

**Title: A DIFFICULT PATH TO WALK: CRITICAL CARE NURSES' LIVED
EXPERIENCE OF CRUCIAL CONVERSATIONS: PERSPECTIVES FROM ONE
AUSTRALIAN TEAM**

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TABLE OF CONTENTS

TABLE OF CONTENTS ii

ACKNOWLEDGEMENTvii

ABSTRACT viii

PREFACE..... 1

Disclaimer..... 2

CHAPTER ONE – INTRODUCTION AND BACKGROUND 3

 Introduction..... 3

 Early history of safety models in health..... 3

 Crew resource management..... 4

 Team STEPPS..... 6

 Evolution of thought that led to the development of Crucial Conversations as a
 safety system 6

 Crucial Conversations in the critical care setting 7

 Summary of chapters 8

 Summary..... 9

CHAPTER TWO - LITERATURE REVIEW 10

 Introduction..... 10

 Search method and filters 10

 Classification of safety concepts in non health care industries 11

 Evidence for the adaptation to health care of safety methods from other fields 11

 Evidence for delineating behaviors in health care that threaten patient safety 13

 Evidence for the clinical effectiveness of Crucial Conversations..... 14

 Synthesis of Crucial Conversation perspectives 15

Critical Care Nurses' Crucial Conversations

Current gaps in the published literature.....	16
Summary.....	17
CHAPTER THREE –METHODOLOGY	18
Introduction.....	18
Qualitative research.....	18
Phenomenology and hermeneutic phenomenology	19
Choice of research method.....	20
Van Manen’s method.....	21
Van Manen’s six components of phenomenological research.....	21
Van Manen’s method for isolating thematic statements.....	22
Rigour and credibility in qualitative research.....	23
Summary.....	24
CHAPTER FOUR – METHODS	25
Introduction.....	25
Ethical considerations.....	25
Participant recruitment	26
Conduct before, during and after the interview.....	26
Data recording, storage and management.....	27
Auditing and confirmability.....	28
Design.....	28
Transferability and dependability.....	30
Data collection	31
Data analysis and interpretation: the place of the researcher's personal experience	33

Critical Care Nurses' Crucial Conversations

1. Turning to the nature of lived experience.....	33
2. Investigating experience as we live it.....	34
3. Reflecting on the essential themes which characterise the phenomenon.....	34
4. Describing the phenomena in the art of writing and rewriting.....	35
5. Maintaining a strong and orientated relation to the phenomenon.....	35
6. Balancing the research context by considering the parts and the whole.....	35
Isolating thematic statements.....	35
The detailed reading approach.....	36
The selective or highlighting approach.....	36
The holistic reading approach.....	37
The development of themes and sub-themes -the first stage of analysis.....	38
The second level of analysis - moving from key words and concepts to sub-themes and themes.....	40
Summary.....	41
CHAPTER FIVE – INTERPRETATION AND DISCUSSION.....	42
Introduction.....	42
Crucial concerns.....	42
Major themes and subthemes.....	45
Summary.....	59
FINAL CHAPTER – DISCUSSION.....	59
Introduction.....	60
Strengths and limitations of the research process.....	60
Implications of crucial conversations for critical care nursing practice.....	62
Synopsis of this thesis.....	64

Critical Care Nurses' Crucial Conversations

Areas for future research.....	65
Concluding comments	65
References:	67
APPENDICES	82
Appendix A – Ethics approval letter	82
Appendix B – Participant information sheet.....	83
Appendix C – Participant consent form	87
Appendix D – Three elements of a Crucial Conversation	89
Appendix E - Key words and concepts initial analysis.....	90
Appendix F - Concepts and themes - second stage of analysis	93
Appendix G – Interview questions	98

SIGNED STATEMENT

I certify that this thesis contains no material that has been accepted for any award of any other degree or diploma in any other university.

To the best of my knowledge, this thesis contains no material previously published or written by another person, except where due references has been made in the text.

I give consent to this thesis being available for loan and photocopying, when deposited in the School of Nursing Library.

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ABSTRACT

This practice inquiry reports the lived experience of Crucial Conversations by a small group of critical care nurses in a South Australian quaternary hospital's critical care unit. Crucial Conversations are high stakes, highly emotional dialogues, where opinions and understanding greatly differ. Executed well, these discourses result in increased collaboration, meaningful solutions to challenging issues and improved team performance. Literature reveals other systems in place for quality improvements in unit performance that include TeamSTEPPS and Safety Learning System (SLS) reporting, however, the unique conflict resolution strategies with reflective events has not been adequately covered. Crucial Conversations are one form of a structured resolution process, which addresses this gap. Research regarding the lived experience of Crucial Conversations is an important piece missing from the literature. Using van Manen's hermeneutic phenomenological methods, 'Too hot to handle', 'Anticipatory responding' and 'Moving from who is right to what is right' emerged as themes of the critical care nurses' lived experience of Crucial Conversations. The inquiry findings give complementary views to previous research, add to the body of knowledge related to Crucial Conversations and bring attention to the importance of improving professional relationships on all levels. The study findings lend themselves to a process of implementing Crucial Conversations into the critical care setting. The value of this research lies in the implementation of multidisciplinary strategies for effective ongoing working relationships.

Critical Care Nurses' Crucial Conversations

PREFACE

My interest in Crucial Conversations began in 2012, during an amalgamation of the standalone cardiac intensive care, and general intensive care units of a major metropolitan public hospital in South Australia. It was anticipated that amalgamating the two teams of experts would result in a safer more effective clinical environment.

Instead distrust, lack of cooperation poor team cohesion, and disrespectful relationships ensued. The emergence of differences in clinical opinions was seen as a failure of the amalgamation, rather than an integral part of team performance. The expression of differing opinions turned into a struggle of power play with marked hierarchal emergence. The new team operated under stress. Internal team dynamics developed which led to lower performance and disrespectful interactions resulting in the Cardiothoracic Intensive Care External Review Report, 2 September 2013, which was subsequently tabled in the South Australian Parliament in 2014.

As a cardiothoracic critical care nurse I frequently witnessed or was personally involved in situations where individuals raised critical safety issues. Sometimes these discussions went well. At other times they resulted in angry emotional outbursts. On occasions, in corridor conversations my colleagues would discuss their reluctance to raise crucial safety issues for fear of being ridiculed or having their concerns dismissed, preferring instead to raise safety concerns in the Safety Learning System (SLS). Patient care suffered and team morale was low.

Change champions were employed to build cohesion, respectful interpersonal relationships and an acceptance of diverse opinions, in order to strengthen the team. The team was encouraged to create collaborative interdisciplinary care pathways, however there was no improvement in team dynamics.

Around this time I participated in a leadership and management program that introduced me to the concept of 'Crucial Conversations'. The concept described by Paterson et al. (2012) as safety system that develops the personal skills necessary to

Critical Care Nurses' Crucial Conversations

articulate difficult to discuss risks in ways that are effective and without the fear of being labelled as confrontational or a bully. My research on Crucial Conversations convinced me that this safety system could offer a way for the two opposing groups to work better together. I provided the book 'Crucial Conversations: tools for talking when stakes are high', to the Clinical Service Coordinator (CSC) of the cardiac intensive care unit (ICU) and the ICU Network Director. Both were supportive of the notion of Crucial Conversations.

The CSC encouraged me to choose Crucial Conversations as a topic for a project component of a Masters' degree. I met with an organisational psychologist, a strong proponent of Crucial Conversations in 2014. Her enthusiasm for the topic and for its exploration in our current working environment further reinforced my commitment. In 2015 I enrolled in a Master's program. In early 2016, I attended a two-day Crucial Conversation training course in Adelaide based on the book, Crucial Conversations by Paterson *et al.* (2012). The purpose was to develop the skills and confidence to have the tough conversations, get great results and build strong relationships.

Disclaimer

Although I have been part of this process described above and, although I know the people involved in this environment, I personally have not been part of any Crucial Conversations with any of the participants in the study and have not discussed this project externally. Hence, this project has been independent of the work environment.

CHAPTER ONE – INTRODUCTION AND BACKGROUND

Introduction

Chapter one introduces the research topic: An investigation of critical care nurses lived experience of Crucial Conversations. A brief overview of the history of safety models is given, followed by an introduction to and summary of the evolution of the thought that led to the development of Crucial Conversations as a safety system. The chapter concludes with an overview of the chapters to follow.

Early history of safety models in health

Providing safe patient care in a critical care unit has always been and still is a great challenge for health care (Pickering *et al.* 2012). Incident reporting was the earliest reported safety model designed to improve health care capability to meet the challenge (Staender, Kaufmann & Scheidegger 2000). It was first applied on a local scale to address issues of anaesthetic equipment malfunction (Blum 1971). In 1987 the Australian Incident Monitoring Study (AIMS), a cutting-edge project in incident reporting in high-stakes medical care was launched nationally (Webb *et al.* 1993; Runciman 2002). In 2010 the paper based AIMS Incident Reporting System was replaced by a computer based Safety Learning System (SLS) (SA Health 2016). Both systems focus on individual limitations that contribute to errors and describe errors as the product of deficiency in perception, attention, motivation, feelings and thoughts. The systems cover retrospective details about situational context, function, and experience of the healthcare professionals involved and any subsequent action taken on behalf of the healthcare provider as well as how decisions arose, what role teamwork played in the incident, and what information was available (SA Health 2016).

Clinicians utilise the SLS to report breaches in safety and care quality (Wachter 2010; Staender 2011; SA Health, 2016). The system provides insight into factors contributing to unsafe conditions or errors, and allows for suggestions as to how similar incidents

can be prevented in the future (Scharein & Trendelenburg 2013; SA Health 2016). In order to be able to draw value from the system and influence change, reports outlining the incidents, their consequences and solutions must be shared with those who reported to promote utilization (Hughes & Blegen 2008; Titler 2008). The main criticism of the SLS system is its underutilisation (Rall van Gessel & Staender 2011; Staender 2011; Haerkens *et al.* 2012; SA Health 2016).

Incidents can indicate isolated problems, but if a similar problem is encountered repeatedly, it disrupts the ongoing or future output of the system (Titler 2008; WHO 2008). If severe incidents or accidents occur, sometimes the approach remains to blame one responsible person. A structured approach to incidents such as root cause analysis, which focuses on the multitude of contributing factors, is recommended when there are systematic errors or severe incidents (Wu, Lipshutz & Pronovost 2008; Latif, Holzmueller & Pronovost 2015).

A consistent and structured approach of asking questions can promote greater team openness and safer systems by focusing on the system perspective (Halbesleben, Cox & Hall 2011). In aviation, the team and the system are central to the safety culture (Boysen 2013), while health care has historically valued individual expertise (Halbesleben, Cox & Hall 2011).

Due to the fact that in the critical care environment there is tendency to focus on the individual's performance in preference to the system of care, the SLS system describes events retrospectively and attempts to find solutions for improving individual performance (Haerkens *et al.* 2012). At best, reported incidents can serve as the trigger point to start an improvement process using Plan-Do Check-Act (PDCA) cycles (Toussaint & Berry 2013). Developing a systemic approach to manage patient safety may lead to better health outcomes but may draw criticism from those clinicians who want to be heroes (Lewis *et al.* 2011).

Crew resource management

Critical Care Nurses' Crucial Conversations

Teamwork is an inherent feature of health care. Teamwork has come into health care safety focus only recently with a shift in a focus from the individual to the team (Leasure *et al.* 2013). Multidisciplinary performance of the care team is as pivotal to critical care as individual expertise (Harris, Humphrey & Cote 2010; Kemper *et al.* 2016).

Teamwork failures have increasingly been noted as causes of errors. It has been reported that 50 to 70% of medical errors are due to failures of communication and teamwork (St. Pierre *et al.* 2011). This mirrors what has been described in the aviation industry. Stimulated by a large body of evidence from high stakes environments such as aviation, health care providers have started to focus on teamwork and adopt and integrate team-training measures such as 'Crew Recourse Management' (CRM) into practice (Maynard, Marshall & Dean 2012). The distinct purpose of CRM is to promote a culture where hierarchy may be respectfully questioned and where teamwork is prized above individual accolades (Haerkens *et al.* 2012). Ricci and Brumsted (2012) assert in health care, CRM training involves teaching clinicians to build cohesion, maintain respectful interpersonal relationships, understand that conflicts are an integral part of team performance and that contribution of diverse opinions strengthens the team (King *et al.* in Henriksen *et al.* 2008; Kemper *et al.* 2016). CRM cultivates an environment that enables open discussion of safety issues and concerns (Fraher 2011; Langewiesche 2014).

CRM advocates different talents and abilities as team strengths not as factors of competition. Successful outcomes of teamwork require proficient interaction of team members (Leasure *et al.* 2013; Gordon, Deland & Kelly 2015). CRM maintains that teamwork flourishes when nurtured in a trustful, collaborative environment. (Fraher 2011; Sullenberger 2013). In health care, CRM training involves teaching clinicians to build cohesion, maintain respectful interpersonal relationships and understand that conflicts are an integral part of team performance. Contribution of diverse opinions strengthens the team (King *et al.* in Henriksen *et al.* 2008; Kemper *et al.* 2016). CRM fosters a prospective open environment that enables discussion of safety issues and concerns (Gordon *et al.* 2012; Maynard, Marshall & Dean 2012).

Team STEPPS

Improving individual and team performance creates a safer more effective clinical environment for patients. However, errors in health care are not only the result of individual and team limitations, but are also influenced by organisational processes (Sevadalis, Hull & Birnbach 2012; Hwang & Ahn 2015). Team STEPPS is an organizational safety process designed to engineer teams of clinicians to share mental models. Prospectively, through Team STEPPS, clinicians achieve shared understanding of the team and the task to be performed (Nacioglu 2016). The notion of a shared mental model is the knowledge and structures held by members of a team that enable them to have accurate explanations and expectations for a particular task (clinical handover, timeout before the surgical procedure) (WHO 2008; Westli *et al.* 2010). This allows them to coordinate their actions and adapt their behavior to the demands of the task before the start of the intervention or at time of transferring professional responsibility and accountability for care (Pllonien & Williams 2015). Team STEPPS allows the team to set a particular practice standard and creates a standardized tool to support safe practice (King *et al.* in Henriksen *et al.* 2008).

Evolution of thought that led to the development of Crucial Conversations as a safety system

Crucial Conversations are described by Patterson *et al.* (2012) as 'a discussion between two or more people where (1) stakes are high, (2) opinions vary, and (3) emotions run strong' (p. 3). Successful conversations depend on 'free flow of relevant information' (p. 20). Successful conversations stem from everyone feeling 'safe enough' to contribute (p. 24).

The Crucial Conversations model is based on the premise that individuals have the necessary skills to be a part of a crucial conversation (Maxfield *et al.* 2010; Haerkens, Jenkins & van der Hoeven 2012; Kemper *et al.* 2016). Having the skills to effectively discuss unsafe situations, advances a safety system beyond blaming individuals, beyond

team cohesion, and beyond shared mental models; to creating the conditions that make high stakes, high emotion dialogue possible (Grenny 2009; Critchfield 2010; Patterson *et al.* 2012).

