



**EXPLORING NURSES CLINICAL DECISION MAKING EXPERIENCE
IN RWANDA MILITARY HOSPITAL**

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IN RWANDA MILITARY HOSPITAL**

By

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DECLARATION

I do hereby declare that this *dissertation* submitted in partial fulfilment of the requirements for the degree of **MASTERS OF SCIENCE** in **NURSING**, at the University of Rwanda/College of Medicine and Health Sciences, is my original work and has not previously been submitted elsewhere. Also, I do declare that a complete list of references is provided indicating all the sources of information quoted or cited.

Date and Signature of the student

12/6/2017

a. Authority to submit the dissertation

Surname and First Name of the Supervisor: Dr. Eleazar NDABARORA

Surname and First Name of the Supervisor: Prof. Sheila SHAIBU

In my capacity as a supervisor, I do hereby authorize the student to submit his/her **dissertation**.

Date and Signature of supervisor/Co-Supervisor

12/6/2017

DEDICATION

To the God almighty who favor me in all my work and endeavors, to my best friends and lovely family Mupenzi, Ella and Eloi , my mother, sisters, brothers, friends and all of my classmates for their invaluable love, support, and their resolute patience all along my studies.

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I wish to express my gratitude to the Government of Rwanda through the Ministry of Education, and the University of Rwanda administration for their support and attention rendered toward education of health care professionals and especially nurses by growth and development of tutorial assistants.

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ABSTRACT

Introduction

Globally, nurses are the biggest number acting at the front line of patient care in health service institutions, their daily activities are taking place in the ongoing evolution of research and technology. This requires nurses to be competent decision makers in order to be able to respond to the patients' needs. However, nurses worldwide are limited in participation in decision making about patient care and those who participated claimed more than they currently do.

Aim

The aim of this study is to explore the lived experience of nurses' clinical decision making at Rwanda Military Hospital.

Methods

This study used a qualitative phenomenological approach. A phenomenological design was used to seek a deeper and fuller understanding of the lived experiences of the nurses' clinical decision making (CDM) on daily activities. An interview guide with open-ended questions was used to collect data and the data were analyzed according to four stages of Giorgi's phenomenological methodology. A total of ten participants allowed saturation and trustworthiness were ensured in this study.

Findings

The findings of the study are presented and discussed according to the three main themes that emerged during the data analysis: (1) Role ambiguity (2) Informal power of nurses to promote patient care (3) disempowering nature of policies. Sub themes of each of these themes have been presented and discussed; deep insight into the experience of the participants in clinical decision making was elaborated.

Conclusion and Recommendations

This study concluded that nurses are experiencing more frustration and facing barriers in clinical decision making. However, they were using their knowledge and experience in team work to apply CDM in patient care regardless of the policy that hindered their practice. It was recommended that NCNM and health institutions review the policy and the scope of practice to include CDM aspect for nurses.

OPERATIONAL DEFINITION OF CONCEPTS

Clinical decision making in nursing

The unique thought process that nurses undertake through information gathering, processing and prioritizing to implement nursing actions which result in making judgement about the provision of professional nursing management and patient care in everyday activities (Manal, 2013 p 4). It was considered as operational definition for this study.

Nurses

In this study a nurse is defined as professional nurse registered with the Rwanda National Council of nurses and midwives and who is working at Rwanda Military Hospital.

Experience

In this study, experience is defined as feeling, observation or a series of nursing activities that the nurse has participated in or lived through, respective to clinical decision making.

LIST OF SYMBOLS AND ABBREVIATIONS

CDM: Clinical Decision Making

RMH: Rwanda Military Hospital

MOH: Ministry Of Health

NCNM: National Council on Nurses and Midwives

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CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

Clinical decision- making plays a vital role in professional nursing as an important factor that affects the quality of care rendered to the patient. Effective decision making is a fundamental concept to be considered by nurses while caring for the patient for better and quality outcomes (Arries, 2004, p. 3; Thompson *et al.*, 2013, p. 5). The health problems which are uniquely nursing have to be defined and resolved correctly by capable practicing nurses for professional recognition and quality patient outcomes (Hagbaghery, Salsali and Ahmadi, 2004, p 9). However, nurses' clinical decision- making is an important area for research that has been rarely studied while nurses' views and experience on decision making need to be known in order to improve the patient outcome.

This chapter covers the background to the study, the problem statement, and objectives of the study, research questions, and significance of the study.

1.2 BACKGROUND OF THE STUDY

Globally, nurses are the biggest number acting at the front line of patient care in health service institutions, their daily activities are taking place in the ongoing evolution of research and technology. This require nurses' to be competent decision maker in order to be able to respond to the patients' needs, help allocate resources efficiently, promote health gain and patient benefit (Hagbaghery *et al.*, 2004, p 12; Deegan, 2013, p 7).

A study done in Israel and USA revealed a discrepancy between nurses' decision making participation and responsibility on patient care in which nurses actually participated and those in which they wanted to participate reason why nurses' claim more involvement in clinical decision making regarding nursing intervention during patient care (Hoffman, Duffield and Donoghue, 2004, p.1). Similarly, Iranian nurse revealed other factors that affect their decision making in the workplace including lack of respect by doctors and managers , lack of control over their daily nursing activities, lack of recognition in their institution which result in

strong emotional frustration that affect the patient care outcome (Hagbaghery *et al.*, 2004, p 8).

In addition, nursing profession is complex and risky which require nurses to be motivated, flexible and change agent in daily activities, contrary, nurses have often dissatisfaction, frustration and anxiety due to disregard and ignorance of their participation in patient care in the health settings (Hoffman *et al.*, 2004, p. 1).

A study done by the South Africa Nursing Council interestingly recognized that there is a need for a system for quality nursing clinical decision making that represents the complexities of the decision making process and evolving context of working environment within which nursing practice occurs (Graan, Williams and Koen, 2015, p. 35). This study show how the nursing board plays an important role not only in protecting the public but also in recognizing the nursing profession challenges and look for adequate resolution to overcome these identified challenges.

A study done in Rwanda revealed that staffing of registered nurse in the health centers was at 55%, while in district hospitals it was at 80.5% (Gitembagara, Relf, and Pyburn, 2015, p. 3). Yet, the guidelines established by the Ministry of Health in 2009 stipulated that the standard number of nurses per population for a health center with a catchment area of 20,000 in population should have 18 nurses/midwives, and the district hospital should have 63 nurses/midwives within the same catchment area. These results reflect the shortage of nurses in Rwandan health care settings that affect nurses' daily activities and patient care outcome (Gitembagara *et al.*, 2015, p 3).

The Rwandan health system has improved radically over the past decade; however, the current significant shortage of nursing staff is a big challenge for nurses who have to struggle in order to manage their heavy workload and meet the comprehensive needs of the patients on a day to day basis. Consequently, nurses are required to be equipped with complex reasoning, judgement and be good decision maker that contribute to quality care for patient outcome.

Clinical decision making, clinical reasoning and clinical judgment are fundamental concepts and often interlinked in way that various reasoning process is used to achieve judgement and

decision. To arrive at clinical decision making in every day nursing process, nurses need to gather and analyze information using cognition which involves clinical reasoning, then after make a judgment about patient's needs to be addressed and decide on action to be taken (Manal, 2013, p. 7; Min Wu *et al.*, 2016, p. 10).

Clinical decision making guidelines are often established by National Councils of Nursing and may differ from one country to another; registered nurses are expected to work within their scope of practice and decision-making frameworks that allow them to practice nursing decisions from which they are approved and competent for to ensure public safety during patient care (Nursing and Midwifery Board of Australia, 2007, pp. 1–3).

The Rwanda Nursing and Midwifery council was established in 2008 to protect the public through the regulation of the nursing profession. However, initially the scope of practice and frameworks did not differentiate the registered nurses' responsibilities according to their education level or specialties. Currently; the council is in the course of reviewing the scope of practice to align it with different cadre of registered nurses as nursing practice evolves in Rwanda.

Furthermore, the Rwandan governments has made great achievements in several key health indicators, for instance, Rwanda is among eleven countries that has declined at least 75% of Maternal Mortality Rate between 1990 and 2013 according to UN agencies and World Bank categorization (Sayinzoga and Bijlmakers, 2016, p 18). However, nurses' role in quality service delivery is much less reported as the key stakeholders on this journey. It would be logical to study the role and influence of nurses' day-to-day clinical decision in continuation and sustainability of these achievements.

Moreover, nurses comprise the largest group of health professionals in Rwanda and they are the ones who spend twenty four hours at the patients' bedside, the value of their clinical decision making is plausible as the positive patient outcome depend on good decisions made in their daily activities (Johansen and O'Brien, 2016, p. 1). However, how they function is determined by the scope of practice, Ministry of Health and hospital policies. There is little known about nurses' views on clinical decision-making experience due to limited research studies, thus the dominant question then arises; what are the views and experience of this

largest group of staff on decision making? Therefore, this study aims to explore nurses' clinical decision-making experience as well as factors facilitating or inhibiting nurses' clinical decision making in Rwanda.

