy, 2002). Considering the nominal home care nursing supports in rural India, staff nurses’ role as patient and family educator appears to compensate for a void in the health care system. Nurses’ roles as an educator, is not a new finding, and aligns with standards of nursing practice in developed countries.

Knowledge-based Practice is one of four standards articulated in the CRNBC Professional Standards (2013). This standard notes the expectation for nurses to consistently
apply knowledge, skill and judgment in practice. Indicators used to evidence this standard include:

- Collecting information on the learning needs of the subjects, including patients and their families;
- Identifying relevant and valid information when planning education;
- Sharing nursing knowledge with clients, colleagues and others.

Standards clarify achievable levels of performance against which actual performance is measured. The CRNBC considers education for patients and their families an integral component of nursing practice. Furthermore, the International Council of Nurses (2012a) advocates that nurses pursue a foundation of research-based professional knowledge that supports evidence-based practice, and enables nurses to support patients towards optimal health.

5.3.3 Professional Development

Nurse participants expressed their desire for opportunities to enhance nursing knowledge and support their professional development. Nurses also requested professional development as a means of enhancing job satisfaction and supporting the advancement of the nursing profession throughout India. Literature suggests that continuing education supports the delivery of quality care, enhances job satisfaction and supports recruitment and retention of health care professionals (Ng et al., 2014; Tame, 2013).

However, lack of formalized professional development in rural health care settings is supported in literature. Seright (2011) suggested that rural practicing nurses often face limited opportunities for continuing education due to challenges enacted by geographical barriers, financial restrictions and limited resources. A similar situation has evolved in India.
Apollo Hospitals (2015) are healthcare leaders in Asia and have brought about a culture of excellence in Indian health care. The vision of the Apollo Group is to bring international standards of health care within reach of individuals in India (Apollo Hospitals). These hospitals have received international accreditation through the American-based Joint Commission International (Apollo Hospitals). To support the delivery of quality healthcare and the professional development of health care providers, the Apollo Group partnered with the National Skill Development Corporation and created Clinical Skills Enhancement Courses for nurses (Apollo Med Skills, 2015). The three courses offered include: hemodynamic monitoring, infection control nurse and wound management nurse. Each course is three days in length and provides advanced knowledge to nurses, with the goal of empowering nurses and creating an appealing workforce image. However, these courses are only available at the Apollo Med Skills centers located in Chennai, Guwahati, Secunderabad, Patna, and soon in Bangalore. Guwahati is the largest city-state in eastern India, and one of the fastest developing cities. The other locations listed are the capital cities of their respective states. Considering the urban and readily accessible locations of the Apollo Med Skills centers, nurses practicing in these cities have access to continuing education resources. Barriers to continuing education, existent in rural health care, are non-issues in urban centers and thus, nurses are provided with enhanced opportunities for professional development.

5.4 Limitations

Although this study was conducted in a rural hospital in Punjab, India, the transferability of the data to other rural health care settings, beyond India, is limited. The influence of culture and the social context on nursing practice is accounted for in literature and reinforced through participants’ responses (Seright, 2011; Watt & Pascoe, 2013). India’s colonial history, the
influence of the caste system and the long-standing history of unmet healthcare needs has shaped current nursing practice and influenced nurses’ perceptions of their role in rural India. Furthermore, due to the great heterogeneity within India, it is likely that transferability of the data to other parts of India is also limited.

Another study limitation originates from the joint involvement of nurses and physicians in two of the focus group interviews. It is unknown whether the presence of another discipline hindered physicians and nurses responses; however, there is possibility that the presence of a different health care provider group may have stifled responses and limited the details shared during focus groups. As well, a small sample size was used and the findings may not be representative of the nursing workforce at GGSH.

Participant selection criteria included only those health care providers who understood the role of a staff nurse and who were comfortable participating in an English-speaking interview. The rationale for selecting only English-speaking participants was based on the assumption that the presence of a translator may present as an authority figure and create bias in the results. Although it is unknown whether the decision to select English-speaking nurse and physician participants misrepresented the nursing workforce at GGSH, this decision allows for bias.

Furthermore, findings from this study may reflect nurses prepared through the BSc. program to a greater extent than nurses who completed the GNM training. The sample consisted of 11 BSc. prepared nurses and 3 GNMs. Thus, there is possibility that the data is more representative of BSc. prepared nurses due to their greater proportion in the sample. As well, some of the participant responses during the focus group interviews may be an artifact of how questions were asked during the data collection in the original study.
5.5 Recommendations for Nursing Practice, Education and Research

The findings from the study provide direction for nursing interventions aimed at supporting nurses in rural health care settings, through the implementation of regular continuing education opportunities. This section describes recommendations for nursing practice, education and research.