It is important to delineate Crucial Conversations from other safety systems. Although the safety models AIMS, SLS, CRM and Team STEPPS have helped to create safer more effective clinical environments, all assume the presence of optimal conflict resolution and interpersonal communication skills. The American Association of Critical Care Nurses (CN) in their 'Silence Kills Study' assert many healthcare workers watch their teammates cut corners, make mistakes or demonstrate serious incompetence. They also report that they are incapable or unable to confront the unsafe practice (Maxfield *et al.* 2005). As a safety system, Crucial Conversations help individuals express delicate feedback, '*speak persuasively not abrasively*' Patterson *et al.* (2012, p.131), listen, get people to talk when they seem nervous and move safety from thought to action (Maxfield *et al.* 2010).

Crucial Conversations in the critical care setting

Until recently, Crucial Conversations were oriented to the corporate world mainly to help employees reflect collaboratively to boost productivity. However VitalSmarts in conjunction with AACN 'Silence Kills' study (2005) and 'The Silent Treatment' (2010) study identified seven categories of especially difficult behaviours within critical care settings that the authors deemed were essential to address to improve safety (Maxfield *et al.* 2005; Maxfield *et al.* 2010).

These seven categories described by the authors as 'likely to lead to unacceptable error rates' were defined as broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect and micromanagement, (Maxfield *et al.* 2005, p. 2; Maxfield *et al.* 2010). Furthermore, Maxfield *et al.* (2005) and Maxfield *et al.* (2010) claim orienting Crucial Conversations to these seven categories can potentially contribute to significant improvement in safety.

Given the events that precipitated this study, acknowledged in the preface of this thesis, Crucial Conversations may offer an opportunity to explore the issues discussed. Unlike CRM, SLS, and Team STEPPS, Crucial Conversations can enable individuals to hold effective dialogue within group dynamics that retrospectively dissect errors and near misses. Consequently the research question became, 'what are critical care nurses lived experience of Crucial Conversations'?

The chapter outlines that follow describe the research process, findings, the implications of the findings for Safety and Quality practice, critical care nursing practice and the health care profession, and raises potential research questions that arose from this work.

Summary of chapters

Chapter One has presented the thesis, including the setting for the study and a statement of the research question. The consequent chapters provide specific information about this research.

Chapter Two will present an overview of the literature on Crucial Conversations including an explanation how Crucial Conversations evolved and how they were implemented into healthcare environments. Gaps in the current literature are identified that support the aims and objectives of this thesis as an important piece missing from the literature.

In Chapter Three, qualitative research will be presented with the validation for the choice of hermeneutic phenomenology as the research methodology for this thesis. The philosophical keystones of hermeneutic phenomenology will be discussed, along with the work of van Manen (1997), whose approach and methods of analysis informed the research methodology.

In Chapter Four the research design for the study is offered, incorporating information

on the ethical considerations and the approval process, recruitment of participants and data collection. Van Manen's (1997) six steps used in the analysis and interpretation of the data are also discussed.

Chapter Five talks about the data obtained from the interviews carried out with participants who had experienced Crucial Conversations, and the central themes that emerged from them. The themes 'Too hot to handle' 'Anticipatory responding' and 'Moving from who is right to what is right' have been identified as repeated during the interview transcripts. They are discussed with reference to the literature of Crucial Conversations.

Chapter Six presents the strengths and limitations of the study, research questions arising from the study and offers some concluding comments.

Summary

This chapter has provided a brief overview of the research question and contextualises the question within the context of the health system. Furthermore it introduces some of the concepts underpinning health care safety systems in general and Crucial Conversations specifically. It concludes with a summary of those chapters to come. The following chapter will review the current research literature.

CHAPTER TWO - LITERATURE REVIEW

Introduction

This chapter will explore the literature focusing on Crucial Conversations from several evidential perspectives. First, evidence for classification of safety initiatives in non health care industries will be presented. Second, evidence for the adaptation to health care of safety methods from other fields will be explored. Third evidence for delineating behaviors in health care that threaten patient safety will be presented. Fourth, evidence for the clinical effectiveness of Crucial Conversations will be outlined. Finally, the literature will be synthesized as a whole to provide context and illustrate the gap in research addressing critical care nurses' experience of Crucial Conversations in the existing literature.

Search method and filters

The literature review used the following databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PubMed, SCOPUS, COCHRANE and the Australian Commission on Safety and Quality in Health Care. Results were filtered to only include full-text, peer-reviewed and non peer-reviewed articles published after 2002, in English. The search used the key words: 'crucial conversations', 'communication', 'patient safety', and 'quality of care', 'intensive care' and 'critical care'. Although the concept of Crucial Conversations has been explored for more than a decade the body of literature remains sparse. Crucial Conversations research can mostly be placed into four broad themes of evidence, classification of safety initiatives in non health care industries, adaptation to health care of safety methods from other fields, behaviors in health care that threaten patient safety, and clinical effectiveness of Crucial Conversations. A final search on the Proquest database and in the writing up stage of the thesis revealed a doctoral thesis,

which evaluated the Crucial Conversations program that informed the concluding chapter of this thesis (Trinidad 2013).

Classification of safety concepts in non health care industries

The literature describes several non health care industry safety initiatives. In commercial aviation no less than fifteen initiatives have been described. These include checklists, crew resource management, joint safety briefing, minimal safety requirements, sterile cock pit rule, alterations of rules, standard layout, black box, corporate responsibility for training, first names only rule, incentivized no-fault reporting, bottle-to throttle rule, mistake proofing, forcing functions and flight envelope protection (Kapur *et al.* 2016). Pilots use checklists during routine events, during unusual circumstances and departure debriefing Lewis *et al.* (2011) describe an aviation safety concept developed from these fifteen aviation safety practices. The concept downplays the role of individuals, emphasizes the importance of teams and whole organizations, seeks to increase and apply group knowledge of safety information and values and promotes safety by design. In a review of five studies Lyndon (2006) and Timmons *et al.* (2014), described a further safety concept in aviation; attitudes regarding interpersonal interaction on the flight deck that predicted effective performance and was amenable to behavior based training.

Evidence for the adaptation to health care of safety methods from other fields

In complex critical care environments, clinicians have been shown to place emphasis on individual technical performance over communication, teamwork and leadership (Reader & Cuthbertson 2011). The literature reports this leads to substandard coordination of multidisciplinary care and results in errors (Latif, Holzmueller & Pronovost 2015; Fengzhi *et al.* 2016). According to a number of authors, learning from other high-risk industries has encouraged research efforts in critical care (Reader & Cuthbertson 2011; Maynard, Marshall & Dean 2012).

Critical Care Nurses' Crucial Conversations

The literature provides evidence for health care looking to other industries for a conceptual approach, to base the development of improved safety initiatives (Lews *et al.* 2011). For example aviation checklists have been adapted to create surgical safety “challenge and response” checklists (WHO 2008). Two such examples are anaesthetic equipment checklists (Ricci and Brumsted, 2012) and postoperative debriefing checklists (Dunn *et al.* 2007; West *et al.* 2014).

The checklists are relatively quick and cheap to implement and have been reported, to reduce deaths and complications for surgical patients by more than a third in some settings, (Haynes *et al.* 2009; Lews *et al.* 2011). The package of interventions used in aviation, that include checklists, common layout for equipment, and the empowerment of junior staff to call for a procedure to be abandoned if guidelines were violated readily translates to health care. One example includes checklists introduced in surgical intensive care units to combat catheter-related bloodstream infections (Rahmathulla *et al.* 2012; Kapur *et al.* 2016; Pham *et al.* 2016).

Crew Recourse Management (CRM) has been implemented in range of health care disciplines to improve multidisciplinary performance of the care team which is as pivotal to critical care as individual expertise (Harris, Humphrey & Cote 2010; Kemper *et al.* 2016). CRM has been demonstrated to change work behavior and reduce surgical mortality (Neily *et al.* 2010). Joint safety briefings have been implemented as recent initiatives. For example ‘hand over huddles’ have been shown to improve patient safety (SA Health 2016). Work-hour restrictions and minimum nurse staffing ratios are other examples of safety requirements that have been introduced in various settings (St. Pierre *et al.* 2011; SA Health 2016). An initiative, similar to a sterile cockpit rule, that prohibits nonessential activities during critical phases, has been introduced into health care to insure practitioners refrain from unnecessary activity during clinical handover: a measure which has been identified in the literature to improve safety (Flin & Mitchel 2009; Kapur *et al.* 2016).

Leaders across the health care industry have taken steps to standardize critical equipment, emergency phone numbers and drug charts to reduce errors (Pronovost *et*

al. 2009). Health care organizations are striving to keep detailed databases of ongoing training competencies compulsory for all staff; and provide, organize and reimburse for the necessary training; and facilitate rostering so that staff can attend (Lews *et al.* 2011).

TeamSTEPPS a United States Department of Defense initiative has been introduced into health care and has demonstrated improved institutional collaboration and communication in relation to patient safety in organizations ready to change. A caveat to this is that leadership must support the organizational climate and staff members are needed to be committed and willing to change (Deering *et al.* 2011; TeamSTEPPS Implementation Guide 2014; Pllonien & Williams 2015).

The authors described that interrelationship and explicit relationship awareness of all team members' knowledge contributions were vital to patient care safety.

Health care organizations can shift towards a culture of safety using team tools and strategies (Barsteiner 2011; Pronovost *et al.* 2011; Pham *et al.* 2016). However, the Team STEPPS initiative only works in organizations ready to change, where leadership and staff members support the culture and are willing to improve (Weaver, Dy & Rosen 2014). The sustainment phase of TeamSTEPPS includes a culture change: coaching and integration, monitoring the plan, and continued improvement. Explicit aims are to spread positive changes to other work areas by combining teamwork behaviors and tools into team's daily practice (TeamSTEPPS Implementation Guide 2014)

Evidence for delineating behaviors in health care that threaten patient safety

Grenny (2009) and Maxfield *et al.* (2010) describe seven specific critical factors that form a fundamental concept of disruptive behaviors relevant to healthcare and preventable errors; broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect and micromanagement. Critchfield (2010) and Longo (2010) broaden this concept as they describe the fundamental concept of disruptive behaviors as any indirect or direct actions ranging from facial expressions to exclusion, bullying and workplace violence, sighing and condescending facial expressions that cause

hostility and have adverse consequences on the health care team and diminish their collaboration. Maddineshat *et al.* (2016) claim disruptive behaviors correlate with health team communication breakdowns. The disruptive behaviors outlined are all claimed to be central to adverse outcomes, requiring a Crucial Conversations approach to prevent patient harm (Rosenstein & O'Daniel 2005; Granny 2009; Maxfield *et al.* 2012; Maddineshat *et al.* 2016).

The disruptive behaviors highlighted by the above are described as relating to specific categories of conversations that are especially difficult and at the same time essential for clinicians to master (Maxfield *et al.* 2005; Maxfield *et al.* 2010). Yet Maxfield *et al.* (2005) report 'fewer than ten percent of people share their full concerns and as a result the problem goes on for years, fostering a culture incapable of confronting unsafe topics' (p1). More recently literature describes a progressive increase from twenty one to thirty one percent of critical care and perioperative nurses confronting unsafe matters (Maxfield *et al.* 2010). The authors report the increase may be due to the focus of health care organizations on creating cultures of safety (Grenny 2009; Maxfield *et al.* 2010).

Evidence for the clinical effectiveness of Crucial Conversations

It is essential to delineate a Crucial Conversation from other safety systems. Although the safety models AIMS, SLS, CRM and Team STEPPS have helped to create safer and more effective clinical environments, they all assume capable conflict resolution and interpersonal communication skills. In reality, studies have demonstrated that individuals when feeling threatened, have predisposition to protect themselves, which may involve avoiding humiliation and disappointment, forcing opinion of being right and punishing others (Burns 2005; VitalSmarts 2005; Maxfield *et al.* 2010; Patterson *et al.* 2012).

Patterson *et al.* (2012) have defined Crucial Conversations as stories people tell that color their perceptions and actions in times of stress. The authors have found that recognizing the emotions in a situation, rather than ensuing in disruptive behaviours leads to a conscious contribution towards shared meaning (Patterson *et al.* 2012).

The AACN in conjunction with VitalSmarts created a fifteen-question survey that is being used within health care organization as a pretest to implementing the Seven Crucial Conversations Program (VitalSmarts 2005). The survey is used to establish pre-training benchmarks as well as being a baseline for measuring change. Saxton (2012) reported improved self-efficacy scores rating the number of specific disruptive behaviors between doctors and nurses after Crucial Conversations training. Major *et al.* (2013) applied the Crucial Conversations theory and training model as a framework for describing certain conversations and disruptive behaviours between nursing professional and described overall safety culture improvements.

Synthesis of Crucial Conversation perspectives

The evidential perspectives for Crucial Conversations will now be synthesized into a coherent whole to provide background to the research into nurses' experience of Crucial Conversations. The literature review described significant progress in identifying number of safety-related domains in aviation. Particular teamwork behaviors and assessment and training in a multidisciplinary environment have been identified as facilitating aviation teams to form shared and positive perceptions on teamwork with demonstrable impact on improved safety. The literature stresses team skills are important for maintaining safety in aviation and also in healthcare, as multidisciplinary teams must work effectively in both domains under highly complex, stressful, and uncertain conditions.

Research into patient safety has demonstrated the transfer of lessons from aviation to healthcare that has been nuanced, with the specific characteristics and needs of healthcare borne in mind (Lyndon 2006; Maynard, Marshall & Dean 2012). In attempting to understand and improve safety in health care, researchers cite teamwork models and training techniques such as CRM, Team STEPPS and Crucial Conversations used to manage and improve teamwork. Disruptive behaviours have been identified as adversely affecting patient outcomes (VitalSmarts 2005; VitalSmarts 2010).

However, teamwork models and training techniques such as CRM and Team STEPPS have largely assumed the presence of optimal conflict resolution and interpersonal communication skills. More recently the assumption that individuals possess optimal conflict resolution and interpersonal communication skills necessary for confronting unsafe practice has been challenged by a number of researchers. This manifests specifically in ineffective communication skills, incapability or inability to confront or speak up about unsafe practice, and witnessing teammates cutting corners, making mistakes or demonstrate serious incompetence without acting (Maxfield *et al.* 2010; Haerkens, Jenkis & van der Hoeven 2012; Langewiesche 2014; Deland, Gordon & Kelly 2015; Law & Chan 2015; Kapur *et al.* 2016).

The literature regarding Crucial Conversation has been reviewed with an emphasis on two issues. First, the difficult amalgamation described in the preface demanded skills that addressed the everyday problems being experienced; in the present case troublesome conversations of individuals within two amalgamating teams. Second many ideas invoked in Crucial Conversations offer a possible way forward for groups to work better together. The Crucial Conversations described '*what*' of Crucial Conversations by making explicit everyday disruptive behaviors. These behaviors resonated with the everyday problems being experienced by the team, outlined in the preface of this thesis. However, the Crucial Conversations literature did not explore the '*how*' of Crucial Conversations, leaving the process for responding to the disruptive behaviors implied.

Current gaps in the published literature

The gap identified suggests that an understanding of the lived experience of Crucial Conversations is needed, to contribute to the growing body of knowledge relating to the subject and to enable the use of Crucial Conversations theory to specific organizational cultural issues. Therefore, this researcher asks what is the critical care

nurses lived experience of Crucial Conversations?

Several other areas for future research were recognized in the literature, including aligning specific patient safety risks with Crucial Conversation training; establishing benchmarks on the existence and frequency of situations addressable to Crucial Conversations, establishing wider and deeper implementation of Crucial Conversation theory and establishing a training model as a framework for describing specific conversations.