1.3 PROBLEM STATEMENT

Nurses are being educated to use critical thinking, problem solving, and decision-making skills with the expectation that they will be highly involved in decision making in nursing practice. Nurses are regularly required to have the autonomy within the health system and are placed in situations that enable them to influence the change on patient outcomes. Consequently, the increase of nurses' involvement in decision making related to nursing interventions improves the quality of patient outcomes (Hoffman *et al.*, 2004; Murphy, 2012). However, globally evidence showed that in middle income countries and even higher income countries, clinical decision making continues to be a challenging issue and undermines the quality of care that nurses render, thus, nurses' clinical decision making is an important research area for a country to improve nursing care rendered to patients in health care settings (Deegan, 2013, p. 10; Tiffen, Corbridge, and Slimmer, 2014, p. 16).

In Rwanda, nurses are the backbone of the health system delivery and act at the frontline to produce quality patient outcomes. In spite of the nurses' skills and abilities to make good decisions on patient care, nurses are still struggling with decision making during the process of nursing care because of a number of barriers. Consequently, this limits their contribution in clinical decision making. Therefore, lack of nursing decision making may result in poor patient outcomes. To the best of my knowledge little has been studied or written about the views and lived experience of nurses' clinical decision making in Rwanda. Hence, this study aims to explore nurses' views on and experiences with clinical decision making in Rwanda Military Hospital.

1.4 THE AIM OF THE STUDY

The aim of this study is to explore nurses' clinical decision making experience at Rwanda Military hospital.

1.5 RESEARCH OBJECTIVES

1. To describe existing nurses' clinical decision making guidelines for care process at Rwanda military hospital
2. To identify factors facilitating nurses' clinical decision making at Rwanda military hospital
3. To identify factors inhibiting nurses' clinical decision making at Rwanda Military Hospital

1.6 RESEARCH QUESTIONS

1. Do nurses have clinical decision making guidelines for care process at Rwanda Military Hospital?
2. What are factors facilitating nursing clinical decision making at Rwanda Military Hospital?
3. What are factors inhibiting nursing clinical decision making at Rwanda Military Hospital?

1.7 SIGNIFICANCE OF THIS STUDY

To practice: It will yield information about the nurses' level of participation in decision making, and the gaps to be addressed by nurses' associations/union and nursing council in Rwanda. It will help to improve the quality of care received by the patient.

To administration: It will inform the policy maker not only about the role of nurses in clinical decision making and quality health care outcomes but also the need for involvement in health system.

To education: It will yield data that can help to reinforce content on decision making component in both the advanced diploma and baccalaureate nursing curriculum.

To research: It will yield information on the aspects of clinical decision making and reveal the gaps for further studies.

1.9 CONCLUSION

This chapter looked at introduction of the study, background, problem statement, and the aim of the study, research objectives, and research questions, significance of the study and the definition of Concepts.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter looked at the literature on factors facilitating or inhibiting nurses' clinical decision making, nursing care process framework and level of confidence in clinical decision making. The literature was systematically searched through internet using MESH terms, MEDLINE, HINARI and PUBMED, these sources of information have been acknowledged through references, using Harvard referencing style.

2.2 THEORETICAL AND EMPIRICAL LITERATURE

2.2.1 Scope of practice and Nursing guidelines

A profession's scope of practice is the full range of roles, functions and responsibility to which individuals within that profession have the capacity and competency to perform with authorization (Nursing and Midwifery Board of Australia, 2007). The extended scope of practice and changing educational qualification for nurses require them to have clear and unique understanding of clinical decision making within their legally defined scope of practice by the nursing council (Tiffen *et al.*, 2014, p. 1).

The optimal utilization of nurses goes with the understanding of their scope of practice based on experience and qualification. The understanding of working to the authorized range of practice enable them to value and respect the clinical decision they undertake during day-to-day task and its contribution to quality healthcare delivery (White *et al.*, 2008, p. 3).

The nature of nursing care is changing and complex consequently, the risk of harm to the consumers is high, the country through the nursing board need to protect the public in the form of laws to regulate the professions, these laws include standards of education and scope of practice. Moreover, organizations that hire nurses use the professional scope of practice to create job description and establish needed competencies for nurses to be hired (Mezey *et al.*, 2007, p. 1).

In addition, the eye of the public use the scope of practice and other standards practice to legitimize the profession, improve and continuously monitor quality of education in schools

of nursing and raise the quality of professional nurses. These part play a key role in protection of patient from unprofessional and unsafe nursing practice (Russell, 2012, pp. 1–5).

2.2.2 Factors facilitating or inhibiting nursing clinical decision making

It is largely expected that nurses with educational qualification in clinical practice have the necessary skills, ability and autonomy to make sound clinical decisions regarding nursing interventions. However, it appears that regardless improved level of education for nurses, many factors in clinical settings still an obstacle to the nurses' involvement in decision making. Therefore, if, as reported, that quality patient outcome depend on effective nurses' decision making, it would be necessary to start working on barriers that can prevent nurses' to use fully clinical decision making skills in their range of practice during patient care (Levett-jones *et al.*, 2010, p. 12).

A. Factors Facilitating Nursing Clinical Decision Making

To be autonomous in nursing practice is one vital aspect of nurses' role and indicator of greater participation in clinical decision making which requires ones to have good interpersonal relationship, experience and education qualification (Hoffman *et al.*, 2004, p 7). Study done in USA by Payton in 2009, has shown that nurse decision autonomy is one facilitating factor that linked to greater retention and job satisfaction, with nurses choosing to work in areas with greater decision authority.

According to Hoffman 2004, there is a great relationship ($r=0.338$, $p<0.01$) between level of appointment, education and participation in decision making. The study revealed significant positive relationship where those holding higher levels of appointment and education are involved more in decision-making than others. In addition, according to Hagbaghery 2004, nurses' self-confidence, clinical competence and self-efficacy are the factors that make nurses become "initiators to help the patients" and facilitate nurses' timeliness in making and implementing the decisions during patient care.

A study done in UK by Levett 2010 showed that there is significant relationship between good decision making and academic process (Levett-jones *et al.*, 2010, p. 17). Similarly to

the result from five countries (Canada, Finland, Sweden, Switzerland, and the United States), reported that professional education, experience were associated with decision making (Wu *et al.*, 2016, p 10) . In contrast, Hoffman in 2004 did not found any relationship between education ,experience and decision making among Australian nurses instead he attribute the value of role to be an important predictor of nurse's clinical decision making.

B. Factors Inhibiting Nursing Clinical Decision Making

Study done by Hagbaghery in 2004 showed factor that hinder nurses to participate in decision making which is lack of support from managers, 92% of participants stated that though colleagues are a useful source of support in the clinical environment, unsupportive managers were barriers to nurses clinical decision making. Also, 65.7% respondents highlighted other factors including inter-personal conflicts, lack of emotional and legal supports from the health organization which prompt other health care provider mainly doctors to do not value nurses' decisions on patient care.

Studies indicate that contingencies of daily work in nursing practice, institutional structures and heavy workloads for nurses can disrupt independent decision making processes which affect the quality of care (Traynor, Boland and Buus, 2010). Furthermore, study done in Canada by Wu presented an attention to stressors such as workload problems, staffing and nurse-physician relationship among factors that inhibit effective clinical decision making among nurses (Min Wu *et al.*, 2016, p. 24).