5.5.1 Nursing Practice and Education

Claflin (2005) has suggested that the goal of continuing education is to enhance and improve nursing practice and support the delivery of high quality care. Furthermore, continuing education is necessary to maintain skilled, competent health care professionals (Jukkala et al., 2008). Nurses’ desire and request for continuing education is documented throughout the study; yet, opportunities for formalized education, upon completion of the basic nursing program, are absent in rural India.

One possible strategy for addressing the challenges that staff nurses’ face in the study site and similar environments is the implementation of a hospital-based nurse educator role. Nurse educators primarily support nurses and nursing practice through the delivery of education sessions, education resources and mentorship. Current nursing education provided by physicians at GGSH is often circumstance-driven, based upon knowledge physicians require of nurses, to compensate for absent rural healthcare providers. The role of a nurse educator allows nurses to learn required knowledge for practice, and further provides opportunity for nurses to make education requests, based upon self-identified needs and areas of interest.

In addition to continuing education, the nurse educator can prepare an orientation program for staff nurses and provide novice nurses with insight into job expectations and
advanced skills required in clinical practice. Orientation to the staff nurse role may bridge the
education-practice gap encountered upon entering the practice setting.

Nurse educators can empower nurses and provide a voice for their needs, thereby
enhancing the staff nurses’ feelings of being respected, valued and heard. Continuing education
supports nurses’ competence and the advancement of the nursing profession (Seright, 2011; Watt
& Pascoe, 2013). Implementation of the nurse educator role demonstrates the intrinsic worth
within the nursing profession, and the necessity to invest in nurses’ competency to support
optimal patient care.

In addition to providing education, embedded in the nurse educator role is the opportunity
for mentorship. The nurse educator could act as a resource for staff nurses in the clinical setting
and could roam hospital wards, providing individualized support and in the moment education.
Individualized approaches support development of nurses’ critical thinking (Hatlevik, 2011).
Furthermore, mentorship opportunities may double as a ‘needs’ assessment, allowing the nurse
educator to assess deficiencies in knowledge, and opportunities for future workshops.

The context of rural health care creates an environment where nurses are expected to
perform advanced skills, beyond their initial training. However, nurses shared their desire to
gain understanding for the rationale behind clinical decisions. Advanced skills are often
performed during critical times, after nurses have received minimal instruction from a physician.
Thus, nurses require opportunities to consolidate their knowledge and practice skills in a safe
environment. Ideally, instruction of advanced skills in a nursing lab would provide support
nurses in mastering the knowledge, skills and judgment required for safe and effective advanced
practice.
5.5.2 Nursing Research

Continued investigation into the content taught in nurses’ basic nursing curriculums, and the knowledge required for clinical practice in rural health care settings is necessary. Analysis of the content included within the basic nursing curriculum will provide an informed understanding of nurses’ education needs and reinforcement for resources in rural practice settings.

Another area of consideration for continued research is the clinical decision-making process nurses assume in rural versus urban settings. Seright (2011) highlights the influence of context on nurses’ decision-making and suggests that evolution of nurses’ decision-making patterns is based on the availability of resources. A comparison study revealing differences between nurses thinking patterns in rural and urban locations, and the influence of resource availability on decision-making capacity may be essential to gain support for continuing education and resources in rural locations.

5.6 Conclusion

Findings from this study provide insight into nurses’ preparation from their basic nursing education for practice in a rural hospital setting in Punjab, India. The results identify nurses’ desire for continuing education and certain education needs. Although India’s standardized nursing education curriculum appears to lack appreciation for the context of clinical practice, nurses demonstrate capacity for critical thinking, and assume an unregulated advanced scope of practice to ensure patient care is provided. Nurses’ capacity for higher-level thinking is observed throughout the findings; nurses’ requests for continuing education needs to be met to affirm nurses’ value, support their professional development and promote advancement of the nursing profession in India.
References

All Indian Institute of Medical Sciences, Neonatal Intensive Care Unit Protocol. (2008).


Bushy, A. (2002). International perspectives on rural nursing: Australia, Canada, USA.


Sundararaman, T., & Gupta, G. (2011). Indian approaches to retaining skilled health


University of Pennsylvania School of Nursing. (2013). *Utilizing*
APNs to solve provider shortage in rural India. Retrieved on June 14th, 2014 from http://www.nursing.upenn.edu/gha/Pages/default.aspx