Summary

A summary of the literature relating to the use of Crucial Conversations as a safety technique has been provided along with an explanation of how it evolved and how it has been implemented into health care environments. Within this broader context, the literature examining Crucial Conversations had been summarised and gaps in the current research discussed. The lived experience of Crucial Conversations in health care environments was identified as an important piece missing from this area therefore supporting the aims and objectives of this research.

CHAPTER THREE –METHODOLOGY

Introduction

This chapter provides an overview of the qualitative research methods used for this study. The choice of hermeneutic phenomenology as a research method is justified and the work of van Manen (1997), whose approach and methods of analysis informed the method of this research, will be discussed. Finally, strategies used to improve rigour and credibility of this study will be discussed.

Qualitative research

Research can be performed using quantitative or qualitative method. While quantitative research is useful for examining cause and effect, qualitative research is based on an interpretive or critical approach (Daly *et al.* 2007; Madill & Gough 2008). Concentrating on context and subjectivity, the aim of qualitative method is to gain insight into the meaning and root causes underlying the thoughts and actions of those being researched (Bryman 2006). Examples of this are phenomenology, ethnography and action research.

Until late last century the majority of research in health care used quantitative methods (Johnson & Onwuegbuzie, 2004). Recently healthcare institutions have begun to use a wider variety of research methods to study a range of clinical issues (The Joanna Briggs Institute 2014). Pearson, Jordan and Munn (2012) argue that qualitative methods are just as valid as quantitative methods and have an important role in evidence-based healthcare.

With respect to quality and safety, the use of quantitative research is acknowledged as the best method for measuring metrics such as mortality, sentinel and adverse events

and near misses, administrative data sets, databases, registries, key performance indicators and medical record reviews. However in addition to this, qualitative measures can highlight broad areas or issues that require improvement (Scobie *et al.* 2006; Pronovost *et al.* 2011). Examples may include clinical practice improvement, accreditation standards set by external bodies, assessments of organisational capacity for clinical governance, focus groups, credentialing and determining the scope of practice for clinicians, patient and staff satisfaction complaints surveys and performance appraisal (Scobie *et al.* 2006; Manias 2011).

Qualitative methods are often used when the subject has been poorly studied in the literature Morse and Field (2002) or in-depth, complex responses are required.

Within the various qualitative methodologies, a number of features are common, Dingwall *et al.* (1998) state that qualitative research is comprised of broadly stated questions relating to human experiences in natural environments, that generate rich and descriptive data. It uses methods such as in-depth interviews to discover unique feelings, perspectives and experiences. The type of question varies with the methodology chosen; *phenomenological* research seeks to describe and understand the lived experience of individuals, *ethnography* looks for cultural meanings and *grounded theory* focuses on social processes (Polit & Beck 2004). Rather than statistics, data is presented in comments and statements (Austin & Sutton 2014).

With regards to Crucial Conversations in a critical care setting, a holistic research paradigm is required, asking, "What are critical care nurses lived experience of crucial conversations?"

Phenomenology and hermeneutic phenomenology

Omery (1983, p 50) states "Phenomenology is a philosophy and an approach to enquiry that seeks truth and logic through critical and intuitive thinking about human existence"

With its roots in epistemology ("how do we know?") and ontology ("what is being?"), there are two distinct forms of phenomenological research, descriptive and interpretive (Flood 2010). There are differences between the two, Husserlian phenomenology is

primarily interested in describing the nature of knowing, focuses on the experiences and seeks to separate the given phenomenon from one's own beliefs (Cohen & Omery 1994; Gearing 2004). In comparison, Hermeneutic phenomenology moves away from merely describing what happens and into the realm of interpretive perspectives, teasing out the essence of the experience. Biases and assumptions are considered as embedded and essential to the interpretive process (Polkinghorne 1983; van Manen 1997).

“Hermeneutic phenomenology uses the concept of the ‘hermeneutic circle’, a metaphor to show how throughout interpretation of the data, there is an active movement between the parts and the whole of a text” (Greene 2009, p. 20). Greene (2009, p. 20) states that “the researcher moves in and out of an imaginary circle, connecting with the parts, then the whole, and then the parts once more”, furthering their understanding each time. “The hermeneutic circle refers to the idea that one’s understanding of a phenomenon as a whole is built upon their understanding of the individual parts, and one’s understanding of each individual part by understanding the whole” (van Manen cited in Greene 2009, p. 20). Context is essential to interpretation of the material, however this may be constantly changing throughout the research process.

Choice of research method

A variety of research designs, such as quantitative surveys, are considered. However, it was thought that survey answers may not provide adequate depth relating to the underlying attitudes and opinions about crucial conversations (Byrne 2004). While grounded theory uses observation, conversation and interviews it primarily involves the researcher seeking to find a theory for what is occurring according to what the researcher has observed (Glaser 1995). In comparison, this study sought to understand the lived experience from the participants’ viewpoint.

Phenomenology describes the ‘lived experience’ of the participants without necessarily being able to fully explain it (Flood 2010). It was therefore appropriate to use phenomenological methods to gather descriptions from subjects and interpret data in order to identify common experiences. These descriptions may add to the sparse pool

of existing literature relating to the effectiveness of crucial conversations in healthcare.

A succinct evaluation of various research methods indicated phenomenology was a suitable choice for this study, therefore for the interpretation and analysis of the research performed in this study, van Manen's method of analysis was used, which is drawn from the hermeneutic circle and other concepts of Heidegger's phenomenology.

Van Manen's method

Van Manen (1997) suggested an approach to research in which the researcher acknowledges their previous experience, knowledge and beliefs, and how these may influence data collection, analysis and interpretation. Van Manen (1997) advises a six step 'methodical structure', which provide a framework for the research method as a whole (p. 30). It allows the identification of any leading themes present in the data.

Van Manen's six components of phenomenological research

The six steps delineated by van Manen (1997, p.30) were chosen to provide the framework for this research. The use of these steps and the separation of thematic statements relevant to this study are discussed further in Chapter Four.

1. *'Turning to a phenomenon which genuinely interests us involves framing a research question'*.
2. *'Investigating experience as we live it'* is concerned with the methods used to investigate the lived experience in question, for example, using in-depth interviews for data collection (Greene 2009, p. 22). Van Manen (1997) suggests that lived experience must be explored and therefore in-depth interviews are suitable way of examining people's unique experiences.
3. *'Reflecting on the essential themes which characterise the phenomenon'* places the emphasis on the analysis process itself, by reflecting on the themes identified from the interviews and attempting to capture the vital meaning or substance of

the lived experience in question (Greene 2009). Van Manen (1997, p. 31) points out that there is “a distinction between appearance and essence”, that which we incline to see as everyday and that which is indistinct; and phenomenological research permits this to be brought into center.

4. *'Describing the phenomenon in the art of writing and rewriting'* is intended to make visible the feelings, thoughts and attitudes of the participants. The writing of phenomenological description “strives for precision and exactness by aiming for interpretive descriptions that contain thorough fullness and completeness of detail, and that explore to a degree of perfection, the fundamental nature of the notion being addressed in the text” (van Manen 1997, p.17).
5. *'Maintaining a strong and orientated relation to the phenomenon'* the researcher's commitment is to remain focused on the research question and to remain animated by the object in a full and human sense (van Manen cited in Greene 2009, p. 23).
6. *'Balancing the research context by considering the parts and the whole'* the researcher is requested to “constantly measure the overall design of the study/text, against the significance that the parts must play in the total textual structure” (van Manen 1997, p. 33).

Though these phases are presented sequentially, during the research there is dynamic movement back and forth between the steps as the data is examined and then re-examined (Greene 2009). It is a cyclical process (van Manen 1997).

Van Manen's method for isolating thematic statements

In direction to attribute meaning to data, van Manen (1997) suggests three methods for isolating thematic statements. Greene (2009, p. 24) states, “These methods are the detailed reading approach, the selective or highlighting approach and the holistic reading approach”

In the detailed reading approach, van Manen (1997, p. 93) advocates that the researcher pays attention to each sentence and/or group of sentences while asking, "What does this sentence, or sentence cluster, reveal about the phenomenon?". This particular selective or highlighting approach asks which account is most revealing about the phenomenon being investigated.

Within the third, the holistic reading approach, van Manen (1997) recommends looking at the text as a whole and asking which prominent phrase captures the fundamental meaning of the text. The framework created of these themes is then used to understand the vital meanings of the phenomenon being studied. The latter two approaches were employed during the preliminary data analysis of this research, recursively including the first approach and on later iterations of review.

Rigour and credibility in qualitative research

Although qualitative research methods are not new, they have been contested as lacking credibility, rigor and trustworthiness (Sandelowski 1993; Tobin & Begley 2004). When using qualitative methods it is therefore necessary to address these concerns by maintaining a high standard of academic integrity and rigor (Morse *et al.* 2002).

Koch (1996) suggests one way of exhibiting rigor is the presentation of the researcher's knowledge of different methods and how each choice may affect the research process, that each method has unique criteria for rigor. When using hermeneutic phenomenology, one must be aware of the "multiple stages of interpretation that allow patterns to emerge, the discussion of how interpretations arise from the data, and the interpretive process itself" (Laverty 2003, p. 23).

Credibility is defined as "The quality of being convincing or believable" (Oxford Living Online Dictionary 2017, n.p.). At the same time, 'rigor' is synonymous with the words 'believable' and 'plausible' and are used by Koch and Harrington (1998). Thus, it is plausible to say that the concepts of rigor and credibility have considerable commonality.

Credibility is the quality of being convincing and believable, it can be achieved when a study presents descriptions or interpretations of a human experience that are immediately recognizable and relatable to those reading the study (Polit & Beck 2012). Credibility also comes when people recognize an experience in the real world after only having read about it in a study. Hence the use of data excerpts to illustrate important themes adds credibility to research.

An audit trail describing and justifying the steps taken during the research process is an additional way of reinforcing the validity and trustworthiness of a study (Koch, 1994). Documentation of procedures such as the recruitment of participants, interview process and the development of themes are several examples. In this study an audit trail outlining the methods used for data collection and analysis has been provided and will be discussed further in Chapter Four.

Summary

The general theory of qualitative research and the fundamentals of phenomenology and philosophical origins have been presented. As little is known about critical care nurses' lived experience of engaging in Crucial Conversations, as was discussed in the literature review, a method providing rich, descriptive and interpretive data was required.

Hermeneutic phenomenology was identified as the most suitable method for performing qualitative research on this subject, as it attempts to understand peoples' perceptions, perspectives and understanding of a particular situation. It is a useful approach when a subject has not yet been thoroughly studied, defined or adequately contextualized (Dowling 2004; Polit & Beck, 2008, p. 227). Van Manen's research methods were recognized as appropriate for this study and were outlined and discussed in relation to the type of data this study aims to produce. Examples of techniques used to improve the rigor and credibility of quantitative studies were also provided.

CHAPTER FOUR – METHODS

Introduction

The research methods used for the study, are outlined in detail in this Chapter. First, technical details such as ethics approval, participant recruitment, data collection and data analysis are provided. Following this is a discussion on the hermeneutic phenomenology framework proposed by van Manen (1997) and how it was applied to the collection and interpretation of the data in this study. Finally, examples of how subthemes and themes were developed from the collected data are provided using excerpts from certain sections of interview transcripts.

Ethical considerations

Prior to commencement of the study ethical approvals were obtained from both the Human Research Ethics Committees of the Metropolitan Hospital where the study was conducted and the University where the researcher was studying to ensure adequate protection of the participants enrolled in the study Appendix A.

The study presented minimal risk to the participants, which is defined as research in which the only foreseeable risk is one of discomfort (NHMRC 2015).

Being a health professional the researcher is experienced in observing and assessing patient responses and therefore was deemed proficient enough to recognise and act to any distress that may have been exhibited by participants. A plan for further assistance and support if required was contained in the ethics approval. No such situation arose during data collection.

Due to confidentiality and privacy requirements, identifiers for participants and interrelated parties were removed, mitigating any potential risk to social relationships or reputation. Pseudonyms were used throughout data collection, interpretation and in

the excerpts of this thesis.

When establishing consent, participants were provided with information including the study approval number, assurances of anonymity and confidentiality, their right to withdraw from the study at any time and the contact details of the researcher, their supervisor and those of the ethics committee Appendix B. In addition, participants were provided with an explanation of the semi-structured face-to-face interview process and a diagram explaining the essential elements of Crucial Conversations in Appendix C.

Participant recruitment

The recruitment of participants began with a flyer calling for voluntarily participation in the study, provided in Appendix D. Additionally information about the study was disseminated via shift change huddles and by the department emails. Group email with study information was sent to critical care nurses' Team 4 in accordance with studies approval.

Recruitment occurred in the forty two-bed critical care unit of a South Australian metropolitan hospital. The hospital provides basic training positions in internal medicine, surgery and general practice, as well as advanced training in a range of specialty areas. Hospital staff are actively involved in research, making the hospital a centre for both medical and research excellence.

Once the participants expressed interest in the study and contacted the researcher via the university email system; they were sent relevant study documents. The initial email comprised the participants' information document, researcher contact information, consent form and Crucial Conversation diagram. Following review of these documents, if a participant was willing to participate in the study they were invited to contact the researcher via the university email system to discuss an appointment for the time and place of the interview.

Conduct before, during and after the interview

Critical Care Nurses' Crucial Conversations

The interview locations and times were mutually agreed upon between the researcher and the participant. Consideration was given to privacy, convenient access for the participant, ambient noise and likelihood of interruptions. Several participants wished to be interviewed away from their workplaces and the majority were happy to be interviewed in their own personal time.

Prior to the interview, each participant was provided with a brief overview of the study, how the interview was to be conducted and what was expected of him or her. They were asked if they understood the purpose of the study and were encouraged to ask questions or seek clarification at any time. They were informed that as per the terms of voluntary participation in the study they could withdraw consent, pause or stop the interview at any point in time.

Interviews consisted of in-depth, face-to-face discussions of thirty to forty minutes with eleven critical care nurses. They were semi-structured and guided by a set of questions, however discussions did not adhere to them rigidly (Appendix G). This interview structure was chosen because “oral presentations provide opportunities for greater elaboration and for participant questioning” (Polit and Beck 2008, p. 177). In addition, voluntary participation and informed consent is linked to the ideas of autonomy and independence, knowledge of the benefits of research, and understanding of the potential risks (Holloway & Wheeler 1995, p. 224; Polit & Beck 2008, p. 172).

At the start of each interview, participants were engaged in an informal conversation unrelated to the study to relax and build rapport with the interviewer, as well as to make them feel comfortable talking while being recorded. They were provided with the research questions, but also informed that these questions were a guide only and that in keeping with phenomenology they could determine the direction of the interview. The diagram of Crucial Conversations provided to them prior to the interview was also provided again to aid description of their experiences. During the interview, the diagram explaining a Crucial Conversation was placed in front of them to aid description of the experience.

Data recording, storage and management

Critical Care Nurses' Crucial Conversations

All participant information was collected using pseudonyms for privacy. Recordings from each session were transcribed verbatim personally by the researcher and subsequently verified against these recordings. Any possible participant identifiers in the transcripts were removed. Once completed, transcribed interviews were sent to each participant for clarification of the transcript and any possible corrections and additions. Most participants were satisfied with the transcripts, changes made by the participants related only to grammar and sentence structure.