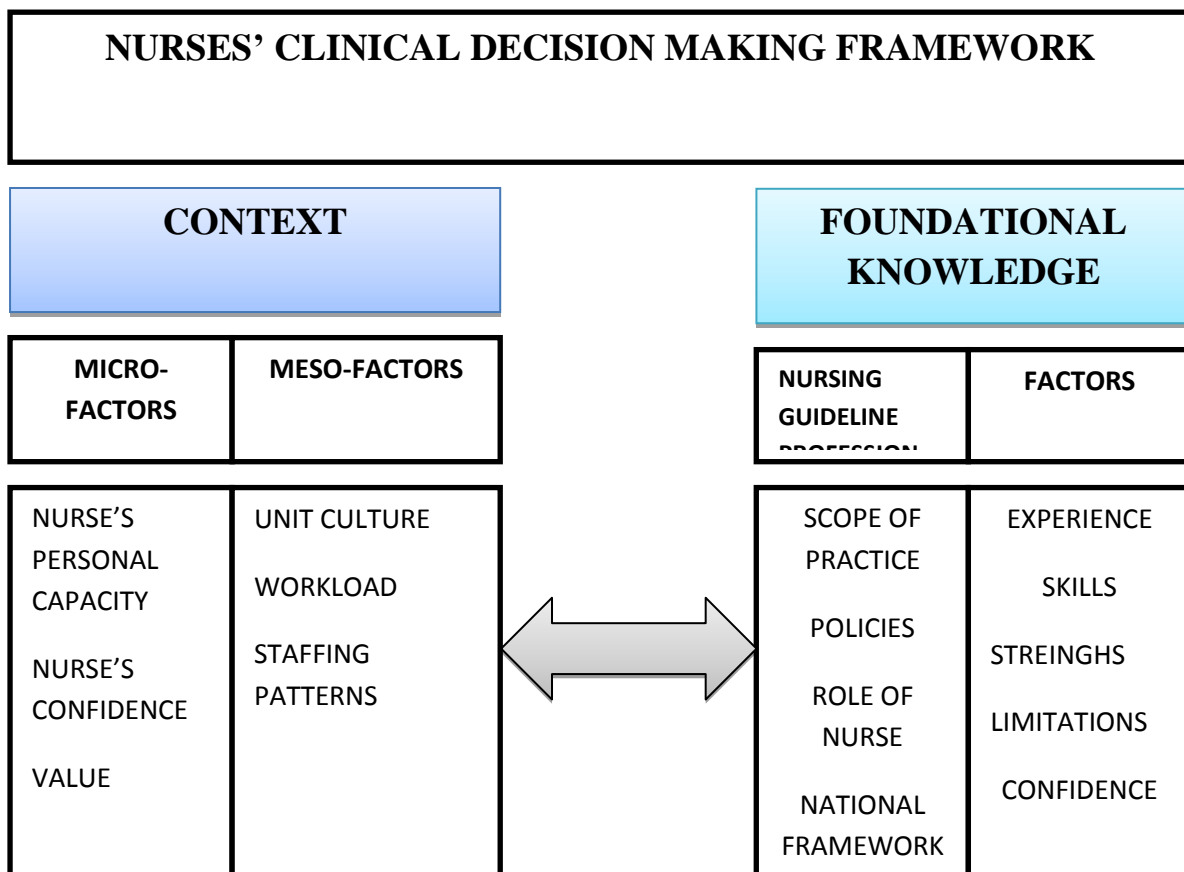
C. Level of confidence

The result of the research by Hagbaghery 2004 has emphasized the importance of self-confidence in effective CDM; the participants highlighted the positive and negative influence on CDM. when the nurse has self-confidence it increase the possibility of making the independent decision and influence the decision in contrast, lack of self- confidence cause the feeling of weak and powerless that result in avoiding to take the decisions. The same study reveals that there are three sub-categories that are linked to self-confidence which are self-efficacy, self-assertiveness and self- reliance (Hagbaghery *et al.*, 2004, p. 3).

In addition, study done by Pfaff 2014 stated that personal characteristics play an important role in self- confidence, however, other factors including professional knowledge, life and clinical experience have positive effects on decision making as essential confidence builder which improve quality of care(Pfaff *et al.*, 2014, p 10).

2.4 CONCEPTUAL FRAMEWORK

The original Situated Clinical Decision-Making Framework incorporates four components: context, foundational knowledge, decision-making processes, and thinking processes. **CONTEXT:** The contextual factors that influence clinical decision-making come into focus when context is viewed as including *micro* (e.g., nurse and patient in relationship), *meso* (e.g., nursing unit or department, health care agency or institution), and *macro* (e.g., society, government, and profession) levels, each level potentially includes social, cultural, political, ideological, economic, historical, temporal, and physical factors (see figure 1).



(Figure 1) Adapted Situated Clinical Decision-Making framework(Gillespie, 2010).

FOUNDATIONAL KNOWLEDGE: Represents the foundational knowledge that informs nurses' clinical decision-making processes. This knowledge arises from various dimensions: Knowing the profession, knowing the self, knowing the case, knowing the client or patient, knowing the person (Gillespie, 2010).

The theoretical foundations of the Situated Clinical Decision-Making Framework include those inherent in a model of nursing clinical judgment developed by Tanner in 2006. Situated learning theory developed by Lave & Wenger, 2003, with its central premises of learning as social and situated within a greater context, also provides theoretical grounding for the Situated Clinical Decision-Making Framework. Situated learning theory emphasizes the role of a community of practice in supporting an individual's learning (Gillespie, 2010).

In this study, nurse's clinical decision making framework was adapted from situated clinical decision making framework which have developed from the NDM paradigm and is offered to provide the view of how nurse's clinical decision making with attention to contextual factors such as environment, task complexity, and individual characteristics and assists in recognizing specific issues within nursing practice. The structure of the framework highlights the key considerations related to the context and foundational knowledge as the main parts to explore the nurse's clinical decision making.

Decision-making in nursing has been studied using this framework, in 2009, researchers used the Situated Clinical Decision-Making Framework as a means to help novice nurses reflect on the decisions they make in their clinical practice and develop features of expert clinicians. The framework has been used in various clinical settings, including critical care, high acuity care, and acute medicine and surgery. In addition, it is used as a component of specialty nursing program curricular in selected British Columbia Institute of Technology (Gillespie, 2015, p. 2).

Similarly in 2010, Gillespie used the framework to guide the analysis of nurse's clinical decision making and situated clinical decision making framework was presented as a tool that provides clinical educators with a structured approach to analyzing nursing students' and novice nurses' decision-making in clinical nursing practice, and assists them in identifying specific issues within nurses' clinical decision-making (Gillespie, 2015, p. 8).

2.3 CRITICAL REVIEW AND RESEARCH GAP IDENTIFICATION

As a final point, clinical decision making factors need to be understood so that enabling factors are encouraged and inhibiting factors are avoided or minimized to protect the public and legitimate the profession through clear national framework including scope and standards of practice (Fedo, 2014, p 9). This literature review Concede with an existing point of view from other researchers, but qualifying that CDM need to be studied in deep to inform the policy and scope of practice and alleviate factors that hinder the process in nursing profession. The gap in literature is that CDM topic has been neglected in terms of research which resulted in little information in the area of nurse's clinical decision making experience. Additionally; no literature exists in Rwanda on nurses' clinical decision making in practice.

2.5 CONCLUSION

This chapter covered the empirical and theoretical literature on factors inhibiting or facilitating nurses' clinical decision making, decision making framework for care process, research gaps identification and conceptual framework.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

This chapter covered research design, research approach, research setting, population, sampling, sampling strategy, sample size, data Collection, data Collection instruments, data collection procedure, data analysis, ethical considerations, data management, data dissemination, limitations and challenges.

3.2 STUDY APPROACH AND DESIGN

Study approach

This study used qualitative approach to explore the experiences of nurses in clinical decision making.

Study design

The study used phenomenological descriptive design, and this design fitted the study because it help to understand deeply the lived experience of nurses' in clinical decision making regarding their daily activities, most qualitative studies seek to understand the existence and context of a phenomenon in the world (Al-busaidi, 2008, p. 2). In this study, the researcher wanted to explore nurses clinical decision making phenomenon using qualitative approach by allowing the participant to express and describe their experience and feelings in their own words (Woodsong, Mack, Macqueen and Guest, 2005, p. 8).

3.3 RESEARCH SETTING

The study was conducted at Rwanda Military Hospital. RMH is referral teaching hospital which is located in Kicukiro district, Kanombe sector. The organizational structure and the summary of job positions for Rwanda Military Hospital (RMH) has been established by the prime minister's order n° 217/03 of 02/12/2013 in the official gazette n° 48 of 02/12/2013. It had 265 inpatient beds, Rwanda Military Hospital treat 80% civilian and 20% military patients. It had 248 as the total number of nursing staff composed of one master's holder nurse, 34 bachelor's holders, 120 A1 registered nurses and 94 A2 enrolled nurses. it had

different services including Ambulatory Care Services, Accident & Emergency Services, Internal Medical Service, Surgical services, Critical Services, Peri- Operative Care Services, General Pediatric, Neo-Natal Care Service, Obstetric Care and Gynecology Service , Oral & Dental Surgery, Dermatology Services, ENT Surgery Service, Eye Care Service, Mental Health Service, Imaging Services, Patient Assessment & Management /PAMs Services, Pharmaceutical Services, Pathology Services, Quality Assurance & Risk Management, Operation Support Services (Unpublished report,2016).

3.4 STUDY POPULATION

The participants in this study was bedside nurse holding a qualification (from A1,A0 and above) as a registered nurse working at Rwanda Military Hospital and experienced on nursing clinical decision making providing bedside care for least two year and was able to tell and share their experience about clinical decision making.

3.5 SAMPLING

3.5.1 SAMPLING STRATEGIES

The Purposive sampling was used for hospital and services. Purposive sampling was based on the judgment of the researcher regarding the characteristics of the hospital that fulfilled the study requirement and six services/wards where nurses did nursing intervention including internal medicine, surgical, critical care and emergency, neonatal, pediatric wards in the hospital (Tongco, 2007, p. 3).

SELECTION CRITERIA

Registered nurse with two years of experience.

Working in the six selected wards.

Willing to participate in the study.

3.5.2 SAMPLE SIZE

The qualitative researcher focused on the quality of the information from the participants rather than the size, the final sample numbers was determined by the evidence of data

redundancy and saturation of information (College *et al.*, 2013, p. 10). The data saturation occurred when participants started to repeat the information that other participants have already talked about during the interview (Leech and Onwuegbuzie, 2011, p. 2). In this study ten participants allowed saturation with a significant generation of data that was sufficient to construe themes and concepts for this study.

3.6 DATA COLLECTION

3.6.1 DATA COLLECTION INSTRUMENT

An interview guide with open ended questions was used to collect data (Appendix A), the interview questions used in this study to collect data was used in the study conducted in Iran by Hagbaghery in 2004 on factors facilitating or inhibiting clinical decision making among Iranian nurses with the permission. However, the questions were adapted to fit the context of the current study. Some questions were not asked as they were not relevant to this study and other questions were added to give the participant the chance to explain their context. Each interview session lasted between 15 to 20 minutes.

The interview guide question was composed of 6 open-ended questions:

1. Do you have any existing frameworks that guide your current clinical decision making in nursing care process? If so which one and how?
2. Please can you tell me about your most recent experience in clinical decision making during nursing process?
3. Did you use any nursing skills guideline to guide your clinical decision? If so which one and how?
4. What were the factors facilitating your clinical decision making during nursing process?
5. What were the factors inhibiting your clinical decision making during nursing process?
6. Do you have any recommendations for the nursing clinical decision making in the future?