All consent forms and interview transcripts were stored separately in a secure location and will be destroyed after five years, as per the University of Adelaide policy. Any computer files are stored under encryption with the researcher holding sole access.

Auditing and confirmability

Confirmability involves explicit documentation of the research process, allowing an external reviewer to follow, reproduce or audit the study. Polit and Beck (2008, p. 545) note six types of qualitative documentation which should be recorded and documented: (1) raw data, coding, reduction, and analysis (2) procedural notes (3) the reflective journal and field notes (4) data interpretation products (reflexive notes), (5) instrument development information and (6) drafts of the final report.

For this study each of these points has been documented for confirmability and auditing. Raw data in this study was collected using digital recording; transcriptions were verified to ensure accuracy (May 1989, p. 179). Text analysis and coding memos have been documented along with repetitive words, word concepts, the definition of thematic phrases and related materials. Reflective notes were used during the data analysis stage, as interviews were performed. These notes began to form the rudimentary direction for the early themes of this study.

Design

The purpose of this study was to describe and interpret the phenomenon of Critical care nurses' lived experience of a Crucial Conversations: Perspectives from one Australian nursing team. The theory of phenomenology was used to guide the design of the

interviews, several key points will be discussed here. Qualitative researchers “seek participants who have the most experience in the topic of interest” (Morse & Field 1998, p.734), in order to obtain participants who can best represent the phenomenon of interest. ‘Purposeful sampling’ therefore was used during recruitment of participants, allowing selection of individuals with particular lived experience or knowledge of Crucial Conversations. Purposeful sampling is regularly used in phenomenological inquiry (Englander 2007; Englander 2012) it can reduce the amount of data and the workload on a researcher, while producing “credible and analytically and/or clinically significant findings” (Sandelowski 1995a, p. 182).

For purposeful sampling, participants are selected based on inclusion criteria (Polit & Beck 2008,) for this study participants were nurses working in a critical care specialty unit and who had been involved in a Crucial Conversation at some point in their nursing career. In phenomenology, “all participants must have experienced the phenomenon and must be able to articulate what it is like to have lived that experience” (Polit & Beck 2008, p. 358). In some studies exclusion criteria are also applied to participant selection, however no exclusion criteria were applied in this study.

Saturation of data is a common concept that guides qualitative research (Miles & Huberman 1994). It is defined as “the point when no new information or themes are observed in the data” (Guest, Bunce & Johnson 2006, p. 59) and “a sense of closure is attained because new data yields redundant information” (Polit & Beck 2008, p. 765). Saturation of data is additionally described as sufficient information, or the adequacy and value of the data (Morse et al. 2002). This supports credibility of the data, indicating the phenomenon has been thoroughly investigated.

To ensure ‘saturation’ of data, eleven participants were interviewed, this is in accordance with the assertion that saturation in qualitative research commonly happens by twelve interviews, and can happen as early as six (Guest, Bunce & Johnson 2006). In this study saturation was reached at nine interviews, indicated by the repetition of answers given by previous participants and when no new information (themes)

presented in the data. The transcription and analysis of the data following each interview and before the next interview allowed the researcher to ascertain when saturation had been achieved.

It is impossible for the researcher to fully eliminate personal opinions and ideas from the research process; they will periodically affect the interpretation of data. As stated by van Manen “one must take hold of the phenomenon and the place outside of it one’s knowledge about phenomenon” (van Manen 1997, p. 47). Therefore in keeping with van Manen’s philosophy, the data was analysed with as little bias as possible though still informed by the researchers back ground and insights. Drew (2004) emphasises the self-awareness aspects of what it is to be a phenomenological researcher.

The researcher provided clear descriptions of the theoretical and philosophical framework. The documented data collection and data analysis showed the relevant link between the research aim/goals and the research methodology. The participant’s own words and stories were presented with the themes. The consistency of related exemplar quotes and the findings strengthened the credibility of the study results. The words and stories presented in chapter four and five with relevant and accurate quotations reinforced the essence and essential themes, thereby strengthening credibility.

Transferability and dependability

A study which is “useful in a broader context has good transferability”, as stated by Polit and Beck (2008, p. 227). “A phenomenological text that describes the results of a study should help the reader ‘see’ something in a different way that enriches their understanding of the experiences” (Polit & Beck 2008, p. 227). In this study, methodology and selection criteria for participants and the type of research setting could be done in another facility or critical area. Detailed descriptions of essential themes, supported by quotes, aid in a clear understanding of the phenomenon being studied and will improve transferability (Kvale 1994).

Dependability is supported by a consistency between the research aims, the research design, data collection and final analysis (Guba & Lincoln 1994). According to Guba and Lincoln (1994), when these elements are supported by a basic philosophical foundation upon which the study is done, the study may be depended upon to deliver a clear message. For this study, hermeneutic interpretive phenomenology was an appropriate methodology upon which to build this study, and the research methods, interviews and interpretations were all guided by this philosophical foundation.

Data collection

Interviews were conducted along phenomenological guidelines, the foundation of which is that the researcher wishes to understand and investigate the lived experience of the participant (van Manen 1997, pp. 97-98). The phenomenon under investigation is the main point of direction and the goal is to express and interpret the phenomenon through language. According to hermeneutic phenomenology, personal life stories and lived experiences have wealth that adds to the description and understanding of a phenomenon. For data of this type, collection with in-depth and semi-structured interviews is a very suitable technique, hence their use in this study.

Each interview began with a probing question '*Have you ever been involved in difficult conversation at work?*' This question provided the opportunity for participants to first reflect upon their experiences and then help them recognise and describe the lived experience of a Crucial Conversation.

In addition, this probe question provided standardisation between each of the interviews, as consistency requires the most relevant questions be asked of as many participants as possible to obtain rich data (May 1989, p. 175; Polit & Beck 2008, p. 394).

Further clarifying questions focused on emotions and experiences, elaboration of descriptions participants provided and clarification of key points in order to obtain the essence of the experience as fully as possible (May 1989, p. 179). For example, questions might follow a form such as "can you elaborate more?" and "how did that

make you feel?" Framing of question and repetition of participants own words were also used as a reflection regarding specific points, such as "I understand you said 'it was difficult' or did you say you 'were scared'?" These framing techniques enhance the meaning by seeking out the full depth of the experience (May 1989, pp. 178-179), drawing the interview from a general discussion to the specific experience of the participant (van Manen 1997, p. 68).

At the conclusion of each interview, an open ended question was asked in order to seek any further information the participants might deem relevant, such as 'is there anything else you might have remembered that you would like to add?' (Polit & Beck 2008, p. 401). By using these techniques, the interviewer may facilitate the interview without actually leading the conversation, hence the conversation remains centered around the main phenomenon, and through the lens of the participant (Polit & Beck 2008, p. 227).

Data interpretation

The reading of interview transcripts was performed carefully so as to experience each one both individually and as part of a whole (van Manen 1997). Following transcription each interview was read several times to absorb its contents as a stand-alone entity. During initial reading repetitive words and phrases were highlighted and commented upon in order to begin identifying key themes.

In hermeneutic phenomenology 'thematic analysis' endeavours to uncover the 'structure of experience', identifying essential themes and subthemes which are foundations to the phenomena being studied (van Manen 1997, p. 79). For this study, Text Analyser, software designed to thematically code transcripts and provide data analysis, aided thematic analysis. Output includes visualisation of word frequency, organisation of key words and phrases. Use of software can assist in the systematic analysis of the data and may improve readability, rigor and auditability (Pope, Ziebland & Mays 2000, p. 114).

Data analysis and interpretation: the place of the researcher's personal experience

Van Manen (1997) postulates that is essential for the researcher to recognize his or her previous experience, knowledge and views, and how these may affect the researcher in all stages of data gathering, analysis and interpretation. Therefore the analysis of the participants' words is a product of the background, training and views of the researcher involved (Greene 2009, p. 30). To address any such influences, the researcher for this study discussed her experience of Crucial Conversations with a colleague and an organizational psychologist who both have a deep understanding of Crucial Conversations. During these discussions, the researcher gained a better awareness of her preconceived notions, opinions and expectations. Further to this, personal reflections from the interviews and through the research process aided the understanding of her own experiences with Crucial Conversations. Although this is not considered data for the purpose of the study, it is vital to be aware of and understand these personal experiences and how they might affect the interpretation of the participant data. These reflections and views were vital as a reminder of preceding thought processes, early impressions of concepts and participants and as a key to the development of thought involved in creating this research paper.

1. Turning to the nature of lived experience

As was explained in the preface of this study, the research question was developed principally out of the researcher's interest in Crucial Conversations. This interest grew after attendance at a leadership seminar where the concept was discussed. It grew further upon study of previous work on Crucial Conversations by Patterson *et al.* (2012) and by the work of VitalSmarts in partnership with American Association of Critical Care Nurses into seven Crucial Conversations in health care. In their study the American Association of Critical Care Nurses suggest that there was further scope for research in exploring Crucial Conversations in healthcare. This research sought to illuminate the critical care nurses' experience of Crucial Conversations in the Australian context. The question thus became, 'What are the lived experiences of critical care nurses of Crucial Conversations'. During the study, this question

was repeatedly referred back making sure that the research method followed an appropriate path to answer it.

2. Investigating experience as we live it

The data collection method commissioned to investigate the lived experience of Crucial Conversations was semi-structured, in-depth interviews, digitally recorded and subsequently transcribed verbatim. Interviews help the participants and the researcher to re-live the participants' original experiences as they recounted them. The participants were asked to explain their experience of Crucial Conversations in their own words, and these accounts were anticipated to add intensity and magnitude to the present understanding of Crucial Conversations as a whole.

3. Reflecting on the essential themes which characterise the phenomenon

During data analysis of initial interviews, the most obvious essential themes and sub-themes were identified. During subsequent interviews, the researcher pursued to distinguish these themes in the participant's responses and encouraged elaboration in these parts, warranting adequate data was gathered for analysis.

Reflection during and promptly after the interview aided in subsequent analysis and pointed the direction of the subsequent interviews. Post each interview the recording was transcribed verbatim and then analyzed for any potential shared themes and conveyance of meaning to these experiences (Polkinghorne 1983; Hagens, Dobrow & Chafe 2009). This was achieved with immersion in the data, by reading, re-reading, shifting between transcripts and looking for similarities and parallel experience the group of participants had. Certain accounts, words or phrases that were felt to be of particular significance were searched for across all the transcripts, these helped to form the early themes and sub-themes. Further details of this process will be provided in the chapter following the heading 'Isolating thematic statements' and tabulated examples of this activity are provided as Appendices E and F. (Key words and concepts and concepts,

subthemes and themes)

4. Describing the phenomena in the art of writing and rewriting

Throughout the research process, ideas formed during data collection became clarified through writing and further iterative revisions. This repeated reflection allowed deeper understanding of the data and the lived experiences therein. Data analysis was initially performed for each individual transcript, followed by comparison between transcripts and analysis of concepts emerging from the data as a whole. Data analysis further evolved from these initial revisions with further techniques such as the text analyser program, isolation of key words and phrases, and identification of key concepts.

5. Maintaining a strong and orientated relation to the phenomenon

During the assignment of interview transcription and analysis, the researcher's interest in the subject was valuable to the continuation of the work. Repeated contact with supervisors in order to reflect on the progression of the research was critical to maintain concentration on the task at hand in addition to continued reading on the topic.

6. Balancing the research context by considering the parts and the whole

Even though data consisted of eleven individual interviews, these 'parts' became a 'whole' upon reflection and consolidation of the stories and experiences. Reading, reflection and writing was an iterative process, whereby each pass over the material provided new insights and a deeper understanding of how the data answered the main research question.

Isolating thematic statements

Themes might be isolated in various ways (van Manen 1997). As already discussed, comprehensive reading reveals what each sentence or section reveals about the phenomenon; the selective approach isolates the essential section of the text most closely related to the phenomenon; the holistic approach asks which phrase best

captures the meaning of the text, which is then seen to be a theme. The comprehensive holistic reading and selective or highlighted approach were chosen because each approach revealed different information from the data.

The detailed reading approach

The first method of data analysis for each interview in this study was to read through the transcript several times, isolating key words and concepts that emerged in certain sentences or sections, which were then categorized. Van Manen (1997, p.93) proposes that the researcher looks at each sentence or cluster of sentences while asking, "What does this sentence, or sentence cluster, reveal about the phenomenon or experience being described"? Appendix E is an example of the key words and concepts that stemmed from this process in the preliminary analysis of the transcripts.

The selective or highlighting approach

During the second phase of data analysis, the selective approach was applied to determine which statements were most informative about the phenomenon. These statements were then selected and documented an example is as follows (participants voice is represented in italics):

'He's a consultant; he's feeling that he can ask for anything in a hospital, that is his attitude...I don't care about anything else, tonight is what matters, was his attitude...Sometimes it made me feel a little bit little in my position. That there is always someone higher up that can use his or her power over you. I didn't really feel empowered, to be honest. I felt very small...just a little nurse...'
(Leptir, lines 41, 80-81, 92-94,80)

When the early analysis was applied, the quote was highlighted and became connected with the key words 'feeling small' which led to the concept of 'Power to influence', the subtheme 'Avoiding crucial conversations' and the theme 'Anticipatory responding'.

Additional examples of selective highlighting are provided in Appendix F, using statements from 'Visnja, Dunja and Maslacak'. Along with similar statements from the other participants' they form the basis of the second theme 'Anticipatory responding.'

The holistic reading approach

The other approach van Manen suggests for isolating thematic statements is the holistic reading approach. This method was used numerous times and comprised of looking at the text as a whole and asking which prominent phrase reflects the essential meaning of the text. For example the theme "Anticipatory responding" encompassed many of the concepts that were revealed in the data, including who has authority to exercise professional responsibility, who has authority to advocate, who doesn't, and who avoids or pursues Crucial Conversations. When searching data for examples of acts of empowerment to raise concerns, the following quote from Dunja was found. It describes her 'power to act' and the ability to exercise professional responsibility when dealing with the unprofessional demeanor observed in a student nurse by others.

'...so with this particular student, I brought her in for a chat and the feedback was from the nurses was quite vague, it was just that perception that she had an attitude and she considered herself better than the nurses and I have seen that before in students, that over-confidence, that cockiness and I decided to have a chat to her. So we got together in a room and I asked her how would you like to be perceived, as a professional, how do you want to be perceived and we made a list, I think she had five items I think, maybe confidence, competence, knowledgeable, caring, whatever, so she had those items that that's how she would like people to see her. And then I made a list of the perception of the staff... I started with the good things and said, look you are perceived as confident, you are perceived as competent but you are also perceived as lazy and you are also perceived as having an attitude towards the nurses that is not adequate to this environment' (Dunja, lines 12-24).

The process of identifying similar concepts was repeated with each of the eleven interview transcripts; key words and concepts found to be common between the interview transcripts were clustered together. Lipa's recollection of a Crucial Conversation resonated with that of Dunja and both were therefore clustered together under the concept of 'authority to raise crucial concerns'.

The development of themes and sub-themes -the first stage of analysis

Each interview was first analysed individually using the comprehensive reading approach. Key words, phrases and ideas were clustered together and then concepts were developed from these clusters by reading and re-reading the data. Substantial time was spent thinking on the meanings emerging from the text at this time. An example of this technique is provided in a comment from Ruza it references her experience of a Crucial Conversation:

'She had different opinions than me she was kind of picking on things and then I was quite emotional, because I was brand new and...very sensitive about anything she did...there was a risk of me being scared of not asking questions or feeling scared of not having to look after sick patients, because I was thinking maybe I am not ready' (Ruza, lines 37-42).

Key words identified as 'risk of asking questions' and 'being scared', a possible concept related to these key terms was 'identifying crucial concerns'. Parallel ideas within each interview, comprising the following quote, were clustered together before identifying a number of sections that gave general impression of the interview.

'...where I was looking after patient and she would pick on little things like what have you written on the chart what is there and why have you done that

Critical Care Nurses' Crucial Conversations

and that was quite intimidating and it was it was like making me feel like I don't know anything' (Ruza, lines 60-63).

This process of isolating parallel concepts was repeated with each of the eleven interview transcripts. Common key words and concepts were then clustered together. For example Lipa's recollections of one of her Crucial Conversation experiences mirrored those of Ruza, and these were clustered together with similar thoughts from all participants under the concept 'identifying crucial concerns'

'On night shift one night, I needed some head lice shampoo for a patient that I had who had head lice. We didn't have any so I walked around General ICU and I asked one of the senior staff members who was a male, I don't recall his name, um, "Do you have any head lice shampoo?" "I am not sure, come with me". We both walked into the drug room and he gave me the shampoo and I said, "Oh, have you got any combs? Because there are special combs to go with the shampoo." And he said "Nope, don't have any combs" and I said "Oh, yes you do" ...there were combs on the shelf right next to the shampoo. I jokingly - what I call was a joke - said, um, "Oh, you just had a boy's look!" He then, he got very, very angry with me and said, "Nope, get out, walked around me...opened the drug room door and pushed me out... stuff you, fuck you!" He actually said to me, ripped the shampoo out of my hand ...I was just shocked really and I just couldn't believe that he thought it was acceptable and the fact that he was so sarcastic and the way he treated me, he treated me like I was stupid...it didn't actually bother me that much, but the thought of him doing it to somebody else made me angry. And I didn't want that, and that's why I took it further, because I didn't want that to happen to some junior nurse. But the situation in itself didn't really affect me whatsoever' (Lipa, lines 10-21, 87-92).

Further examples of how key concepts were clustered in these early stages are shown in Appendix E, demonstrating with Ruza's and Maslacak's excerpts, and the concept of 'identifying crucial concerns' as an illustration. Their experiences differ in many

respects, with Ruza describing not being able to ask questions to support the care she delivers as a 'crucial concern', while Maslacak identifies a proposed treatment plan he considers inappropriate as a crucial concern. This process of analysis was undertaken using the interview transcripts of all eleven participants and the key concepts were developed into themes and sub-themes found through the study; examples are provided in Appendix E.

The second level of analysis - moving from key words and concepts to sub-themes and themes

The sub-themes and themes developed, although different from the early approach, had many resemblances. Meaningful statements were highlighted, copied and tabulated with the emphasis changing from the identification of key words to the identification of themes from the initial concepts. Collecting the transcripts from all eleven participants and examining them as a whole, allowed statements to be clustered into parallel categories. At this point, the sub-themes and themes were not finalised; in fact, they were altered many times before refinement into those presented in the following chapter. Appendix F explains the process of early concepts clustering within themes. For example, the theme 'Too hot to handle' was developed from the reluctance or refusal of participants to respond to situations where they foresaw a disagreeable outcome from speaking up. Within this theme, explanations for the participant's responses emerged and were sub themed into 'Controlling Behavior', 'Illegitimacy' and 'Restricted Professional Self Concept'.

An example of the first area 'Controlling Behavior' is participants encountering an angry outburst of a more senior colleague, which left them unable to raise a crucial concern. The second was 'Illegitimacy', a condition in which participants found themselves in a position where they wanted to raise a crucial concern, but did not do so, as they had not been a part of the team long enough to feel legitimate members of the group. The third, was participants acting from a position of a 'Restricted Professional Self Concept', a condition related to 'Legitimacy, but one where

participants felt they had insufficient knowledge or experience related to a concern to raise it validly.

Summary

The details of the research plan; data collection, analysis and formation of key themes have been provided. Technical details including ethics, recruitment, interview process and data collection were first described in order to provide transparency and auditability. Following van Manen (1997), philosophical justification for the research methods and techniques used throughout the interviews and subsequent data analysis has been outlined. Finally, examples of the development of themes from key concepts found within the data are provided in order to provide context for the following Chapters.

CHAPTER FIVE – INTERPRETATION AND DISCUSSION

Introduction

This chapter discusses the data and the central themes that emerged from interviews performed with eleven critical care nurses who experienced Crucial Conversations. Maslacak, Leptir, Dunja, Visna, Tresna, Lipa, Breskva, Ruza, Jabuka, Pcela, Jagoda (pseudonyms) were employed in the critical care unit (CCU) at the time of the study. Ten of the eleven held a postgraduate qualification in critical care nursing, nine were females.

This chapter is divided into three sections. The first section depicts seven crucial concerns identified by the participants. These will be described first to contextualize the three major themes and subthemes. The themes will be discussed in section two. The subthemes, into which the themes are further divided, will be discussed in section three. In the final section, the themes and sub-themes are further explored and interpreted.

Crucial concerns

It became apparent during the initial data analysis that participants broadly described encounters with Crucial Conversations, as 'unpleasant', 'uncomfortable', 'frequently upsetting' and always 'challenging'. More specifically, initial identification of crucial concerns that participants referred to were 'broken rules', 'mistakes', 'lack of support', 'incompetence', 'poor team work', 'disrespect' and 'micromanagement'. To illustrate:

Critical Care Nurses' Crucial Conversations

Leptir for example describes a consultant's disregard for hospital protocol as a 'Broken Rules' concern.

'...his attitude was that I was being difficult with him, by not giving him the {dressing}... We had already seen {dressing} work wonders when it was first out. It was brilliant, we loved it. But it was still a restricted item. We just couldn't give it out to anyone. So he's basically saying, I am a consultant I am telling you to give it to me. I'm saying well, actually, I have been instructed, it's under lock and key for good reason, I cannot give it out to anyone under the processes that were working in the hospital' (Leptir, lines 16-22).

Jagoda recounts a different crucial concern, a 'Mistake' a newly employed nurse made which, if not intercepted, may have impacted her patient's life, with a catastrophic outcome.

'I saw somebody about to push in full syringe of Metaraminol... they asked for one ml and ... she pushed three in before I basically... jammed her hand and stopped it. It felt like whilst we were in this emergency situation she was not listening to me. She would not move her body away... we had to have discussion over ... why she did not seem to engage with me, she did not listen to me when I was saying can you please move away and what was stopping her' (Jagoda, lines 212-224).

Ruza recalls 'Lack of support' she experienced as a crucial concern.

'... it was quite bad to tell you the truth. Because I was new and I did not have confidence to speak up and if I ... ask her for help she would either refuse or say something that would upset me. So I was scared to ask her for any kind of help, I was feeling ...that I don't want to work in this area. I have chosen wrong place to work, I was thinking it isn't my area I will change. Then I came home, spoke with my husband and he said to me, one thing, you either stop complaining about your work every night you come home or you just change

Critical Care Nurses' Crucial Conversations

your work...decided to talk to her with another nurse to clear things up...she did not explain anything she did not explain reason why she was doing it or if she has noticed what was happening...But it helped with the situation... the other nurse was quite good she explained to her as well that it was not right because she was quite emotional and sensitive. She {was} taking everything even little things very seriously and it stopped after that but it was very difficult communication because I did not know how I am going to confront this person... who is going to this with me and I was quite scared I was a bit nervous as well, but bringing that other person in really helped' (Ruza, lines 226-233; 64-68; 93; 116-125).

Tresnja describes a crucial concern of a doctor's 'Incompetence' in managing end of life care.

'So I had a discussion with this doctor regarding starting some analgesia before we turn off his inotropes so that {the patient} is comfortable also for his family as well. This doctor was very reluctant she did not want to write up any {pain relief} ... she just wanted to turn (the blood pressure medication support} under the believe that he would pass away quite quickly...so I had multiple conversations with her where I tried to offer my experiences in the similar situations' (Tresnja, lines 18-25).

In her interview, Breskva talks about a co-worker's 'poor team performance'.

'I worked at research foundation... one of the community liaison staff didn't agree where the organisation was going... she would actively work against {the organisation} ...I had to get HR {human resource} to come and witness the conversation and she got quite aggressive at different times and would try to attack me then I would have to say "I acknowledge that we will talk about that later on but right now we are talking about this performance here' (Breskva, lines 69-75).

Jabuka refers to 'Disrespect' as a crucial concern in her interview.

Critical Care Nurses' Crucial Conversations

'...he actually used the term of just get on with it, or something, something like that. And that made me more angry because I felt that again in a way we were sort of dismissed and sort of not taken seriously... ultimately you think about how is it going to affect the patient, and not worry about how I am feeling, because I think at the time I was too busy worrying about the fact that the medical staff had dismissed me and my opinion, it was kind of all about me, which was not the point at all, initially I was angry for the patient, but it became more about me, personal, than about the patient and that should never happen' (Jabuka, lines 34-37; 78-83).

Ruza refers to *'Micromanagement'* as one crucial concern she experienced. She says

'...she would walk into my room and she would pick on little things, like what have you written on that chart...why have you done that...and it was making me feel I don't know anything' (Ruza, lines 60-63).

These crucial concerns supported previous work done by an American study; Silence Kills (Maxfield *et al.* 2005) in collaboration with the American Association of Critical Care Nurses where similar crucial concerns were identified and correlate with a variance of patient outcomes (Maxfield *et al.* 2005, pp. 2-3). These seven critical factors form a fundamental concept describing disruptive behaviors relevant to healthcare and preventable errors (Maxfield *et al.* 2005; Grenny 2009). However, the data was further analyzed and in addition to the seven crucial concerns identified and discussed above a number of themes and subthemes emerged from the data that provide a more in-depth understanding of the experience.

Major themes and subthemes

Identifying crucial concerns reveals an incomplete understanding of the lived

experience. Further analysis of the interview transcripts exposed a deeper experience captured in three recurring themes, 'Too hot to handle' 'Anticipatory responding' and 'Moving from who is right to what is right'. The themes and subthemes will be clarified with the aid of a diagram (Figure 1) and discussed with reference to the literature and the philosophical notions of 'locus of control'.

The first theme 'Too hot to handle' describes circumstances recounted by the participants that left them feeling powerless in raising critical safety issues. Negative images of angry and condescending behavior directed toward the participants, being judged, being thought of as stupid and not being a part of the in-group characterize these conditions. This theme is made up of the sub-themes 'Illegitimacy' 'Controlling behavior' and 'Restricted professional self-concept'. These circumstances are described in the following transcripts. Jagoda describes the potential loss of legitimacy within the group making her feel powerless to raise a particular concern.

'you are ether allied or not allied, and it really felt like survivor...I mean you are in or you are out. I was afraid of being out and essentially ... I felt as long as I kept my mouth shut and draw the line then you know you get invited to the weddings you get invited to social things but also professionally you have more benefits' (Jagoda, lines 84-88).

Lipa describes controlling behaviour she encounters that made her feel powerless to raise a safety issue

'...he was very intimidating and I think, I am not really sure because I am quite a strong sort of character and I don't usually tolerate things like that, but I think because I was new and I didn't really, you know, I did not know what I was doing when I first started, I was scared myself... and I was not the only person, he was like that to others' (Lipa, lines 42-26).

Dunja describes her powerlessness as a lack of confidence in her ability to legitimately raise critical safety issues.

Critical Care Nurses' Crucial Conversations

'I think I am scared of these conversations. I am very hesitant going into {crucial conversations} and I think that comes from a place of insecurity of maybe how I perceived the facts, it is not really how it happened. Because at the end of the day, a fact is not a fact, it's my interpretation of a fact...what I felt at that time that I am not good enough, I am not good enough for these situations, I wish there was someone else doing this job, someone else would have handled this differently, and him, yelling at me, punishing me for being incompetent. So what it tells me about myself is that, the more I know who I am and what I am capable of, the more I will be able to {have} confidence in my ability clinically...I am very confident in what I do from a teaching perspective, I am not as confident from what I do in a clinical perspective' (Dunja, lines 133-138, 227-229).

Tresnja and Pcela describe their powerlessness as *'restricted professional self-concept'* emphasizing the role subjective professional identity plays in the participants' communicating critical safety issues. The following excerpts illustrate the less subjectively important the participants feel, the less individual participants will seek to enact Crucial Conversations.

Tresnja says

'You worry that they are not going to like me, it is going to be bad report, between us when we work' (Tresnja, lines 177-179).

And Pcela says

'...knowledge and your skills that come {into crucial conversations} if I have known how to do it I would not have a problem. It would have been fine. The knowledge and the skills are my defence. If I know what I am talking about that would not have been problem, I can say what I think but if I don't know what I am doing I am at their mercy' (Pcela, lines 266-270).

Critical Care Nurses' Crucial Conversations

The second theme 'Anticipatory responding' contains two subthemes; 'Avoid' a Crucial Conversation in anticipation of being judged as not the authority to do so and 'Pursue' a Crucial Conversation from the position of having the authority to exercise professional accountability to advocate in crucial encounters. The theme and subthemes present conditions described by the participants as having the power to compel participants to follow a direction of avoiding or pursuing a crucial concern. Together they offer an examination of the association between how the participants respond (avoid or pursue a Crucial Conversation), the perceived consequences; 'if I'm wrong, I will be judged and what I think is right and should be done', and the authority the participants believe they have in crucial situations. This is illustrated in Maslacak's, Jagoda's and Tresnja's transcripts. Maslacak says

'I had very different opinion on how the management should have proceeded... and I asked [the consultant] why... we were treating [heart failure] in the particular way and the doctor explain it to me ...and I did not agree with his explanation, why we could not do it my way and we went back and forth debating each other's perspective and explaining why we thought why our individual perspective was better way of approaching it' (Maslacak, lines 20-21; 31-34).

Jagoda says

'I had an issue with a clinical nurse who I worked closely with, who was supervising me through my course. She made numerous racially inappropriate comments about students and fellow nurses. I found that difficult personally, specifically regarding Asian nurses. I found that difficult to deal with from a personal ethical point of view and I knew professionally it was more compromised but as a more junior staff member I found it difficult to confront her on that' (Jagoda, lines, 8-14).

Tresnja says

Critical Care Nurses' Crucial Conversations

'I had confrontation with the doctor regarding the patient we were palliating regarding starting some analgesia...so that he {patient} is comfortable also for his family as well. This doctor was very reluctant she did not want to write up anything ...rattling with secretions and I just thought how horrible and distressing it must be for him' (Tresnja, lines 12-13; 18-21; 39-40).

The data showed anticipatory responses are generally initiated by crucial situations and events that are perceived by participants as presenting a safety concern with the response influenced by who the participant believes is right. The responses are underpinned by participants' authority to express professional accountability to raise crucial gaps in care and externally manifested as advocacy. Being clinically competent and comprehensively educated for their role in caring for the participants saw the critically ill as an essential prior condition for advocating/raising crucial gaps in care. An excerpt from Visnja's transcript illustrates this

'My professional qualifications mean a lot to me or integrity means a lot to me so I can't say that something is safe if it is not or I can't say that someone has done something effectively if they have not that is really important' (Visnja, lines 243-246).