3.6.2 DATA COLLECTION PROCEDURES

The researcher sought out the permission to conduct the study from the University of Rwanda research committee and the hospital administration. After getting the permission, the investigator explained to the nurse managers at the hospital, the aim of this study and

requested them to avail the sampled nurses and provide a quiet place for interview process during data collection.

The researcher approached the nurses who were sampled in selected services to participate in the study and explained to them the aim of the study, and the procedure to be followed. The researcher explained and asked the participants the permission to record during the interview.

After getting the permission to record, the interviews were conducted face-to-face in a quiet and private room during the day duty between 7am and 5 pm of working days. The researcher did individuals' interviews. Interviews were conducted in English and Kinyarwanda language depending on the language that the participants is comfortable with and were then be transcribed immediately after the interview. The researcher probed and asked questions seeking depth and clear information without trying to interpret or summarize the words of the participants. The interview lasted from 15 to 20 minutes and took place in a private room where others couldn't hear the interview process and got access to the information that they didn't have right to. Each participant's comfort was ensured from the beginning to the end the interview and throughout the study.

3.7 DATA ANALYSIS

The recorded data were transcribed verbatim, then the researcher immersed in the data first by reading the transcribed data thoroughly and the analysis was done using the Giorgi' phenomenological methodology which had four essential stage to be followed during data analysis. This method was grounded on the assumption that data analysis of all phenomenon starts with a naive description of the experience.

The first step was listening to the audio several times and gets a global view of nurses 'clinical decision making experience.

In the second step the researcher read the text, and divided it into meaning units and descriptive quotations which was grouped accordingly.

The third step was to develop and make clarity to the units and move from abstract to concrete information from which the researcher organized the participants' citation.

The last step the researcher read the concrete units and make sentences that reflect and respond the research questions of the study (Penner, 2008, p. 5).

The operationalization of Giorgi's step to the study is as follow:

- 1) Data transcription

- 2) Reading and re-reading the transcribe text, to compare with the recorded data(Data immersion).
- 3) Identify emerging themes for each questions asked.
- 4) Organizing them according to our study objectives.
- 5) Identify key quotations that will support each theme.

3.7.1 Trustworthiness

It ensures that the findings of the study have quality which comes from the logical flow and connections of all steps from the beginning to the end in the research process. This increase the readers trust in findings and it was utilized to establish the reliability and validity of this study (Elo *et al.*, 2014, p. 3). It has the following four components: credibility, transferability, dependability and conformability.

3.7.2 Credibility

It is the way the research findings are accurate and truthful for the reader to believe in it (Elo *et al.*, 2014, p.3). In this study, during the interview, the information was tape-recorded and the researcher took notes to ensure that all relevant information was captured correctly. It was also achieved through peer debriefing during data analysis as well as member checking to ensure that the researcher presented the experience of nurses' clinical decision making as it was understood by the participants.

3.7.3 Dependability

The main concern of dependability is whether the same findings would be achieved if the same study were to be conducted the second time (Shenton, 2016, p. 4). In this study, the method used for data collection and analysis in this study was validated by the researcher and the supervisors. Detailed steps illustrating the data collection process was documented and systemically subsequent the methods of Giorgi in the analysis of the study. The audit of the process was also crucial to ensure dependability (Baillie, 2015, p. 29). Individual interviews

were conducted based on the interview guide; recorded information was transcribed and verified by the researcher. All these procedures were constantly checked by the supervisors of the study.

3.7.4 Transferability

Transferability in qualitative research relates to the concept of external validity in quantitative research (Baillie, 2015, p. 9). Thus, it refers to the extent to which the findings of one study can be transferred to another situation or applied in another place or group (Shenton, 2016, p. 21). To determine transferability, the original context of the research must be described sufficiently so that judgments can be made. It is, therefore, the responsibility of the researcher to provide extensive descriptions, enabling the reader to make informed decisions about the transferability of the findings to their specific contexts (Elo *et al.*, 2014, p. 13). To ensure the feasibility of findings transfer, the study population and research setting were described in enough details. The findings of this study can be applied to bedside nurses experienced in clinical decision making in other referral hospitals.

3.7.5 Conformability

It refers to the degree to which other researchers confirm the study findings, to ensure the conformability of this study, the researcher availed all the references used; individual interviews with accompanying field notes for peer review and member checks in order to validate how the result were obtained (Shenton, 2016, p 5).

3.8 ETHICAL CONSIDERATIONS

This study was carried out as part of a Master's dissertation in University of Rwanda, College of Medicine and Health Sciences, School of Nursing and Midwifery. The process of getting the permission to conduct the study pursued; the ethics committee of the University of Rwanda and the Rwanda Military Hospital gave permission for the study and Ethics. The research insured the confidentiality and anonymity of the participant. The voluntary nature,

the right to withdraw or withhold from this research, the aim and the design of the study was explained to the participant.

The interviews were audio-recorded with the participants' permission by signing a consent form and participants were informed that they will not need to reveal their full identification, and the data that collected will not be linked to individuals, during the time of the audio-recorded interview, data analysis and report writing.

3.9 DATA MANAGEMENT

The interviews were conducted by the researcher herself and all field note and audiotapes were secured by the researcher in a place where she is the authorized person to access them for confidentiality purpose. Electronic copy was stored in a filed document which is accessed by the researcher, in arrangement with the supervisor. The data will be kept for three years.

3.10 DATA DISSEMINATION

The findings of this study will be shared through publication and the copy of the dissertation will be available at University of Rwanda library.

3.11 LIMITATION AND CHALLENGES

The limitation of this study was the generalizability of the findings because it was only conducted at one hospital. In addition, the fact that the investigator used a tape recorder during the interviews, where the culture of expressing themselves (participants) was a barrier, might cause the participants to be less spontaneous and hinder their responses.

3.12 CONCLUSION

A qualitative phenomenology study design was used to collect data from a purposive sample of ten nurses from RMH. A semi structured interview guide was used to collect data. The data analysis, management and dissemination were discussed. Limitation and challenges, ethical consideration were addressed.

CHAPTER 4: PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This study explored the phenomenon of nurses' lived experience in clinical decision making at Rwanda Military Hospital. The research objectives that guided this study are as follows:

1. To describe existing nursing clinical decision making guidelines for care process at Rwanda military hospital.
2. To find out factors facilitating nursing clinical decision making at Rwanda military hospital.
3. To identify factors inhibiting nursing clinical decision making at Rwanda military hospital.

Nurses (n=10) from the Rwanda Military Hospital were interviewed during the months of February and March, 2017. The nurses who were registered and had A1 or A0 degree described their lived experiences with CDM during patient care. The questions that were asked to prompt the discussion were:

1. Do you have any existing frameworks that guide your current clinical decision making in nursing care process? If so which one and how?
2. Please can you tell me about your most recent experience in clinical decision making during nursing process?
3. Did you use any nursing skills guideline to guide your clinical decision? If so which one and how?
4. What were the factors facilitating your clinical decision making during nursing process?
5. What were the factors inhibiting your clinical decision making during nursing process?
6. Do you have any recommendations for the nursing clinical decision making in the future?

In this study, a number of probing questions were also asked based on the responses from the participants, in order to obtain more information about the phenomenon under investigation. The focus of this chapter is to present the research findings.

4.2 PROFILE OF THE PARTICIPANTS

The researcher interviewed 10 participants and they were all registered nurses who had at least two year or more years of experience. Among the ten participants, six were female while four were male; their age group ranged between 28 years and 56 years old, which explain that mixture of experience among participant. Six participants had advanced diploma while four had bachelor's degree. Refer to Table 4.1 below for a profile of the participants in this study.

Table 4.2: Profiles of the participants

Participant number	Age	Gender	Level of education	Years of experience
Participant 1	32	M	RN-A0	7 years
Participant 2	40	F	RN-A0	20 years
Participant 3	43	F	RN-A1	15 years
Participant 4	30	F	RN-A1	5 years
Participant 5	35	F	RN-A1	11 years
Participant 6	56	F	RN-A1	36 years
Participant 7	38	M	RN-A0	13 years
Participant 8	26	M	RN-A0	3 years
Participant 9	28	F	RN-A1	2 years
Participant 10	30	M	RN-A1	5 years

4.3 FINDINGS OF THE STUDY

After data collection, the researcher transcribed the data, immersed in to identify emerging themes and then organized them according to the study objectives; key quotations that supported them were also identified. The Three themes emerged from the data are as follows: (1) Role ambiguity (2) Informal power of nurses to promote care (3) Disempowering nature of policy. These themes and their sub themes are illustrated in the Table 4.3.

Table 4.3: Summary of themes and sub themes

THEMES	SUB THEMES
Role ambiguity	Frustration and Devaluing nursing work
	Unclear job description
Informal power of nurses to promote patient care	Team work, advocacy for patient care
	Knowledge, experience and collaboration
Disempowering nature of policies	Discrepancy of autonomy in decision making among nurses at different levels of health system
	Doctors power over nurses in clinical decision making
	Delayed patient care

Objective one: Describe existing nursing clinical decision-making guidelines for care process at RMH

4.2.1 Theme I: Role ambiguity

The participants described and expressed the vagueness in clinical decision making based on an unclear scope of practice given by the National Council of Nurses and Midwives as a regulatory body in charge of clinical practice and education. The participants expressed the ambiguous role in the care process they participated in with other health care providers mainly doctors that resulted in frustration and devaluing of nurses. The ambiguous role in nursing work was characterized by an unclear scope of practice and job description that

lacked boundaries with respect to what they were doing. This theme had the following two subthemes: frustration and devaluing nursing work and unclear job description.