Raising critical issues was identified in the text in using words such as 'expectations', 'strategy', 'patient' and 'family'. The process of advocacy was seen as identifying the individual need, determining the goal, planning and implementing advocacy actions, and evaluating the outcomes of advocacy. The analysis identified 'intimidated colleagues', 'vulnerable patients' and 'distressed families' as subjects of advocacy. Easing suffering was identified as an advocacy goal for patients and families as seen in Tresnja's excerpt

'You are not just advocating for the patient ...because he was in the state of distressed breathing and he was working very hard... but also for the family... it was quite distressing for his family to see him like that...we don't want to see them {family} distressed' (Tresnja, lines 35, 16-18).

Critical Care Nurses' Crucial Conversations

Bringing an end to repeated, coercive, aggressive behaviours towards others was identified as an advocacy goal for colleagues as shown in Lipa's excerpt

'I was just shocked really and I just couldn't believe that he thought it was acceptable and the fact that he was so sarcastic and the way he treated me, he treated me like I was stupid and...the thought of him doing it to somebody else made me angry. And...that's why I took it further, because... I didn't want that to happen to some junior nurse' (Lipa, lines 56-59).

The data showed after identifying the goals of advocacy, the critical care nurses make plans and adopt a variety of advocacy practices.

'And...that's why I took it further, because... I didn't want that to happen to some junior nurse' (Lipa, line 58).

In Tresnja's excerpt a different goal is revealed

'I really just want to explain...why I have been coming up to you about...{the} comfort of the patient and the family distress...I did not think it was appropriate for an hourly pain relief order, which was very low dose for the patient who was 120 kg it was 2.5 mg {the} peak effect was not going to be effective...my view was we are palliating, whatever we do it isn't going to change his care but only maybe make him more peaceful and comfortable' (Tresnja, lines 51-58).

The data showed participants evaluate the outcomes of patient advocacy. Jagoda is relieved that the patient is safe. Then she can pursue addressing the concern

'...It is beneficial...if you can stabilise some of those strong emotions by delaying it, if you talk immediately you might say number of things that are high provoking and sort of unnecessary, but if you can synthesised it personally and just discuss the key issues and try to break it down to what is core, you know while the adrenaline is high, all I am thinking is ooooo my God the patient has systolic blood pressure of 210... you are very concerned about patient's wellbeing but once that has resolved and patient is fine you can then bring it

Critical Care Nurses' Crucial Conversations

down to the key issues which were the communication and trust and ...correct the protocol' (Jagoda, lines 281-289).

Reflection on the first two themes offers possible insights into the published literature. The literature comments on ten percent of health care workers pursuing Crucial Conversations while the rest simply stand by and watch their colleagues break rules, micromanage, be disrespectful, exhibit poor team work, make mistakes, fail to support others and display incompetence (Maxfield *et al.* 2005, p. 2; Maxfield *et al.* 2010, p. 2). The literature does not attempt to establish why. The data surrounding the first two themes suggests that critical care nurses are not simply standing by, with their responses influenced by the consequences and responses they anticipate will follow. The participants only raise issues if they believe they have the authority to do so. The Crucial Conversation that follows is based on who has the authority to raise an issue, who is right and around converting others to their point of view.

The third theme 'Moving from who is right to what is right' characterizes the change in seeing differences in clinical opinion as integral to team performance rather than failures and seeing diverse opinions in terms of what is right for the patient not in terms of who is right. Maslach's transcript depicts the shifting consideration of diverse opinions.

'5 years ago I would have come out of the room guns blazing saying "You are not doing it right way, You have to do it this way, I disagree you are 100 % wrong, You are putting the patient under undue risk. I would have been... headstrong... as I became more experienced... I have understood the differences of opinions and I have been able to put myself in the other person's shoes and understand their opinion better, and also explain my opinion better and a lot of that is by removing emotions or try to minimise the emotions ...and there are always going to be differences in the opinion and you understand that you know the saying there is more than one way to skin a cat. And just because it is different opinion it does not mean that it is wrong and the part of understanding

Critical Care Nurses' Crucial Conversations

sorry, part of accepting someone else's opinion is understanding their opinion' (Maslacak, lines 290-299; 216 -221).

This theme is made up of two subthemes; 'Validating anticipatory responses (reflection)' and 'Tangible comprehension of elements of Crucial Conversations (reflexivity)'. The sub-theme 'validating anticipatory responses' revealed the participants' capacity to consider, in an introspective manner, how they engaged in Crucial Conversations and changed their future Crucial Conversations accordingly. The data showed reflection took place after an anticipatory response regardless of whether the participant pursued or avoided the conversation. At this time the data revealed participants contemplated how they handled the conversations, what the outcomes were and where they could improve. Many of the participants expressed they did not perform in the conversations as well as they could have. Tresnja's and Maslacak's excerpts illustrate this

'I think I did well, because she did not get defensive, people often get defensive...I don't know how much she absorbed of that conversation but I guess for me I felt nervous as well...because I am only new to the critical care role...I just need to take a step back...rather than be a bit hot headed or fast to react...so rather than just being on the offensive thinking... my way is right way ...just stepping back and listening a bit more rather then you need to do this do it now do what I say step back and having the understanding I think' (Tresnja, lines 193-194; 198-200; 125-133).

'It told me that I wasn't very well equipped to manage difficult conversations, that my method of approaching the conversation meant that conversation wasn't going to be successful and that when the conversation did not go my way my response was to get frustrated rather than... approaching {the conversation} differently...maybe ascertaining whether the doctor was understanding it or it was just the matter of difference in opinion, yet I went into strong emotions very

Critical Care Nurses' Crucial Conversations

quickly frustrated and that prevented the conversation to go any further' (Maslacak, lines 111-118).

The theme validating anticipatory responses refers to the participants being shown a diagram of Crucial Conversations during the interview (Appendix D). The diagram depicted Crucial Conversations comprising of '*high stakes*', '*opposing opinions*' and '*strong emotions*'. When the participants visualised the diagram they immediately could associate their feelings and experiences in the events that they were describing. In other words they considered their Crucial Conversation dialogues through the lens of the Crucial Conversation diagram that resulted in a '*tangible comprehension of the elements of Crucial Conversations*'

This is evident in the following excerpts.

Maslacak says

'Absolutely, definitely high stakes, definitely opposing opinions and as we started there was not strong emotions but as the conversation went on strong emotions develop especially on my side the consultant stayed very calm very neutral through the whole conversation' (Maslacak, lines 50-53).

Dunja says

'I think the strong emotions was ... was sort of what dominated that conversation, because that was a surprise for her and opposing opinions as well, because she didn't know that people saw her that way and it was a big surprise, and she struggled to believe. So only after we went through, look, if you are getting the same feedback from different people in different situations, you really need to look into that. And high stakes, because, considering that's a student that will have a program or not how they are perceived and all that, makes a big difference in their future employment and if people want them back, or not' (Dunja, lines 51-58).

Critical Care Nurses' Crucial Conversations

Leptir says

'I would probably start off with the high stakes. Everyone wants their patient to have a good outcome. I think it's the highest stake you could possibly have in nursing, medical field. The opposing opinions, actually, I really feel, mainly through hospital protocol on who could actually obtain the dressing, and the doctor feeling that he could go above these directions. Strong emotions, he was in a position where {he didn't want} to back down...I couldn't give it out because I had been told I can't... He's a consultant; he's feeling that he can ask for anything in a hospital that is his attitude' (Leptir, lines 35-42).

The subtheme is additionally revealed in the data in transcripts where the participants are acknowledging and respecting opposing positions in Crucial Conversations, and how in raising crucial concerns they are able to consider the opinions of others.

Maslacak says

'...surprisingly or interestingly for myself I am more confident person now than I was when I had conversation that we talked about earlier but it made me lot less head strong in my approach. I have been a lot calmer and I have been a lot more amenable to understanding differences of opinions and excepting differences of opinions... I have learnt as I become more experienced that I have understood the differences of opinions and I have been able to put myself in the other person's shoes and understand their opinion better and also explain my opinion better and a lot of that is by removing emotions or try to minimise the emotions...It told me that I wasn't very well equipped to manage difficult conversations that my method of approaching the conversation meant that conversation wasn't going to be successful and that when the conversation did not go my way my response was to get frustrated rather than I guess approaching differently maybe ascertaining weather the doctor was understanding it or it was just the matter of difference in the opinion yet I went into strong emotions very quickly frustrated and that prevented the conversation to go any further' (Maslacak, lines 111-118; 204-208; 295-299).

Jabuka says

'I have reflected over these things many times but I think, especially in that incident I talked to you about, but I think sort of talking to you about it makes you more aware of just how important that is, that communication and those conversations, how important they are for patient care and how you have got to work, even though there might be different opinions, you have got to work with that person and come up with a solution and you've got to take out your emotions, you can't worry about whether you're tired or whether you don't like that person, or whether you're angry with them, or whether they annoyed you before, um, I just think it makes me more aware of what I am doing and how I am speaking to people and how I can get everybody involved in communicating, you know, I can say have you spoken to such and such and does this person know what is happening with this, I think you're more up front without being sort of aggressive about it' (Jabuka, lines 204-215).

The data suggests that tangible understanding of Crucial Conversations and validation of previous anticipatory responses leads to a shift in consideration from who is right to what is right in crucial situations. The themes and subthemes discussed above are represented in the following diagram.

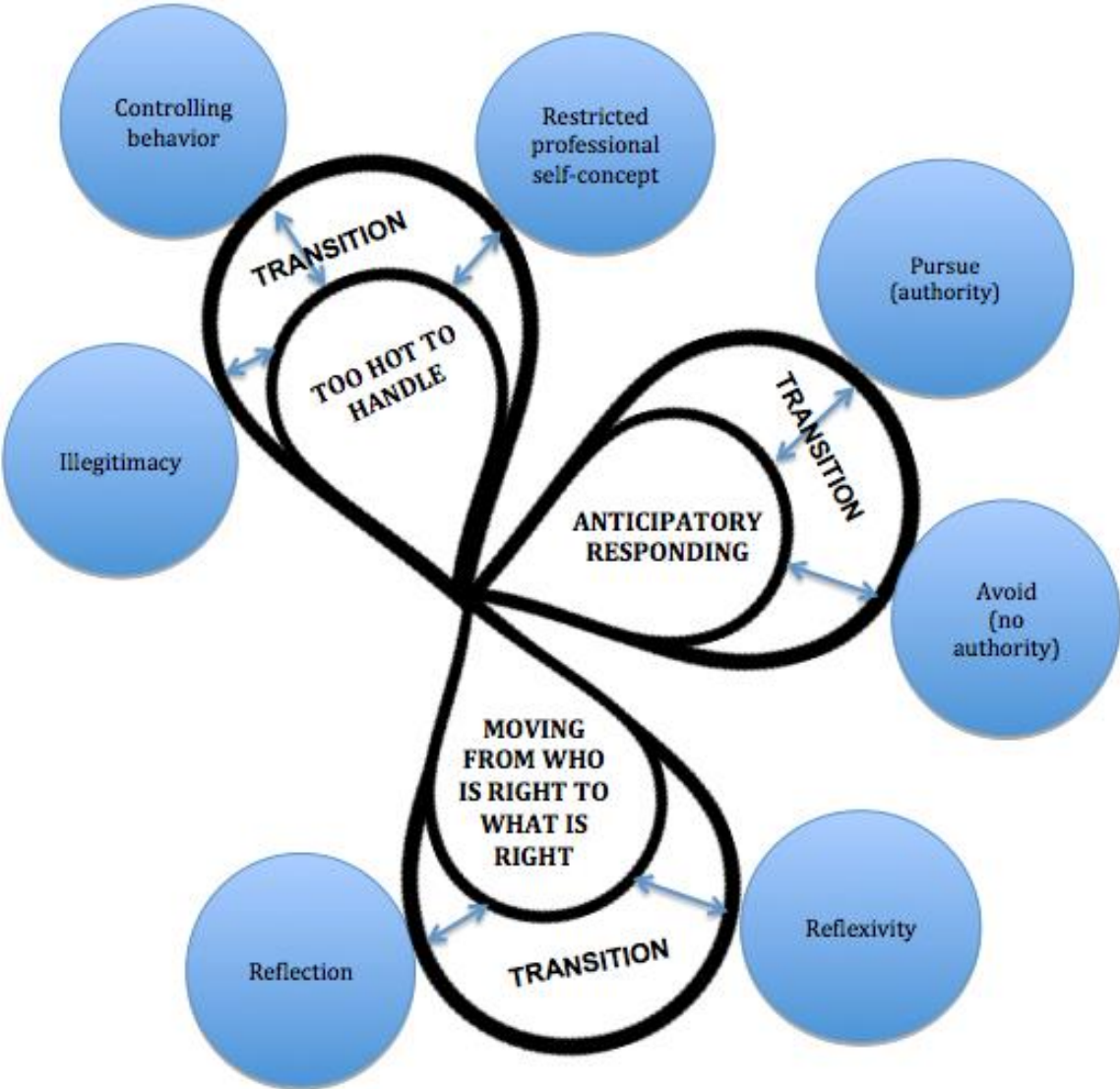


Figure 1.

Critical Care Nurses' Crucial Conversations

Figure 1 illustrates the themes and subthemes that emerged out of the transcripts. In the centre of the diagram are the three themes '*Too hot to handle*', '*Anticipatory responding*'; and '*Moving from who is right to what is right*'. The circles on the outside of the diagram represent the seven subthemes emerging from further data analysis in this study. For example in the theme '*Too hot to handle*', participants are seen as transitioning from identifying a crucial concern to not raising the concern. The transition of identifying the concern to finding it too hot to handle and therefore not raising it can occur in three ways. Firstly, through the actions of others identified by the participants as '*Controlling behaviors*'. One example included an angry outburst of a more senior colleague. The transition may also occur because the participants feel they are not legitimate members of the group '*Illegitimacy*' or have inadequate knowledge and experience '*Restricted professional self-concept*', to raise the crucial concern.

To illustrate further, the subthemes '*Avoid*' and '*Pursue*' show how participants transition to '*Anticipatory responding*'. The participants transition by contemplating whether they had authority (clinically competent and comprehensively educated for their role in caring for the critically ill) or lacked authority (uncertain about the requisite knowledge and experience) to raise the concern with validity. The participants who avoid '*Avoid*' to raise crucial concern do so in anticipation of being judged as not having the authority to do so and '*Pursue*' a crucial concern from the position of having the authority to exercise professional accountability to advocate in crucial encounters.

In the theme '*Moving from who is right to what is right*' the diagram illustrates how participants transition to being able to consider and respect opposing views of others. The diagram illustrates this transition occurs through validation of their previous anticipatory responses in Crucial Conversations '*Reflection*' and through an appreciation of the elements of Crucial Conversation '*Reflexivity*'.

On reflection the researcher turned to the broader literature and was reminded to ensure that throughout the interpretation and discussion that participants have unique worldviews, which are interwoven into Crucial Conversations. Rotter (1954) describes

how a person's locus of control is defined as either internal or external. A person with an internal locus of control believes that he or she can influence events and their outcomes, while someone with an external locus of control blames outside forces over the events of their life, which they cannot influence (Rotter 1954).

While the participants in this research were not questioned specifically about the degree to which they believe they have control over the outcome of events in their lives, the interview process inevitably gave insight into their individual locus of control. Reflecting on the transcripts it is conceivable that individuals with a strong internal locus of control who believe events in their life derive primarily from their own actions, may be more able to assume professional accountability for advocating critical safety concerns. These participants would spend time on planning the conversation and setting goals and reflect on how they performed and whether they achieved set goals.

Participants who act from the opposite position of external influence are more likely to fear ridicule or judgment. This is evident in Jagoda's description of her Crucial Conversation experience that was dependent upon what was going on around her. She acted from the position of external influence, fearing isolation from the group and missing out on personal benefit. Maslacak on the other hand, raised with a consultant, what he considered the consultant's poor management of a patient with heart failure. Maslacak's descriptions contained many accounts reflective of his knowledge, professional accountability and advocacy. He asked questions about alternatives and what else could be done to mitigate what he considered a risk to the patient and to justify his actions. He was acting from the belief that he had control over the outcome of the Crucial Conversation. Furthermore, Maslacak's accounts of raising a critical safety concern show a changing response with growing experience. Five years previous he would approach people *"with guns blazing, telling people this is what we have to do, this is how we are going to do it"* Now he is conscious that "strong emotions" can impact on the delivery of the message, how it is delivered and how it is received. He avoids emotions, stays calm and does not force an opinion.

Summary

Analysis of the interview transcripts indicated that the experience of Crucial Conversations varied. The data revealed the critical care nurses' lived experience of Crucial Conversations fell into three themes, 'Too hot to handle' 'Anticipatory responding' and 'Moving from who is right to what is right'. Many of the findings corroborated past research; some offered extended insights. The implications for these findings will be explored in the final chapter, 'Discussion'.

FINAL CHAPTER – DISCUSSION

Introduction

This chapter will discuss the study's strengths and limitations. Implications of Crucial Conversations for critical care nursing practice will be deliberated. Possible research questions that arose from this study will be contemplated. A synopsis of this thesis' chapters will be provided together with closing remarks.

Strengths and limitations of the research process

This phenomenological hermeneutic study explored the lived experience of eleven critical care nurses from one Australian critical care unit. The sample size was small compared to the total number of staff working in the unit. However the sample size was determined by the course of phenomenological research that anticipates a small number of participants, and the time restrictions of a master thesis. Although it could be debated that small number of interviews would curb the richness of data, nine interviews resulted in data saturation with no new themes emerging during the last two interviews.

When participants were asked to recall Crucial Conversations they may have chosen conversations that took place weeks, months or even years ago. This time lapse may have transformed the ability of the participants to remember exactly the meaning of the experience. Interview questions did not probe into the participants' personal locus of control, but data analysis revealed locus of control appeared to have had an influence on the experience of Crucial Conversations. Therefore it is acknowledged that locus of control may have played a significant role in the participants' responses to experiences. Future research may possibly explore the role locus of control plays in how participants act in Crucial Conversations.

In addition it is acknowledged that the fact that nine of the eleven participants were female and ten were trained in critical care nursing also give a certain character to the narratives gathered. The language that they used to describe their experiences gave a

certain shape to the interpretation of those experiences. Male staff, non-critical care trained staff, staff from another unit in another hospital, state or country may have possibly given a different account. Future research should attempt to include both trained and untrained participants and more male participants, which would allow for different responsiveness to Crucial Conversations and questioning. It is impossible to say with any accuracy how the untrained participants' Crucial Conversations experience may have differed.

The origin of the participant should also be taken into consideration in designing research into the experience of Crucial Conversations as different cultural groups may have divergent experiences. To what degree these characteristics are limitations is not evident, as qualitative research of this measure does not normally require the participants to demonstrate broad deviation in age, gender, culture and background. It is recognized though that the small sample size, a single context, and relative homogeneity of the participants in terms of gender and critical care training means that findings cannot necessarily be transferred to different settings and different groups of critical care nurses who may recall different experiences. However, the common experience of a Crucial Conversation may be investigated under the same conditions of this study, using a similar analysis technique to explore different environments to compare how Crucial Conversation techniques can impact professional relationships in multiple settings.

Even though there are limitations, this study does offer a rich description of the 'lived experience of Crucial Conversations' and promotes a body of knowledge that is limited in nature. Crucial Conversations literature makes explicit disruptive behaviors that contribute to adverse events, and while this approach is of considerable importance, there is a distinct need for research that addresses the lived nature of Crucial Conversations. This research adds to the findings of Maxfield *et al.* (2005 & 2010); Saxton (2012) and Major, Alvarez and Sweeney (2013), who also explored aspects of Crucial Conversations, and may help individuals make sense of their own Crucial Conversations experiences.

As phenomenology has been defined earlier, having a goal to explore the nature of a lived experience of a phenomenon. This method ascertained to be appropriate in order to illuminate the lived experience of Crucial Conversations. In following a research methodology that is truthful to the research goal and providing a clear audit trail of the research course, the study has established credibility and rigor. The activity of preparing the research question as a critical care nurse and progressing to the role of a researcher has facilitated a broader vision of the domain of Crucial Conversations to be explored.

Implications of crucial conversations for critical care nursing practice

This research has brought attention to the lived experience of Crucial Conversations that has implications for critical care nurses. The study findings show most nurses are not adequately prepared to effectively handle Crucial Conversations. These findings are supported by Maxfield *et al.* (2005 & 2010), who claim most people perform poorly in Crucial Conversation, in part because they have been immersed in a culture that is full of poor examples from people who lack the requisite skills; further supported by Patterson *et al.* (2012, p. 58), who acknowledges that human tendencies under threat are *silence* (failures to communicate clearly or sufficiently) and *violence* (attempts to coerce compliance). This study and the studies conducted by Maxfield *et al.* (2005 & 2010) in conjunction with the American Association of Critical Care Nurses, show silence and violence do not contribute to shared meaning necessary for problem resolution, but can harm relationships and perpetuate disruptive behaviours.

In this study, Crucial Conversations began with a specific situation, progressed to decision making of how to act and concluded with a response, reflection and adjustment. These findings lend themselves to a process of implementing Crucial Conversations into health care settings described by Maxfield *et al.* (2011) and Saxton (2012). The authors recommend widespread application of Crucial Conversations to specific cultural problems with the implementation process to include: identifying high

Critical Care Nurses' Crucial Conversations

risk situations where obstructive behaviours may occur; defining expected behaviours; and developing organizational wide safe operating procedures for expected behaviours.

In order to implement Crucial Conversations, Maxfield *et al.* (2011) and Kernaghan (2013) also recommend that nurses and doctors regularly share stories where the Crucial Conversations prevented the error from occurring or an error from becoming an adverse event. The authors' also advocate sharing the stories defining situations where patient harm occurred and a Crucial Conversations did not occur or the team remained silent. Sharing the experience with teammates may enhance the overall understanding of Crucial Conversations. Furthermore the authors suggest the organisation needs champions promoting the culture to have Crucial Conversations.

These study findings encourage nurses to engage in Crucial Conversations, The findings suggest Crucial Conversations require practice. These study findings suggest, it may be advantageous to debrief after Crucial Conversations so that the team can learn from an assortment of experiences that evolve over time. Moreover, sharing of the post Crucial Conversations outcomes may be helpful. Additionally this research suggests emphasis should be given to post Crucial Conversation effects. All the participants in this study reported after effects of Crucial Conversations, some unpleasant, some uplifting that should be conveyed to colleagues.

Finally, this research highlights the compelling results obtainable when using Crucial Conversations. It highlights the need to communicate the concept to the broader critical care community. Ideally, critical care nurses would receive education and mentoring alongside an experienced practitioner of Crucial Conversations, fostering an environment where important discussions may occur through a secure and respectful discourse. This study shows the value of Crucial Conversations for professional development, improved working relationships and interpersonal conflict management as well as empowering critical care nurses in the hierarchical structure.

In terms of applying this knowledge to formal critical care team-training programs, courses such as Cardiac Surgery Advanced Life Support teach team skills and may

provide a model for introducing team training into clinical practice. Training would consist of general principles underlying optimal team performance in the critical care unit (for example, communication openness) and also the behavioral strategies associated with specific practices. Key difficulties in developing such a program would likely be related to the resources involved in managing a comprehensive team training program (for example, trainers, simulators, and clinician time to participate), ensuring that programs are consistent across critical care units, generating institutional support for team training, and identifying the key team training requirements for multidisciplinary critical care teams.

This study and the study of Maxfield *et al.* (2010) support Saxton (2012), Major, Alvarez and Sweeney (2013) and Trinidad (2013) assertions that healthcare could follow aviation in resourcing of staff that specialize in human factor aspects of patient care. However they stress several cultural attributes appear to distinguish aviation from healthcare. Aviation has much more of a blame-free culture for reporting and owning up to safety incidents whereas in healthcare it is still regarded as the priority of some, not the obligation of all (Kapur *et al.* 2016). What is common to both industries is the concept of professionalism that Sullenberger cited in Kapur *et al.* (2016, p. 2) has pointed out to as time in aviation where pilots ‘acted like gods with a little “g” and cowboys with a capital “C”’. Despondently, the research participants report similar instances of this culture in healthcare. As Timmons *et al.* (2014) have argued, full and effective employment of human factors initiatives could stall if the culture is not accommodating. The authors found that human factors training courses although valued by staff who take part, stall because of long-standing cultural and organizational issues (Fraher 2011). It then presents an economic framework for determining the likely costs and benefits of different patient safety initiatives.

Synopsis of this thesis

Chapter One of this thesis introduced the research topic: An investigation of critical care nurses lived experience of Crucial Conversations. A brief overview of the history of safety models was given, followed by an introduction to and summary of the

evolution of the thought that led to the development of Crucial Conversations as a safety system. In Chapter Two a summary of the literature relating to the evolution and implementation of Crucial Conversations as a safety technique in health care environments is given. Gaps in the current research were discussed and lived experience of Crucial Conversations in health care environments was identified as an important piece missing from the literature, thus supporting the aims and objectives of this research. In Chapter Three, rationale for the choice of hermeneutic phenomenology as the research methodology for this thesis was given with particular emphasis on van Manen (1997), hermeneutic phenomenological approach and methods of analysis. Chapter Four outlined the research design and provided van Manen's (1997) six steps used in the analysis and interpretation of the data. The main themes 'Too hot to handle' 'Anticipatory responding' and 'Moving from who is right to what is right' and the subthemes that emerged from the data analysis were presented and discussed with reference to the literature of Crucial Conversations. In Chapter Six limitations and strengths of the study were discussed and questions arising from the research were presented.

Areas for future research

Several areas for future research have been identified, including aligning specific patient safety risks with Crucial Conversation training; establishing benchmarks on the existence and frequency of situations addressable to Crucial Conversations, establishing wider and deeper implementation of a Crucial Conversation theory and establishing training model as a framework for describing specific conversations.

Concluding comments

This research represents the experience of Crucial Conversations from the perspectives of nurses working in a one Australian critical care unit. It is important to note that this is only one interpretation of any number of interpretations that could have resulted from

analysis of the data collected. Other research namely Maxfield *et al.* (2005 & 2010), Saxton (2012) and Major, Alvarez and Sweeney cited in Trinidad (2013) give complementary views that add to the body of knowledge related to the lived experience of Crucial Conversations. Trinidad (2013) claims that research conducted by Maxfield *et al.* (2005 & 2010), Saxton (2012) and Major, Alvarez and Sweeney (2013) helps move understanding of Crucial Conversations beyond the description, he quotes from Patterson *et al.* (2011), Crucial Conversations are a 'path to action see and hear, tell a story, feel and act'. This research advances the understanding of a Crucial Conversation from a path to action to a path difficult to walk.

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APPENDICIES

Appendix A – Ethics approval letter



Government of South Australia
SA Health

Approval date: 14 November 2016

Central Adelaide Local Health Network
Research Office

Ms Nihada Basic
Adelaide Nursing School
University of Adelaide

Level 4, Women's Health Centre
North Terrace, Adelaide SA
Australia 5000
T : 08 8222 3337

Ground Floor, Basil Hetzel Institute for Translational Research
28 Woodville Road, Woodville SA
Australia 5000
T : 08 8222 6841

Dear Ms Basic

Project title: Critical care nurses' lived experience of crucial conversation: Perspectives from one Australian nursing team

MyIP ref: 8582
CALHN ref: R20161024
HREC ref: HREC/16/RAH/456
SSA ref: SSA/16/RAH/457

RE: Governance authorisation

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to commence at the Royal Adelaide Hospital, SA.

The following conditions apply to the authorisation of this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval to this project:

1. Authorisation is limited to the site/s identified in this letter only.
2. Project authorisation is granted for the term of your project outlined in the Low/Negligible Risk Ethics and Governance Application Form, or until the project is complete (whichever date is earlier).
3. The study must be conducted in accordance with the conditions of ethical approval provided by the lead HREC, SA Health policies, and in conjunction with the standards outlined in the *National Statement on Ethical Conduct in Human Research (2007)* and the *Australian Code for the Responsible Conduct of Research (2007)*.
4. Proposed amendments to the research protocol or conduct of the research which may affect both the ongoing ethical acceptability of the project and the site acceptability of the project are to be submitted to this Research Governance Office after a HREC decision is made.
5. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted via email to this Research Governance Office;
6. For all clinical trials, the study must be registered in a publicly accessible trials registry prior to enrolment of the first participant.
7. A copy of this letter should also be maintained on file by the Coordinating Principal Investigator as evidence of project authorisation.
8. Notification of completion of the study at this site is to be provided to this Research Governance Office.

All future correspondence regarding this study must include the MyIP reference number and CALHN reference number in the subject header.

We wish you every success in your research project.

Yours sincerely

Bernadette Swart
Manager, CALHN Research Office
Ph: 8222 3890
Inrega approval letter.doc

Appendix B – Participant information sheet

PROJECT TITLE

Critical care nurses' lived experience of a crucial conversation: Perspectives from one Australian nursing team.

PRINCIPAL INVESTIGATOR: Nihada Besic

SUPERVISORS: Josephine Perry, Sindy Millington

STUDENTS DEGREE: Masters

Dear Participant, You are invited to participate in the research project described below.

What is the project about?

This project will explore range of lived experiences and viewpoints about crucial conversations. Crucial Conversation is the communication of critical safety information in emotionally charged situations where professional opinions differ and risk of consequences is perceived to be high. Specifically, the researcher intends to interview volunteer critical care nurses working in the critical care unit who have lived experience in crucial conversations.

Who is undertaking the project?

Nihada Besic is conducting this project.

This research will form the basis for Nihada's Masters degree at the University of Adelaide under the supervision of Josephine M Perry and Sindy Millington School of Nursing, University of Adelaide

Why am I being invited to participate?

Your experience of crucial conversations will help identify the meaning of crucial conversations in the critical care setting. The illumination of this phenomenon may give direction to nurses responding differently to health care safety breaches.

What will I be asked to do?

Critical Care Nurses' Crucial Conversations

You will be asked to participate in an individual interview. The interview will be digitally recorded and will be transcribed verbatim for the sole purpose of this study. The interviews will consist of several open-ended questions. The questions will enable you to share your experience of crucial conversations.

How much time will the project take?

The nature of phenomenological study is to interpret lived experiences through interviews until new data stops emerging and saturation is reached. Each interview is expected to take between 30-60 minutes.

Are there any risks associated with participating in this project?