Frustration and devaluing nursing work

Participants expressed frustration, they performed patient care successfully because they had studied, and mastered those activities, and yet, they were not allowed to do certain specific activities. The policy clearly states that nurses had to wait for the doctors to execute certain interventions which they were capable of doing without a doctors' order, by doing things that were not allowed by the policy, they were taking the risk for a good cause, saving lives in cases of an emergency. This made nurse feel that their contribution to patient and nursing care was devalued as they had to be instructed by doctors, and this defeated the spirit of team work. Although the policy requires that initiation of procedures such as oxygen therapy should be ordered by a doctor; the participants explained how they performed care successfully without waiting for the doctors as stated in the policy, as this nurse explained:

"...I received a patient an old woman who had colon cancer; she was in a bad situation. I checked the saturation and she had 32, you understand it was an emergency case, I decided to put her on oxygen but I didn't call the doctor because of stress, others were blaming me that I put the patient on oxygen and didn't call the doctor, I called him later and explained to him that the patient had 32 saturation and that I decided to put her on oxygen..."
(PARTICIPANT 10)

Yet another nurse explained:

"...I came for day duty, the patient had 1.4 glycaemia, I gave her again Dextrose 50% and then called the doctor. The doctor told us that he is busy with the morning report and I waited while checking all 30 minutes, and sometimes it would go up to 1.9 and down to 1.5. and then we decided to put on naso-gastric tube because the patient couldn't eat, and we feed the patient with food rich in glucose. From that time the glycaemia was stable and the time the doctor came, he didn't even change the plan, we continued with those interventions....." (PARTICIPANT 9)

Participants felt that their contributions to patient care were devalued. Yet, they were taking the risk to save patients' lives, despite the policy that didn't allow them to perform those

interventions, which consequently could result in penalty. However, they felt that their work was not valued or seen as worthy.

The nurse noted how they attributed the failure to nurses without studying the cause.

“.....for example, you will find patient who has problems after surgery and none is studying the cause of that infection, it is simply attributed to nurses.....” (PARTICIPANT 1)

One participant explained how humanity underpinned her risk taking in order to save a life, she noted:

“...is humanity and risk taking while you know that it is not allowed but when you look at what you allowed to do and follow it, the patient dies in your hand and then you personally take the decision, ... You see it is only humanity and being responsible of the life of someone.”(PARTICIPANT 9)

Yet another nurse poignantly explained how she felt nurses were unappreciated and constantly blamed instead of being appreciated:

“.....And then regarding the value, a nurse mainly you hear the blame more than the encouragement and congratulations, to this point, therefore, don't take our work for granted , please recognize their consistent sacrifice, extra hours, fatigue and effort that are not paid by the salary...”(PARTICIPANT 4)

Unclear job description

The participants felt inundated with multiple responsibilities and overloaded based on an unclear nurses' job description. A nurse apart from doing the nursing job, spent more time in other different activities. These impaired their effectiveness in the job and affected the quality of care rendered to the patient.

Participant noted:

“.... you will find nurses having a lot of things some are known others are unknown, I give you an example, here when the toilet is not cleaned, they ask a nurse, and you find uuuuhhh, everything they ask the nurse, there is a lot of things that are added to the nursing task,.... For example, a visitor come to the hospital and start asking the nurse to accompany/orient

him in the other service, ...on the organizational structure, you find people who are hired for that specific task like customer care personnel but because the one who is seen in the hospital is a nurse every task is on her ... mostly they leave what they are supposed to do for that other task. Nurses are not stable, they are moving from here to there because of lack of task description...” (PARTICIPANT 7)

The participants explained the way their day was full of activities like bring specimen to laboratory, bring the patient to radiography that required them to move from their post and this was impairing their nursing activities. One nurse mentioned:

“.... it is a big problem, a big barrier and you don't only have to do nursing care, you have to bring specimen to the laboratory, x-ray and CT scan and then when you are circulating... means that everyone has his/her job but mostly, you see the nurse is the one moving from here to there, how can you be effective! If they can hire someone who is in charge of that movement, the nurse can have time to focus on the nursing job. But moving and care are not going together!”(PARTICIPANT 5)

Objective two: Find out factors facilitating nursing CDM

4.2.2 Theme II: Informal power of nurses to promote patient care

The participants expressed their power in the promotion of patient care. This informal power was backed by the time they spent with the patient which subsequently attached them to patient and gave them enough information on the patient's condition. From the information and experience they had, they were able to work collaboratively in team and advocate for better management of the patients. This theme resulted from team work, advocacy for the patient care and knowledge, experience and collaboration as enabling factors in clinical decision making.

Team work, advocacy for patient care

The participants felt that team work through support from colleagues and nurse managers was a facilitating factor in clinical decision making, which allowed them to go beyond the barriers and continue advocacy for patient care.

Participant stated:

“Yeah, we are working in the team because when you want to take a decision, you can’t keep it to yourself, you come and discuss in the team, I have this case and I want to do this. Sometimes they can even tell, wait a bit so that we examine together the intervention or they immediately give you a go ahead. In charge (Nurse Manager) also give us support when you want to take a decision, sometimes the in charge tells you to do it or wait so that he can look for the doctor urgently because it is easier for him than us.”(PARTICIPANT 9)

Other agreed:

“...second is the team that I am working with, because nursing work involves the team, especially in theater where the team is composed of nurses, anesthetist, surgeon,”(PARTICIPANT 1)

The participant explained how they advocated for their patient to have surgery in a private hospital as the patient was not eligible for admission in a private hospital, however, she succeeded as illustrated in the following scenario

“....Normally the total hip fracture is not managed or operated here, we transfer to King Faisal Hospital and the patient was using community health insurance, I first talked to the congregation where the patient came, explaining why the patient couldn’t be operate at RMH (public hospital) and asking if they will be able to manage the King Faisal Hospital (private hospital) requirements, and called the doctor, when he saw the patient, he immediately scheduled her for operation on the next day, it was on a Wednesday and Thursday should be the operation, I returned home late because I had to make sure that the patient is transferred safely. She was old and weak, we did what we were supposed to do and we succeeded.”(PARTICIPANT 7)

Knowledge, experience and collaboration

The participants explained that knowledge from school, experience they have and the collaboration between nurses and other health care providers were also factors that contributed to the clinical decision making for nurses. These factors enabled them to make

effective decisions during their daily nursing activities. One experienced nurse explained the role of her studies and senior position:

“...Studies I’ve done increased my knowledge that permits me to intervene...what I did as a pediatric nurse with experience and am knowledgeable regarding handling pediatric problems and then I looked at the time spent in this service as a senior who is leading the team.....”(PARTICIPANT 3)

Yet another nurse highlighted the role of his experience in the care of surgical patients: Other mentioned:

“When I am going to take a decision, I am guided first by the experience, I have been working in surgical ward for 8 years, I can look at the wound and suggest that we change the way of dressing or change the solution because of its status, the doctor often accepts because they know that you have experience, Personally I base on experience.”(PARTICIPANT 7)

Collaboration with doctors was explained in terms of reporting to the doctors what they have done, that not allowed by the policy and the doctors wrote the interventions in the file of the patients without any query. This collaboration was viewed as a facilitating factor, yet it was paradoxical in that it also perpetuated the nurses’ lack of autonomy.

Another shared:

“... After all those intervention, I called the doctor and told him what I had done...”(PARTICIPANT 3)

The participant explained their nurse’s role in care where they were not relying on doctors’ note but assessed and decided according to the finding. The following scenario illustrate that according to the nurse’s assessment the patient’s pain no longer required heavy medication like morphine and the decision he took.

“...Knowing that morphine is given to patient with severe pain and considering its side effect I decided to stop, and in the morning, I informed the medical doctor that I decided to stop morphine. The doctor was happy and he told me that it is ok ...” (PARTICIPANT 7)

Objective three: Identify factors inhibiting nursing CDM

4.2.3 Theme III: Disempowering nature of policy

All participants expressed the anxiety and challenges related to policy especially, the internal policy in the institution that limits the nurse in terms of decision making. The policy was seen as a barrier to all participants, and seemed to be the main cause of other challenges that affect nurses' clinical decision making and patient care. . The policy no: CLIN CC 021/2014 stated that medication includes all tablets, transdermal patches, injections, and infusions, naso-gastric and parental feeding, and oxygen. Only licensed clinicians (medical doctors and clinical medicine staff) are allowed to administer medications in the hospital. Given that most activities are curative; this policy constrained the nurses' activities related to patient care in a tertiary setting.