There are no predictable risks associated with your participation in this study. The interviews will be held at a venue of your choice where you will feel comfortable to share your experiences without someone walking in on our conversation. In the event of any distress you will have the option of immediate withdrawal from the study and follow up counseling available through SA Health.

What are the benefits of the research project?

There may not be an immediate direct benefit to you. However your responses will act to inform the discipline of nursing and add to the body of knowledge of crucial conversations in the critical care setting.

Can I withdraw from the project?

Your participation in this project is completely voluntary. You may decline to answer any questions, request to stop recording or terminate the interview. You can withdraw from this study at any time without any repercussions.

What will happen to my information?

Written notes and digital record data of all conversations made during the interview will be kept strictly confidential. There will be no names divulged. Pseudonyms will be used on the written interview notes, in the written thesis and in published information. No other person than the lead researcher will have access to the data.

Data will be solely used for this study. The lead researcher will only know the identity

of the participants in the study.

Upon study completion, all paper and electronic information will be kept in a confidential and secure manner for 5 years. Once the study has been evaluated, the audio recordings will be erased. Paper documents will be shredded and any computer files will be deleted after 5 years. Upon completion of the study the results will be submitted for the journal publication. All the examples will be deidentified. Once the article is successfully published it will be made available for perusal by any interested participant.

Who do I contact if I have questions about the project?

You can contact the student researcher Nihada Besic at nihada.besic@adelaide.edu.au or the supervisors of this study Jo Perry at jo.perry@adelaide.edu.au and Sindy Millington at sindy.milington@adelaide.edu.au

What if I have a complaint or any concerns?

The Human Research Ethics Committee at the Royal Adelaide Hospital has approved the study.

Approval number is R20161024. If you wish to speak to someone who is not involved with the study about the conduct of the study or your rights as a participant, please contact the Executive Officer of the Royal Adelaide Hospital Research Ethics Committee on 8222-4139 or CALHNResearchEthics@sa.gov.au Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the result.

If I want to participate, what do I do?

If you are interested contact the principal researcher Nihada Besic on nihada.besic.adelaide.edu.au to negotiate an appropriate time for your interview with the researcher. The researcher will be available to answer any questions about the study. The study will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research.

Yours sincerely,

Nihada Basic

Appendix C – Participant consent form

PROTOCOL NAME

Critical care nurses' lived experience of a crucial conversation: Perspectives from one Australian nursing team.

PRINCIPAL INVESTIGATOR: Nihada Besic, CCRN, BN, Grad Dip Cardiac Nursing

PARTICIPANT CODE:

This is to certify that I hereby agree to participate in a scientific investigation as a part of the Master Degree Program of Adelaide University, under the supervision of (Josephine M. Perry and Sindy Millington).

1. The nature, purpose and risks of the research project have been explained to me. I understand them and agree to take part.
2. I understand that I may not benefit from taking part in the trial.
3. I understand that, while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
4. I understand that I can withdraw from the study at any stage and that this will not affect my relationship with my employer now or in the future.
5. I have had the opportunity to discuss taking part in this investigation with a family member, colleague or friend.

Critical Care Nurses' Crucial Conversations

Name of Subject:

Signed: _____

Dated: _____

I certify that I have explained the study to the patient/volunteer and consider that he/she understands what is involved.

Signed: _____

Dated: _____

(Investigator)

Appendix D – Three elements of a Crucial Conversation

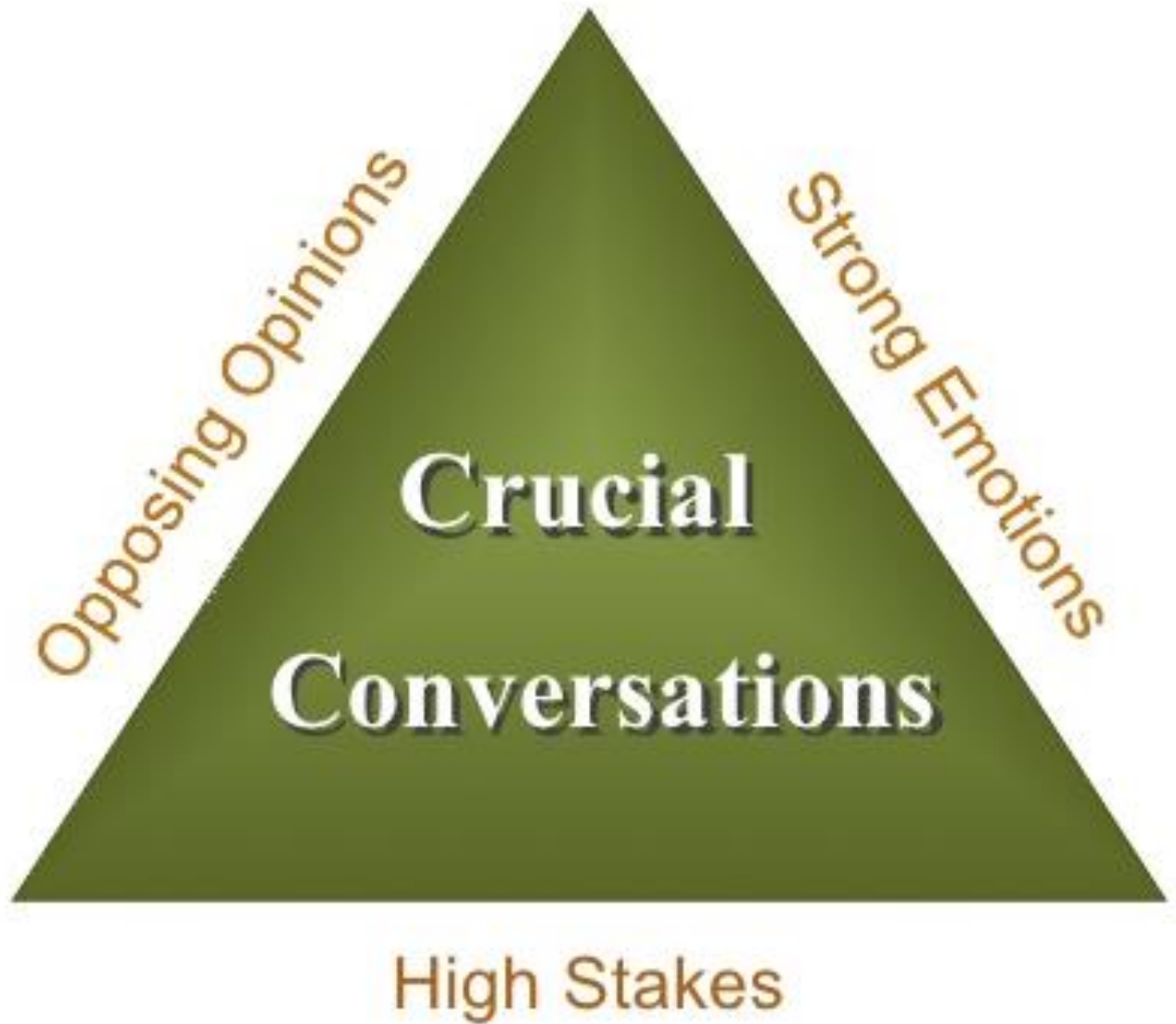


Figure 2. Patterson *et al.* 2012

Critical Care Nurses' Crucial Conversations

Appendix E - Key words and concepts initial analysis

Participants Voice	Key words	Concepts
<p>Leptir <i>He's a consultant; he's feeling that he can ask for anything in a hospital, that is his attitude. I don't care about anything else, tonight is what matters, was his attitude...Sometimes it made me feel a little bit little in my position. That there is always someone higher up that can use their power over you. I didn't really feel empowered, to be honest. I felt very small...just a little nurse...</i></p>	<p>Feeling small Attitude</p>	<p>Identifying crucial concerns</p>
<p>Lipa <i>On night shift one night, I needed some head lice shampoo for a patient that I had who had head lice. We didn't have any so I walked around General ICU and I asked one of the senior staff members who was a male, I don't recall his name, um, "Do you have any head lice shampoo?" "I am not sure, come with me". We both walked into the drug room and he gave me the shampoo and I said "Oh, have you got any combs? Because there are special combs to go with the shampoo." And he said "Nope, don't have any combs" and I said "Oh, yes you do", and there was a little ...there were combs on the shelf right next to the shampoo. I jokingly - what I call was a joke – said, um, "Oh, you just had a boy's look!" He then he got very, very angry with me and said, "Nope, get out of me</i></p>	<p>I just couldn't believe that he thought it was acceptable he treated me like I was stupid the thought of him doing it to somebody else I didn't want that, and that's why I took it further</p>	<p>Identifying crucial concerns</p>

Critical Care Nurses' Crucial Conversations

<p><i>around and opened the drug room door and pushed me out of the drug here, stuff you, fuck you!” he actually said to me, ripped the shampoo out of my hand</i></p> <p><i>I was just shocked really and I just couldn't believe that he thought it was acceptable and the fact that he was so sarcastic and the way he treated me, he treated me like I was stupid and it made me, it didn't actually bother me that much, but the thought of him doing it to somebody else made me angry. And I didn't want that, and that's why I took it further, because I didn't want that to happen to some junior nurse. But the situation in itself didn't really affect me whatsoever.</i></p>		
<p>Maslacak</p> <p><i>It was between myself and the intensive care consultant looking after the patient with heart failure, and we I had very different opinion on how the management should have proceeded</i></p>	<p>different opinion on management</p>	<p>Identifying crucial concerns</p>
<p>Ruza</p> <p><i>She had different opinions than me she was kind of picking on things and then I was quite emotional because I was brand new and it was very sensitive about anything she did and there was a risk of me being scared of not asking questions or feeling scared of not having to look after sick patients because I was thinking maybe I am not ready</i></p>	<p>different opinion</p> <p>risk of me being scared of not asking questions or feeling scared of not having to look after sick patients</p>	<p>Identifying crucial concerns</p>
<p>Leptir</p>	<p>Ignore it</p>	<p>Willingness or reluctance to engage</p>

Critical Care Nurses' Crucial Conversations

<p><i>I should just ignore it and try not to get involved as much as possible. Try to make work something I go to under those circumstances, and go home and forget about it.</i></p>	<p>Forget about</p>	
<p>Lipa <i>I'm not going to accept that he spoke to me that way", I am glad that I went back there because to have that conversation</i></p>	<p>not going to accept went back to have that conversation</p>	<p>Willingness or reluctance to engage</p>
<p>Maslacek <i>It got to the point where I had explained my point of view as best as I could and I was satisfied that consultant understood my point of view but did not necessarily agree with it and I gave up on trying to convince him other wise and just tried to sum up conversation saying we have to agree to disagree and at the end it is doctor's decision how we go about it and the doctor thanked me for the robust conversation left the room and my boss I will never forget word for word</i></p>	<p>I had explained my point Satisfied the consultant understood my point of view Robust discussion</p>	<p>Willingness or reluctance to engage</p>
<p>Ruza <i>Decided to talk to her in the front of other nurse to clear things up</i></p>	<p>Decided to talk to her</p>	<p>Willingness or reluctance to engage</p>

Critical Care Nurses' Crucial Conversations

Appendix F - Concepts and themes - second stage of analysis

Participants Voice	Concept	Sub-themes	Theme
<p>Tresnja</p> <p><i>I think when you lack confidence you avoid having any sort of CC, which can be probably detriment to the patient.</i></p>	Powerlessness	Illegitimacy	Too hot to handle
<p>Dunja</p> <p><i>I think I am scared of these conversations. I am very hesitant going into them and I think that comes from a place of insecurity of maybe how I perceived the facts is not really how it happened. Because at the end of the day, a fact is not a fact, it's my interpretation of a fact. And I remember a situation where I would have liked to have done it differently. I didn't have a crucial conversation, I had a conversation that was very much unilateral but I would have liked that to have gone different.</i></p>		Restricted professional self-concept	Too hot to handle
<p>Dunja ...there was an emergency in the ward and the consultant...wanted a specific equipment, we didn't have ... I was Team Leader and he started yelling, yelling my name, yelling why don't we have this and that made me really angry that the whole team was then on edge, everyone was extremely nervous and I could not get hold of the equipment because it was after hours, theatre was closed... it was just one of those situations that we didn't have it, we needed a Plan B.</p>		Controlling behavior	Too hot to handle

Critical Care Nurses' Crucial Conversations

<p><i>items that that's how she would like people to see her. And then I made a list of the perception of the staff, so I said, I started with the good things and said, look you are perceived as confident, you are perceived as competent but you are also perceived as lazy and you are also perceived as having an attitude towards the nurses that is not adequate to this environment.</i></p> <p>Maslacak</p> <p><i>I had different opinion on management of Heart failure patient.</i></p>			
<p>Malacak</p> <p><i>Absolutely, definitely high stakes, definitely opposing opinions and as we started there was not strong emotions but as the conversation went on strong emotions develop especially on my side the consultant stayed very calm very neutral through the whole conversation.</i></p> <p>Dunja <i>I think the strong emotions was a very, was sort of what dominated that conversation because that was a surprise for her and opposing opinions as well, because she didn't know that people saw her that way and it was a big surprise, and she struggles to believe, so only after we went through, look, if you are getting the same feedback from different people in different situations, you really need to look into that. And high stakes, because, considering that's a student that will have a program or not how they are</i></p>	<p style="text-align: center;">Memorandum of understanding</p>	<p style="text-align: center;">Tangible comprehension of the elements of crucial conversations (reflexivity)</p> <p style="text-align: center;">Tangible comprehension of the elements of crucial conversations (reflexivity)</p>	<p style="text-align: center;">Moving from who is right to what is right</p>

Critical Care Nurses' Crucial Conversations

<p><i>perceived and all that, makes a big difference in their future employment and if people want them back, or not.</i></p> <p>Maslacak <i>Yes but surprisingly or interestingly for myself I am more confident person now than I was when I had conversation that we talked about earlier but it made me lot less head strong in my approach I have been a lot calmer and I have been a lot more amenable to understanding differences of opinions and excepting differences of opinions. Minimizing the emotions.</i></p> <p>Jabuka <i>... I have reflected over these things many times but I think, especially in that incident I talked to you about, but I think sort of talking to you about it makes you more aware of just how important that is, that communication and those conversations, how important they are for patient care and how you have got to take out, you've got to work, even though there might be different opinions, you have got to work with that person and come up with a solution and you've got to take out your emotions, you can't worry about whether you're tired or whether you don't like that person, or whether you're angry with them, or whether they annoyed you before, um, I just think it makes me more aware of what I am doing and how I am speaking to people and how I can get everybody involved in communicating, you know, I can say have you spoken to such and such and does this person know what is happening with this, I think you're more up front without being sort of</i></p>		<p style="text-align: center;">Validating anticipatory response (reflection)</p> <p style="text-align: center;">Validating anticipatory response (reflection)</p>	
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Critical Care Nurses' Crucial Conversations

<i>aggressive about it</i>			
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Appendix G – Interview questions

The following broad questions will be used to guide the interview process

1. Have you ever been in a situation at work where you had to engage in a difficult communication?
2. Can you please describe in detail this situation
3. Can you look at this model of a crucial conversation and frame the situation around this model?
4. Were the elements present?
5. What exactly happened?
6. What was at stake?
7. What did the experience tell you about yourself?

Questions Van Manen (1990) suggests can be used to illicit more information will also be used as a prompts

- a. How were you feeling at the time?
- b. What else was going on then?
- c. Tell me more about that.

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