The participants said that the policy at the institutional level did not allow nurses to decide on most of the activities they are doing regardless of their level of education, it has to be ordered by the doctor

One participant explained the disadvantage of the policy to patient outcomes as care could be delayed to the detriment of the patient's condition. She noted:

".... the policy we have it is not allowing us to do anything without the doctors orderthen you understand calling the doctor and come after 30 minutes, sometimes he may come when the patient is getting worse ,..."(PARTICIPANT 9)

Yet another nurse explained the consequences of the policy for nurses:

"..., it is a barrier to nurse. Sometimes you see things that you are able to do but you can't because of the policy. We are always explaining to the patient that we can't help them, we have to wait for the doctor....."(PARTICIPANT 2)

Discrepancy of autonomy in decision making among nurses at different levels of health system

The participants mentioned that there was a policy discrepancy with respect to the nurses' autonomy within the different areas of the health care system, where from health center, the nurse have autonomy in clinical decision making from promotion to curative activities. She is

allowed to prescribe all drugs on the list of essential drugs, as stated by the Ministry of Health essential drug administration policy. However, as the nurse went above the health center to district and referral hospital, the nurse is unable to perform those activities carried at health center.

Participant explained how the policy at referral hospital limited them from prescribing the medications that were allowed to the nurse at health center and yet, finding the doctor to do so in a referral hospital is a problem. This participant noted the discrepancy from her work experience in both settings:

“... , I had a chance to work in all levels of health care system, at health center level, a nurse is able to take decision and they have few problems with the clients, because they provide solutions on time with essential drugs which is different from a nurse at the hospital level where a patient come to the emergency and the doctor maybe he is in theater, the nurse can't do anything apart from going and look for the doctor or wait and the patient is in front of you, you know what to do but you are not allowed to do so. What a shame, sometimes, you take the risk....” (PARTICIPANT 6)

The participant felt and explained how being unable to prescribe drugs while finding the doctor to do so is hard as a big challenge in decision making to them. This was noted as a particular challenge in situations involving pediatric patients where sometimes the dose would require to be adjusted, and the doctor would be unavailable. This nurse explained:

“.....I face a barrier because of the policy we have here stating that all drugs should be prescribed by a doctor only and then when they prescribe overdose, you can't find the surgeon quickly to resolve the problem and we are supposed to give the medication on time, eeehhh,and as a pediatric nurse you know very well the dosage and you can't change the dosage. This is a very big challenge, or the other time you find the child with fever, you can prescribe and administer the antipyretics because you know the dosage but the policy regardless of the level and the knowledge is not allowing the nurse to administer any drug which is not prescribed by the doctor, it requires you to call the doctor and sometimes you don't find them even on phone, it is a big challenge!”(PARTICIPANT 3)

Doctors power over nurses in clinical decision making

The participant expressed the feeling they were being commanded by doctors that affected their feeling about the profession. Nurses expressed the willing to change or challenge the status quo with the support of the institution's policies.

Participant noted:

“.... it is well known or allowed that medical doctors are the one having the final say on patient care, which is not good, because as a team we must have an equal say on patient care,. From this, the doctor is always giving order saying, do this! Act like this! This kind of commanding attitude in communication influence nurses decisions....” (PARTICIPANT 1)

Participants expressed the need to stop perpetuating the history of believing in doctors only and the bad perception about the nursing profession. One nurse explained that the society had obliterated the nurses' role in care. She noted:

“...the history of believing in doctor, doctor, doctor! And you think that everything is doctor, doctor, doctor! It has been like a wall or darkness that blocks nurses to feel their capacity of doing or intervene...” (PARTICIPANT 3)

Participant explained how the doctors' power over nurses, resulted in lack of job retention and low esteem of the nurses because of the negative perception of nursing.

“... This even causes some nurses to leave the profession because we don't have policy, guidelines that support our job and some nurses end up leaving the job because this profession is cheap and no one is valuing or defending what we are doing...” (PARTICIPANT 4)

Delayed patient care

The participant stated the consequences that ensued from the nurses' barrier in clinical decision making for patient care. Nurses had to sometimes wait for the doctor to act; this resulted in delayed patient care that negatively affected the quality of care and the image of nursing in general. One nurse lamented this delay as she explained the constraints and consequences of the policy:

“...Our job is delayed by waiting for the doctors, medications, lab exam... are delayed. And you are writing in the nursing note, explaining why you didn't give the medication on time which was not necessary, if we could decide. This is like a wall they have created for nurses....” (PARTICIPANT 2)

Yet another nurse explained how this unnecessarily tarnished the image of nursing:

“...the nurse took the vital signs and found that the patient had fever 39.5celcius degree and he needed paracetamol. The nurse moved around to look for the doctor to prescribe that drug because the pharmacy couldn't give any drug if it was not ordered by the doctor, can you imagine! That delay, the patient counts it on nurses because she is the one who took the temperature and sincerely it is not the nurse, it is the structure...” (PARTICIPANT 6)

4.4 CONCLUSION

This chapter dealt with the experiences of nurses who participated in the study, they were working in six services at Rwanda Military Hospital. The nurses' general experiences were highlighted, providing context for their lived experiences of CDM in patient care.

CHAPTER 5: DISCUSSION OF STUDY FINDINGS

5.1 INTRODUCTION

This chapter discusses the findings of this study. The purpose of this study was to explore nurses' clinical decision-making experience. The study had the following three research objectives: (1) To describe existing nursing clinical decision making guidelines for care process at Rwanda military hospital (2) To explore factors facilitating nursing clinical decision making at Rwanda military hospital and (3) To explore factors inhibiting nursing clinical decision making at Rwanda military hospital. The three themes and subthemes which emerged from the data are: (1) role ambiguity, (2) informal power of nurses to promote patient care, and (3) disempowering nature of policies were discussed with other studies previously conducted in the same area of interest.

5.2 DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

The findings of this study revealed that the participants were mainly females, that is, 6 of the 10 participants, while there were four male participants. These demographics were representative of nursing demographics in Rwanda. According to the national council of nurses and midwives statistics in April 2016, females remain the majority of all categories of nurses. It is historically known, nursing was considered as a profession related to women and mothers where they use their nature of caring to accomplish the caring aspect, this excluded mainly the men from doing nursing profession (Loughrey, 2008, p. 4). Similar findings were found in the study conducted in the United States of America by Budden et al, revealed that though the number of male nurses was doubling during the time of the study, these were not more than five to seven per cent of the total nursing population (Budden *et al.*, 2013, p. 4).

The current study revealed that the minimum age of the participants was 28, and the maximum was 56 years old. The experience varied from 2 to 36 years. This may be based on the fact that nurses generally joined the hospital after their advanced diploma level or bachelor's degree which in general they finish at the age of twenty four. The majority of the nurse who participated in this study had advanced diploma, six participants out of ten, which is in line with the education

system in Rwanda that started with secondary level and upgraded after the phasing out of the program in 2007 and the bachelor's level started later in 2006 (Mukamana, Uwiyeze and Sliney, 2015, p. 7).

5.3 NURSES' CLINICAL DECISION MAKING EXPERIENCE

The discussion of the nurses' experiences is directed by the three main themes that emerged from the data of the interviewed participant in this study which are: (1) role ambiguity; (2) informal power of nurses to promote patient care; and (3) disempowering nature of policies.

5.3.1 Existing nursing guideline for care process

The discussion of theme one has two sub-themes which are (1) frustration and Devaluing nursing work; (2) Unclear job description

The overall Role ambiguity

In this study, role ambiguity emerged as a theme describing the experience of nurses who were working at the bedside, rendering care to patients. This was worsened by an unclear job description in nursing and led to frustration and devaluing of the nurses' work.

Frustration and devaluing of nursing care have been observed in clinical settings (Paynton, 2009, p. 6). In this study, the nurses expressed the environment in which they exercise their profession as very frustrating and devaluing nursing care. They felt overwhelmed by their stressful and frustrating working environment, since they are the ones who are always present to the patients and they found themselves rendering emergency care even though the policies may have required them to wait for the medical doctor. The nurses did this as risk taking for a good cause, because they were competent in their practices and they assisted the patients successfully. For the successful interventions, the medical doctor would sign to endorse and own it alone and there is no way this is shared by the nurse and the medical doctor. It was only when there would be failure that it would be attributed to the nurses' acts before the medical doctor gave an order. This lack of nursing professional freedom resulted in frustration and a feeling of devalued by the co-workers and leadership.

This is supported by the study done in Canada (Mckay and Narasimhan, 2012, p. 53) which revealed that nursing work, skills, and educational level were devalued by a co-worker and institutional leaders in a clinical settings, where they were supposed to keep quiet on whatever happened but ensure that ward rounds, documentation, and other non- nursing tasks were smoothly and efficiently done. Nurses were considered as housekeepers and they were seen as inferior to doctors and paramedical personnel in health settings, this resulted in feeling devalued and led to frustration and loss of professional compassion.

The findings of the study done in Iran reinforced those of other researchers. It was found that Iranian nurses had frustration related to the lack of recognition of their work in health settings, while they believed in their knowledge, skills, and attitudes to assume their nursing responsibility effectively, doctors continued to have final authority on nursing decisions (Hagbaghery, Salsali and Ahmadi, 2011, pp. 17–18).

Unclear job description in the work place for nurses was expressed and perceived by the participants a threatening factor which affected negatively their clinical decisions on daily patients care. Nurses had multiple responsibilities that are known and unknown in their daily activities as opposed to other health care providers who worked under clear and known job description. The participants reported the role of the undefined nursing scope of practice (official gazette no special of 24/12/2010) on this issue, where they expected the NCNM to define well the scope of practice in line with their level of education, knowledge, as skills as reference to which the leaders in health care settings refer to and define the job description of a nurse even before recruitment.

These findings are consistent with the study done in Iran by Hagbaghery 2011 which recommended that nurses had to increase non nursing duties that affected their relationship with the patient and result in task orientated than patient orientated, thus, change in nurse's perceived professional roles and the roles that the institution expected to them (Hagbaghery et al., 2011, p. 12). It was disappointing to find that the participants in this study did not appreciate the way their role was overlapped within other professionals' role in the hospital. But surprisingly, none one care about working on the job description or the scope of practice, instead, they blamed them for being ineffective at work.

Similarly, in the study done in Canada (White *et al.*, 2008) revealed that their roles were overlapped with other's professional roles and there was lack of differentiations on their roles with other health professionals, which resulted in the lack of acknowledgement of nurses' contribution, devaluing their work, and under or overutilization in other areas. It was recommended that the scope of practice may highlight the autonomy in decision making so that practitioners are able to judge their competence in such situation where their job description is not clear.

A well-defined scope of practice and clear job description are major guidelines in practice that facilitate not only the decision making process but also increase workers performance and quality of care. In addition, the study done in Tanzania by Halima 2014 on the impact of job description on employee's performance revealed that unclear job description resulted in the poor participation of workers in decision making process and underutilization of skills and knowledge of employees. It was found that 38% of the participants did not have a well defined job description that was in line with their responsibilities and qualification, while, 97% of the participants mentioned that they needed clear job descriptions which indicate working conditions (Halima Ramadhan Taufik, 2014, p. 5).

5.3.2 Factors facilitating nurses' clinical decision making

The discussion of theme two has two sub-themes which are (1) team work, advocacy for patient care; (2) Knowledge, experience and collaboration

Informal power of nurses to promote patient care

It emerged from this study that nurses clinical decision making facilitated by the informal power the nurse had over the patient care. This power was related to the attachment and the willing to save the lives of the patient in critical conditions, the information on the patient history pushed them to decide beyond the policy about patient care. The participant explained how their knowledge, experience, collaboration and team work promoted patient advocacy, especially in emergency situations.

The finding from this study showed that the nurses have proper knowledge, skills and attitudes they gained from school and experience, which enabled them to make proper judgment and decisions on specific patient care, without causing any harm. These findings

are confirmed by Mckay and Narasimhan who noted that since the introduction of formal nursing school, nursing has changed from vocation to profession whereby nurses are equipped with strong knowledge and skills to practice clinical decision regarding patient care with full autonomy (Mckay and Narasimhan, 2012, p. 4). This study concord with other evidences which showed that although the power is not something tangible and it is believed that knowledge is power, and once one is holding this power can influence the way of working and obtain effective outcome from the task accomplished (Hughes, 2008, p. 10).

It was reported in this study that experience was the best facilitating factor to nurses in clinical decision making. The participants expressed that they are experienced in nursing field and this shaped their influence on patient care. A study conducted in Landon agreed that clinical experience serves as a reference in clinical decision making skills and has a positive impact on the patient outcome (Traynor, Boland and Buus, 2010). This was the case in the current study, whereby the nurses revealed that the ideas of most experienced nurses were accepted and respected despite their level of education and position. Consequently, they were able to advocate for the patient who had complicated or critical conditions for better management.

In contrast, the study done by Hughes 2008 noted that there is no correlation between experience and positive outcome, where they argue that experience is not expertise and stressed that after three to five years one's experience is no longer significant. Furthermore, the rapid evolution of science and change in disease require experienced nurses to refresh or update their knowledge for their previous experience to be applicable to the current situation (Hughes, 2008, p. 20).

Team work in this study was expressed in this study as a weapon to the success of nursing care. The participants explained that the type of their profession and their working environment required team work. The participants felt obliged to work in teams so that they were assured that what they decided is right for the patient care. This resonates with findings of the study done in Canada, which noted that team work in nursing practice result in positive patient care outcome and help the staff to learn from each other as they develop their capacity (Brown *et al.*, 2011, pp. 4–5).

5.3.3 Factors inhibiting/barriers to clinical decision making

The discussion of theme three has three sub-themes which are (1) Discrepancy of autonomy in decision making among nurses at different levels of health system ; (2) Doctors power over nurses in clinical decision making ; (3) Delayed patient care.

Disempowering nature of policies

The findings of this study showed that mainly nurses' clinical decision making were inhibited by the policy (no: CLIN CC 021/2014) that didn't allow them to do most of the intervention without doctor's order. This is the context of referral hospital where the study took place. Participants in this study reported that this concern was shared by even those who had worked in other health care delivery settings, either than the setting in the study complained about it. This resulted in discrepancy of autonomy in decision making among nurses at different levels of the health system, doctors power over nurses in clinical decision making, and delayed patient care.

This study revealed that there was a discrepancy in autonomy in decision making among nurses in Rwanda at different levels of a health system. Some of the participants explained how they were autonomous at health centers, which is the lowest level in the health system in Rwanda. The amount of clinical decisions varied from the health center to the hospital. The minimum package prescribes what should be done by health care workers at each health care level. At Health Center level, the nurses' clinical decisions were high whereby they were working according to the minimum package of activities designed by the Ministry of Health. However, once hired at district or referral hospitals, the nurses could no longer carry that autonomy on the same activities that they undertaking at Health Center level.

The more nurses increase their level of education and the more they moved from lower levels of to the higher levels of the health system, the less they worked autonomously, and the more they started to depend on doctor's order as stated by the institutional policy. These findings are consistent with the study done in Australia, that noted that there was a concern in line with decision making warrant between medical doctors and nurses whereby they discrepancy

between current decision making situation and desired level of decision making among nurses (Hoffman *et al.*, 2004, p. 7).

The participants expressed the paradoxical nature of the policies in the Rwandan context as a big barrier that inhibited quality care and they felt that this needed to be addressed by policy makers. They believed that policy makers could consider the current situation of the nursing profession, in terms of educational level the content delivered, and experience in designing the policy in a way that allows the nurses to practice independently. This is particular important given that nurses comprise the biggest number in the health sector. A study done in Nigeria, has stated that doctor-nurse game is not over, referring to the power of doctors over the nurses regardless the professionalism of nursing (Olajide, Asuzu and Obembe, 2015, pp. 6–8). This current study revealed that doctors exercise power over nurses in clinical decision making during patient care and the participant expressed the frustration caused by this dominant and monopolizing attitude of a doctor in clinical decision making.

The findings were congruent with other several studies that showed how nursing status was redefined and formal university qualifications were introduced. However, the traditional relationship between doctor and nurses continued, whereby hierarchically doctors were superior to nurses. Additionally, the society attributed a great importance to doctors in patient care whereas nurses were seen as helpers or followers of medical doctors during patient care (Mckay and Narasimhan, 2012, p. 24; Min Wu *et al.*, 2016, p. 10) . The participants in this study expressed the needs to challenge and change this status quo, as each profession need to work independently but in a collaborative manner for better patient care. These findings reinforce those of other studies which stated that no profession can render and fulfill suitable and qualified services without having autonomy of controlling their own practices (White *et al.*, 2008, p. 8; Hagbaghery, Salsali and Ahmadi, 2011, p. 17).

The delayed patient care was revealed in the current study, as a consequence of the disempowering policies, power over nurses in clinical decision making. The participant noted that while waiting for the doctors to initiate the patient care as stated in the policy, they delayed timely drug administration, laboratory examination, among many other tasks. Moreover, this delay was always blamed on nurses. This finding is in line with the findings of a study by Hoffman, which reported that nurses were unable to change the status of the patient care because of the lack of autonomy in decision making within the hospital system

(Hoffman *et al.*, 2004, p. 21). Several studies that have echoed these findings noted that the lack of autonomy in patient care resulted in poor patient outcome, as they believed that power of decision was the mean to better and timely patient care (Hagbaghery *et al.*, 2011, p. 12; Dalal T. Akel, 2015, p. 115).

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

Clinical decision making experience among nurses at Rwanda Military Hospital was explored in order to identify the barriers and facilitators in this regard. Experienced barriers were embedded in unclear nursing guidelines. In this study, three main themes emerged from the data as follow: (1) role ambiguity (2) informal power of nurses to promote patient care and (3) disempowering nature of policies.

In this study, the examination of the existing nursing guidelines revealed that nurses faced role ambiguity as a result of unclear job description and scope of practice. The frustration and devaluing of nursing from role ambiguity and loss of professional autonomy characterized the nursing work and affected nursing practice.

The findings demonstrated that nurses were facilitated by the informal power they have in the promotion of patient care. This was supported by nurses' team work, their knowledge and experience, which dominated other facilitating factors in clinical decision making.

In this study, it was found that nurses faced many barriers in their clinical decision making processes. The main barrier was the policy that limited them to initiate most of the interventions without doctor's order. This disempowering policy resulted in a discrepancy of autonomy in decision making among nurses at different levels of the health system. A reversed cycle of nurses' professional promotion was observed. The more nurses upgraded themselves in their education levels, and the more they moved from health center to hospital levels, the less they exercised their profession autonomously, the more they depended on medical doctors. Doctors' power over nurses in clinical decision making, at the same time delayed patient care and/or nurses took proper decisions, though not recognized, which discouraged them and reinforced the continuous frustration.

6.2 RECOMMENDATIONS

6.2.1 For nursing practice

This study recommends the review of policy for nursing profession, nursing scope of practice and job description throughout different levels of health care system by the Nursing Council and nurses from all specialties need to be involved. This exercise should take into consideration the role of the nurse in an African setting such as Rwanda where nurses are the backbone of the health care system. Policies should indeed take into consideration the settings in which nurses are embedded looking at nurse patient ratios and doctor patient ratios. It should also consider the level of education of nurse and the content they are given. This should be framed in light of the ambitious SDG goal to achieve universal care for all.

To address the issue of medical doctors' power over nurses, this study recommends reviewing the line of command where nurses should supervise their fellow nurses and put in place the collaboration framework between nurses and medical doctors.

6.2.2 For nursing research

As clinical decision making area seems to be rarely studied and it is a relatively new concept in Rwandan health sector, more with regards to this practice needs to be researched. As the study was conducted at only one referral hospital, therefore, it is recommended that future studies be conducted at other geographically dispersed private and public hospitals and health centers. Separately, in the current study participants reported some effect of clinical decision making on the quality of patient care; it is recommended that future studies explore the effect of clinical decision making on quality care. There is a need to do a wider study on task that nurses are doing but not allowed by the policy and their impact on patient care outcome.

6.2.3 For nursing education

Considering nurses concerns and uncertainties about their scope of practice, job description, and the importance of clinical decision making in practice. It is recommended to include CDM into the curriculum of nurses at all levels of education. Incorporate CDM topic on the agenda of continuous professional development in Rwanda. It is also recommended to provide continuing and accessible education about the scope of practice and practitioner

accountability that encourage them to more empowered and independent practice in clinical decision making.

6.2.4 For nursing administration

As data from this research indicated, organizational policy and unclear job description are important considerations that inhibits nurses' clinical decision making. The study found the need to redesign the existing scope of practice and job description by the NCNM which could help in balancing medical, nursing and administration role ambiguity and its consequences. The policy maker should also involve nurses in the process of policy making as the key players in the review and implementation of those policies.

The study recommends that in order to redress the situation and increase performance related to job description, RMH should formulate effective job descriptions, which would include job specification, job qualification, working condition and responsibilities of the employees.

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APPENDICES

APPENDIX 1: INTERVIEW GUIDE

A) Demographic data

1. Year of Birth: _____

2. Gender: Female / Male

3. Education /completed:

RN Diploma/ RPN Diploma Baccalaureate /Degree /Master's Degree/

4. Years of experience as a registered nurse _____

If less than one year experience as a registered nurse, indicate number of months/

7. Current employment status: Full time / Part time

8. Years of experience in current ward as a registered nurse

B) Interview Questions

1. Do you have any existing frameworks that guide your current clinical decision making in nursing care process? If so which one and how?

2. Please can you tell me about your most recent experience in clinical decision making during nursing process?

3. Did you use any nursing skills (framework) to guide your clinical decision? If so which one and how?

4. What were the factors that facilitated your clinical decision making during nursing process?

5. What were the factors that inhibited your clinical decision making during nursing process?

6. Do you have any recommendations for the nursing clinical decision making in the future?

APPENDIX 2: INFORMATION DOCUMENT

Dear Participant,

I am Ugirase Sibylle, a student in Master of Science Degree in nursing, track of Education, Leadership and Management within the College of Medicine and Health Sciences, School of Nursing and Midwifery, Department of General Nursing. I am interested in doing a study on exploring nurses' clinical decision making experience in Rwanda Military Hospital. The aim of the study is to capture the lived experiences of nurses' in clinical decision making during patient care. Your participation will be highly appreciated in order to make my study successful.

Terms and conditions of the agreement: Should you agree to participate in the study please note the following; your participation is voluntarily and the interview will be conducted with respect for your privacy. Your information will be treated with confidentiality and will remain anonymous (i.e. your name will not be mentioned to anyone).

During the study you are free to withdraw from the study anytime you feel uncomfortable, the interview will be audio-recorded for analysis and all information will be kept secure by the researcher at all times.

If you agree to participate in this research study please find attached with a consent form.

If you have any questions, comments, or suggestions please feel free to contact me at + 250 0788578277 or on my e-mail: usibylles@gmail.com

UGIRASE Sibylle

UR-CMHS Student in research

SUPERVISOR: Dr. NDABARORA Eleazar

CO- SUPERVISOR: Professor SHEILA Shaibu

APPENDIX 3: INFORMED CONSENT FORM

I, (Full names of participant) hereby consent to participate in this study, I confirm that I have read and understood the information of this study. I understand the purpose of this study is to explore nurses' clinical decision making experience in Rwanda Military Hospital. I have had the opportunity to question about the study with clear answer. My participation in this research is voluntary.

I understand that I have the right to withdraw from this study at any time without giving any reason.

Name of subject

Date

Signature

APPENDIX 4: LETTER OF PERMISSION

UGIRASE SIBYLLE

UNIVERSITY OF RWANDA/CMHS

E-mail: usibylles@gmail.com

Tel: +250 788 578277

February 2nd, 2017

To: The Commandant of Rwanda Military Hospital, Kigali-Rwanda

RE: Request for permission to conduct research

Dear Sir,

I am UGIRASE Sibylle, a student in Master of Sciences in nursing. University of Rwanda, College of Medicine and Health Sciences, track of Education, Leadership and Management whereby I am required to do and submit a research dissertation to fulfill this program.

It is in this regard, I am requesting the permission to conduct the research in the hospital, under your authority. The research project is titled “**EXPLORING NURSES CLINICAL DECISION MAKING AT RWANDA MILITARY HOSPITAL**” Upon completion of the study; I undertake to share with you the result from the study.

I have attached the copy of an ethical clearance certificate issued by IRB, the recommendation letter from the University and a full protocol of the proposal.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

UGIRASE Sibylle, RN

Supervisor: Dr. Ndabarora Eleazar

APPENDIX 5: ETHICAL CLEARANCE



UNIVERSITY OF
RWANDA

COLLEGE OF MEDICINE AND HEALTH SCIENCES

CMHS INSTITUTIONAL REVIEW BOARD (IRB)

Kigali, 09/01/2017
Ref: CMHS/IRB/028/2017

UGIRASE Sibylle
School of Nursing and Midwifery , CMHS, UR

Dear UGIRASE Sibylle

RE: ETHICAL CLEARANCE

Reference is made to your application for ethical clearance for the study entitled *"Exploring Nurses Clinical Decision Making Experience In Rwanda Military Hospital "*

Having reviewed your protocol and found it satisfying the ethical requirements, your study is hereby granted ethical clearance. The ethical clearance is valid for one year starting from the date it is issued and shall be renewed on request. You will be required to submit the progress report and any major changes made in the proposal during the implementation stage. In addition, at the end, the IRB shall need to be given the final report of your study.

We wish you success in this important study.

for Professor Kato J. NJUNWA
Chairperson Institutional Review Board,
College of Medicine and Health Sciences, UR

Cc:

- Principal College of Medicine and Health Sciences, UR
- University Director of Research and Postgraduate studies, UR

A handwritten signature in blue ink over a circular official stamp of the CMHS Institutional Review Board. The stamp contains the text 'COLLEGE OF MEDICINE AND HEALTH SCIENCES CMHS' and 'INSTITUTIONAL REVIEW BOARD'.

APPENDIX6: REQUEST LETTER TO COLLECT DATA



UNIVERSITY OF
RWANDA

COLLEGE OF MEDICINE AND HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

Kigali, on 30 / 01 /2017

Ref. No: 79 / UR-CMHS/SoNM/17

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

Re: Request to collect data

Referring to the above subject, I am requesting for permission for UGIRASE Sibylle, a final year student in the Masters of Science in Nursing at the University of Rwanda/College of Medicine and Health Science to collect data for his/her research dissertation entitled "Exploring Nurses Clinical Decision Making Experience at Rwanda Military Hospital"

This exercise that is going to take a period of 2 months starting from 13th February 2017 to 12th April 2017 will be done at Rwanda Military Hospital.

We are looking forward for your usual cooperation.

Sincerely,

A handwritten signature in blue ink, appearing to be 'Dr. Donatilla Mukamana'.

Dr. Donatilla MUKAMANA, RN, PhD
Dean, School of Nursing and Midwifery
College of Medicine and Health Sciences



Email: schoolofnursingandmidwifery@ur.ac.rw, P.O.Box: 3286 Kigali-Rwanda, Website: www.ur.ac.rw

APPENDIX 7: RMH AUTHORIZATION LETTER



February 3rd, 2017

Ref.: EC/ RMH/ 107/ 2017

REVIEW APPROVAL NOTICE

Dear UGIRASE Sibylle
UNIVERSITY OF RWANDA

Your research project: **“Exploring Nurses Clinical Decision Making Experience in Rwanda Military Hospital”**.

With respect to your application for ethical approval to conduct the above stated study at Rwanda Military Hospital, I am pleased to confirm that RMH Ethics Committee has approved your study. This approval lasts for a period of **12 months** from the date of this notice, and after which, you will be required to seek another approval if the study is not yet completed.

You are welcome to seek other support or report any other study related matter to the Research office at Rwanda Military Hospital during the period of approval.

You will be required to submit the progress report and any major changes made in the proposal during the implementation stage. In addition, you are required to present the results of your study to RMH Ethics Committee before publication.

Sincerely,



Dr. Pacifique Mugenzi
Lieutenant Colonel
Co Chair: Rwanda Military Hospital Research Ethics Committee

Email: Info@rwandamilitaryhospital.rw
Tel: 0252586420

P.o Box: 3377RWANDA MILITARY HOSPITAL